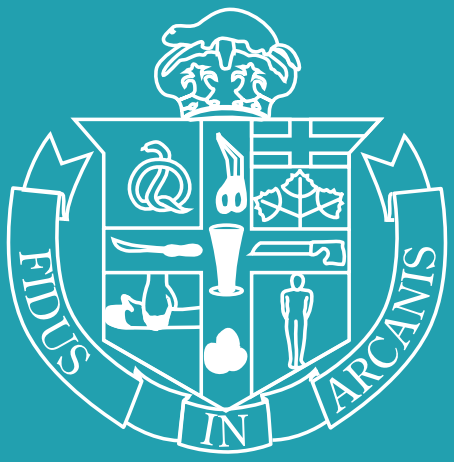
The College of Physicians and Surgeons of Ontario

Meeting of Council



December 6 & 7, 2018

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 December 6 and Friday December 7, 2018 in the Council Chamber of the College, at 80 College Street, Toronto, Ontario.

The meeting will convene at 9:00 a.m. on Thursday December 6, 2018.

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

November 8, 2018

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

MEETING OF COUNCIL

December 6 & 7, 2018

Council Chamber, 3rd Floor, 80 College Street, Toronto

December 6, 2018

CALL TO ORDER

9:00 President's Announcements

GROUP PHOTO

9:10 Council Meeting Minutes of September 7, 2018 1

Executive Committee's Report to Council, May – November, 2018 11

REGISTRAR/CEO REPORT

9:10 Registrar/CEO Report 15

- ***Right Touch Regulation***
- ***KPIs – Key Performance Indicators***

10:10 Medical Assistance in Dying (MAID): Federal Reporting Requirements and Policy Update 36

- ***For Decision***

Federal regulations for the monitoring of medical assistance in dying (MAID) came into force on November 1, 2018. These regulations require physicians to report specified information directly to Health Canada pertaining to MAID. To ensure the College continues to provide accurate and timely guidance on MAID to the profession, updates to the *Medical Assistance in Dying* policy are proposed to reflect the federal regulations. Additionally, policy updates are proposed to address areas identified by the Office of the Chief Coroner (the "OCC") and the Ministry of Health and Long-Term Care (the "MOHLTC") as warranting further clarification.

Council is provided with a brief summary of the federal monitoring regulations, along with an overview of proposed policy updates. Council is asked whether it approves the revised *Medical Assistance in Dying* policy as a policy of the College.

BREAK at 10:30 am

10:45 Policy Redesign – Proposed Approach 58

- ***For Decision***

The 2018-2019 Corporate Plan includes commitments to redesign College policies to be more clear and concise with a focus on enhancing their utility for physicians, as well as to evaluate whether a naming convention other than 'policy' might be more intuitive to the profession.

Council is provided with an overview of the work undertaken to date and the proposed approach that has been developed to redesigning policy. Council is asked for feedback on the proposed approach and whether it recommends adopting this approach. Council is also asked for feedback regarding the adoption of a new naming convention, to help inform ongoing work and future decision-making.

11:45 Approval to Rescind the Following Three Policies: (1) Anabolic Steroids, Substances and Methods Prohibited in Sport; (2) Female Genital Cutting (Mutilation); and (3) Fetal Ultrasound for Non-Medical Reasons 78

- ***For Decision***

The 2018-2019 Corporate Plan includes a commitment to evaluate all existing College policies in order to identify those that are no longer required. The Council is provided with an overview of the evaluation undertaken and asked to approve the rescission of the aforementioned policies.

LUNCH BREAK at NOON

1:00 IN-CAMERA SESSION

1:30 GUEST SPEAKER

EDUCATION PRESENTATION: Cultural Competency/Truth and Reconciliation

Guest Speaker: ***George Couchie***

BREAK at 2:30 pm

2:45 CPSO Governance Review - Recommendations for Governance Change 87

- ***For Decision***

Council adopted the CNO's Governance Principles and supported the Governance Review Working Group's (GRWG) general recommendations for legislative and non-legislative governance change (within CPSO's control) in September. The GRWG committed to refining the recommendations and bringing them back to December Council for decision. Council is asked whether it supports the GRWG's final recommendations for governance change.

3:45 Register By-law Amendments (circulated in September) 94

- ***For Decision***

Council is asked whether it approves the amendments to the General By-law relating to the public register and mandatory reporting.

3:50 INFORMATION ITEMS

Annual Committee Reports

ADJOURNMENT DAY 1

December 7, 2018

CALL TO ORDER

9:00 President's Announcements

9:05 Report of the Finance and Audit Committee..... 163

- ***For Decision***

The Finance and Audit Committee is recommending to Council the approval of the 2019 Budget, as presented with no increase in the annual fee. This includes a 2.2% increase to per diems. The Committee is further recommending to Council the approval of the proposed amendment to the Indemnity General By-Law and amendment to the Council and Committee Remuneration By-law No. 123.

9:35

PRESIDENT'S TOPICS

Presidential Address: Dr. Steven Bodley

Induction of New President: Dr. Peeter Poldre

BREAK at 10:05

10:20 CPSO Governance Committee Report..... 182

FOR DISCUSSION:

1. 2018 Council Performance Assessment Results

FOR DECISION:

2. Proposed By-law Amendments to Facilitate Public Member Presidents
3. 2018-2019 Governance Committee Election
3. Committee Membership Appointments for 2018-2019

FOR INFORMATION:

4. Completion of Annual Declaration of Adherence Form

11:30 INFORMATION ITEMS

CLOSING REMARKS

ADJOURNMENT DAY 2

DRAFT **PROCEEDINGS OF THE**
MEETING OF COUNCIL
OF
THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
September 7, 2018

Attendees:

Dr. Steven Bodley (President)
Dr. Philip Berger
Dr. Brenda Copps
Ms. Lynne Cram
Mr. Harry Erlichman
Ms. Joan Fisk
Mr. Pierre Giroux
Dr. Rob Gratton
Dr. Deborah Hellyer
Dr. Paul Hendry
Mr. Mehdi Kanji
Ms. Catherine Kerr
Major A. Khalifa
Mr. John Langs
Dr. Haidar Mahmoud
Mr. Paul Malette
Ms. Ellen Mary Mills
Ms. Judy Mintz
Dr. Akbar Panju
Mr. Peter Pielsticker
Dr. Dennis Pitt
Dr. Judith Plante
Dr. Peeter Poldre
Ms. Joan Powell
Dr. John Rapin
Dr. Jerry Rosenblum
Dr. David Rouselle
Dr. Patrick Safieh
Dr. Elizabeth Samson
Ms. Gerry Sparrow
Dr. Andrew Turner
Dr. Scott Wooder

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

Regrets: Dr. Barbara Lent

CALL TO ORDER

President's Announcements

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

Council Meeting Minutes of May 24 and 25, 2018:

01-C-09-2018

It is moved by Dr. Patrick Safieh and seconded by Ms. Joan Powell that:

The Council accepts the minutes of the meeting of the Council held on May 25, 2018 with the following corrections:

- Correction of Ms. Ellen Mary Mills' name on page 6 and,

- Replace the minutes concerning the motion 13-C-05-2018: 2019 Executive Committee Election, with the following:

  13-C-05-2018

  It is moved by Ms. Joan Powell and seconded by Ms. Joan Fisk that:

  The Council appoints: Dr. Peeter Poldre (as President), Dr. Brenda Copps (as Vice President), Dr. Akbar Panju (as physician member), Ms. Lynne Cram (as public member), Mr. Peter Pielsticker (as public member), and Dr. Steven Bodley (as Past President), to the Executive Committee for the year that commences with the adjournment of the annual general meeting of Council in December 2018.

  CARRIED

REGISTRAR'S REPORT

In her first report to Council, Dr. Nancy Whitmore, Registrar and CEO, discussed two high priority areas for the College - the handling of complaints, and the enhancement and modernization of our communication platform (a copy of which forms **Appendix "A"** to the minutes of this meeting).

Amendments to Register By-Laws

02-C-09-2018

It is moved by Mr. Mehdi Kanji and seconded by Dr. Jerry Rosenblum that:

The Council of the College of Physicians and Surgeons of Ontario proposes to make the following By-law No. 120, after circulation to stakeholders:

By-law No. 120

1. **Paragraph 49(1)19 of By-law No. 1 (the General By-Law) is revoked and the following is substituted:**

    19. Where there has been a finding of an offence against a member under the *Health Insurance Act*, made on or after June 1, 2015, and if the finding and/or appeal is known to the College:

    (i) a brief summary of the finding;

    (ii) a brief summary of the sentence;

    (iii) where the finding is under appeal, a notation that it is under appeal, until the appeal is finally disposed of; and

    (iv) the dates of (i)-(iii), if known to the College,

    except if one or more of the conditions set out in section 1(2) of Ontario Regulation 261/18 have been satisfied.

2. **Paragraph 49(1)20 of By-law No. 1 (the General By-Law) is revoked and the following is substituted:**

    20. Any currently existing conditions of release following a charge for a *Health Insurance Act* offence, or subsequent to a finding of a *Health Insurance Act* offence and pending appeal, or any variations to those conditions, when known to the College.

3. **Paragraphs 49(1)21 and 23 of By-law No. 1 (the General By-law) are revoked and the following are substituted:**

    21. In respect of a decision of the Inquiries, Complaints and Reports Committee that includes a disposition of a caution-in-person, if the complaint that led to the decision, or, in a case where there is no

complaint, the first appointment of investigators in the file, is dated on or after January 1, 2015, a summary of that decision, and, where applicable, a notation that the decision has been appealed or reviewed.

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

4. Paragraph 49(1)26 of By-law No. 1 (the General By-Law) is revoked and the following is substituted:

26. Where a member has been charged with an offence under the *Health Insurance Act*, and the charge is outstanding and is known to the College, the fact and content of the charge and, if known to the College, the date and place of the charge.

5. Paragraphs 49(1)27 and 28 of By-law No. 1 (the General By-Law) are revoked.

6. Paragraph 51(1)(d) of By-law No. 1 (the General By-Law) is revoked.

CARRIED

Delegation of the Registrar's Powers

03-C-09-2018

It is moved by Mr. John Langs and seconded by Major A. Khalifa that:

The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 121:

By-law No. 121

The general by-law, which is By-Law No. 1, is amended by adding the following heading and subsection:

Delegation

1b. The Registrar may delegate any of his or her powers or duties to other officers, agents, or employees of the College.

CARRIED

Revised Opioid Strategy: 2018/'19

Council considered a revised opioid strategy, set out in **Appendix "B"** to these minutes.

04-C-09-2018

It is moved by Ms. Joan Fisk and seconded by Ms. Lynne Cram that:

Council approves the revised opioid strategy for 2018-19 (a copy of which forms Appendix "B" to the minutes of this meeting).

CARRIED

STRATEGIC PLAN

Maureen Boon, Director, Strategy, presented to Council on strategic planning and process, given that the current plan ends in 2018. The presentation is attached as **Appendix "C"** to these minutes. Council agreed, by show of hands, with the objective set out in the presentation:

> To create a clear and compelling strategic plan that will balance focus on core regulatory responsibilities with an ability to respond to the changing environment in order to best serve the public.

Council further approved, by a show of hands, the proposed plan and timelines set out in Appendix C.

Further discussion will take place at December's Council meeting.

COUNCIL AWARD WINNER

Ms. Joan Powell presented the Council Award to Dr. Jason Malinowski of Barry's Bay, Ontario.

Motion to Go In Camera

5-C-09-2018

It is moved by Dr. David Rouselle and seconded by Dr. Jerry Rosenblum that:

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

CARRIED

IN CAMERA

Council entered into an in camera session at 11:30 a.m. and returned to open session at 11:40 a.m.

GOVERNANCE REVIEW

Council continues to move forward with discussions about making governance change to the College. Council supported the following governance principles: Accountability, Adaptability, Competence, Diversity, Independence, Integrity and Transparency.

Council also considered and was supportive of preliminary recommendations for governance reform (those that could be made without legislative change and those that could not). Council will consider recommendations for governance reform in December.

06-C-09-2018

It is moved by Dr. Elizabeth Samson and seconded by Mr. John Langs that:

Council supports adopting the College of Nurses of Ontario's governance principles (a copy of which forms Appendix "D" to the minutes of this meeting).

CARRIED

GUEST SPEAKER PRESENTATION
ANNE COGHLAN – VISION 2020 UPDATE

Anne Coghlan, Registrar and CEO of the College of Nurses of Ontario, provided Council with an update on the status of the CNO's efforts to help realize governance change (a copy of which forms **Appendix "E"** to the minutes of this meeting).

GOVERNANCE COMMITTEE REPORT

Election of 2018/2019 Academic Representatives on Council

Council voted to accept the following three academic representatives for 2018-2019 Councilors, as proposed by the Academic Advisory Committee: Dr. Paul Hendry from the University of Ottawa, Dr. Akbar Panju from McMaster University and Dr. Robert Smith from the Northern Ontario School of Medicine.

Chair Appointments for the Next Council Year

6-C-09-2018

It is moved by Dr. Akbar Panju and seconded by Ms. Ellen Mary Mills that:

The Council appoints the following committee members as chairs, co-chairs or vice chairs of the following committees as of the close of the annual general meeting of Council in December 2018:

Council Award Selection Committee:
Dr. Steven Bodley

Discipline Committee:
Dr. Melinda Davie
Dr. Eric Stanton

Education Committee:
Dr. Akbar Panju

Executive Committee:
Dr. Peeter Poldre

Finance and Audit Committee:
Mr. Peter Pielsticker

Fitness to Practise Committee:
Dr. Steven Bodley

Governance Committee:
Dr. Steven Bodley

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:
Dr. Jerry Rosenblum

Patient Relations Committee:
Ms. Lisa McCool-Philbin

Premises Inspection Committee:
Dr. Dennis Pitt

Quality Assurance Committee:
Dr. Hugh Kendall
Dr. Deborah Robertson
Dr. Meredith MacKenzie, Vice Chair

Registration Committee:
Dr. Akbar Panju

CARRIED

MEMBERS TOPICS

ITEMS FOR INFORMATION

1. College Oversight of Fertility Services
2. Policy Report
3. Discipline Committee – Report of Complete Cases
4. 2019 Council and Executive Committee Meeting Dates

ADJOURNMENT

As there was no further business, the President adjourned the meeting at 3:30 p.m.

_____
Dr. Steven Bodley, President

_____
Executive Office Recording Secretary

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 2018

TOPIC: Executive Committee's Report to Council
May – November 2018
In Accordance with Section 12 HPPC

FOR INFORMATION

April 24, 2018 Executive Committee Meeting

1. Physician Assistants

The Executive Committee reviewed the College's proposed response to the Minister of Health's request that the College develop a proposal for the direct oversight of Physician Assistants (PAs). The Minister, Dr. Helena Jaczek, has directed that the College proposal include the establishment of a new class of members and a registry.

The College's response emphasizes that the full regulation of PAs by the College requires significant additional elements beyond the creation of a new class of membership and a mandatory registry, as proposed by the Minister. These additional elements, which would each require substantial time and effort to put in place, include, but are not limited to:

- A clearly defined scope of practice for PAs;
- Title protection;
- Entry to practice (registration) requirements, including out of province requirements and criminal records checks;
- Continuing education requirements; and
- Quality assurance oversight

Given the scope of the work that would be involved, the draft response emphasizes that such an undertaking would take several years, and require both significant legislative change, as well as broad and ongoing stakeholder collaboration. The College response states that we are pleased to work with the Ministry towards the objective of direct oversight of PAs and suggests the creation of a joint MOH/CPSO table, separate from the PA Integration Working Group, with confirmed objectives and an implementation timeline.

The Executive Committee was supportive of sending the response, as drafted.

9. Committee Appointments

The Executive Committee appointed Drs. Gil Faclier, Val Rachlis, Dori Seccareccia , and Anne Walsh to the Inquiries, Complaints and Reports Committee, and Dr. Mark Mensour to the Premises Inspection Committee

June 19, 2018 Executive Committee Meeting

4. Governance Committee Report

The Executive Committee appointed Dr. Andrew Browning to the Premises Inspection Committee and Dr. Angela Wang to the Patient Relations Committee.

The Executive Committee appointed Dr. Eric Stanton as Co-Chair of the Discipline Committee.

7. Consultation Request: RN Prescribing

The College of Nurses of Ontario (CNO) recently launched a consultation related to prescribing by Registered Nurses. A review of the consultation materials did not reveal any negative implications for patient safety. The College's informal response provided suggestions and constructive comments to enhance clarity and precision of language.

8. College of Registered Psychotherapists: Draft Policy

The College of Registered Psychotherapists of Ontario (CRPO) recently consulted on a draft policy relating to sexual contact with former patients, which will extend the definition of a patient to five years following the termination of the provider-physician relationship. The CPSO provided a response to the CRPO to express support of the draft policy and signal alignment between the CPSO and CRPO on this issue.

9. College of Registered Psychotherapists of Ontario – Draft Regulation on Categories of Prescribed Therapies Involving the Practice of Psychotherapy

The College of Registered Psychotherapists of Ontario (CRPO) is consulting on a draft regulation prescribing therapies involving the practice of psychotherapy. The CPSO did

not identify any concerns with respect to patient safety and decided not to provide a response.

11. Changing Scope of Practice – Emergency Medicine in Rural Communities

Since the CPSO released its "Expectations of Physicians Not Certified in Emergency Medicine Intending to Include Emergency Medicine as Part of Their Rural Practice – Changing Scope of Practice Process" document for physicians who wish to change their scope of practice to include emergency medicine in rural communities, the College of Family Physicians of Canada and the CPSO have continued to communicate regularly. As a result of these conversations, and the feedback of many engaged family physicians from across Ontario, we have identified opportunities to further strengthen our respective requirements.

The CPSO has amended its expectations document to recognize the experience family physicians receive in urban emergency departments as meeting the necessary criteria to include emergency medicine in a rural practice; including new graduates of a family medicine residency program. This change will support expected standards of care for Ontario patients, while also eliminating unnecessary hurdles to physician recruitment in rural and remote communities.

In support of the role the CFPC plays in graduating and certifying family physicians, the CFPC has indicated that it will continue to review the emergency and acute care components of accredited residency programs to ensure that family physicians have the training and experience they need to provide comprehensive care for all patients regardless of whether it is in an urban setting or in a remote or rural community.

<u>August 14, 2018 Executive Committee Meeting</u>

7. College Oversight of Fertility Services – Ministry Comments on Proposed Regulation Amendment

The Executive Committee was provided with several comments from the Ministry on the College's proposed Regulation Amendment that would allow the College to enter and inspect premises where fertility services are performed. The Ministry's proposed revisions do not impact the overall direction of the regulation. However, one key change is the Ministry is now of the view that hospitals be excluded from the framework's oversight scope. The College's proposed response was to accept this change.

The College, however, disagrees with the Ministry's assertion that the regulation does not need the broad authority to request information from premises offering fertility

services. The College believes such a power is required. For example, the change would give the College the appropriate authority to require collection of information in third party reports, such as data submitted by fertility clinics to the Better Outcomes Registry & Network (BORN). This power will also encourage facilities to use BORN, thereby enhancing patient care.

The Executive Committee directed that the College's responses to the Ministry's comments on the proposed regulation amendment on Fertility Services be forwarded to the Ministry.

October 2, 2018 Executive Committee Meeting

3. Reconciliation with Indigenous Peoples: A General Territorial Statement

After reviewing several options, the Executive Committee has identified a land acknowledgement statement to be read at the beginning of Council meetings. The December meeting of Council will open with the following statement:

We acknowledge the land we are meeting on is the traditional territory of many nations including the Mississaugas of the Credit, the Anishnabeg, the Chippewa, the Haudenosaunaee and the Wendat peoples and is now home to many diverse First Nations, Inuit and Métis peoples.

4. Council Meetings: Alternatives to In Person Participation

The Executive Committee considered the implications of providing a teleconference option for Council. They believe that in person attendance at Council is preferred, as it enhances strategic discussions. However, beginning in 2019, teleconferencing may be provided for Council members who are unable to travel to the College. A Council member who is unable to attend the meeting for medical or weather reasons, for example, should speak to the President beforehand so appropriate arrangements can be made.

Contact: Steven Bodley, President
Lisa Brownstone, x 472

Date: November 16, 2018

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

TOPIC: **Registrar/CEO Report** December 2018

FOR INFORMATION

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1. Right Touch Regulation

Regulators around the world are embracing the concept of Right Touch Regulation, which indicates that regulation should be proportionate, consistent, targeted, transparent, accountable and agile. It is the minimum regulatory force required to achieve the desired result. More information about Right Touch Regulation is set out in the attached paper from the Professional Standards Authority in the UK.

2. 2018/2019 Corporate Plan

The Corporate Plan is an internal document that supports objectives for the Registrar/CEO and enables monitoring of significant initiatives across the College. The Plan sets out the focus of CPSO work in 2018/2019, in anticipation of the Strategic Plan to be completed in 2019. It is informed by the principles of Right Touch Regulation.

The Corporate Plan refocuses the CPSO's work on core regulatory functions, with investigations as the first priority. The goal is to improve the timeliness, efficiency and effectiveness of core processes within the existing legislative and regulatory framework. Council will be provided with an updated on progress on the corporate plan.

3. Key Performance Indicators

At the December meeting, Council will be provided with a new scorecard which will measure the performance and set targets for all the core regulatory functions. This scorecard will align with the revised 2018/2019 Corporate Plan.

FOR INFORMATION

Contact: Dr. Nancy Whitmore, ext. 400
Maureen Boon, ext. 276

Date: November 12, 2018

Attachment:

Appendix A: Right Touch Regulation, Professional Standards Authority, October 2015

Appendix A

Right-touch regulation

Revised

October 2015

professional standards authority

About the Professional Standards Authority

The Professional Standards Authority for Health and Social Care promotes the health, safety and wellbeing of patients, service users and the public by raising standards of regulation and registration of people working in health and care. We are an independent body, accountable to the UK Parliament.

We oversee the work of nine statutory bodies that regulate health professionals in the UK and social workers in England. We review the regulators' performance and audit and scrutinise their decisions about whether people on their registers are fit to practise.

We also set standards for organisations holding voluntary registers for people in unregulated health and care occupations and accredit those organisations that meet our standards.

To encourage improvement we share good practice and knowledge, conduct research and introduce new ideas including our concept of right-touch regulation. We monitor policy developments in the UK and internationally and provide advice to governments and others on matters relating to people working in health and care. We also undertake some international commissions to extend our understanding of regulation and to promote safety in the mobility of the health and care workforce.

We are committed to being independent, impartial, fair, accessible and consistent. More information about our work and the approach we take is available at www.professionalstandards.org.uk

Contents

Introduction

This revised paper sets out the Professional Standards Authority's refreshed thinking as we explore the role and value of regulation in controlling the risk of harm to the public. Common themes have emerged through our oversight of the health and care professional regulators, in our advice to Governments on areas of regulatory policy and in our development of accredited registers. Our original paper was published in 2010. Since then, we and others have applied it to a variety of problems in regulation both in the UK and internationally.

Right-touch regulation describes the approach we adopt in the work we do. It is the approach that we encourage regulators to work towards, and it frames the contributions we make to wider debates about the quality and safety of health and social care and the development of regulation. It also provides a framework for thinking about wholesale reform of existing regulatory arrangements.[a]

This paper reaffirms that this approach is the right one to take. It explains Right-touch regulation in practice and outlines the benefits it offers for professional regulation and to wider health and care delivery, as our area of expertise and experience.

In 2010, we hoped that other areas of regulation might find this approach useful too; in 2015, we know that others have tried it and found it so. We have drawn on these collective experiences, clarified some areas, expanded on the concept of risk, discussed responsibility, and defined Right-touch regulation more clearly. We have also provided some practical examples to illustrate the approach. The core principles, however, remain unchanged.

We continue to see this as a work in progress, and an approach to be debated and improved over time.

What is Right-touch regulation?

The concept of Right-touch regulation emerges from the application of the principles of good regulation identified by the Better Regulation Executive in 2000[2], to which the Professional Standards Authority has added agility as a sixth principle.[b] With this addition, the principles state that regulation should aim to be:

- **Proportionate**: regulators should only intervene when necessary. Remedies should be appropriate to the risk posed, and costs identified and minimised
- **Consistent**: rules and standards must be joined up and implemented fairly
- **Targeted**: regulation should be focused on the problem, and minimise side effects
- **Transparent**: regulators should be open, and keep regulations simple and user friendly
- **Accountable**: regulators must be able to justify decisions, and be subject to public scrutiny
- **Agile**[c]: regulation must look forward and be able to adapt to anticipate change.

These principles provide the foundation for thinking on regulatory policy in all sectors

[a] In our paper *Rethinking regulation*[1] we argue that the current regulatory arrangements are outdated, inefficient and ineffective. We suggest that the principles of Right-touch regulation should be used to help design a better, more coherent regulatory system.

[b] In their 2009 report on *Themes and Trends in Regulatory Reform*[3], The House of Commons Regulatory Reform Committee agreed with us that 'agility' is an important objective for the regulatory agenda.

[c] Agility in regulation means looking forward to anticipate change rather than looking back to prevent the last crisis from happening again. We consider that an agile regulator would foresee changes that are going to occur in its field, anticipate the risks that will arise as a result of those changes, and take timely action to mitigate those risks. At the same time, an agile regulator would not react to everything as changes may occur which do not need a regulatory response.

of society.[d] We see the concept of Right-touch regulation emerging naturally from the application of these six principles: bringing together commonly agreed principles of good regulation with understanding of a sector, and a quantified and qualified assessment of risk of harm. It is intended for those making decisions about the design of an assurance framework.

In practice this means we work to identify the regulatory force needed to achieve a desired effect. Our analogy is finding the right balance on a set of scales (Figure 1). When weighing something on balancing scales, nothing happens until you reach the desired weight, at which point the scales tip over. Once they have tipped any further weight added to the other side is ineffectual. So the right amount of regulation is exactly that which is needed for the desired effect. Too little is ineffective; too much is a waste of effort.

Our thinking is in line with what others have called better regulation,[5] or common sense or rational approaches to regulation, but it is categorically not 'light-touch'. For us, Right-touch neatly describes the role that regulation should play. It builds on an accurate and informed assessment and analysis of the sector and the risks in it; it is common sense in that it describes the role regulation should play, building on its strengths, staying true to its objectives, and working with the tools it has at its disposal. It recognises that there is no such thing as 'zero risk', and that all decisions about what and how to regulate will involve a trade-off between different risks and competing benefits.

Right-touch regulation recognises that there is usually more than one way

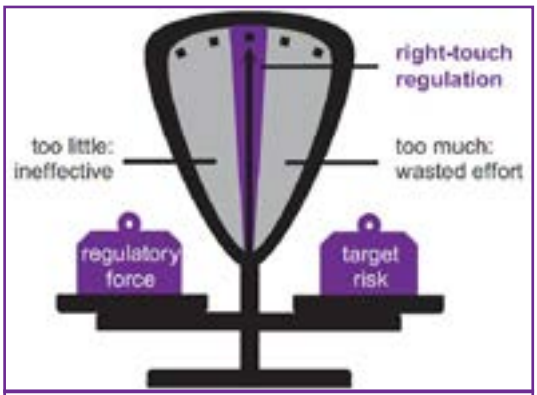


Figure 1. **Regulatory force.**

to solve a problem and regulation is not always the best answer. It may be more proportionate and effective, for instance, to strengthen employment practices or to foster professionalism. New regulations should be introduced only as a last resort. The regulator is usually furthest removed from the harms it is trying to prevent and as such regulation is a blunt instrument for promoting behaviour change. Today, more than ever given economic circumstances, the challenge is to find the most efficient, common sense solutions that are close to the problem.

Right-touch regulation is the minimum regulatory force required to achieve the desired result.

Right-touch regulation in practice

Through our work we have identified eight elements that sit at the heart of using the concept of Right-touch regulation in practice. Built into these elements are commitments to use evidence to identify and understand problems, and to draw on the roles and responsibilities of different parts of the system to deliver the best solution. The consequences of adopting this approach may be less regulation or more regulation, but should certainly mean better regulation.

[d]The idea that governments should have an over-arching policy for decisions about regulation was supported by the OECD in their 2012 report Recommendation of the Council on Regulatory Policy Governance.[4]

The appendix on page 14 contains a number of case studies illustrating this approach.

One: identify the problem before the solution

We need to identify the problem before we can determine whether any particular policy is the right one. Often in policy development the need for regulatory change, as a solution, is identified before the problem is properly described and understood. This can lead to inefficiencies as resources are spent developing a regulatory solution when the problem may be better dealt with in other ways. *See case study 1 in the appendix for a practical example.*

Two: quantify and qualify the risks

Once the problem has been identified, we need to understand it fully and quantify and qualify the risks associated with it. Quantifying risks means gauging the likelihood of harm occurring and its severity. Qualifying risks means looking closely at the nature of the harm, and understanding how and why it occurs.

Without this two-fold evaluation, which must be based on evidence, it is impossible to judge whether regulatory action is necessary, what type of regulatory response might be needed, or whether it would be better to use other means of managing the issues. Regulation should only be chosen when it clearly provides the best solution. Simply identifying a real or potential risk is not sufficient. We have to understand whether the risk is new or currently unmanaged. We provide more detail about the evaluation of risk on page 11. *See case study 1 in the appendix for a practical example.*

Three: get as close to the problem as possible

Once we have identified the problem and fully understood the risks, we must look for a solution that is as close to the problem as possible. Regulation is distant and removed from the point of care and problems are best solved near to where they occur. Targeted regulation needs to understand, both the range of hazards and the factors that increase or decrease the risk of them resulting in harm. In healthcare this means understanding the context in which the problem arises and the different tools that may be available to tackle the issues. We may need to work with organisations and individuals that are closer to the problem to bring about change. Some problems may be best tackled by regulatory measures applying to a whole profession, while others may require more targeted regulation or a non-regulatory approach. *See case studies 2 and 3 in the appendix for a practical example.*

Four: focus on the outcome

Adopting a Right-touch approach means staying focused on the outcome that we are looking to achieve, rather than being concerned about process, or prioritising interests other than public safety.

The outcome should be both tangible and measurable, and it must be directed towards the reduction of harm. Staying focused on the outcome helps identify the most appropriate solution. Having a clearly defined and measurable outcome also makes it easier to measure effectiveness. *See case studies 1 and 3 in the appendix for a practical example.*

Five: use regulation only when necessary

Once the problem has been considered, we may begin to examine whether a regulatory change is the right proposal, evaluating this

against the options of doing nothing and the risks and benefits of intervening. Making changes to regulation, especially statutory regulation, can be a slow process, so regulation should only be used as a solution when other actions are unable to deliver the desired results. A Right-touch regulatory solution must keep to the six principles of good regulation and should build on existing approaches where possible. This will often involve looking for solutions other than regulation and may require regulators to work with other organisations and people to bring about change. *See case studies 1 and 3 in the appendix for a practical example.*

Six: keep it simple
For regulation to work, it must be clear to those who are regulated, clear to the public, clear to employers, and clear to the regulator. If each cannot explain to the other what the purpose of a regulation is and why it will work, it is not simple. This is as true in health and social care, with such a wide variety of agencies and individuals involved, as it is in other sectors. Avoiding complexity will lead to a greater impact. A regulatory response should be as simple as it can be while achieving the desired outcome. *See case study 1 in the appendix for a practical example.*

Seven: check for unintended consequences
Assessing the probable impact of a particular solution is an essential step to help us avoid unintended consequences.[6] In a system as interconnected and complex as health and social care, it is inevitable that proposing a change in policy and practice will have consequences for other parts of the system. If regulations are not workable, people will work around them and in doing so create new risks. Regulating to remove one risk without a proper analysis of the consequences may create new risks or merely move the risk to a different place. *See case studies 3 and 4 in the appendix for a practical example.*

Eight: review and respond to change
We should build flexibility into regulatory strategy to enable regulation to respond to change. All sectors evolve over time, as a result of a range of different influences. Regulators must not be left managing the crises of the past, whilst ignoring or being unable to react to new evidence that calls for change. This is what we mean by agility. A programme of regular reviews, post-implementation evaluation and sunset clauses can all help here. *See case study 1 in the appendix for a practical example.*

The decision tree (Figure 2) shows how these eight steps translate into a decision-making process.

Right-touch regulation and responsibility in health and social care

In our work with regulators, accredited registers and others we formally define Right-touch regulation as follows:

'*Right-touch regulation is based on a proper evaluation of risk, is proportionate and outcome focused; it creates a framework in which professionalism can flourish and organisations can be excellent*'

The interests of patients and service users are at the heart of all our work, and this is clearly set out in our legislation.[7] Many health and care organisations share this aim, either explicitly or implicitly. They have a role to play to achieve this wider benefit.

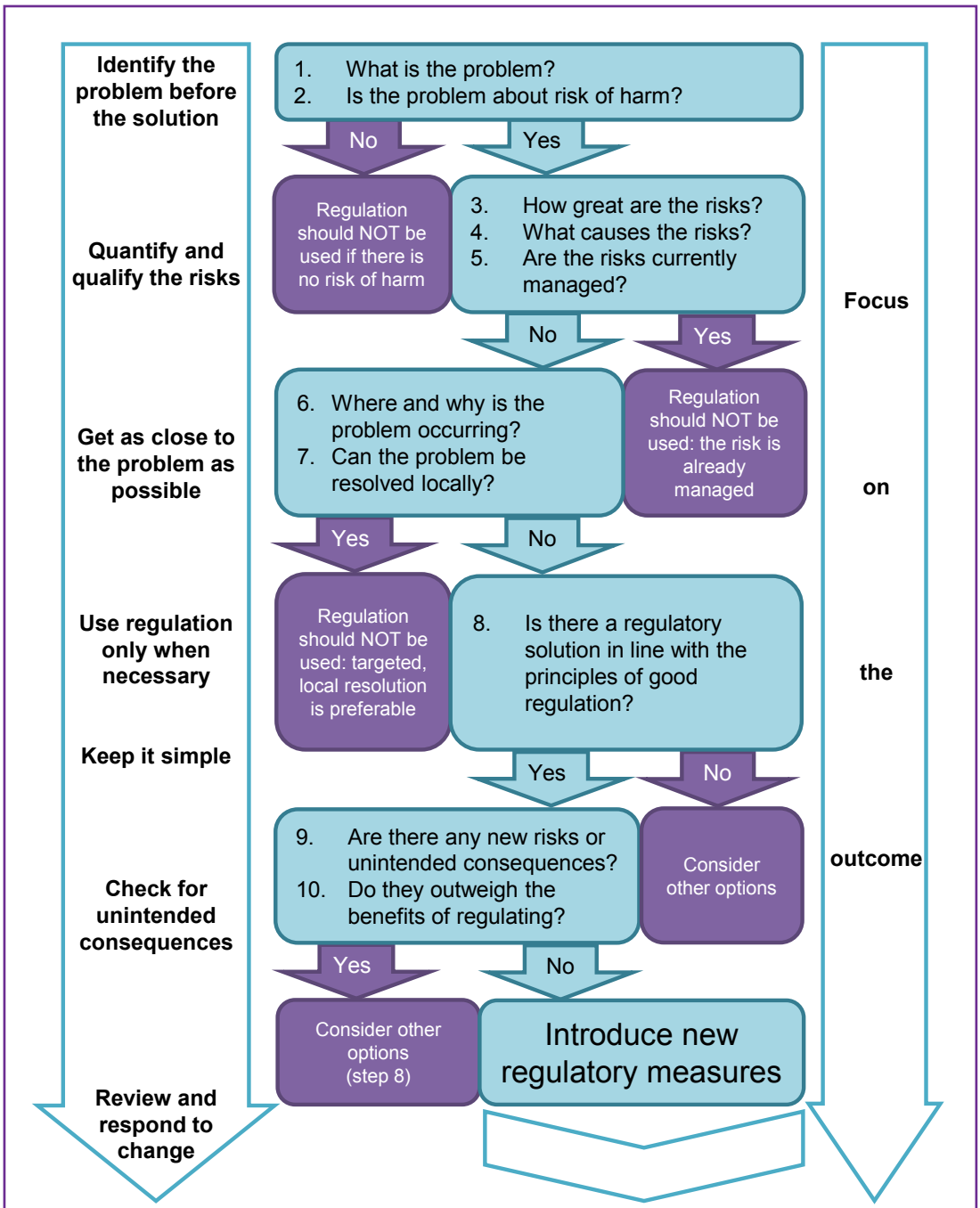


Figure 2. The Right-touch regulation decision tree.

The quality of care received by individual patients and service users is the end result of a wide range of decisions made by a number of different agents. For example:

- **People**: self-management decisions taken or not taken by people
- **Professionals**: education, training and continuing professional development
- **Providers**: their policies and guidance, and local clinical governance arrangements
- **Commissioners**: through contracting arrangements
- **Regulators**: setting and maintaining standards, controlling entry to the profession, and taking action in response to concerns
- **Other bodies**: any organisations who have an impact on standards of practice, such as accredited registers, professional organisations, royal colleges, arm's-length bodies, and government departments.
- **Legislation**: for example, human rights, equality, data protection, consumer protection, health and safety.

Regulation is part of a set of possible solutions to risks in a sector. This is recognised in our development of the accredited registers programme under the Health and Social Care Act 2012, which offers a new model of assured registration to manage risks associated with unregulated occupations.[8] All regulatory policy development should be seen in this context, and regulation will only be effective if this wider perspective is taken. It may be necessary for regulators to look for ways in which they can influence registrant behaviour through other organisations or people.

Right-touch regulation is about sharing the responsibility for mitigating the risk of harm between the different organisations and people involved in its management.We believe that it is primarily the professionalism of individuals that keeps the public safe, and in the case of health and social care also ensures the delivery of good care.

Professional regulation is working in the public interest when it supports professionalism and allows it to flourish. It does this through promotion of standards of competence and conduct, by taking action where these standards are breached, and through quality assuring education. It does not seek to address all aspects of risk. It cannot prevent every possible thing that could go wrong. Indeed over-regulation can give a false level of assurance and lead to increased risk.

Right-touch regulation supports professionalism by:

- Discouraging the use of regulation if the risk can be addressed more effectively by the professionals themselves; and
- Encouraging the use of regulatory measures that support positive behaviour change and the exercise of professional judgement, rather than seeking to be overly prescriptive.

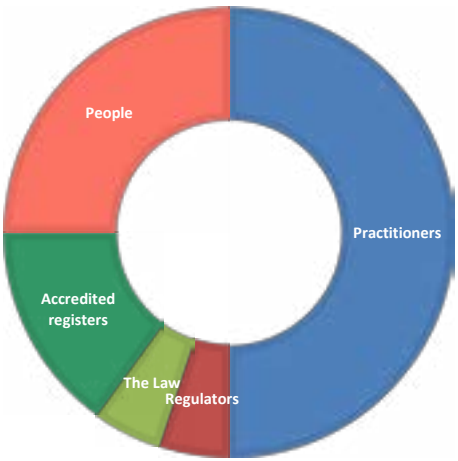
Patients and the public also have responsibility for managing risks, becoming involved in discussions about their treatment options, the different levels of risk involved, and the possible consequences for their health. For vulnerable people this responsibility is shared and extended to family, carers and advocates. People have a fundamental and essential contribution to make to high-quality healthcare. The concept of Right-touch regulation recognises the value and importance of the involvement of patients and service users in assessing risks for themselves and making appropriate choices. Right-touch regulation requires the active participation of patients and service user.

There is an inherent risk in all interventions in health and social care and

Paramedics

Paramedics practise in the relatively controlled environment of the NHS. Practitioners still bear a large share of the responsibility, but employers, commissioners, and regulators (both service and professional) between them play an important part in preventing harm. As paramedics work in emergency care, people do not have any significant control over the care a paramedic provides them.

Acupuncturists



The vast majority of acupuncturists work in private practices, and they are usually self-employed. Both practitioners and patients can therefore be expected to bear a larger share of the responsibility for preventing harm than in the previous example. Their premises are nevertheless inspected by local authorities and the products they use are subject to controls. Some are on registers accredited by the Authority, which are also responsible for preventing harm.

Figure 3. Indicative illustration of how different agents might share the responsibility for mitigating the risk of harm for two occupations in healthcare.

nothing can be said to be completely safe. For example, there is no such thing as an absolutely safe medicine, since someone will suffer an adverse reaction or side effect. Given the wide range of influences on care outcomes, it is neither proportionate nor targeted to expect regulation to act on every safety or quality concern (potential or actual) that may arise. Ultimately, the responsibility for managing risks in healthcare is shared between all parties.

Figure 3 illustrates how the share of responsibility for preventing harm might vary depending on the occupation. Each of these bears a greater or lesser share of the responsibility for mitigating risks. These examples indicate how the proportions might vary according to the respective contribution of each agent. In both examples, practitioners hold a large share of the responsibility. The share of people, employers, and regulators varies greatly. Commissioners also play a role.

Right-touch regulation and risk

When we talk about risk, we mean the risk of harm to the public that the regulator is there to reduce.

In the first version of Right-touch regulation we said that risks must be quantified. In reviewing how the approach has worked we now suggest that to understand a problem fully we must both quantify and qualify risks to enable us to see how frequently harm occurs, what impact it has, and what causes it. We recognise that risk quantification is complex and challenging, but it is essential if we are to make informed decisions about which harms to address. Risk qualification is equally important because it allows us to understand what causes the harm and how it could be prevented. Regulation should focus on identifying and addressing the causes of a risk of harm, rather than responding after the harm has occurred.[9,10]

This two-fold evaluation is essential if we want to describe regulation as 'risk-based'. The term 'risk-based regulation' should only be used when such an evaluation has taken place. Describing regulation as risk-based in the absence of a proper evaluation of risk is, in our view, misleading and can undermine wider confidence and trust in regulation.

Once a risk has been evaluated, a decision needs to be made about its tolerability. This is a difficult moral decision that will require clear justification. If the risk cannot be tolerated, action will need to be taken – although a further decision will need to be made about whether it can indeed be effectively addressed through regulatory means.

There is no justification for regulation when a risk has merely been identified but not quantified or qualified. In particular we should be cautious of justifying regulation on the basis of theoretical harm without a proper assessment of risk. In this way, Right-touch regulation runs counter to the 'precautionary principle', which is used as a licence to intervene before a risk has been evaluated and identified as meeting the threshold for action. The only exception to this is where the severity of the theoretical harm is very high, and it is not possible to quantify the risks robustly. The precautionary principle is distinct from the exercise of foresight, which we see as part of the agility principle – the ability to anticipate risks is essential to good regulation.

We find it helpful to separate hazards, risks and harms (Figure 4).[11] Hazards are the conditions or events that can lead to or contribute to harm. Risk is the likelihood of a harm materialising. In health and social care, harm is physical injury or psychological distress experienced by people through interaction with health or social care practitioners and services. In other sectors

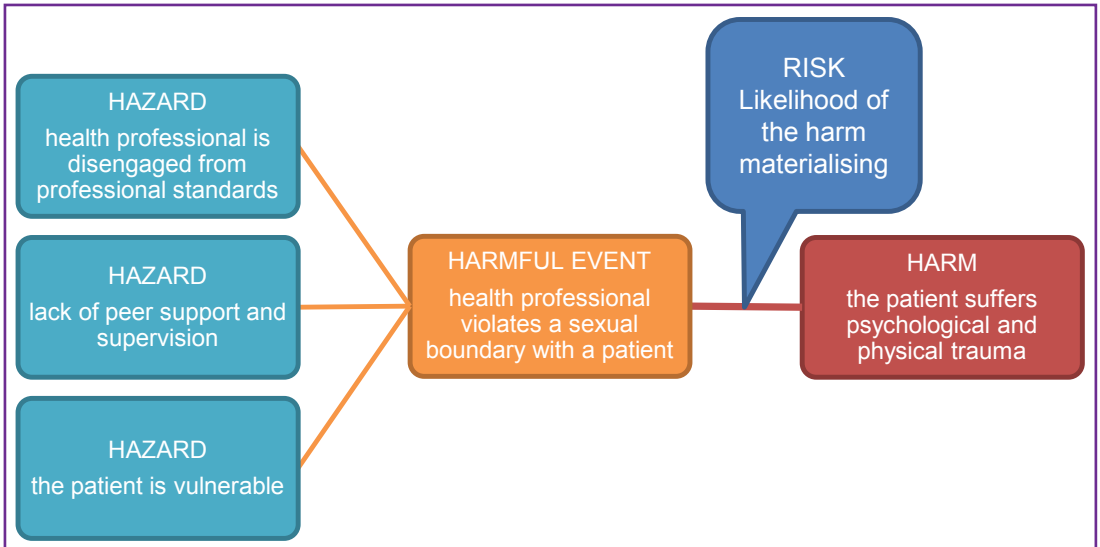


Figure 4. How hazards create the risk of harm – an example from healthcare.

harm may be defined differently.

Any regulatory response should be proportionate to the risks identified. We find it helpful to think of the range of possible responses on a risk-based continuum of assurance, with those providing the greatest regulatory force (e.g. for the highest-risk professions) at one end of the continuum, and decreasing amounts of regulatory force as the risk decreases. Regulation should only be used where the risk of harm is sufficient to warrant it and it is the most effective means of control.

Regulators need to understand the range of possible physical and psychological harms to patients and service users. In our sector, this focus is on harms that are caused by the actions of professionals.

They also need to understand the range of possible hazards and what increases and decreases risk. In health and care this means understanding the range of hazards created by problems with practitioners' conduct and competence – as well as those created by the working environment.[10]

Broadly speaking, these hazards can be categorised as follows:

- **Intervention**: the complexity and inherent dangers of the activity
- **Context**: the environment in which the intervention takes place
- **Agency**: service user vulnerability or autonomy.

In looking for categories of people who are statistically more likely to cause harm, caution must be exercised, particularly when using data about diversity characteristics.[e] Taking regulatory action based on an apparent statistical correlation between harmful behaviour and a group defined by, say its age or ethnicity, is likely to be discriminatory. It may also be ineffective and wasteful, because a correlation does not necessarily signify a causal link. Any correlation should therefore be examined

[e]Some regulators collect diversity data about their registrants and may use this to look for links between such characteristics and likelihood of harm.

more closely to discard the spurious[f] links and identify the circumstantial hazards that create an increased risk of harm.

One of the key strengths of risk-based regulation is that when used well, it provides a clear, transparent and rational basis for determining what and how to regulate. It can therefore be an effective means of pushing back against other pressures and justifying decisions about resource allocation. For risk-based regulation to be effective, regulators must communicate their approach clearly to the public, their registrants, and other stakeholders.

Conclusion

Right-touch regulation is an approach to regulatory decision-making. It means always asking what risk we are trying to address, being proportionate and targeted in regulating that risk or finding ways other than regulation to promote good practice and manage risks of harm. It allows the development of the appropriate contribution of the regulatory regime to the delivery of wider aims.

It promotes the creative use of existing mechanisms for the reduction of harm and supports professionalism and a joined-up approach to regulation. It is agile and responsive to the ever-changing circumstances and risks in which it operates

In practical terms, the benefits of Right-touch are seen in a number of ways:

- Outcomes are described in terms of the beneficiaries of regulation rather than the needs of others involved in delivery of health and social care, and policy development is devoted to achieving this aim
- It builds in the need for regular reviews to ensure that regulatory approaches and frameworks remain up to date and fit for purpose
- It provides a coherent framework for tackling a range of regulatory issues, such as managing new areas of practice and extending regulation to new groups
- Policy making is well informed, reflecting realities and the wider context, building on evidence and risk assessment.

We believe that this approach also yields broader benefits. The analogy (Figure 1) with weighing scales demonstrates the impact we want regulation to have. At the balancing point, regulation is having its most efficient impact on the problem being tackled. This will continue to be of vital importance as the costs of health and social care increase over time. Right-touch regulation forces us to be certain that the costs of regulation are worth the benefits they also bring. While patients and the public have the right to expect safe care, the cost of regulation is ultimately passed onto the public. Adopting the Right-touch approach will help regulation maximise the benefits.

The Right-touch approach can enhance trust and confidence. Recent, well-publicised 'failures of regulation' emphasise the value of public confidence in regulation. We need to make sure regulation remains relevant to the needs of today's society, and that it reacts appropriately to issues as they arise. We should also not exaggerate claims for regulation, implying that everything can be safe and nothing will go wrong. Adopting Right-touch regulation will allow people to feel confident that regulation is acting in the best way it can.

The Professional Standards Authority will continue to promote this approach, which we believe has already led to improvements in regulation in the UK and elsewhere. It provides a valuable set of guiding principles

[f] A spurious correlation is a false presumption that two variables are causally connected or correlated. Often the connection is the result of a third variable that has yet to be identified.

to help regulation work efficiently and to enhance confidence in the contribution of regulatory systems to society.

Appendix: Case studies

On page 6, we described eight elements that were key to putting Right-touch regulation into practice. The importance of each of these steps will depend on the regulatory question being asked. The following case studies show how particular elements of Right-touch regulation have been applied to individual pieces of work.

Case study 1: Transition to independent practice for dentists

The General Dental Council (GDC) had been considering whether or not there should be a period of provisional registration for dentists between their initial qualification and entry to the full dentists register. However, it was important to identify the problem before the solution first. So the dental regulator changed the policy question from 'Should we have a period of provisional registration?' to 'Is the problem about risk to patients and the public?' This meant the GDC could focus on the outcome of patient and public safety.

To inform the work, the regulator committed to use evidence and data to quantify and qualify the risks. This included a call for information and workshops with key stakeholders, a literature review and an analysis of fitness to practise and registration data. Although a substantial amount of information was collected, it was difficult to draw definite conclusions about risks posed specifically by new entrants to the dentists register. Since we should use regulation only when necessary, the GDC decided the evidence was simply not strong enough to support major regulatory change at that stage. Instead, its approach was to build on structures already in place, as outlined below.

Despite the inconclusive evidence, the regulator could not rule out that some risks might exist, since informed professional stakeholders had raised anecdotal concerns. In addition, a common theme across the various information-gathering exercises was that newly qualified healthcare professionals needed additional support or supervision in order to make the transition to independent practice. So, the GDC fostered a collaborative approach across the dental sector to ensure that all those involved in the early stages of a dentist's career worked together to deliver the common outcome of protecting patients and the public.

In practice and to keep things simple, this meant clearly setting out the roles of the various bodies who support dental students and new registrants and defining the linkages between them. The postgraduate dental deans developed their foundation training programmes, which were available to dentists after they qualify and join the register, in order to promote consistency and quality across training and assessment. The two bodies that represented undergraduate education and postgraduate training worked together on a 'clinical passport' for new UK graduates to take from their dental school into foundation training.

The GDC also worked collaboratively to facilitate information-gathering on any risks to patient and public safety. This, together with other initiatives to improve the quality of data and evidence available, provided the GDC with a robust mechanism to review the policy and respond to change, if necessary.

Case study 2: Handling complaints against doctors

In order to manage certain complaints, the General Medical Council (GMC) decided to get as close to the problem as possible.

The GMC has changed the way it deals with certain complaints that do not meet

the threshold for investigation.[g] Rather than opening a new investigation to look at each of the concerns and writing to all the doctors' employers, the GMC now shares this information with the doctor and his or her Responsible Officer (RO). The GMC asks the doctor to make the local complaints manager aware of the complaint and advises him or her that they must reflect on the complaint as part of their revalidation. If the RO or complaints manager identifies further issues, they can escalate the matter to the GMC for further consideration. The GMC's Employer Liaison Advisors are also available to follow up these letters and discuss them with the RO as required. This approach allows less serious matters to be dealt with closer to the actual problem, and is also a proportionate regulatory intervention.

Case study 3: The Cavendish Review[12]
The Francis Report and other reports highlighted poor care in health and social care. One possible response to these reports would have been to regulate healthcare assistants and support workers. However, the outcome of a review led by Camilla Cavendish showed how this vitally important part of the healthcare workforce could be developed though ways other than professional regulation.

The quality of care for patients and service users depends upon the skills, knowledge, experience and compassion of those on the front line. In the case of healthcare assistants and support workers, this can be achieved through effective local management processes, such as recruitment and training, delegation, appraisal and supervision. Therefore, the Review recommended that:

- Training and education be developed for healthcare assistants and support workers (for example, through a Certificate of Fundamental Care)
- Employers be supported to test values, attitudes and aptitude for caring at recruitment stage
- Caring be made a career (for example, through bridging programmes into pre-registration nursing and other health degrees)
- Healthcare assistants and support workers be developed through leadership, supervision and support in the workplace
- Healthcare assistants and support workers have the time to care (for example, local authorities should commission for outcomes and not by the minute).

In this case study, the problem, risks and context were considered and professional regulation was not the answer. Other solutions – closer to the point of care – were proposed in order to help achieve patient and service user safety (get as close to the problem as possible, focus on the outcome, use regulation only when necessary).

This approach may also have prevented an unintended consequence: if professional regulation had been adopted, the role of healthcare assistants and support workers may have become more tightly defined; the scope of their roles might then have become less flexible and less able to meet the needs of local populations.

Case study 4: Continuing fitness to practise of osteopaths[h]
On piloting its revalidation scheme, the General Osteopathic Council (GOsC) undertook to check for unintended consequences.

[g] While we support this approach in principle, its effectiveness has yet to be determined.

[h] While we support this approach in principle, its effectiveness has yet to be determined.

The initial scheme required a multi-layered self-assessment followed by the submission of a portfolio for review by GOsC appointed assessors. Throughout the pilot phase, nearly three quarters of participants reported that the completion of revalidation tools helped them to reflect on their current clinical practice. However, if the scheme were to be presented and administered in the way initially proposed, osteopaths would see it as a test that needed to be passed, rather than an opportunity for reflecting honestly on their practice. There was a risk that osteopaths would be cautious about admitting – especially to GOsC appointed assessors – that there were areas of practice in which they needed to improve. Ironically, the unintended consequence of a policy designed to support professionalism and protect patients and the public could be to discourage osteopaths from developing professionally through self-reflective learning.

The GOsC took on board this risk and proposed a new scheme based on peer review of CPD activity and sign-off by another healthcare professional. The aim was to support professionalism by enabling honest self-reflection and feedback amongst peers. In addition, it would reduce the isolation of osteopaths working on their own and so improve quality of practice in this way too.

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Council Briefing Note

December 2018

TOPIC: **MEDICAL ASSISTANCE IN DYING (MAID): Federal Reporting Requirements and Policy Update**

FOR DECISION

ISSUE:

- Federal regulations for the monitoring of medical assistance in dying (MAID) came into force on November 1, 2018. These regulations require physicians to report specified information directly to Health Canada pertaining to MAID.

- To ensure the College continues to provide accurate and timely guidance on MAID to the profession, updates to the *Medical Assistance in Dying* policy are proposed to reflect the federal regulations.

- Additionally, policy updates are proposed to address areas identified by the Office of the Chief Coroner (the "OCC") and the Ministry of Health and Long-Term Care (the "MOHLTC") as warranting further clarification.

- Council is provided with a brief summary of the federal monitoring regulations, along with an overview of proposed policy updates. Council is asked whether it approves the revised *Medical Assistance in Dying* policy as a policy of the College.

BACKGROUND:

- In June 2016, federal legislation was enacted to establish a legal framework for MAID in Canada. This legislation, contained in the *Criminal Code of Canada*, does the following:
    - Defines MAID;
    - Sets out eligibility criteria for MAID;
    - Articulates safeguards to ensure that vulnerable populations are protected; and
    - Provides protections for providers of MAID, and for those who support the provider or patient throughout the MAID process.

- The College's MAID policy articulates the legal obligations and professional expectations for physicians with respect to MAID, as set out in federal legislation, provincial legislation, and other relevant College policies. This includes physicians' reporting obligations.

- Currently in Ontario, the OCC provides oversight and monitoring of MAID. Under Ontario law, physicians and nurse practitioners who provide MAID are required to notify the OCC of a

medically assisted death, and provide information on the facts and circumstances of the death. Given this oversight role, the OCC collects data on every MAID death in the province.

- The new federal regulations for MAID monitoring broaden existing reporting requirements. Specifically, in addition to capturing medically assisted deaths, the federal monitoring regulations require that physicians report when they receive a written request for MAID, even if death does not occur.

- Further details on physicians' obligations under the federal monitoring regulations follow.

CURRENT STATUS:

a) Federal Reporting Regime

- The federal regulations for MAID monitoring came into force on November 1, 2018. The regulations identify who must report, what information is required, timelines for reporting, and to whom this information must be provided. The monitoring system serves a number of purposes, including, public accountability and transparency, and providing insight into whether the legislation is meeting its objectives.

- In Ontario, physicians will continue to report medically assisted deaths to the OCC. The OCC will then provide this information to Health Canada on the physician's behalf.

- Additionally, the federal regulations require physicians to report, directly to Health Canada, where a patient has made a written request for MAID but death does not occur.

- Any written request for MAID will trigger a report, as long as it:
  - Is in writing, in any form (including, for example, email or text);
  - Is an explicit request for MAID; and
  - Originates with the patient.

- The following two tables summarize physicians' reporting obligations under the federal monitoring regulations, and to whom these reports are to be directed.

Table 1

Reporting Obligations: Medically Assisted **Death HAS** Occurred		
OUTCOME	**TIMELINE**	**REPORT RECIPIENT**
SELF-ADMINISTERED MAID: Physician provided MAID by prescribing or providing a substance for self-administration by the patient.	Immediately, after physician becomes aware of death	OFFICE OF THE CHIEF CORONER (Recipient designated by Federal Government)
PHYSICIAN-ADMINISTERED MAID: Physician provided MAID by administering a substance to a patient.	Immediately, after death is confirmed	

Table 2

Reporting Obligations: Written Request Received, **Death HAS NOT** Occurred		
OUTCOME	**TIMELINE**	**REPORT RECIPIENT**
PATIENT INELIGIBLE: Physician finds patient ineligible for MAID	Within 30 days of outcome	HEALTH CANADA (via Canadian MAID Data Collection Portal)
PATIENT REFERRED: Physician refers patient to another practitioner or the province's Care Coordination Service		
DEATH – Other Cause: Physician is aware that patient has died from another cause		
REQUEST WITHDRAWN: Physician is aware that the patient withdrew their request for MAID		
MAID DRUGS PRESCRIBED: Physician prescribed MAID drugs and patient is still alive, died from other cause, or outcome is unknown.	Between 90 and 120 days of outcome	

b) Changes in the Landscape and Lessons Learned

- Currently, the OCC reviews all MAID deaths and evaluates them for compliance with legal and regulatory obligations. This role will continue.

- Through this oversight experience, the OCC has provided feedback to the College that the current MAID policy could be updated to:
  - Set expectations regarding the involvement of postgraduate trainees in MAID;
  - Clarify and support physician understanding of the term "reasonably foreseeable", especially in light of recent Court decisions; and
  - Update the Process Map to more accurately reflect the realities of providing MAID in practice.

- On November 1, 2018, the OCC implemented a more structured approach to address matters of legal and regulatory compliance. Highlights of this approach include the following:
  - Compliance matters are assigned a ranking from Level 1 to Level 5;
  - The assigned level and associated response by the OCC is dependent, in part, on whether the legal or regulatory breach was previously brought to the physician's attention and has recurred; and
  - The OCC's response ranges from an informal conversation or educational email for lower-risk incidents, to a report to the College where the breach is more serious.

- The OCC's communication to clinicians advising them of this new approach is available online, on the OCC's website.

- The MOHLTC has also communicated information from Health Canada regarding the permissibility of providing physician-administered MAID as a back-up when self-administered MAID fails.
    - In particular, Health Canada has advised that the current legislative framework only permits the provision of physician-administered MAID as a back-up to self-administered MAID if the patient retains capacity and consents immediately prior to its provision.

c) Proposed Updates to MAID Policy

- In light of federal regulations for MAID monitoring, updates to the policy are proposed to ensure that physicians' new reporting obligations are captured.

- Further, additional policy content is proposed to address areas identified by the OCC and MOHLTC as warranting further clarification.

- The updated draft policy, including proposed edits, is attached as **Appendix A**. Key updates, which are highlighted in the draft attached, include the following:

    - Existing content on data collection and reporting has been consolidated in section titled *Reporting Obligations* that outlines both federal and provincial reporting requirements;

    - Added content on the role of postgraduate medical trainees in MAID, and the capacities in which they may be involved;

    - Clarification that where a patient has opted for self-administered MAID and death is prolonged or not achieved, a physician may only administer an IV backup if the patient is capable of providing their express consent immediately before the medication is administered; and

    - Clarification that the Process Map contained in the policy is not prescriptive in terms of sequencing. Any departure from the Process Map, however, must comply with the federal legislation.

NEXT STEPS

- Should Council approve the revised *Medical Assistance in Dying* policy, the updated policy will replace the former version on the CPSO website.

- Further, a companion article to remind physicians of new reporting obligations pertaining to MAID will appear in the upcoming issue of *Dialogue* magazine.

DECISION FOR COUNCIL:

- Does Council approve the revised *Medical Assistance in Dying* policy as a policy of the College?

Contact: Dionne Woodward, Ext. 753

Date: November 15, 2018

Attachments: Appendix A - MAID Policy with Proposed Updates

Medical Assistance in Dying

Introduction

Historically, it has been a crime in Canada to assist another person to end their own life. This criminal prohibition has applied to circumstances where a physician provides or administers medication that intentionally brings about a patient's death, at the request of the patient.

In the case of *Carter v. Canada*,[1] the Supreme Court of Canada (SCC) considered whether the criminal prohibition on medical assistance in dying (referred to as 'physician-assisted death' by the SCC), violates the *Charter* rights of competent adults, who are suffering intolerably from grievous and irremediable medical conditions, and seek assistance in dying. The SCC unanimously determined that an absolute prohibition on medical assistance in dying does violate the *Charter* rights of these individuals, and is unconstitutional.

The SCC suspended its decision to allow the federal and/or provincial[2] governments to design, should they so choose, a framework to govern the provision of medical assistance in dying. In response, the federal government enacted legislation, through amendments to the *Criminal Code*,[3] to establish a federal framework for medical assistance in dying in Canada.

Definitions

Medical Assistance in Dying: In accordance with federal legislation, medical assistance in dying includes circumstances where a medical practitioner or nurse practitioner, at an individual's request: (a) administers a substance that causes an individual's death; or (b) prescribes a substance for an individual to self-administer to cause their own death.

Medical Practitioner: A physician who is entitled to practise medicine in Ontario, including postgraduate medical trainees.[4]

Nurse Practitioner: A registered nurse who, under the laws of Ontario, is entitled to practise as a nurse practitioner, and autonomously make diagnoses, order and interpret diagnostic tests, prescribe substances, and treat patients.

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[1] *Carter v. Canada (Attorney General)*, 2015 SCC 5 [*Carter*].

[2] Physicians are advised to consult the Ontario Ministry of Health and Long-Term Care (MOHLTC) website for additional information and resources on medical assistance in dying: https://www.ontario.ca/page/medical-assistance-dying-and-end-life-decisions.

Criminal Code, R.S.C., 1985, c. C-46.

[4] Details regarding the College's expectations of postgraduate medical trainees in relation to medical assistance in dying are set out below.

Purpose and Scope of Document

This policy articulates the following:

- The legal obligations and professional expectations of physicians with respect to medical assistance in dying;[5]
- The College's expectations of postgraduate medical trainees in relation to medical assistance in dying;
- The eligibility criteria, as set out in federal legislation, for medical assistance in dying; and
- A process map to assist those managing requests for medical assistance in dying.

Principles

The key values of medical professionalism, as articulated in the College's *Practice Guide*, are compassion, service, altruism, and trustworthiness. The fiduciary nature of the physician-patient relationship requires that physicians prioritize patient interests. In doing so, physicians must strive to create and foster an environment in which the rights, dignity, and autonomy of all patients are respected.

Physicians embody the key values of medical professionalism and uphold the reputation of the profession by, among other things:

- Respecting patient autonomy with respect to healthcare goals and treatment decisions;
- Acting in the best interests of their patients, and ensuring that all patients receive equitable access to care;
- Communicating sensitively and effectively with patients in a manner that supports patients' autonomy in decision-making, and ensures they are informed about their medical care; and
- Demonstrating professional competence, which includes meeting the standard of care, and acting in accordance with all relevant and applicable legal and professional obligations.

[5] This policy will refer to nurse practitioners and pharmacists, where relevant, in order to reflect the language of the federal law. The policy does not set professional expectations and accountabilities for members of the College of Nurses of Ontario, or members of the Ontario College of Pharmacists. For information on the professional accountabilities of nurse practitioners and other members of the College of Nurses of Ontario, please see the College of Nurses of Ontario document titled: Guidance on Nurses' Roles in Medical Assistance in Dying. For information on the professional accountabilities for members of the Ontario College of Pharmacists, please see the Ontario College of Pharmacists document titled: Medical Assistance in Dying: Guidance to Pharmacists and Pharmacy Technicians.

Policy

Physicians are expected to manage all requests for medical assistance in dying in accordance with the expectations set out in this policy.

Criteria for Medical Assistance in Dying

In accordance with federal legislation, for an individual to access medical assistance in dying, they must:

1. Be eligible for publicly funded health services in Canada;
2. Be at least 18 years of age and capable of making decisions with respect to their health;
3. Have a grievous and irremediable medical condition (including an illness, disease or disability);
4. Make a voluntary request for medical assistance in dying that is not the result of external pressure; and
5. Provide informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.

Physicians must use their professional judgement to assess an individual's suitability for medical assistance in dying against the above criteria. The content that follows elaborates upon each element of the criteria for medical assistance in dying.

1. Eligible for publicly funded health-care services in Canada

In accordance with federal legislation, medical assistance in dying must only be provided to patients who are eligible for publicly-funded health services in Canada.

The activities involved in both assessing whether a patient meets the criteria for medical assistance in dying, and providing medical assistance in dying, are insured services. These activities may include, for instance, counselling and prescribing. Accordingly, physicians must not charge patients directly for medical assistance in dying or associated activities. Physicians are advised to refer to the OHIP Schedule of Benefits for further information.

2. Capable adult of at least 18 years of age

(i) Age Requirement

The federal legislation specifies that medical assistance in dying is available only to individuals who are at least 18 years of age and capable of making decisions with respect to their health.

Physicians will note that the requirement that patients be at least 18 years of age and capable departs from Ontario's *Health Care Consent Act, 1996*,[6] which does not specify an 'age of consent'.

(ii) Capacity

Under Ontario's *Health Care Consent Act, 1996*, a patient has capacity to consent to treatment if they are able to understand the information that is relevant to making the decision, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.[7] The patient must be able to understand and appreciate the history and prognosis of their medical condition, treatment options, and the risks and benefits of each treatment option.

In the context of medical assistance in dying, the patient must be able to understand and appreciate the certainty of death upon self-administering or having the physician administer the fatal dose of medication. A patient's capacity is fluid and may change over time. Therefore, physicians must be alert to potential changes in the patient's capacity.

When assessing capacity in the context of a request for medical assistance in dying, physicians are advised to rely on existing practices and procedures for capacity assessments.

3. Grievous and Irremediable Medical Condition

Under federal legislation, an individual has a grievous and irremediable medical condition if:

a. They have a serious and incurable illness, disease or disability;
b. They are in an advanced state of irreversible decline in capability;
c. That illness, disease or disability, or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and
d. Their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that the individual has to live.

The College acknowledges that the above definition of a 'grievous and irremediable medical condition' does not follow terminology typically used in a clinical context. In determining whether a patient has a grievous and irremediable medical condition, physicians must use their

[6] *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A. (hereinafter *HCCA*).
[7] Section 4(1) of the *HCCA*.

professional judgement to assess the patient.[8] Physicians may also wish to obtain independent legal advice.[9]

4. Voluntary Request for Medical Assistance in Dying

In accordance with federal legislation and the requirements for consent under the *Health Care Consent Act, 1996*, requests for medical assistance in dying must be voluntary and not made as a result of external pressure or coercion.

The physician must be satisfied that the patient's decision to undergo medical assistance in dying has been made freely, without undue influence from family members, healthcare providers, or others. The patient must have requested medical assistance in dying themself, thoughtfully and in a free and informed manner.

5. Informed Consent

In order to receive medical assistance in dying, a patient must provide their informed consent. The process and requirements for obtaining informed consent in other medical decision-making contexts are also applicable to medical assistance in dying.

The College's *Consent to Treatment* policy outlines the legal requirements of valid consent as set out in the *Health Care Consent Act, 1996*. In order for consent to be valid it must be related to the treatment, informed, given voluntarily, and not obtained through misrepresentation or fraud.[10]

As noted above, a patient must be capable of making decisions with respect to their health to meet the criteria for medical assistance in dying. Therefore, consent to medical assistance in dying must be provided by a capable patient and not by a substitute decision maker.

As part of obtaining informed consent, physicians must discuss all treatment options with the patient, including the associated benefits, risks and side effects. With respect to medical assistance in dying specifically, federal legislation requires that the patient be informed of the means that are available to relieve their suffering, including palliative care. The College's *Planning for and Providing Quality End-of-Life Care* policy sets out the College's expectations of physicians regarding planning for and providing quality care at the end of life, including proposing and/or providing palliative care where appropriate.

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[8] Further details on interpreting the statutory definition of a grievous and irremediable medical condition can be found in companion resources authored by the federal government: http://www.justice.gc.ca/eng/cj-jp/ad-am/glos.html

[9] Physicians may wish to consult their own lawyer or the Canadian Medical Protective Association (CMPA) for independent legal advice.

[10] Section 11(1) of the *HCCA*.

In accordance with the *Health Care Consent Act, 1996,* consent must relate to the specific treatment being provided.[11] Where a patient indicates a preference for self-administered medical assistance in dying, in obtaining the patient's consent, the physician must inform the patient of potential complications, including the possibility that death may not be achieved. Physicians are advised to encourage the patient to include the physician or nurse practitioner who prescribed the medication among those present when the medication is self-administered.

In circumstances where death is prolonged or not achieved, it is essential for the patient to understand that their consent must be obtained in order for an attending physician to intervene by administering a substance to cause death. Specifically, in such circumstances, the patient must be capable of providing their express consent immediately before the physician administers the fatal dose of medication.

Conscientious Objection

The federal legislation does not address how conscientious objections of physicians, nurse practitioners, or other healthcare providers are to be managed. In the *Carter* case, the Supreme Court of Canada noted that the *Charter* rights of patients and physicians would have to be reconciled. Physicians who have a conscientious objection to providing medical assistance in dying are directed to comply with the College's expectations for conscientious objections in general, set out in the *Professional Obligations and Human Rights* policy.[12]

These expectations are as follows:

- Where a physician declines to provide medical assistance in dying for reasons of conscience or religion, the physician must do so in a manner that respects patient dignity. Physicians must not impede access to medical assistance in dying, even if it conflicts with their conscience or religious beliefs.
- The physician must communicate his/her objection to medical assistance in dying to the patient directly and with sensitivity. The physician must inform the patient that the objection is due to personal and not clinical reasons. In the course of communicating an objection, physicians must not express personal moral judgments about the beliefs, lifestyle, identity or characteristics of the patient.
- In order to uphold patient autonomy and facilitate the decision-making process, physicians must provide the patient with information about all options for care that may be available or appropriate to meet the patient's clinical needs, concerns, and/or

[11] Section 11(1) of the *HCCA*.

[12] Physicians who have a religious or conscientious objection to providing medical assistance in dying are not required to provide medical assistance in dying, in any circumstance. A request for medical assistance in dying is not considered an emergency.

wishes. Physicians must not withhold information about the existence of any procedure or treatment because it conflicts with their conscience or religious beliefs.

- Where a physician declines to provide medical assistance in dying for reasons of conscience or religion, the physician must not abandon the patient. An effective referral must be provided. An effective referral means a referral made in good faith, to a non-objecting, available, and accessible physician, nurse practitioner or agency. The referral must be made in a timely manner to allow the patient to access medical assistance in dying. Patients must not be exposed to adverse clinical outcomes due to delayed referrals.[13, 14]

The federal legislation does not compel physicians to provide or assist in providing medical assistance in dying. For clarity, the College does not consider providing the patient with an 'effective referral' as 'assisting' in providing medical assistance in dying.

Involvement of Postgraduate Medical Trainees

As medical practitioners licensed to practice medicine in Ontario, postgraduate medical trainees can participate in the medical assistance in dying process. Specifically, postgraduates may assess a patient's eligibility for medical assistance in dying and/or provide medical assistance in dying, in compliance with the federal legislation. As in other contexts, when involved in medical assistance in dying, postgraduate medical trainees must stay within the terms, conditions and limitations of their certificate of registration. [15]

[13] For more information on and examples of what constitutes an 'effective referral', please see document titled, 'Fact Sheet: Ensuring Access to Care: Effective Referral', available on the College's website: http://www.cpso.on.ca/CPSO/media/documents/Policies/Policy-Items/PAD-Effective-Referral-FactSheet.pdf.

[14] The Ministry of Health and Long-Term Care has established the Care Coordination Service (CCS) to allow clinicians, patients, and caregivers to access information about medical assistance in dying and end-of-life care options, and to request referrals for medical assistance in dying. Clinicians seeking assistance in making a referral can call the CCS toll-free: 1-866-286-4023. If physicians have general questions about the CCS, or wish to register for the CCS as a willing provider, please contact the Ministry of Health and Long-Term Care at maidregistration@sasc.ca. The College expects physicians to make reasonable efforts to remain apprised of resources that become available in this new landscape.

[15] Under section 11(8) of Ontario Regulation 865/93, made under the *Medicine Act, 1991* (the "Registration Regulation"), the following are terms, conditions and limitations of a certificate of registration authorizing postgraduate education:

1. The holder shall,
   - i. Practise medicine only as required by the program in which the holder is enrolled,
   - ii. Prescribe drugs only for in-patients or out-patients of a clinical teaching unit that is formally affiliated with the department where he or she is properly practising medicine and to which postgraduate trainees are regularly assigned by the department as part of its program of postgraduate medical education, and
   - iii. Not charge a fee for medical services.

The federal legislation requires that two independent physicians or nurse practitioners assess a patient's eligibility for medical assistance in dying. Where one assessor is mentor to, or supervises the work of the other assessor, the assessors are not independent. As such, where a postgraduate is involved in assessing a patient's eligibility for medical assistance in dying, particular attention must be paid to ensuring that the provider of the other assessment is entirely independent of the postgraduate.

Reporting Obligations

Federal regulations for monitoring medical assistance in dying came into force on November 1st, 2018. These regulations identify who must report, what information is required, timelines for reporting, and to whom information must be provided.

In Ontario, physicians must report medically assisted deaths to the Office of the Chief Coroner for Ontario (OCC). Additionally, in most cases, the federal regulations require that physicians report when a patient makes a written request for medical assistance in dying, but death does not occur. These reports are made directly to Health Canada by the physician who received the patient's written request. Additional details on physicians' reporting obligations are set out below.

Report to the Office of the Chief Coroner for Ontario

Physicians who provide medical assistance in dying must report the medically assisted death to the OCC.[16] While the OCC must be notified of all medically assisted deaths, an investigation is not required unless the OCC deems one to be necessary.[17]

Physicians must provide the OCC with any information about the facts and circumstances relating to the medically assisted death that the OCC considers necessary to form an opinion as to whether the death ought to be investigated.[18] In practice, the College understands that physicians would typically fulfill this reporting obligation by contacting the OCC and submitting the section(s) of the patient's medical record that pertains to the medically assisted death.[19] Details on medical record keeping requirements in the medical assistance in dying context are set out below.

[16] Section 10.1(1) of the *Coroners Act,* R.S.O. 1990, c. C.3 (hereinafter "*Coroner's Act*").
[17] Section 10.1(1) of the *Coroners Act*.
[18] Section 10.1(2) of the *Coroners Act*.
[19] Following the provision of medical assistance in dying, the physician must notify a coroner by contacting provincial dispatch. Provincial dispatch will then contact the on-duty member of the OCC MAID Review Team, who will obtain information from the reporting physician regarding the facts and circumstances relating to the death. Documentation pertaining to the medically assisted death is to be faxed, as soon as is reasonably possible, to the MAID review team at 416-848-7791.

Report to Health Canada

There are circumstances where a physician receives a written request for medical assistance in dying, however, for a number of reasons, the patient's death does not occur. The federal regulations include reporting requirements to capture these circumstances.

When a physician receives a written request for medical assistance in dying, and that request does not result in a medically assisted death, in most cases, a report to Health Canada must be made. The written request must originate with the patient, explicitly request medical assistance in dying, and take any written form, including email or text message.[20]

The federal regulations require that physicians report any of the following outcomes, where a written request is received and a medically assisted death does not occur:

- The patient was found ineligible for medical assistance in dying;
- The patient was referred to another practitioner or care coordination service;
- The patient died from another cause;
- The patient withdrew their request for medical assistance in dying; or
- The physician prescribed a substance for medical assistance in dying that to the physician's knowledge did not result in a medically assisted death within the prescribed timeframe.

Generally, physicians must report to Health Canada within 30 days of any of the above outcomes. Where a physician has prescribed a substance for the patient to self-administer and a medically-assisted death does not occur, a report to Health Canada must be made between 90 and 120 days of the substance being prescribed. All reports to Health Canada are made using the Canadian MAID Data Collection Portal.[21,22]

Medical Record Keeping

The College's *Medical Records* policy sets out physicians' professional and legal obligations with respect to medical records. The policy requires that physicians document each physician-patient encounter in the medical record. This would include encounters concerning medical assistance in dying. The medical record must be legible, and the information in the medical record must be understood by other healthcare professionals. Where there are multiple

[20] In order for a report to be required, the written request for medical assistance in dying need not be in the form required as a safeguard under the *Criminal Code* (i.e. duly signed, dated and witnessed).
[21] For more information on physicians' reporting obligations, including reporting deadlines, please visit the Ministry of Health and Long-Term Care website: http://health.gov.on.ca/en/pro/programs/maid/#regulations
[22] The Canadian MAID Data Collection Portal may be accessed via the Health Canada website: https://www.canada.ca/en/health-canada/services/medical-assistance-dying/guidance-reporting-summary.html.

healthcare professionals making entries in a record, the author of each entry must be identifiable.

Each record of a physician-patient encounter, regardless of where the patient is seen, must include a focused relevant history, documentation of an assessment and an appropriately focused physical exam (when indicated), including a provisional diagnosis (where indicated), and a management plan.

Where a patient has requested medical assistance in dying, the physician must document each element of the patient's assessment in accordance with the criteria for medical assistance in dying, and include a copy of their written opinion in the medical record. Further, all oral and written requests for medical assistance in dying, as well as the dates of these requests, must be documented in the medical record. A copy of the patient's written request must also be included.[23]

Where medical assistance in dying is provided, physicians must also document additional information in the patient's medical record. Such information will assist physicians in fulfilling their reporting obligation to the Office of the Chief Coroner for Ontario (OCC). The information to be recorded in the medical record includes but is not limited to:

- The steps taken to satisfy themselves that the patient's written request for medical assistance in dying was signed by two *independent* witnesses;
- The start and end-date of the required 10-day reflection period between the patient's signed request for medical assistance in dying and the date on which medical assistance in dying is provided;
- The rationale for shortening the 10-day reflection period, if applicable (i.e., both clinicians and/or nurse practitioners are of the opinion that the patient's death or loss of capacity is imminent);
- The time of the patient's death; and
- The medication protocol utilized (i.e., drug type(s) and dosages).

In circumstances where a physician declines to provide medical assistance in dying, the physician must document that an effective referral was provided to the patient. This includes documenting, in the medical record, the date on which the effective referral was made and the physician, practitioner and/or agency to which the referral was directed.

[23] The Ministry of Health and Long-Term Care (MOHLTC) has developed clinician aids to support the provision of medical assistance in dying. These include forms to: (a) assist patients who request medical assistance in dying (http://bit.ly/29Sovs0); (b) assist physicians who provide medical assistance in dying (http://bit.ly/2a9M8Pf); and (c) assist physicians who provide a written opinion confirming that the patient meets the eligibility criteria to receive medical assistance in dying (http://bit.ly/29Spk3Y).

Completion of Death Certificate

Upon receipt of a report regarding a medically assisted death, the Office of the Chief Coroner for Ontario (OCC) will determine whether the death ought to be investigated.[24] If the OCC determines that an investigation is not required, the attending physician or nurse practitioner who provided medical assistance in dying completes the medical certificate of death. If the OCC is of the opinion that the death ought to be investigated, the OCC will provide a replacement death certificate at a later date.[25]

As directed by the province, when completing the death certificate for a medically assisted death, the illness, disease, or disability leading to the request for medical assistance in dying must be recorded as the underlying cause of death. Physicians are to make no reference to medical assistance in dying, or the drugs administered to achieve medical assistance in dying, on the death certificate.[26]

~~**Data Collection**~~

~~The federal legislation authorizes the Federal Minister of Health to make regulations to establish a monitoring regime for medical assistance in dying in Canada. According to the federal government, these regulations could, for instance, stipulate the types of data to be provided and to whom; the body that would collect and analyze the data; and how often reports would be published. The federal regulations remain under development, and the College will keep its members abreast of any developments in this regard.~~

Process Map for Medical Assistances in Dying

The process map that follows details the steps that physicians must undertake in relation to medical assistance in dying. It complies with federal legislation and outlines safeguards that must be adhered to, by law, prior to the provision of medical assistance in dying.

The federal legislation sets out safeguards that must be met before medical assistance in dying is provided. The process map that follows provides an illustration of how medical assistance in dying may be carried out, from initial patient inquiry to provision, in compliance with the federal legislation.

[24] Section 10.1(2) of the *Coroners Act*.
[25] Section 21(7) of the *Vital Statistics Act*, R.S.O. 1990, c. V.4.
[26] Instructions on completing the Medical Certificate of Death reflect joint guidance developed by the Ministry of Health and Long-Term Care, the Ministry of Government and Consumer Services, and the Office of the Chief Coroner.

Nurse practitioners and other professionals are noted in the Process Map only to the extent necessary to reflect relevant provisions of the federal legislation. Expectations for the responsibilities and accountabilities of nurse practitioners, pharmacists and other health care providers are set by their respective regulatory bodies.

Physicians and nurse practitioners, along with those who support them, are protected from liability if acting in compliance with the federal legislation and any applicable provincial or territorial laws, standards or rules.[27]

Initial Inquiry for Medical Assistance in Dying

~~STEP 1:~~ Patient makes initial inquiry for medical assistance in dying to a physician or nurse practitioner.

Physicians who have a conscientious objection to medical assistance in dying are not obliged to proceed further through the process map and evaluate a patient's inquiry for medical assistance in dying. As described above, objecting physicians must provide the patient with an effective referral to a non-objecting physician, nurse practitioner, or agency. The objecting physician must document, in the medical record, the date on which the effective referral was made, and the physician, nurse practitioner and/or agency to which the referral was directed.

Safeguards for Medical Assistance in Dying

~~STEP 2:~~ Physician or nurse practitioner assesses the patient against eligibility criteria for medical assistance in dying.

The physician or nurse practitioner must ensure that the patient meets the criteria for medical assistance in dying. As described above, the patient must:

1. Be eligible for publicly funded health services in Canada;
2. Be at least 18 years of age and capable of making decisions with respect to their health;
3. Have a grievous and irremediable medical condition (including an illness, disease or disability);
4. Make a voluntary request for medical assistance in dying that is not the result of external pressure; and
5. Provide informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.

[27] Liability protections extend to pharmacists, any individuals supporting physicians or nurse practitioners (not limited to regulated health professionals), and individuals who aid a patient to self-administer the fatal dose of medication, when acting in compliance with the federal legislation and any applicable provincial or territorial laws, standards or rules.

Where the patient's capacity or voluntariness is in question, the attending physician must refer the patient for a specialized capacity assessment.

With respect to the third element of the above criteria, a patient has a grievous and irremediable medical condition if:

- They have a serious and incurable illness, disease or disability;
- They are in an advanced state of irreversible decline in capability;
- That illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and
- Their natural death has become reasonably foreseeable,[28] taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that the individual has to live.

If the physician concludes that the patient does not meet the criteria for medical assistance in dying as outlined above, the patient is entitled to make a request for medical assistance in dying to another physician who would again assess the patient using the above criteria.

The physician must document the outcome of the patient's assessment in the medical record.

~~STEP 3:~~ Patient makes written request for medical assistance in dying before two independent witnesses.

The patient's request for medical assistance in dying must be made in writing. The written request must be signed and dated by the patient requesting medical assistance in dying on a date after the patient has been informed that they have a grievous and irremediable medical condition.

Physicians are advised that a patient may have been informed that they have a grievous and irremediable medical condition by a physician who is not involved in assessing their eligibility

[28] The case of *A.B. v. Canada (Attorney General),* 2017 ONSC 3759, provides some assistance on what is meant by "reasonably foreseeable" in this context, stating at paras. 79 and 80:

> […] *natural death need not be imminent and that what is a reasonably foreseeable death is a person-specific medical question to be made without necessarily making, but not necessarily precluding, a prognosis of the remaining lifespan.*
> *Although it is impossible to imagine that the exercise of professional knowledge and judgment will ever be easy, in those cases where a prognosis can be made that death is imminent, then it may be easier to say that the natural death is reasonably foreseeable. Physicians, of course have considerable experience in making a prognosis, but the legislation makes it clear that in formulating an opinion, the physician need not opine about the specific length of time that the person requesting medical assistance in dying has remaining in his or her lifetime.*

for medical assistance in dying. The federal legislation does not require that a patient be informed that they have a grievous and irremediable medical condition in the context of an eligibility assessment for medical assistance in dying. As long as the patient was informed that their condition is grievous and irremediable before making a formal written request for medical assistance in dying, these requirements of the federal legislation are met.

If the patient requesting medical assistance in dying is unable to sign and date the request, another person who is at least 18 years of age, who understands the nature of the request for medical assistance in dying, and who does not know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or material benefit resulting from the patient`s death, may do so in the patient's presence, on the patient's behalf, and under the patient's express direction.

The patient's request for medical assistance in dying must be signed and dated before two independent witnesses, who then must also sign and date the request. An independent witness is someone who is at least 18 years of age, and who understands the nature of the request for medical assistance in dying.

An individual may not act as an independent witness if they are a beneficiary under the patient's will, or are a recipient in any other way of a financial or other material benefit resulting from the patient's death; own or operate the health care facility at which the patient making the request is being treated; or are directly involved in providing the patient's healthcare and/or personal care.

Physicians must document the date of the patient's request for medical assistance in dying in the medical record. Additionally, physicians must document the steps taken to satisfy themselves that the patient's written request for medical assistance in dying was signed by two independent witnesses. A copy of the physician's written opinion regarding whether the patient meets the eligibility criteria must also be included in the medical record.

~~STEP 4:~~ The physician or nurse practitioner must remind the patient of his/her ability to rescind the request at any time.

The physician or nurse practitioner must remind the patient that they may, at any time and in any manner, withdraw their request.

~~STEP 5:~~ An independent second physician or nurse practitioner confirms, in writing, that the patient meets the eligibility criteria for medical assistance in dying.

A second physician or nurse practitioner must assess the patient in accordance with the criteria provided above, and provide their written opinion confirming that the requisite criteria for medical assistance in dying have been met.

The first and second physician or nurse practitioner assessing a patient's eligibility for medical assistance in dying must be independent of each other. This means that they must not:

- Be a mentor to, or be responsible for supervising the work of the other physician or nurse practitioner;
- Know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death, other than standard compensation for their services relating to the request; or
- Know or believe that they are connected to the other practitioner or to the person making the request in any other way that would affect their objectivity.

If the second physician concludes that the patient does not meet the criteria for medical assistance in dying as outlined above, the patient is entitled to have another physician assess them against the criteria.

~~STEP 6:~~ A 10-day period of reflection from date of request to provision of medical assistance in dying.

A period of at least 10 clear days[29] must pass between the day on which the request for medical assistance in dying is signed by or on behalf of the patient, and the day on which medical assistance in dying is provided.

In accordance with federal legislation, this timeframe may be shortened if both the physician(s) and/or nurse practitioner(s) agree that death or loss of capacity to provide consent is imminent.

Physicians must document the start and end-date of the 10-day reflection period in the medical record, and their rationale for shortening the 10-day reflection period if applicable.

~~STEP 7:~~ Physician or nurse practitioner informs the dispensing pharmacist that prescribed substance is intended for medical assistance in dying.

Medical assistance in dying includes both situations where the physician or nurse practitioner writes a prescription for medication that the patient self-administers, and situations where the

[29] The term "clear days" is defined as the number of days, from one day to another, excluding both the first and the last day. Therefore, in the context of medical assistance in dying, the 10-day reflection period would commence on the day following the day on which the patient's request is made, and would end the day following the tenth day.

physician or nurse practitioner is directly involved in administering an agent to end the patient's life.

Physician(s) and/or nurse practitioner(s) must inform the pharmacist of the purpose for which the substance is intended before the pharmacist dispenses the substance.

Physicians are advised to notify the pharmacist as early as possible (e.g. at the commencement of the reflection period) that medications for medical assistance in dying will likely be required. This will provide the pharmacist with sufficient time to obtain the required medications.

Physicians must exercise their professional judgement in determining the appropriate drug protocol to follow to achieve medical assistance in dying. The goals of any drug protocol for medical assistance in dying include ensuring the patient is comfortable, and that pain and anxiety are controlled.

Physicians must document the medication protocol utilized (i.e. drug type(s) and dosages) in the medical record.

College members may wish to consult resources on drug protocols used in other jurisdictions. Examples of such protocols are available on the *CPSO Members* login page on the College's website.

Providing Medical Assistance in Dying

~~**STEP 8: Provision of Medical Assistance in Dying**~~

The patient must be capable not only at the time the request for medical assistance in dying is made, but also at the time they receive medical assistance in dying.

Immediately before providing medical assistance in dying, the physician(s) and/or nurse practitioner(s) involved must provide the patient with an opportunity to withdraw the request and if the patient wishes to proceed, confirm that the patient has provided express consent. This must occur either immediately before the medication is administered or immediately before the prescription is provided.

Where medical assistance in dying is provided, physicians must document the patient's time of death in the medical record.

Physicians and nurse practitioners who provide medical assistance in dying, and those who assist them throughout the process, are protected from liability if they are acting in compliance with the federal legislation and any applicable provincial or territorial laws, standards or rules. These protections would extend, for example, to pharmacists, any individual who supports a

physician or nurse practitioner (not limited to regulated health professionals), or individuals who aid a patient to self-administer the fatal dose of medication.

Where the patient plans to self-administer the fatal dose of medication at home, physicians must help patients and caregivers assess whether this is a manageable option. This includes ensuring that the patient is able to store the medication in a safe and secure manner so that it cannot be accessed by others.

Further, physicians must ensure that patients and caregivers are educated and prepared for what to expect, and what to do when the patient is about to die or has just died. This includes ensuring that caregivers are instructed regarding whom to contact at the time of death. For further information, physicians are advised to consult the College's *Planning for and Providing Quality End-of-Life Care* policy.

Reporting Requirements and Certification of Death

~~STEP 9: Mandatory Report to Coroner and Certification of Death~~

Physicians who provide medical assistance in dying must report the medically assisted death to the Office of the Chief Coroner for Ontario (OCC).[30, 31] Upon notification, the OCC will determine whether the death ought to be investigated. If the OCC determines that an investigation is not required, the physician or nurse practitioner who provided medical assistance in dying completes the death certificate. If the OCC is of the opinion that an investigation is required, the OCC would complete the death certificate.[32]

When completing the death certificate for a medically assisted death, the illness, disease, or disability leading to the request for medical assistance in dying must be recorded as the underlying cause of death. The death certificate must not make reference to medical assistance in dying, or the drugs administered to achieve medical assistance in dying.[33]

[30] Section 10.1(2) of the *Coroners Act*.

[31] Physicians notify the OCC of a medically assisted death by contacting provincial dispatch. Provincial dispatch will then contact the on-duty member of the OCC MAID Review Team, who will obtain information from the reporting physician regarding the facts and circumstances relating to the death. Documentation pertaining to the medically assisted death is to be faxed, as soon as is reasonably possible, to the MAID review team at 416-848-7791.

[32] Section 21(7) of the *Vital Statistics Act*, R.S.O. 1990, c. V.4.

[33] Instructions on completing the Medical Certificate of Death reflect joint guidance developed by the Ministry of Health and Long-Term Care, the Ministry of Government and Consumer Services, and the Office of the Chief Coroner.

Council Briefing Note

December 2018

TOPIC: Policy Redesign – Proposed Approach

FOR DECISION

ISSUE:

- The 2018-2019 Corporate Plan includes commitments to redesign College policies to be more clear and concise with a focus on enhancing their utility for physicians, as well as to evaluate whether a naming convention other than 'policy' might be more intuitive to the profession.

- Council is provided with an overview of the work undertaken to date and the proposed approach that has been developed to redesigning policy. Council is asked for feedback on the proposed approach and whether it recommends adopting this approach. Council is also asked for feedback regarding the adoption of a new naming convention, to help inform ongoing work and future decision-making.

BACKGROUND:

- Internal and external feedback indicates that College policies can be difficult to navigate and understand. This is due in part to their length and format.

    - Currently, policies are drafted in a long-form narrative style which contains both mandatory (i.e., "physicians must...") and permissive (i.e., "physicians are advised...") expectations, as well as additional contextual information.

    - This approach can make it difficult to quickly identify expectations and to easily distinguish between those that are required and those that are advised.

- The 2018-2019 Corporate Plan includes a commitment to address this issue, by redesigning policies to be more clear and concise, and in particular, to do so in a manner that better distinguishes between expectations that are required and those that are advised.

- The Corporate Plan also includes a commitment to evaluating whether 'policy' is the most intuitive naming convention, and whether alternative options may better reflect and capture the purpose and function of these documents.

CURRENT STATUS:

- To support the development of a proposed approach to redesigning policies and to being evaluating naming convention options, an environmental scan of other medical regulators and some provincial health regulatory Colleges was undertaken (see **Appendix A**), and the Medical Advisors and Outreach Committee were consulted and asked for feedback.

- The approach used by the College of Physicians and Surgeons of Alberta (CPSA), was identified early in the process as being a model that was potentially worth emulating.

    - The CPSA sets out predominantly (although not exclusively) mandatory expectations in "Standard of Practice" documents that are short and use a numbered/bulleted list approach. The CPSA provides additional "Advice to the Profession" in long-form narrative documents that often accompany a corresponding standard.

- The proposed approach to redesigning policies is set out below, along with a summary of the feedback received to date through informal consultations with staff and members of the profession. An overview of the work undertaken to date in relation to evaluating naming convention options is then set out for Council's consideration and feedback at the end of the briefing note.

A. Redesigning Policies

1) Proposed Approach

- The purpose of the redesign is to transition all current policies to a format that is clear, concise, and allows for easier identification of mandatory and permissive expectations.

- The aim is to transition all existing policies to the new approach by the end of 2019 without triggering the need for external consultation on the proposed changes (e.g., by changing the function of policies, their meaning, or altering what is expected of physicians).

- With these considerations in mind, it is proposed that:

    - All expectations currently set out in policy (both mandatory and permissive) be retained in single documents rather than divided into separate documents (as per the CPSA approach);

    - A numbered/bulleted list format be adopted instead of the current long-form narrative approach;

    - Formatting be used to better identify and delineate between mandatory and permissive expectations; and

    - A statement of the purpose of the document and definition of key terms (i.e., 'must' and 'advised') be added to each document.

- Using this approach, a number of draft mock-ups of existing policies have been developed. In each instance, significant improvements in clarity have been achieved and the documents have been reduced in length by 50% or more. Draft mock-ups of two existing policies are provided to Council for illustrative purposes[1] (see **Appendix B** and **C**).

- In developing the proposed approach, significant consideration was given to separating mandatory and permissive expectations into separate documents, similar to the CPSA, as part of the transition process. This approach was ultimately not proposed for the following reasons.

    - Policies currently set out mandatory and permissive expectations and physician conduct is evaluated against both. Separating the mandatory and permissive expectations would mean that either (1) physician conduct would be assessed against two documents or (2) existing permissive expectations would no longer be used to assess physician conduct (i.e., would not inform the adjudication of complaints).

    - The first outcome is not consistent with the spirit of the redesign as it would increase the burden on physicians in terms of understanding the expectations set out by the College. The second outcome presents a number of challenges as well.

        - Council has deliberately set some expectations as permissive in nature, allowing for some discretion. These decisions may have been quite different had Council known at the time that they would not be included in the policy and would have no role to play in the adjudication of complaints.

        - There is at least anecdotal evidence that permissive expectations are used by the Inquires, Reports, and Complaints and Quality Assurance Committees.

        - Historically changing the policy in this way would have triggered the need for an external consultation, allowing stakeholders (including the public) to provide input to inform decision-making process.

        - Notwithstanding their permissive nature, some core expectations would be lost from a number of policies and in some instances, the integrity, spirit or intention of the policy would be significantly compromised if this approach were adopted as part of this transition process (see **Appendix D** for examples of key permissive expectations).

[1] The draft mock-ups provided are not finalized and additional work is outstanding to, for example, ensure that expectations have not been altered and to determine how to best capture existing content in footnotes.

- The proposed approach also includes a commitment to critically evaluating the use of permissive expectations on a go-forward basis. In particular, with an aim to limit their use where possible and under the direction of Council as policies are reviewed and revised.

- Additionally, it is anticipated that companion documents will continue to be produced where necessary to: provide advice regarding discharging specific expectations, capture rationale/context where it is needed, and outline best practices or recommendations for conduct where appropriate to do so outside of the policy itself.

2) Feedback on the Proposed Approach

- Feedback on the draft mock-ups was sought from members of staff in the Investigations & Resolutions and Physician and Public Advisory Services departments, as these areas regularly rely on and apply policies. In general, feedback was positive and indicated that the proposed approach could improve the utility of the policies, including improving how staff apply policies to specific circumstances and communicate with physicians or members of the public.

- Feedback was also sought as part of the most recent Chiefs' and Presidents' Day. The feedback received was positive with a strong endorsement of the redesigned draft mock-ups, although there was a recommendation to retain the existing context/rationale in companion documents and to be cautious about eliminating the use of permissive expectations altogether.

3) Transition Plan

- Should Council approve the proposed approach:

    - All current policies not under review will be transitioned to the new format by the end of 2019. Council will be asked at one or more points throughout 2019 to approve sets of policies that have been transitioned to the new format.

    - All policies currently under review will be transitioned to the new format as part of their respective review process and presented to Council as per that process.

DECISION FOR COUNCIL:

1. Does Council have any feedback on the proposed approach to redesigning policies?

2. Does Council direct staff to redesign Council's current policies in accordance with the proposed approach set out above?

B. Naming Convention

- Work is also underway to evaluate whether 'policy' is the most appropriate and intuitive naming convention, or whether there are better alternatives.

- The purpose of College policies is to articulate broad expectations of physician behaviour with a focus on issues of professionalism. They do not establish legally binding rules or prescribed standards of practice with legal force, but are rather guidelines with normative or persuasive force.

- Any new naming convention will need to reflect this purpose and navigate considerations such as:

    - Avoiding representing these documents in a manner that is potentially misleading or that may introduce legal risk;

    - Minimizing any risk of confusion with other terms used within the regulatory context;

    - Ensuring the naming convention resonates with members of the profession and communicates the intended purpose of these documents in an intuitive way; and

    - Adopting, where possible, an approach that is consistent with other medical or health regulatory bodies.

- Results of an environmental scan indicate that medical and health regulatory bodies adopt a range of naming conventions, but that variations of policy, guidelines, and standards of practice are common. Additionally, in light of early analysis and feedback 'Professional Expectations' has been piloted as a potential option. This option resonated strongly with participants at the most recent Chiefs' and Presidents' Day, although some felt that 'policy' was a stronger and more directive term.

- Alternative options will continue to be considered and evaluated with an aim to bring a recommendation forward to Council at a subsequent meeting. This continued work will be informed by feedback provided by Council, as well as results of the policy redesign should Council direct that the proposed approach be adopted.

DISCUSSION FOR COUNCIL:

1. Does Council have any feedback regarding the adoption of a new naming convention?

Contact: Craig Roxborough, ext. 339

Date: November 16, 2018

Attachments:

Appendix A: Policy Redesign: Environmental Scan
Appendix B: *Accepting New Patients* draft mock-up
Appendix C: *Uninsured Services: Billing and Block Fees* draft mock-up
Appendix D: Permissive Expectations - Examples of Expectations Currently Set Out in Policy

Policy Redesign: Environmental Scan

Document Type, Document Format, & Inclusion of Mandatory Language

Regulatory Authority	Document Type (E.g.: Policy, Standard, Guideline, etc.) *This analysis did not include Codes of Ethics / Codes of Conduct / Regulations, etc.	Document Format	Inclusion of Mandatory and/or Discretionary Provisions
College of Physicians and Surgeons of Ontario 36 x Policies[1]			
College of Physicians and Surgeons of British Columbia 30 x Practice Standards 12 x Professional Guidelines	1) **Practice Standards:** *"…reflect the minimum standard of professional behaviour and ethical conduct on a specific topic or issue ... Standards also reflect relevant legal requirements and are enforceable under the* Health Professions Act*, RSBC 1996, c.183 (*HPA*) and College Bylaws under the* HPA*."* 2) **Professional Guidelines:** "*…reflect a recommended course of action established based on the values, principles and duties of the medical profession. Physicians may exercise reasonable discretion in their decision making based on the guidance provided."*	1) **Practice Standard**[2]**:** Long-form with bulleted lists. Length and level of detail appears similar to CPSO policy. 2) **Professional Guideline**[3]: Long-form with bulleted lists. Guidelines appear significantly shorter than Practice Standards.	1) **Practice Standards:** Include both mandatory and discretionary provisions.[4] More recent standards appear to include *only* mandatory expectations, which may reflect a new approach being taken by the College. Otherwise, style, structure, and language is similar to CPSO policy. 2) **Professional Guidelines:** Mostly (but not exclusively) discretionary (E.g.: *"Physicians are encouraged to adhere to the following guidelines…"*). Guidelines consist mainly of recommendations, best practices, and other key considerations.

[1] Excludes 18 Registration Policies (*Ensuring Competence: Changing Scope of Practice and Re-entering Practice* is included)
[2] Standards reviewed: *Leaving a Practice* and *Cannabis for Medical Purposes.*
[3] Guidelines reviewed: *Emailing Patient Information* and *Social Media*.
[4] The *Leaving Practice* Standard includes only "must" statements (last updated in June, 2018). The *Cannabis for Medical Purposes* Standard (last updated in December, 2016) includes both requirements and recommendations.

College of Physicians and Surgeons of Alberta 41 x Standards of Practice 32 x Advice to the Profession	**1) Standards of Practice:** *"The* CPSA Standards of Practice *are the minimum standards of professional behavior and good medical practice Alberta physicians are expected to meet. The standards of practice complement the* Code of Ethics *and are used as a reference in reviewing complaints against physicians."* **2) Advice to the Profession:** *"…Specific standards are supplemented with Advice to the Profession, which supports physicians in implementing the standards in their practice."*	**1) Standard of Practice**[5]**:** Very concise numbered lists. Minimal context or added detail. **2) Advice to the Profession**[6]**:** Long-form. Organized around an introduction and table of contents (very similar to CPSO policy).	**1) Standards of Practice:** Mandatory. CPSA Standards of Practice include almost exclusively "must" statements, although periodically include "may". **2) Advice to the Profession:** Includes both mandatory and discretionary provisions ("must" is used alongside "recommend", "should", and other terminology).
College of Physicians and Surgeons of Saskatchewan 2 x Standards 28 x Policies 14 x Guidelines	**1) Standards:** *"Standards are the formal requirements established by the College with which members must comply. They supplement the College's bylaws and mandate clinical and/or ethical standards in relation to defined areas of practice."*[7] **2) Policies:**[8] *"Policies contain requirements set by the Council of the College to supplement the Act and Bylaws. Policies are formal positions of the College in relation to defined areas of practice with which members must comply. The Council also sets policies on registration, administration, and governance of the College."* **3) Guidelines:** *"Guidelines describe practices that are generally recommended by the Council of the College as part of providing quality medical care in a professional manner. Physicians licensed with the*	**1) Standards**[9]**:** Only 2 active Standards are available for review, and they differ from one another in regards to length, detail and organisation. Overall, CPSS Standards appear to be long-form documents organized around a full introduction, table of contents, definitions, etc. **2) Policies**[10]**:** Policies are generally long-form, but still organized around relatively concise bulleted lists. **3) Guidelines**[11]**:** Variable format. E.g.: *Patient-Physician Relationships* is long-form, consistent with CPSO policy, whereas *Providing Care to Employees or Co-workers* is a more concise, bulleted list of recommendations.	**1) Standards**: Includes both mandatory and discretionary provisions. The preamble to the Standard specifically clarifies the meaning of key terms: "shall", "should", and "may". **2) Policies:** Focus on mandatory provisions; however, with some exceptions. **3) Guidelines:** Include both mandatory and discretionary provisions. Largely consistent with the CPSO's approach to policy; however, the emphasis is on advice and recommendations rather than requirements.

[5] Standards reviewed: *Relocating a Medical Practice* and *Medical Assistance in Dying*.
[6] Advice reviewed: *Cannabis for Medical Purposes*, *Informed Consent for Minors*, and *Lost or Stolen Patient Records*.
[7] Of note: There are currently only 2 active Standards.
[8] Policies significantly outnumber Standards at the CPSS. New (and revised) policies have been approved in 2018. It would not seem that the CPSS is specifically moving away from policies towards Standards.
[9] Standards reviewed: *Assisted Reproductive Technology* and *Opioid Substitution Therapy.*
[10] Policies reviewed include *Complementary and Alternative Medicine, Hepatitis B C HIV Infected Physicians, Medical Assistance in Dying,* and *Physicians Accessing Patient Specific Information from PIP.*
[11] Guidelines reviewed: *Patient-Physician Communication, Patient-Physician Relationships,* and *Providing Care to Employees and Co-workers.*

	College are encouraged to follow these recommended courses of action and should exercise reasonable discretion in their decision-making based on this guidance."		
College of Physicians and Surgeons of Manitoba 1 x Standards of Practice Bylaw	1) **Standards of Practice of Medicine (Bylaw 11)**	1) **Standards of Practice (Bylaw):** All Standards are captured in a single, continuous document.	1) **Standards of Practice (Bylaw):** Mandatory. With only *very* limited exceptions, the Standards of Practice (Bylaw) uses only the word "must" to qualify provisions.
Collège des Médecins du Québec	Unable to find English language documents to review.		
College of Physicians and Surgeons of New Brunswick 18 x Guidelines 25 x Selected Commentary	1) **Guidelines:** *No description provided by the CPSNB.* 2) **"Selected Commentary":** *No description provided by the CPSNB.* ** Note: While not currently included in this analysis, it appears that the CPSNB* Code of Ethics *forms the basis of key expectations*	1) **Guidelines**[12]**:** There is significant variation in format between Guidelines. For example, *Medical Marijuana* is a long-form document akin to a CPSO policy, while *Sexual Boundary Violations* is organized around numbered statements and lists. 2) **Selected Commentary**[13]**:** Very concise, single-paragraph elaborations on existing professional standards.	1) **Guidelines**[14]**:** There is some variability between Guidelines; however, most include both mandatory and discretionary provisions. 2) **Selected Commentary:** Includes both mandatory and discretionary provisions with the following caveat: Selected Commentary appears to provide situation-specific guidance that is grounded in existing Guidelines and the CPSNB Code of Ethics. My sense is that, in themselves, they may not create new expectations or set a new bar.
College of Physicians and Surgeons of Newfoundland and Labrador 13 x Standard of Practice	1) **Standard of Practice:** *"… is the minimum standard of professional behaviour and ethical conduct on a specific issue expected by the College."* 2) **Practice Guideline:** *"…is a recommendation developed by the College with which members should*	1) **Standards of Practice**[15]**:** Standards are long-form. They are generally less comprehensive than CPSO policy, but similarly structured and organized. 2) **Practice Guideline**[16]: There is significant variation in format between Guidelines. For example, *Independent*	1) **Standards of Practice**: Mandatory. With only *very* limited exceptions, NPSNL Standards are solely comprised of mandatory provisions. 2) **Practice Guideline**: Includes both mandatory and discretionary provisions.

[12] Guidelines reviewed: *Medical Marijuana, Sexual Boundary Violations,* and *Termination of Care.*
[13] Selected Commentary reviewed: *Annual Physicals, Facebook,* and *Prescribing to Self and Family.*
[14] Many Guidelines rely heavily on the word "should".
[15] Standards reviewed: *Prescribing, Ending the Physician-Patient Relationship,* and *Telemedicine*

16 x Practice Guideline	*be familiar and follow whenever and wherever possible and appropriate."*	*Medical Examinations* is a long-form document akin to a CPSO policy, while *Advertising and Public Communications* is organized around numbered statements and lists.	
College of Physicians and Surgeons of Nova Scotia 34 x Professional Standards[17] 9 x Guidelines	**1) Professional Standards:** *"…reflect the minimum professional and ethical behaviour, conduct or practice expected by the College of Physicians and Surgeons of Nova Scotia. Physicians licensed with the College are required to be familiar with and comply with the College standards."* **2) Guidelines:** *"…contain recommendations endorsed by the College of Physicians and Surgeons of Nova Scotia. The College encourages its members to be familiar with and to follow its guidelines whenever possible and appropriate."*	**1) Professional Standards**[18]: Very concise documents. In most cases, there is a limited preamble that is followed by bulleted list of mandatory provisions. **2) Guidelines**[19]: Long-form documents with some variability in organization. Guidelines are generally longer than professional standards, and many are organized around section headings roughly consistent with CPSO policy.	**1) Professional Standards**: Mandatory. No substantive exceptions were noted in the Standards reviewed. **2) Guidelines**: CPSNS Guidelines are comprised of recommendations with a limited number of mandatory expectations (mandatory provisions appear to articulate requirements grounded in other documents).
College of Physicians and Surgeons of Prince Edward Island 29 x Policies 6 x Guidelines 2 x Statements	**1) Policies:** *No description provided by the CPSPEI.* **2) Guidelines:** *No description provided by the CPSPEI.* **3) Statements:** *No description provided by the CPSPEI.*	**1) Policies**[20]**:** There is significant variability between policies in terms of length and organization. Many appear heavily rooted in CMA Code of Ethics (cited in policies). Some take the form of bulleted lists, while others are long-form. **2) Guidelines** [21]**:** Are generally organized by topic heading with specific practice advice articulated below. Guidelines are often captured within one or two pages.	**1) Policies**: Includes both mandatory and discretionary provisions.[23] **2) Guidelines:** Include both mandatory and discretionary provisions. **3) Statements:** Articulate principles of practice and – in some cases – College "expectations". Statements do not appear to contain explicit "mandatory" provisions.

[16] Guidelines reviewed: *Prescribing Opioids for Acute Pain, Advertising and Public Communications,* and *Independent Medical Examinations*
[17] 7 *Professional Standards* and combined *"Professional Standards"* and *"Guidelines"*.
[18] Standards reviewed: *Marijuana for Medical Purposes, Qualifications Required to Perform Certain Cosmetic Procedures,* and *Walk-in Clinics.*
[19] Guidelines reviewed: *Closing a Medical Practice – Permanently or Temporarily, Referral and Consultation,* and *Telemedicine Services.*
[20] Policies reviewed: *Conscientious Objection to Provision of Service; Prescribing of Medical Marijuana;* and *Retention, Access and Transfer of Medical Records.*
[21] Guidelines reviewed: *Infection Prevention and Control* and *Walk-in Clinics.*

		3) Statements[22]**:** Are generally organized around a "preamble" or "introductory section" which sets out an issue, followed by an extrapolation of the ethical and professional duties that apply. In some cases "expectations" may be articulated, however, the tone of CPSPEI Statements suggests that they are meant to be read as articulating an "ideal", rather than setting a minimum standard of practice.	
College of Nurses of Ontario 10 x Practice Standards 18 x Practice Guidelines	**1) Practice Standards:** *"…outline the expectations for nurses that contribute to public protection. They inform nurses of their accountabilities and the public of what to expect of nurses. The standards apply to all nurses regardless of their role, job description or area of practice."* **2) Practice Guidelines:** *"…which often address specific practice-related issues, help nurses understand their responsibilities and how to make safe and ethical decisions in their practice."*	**1) Practice Standards**[24]**:** Are long-form documents. The Standards reviewed for this analysis include statements which define the Standard of Care in a specific practice context. Context and additional detail are provided to help nurses understand whether and how to meet specific statements within the standard. **2) Practice Guidelines**[25]**:** Are detailed, comprehensive, long format documents organized around a standard structure: introduction, topic-specific headings, case studies, appendices, and other resources.	**1) Practice Standards:** While CNO Practice Standards vary in format, the Standards reviewed for this analysis do not appear to include mandatory **or** discretionary provisions. Instead, Practice Standards include statements which define the Standard of Care in a specific practice context, and nurses are expected to decide whether and how to meet the Standard in practice. **2) Practice Guidelines**: Include primarily mandatory provisions (with only limited exceptions).
Ontario College of Pharmacists 8 x Standards of practice 15 x Policies 10 x Guidelines	**1) Standards of Practice: "…***Standards of Practice outline the* minimum *standards that all registered pharmacists and pharmacy technicians must meet. Regardless of a practitioner's position or practice environment, when a pharmacist or pharmacy*	**1) Standards of Practice**[26]**:** Standards of Practice are long-from technical documents that comprise legislative requirements, OCP guidance, and broader Standards established by external stakeholder and regulatory bodies (such as NAPRA).	**1) Standards of Practice**: Given the extensive and often technical nature of OCP Standards of Practice, there is inevitably a combination of both mandatory and discretionary provisions.

[23] The CPSPEI relies on a particularly diverse set of terms to qualify whether a provision is mandatory, including "shall", "must", "may", and "recommend", even within the same document.
[22] Statements reviewed: *Pandemics: Practising with Risk to Self* and *Withdrawal of Physician Services.*
[24] Standards reviewed: *Infection Prevention and Control, Restraints* and *Therapeutic Nurse-Client Relationships.*
[25] Guidelines reviewed: *Complementary Therapies*, *Disagreeing With the Plan of Care*, and *Working with Unregulated Care Providers*.
[26] Standards reviewed: *Model Standards for Pharmacy Compounding of Non-Hazardous Sterile Preparations, Model Standards for Pharmacy Compounding of Non-Sterile Preparations,* and *Standards for Pharmacists Providing Services to Licensed Long-Term Care Facilities.*

	technician performs a specific role, they must *perform it to the level specified in the Standards of Practice and meet* all *of the standards associated with that role."* **2) Policies:** *No description provided by the OCP.* **3) Guidelines:** *No description provided by the OCP.* *Additionally, the OCP has a limited number of "Guidance", "Position Statement", and "Other" documents.	**2) Policies**[27]: OCP Policies are concise relative to CPSO policies. Most policies consist of a Definitions section followed by limited subset of subject-specific headings. **3) Guidelines**[28]: While there is some variability, OCP Guidelines adopt a similar format to CPSO policies: they are long-form documents which are generally organized around an Introduction, Definitions, and oftentimes a Principles section.	**2) Policies:** The policies reviewed contained only mandatory provisions. **3) Gudielines:** Includes both mandatory and discretionary provisions.
Royal College of Dental Surgeons of Ontario 3x Standards 7x Guidelines 13 x Practice Advisories	**1) Standards:** ***"…*** *Members are reminded that dentists are obligated at all times to maintain the standards of practice of the profession including those published by the College. A member who fails to comply with a standard published by the College or the generally accepted standards of practice of the profession may be acting in a manner that could result in allegations of professional misconduct."* **2) Guidelines:** ***"…*** *Guidelines … contain practice parameters and standards which should be considered by all Ontario dentists in the care of their patients. It is important to note that these Guidelines may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained."* **3) Practice Advisories:** ***"…****Practice Advisories … contain practice parameters and advice which should be considered by all Ontario dentists in the care of their*	**1) Standards**[29]: RCDSO Standards are technical standards rooted in legislation and established clinical practice. They are extensive, detailed long-form documents. **2) Guidelines**[30]: RCDSO Guidelines and detailed, comprehensive, long-form documents, similar in scope and detail to CPSO policies. **3) Practice Advisories**[31]: The distinction between Guidelines and Practice Advisories is not clear. Both are long-form documents with provisions organized under topic-specific headings.	**1) Standards:** Contain a combination of mandatory and discretionary provisions rooted in legislation and best clinical practice. **2) Guidelines**: Includes both mandatory and discretionary provisions. **3) Practice Advisories**: Includes both mandatory and discretionary provisions.

[27] Policies reviewed: *Distribution of Medication Samples, Faxed Transmission of Prescriptions,* and *Prescriptions-Out of Country.*
[28] Guidelines reviewed: *Administering a Substance by Injection of Inhalation, Ending the Pharmacist-Patient Relationship,* and *Preventing Sexual Abuse and Harassment.*
[29] Standards reviewed: *Amalgam Waste Disposal, Dental CT Scanners,* and *Use of Sedation and General Anesthesia in Dental Practice.*
[30] Guidelines reviewed: *Dental Record Keeping, Electronic Records Management,* and *The Role of Opioids in the Management of Acute and Chronic Pain…*
[31] Practice Advisories reviewed: *Guidance on the Use of Social Media, Maintaining a Professional Patient-Dentist Relationship,* and *Prevention of Sexual Abuse and Boundary Violations.*

	patients and in the operation of their practices. It is important to note that these Practice Advisories may be considered by the College and its committees in determining whether professional responsibilities have been maintained."		
General Medical Council (UK)	**Good Medical Practice:** *Good medical practice describes what is expected of all doctors registered with the General Medical Council (GMC). It is your responsibility to be familiar with Good medical practice and the explanatory guidance which supports it, and to follow the guidance they contain.* *You must use your judgement in applying the principles to the various situations you will face as a doctor, whether or not you hold a licence to practise, whatever field of medicine you work in, and whether or not you routinely see patients. You must be prepared to explain and justify your decisions and actions.*		*"In Good medical practice, we use the terms 'you must' and 'you should' in the following ways.* • ***'You must' is used for an overriding duty or principle.*** • ***You should' is used when we are providing an explanation of how you will meet the overriding duty.*** • ***'You should' is also used where the duty or principle will not apply in all situations or circumstances, or where there are factors outside your control that affect whether or how you can follow the guidance."***

Accepting New Patients

Definitions

First-Come-First Served Approach: This approach requires physicians, who are accepting new patients, to do so on a first-come, first-served basis, when the patient's needs are within their:

- Clinical competence and/ or scope of practice;
- Focused practice area; and/or
- Terms and conditions of the physician's practice certificate and associated practice restrictions, if applicable.

Higher Need and Complex Patients: Patients who may be categorized as higher need and/or complex include, but are not limited to, those requiring urgent access to care, those with chronic conditions, particularly where the chronic condition is unmanaged, an activity-limiting disability and/or mental illness.

Policy[1]

1. Physicians **must** follow the *first-come, first-served approach* when accepting new patients into their practices.

    a. Notwithstanding the first-come, first-served approach, physicians are not prevented from making decisions about whether their practice is accepting new patients.

2. In accordance with the Ontario *Human Rights Code*, physicians **must not** refuse to accept prospective patients based on any of the prohibited grounds of discrimination. Prohibited grounds of discrimination include, but are not limited to, race, ancestry, place of origin, color, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

3. Physicians **must not** use clinical competence and/or scope of practice as a means of discriminating against prospective patients or to refuse patients:
    i. With complex or chronic health needs;
    ii. With a history of prescribed opioids and/or psychotropic medication;
    iii. Requiring more time than another patient with fewer medical needs; or
    iv. With an injury, medical condition, psychiatric condition or disability that may require the physician to prepare and provide additional documentation or reports.

[1] Policies of the College of Physicians and Surgeons of Ontario (the "College) set out expectations for the professional conduct of physicians practicing in Ontario. Together with the *Practice Guide*, College policies serve as the benchmark against which the conduct of individual physicians will be assessed. Within policies, the term 'must' refers to what the College expects of physicians, and includes requirements prescribed by law, whereas the term 'advised' refers to expectations where physicians can exercise reasonable discretion when applying to practice.

4. Where a physician refuses a patient based on clinic competence, scope of practice, and/or a focused practice area, the physician **must** consider the impact on the patient and clearly communicate the reasons for the refusal to the patient (or referring practitioner where appropriate).

5. Physicians **are advised** that given the broad scope of practice of primary care physicians, there are few occasions where scope of practice would be an appropriate ground to refuse a prospective patient.

6. Once a patient has been accepted into a primary care practice, should elements of the patient's health-care needs be outside of the physician's clinical competence and/or scope of practice, the patient **must not** be abandoned. The physician **must** provide the patient with a referral to another appropriate health-care provider for those elements of care that the physician is unable to manage directly

7. Physicians **must not** use introductory meetings such as 'meet and greet' appointments, and/or medical questionnaires to vet prospective patients and determine whether to accept them into their practice.

8. Introductory meetings and/or medical questionnaires are permitted once a patient has been accepted into a practice to, for instance, share information about the practice and obtain information about the patient.

Specialist Care

9. Physicians who provide specialist care **must** employ the first-come, first-served approach by accepting new patients in the order in which the referral was received. Departing from this practice is appropriate only to accommodate patients requiring priority access to care due to urgent health-care needs.

Waiting Lists

10. Physicians who maintain a waiting of prospective patients **must** accept patients in the same order in which they were added to the list.

Potential Exceptions to First-Come, First-Served Approach

11. In limited circumstances, physicians are permitted to depart from the first-come, first-served approach to prioritize access to care for higher need/complex patients.

12. Physicians **must** use their professional judgment to determine whether prioritizing or triaging patients based on need is appropriate, taking into account the patient's health care needs, and any social factors, including education, housing, food security, employment and income that may influence the patient's health outcomes.

13. The College acknowledges that caring for patients and their family members may assist in the provision of quality care. Accordingly, where a physician's practice is otherwise closed, physicians may choose to prioritize the family members of current patients.

Uninsured Services: Billing and Block Fees

Definitions

Insured services: Services, including their constituent elements, listed in the *Health Insurance Act* and the Schedule of Benefits that are publicly funded under the Ontario Health Insurance Plan (OHIP), provided that the service is being rendered to an insured person.

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

Block fee: 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.

Policy[1]

1. Physicians **must not** charge:

    a. For the provision of insured services (including the constituent elements of insured services);
    b. Any amount in excess to what OHIP has paid or will pay;
    c. For services not performed;
    d. For an undertaking to be available to provide services to a patient; or
    e. For uninsured services the government has agreed to remunerate physicians for.

Setting Fees that are Reasonable

2. Physicians **must** ensure the fees they charge for uninsured services, including block fees, and missed or cancelled appointments without the required notice are reasonable. In doing so physicians **must**:

    a. Ensure that the fee for individual uninsured services is commensurate with the nature of the services provided and their professional costs;
    b. Consider the recommended fees set out in the Ontario Medical Association's *Physicians Guide to Uninsured Services* (the OMA Guide) and any recommended fees set out by professional specialty association(s).

[1] Policies of the College of Physicians and Surgeons of Ontario (the "College) set out expectations for the professional conduct of physicians practicing in Ontario. Together with the *Practice Guide*, College policies serve as the benchmark against which the conduct of individual physicians will be assessed. Within policies, the term 'must' refers to what the College expects of physicians, and includes requirements prescribed by law, whereas the term 'advised' refers to expectations where physicians can exercise reasonable discretion when applying to practice.

c. Notify patients if they charge more than the OMA Guide and the excess amount that will be charged;
d. Ensure that the amount charged for a block fee is reasonable in relation to the services and period of time covered by the block fee.
e. Consider what would constitute reasonable cost recovery, as well as what would act as a reasonable deterrent to patients, when setting fees for missed appointments.

3. Physicians **must** 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:

    a. Whether it would be appropriate to reduce, waive, or allow for flexibility on compassionate grounds.
    b. Granting exceptions for missed or cancelled appointments without required notice when it is reasonable to do so (e.g., first or isolated incident, intervening circumstances, etc.)

Communicating Fees

4. Physicians **must** ensure that a patient or third party is directly 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 and be available to offer explanations and/or answer questions about their fees, but are permitted to rely on staff to provide fee information.

Charging for Missed or Cancelled Appointments

5. Physicians are permitted to charge for a missed or cancelled appointment with less than 24 hours' notice (or in a psychotherapy practice, in accordance with any reasonable written agreement), but **must**:

    a. Have a system in place to facilitate the cancelation process;
    b. Ensure the patient was informed of the cancellation policy and fees in advance; and
    c. Been available to see the patient at the time of the appointment.

Providing an Invoice

6. Physicians are **advised** to always provide an itemized invoice for any uninsured services that are provided and for which fees are paid, but **must** provide an invoice when asked for one.

Combining Insured and Uninsured Services

7. Physicians who propose or provide insured and uninsured services together or offer uninsured services as an alternative or adjunct to insured services **must**:

a. Clearly communicate which services or elements of a service are associated with a fee and which are not;
b. Describe the patient's options in clear and impartial manner;
c. Ensure that if their practice structure leads to different wait times for the insured and uninsured services they provide, that doing so complies with the *Commitment to the Future of Medicare Act* prohibitions regarding preferential access to insured services;
d. Place the interests of their patients over their own and manage any real or perceived conflicts of interest that might arise. This includes not referring a patient to a facility in which they or a member of their family has a financial interest without first disclosing that fact and sell or otherwise supply any medical appliance or medical product to a patient at a profit.

Offering a Block Fee

8. A block fee may not be appropriate in all practice settings and physicians **must** consider the nature of their practice and specialty when determining whether or not to offer a block fee.

9. Physicians who offer a block fee **must** ensure the fee covers a period of not less than 3 months and not more than 12 months.

10. Physicians offering the option of a block fee **must** always provide the patient with the alternative of paying for each service individually and **must not**:

    a. Require that patients pay a block fee before accessing an insured or uninsured service;
    b. Treat or offer to treat patients preferentially because they agree to pay a block fee; or
    c. Terminate a patient or refuse to accept a new patient because that individual chooses not to pay a block fee.

11. When offering a block fee to patients, physicians **must**:

    a. Offer a block fee in writing and:
        i. Indicate that payment of a block fee is optional and that patients may choose to pay for uninsured services as they are provided;
        ii. Indicate that the patient's decision to pay for uninsured services individually or through a block fee will not affect their ability to access health-care services;
        iii. 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;
        iv. Use plain language, give consideration as to how to address language and/or communication barriers that may impede patients' ability to understand what is

being offered, and refrain from using language that is or could be perceived as coercive or suggestive that without payment of the block fee, services will be limited or reduced, or that quality of care may suffer;

v. Invite patients to consider whether payment of a block fee is in their best interest given their needs or usage of uninsured services; and
vi. Direct patients to the appended Patient Information Sheet.

b. 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.
c. Obtain written confirmation if the block fee option is chosen and maintain it as part of the patient's medical record.

12. Physicians **must** give patients the opportunity to rescind their decision to pay a block fee within a week of the original decision.

13. If the physician-patient relationship ends, physicians are **advised** to consider whether it would be reasonable to refund a portion of the block fee, considering both the time remaining and the services provided to date.

Using Third Party Companies

14. Physicians using a third party to administer their block fee **must**:

a. Ensure that any communication between the third party and patients identifies the third party by name and indicates they are acting on the physicians behalf, and
b. Ensuring that the third party adheres to the same expectations required of physicians.

Appendix D

Permissive Expectations – Examples of Expectations Currently Set Out in Policy

College policies currently include expectations that are either "mandatory" or "permissive".

- A mandatory expectation is one where the College expects that physicians always meet this expectation. These are denoted in policy through the use of "must" or "required".
- A permissive expectation is one where the College recommends that a particular action be taken or expectation be met. Importantly, physicians may exercise a reasonable degree of discretion in terms of implementing the expectation. These are denoted in policy through the use of "advised" or "recommended".

A non-exhaustive list of core or important permissive expectations is set out below.

……..

- Blood Borne Viruses (approved 2015)
  - "It is **strongly recommended** that physicians who are not currently and have not previously been infected with HBV be immunized for HBV and tested to confirm the presence of an effective antibody response, unless a contraindication exists, or there is evidence of prior immunity."
- Consent to Treatment (approved 2015)
  - "The College **advises** physicians to consider and address language and/or communication issues that may impede a patient's ability to give valid consent. Physicians may consider using family members instead of third-party interpreters; however, physicians are **advised** to take the potential limitations of doing so into account."
  - The College **strongly advises** physicians to obtain express consent, particularly when the treatment is likely to be more than mildly painful, carries appreciable risk, will result in ablation of a bodily function, is a surgical procedure or an invasive investigative procedure, or will lead to significant changes in consciousness.
- Physician Behaviour in the Professional Environment (approved 2016)
  - "If the physician is unable to control the behaviour on his or her own, the physician is **advised** to seek appropriate assistance to do so."
- Physician Treatment of Self, Family Members, and Others Close to Them (approved 2016)
  - "The College **recommends** that physicians carefully consider whether it is appropriate to provide treatment to others close to them.
- Planning for and Providing Quality End-of-Life Care (approved 2016)
  - "As part of routine care in an ongoing physician-patient relationship, physicians are **advised** to discuss with their patients…the importance and the benefits of advance care planning."
  - "Physicians are strongly **advised** to discuss options with respect to potentially life-saving and life-sustaining treatments as early as possible and where appropriate."
- Public Health Emergencies (approved 2018)
  - "It is **recommended** that physicians prepare for the occurrence of public health emergencies."
- Uninsured Services: Billing and Block Fees (approved 2017)
  - "Physicians are **advised** to always provide an itemized invoice for any uninsured services that are provided and for which fees are paid."

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 2018

TOPIC: **APPROVAL TO RESCIND THE FOLLOWING THREE POLICIES:**

- ***Anabolic Steroids, Substances and Methods Prohibited in Sport*;**
- ***Female Genital Cutting (Mutilation);* and**
- ***Fetal Ultrasound for Non-Medical Reasons***

FOR DECISION

ISSUE:

- The 2018-2019 Corporate Plan includes a commitment to evaluate all existing College policies in order to identify those that are no longer required.

- Following an initial review, three policies have been identified for possible rescission. These are:
    1. Anabolic Steroids, Substances and Methods Prohibited in Sport
    2. Female Genital Cutting (Mutilation)
    3. Fetal Ultrasound for Non-Medical Reasons

- Council is provided with an overview of the evaluation undertaken, and is asked to approve the recission of the aforementioned policies.

BACKGROUND:

- In evaluating the suitability of each of the above policies for rescission, a number of factors were considered. These include:

    - Existing legislative requirements and clinical standards;
    - Professional expectations established in other College policies;
    - Public and physician engagement with the policies as evidenced by: Inquiries received by Public and Physician Advisory Services (PPAS); Investigations and Resolutions (I&R) data; policy webpage traffic; and
    - Feedback received as part of a preliminary consultation assessing the utility and value of these policies.[1]

[1] A joint consultation on these three policies was undertaken in the fall of 2018 in order to assess whether the policies were useful, whether there are other resources stakeholders consult for guidance on these issues, and to determine if there is value in the College continuing to provide guidance on these issues. The consultation received 52 responses via the online discussion page, the online survey, and email.

- Overall, this evaluation revealed that the three polices reiterate expectations already established in law, other College policies, or set out in clinical standards. Further, internal data indicates that the policies are accessed infrequently, and have not been the subject of significant physician and/or public engagement.

POLICY #1: Anabolic Steroids, Substances and Methods Prohibited in Sport

CURRENT STATUS:

- The *Anabolic Steroids, Substances and Methods Prohibited in Sport* policy ("*Anabolic Steroids"*), initially developed in 1988, prohibits physicians from prescribing, administering or assisting in the use of substances or methods for performance enhancing purposes.

- A summary of the factors that were evaluated to help assess the suitability of the policy for rescission is set out below.

a) Legislation and Applicable Standards

- The College's *Anabolic Steroids* policy references a number of existing international and national bodies that set anti-doping standards.[2] These bodies provide guidance to physicians, athletes and other individuals involved in sport on their roles and responsibilities pertaining to performance enhancing substances and methods.

- Under the *Medicine Act*, *1991*, prescribing, dispensing or selling drugs for an improper purpose are acts of professional misconduct. It is commonly held by international and national anti-doping bodies, that prescribing, administering or assisting in the use of anabolic steroids, and other substances or methods prohibited in sport, without medical indication, is an improper purpose. Physicians' involvement in such activities, therefore, may constitute professional misconduct.

b) Relevant CPSO Professional Expectations

- The College's *Prescribing Drugs* policy requires that physicians prescribe drugs only where there is a clinical indication for doing so, based on a clinical assessment and other relevant information.

c) I&R and PPAS Data

- The *Anabolic Steroids* policy has been cited twice in decisions of the Inquiries, Complaints, and Reports Committee (ICRC) since 2012. PPAS has not received a sufficient number of inquiries to enable data reporting in this area.

[2] These include, but are not limited to, the: World Anti-Doping Agency's International Standards; United Nations Educational, Scientific and Cultural Organization's International Convention against Doping in Sport; and Canadian Policy Against Doping in Sport.

d) Website Visits

- Between September 1, 2017 and August 31, 2018, the *Anabolic Steroids* policy page had 323 views. This accounts for 0.003% of visits to the policy section of the website. Notably, the majority of page views were from outside Ontario.

e) Jurisdictional Review

- No other Canadian medical regulatory authority appears to have a specific policy providing guidance and expectations with regards to the use of anabolic steroids in sport.

f) Consultation Feedback

- The majority of the survey of respondents were aware of the *Anabolic Steroids* policy. However, only a small percentage indicated thay have read, consulted or otherwise used the policy. Respondents who had read the policy were divided on the usefulness of the guidance provided.

- The majority of respondents, including those who have and have not read the policy, indicated that is in important for the CPSO to set out expectations on this issue.

- The Ontario Medical Assoication (OMA) noted that any issues of importance regarding anabolic steroids and other related substances can be addressed through the *Perscribing Drugs* policy, and that given the guidance available from national and international sporting regulators it is redundant for the CPSO to have a specific policy.

KEY CONSIDERATIONS:

- Should Council approve the rescission of the *Anabolic Steroids* policy, the following steps could be undertaken:

    - Remind members via the College's communication channels[3] that the professional expectations set out in the *Prescribing Drugs* policy are also applicable when prescribing anabolic steroids or other substances commonly used in sport.

DECISION FOR COUNCIL:

- Does Council approve that the *Anabolic Steroids, Substances and Methods Prohibited in Sport* policy be rescinded?

[3] This may include, for instance, *Dialogue* magazine, the CPSO website, via a press release and/or social media.

POLICY #2: Female Genital Cutting (Mutilation)

CURRENT STATUS

- The *Female Genital Cutting (Mutilation)* policy ("*FGC/M"*) was initially approved by College Council in February 2001. The policy prohibits physicians from performing FGC/M procedures, or referring patients for the performance of FGC/M.

- A summary of the factors that were evaluated to help assess the suitability of the policy for rescission is set out below.

a) Legislation and Clinical Standards

- Under the Canada's *Criminal Code*, the performance of FGC/M procedures is considered aggravated assault. Further, the Ontario Human Rights Commission recognizes that FGC/M violates the basic human rights and human dignity of women and girls.

- It is an act of professional misconduct under the *Medicine Act, 1991* to contravene a federal law (e.g. the *Criminal Code*), where the purpose of the law is to protect the public's health or the contravention is relevant to the member's suitability to practise. The performance of or referral for FGC/M procedures would, therefore, be regarded as professional misconduct.

- To support physicians who encounter instances or potential instances of FGC/M in a clinical environment, the Society of Obstetricians and Gynecologists of Canada (SOGC) has developed comprehensive clinical guidelines.[4]

b) *Relevant CPSO Professional Expectations*

- In addition to prohibiting physicians from performing FGC/M procedures, the current policy states that FGC/M procedures on females under the age of 18 may constitute child abuse.

- The College's *Mandatory and Permissive Reporting* policy details physicians' duty to report suspected child abuse to the appropriate child protection authorities under the *Child and Family Services Act, 1990*.

c) I&R and PPAS Data

- The *FGC/M* policy has not been cited in deisions of the ICRC since 2012. PPAS has not received a sufficient number of inquiries to enable data reporting in this area.

d) Website Visits

- Between September 1, 2017 and August 31, 2018, the *FGC/M* policy has had 521 views. This accounts for 0.01% of visits to the policy section of the website.

e) Jurisdictional review

- The College of Physicians and Surgeons in Manitoba and Nova Scotia have policies related to FGC/M and the Collège de Médicines due Québec issued a statement applying the principles of the Canadian Medical Association's Code of Ethics to the performance of FGC/M.

[4] For more information please see the SOGC's Clinical Practice Guidelines: Female Genital Cutting.

f) Consultation Feedback

- The majority of the survey of respondents were aware of the *FGC/M* policy. However, only a small percentage indicated thay have read, consulted or otherwise used the policy. Respondents who had read the policy found the guidance helpful.

- The majority of respondents, including those who have and have not read the policy, indicated that it is important for the CPSO to set out expectations on this issue.

- The OMA suggested that the CPSO provide clear guidance to physicians about the importance of reporting instances of FGC/M and incorporate the more significant aspects of the *FGC/M* policy into the CPSO's *Mandatory and Permissive Reporting* policy.

KEY CONSIDERATIONS:

- Should Council approve the rescission of the *FGC/M* policy, the following steps could be undertaken:

  - Remind members, via the College's communication channels, that providing or referring patients for FGC/M procedures is a criminal offence and constitutes professional misconduct, that their reporting obligations with respect to child abuse set out in the College's *Mandatory and Permissive Reporting* policy, also apply in this context, and provide a link to the SOGC's clinical standards regarding FGC/M.

DECISION FOR COUNCIL:

- Does Council approve that the *Female Genital Cutting (Mutilation)* policy be rescinded?

POLICY #3: Fetal Ultrasound for Non-Medical Reasons

CURRENT STATUS:

- The *Fetal Ultrasound for Non-Medical Reasons* policy ("*Fetal Ultrasound*") was first approved by College Council in May 2004. The policy was developed in response to concerns related to gender selective abortions, coupled with the growing popularity of entertainment ultrasounds.

- The policy requires that physicians order and conduct diagnostic fetal ultrasounds for appropriate clinical indications, in accordance with relevant statements and guidelines.

- Best practices currently require two diagnostic ultrasounds in the first and second trimesters to monitor the growth of the fetus and identify potential risks. Fetal sex identification can be part of these diagnostic examinations.

- A summary of the factors that were evaluated to help assess the suitability of the policy for rescission is set out below.

a) Applicable Legislation and Clinical Standards

- Key stakeholders, including but not limited to, Health Canada, the Canadian Association of Radiologists (CAR), and the SOGC, agree that while ultrasound technology is deemed safe for diagnostic purposes, practitioners should reduce unnecessary, potentially hazardous exposure.

- Health Canada, which regulates medical devices in Canada under the *Food and Drugs Act* states: "The use of ultrasound for entertainment purposes, to determine the sex of the fetus for non-medical reasons or for the purposes of a trade show or [solely] to produce pictures or videos of a fetus, is considered an unapproved use of a medical device."

b) Regulatory and Clinical Environment

- Since Council last reviewed the *Fetal Ultrasound* policy in 2010, the regulatory landscape has changed. As of January 2018, sonographers are regulated by the College of Medical Radiation Technologists of Ontario (CMRTO).

- Originally, this policy was intended to reduce access to gender selective abortions. However, expectant parents have access to commercially available tests, including genetic testing, that reveal the sex of the fetus prior to the standard 10-20 week diagnostic ultrasound when parents can be informed of fetal sex. Given that these tests are widely available, the policy may not be an effective tool to address gender selective abortions.

c) I&R and PPAS Data

- The *Fetal Ultrasound* policy has not been cited in deisions of the ICRC since 2012. PPAS has not received a sufficient number of inquiries to enable data reporting in this area.

d) Website Visits

- Between September 1, 2017 and August 31, 2018, the *Fetal Ultrasound* policy had 764 views. This accounts for 0.016% of visits to the policy section of the website.

e) Jurisdictional Review

- Two other Colleges of Physicians and Surgeons in Canada, Saskatchewan and Nova Scotia, have policies on fetal ultrasound for non-medical reasons. Both colleges reference the CPSO as a key source for these policies.

- The College of Physicians and Surgeons of British Columbia rescinded their Fetal Ultrasound for Non-Medical reasons policy on May 25, 2017. Minutes from the council meeting cited new technologies, the appropriateness of regulatory tools to address broader social issues such as gender inequity, and the availability of ultrasound at private establishments as rationale for rescission.

f) Consultation Feedback

- Survey respondents were aware of the *Fetal Ultrasound* policy. However, only a small percentage indicated thay have read, consulted or otherwise used the policy. Respondents who had read the policy found the guidance helpful.

- The majority of respondents, including those who have and have not read the policy, indicated that is in important for the CPSO to set out expectations on this issue.
- The CMRTO has provided informal feedback that while this policy has previously been helpful for their own purposes, they are comfortable with it being rescinded.
- The OMA notes that while the SOGC and the CAR provide guidance on this issue, it remains important for the College to provide clear guidance specifically for physicians.

KEY CONSIDERATIONS:

- Should Council decide to rescind the *Fetal Ultrasound* policy, the following steps could be undertaken:
  - Remind physicians, via the College's communication channels, that under the *Food and Drugs Act*, Health Canada is responsible for the regulation of medical devices in Canada and considers the use of ultrasound for non-diagnostic purposes an inappropriate use of a medical device and provide links to key clinical standards including the joint CAR/SOGC statement.[5]

DECISION FOR COUNCIL:

- Does Council approve that the *Fetal Ultrasound for Non-Medical Reasons* policy be rescinded?

Contact: Jessica Lyon, Ext. 439
Dionne Woodward, Ext. 753

Date: Novmeber 16, 2018

[5] CAR and SOGC released a joint statement opposing the use of fetal ultrasound for non-medical reasons in 2014.

IN CAMERA

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

EDUCATION PRESENTATION:
Cultural Competency/Truth and Reconciliation

Guest Speaker: George Couchie

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 2018

TOPIC: CPSO Governance Review - Recommendations for Governance Change

FOR DECISION

ISSUE:

- Council adopted the CNO's Governance Principles and supported the Governance Review Working Group's (GRWG) general recommendations for legislative and non-legislative governance change (within CPSO's control) in September.
- The GRWG committed to refining the recommendations and bringing them back to December Council for decision.
- Council is asked whether it supports the GRWG's final recommendations for governance change.

BACKGROUND:

Governance Review to date

- In February 2018 the Governance Review Working Group was established to identify governance principles and best practice structural changes in support of governance reform.
- The Working Group is comprised of members of the Executive and Governance Committees and has actively engaged Council in its' work.
- The Working Group has met regularly (eight times over the past ten months) in order to understand best practices in governance, to review literature reviews and trends in regulatory governance as well as better understand the mechanics of other governance models.
- The GRWG also heard from Harry Cayton, former Chief Executive of the Professional Standards Authority in the UK, who is considered an international expert in regulatory governance.
- The GRWG has worked to bring forward meaningful information to each Council meeting this year.

- In May, Council considered the external environment, other governance structures and best practices and trends in regulatory governance. This was followed by engaging discussion in small groups.
- In September, Council heard from the CNO's CEO, Anne Coghlan, about the status of their review. Council supported governance principles (consistent with those of the CNO)[1] and the general direction of recommendations for governance reform proposed by the GRWG (those requiring legislative change and those that are within the College's control).
- At the September meeting, the GRWG committed to refining the recommendations and bringing them back to December Council for decision.

Council Survey

- Council members were asked by the Working Group to complete a survey about possible governance changes to help inform final recommendations for the December meeting of Council.
- 37 Council members (includes non-voting academic appointees) were provided with a link to the survey and 24 surveys were completed. This represents a response rate of 65%.
- Questions focused on board size, composition, selection process, and participation preferences with respect to board and statutory committees. Respondents also had an opportunity to provide additional feedback.
- It is clear from both the governance survey and feedback received through the Council Performance Assessment survey that Council is supportive of governance changes.
- The survey results are reflected in the summaries for each recommendation for structural or legislative change.

CURRENT STATUS:

Recommendations requiring legislative change

- The GRWG is generally supportive of the CNO governance approach and direction.
- The final recommendations are reflective in principle of the CNO approach with some refinements.
- A number of options for change were considered. Consideration was given to the size of the board, the role of an Executive Committee with a smaller board, approaches to achieving a competency based board, separation of statutory committees and the board, equal compensation for public and physician board members, and timelines for change.

[1] The adopted Governance Principles include: accountability, adaptability, competence, diversity, independence, integrity, transparency.

- Council survey results and feedback, along with literature on best practices and trends in regulatory governance helped to inform the recommendations for structural governance changes identified by the GRWG.
- The Working Group recommends the following changes to the College's governance structure:

    1. Composition: 50% public members and 50% physician members
    2. Smaller board: 8 – 16 board members, to be determined by each regulatory college
    3. Executive Committee: Each college should have flexibility to determine whether an Executive Committee is required (the number of board members is a determining factor)
    4. Separation between statutory committees and the board (no overlap in membership between statutory committees and the board)
    5. A competency based board model, whereby members, together, have desired attributes and competencies
    6. Selection Process: Hybrid model (some competency based appointments, some elected positions for professional members) (i.e., would like to maintain some elections)
    7. Equal compensation for public and physician members of the board
    8. A timeline of 3 years for legislative change (2021)
- Council is asked whether it supports the recommendations of the GRWG.
- The rationale for each recommendation is set out below.

1. Composition: 50% public members and 50% physician members

- Internationally, regulators see value and are moving towards an equal number of professional and public members on their boards.
- The College Council consists of 15 public members and 19 physicians. When government appoints the full complement of 15 public members, public members comprise 44% of board members. This is not far off from a board composed of 50% public members and 50% physician members.
- At its September meeting, Council supported a board composed of 50% public members and 50% physician members.
- Over half of survey respondents support this approach (54%); one-sixth support a greater number of public members on the board (12.5%).

Decision

1. Does Council support the recommendation that the board be comprised of 50% public members and 50% physician members?

2. Board Size

- In September, Council supported a smaller board. A specific board size was not determined.
- Literature suggests that groups of 6-9 members are most effective in decision making.
- CNO has recommended 12 members in order to have representation from the different categories of nurses and an equal number of public members.
- Size of the board is currently set out in profession-specific Acts (i.e., *Medicine Act*) which allows colleges to have a different number of board members.
- The GRWG suggests Colleges should have the flexibility to determine the appropriate number of board members to suit their needs (dependent on the size of each College) and recommends a range of 8 - 16 members; to be determined by each College.
- Survey respondents showed support for this approach with 58% choosing this option.

Decision

1. Does Council support the recommendation that the Council consist of 8 – 16 board members, to be determined by each regulatory college?

3. Executive Committee

- Aligned with international trends, the CNO has recommended the removal of an Executive Committee.
- The Executive Committee has the ability to exercise the powers and duties of Council regarding any matter that may require attention between meetings of Council.[2]
- Since a smaller board would be able to meet more frequently and respond to emerging issues, an Executive Committee may not be necessary.[3]
- Consistent with the goal of maintaining flexibility, the GRWG recommends Colleges have the option of retaining an Executive Committee and that its maintenance be dependent on the size of the board (i.e., a board of 8 would likely not require an Executive Committee).

Decision

1. Does Council support the recommendation that the necessity or requirement for an Executive Committee be determined by each College (dependent on the size of the board)?

4. Separation of the Board and Statutory Committees

- Separation of the board and statutory committees is considered a best practice.

[2] The duties of the executive committee are set out in section 30 of the General by-law and section 12 (1) of the Health Professions Procedural Code under the *Regulated Health Professions Act*.
[3] Elimination of an Executive Committee does not necessarily eliminate the role for President, Vice President, or Past President.

- This is in part because the role of board members and statutory committee members are quite different (strategic v. member specific decisions). Distinction in board membership also introduces an important element of independence to these entities.
- Council has supported the proposal to eliminate overlap of board and committee members (previous agreement that there should be no overlap in membership between the Discipline Committee and Council).

Decision

1. Does Council support the recommendation that there be no overlap in membership between statutory committees and the board?

5. Competency Based Board

- Research on board best practices supports a membership that has the skillset required to support the function of the board.
- Council has expressed support for a competency based board (Council survey results indicated strong support for a board composed of members who, together, have desired attributes and competencies).
- An example of desirable competencies of a regulatory board can be found in the Attributes and Competencies Framework developed for the CNO by an expert consultant (Governance Solutions). The board profile, intended to be used for identifying and recruiting qualified candidates for the CNO board, includes both competencies (the ability to do things successfully) and attributes (a quality which is a characteristic or inherent part of someone).
- A full list of the competencies and attributes contained in the framework can be found here.

Decision

1. Does Council support the recommendation that the board be composed of members who, together, have desired attributes and competencies (i.e., competency based board)?

6. Selection Process

- The selection process and the role of elections in a new governance model has been a prominent issue under consideration by the CPSO and amongst regulators more broadly.
- Different approaches can facilitate achieving a competency based board.
- The CNO model involves competency based appointments whereby the appointments process is administered by the College (i.e., Nominating, and Governance committees) and includes submission of an application and resume, reference checks, and interviews.[4]

[4] The CNO will be piloting an appointments process with these screening elements for members of statutory committees.

- An October article in Grey Areas[5] highlighted that 92% of respondents at a recent regulator conference supported a merit-based selection process.
- An alternative is a hybrid model, whereby some elected positions are maintained and some members of the board are selected through an appointments process. This would retain an element of democracy while also offering the benefit of competency based appointments.
- Elections have been criticized for creating the false impression that board members are accountable to voters. However, some feel that elections are a way to achieve diversity of physician experience on the board and that elections promote professional engagement.[6]
- Almost half of Council survey respondents support a hybrid model, whereby some professional board members are elected by the profession (46%).
- After considerable discussion, the Working Group recommends a hybrid selection model. A precise number of elected professional positions has not been determined.

Decision

1. Does Council support the recommendation of a hybrid selection model (some elected positions and some competency based appointments for professional members)?

7. Equal compensation for public and physician members

- The College has a longstanding position that existing compensation for public members is inadequate and unfair and has asked for the ability to compensate public members directly.
- CPSO has recommended that public and physician members of Council be compensated at the same rate. Public members of College committees who are not members of Council are currently compensated at the physician rate.
- The CNO recommends that all board members be paid equally. This aligns with their recommendation that all board members be required to meet specific competencies.
- The CNO also recommends that the College be accountable for funding the governance and statutory processes (remuneration for all board members would come from the CNO).
- The GRWG supports the inclusion of equal compensation of public members as part of the governance review recommendations.

Decision

1. Does Council support the recommendation that public member compensation be equal to physician member reimbursement?

[5] Published by Steinecke Maciura LeBlanc, a law firm practising in the field of professional regulation.
[6] In 2018, three of the four districts with positions up for election resulted in acclamations.

8. Timelines for Governance Change

- To capitalize on the work to date, the GRWG recommends advocating for legislative change before the current government's term is up (in June 2022).
- The CNO has proposed a 2020 timeline. This is a fairly short timeframe for transition and implementation.
- The GRWG recommends a three year timeframe for change, to provide the College with the time necessary to develop and facilitate an implementation strategy and work with the current government on change.

Decision

1. Does Council support a three year timeline for change?

NEXT STEPS:

- Some work is required to support implementation of structural governance changes. This will be one area of focus for the Governance Committee in 2019.
- The Governance Committee will also be focused on the following objectives in 2019:
  1. Strengthening board member orientation and education
  2. Focus on diversity (recruitment objectives/targets for committees, building cultural competence of the board)
  3. A more flexible approach to utilizing board members on statutory committees
  4. New professional members directed to DC not ICR, where possible over the short term.

DECISION FOR COUNCIL:

1. Does Council support the governance recommendations that require legislative change?

Contact: Dr. David Rouselle
Louise Verity, ext. 466
Maureen Boon, ext. 276
Tanya Terzis ext. 545

Date: November 16, 2018

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 2018

TOPIC: Register By-law Amendments (circulated in September)

FOR DECISION

ISSUE:

- In September, Council approved proposed amendments to certain General By-law provisions relating to the public register and mandatory reporting. The amendments remove duplications and inconsistencies with new legislative and regulation provisions that came into force in May.
- The amendments were circulated (posted) for members as required by the RHPA.
- No comments were received.
- The proposed amendments are attached in Appendix A.

DECISION FOR COUNCIL:

1. Does Council approve the amendments to the General By-law in respect of register provisions?

Contact: Marcia Cooper, Ext. 546

Date: November 16, 2018

Attachments:

Appendix A: Proposed By-law Amendments

Appendix A

Proposed By-law Amendments

1. Paragraph 49(1)19 of By-law No. 1 (the General By-Law) is revoked and the following is substituted:

19. Where there has been a finding of guilt against a member ~~under the *Criminal Code* or a finding of an offence~~ under the *Health Insurance Act*, made on or after June 1, 2015, ~~if the person against whom the finding was made was a member at the time of the finding,~~ and if the finding and/ or appeal is known to the College~~, a brief summary of:~~

(i) a brief summary of the finding;

(ii) a brief summary of the sentence;

(iii) where the finding is under appeal, a notation that it is under appeal, until the appeal is finally disposed of; and

(iv) the dates of (i)-(iii), ~~where~~ if known to the College~~.~~,

except if one or more of the conditions set out in section 1(2) of Ontario Regulation 261/18 have been satisfied.

2. Paragraph 49(1)20 of By-law No. 1 (the General By-Law) is revoked and the following is substituted:

20. Any currently existing conditions of release following a charge for a ~~criminal or provincial~~ *Health Insurance Act* offence, or subsequent to a finding of guilt under the *Health Insurance Act* and pending appeal, ~~that relate to the member's practice,~~ or any variations to those conditions, when known to the College.

3. Paragraphs 49(1)21 and 23 of By-law No. 1 (the General By-law) are revoked and the following are substituted:

21. In respect of a decision of the Inquiries, Complaints and Reports Committee that includes a disposition of a caution-in-person, if the complaint that led to the decision, or, in a case where there is no complaint, the first appointment of investigators in the file, is dated on or after January 1, 2015, a summary of that decision, and, where applicable, a notation that the decision has been appealed or reviewed.

23. In respect of a decision of the Inquiries, Complaints and Reports Committee that includes a disposition of a Specified Continuing Education or Remediation Program ("SCERP"), if the complaint that led to the decision, or, in a case where there is no complaint, the first appointment of investigators in the file is dated on or

after January 1, 2015, a summary of that decision, including the elements of the SCERP, and, where applicable, a notation that the decision has been appealed or reviewed.

4. Paragraph 49(1)26 of By-law No. 1 (the General By-Law) is revoked and the following is substituted:

26. Where a member has been charged with an offence under ~~the *Criminal Code of Canada* or~~ the *Health Insurance Act*, and the charge is outstanding and is known to the College, the fact and content of the charge and, ~~where~~ if known to the College, the date and place of the charge.

5. Paragraphs 49(1)27 and 28 of By-law No. 1 (the General By-Law) are revoked:

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

~~28. Where a member has been the subject of a disciplinary finding by another medical regulatory or licensing authority on or after September 1, 2015, and that finding is known to the College,~~

~~(i) the fact of the finding;~~

~~(ii) the date of the finding, where known to the College;~~

~~(iii) the jurisdiction in which the finding was made;~~

~~(iv) the date upon which the College was notified of the finding; and~~

~~(v) the existence and status of any appeal, when known to the College.~~

6. Paragraph 51(1)(d) of By-law No. 1 (the General By-Law) is revoked:

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

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Discipline Committee

Annual Committee Report 2018

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.** Demonstrate financial accountability.

I. Orientation and Specialized Education Sessions

In 2018, the Discipline Committee delivered the following training sessions:

New Member Orientation	January 17, February 2 March 16 and May 25, 2018
Chairing Case Conferences / Hearings	June 5, 2018
Decision Writing	September 12, 2018

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 June 26 and October 23, 2018.

a) Social Context Education

The Discipline Committee's social context education regarding equality, diversity and the adjudicative role is continuing. In June 2018, the Committee considered the Law Society of Ontario's Review Panel Report on Regulatory and Hearing Processes Affecting Indigenous Peoples regarding culturally competent and culturally safe processes. In October 2018, Dr. Stephen Hucker, forensic psychiatrist, presented on sexual misconduct and physicians.

b) 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.

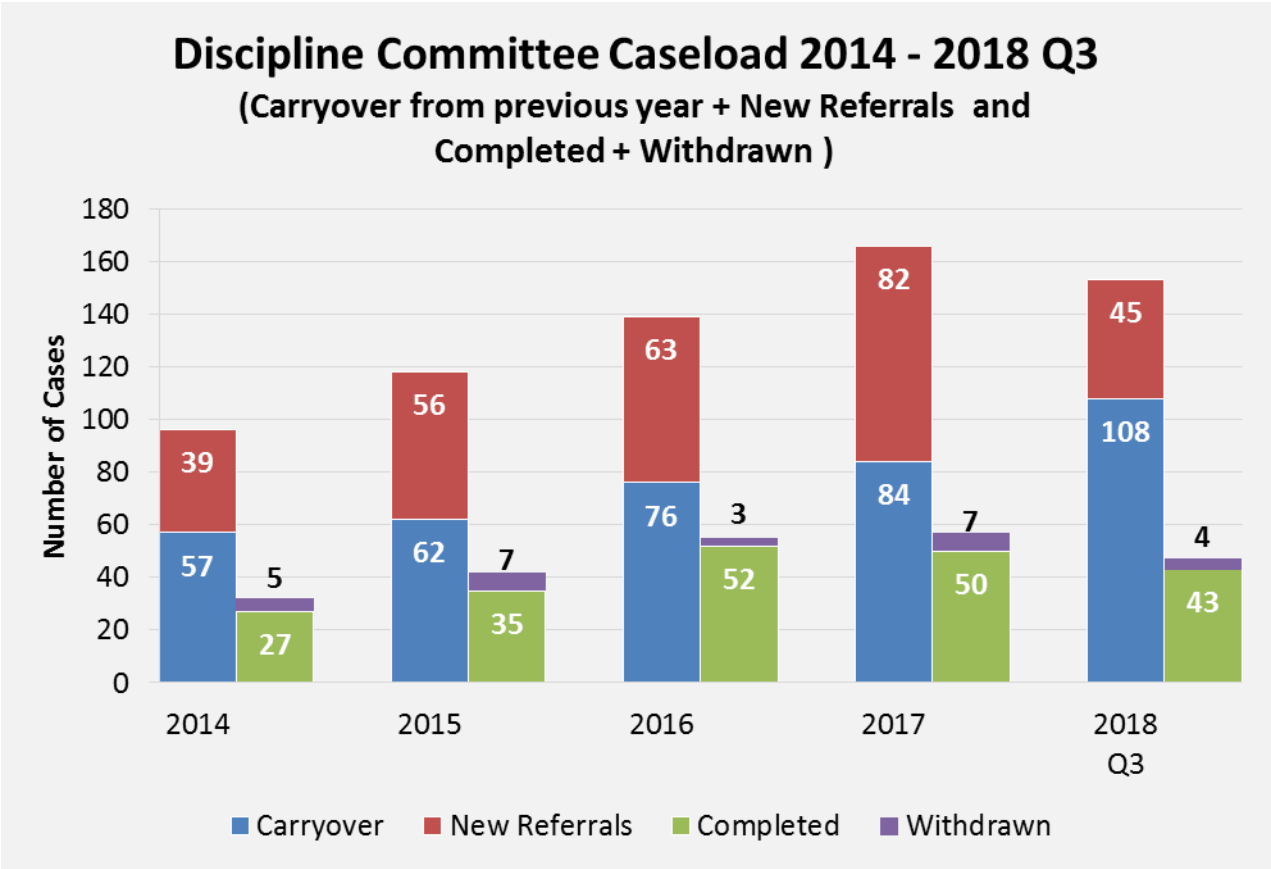
b) Caseload

As of 2018 Q3, the discipline caseload was 105. There were 45 referrals as of 2018 Q3, which represents a 36% decrease in referrals as compared to 70 at 2017 Q3. The Committee completed 43 cases as of 2018 Q3.

As of 2018 Q3, the College withdrew all allegations in four cases. In one case, the physician was revoked on another matter and signed an undertaking not to reapply, one physician had resigned and acknowledged no intention to reapply, and two physicians signed undertakings to resign and

not to reapply.

The following chart reflects the caseload from 2014 to 2018 Q3, including carryover from the previous year, and the number of referrals, completed cases, and withdrawn cases.



As of September 30, 2018

There was 1 case in 2013, 2 cases in 2014, and 1 case in 2017 that did not proceed because the physician died. There was one case that the Divisional Court had returned for a penalty hearing and in 2018, the Court of Appeal granted the physician's appeal and restored the Committee's penalty decision.

c) Managing the Caseload

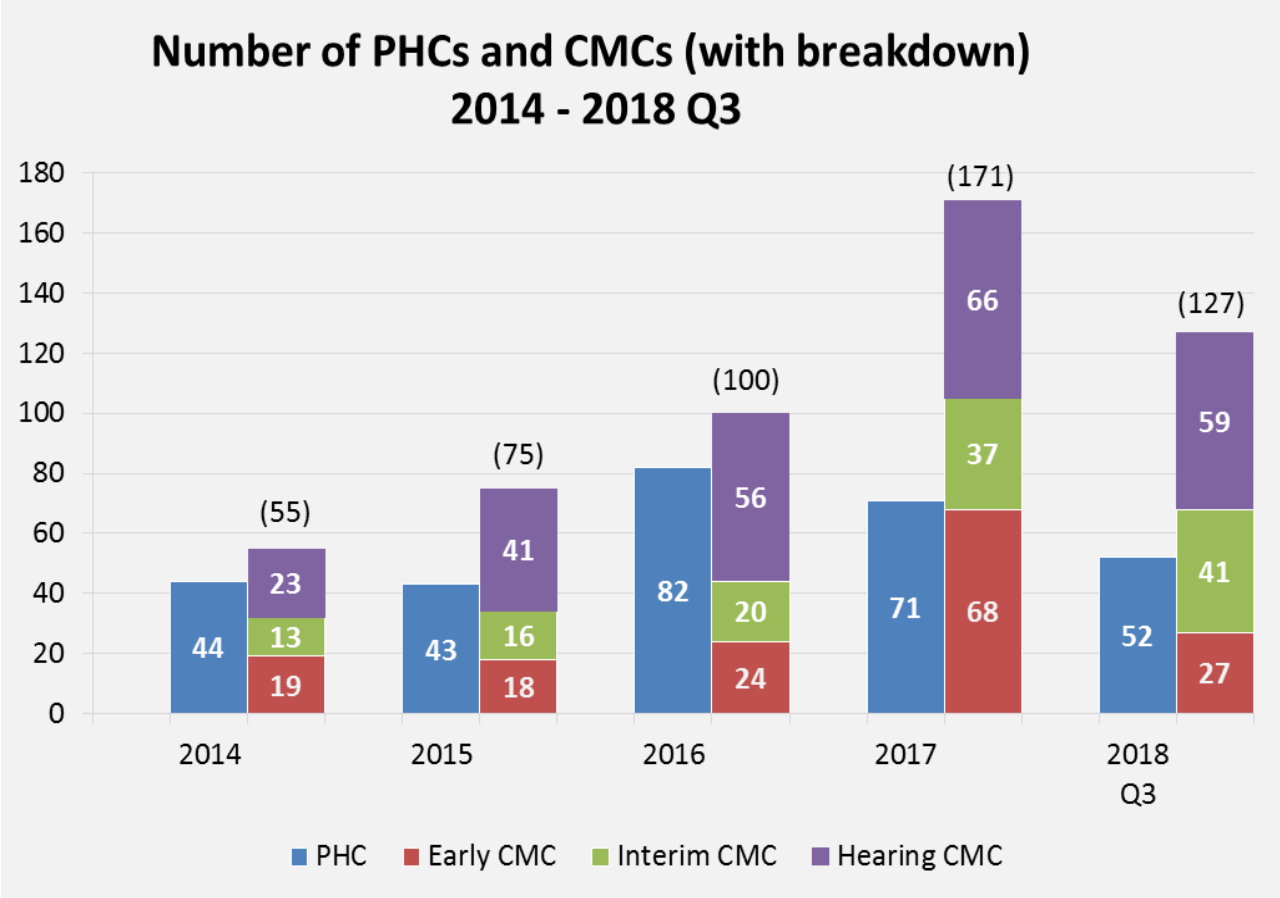
In managing its cases, the Committee must balance process efficiency, effectiveness and fairness. Recognizing that there will always be a percentage of cases that for legitimate reasons take longer to commence and complete, the Committee's aim is to eliminate *unreasonable* delay in the hearings process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

The Discipline Committee conducts pre-hearing conferences and case management conferences to manage cases in accordance with its Practice Direction on Case Management, which was implemented in January 2014.

Pre-hearing conferences (PHCs) have both a case resolution function, to narrow issues and negotiate potential settlements, and a case management function, including the scheduling of hearing dates.

Three types of Case Management Conferences (CMCs) have primarily a case management function. Early CMCs facilitate the scheduling of PHCs. Interim CMCs provide periodic oversight based on the needs of the case. Hearing CMCs identify any new issues prior to a multiple-day hearing and ensure an adequate number of hearing days/efficient use of hearing time and aid in scheduling penalty hearing dates.

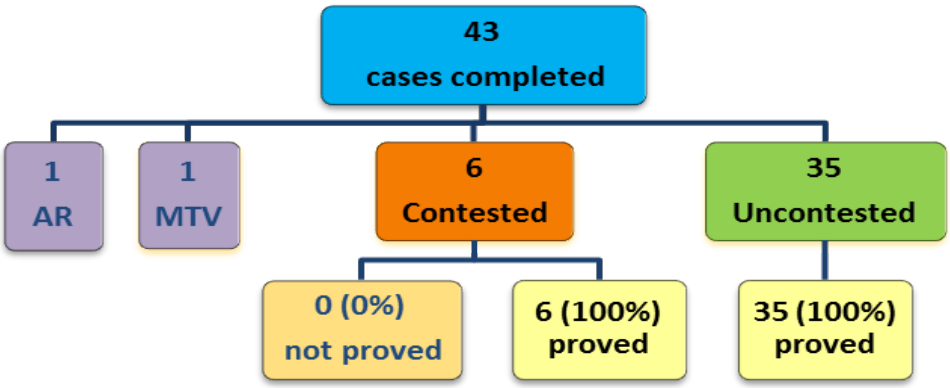
The following table provides the number of PHCs and CMCs, with a breakdown per CMC type, from 2014 to 2018 Q3.



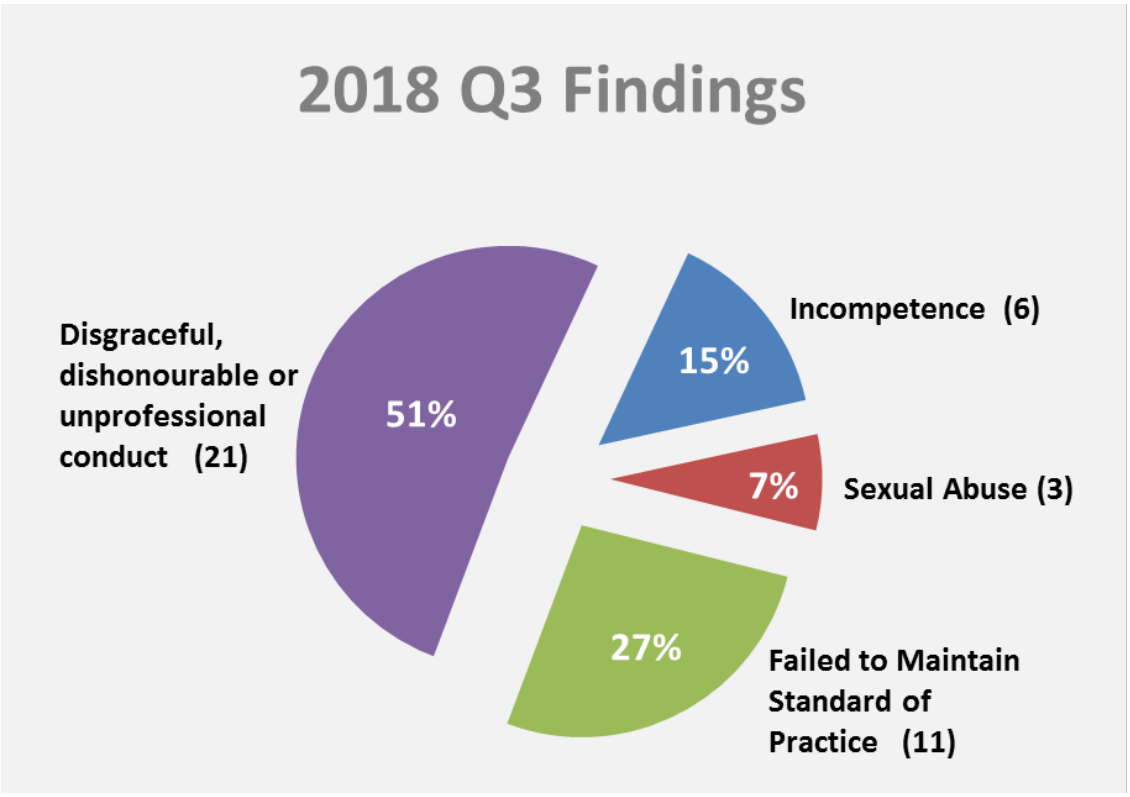
As of September 30, 2018

d) Conducting Timely Hearings

The Discipline Committee also manages its caseload by conducting hearings of the cases referred to it. As of 2018 Q3, the Committee completed 43 cases, including 41 cases of allegations of professional misconduct and/or incompetence, one application for reinstatement (AR) which was denied, and one motion to vary (MTV), which was granted.



The following depicts the percentage and types of findings in the 41 proved cases as of 2018 Q3.



e) Council's Strategic Indicator for Hearings

In 2014, Council established a strategic objective to schedule discipline hearings more quickly.

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

As at the end of 2018 Q3, 90% of hearings (36) began on average within 10.8 months of referral.

f) Case Time Span Analysis

To further understand the factors that influence case timelines, the Discipline Committee tracks the 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 a year. The Committee also tracks the average case time span and the average time span between process stages (e.g., time from referral to a pre-hearing conference, time to the first date of hearing and time to decision).

The Committee reports a downward trend since 2014 in the average time from referral to the first hearing date and the average case time span. Also, there is an increasing 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 timely discipline decisions.

The strategic targets for decisions are:

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

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

As of 2018 Q3:

- 90% of decisions in *uncontested cases (*27) were released on average 1.4 months from the last hearing date; and

- 90% of decisions in *contested cases* (18) were released on average 5.5 months from the last hearing date.

The strategic targets for decisions will change in 2019 to:

- 90% of written decisions and reasons in *uncontested cases* to be released within eight weeks of the last hearing date; and

- 90% of written decisions and reasons in *contested cases* to be released within twelve weeks of the last hearing date.

b) Appeals

As of 2018 Q3, the Divisional Court dismissed five appeals by physicians (two physicians are seeking leave to appeal to the Court of Appeal) and the Divisional Court granted one physician's appeal of the Committee's penalty decision (College motion for leave to appeal denied) remitting the matter to the committee for re-determination of penalty. In one case, the Court of Appeal granted a physician's appeal of the Divisional Court's decision and restored the penalty decision of the Discipline Committee (*Dr. Peirovy v. CPSO*).

Seven appeals are awaiting determination - five physician appeals to the Divisional Court and two physician motions for leave to appeal the Divisional Court's decision to the Court of Appeal.

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. Committee Financial Accountability

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

a) Paid Hearing Days and Late Cancelled Days

As of 2018 Q3, a number of cases that were scheduled for multiple day hearings resolved to take place in one day or adjourned, resulting in a reduced number of hearing days.

Paid hearing days (PHD) = Days used + Days not used but paid (due to late cancellation). The number of paid hearing days (PHD) for 2014 to 2018 Q3 was as follows:

Year	2014	2015	2016	2017	2018Q3
PHD	109	210	232	208	115

Late cancellation costs are incurred due to late resolution (less than 10 business days' notice of hearing commencement) or adjournment of cases or early completion of hearings. The number of late cancelled days (LCD) for 2014 to 2018 Q3 was:

Year	2014	2015	2016	2017	2018Q3
LCD	28	92	75	74	31

Reducing the number of late cancelled days is an aspirational goal of case management, although not entirely in the Committee's control. For example, in 2014, late cancelled days were reduced to 28. In 2015, late cancelled days increased due to late settlement of four cases and the withdrawal, dismissal and loss of hearing days in three cases, respectively, in which patients did not wish to attend to testify. Late cancellation days in 2016 and 2017 related to late settlement and late adjournment of cases. There were 31 late cancelled days as of 2018 Q3.

b) Scheduling Two Half Day Hearings in One Day

In June of 2018, the Discipline Committee implemented a practice to schedule two half-day hearings in one day for eligible cases. Advantages of this practice include: timely justice, as cases move through the process more quickly; efficient use of hearing days and committee member resources, as two cases are completed in one day and the same panel hears both cases; the potential incentive to resolve cases as the College has sought costs of $6,000 for a half-day hearing rather than the tariff rate of $10,180; and, costs recovery and savings. From the Committee perspective, the recovery of costs of two half day hearings at $6,000 for each hearing is higher than recovery at the tariff rate. However, this must be balanced with the additional cost to the Committee of panel member preparation time for advanced review of materials, which is required for matters to complete within a half day. Overall cost savings are anticipated as two hearings are dealt with in one day and more cases may resolve to a half day.

c) Costs

Council policy is that the usual amount of costs sought by the College in appropriate discipline cases would be in accordance with the Discipline Committee tariff for one day of hearing. On February 23, 2018 Council increased the costs tariff from $5,500 to $10,180 per day. The referring committee retains the discretion to change the amount sought in specific cases. As of 2018 Q3, the Discipline Committee has ordered $742,240 in costs payable to the College.

2019 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 earlier settlement and to decrease the time for release of decisions in contested cases. 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 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 and embedding social context education in our curriculum.

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. Eric Stanton
Co-Chair, Discipline Committee

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

EDUCATION COMMITTEE Annual Committee Report 2018

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 2018, 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 shaping CPSO educational initiatives, including educational data mapping, development of a remediation model and the New Member Orientation.

1. CPSO Educational Initiatives

The Committee engaged in further shaping and refining of educational initiatives of the CPSO.

1.1. Remediation model for physicians in practice

The Committee provided input into the development of a remediation model for physicians with identified learning needs. The proposed model uses an evidence-based approach to identify the elements which will support a consistent and evidence-based approach to remediation across the College. The Committee supported the direction of this work and provided feedback to help further align the CPSO approach with the wider system of continuing professional development.

1.2. New Member Orientation

The Committee engaged in providing direction to the development of the New Member Orientation project. Specifically, the Committee members provided several considerations for the e-learning module development, including the tone and tenor of the experience, the fit in the overall program of new physician on-boarding, and maintaining a high level of interactivity. The Committee highlighted the importance of piloting the modules with students and residents, and continuing to seek feedback from stakeholders.

1.3. Educational data mapping

The Committee received an update on the development of the College data mapping and the specific focus on educational data. The Committee encouraged this direction and stressed the importance of understanding administrative data to support evidence-based educational practices.

2. Undergraduate Student (UGME) and Postgraduate (PGME) Engagement

2.1. Finalizing the Role of the Academic Representatives

In 2018, the Committee finalized the role description of the Academic Representative and proposed it be provided to the Deans of the medical schools. The document will assist the Deans in understanding the role of the Academic Representative and in selecting future representatives.

3. Continuing Professional Development (CPD)

3.1. Individualized Instruction Program Development

The Committee reviewed and provided feedback on the proposed approach to ensure that the program of one-on-one instruction currently targeted at physicians with identified learning needs in communications, ethics and professionalism remains effective and current. The Committee encouraged continued collaboration with postgraduate wellness offices and CPD offices, as well as initiating collaborations with medical schools to develop programs in professionalism and communication in tandem.

3.2. Update on the Medical Psychotherapy Association of Canada 's (MDPAC) Continued Status as a Third Pathway (Alternative CPD Tracking Organization)

The Committee received the annual report of the MDPAC submitted as part of their ongoing commitment to the CPSO to maintain their status as the alternative CPD tracking organization. The Committee commended the MDPAC for their high-quality work and recommended that the MDPAC

no longer be required to submit an annual interim report, but continue to submit a triennial summative report.

4. Research at the College

The Committee was provided with updates and gave feedback on the following research projects at CPSO:

- Developing a framework for risk-informed regulation in Quality Improvement/Quality Assurance
- Peer Assessment Redesign
- Physician-level reporting (Quality Management Partnership)

Respectfully submitted,

Akbar Panju,
Chair, Education Committee

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Executive Committee Annual Committee Report 2018

Executive Committee Annual Report 2018

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 after 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 2018.

The Executive Committee held 7 meetings in 2018. Specific issues considered included:

- **Policies**: Closing a Medical Practice, Public Health Emergencies, Continuity of Care, MAID, Policy Rescissions, Policy Redesign

- **Other**: Governance Review, Opioid Strategy, Bill 87 Psychotherapy Regulation Proposal, Methadone Committee, Indigenous Acknowledgement, Health Sector Payment Transparency, Physician Assistants, Delegation of Registrar's Powers.

Selection Committee

In addition to its regular work, the Executive Committee spent considerable time in 2018 on activities related to the selection of the new Registrar/CEO and development of a new performance management framework.

Strategic Planning

Some members of the Executive Committee participated in the selection of the consulting firm for Strategic Planning - Optimus SBR. The Executive Committee also reviewed the planned approach and stakeholder engagement plan.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Fitness to Practise Committee

Annual Committee Report 2018

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:

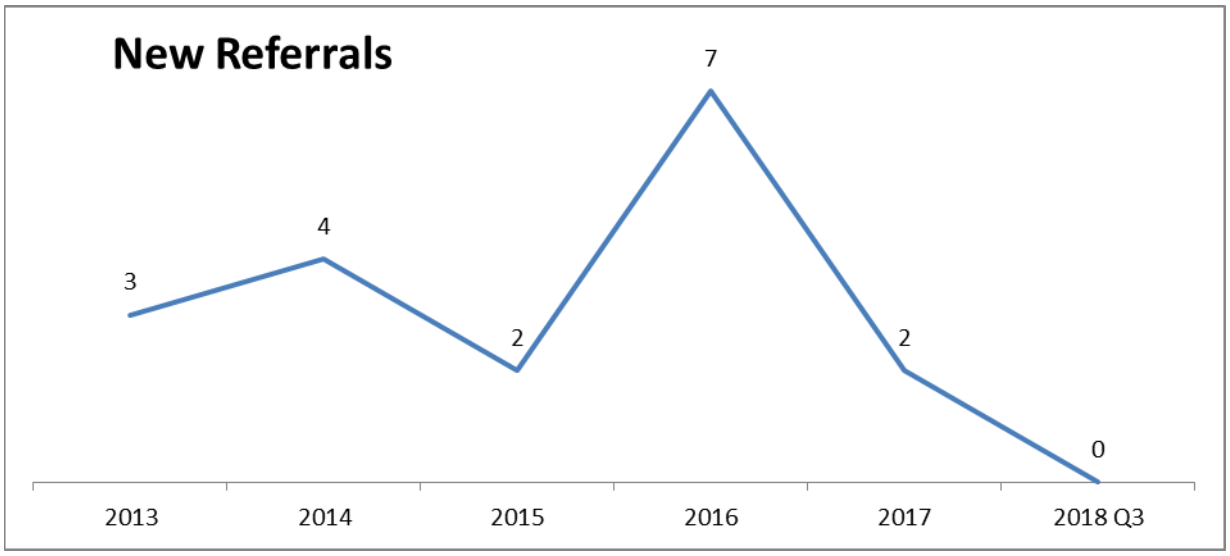
- directing the Registrar to revoke the member's certificate of registration.
- directing the Registrar to suspend the member's certificate;
- directing the Registrar to impose specified terms, conditions or limitations on the member's certificate.

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.

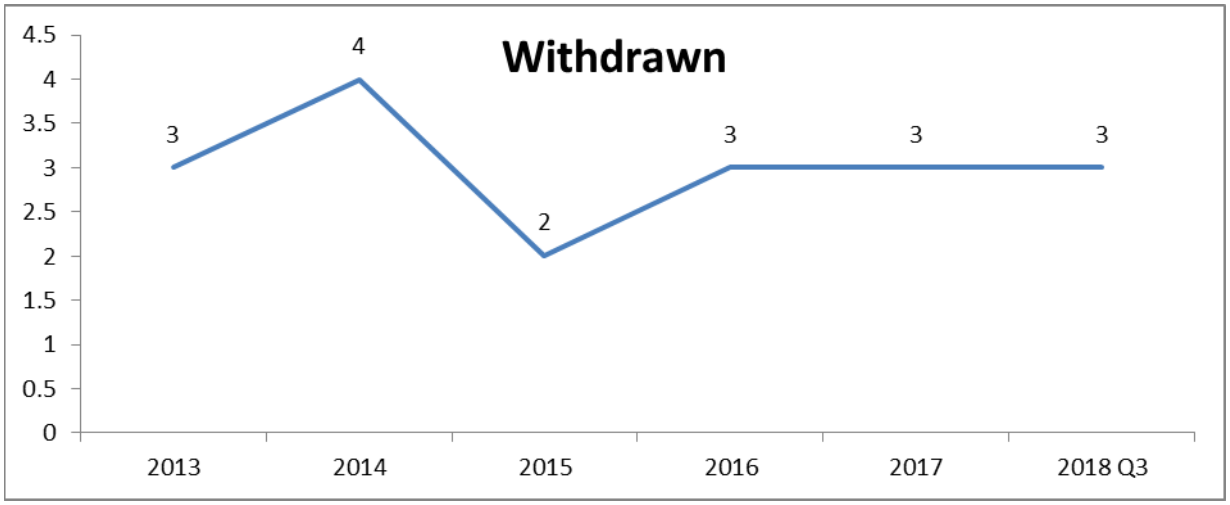
Core Activities:

Referrals

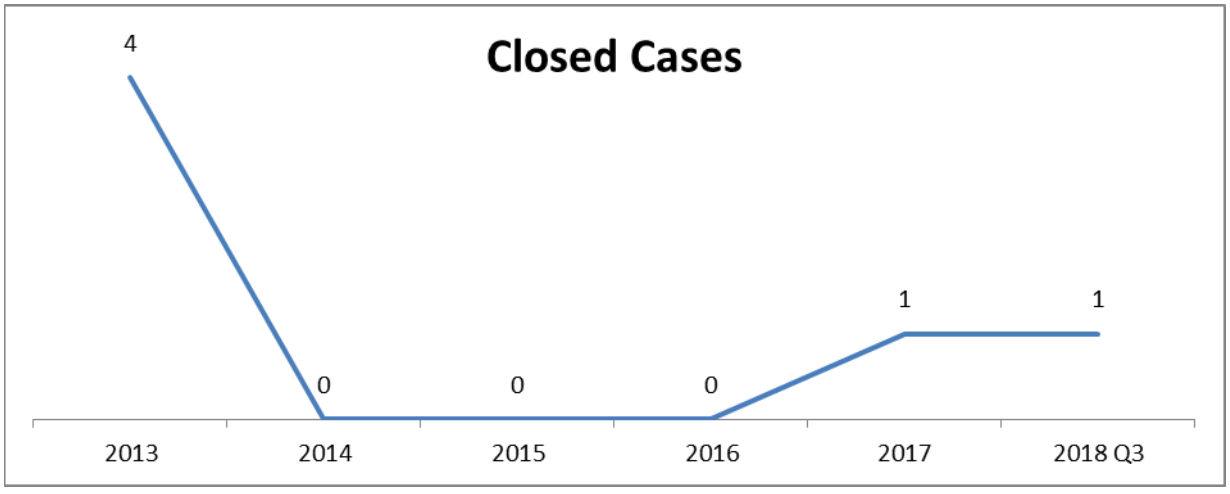
Overall, there has been a decrease in the number of referrals to the Committee. Although the Committee received seven referrals in 2016, in 2017, it received two referrals, and it has received no referrals as of September 30, 2018 (2018 Q3).



The practice to resolve incapacity matters through monitoring agreements continues. As of 2018 Q3, three matters were resolved and the referrals withdrawn.



Consequently, there was also a decrease in the Committee's pre-hearing and hearing activity. There was one pre-hearing conference and one case management conference as of 2018 Q3. There were no hearings in relation to an allegation of incapacity in 2014, 2015 and 2016; there was one hearing with a finding of incapacity and the imposition of terms, conditions and limitations on the physician's certificate of registration in 2017, with reasons for decision released in 2018. 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 2013 to 2018 Q3.



There are five matters currently before the Committee regarding an allegation of incapacity. One physician is subject to interim suspension 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 held its educational and business meeting for Fitness to Practise Committee members on November 20, 2018.

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.

Committee Financial Accountability

Given Fitness to Practise hearings are rare, the seventeen members of the Fitness to Practise Committee 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 and gain hearing experience through the Discipline Committee. Also, the Fitness to Practise Committee holds an annual half day education / business meeting.

Future Initiatives:

In 2019, 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 2018

Governance Committee
2018 Annual Report

Overview

The Governance Committee is a standing committee of the College and the mandate and composition of the committee is set out in the College by-law. The Governance 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.

Areas of Focus

Areas of focus in 2018 included the following:

- Review of the College's Governance Structure
- Oversight of College nominations processes
- Charting the course for a Public Member President
- Strengthened Orientation and Education Programming
- Oversight of Assessment/Feedback Program

Review of the College's Governance Structure

The Governance Review Working Group (GRWG) was created in March 2018, consisting of members of the Executive and Governance Committees. This focus on governance reform follows activity over several years at CPSO in support of governance change such as facilitating a process to elect a public president; advocacy in support of greater independence of the Discipline Committee and advocacy to address quorum as well as a number of public appointment related issues.

The College recognizes that governance change is coming and wants to contribute to these anticipated changes and a more effective governance structure. Objectives for this work include identifying governance principles and best practice structural changes to update and strengthen the integrity of the regulatory system.

To inform this activity the GRWG reviewed research that has been compiled about the governance models of other regulators and considered literature reviews regarding best

practice for effective board and governance structures. Select external experts and speakers were utilized to inform this work.

The GRWG worked to ensure active consideration and discussion about issues associated with the governance review at every meeting of Council in 2018. Council adopted governance principles to guide the College's ongoing governance work in September. The principles are consistent with those developed by the College of Nurses as part of their review and include the following: Accountability; Adaptability; Competence; Diversity; Independence; Integrity and Transparency.

The working group has identified a number of structural recommendations to strengthen and ensure the integrity of the College's governance structure. Some of the changes are within the College's control (via by-law). Others require legislative change. These recommendations will be considered by Council in December. They include recommendations to reduce the size of Council, and change the composition of Council to ensure an equal number of physician and public members. A Council survey was conducted in October to help inform the working group's recommendations to Council. Once Council decides on recommendations for governance reform the focus will shift to advocacy and implementation.

Oversight of College nominations processes

Chair and committee membership appointments are a focus for the Governance Committee each year. Committee appointments are made on an annual basis and the Governance Committee oversees the recruitment and screening processes for these positions. Ultimately, all committee appointments are made by Council.

Committee membership renewal and succession planning are important factors in the nominations process. Finding that right balance of bringing in new qualified committee members and retaining expertise is important.

There are currently 13 committees and 210 positions on these committees. Council members serve on 90 of these committee member positions and 120 are filled by committee members who are not on the College Council. Of these 120 non-Council positions, 116 are filled by physicians and 4 are filled by members of the public.

Non-Council Committee Appointments

Committee recruitment for Non-Council Committee positions is an important aspect of the nominations process. Some committees have had vacancies as a result of difficulty that the College has had recruiting in certain specialties. This year, as a result of focused attention and use of new recruitment strategies, we are on track to fill all committee positions. These new approaches have included stronger communication and targeted outreach with medical leaders, Council members, committee chairs and qualified candidates. This work is also

supported by strengthened administrative systems and governance support staff.

To help manage the College's workload and make best use of Council member time, the Governance Committee is looking at ways of appointing a greater proportion of non-Council physician and public members to College committees. There are a number of compelling reasons to do this. First, as it stands there are quorum requirements set in statute that require public members and a physician Council member to serve on the Discipline Committee. There is also a requirement that a public member must serve on each ICR panel. For this reason, public and physician Council member time must be focused in these areas. Second, there is an opportunity to move Council members off of other statutory committees over time to help ensure that these committees have the resources they need to meet expectations. Finally, we anticipate that in the future there will be no overlap in membership between the Council (assuming it will be much smaller) and the College's statutory committees.

Recruitment of non-Council committee members is expected to increase in the years ahead, particularly as we anticipate a move to less overlap in membership between the Council and the College's statutory committees.

Public Member Appointments

The College relies and depends on the government to appoint 15 qualified public members to the College Council. Issues pertaining to public appointments continue to be closely watched and a topic of ongoing advocacy with government.

Four public member appointments will expire on December 31, 2018. The Governance Committee Chair has provided letters of endorsement for reappointment of the four public members whose current public appointments expire on December 31, 2018. All of these members are active contributors to the work of the College and the statutory committees. The College continues to advocate for reappointment of the four public members and the appointment of a new public member for the vacant position. The significant issues and concern created by the uncertainty of the four public appointments that are up at the end of the year and the implications has been a regular topic of discussion and considerable advocacy with the new government. The issue of public member compensation is a long-standing concern and forms part of the recommendations coming forward from Council's Governance Review Working Group.

Charting the course for a Public Member President

Work is underway to facilitate a smooth process to provide for the election of a public member president of the College Council. The process was developed last year and will be supported by by-law changes and supporting communication to ensure that the new provisions are in place in time for the May 2019 election for the 2020 Council year.

Strengthened Orientation and Education Programming

Strengthening the Council and committee orientation and training programming continues to be a focus for the Committee. Looking ahead to the 2019 year, plans are under development to provide members of Council with the opportunity to participate in a more focussed board training program. This direction is consistent with the recommendations of the College Governance Review.

While the annual orientation/education day for Council and committee members continues to be highly rated, there is an opportunity to provide orientation/education on a more regular basis. In particular, there is an opportunity to provide more nuanced training that would better support board members. New CPSO Council members require a different type of program (more of an orientation focus) than more experienced board members. Committee members who are not members of Council require different training than Council members.

Plans are under development to ensure some education for Council (board) members is available at every Council meeting.

To help support this work staff are building out and consolidating resources to ensure information is easily accessed.

The mentorship program for new board members continues to be an important element of the orientation and education program. A special thank you to our Council members who have served as mentors in 2018: Dr. Barbara Lent, Dr. Dennis Pitt, Dr. Peeter Poldre, Dr. Bob Smith, Dr. David Rouselle, Mr. John Langs, Mr. Harry Erlichman, Mr. Peter Pielsticker, Mr. Pierre Giroux and Ms. Joan Powell.

Oversight of Assessment/Feedback Program

The Committee continues to oversee the Council Performance Feedback program. The program consists of a number of tools and surveys utilized 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.

Council's 2018 performance assessment report is contained in the Governance Committee's December Council report. The results are again quite positive. Areas where there is opportunity to improve include work to enhance the effectiveness of board education and orientation programming and changes to the College's governance structure to facilitate a smaller and more diverse board.

Looking ahead to 2019

While 2018 was a year of Governance review and reflection, 2019 will be a year of implementation. Council's decisions in December with respect to governance reform and the degree of change that it wishes to pursue will need to be translated into action. While the governance structural reforms that require legislative changes will require the support of the government, the committee has identified a number of objectives coming out of the Governance Review that are within the College's control including the following:

- Strengthening board member orientation and education
- Focus on diversity (recruitment objectives/targets for committees, building cultural competence of the board)
- A more flexible approach to utilizing board members on statutory committees
- Appointment of new physician members of Council to Discipline Committee rather than ICRC (where possible and only over the short term)

Once the College's governance direction and associated changes are established at the end of 2018, the College's Governance Process manual will need to be updated. Those areas that require more immediate attention include: The Council member role description, competencies, nominations guidelines and the performance assessment system and process.

We anticipate ongoing collaborative work with other health regulators to develop the best possible resources in support of continuous improvement in governance.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Inquires Complaints and Reports Committee

Annual Committee Report 2018

The Inquiries, Complaints and Reports Committee

MANDATE

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
- Registrar's investigations
- Incapacity investigations

ICRC Composition

The entire ICRC is currently (November 2018) composed of 58 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 six public members.

Quorum consists of three panel members, at least one of whom must be a public member of Council.

ICRC Review and Disposition Authority

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 practicing 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 Practice 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.

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***.

The Committee exercised its authority to issue an interim order without notice under section 25.4 on May 17, 2018 in respect to a physician who was criminally charged in respect of allegations of sexual assault and voyeurism.

Process Changes to ICRC in 2018

In 2018 the ICRC has seen significant process changes towards decreasing the time within which decisions are made and released to the parties. Some of these changes will be implemented in 2019 while others have been implemented in 2018. The work of ICRC has been with a view to ensuring timely conclusion of investigations and decision delivery to both members and complainants. ICRC continues to strive to strike a balance between an effective, complete investigation through to a reasonable ICRC decision while maximizing efficiencies and use of resources.

In addition, the Investigations and Resolutions division has embraced the legislative provisions for alternative dispute resolution (ADR) to message the College's new approach in resolving disputes in a meaningful manner with consent of the parties. The implications for ICRC may be considerable with a goal of reducing ICRC listings by 30% by the end of 2019.

Of note, process changes within ICRC include (to be implemented in 2019 where noted):

- decreased listing time for panels on an ongoing basis in 2019 (from 6 weeks to 3 weeks);
- a new decision template with a simplified format to reduce drafting time ;
- moved to an electronic process to support cautions;

- new type of ICRC panel, the “hybrid panel” to address low level and medium risk matters on a regular, weekly basis will commence in 2019;
- regular general panels with specialists to handle low level risk surgical and obstetrics/gynecology complaints in a more timely manner in 2019;
- increased use of teleconferences for panels; and
- Individual Education Plan (IEP) form to be completed by panel members to direct staff to appropriate remedial education for subject physicians

CORE ACTIVITIES

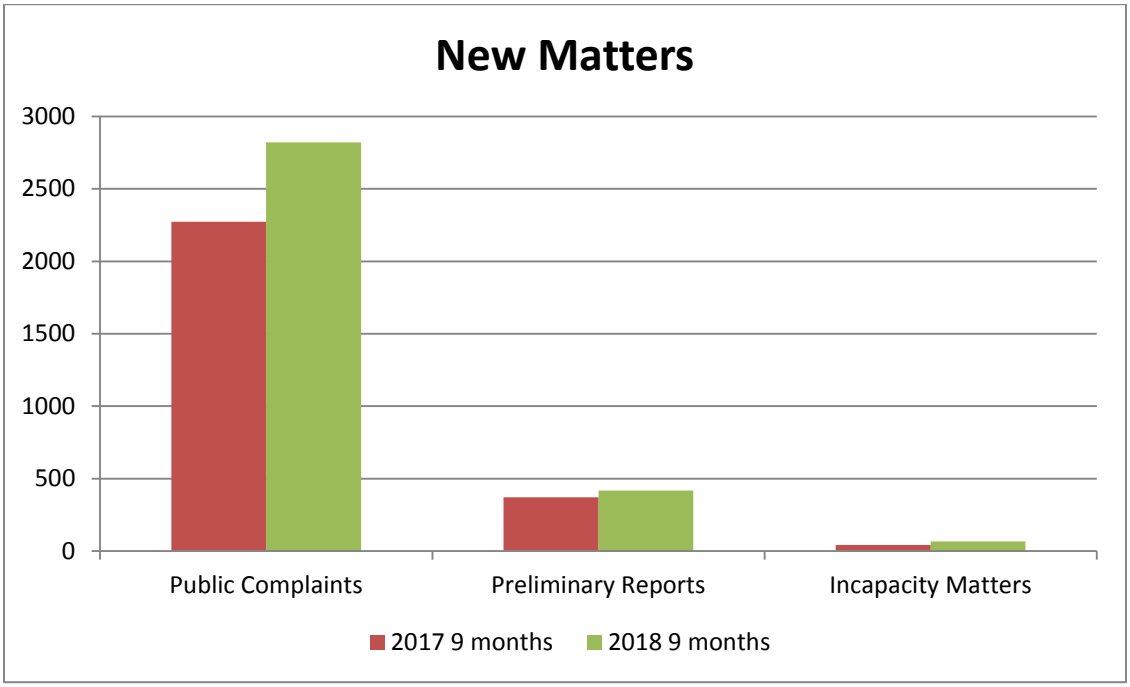
Panel Meeting Types and Formats

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 Matters January 1-September 30, 2018

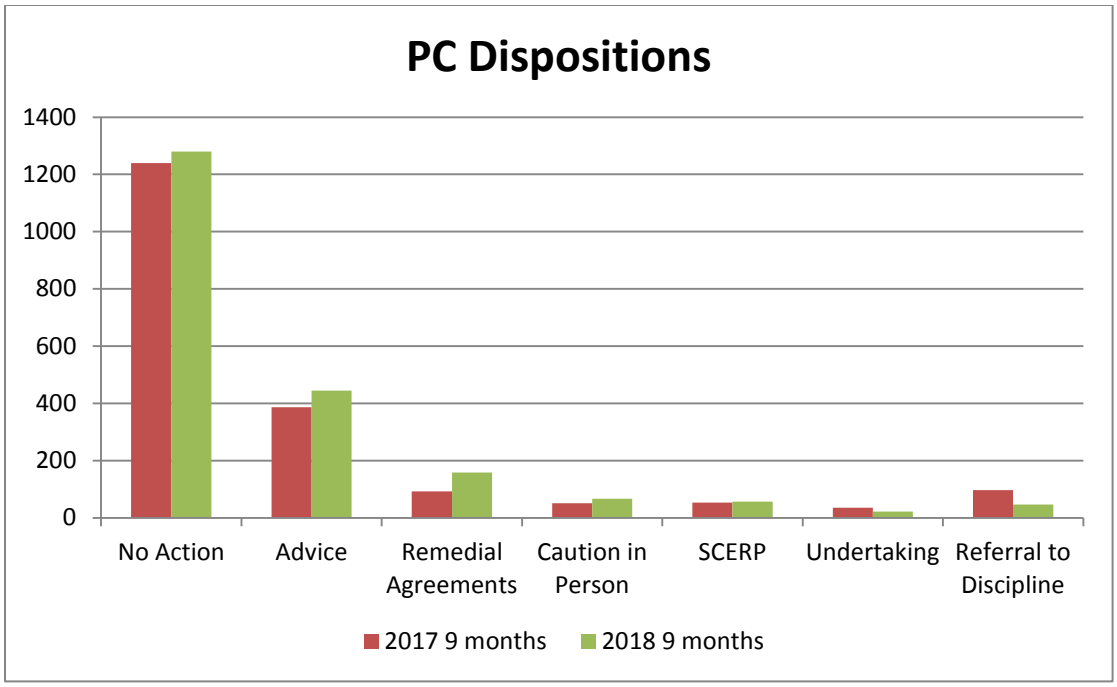
	2017 9 months	2018 9 months	% Change from 2017
Public Complaints	2273	2820	24%
Preliminary Reports	371	417	12%
Incapacity Matters	42	66	57%
TOTAL	**2686**	**3303**	**23%**



Intake and Closures January 1-September 30, 2018

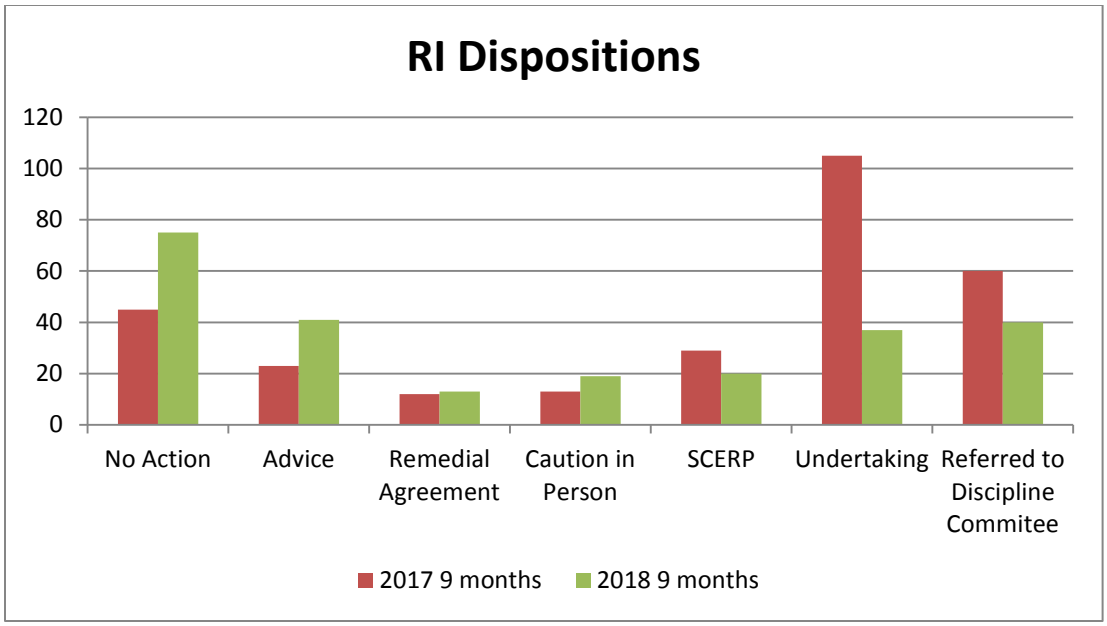
Intake and Closures

	2017 9 months	2018 9 months	% Change from 2017
Intake Files	446	547	23%
Withdrawals	*NA*	*130*	
Did Not Meet Threshold	*NA*	*166*	
Pre-RI Closures (RPGs Declined)	155	186	20%
Pre-Incapacity Closures	28	21	-25%



Public Complaints

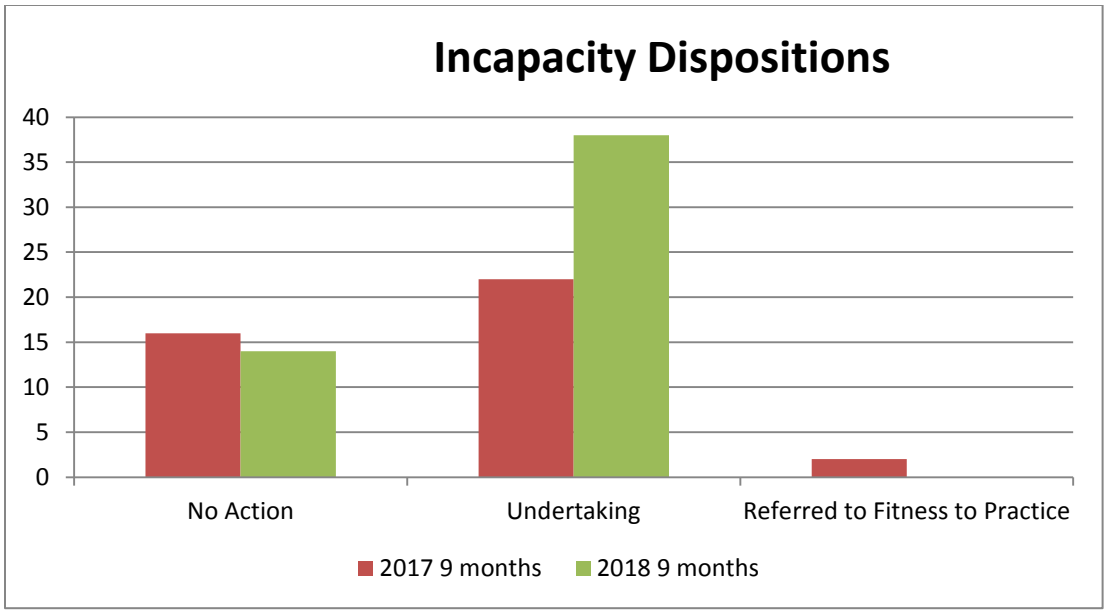
	2017 9 months	2018 9 months	% Change from 2017
No Action	1240	1280	3%
Advice	386	445	15%
Remedial Agreements	92	158	72%
Caution in Person	51	67	31%
SCERP	53	57	8%
Undertaking	35	22	-37%
Referral to Discipline	97	47	-52%
Total	**1954**	**2076**	**6%**



Registrar's Investigations

	2017 9 months	2018 9 months	% Change from 2017
No Action	45	75	67%
Advice	23	41	78%
Remedial Agreement	12	13	8%
Caution in Person	13	19	46%
SCERP	29	20	-31%
Undertaking	105	37	-65%
Referred to Discipline Committee	60	40	-33%
Total	**287**	**245**	**-15%**

RPGs Declined by Quarter		
Q1	**Q2**	**Q3**
15	45	91



Incapacity Investigations

	2017 9 months	2018 9 months	% Change from 2017
No Action	16	14	-13%
Undertaking	22	38	73%
Referred to Fitness to Practice	2	0	0%
Total	**40**	**52**	**30%**

Decision Release

The ICRC continued in 2018 to fulfill its statutory mandate to release written decisions and reasons, as required under the *Health Professions Procedural Code*.

Decision Release

	Jan 1-September 30 2017			Jan 1-September 30 2018		
Disposed Matters	**Decisions Drafted**	**Avg. Decision Release (weeks)**	**Decision Release (90th Percentile - weeks)**	**Decisions Drafted**	**Avg. Decision Release (weeks)**	**Decision Release (90th Percentile - weeks)**
	1718	10.9	15.7	2369	16.5	24.6

Decision timelines

	Jan 1-September 30 2017		Jan 1-September 30 2018				
Disposed Matters	**# of Investigations**	**Ave. file open days**	**# of Investigations**	**Ave. file open days**	**90th Percentile (days)**	**% change in # of Investigations 2017-2018**	**%change in avg. timeline 2017-2018**
Public Complaints							
Intake	446	106.3	547	69.4	150.2	23%	-35%
ICRC Decisions	1954	241.4	2076	256.9	433	6%	6%
Registrar's Investigations							
Closures/Resolutions	155	124	186			20%	23%
ICRC Decisions	287	462.9	245	568	1009	-15%	23%
Incapacity Investigations							
Closures/Resolutions	28	101.3	21			-25%	-100%
ICRC Decisions	40	198.4	52	242	493	30%	22%

Reviews by the Health Professions Appeal and Review Board

- **Note: New All-electronic process at the College for HPARB appeal filings**

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"). S. 25.4 orders may only be reviewed by the Court.

Until October 2018 the College relied on a largely paper-based document production process using a courier service to deliver materials to HPARB. This presented inefficiencies that made it difficult to continue to meet the deadline for submitting the Records of Investigation (ROIs) which are due to HPARB within 15 days of the request. In October 2018, a new all-electronic process was implemented. A secure email for use only by the College and HPARB staff was created and HPARB requests for documents and exchanges of information between the College and HPARB occur through this private, secure email. The result is a safer, more secure transfer of documents that is efficiently delivered allowing for more timely disclosure.

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.

The Board, consisting of non-medical members, reviews ICRC decisions with a view to both the reasonableness and adequacy of ICRC investigations and the reasonableness of the decisions.

ICRC Committee members discuss matters returned by HPARB at the semi-annual business/policy meetings, to highlight trends and to inform future decision-making.

HPARB Statistics

Year Decision Issued	Appealable Decisions Issued	Total HPARB Appeals (% of appealable decisions that were appealed)	Total HPARB Decisions Upheld (% of appealed investigations that were upheld)	Average Length of time for HPARB process (days)
2009	1317	338 (26%)	296 (88%)	773.9
2010	1986	297 (15%)	252 (85%)	914.8
2011	2252	550 (24%)	479 (87%)	601.9
2012	2406	459 (19%)	412 (90%)	440.5
2013	2161	349 (16%)	315 (90%)	369.2
2014	2326	336 (14%)	303 (90%)	412.4
2015	2162	308 (14%)	282 (92%)	372.2
2016	2255	365 (16%)	329 (90%)	335.3
2017	2425	335 (14%)	Unknown until HPARB process complete	

Committee Financial Accountability

The majority of the ICRC committee costs pertain to preparation and attendance. There are also costs that relate to travel time and travel expenses albeit a lower amount. In looking to achieve cost savings this year, the following was carried out:

- ICRC turned multiple in-person panel meetings into teleconferences to eliminate costs associated with travel time and travel expenses. In the last quarter of the year, there was an increase of 25 new ICRC panel in-person meetings of which, 32% were held via teleconference.
- ICRC held a Committee educational training session on legislative updates for members via Webex to reduce costs associated with travel. ICRC held 3 vs 4 leadership team meetings.
- ICRC also moved to having fewer members (3vs5) on the newly added general and specialty panels in the last quarter of the year which contributed to some savings in attendance costs.

It should be noted that ICRC operates fully electronically using Microsoft Sharepoint and for this reason we do not have any costs relating to couriering materials or USBs, photocopying or printing of ICRC materials. We are also moving to have more ICRC submissions prepared with hyperlinks and bookmarks within the document to allow for easier navigation of the investigative file in order to assist in reducing preparation time.

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 2018, an education training session for Chairs/Vice Chairs and Alternates was held. Topics included causation, cautions, regression analysis study results, articulating good reasons and the Registrar's new powers to withdraw a complaint.

In September 2018, the leadership team and some ICRC members attended for a webinar on legislative updates that included *Rohringer* v. *Royal College of Dental Surgeons of Ontario*, 2017 and *Fingerote* v. *College of Physicians and Surgeons*, 2018 cases. Other presentations at this time included HPARB trends and the increase in appeals, the decrease in s.75(1)c approvals, an ADR overview and some dashboard and I&R statistics.

The ICRC panel members regularly incorporate educational session into the Committee's semi-annual business meetings. At its spring business meeting, presentations on regulatory updates, negligence analysis by the courts, the discipline process, continuity of care policy development update, CPD & practice improvement sites and interim orders case studies by legal were provided to the ICRC. At its fall business meeting, the ICRC heard from the Canadian Institute for Administration of Justice (CIAJ) with an introduction to decision making best practices. The ICRC also heard from Justice Peter D. Lauwers of the Court of Appeal for Ontario. In addition, the legal office provided training on the importance of independent decision making.

Staff Support

The members of the ICRC wish to thank staff for their excellent work in assisting the Committee to implement operations and fulfill its mandate.

Dr. David Rouselle
Chair, Inquiries, Complaints and Reports Committee

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Outreach Committee
Annual Committee Report 2018

Outreach Committee
2018 Annual Report

Overview

The Outreach Committee is a College standing committee and the mandate of the committee is set out in the General By-Laws. The 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 plan.

The Committee is supported by the Policy and Communications Division.

Areas of Focus

Committee attention and focus over the past year has included the following:

- The development of new and updated communications plan in support of the updated Corporate plan
- Media monitoring and measurement
- Continued development of the College's social media strategy
- The College's membership/public outreach strategy
- Ongoing work to enhance engagement of with the public and profession in College work (with an emphasis on policy activity)
- Government relations

Following is a high level overview that summarizes activity in each of these areas.

Communications Planning

A new approach to communication is underway to support CPSO's transformational changes to investigations and other core regulatory processes, and to modernize and enhance our communications products and activities.

The two primary components of the strategy include:

1. Relationship building and influence: a focus on public/patients, the profession, the media, government and internal audiences; and

2. Modernizing communications products (including College policies): In particular, the focus of the plan in 2018/19 is on enhancing and modernizing the website and Dialogue,

including transforming the latter from a print based magazine to a digital format where information is current, dynamic and easy to access.

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 varied over the course of the first three quarters in 2018, with media attention largely occupied by provincial politics over the summer months and some historically significant issues – principally MAID and opioids – largely having exhausted media attention. In the first three quarters of 2018, we have seen 719 stories. This represents a 27% decrease over last year, though still significantly higher than the historical baseline. To put this in context, we only saw 776 stories for the entire year of 2015.

Notably, while we've seen the overall volume of media attention decline, we have also seen a corresponding increase in the overall tone of that coverage. During the second quarter, we achieved our highest positive scores since we began scoring media, at 56% positive coverage, up from 36% positive coverage in the first quarter – which was, itself, a record at the time. As usual, CPSO discipline cases received extensive media attention this year.

Although we've seen intense but short-lived attention on a handful of issues - The Star, in particular, continues to focus on issues of transparency, while issues of infection prevention were particularly serious over the late summer and early fall months – we anticipate the dominant issue going forward will continue to be discipline and investigations, however we anticipate other issues, including the CPSO's Continuity of Care Policy, will garner some additional attention as they grow closer to fruition.

Communications/Social Media

In 2018, the College continued to build its social media audience across its four key platforms: Twitter, Facebook, LinkedIn and YouTube, as well as launch a new presence, on the popular social media site Instagram. These platforms now have a total combined audience of nearly 6,000 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 2018 include:

- launch of a new CPSO website next year. This initiative is designed to:
    - reorganize the information architecture/navigations to simplify them
    - update the tone of the content to align with a new approach to tone in College communications more generally
    - do a widespread rewrite of the content to simplify it
    - implement changes to content and navigation structures to ensure that our website is compliant with the *Accessibility for Ontarians with Disabilities Act (AODA)* by the 2020 deadline.
    - align the website with our long-term plan to launch a new digital version of *Dialogue*

- an extended social media campaign for our Continuity of Care consultation. This campaign, which began when the consultation launched in May 2018 and will conclude when the consultation closes in December, included some 50+ tweets as part of the first phase, and a second phase that involved sharing comments from our discussion board on Twitter to garner even more feedback.

Digital Dialogue

In early 2018, research was begun about transforming *Dialogue* magazine into an online format.

- The CPSO has published *Dialogue* since 1993. At the time, it was the first magazine in the broad Ontario regulatory field to develop a magazine of such quality and scope. 25 years later, and with the prevalence of social media and online communications, the need to ensure *Dialogue's* continued relevance and accessibility in the 21st century necessitated a serious look at creating a new online *Dialogue* platform.
- An environmental scan found that the majority of medical regulators and many other medical organizations have already transitioned to digital communications, with some abandoning print communications all together.
- The Outreach Committee supported the continued research and eventual implementation of a new format that would include a unique *Dialogue* micro-website and a monthly membership e-newsletter to highlight new content.
- While significant cost savings may be achieved by moving to an exclusively digital format, current discussions concern whether or not to also maintain a print version, as there may be members who prefer to receive a print magazine. Consideration is being given, as part of the 2019 annual renewal questionnaire, to ask physicians to indicate their preference for a printed or digital magazine. The results of that survey will help determine the path forward.
- Development of the digital magazine is directly tied to the redesign of the CPSO

website; thus, while implementation is expected in late 2019, that timeline is dependent upon the rollout of the new website.

Membership/Public Outreach

Outreach activities provide an excellent opportunity to influence and educate several key audiences including members of the public, medical students, residents, CPSO members and other health care stakeholders

At the time of this report College representatives have completed more than 60 outreach engagements with several more planned before the end of 2018. To date there have been:

- 7 public outreach sessions
- 3 International delegations (Brazil & Indonesia, China)
- 7 resident education sessions
- 11 student events
- 8 events with other health care stakeholders
- 23 meetings with the membership

Continuity of Care continues to garner significant attention and there have been many outreach sessions throughout the province about the College's opioid strategy.

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 and inform the policy review and development process.

Public opinion polling is one way in which the College obtains public perspectives and feedback in its work. In 2018, a survey cycle has been planned for late fall that will poll the public on specific issues that have emerged as part of the *Continuity of Care* consultation. The results will be shared with the Working Group and used to inform decision-making regarding the expectations that should be set out in the final version of these policies.

The College has also recently joined a partnership of health regulators in Ontario which in supporting a Citizen Advisory Group (CAG). The CAG is comprised of engaged patients and caregivers who provide feedback and advice on a variety of health regulatory issues. In October 2018, the College co-sponsored a meeting of the CAG to seek their feedback and perspectives on continuity of care. A summary of the key findings will be shared with the Working Group to help inform their outstanding work.

Two "Stakeholder Summits" were also organized in the fall of 2018 to engage a variety of stakeholders in a discussion on key elements of the *Continuity of Care* draft policies. Health-care providers, stakeholder organizations, and patients were all invited to share their

perspectives and engage in a discussion with the aim to inform the College's work on this important policy initiative.

Finally, the policy consultation process is being reviewed and evaluated to identify opportunities to improve participation or remove barriers to participation. For example, ensuring that the materials provided are clear and concise, and that recent attempts to enhance participation are not thwarted by the perceived burden stakeholders might feel when they see the amount of information we provide. This includes the development of 'draft policy primers' which were used in the *Continuity of Care* consultation in order to capture key draft expectations and the rationale for them in an easy to read and short companion document.

Government Relations Activities

The College's government relations activities were varied in 2018 and impacted by a change in government in June. Prior to the provincial election, the College continued its work with the Liberal government on a number of initiatives, including:

- working closely with government on the prevention of sexual abuse of patients, including the implementation of Bill 87, the *Protecting Patients Act*;
- appointment and compensation of public members of Council;
- overhaul of out-of-hospital facility regulation through implementation of Bill 160, the *Strengthening Quality and Accountability for Patients Act, 2017*;
- preliminary work on potential regulation of physician assistants; and
- opioids and medication management.

In the time since the June election, the College's government relations activities have focused largely on relationship-building with key decision-makers in the new PC government. This includes outreach to, and meetings with decision-makers.

Through this activity the College is ensuring that decision-makers are aware of the College's mandate and that appropriate systems are in place to facilitate effective communication with key staff. In addition, the College is continuing to bring forward key organizational priorities, including:

- ongoing advocacy regarding the appointment and government support of public members of Council;
- the regulation of out-of-hospital fertility services;
- opioids and medication management;
- organizational work refocusing on regulatory functions and complaints processes; and
- the College's governance review.

In order to carry out this work, the College is in contact with a variety of government decision-makers.

In Summary:

2018 was a productive year for the Outreach Committee. The College's profile was raised in a myriad ways with an increased focus on public engagement and many efforts to improve communication across the spectrum of products and activities.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Patient Relations Committee Annual Committee Report 2018

Patient Relations Committee
2018 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 regulatory 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, 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 is also responsible for advising Council with respect to the patient relations program, as necessary.

Committee Composition

The PRC is currently 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 majority of PRC members have experience in the areas of mental health, psychotherapy, psychiatry as well as knowledge of sexual abuse issues.

The Committee has monthly teleconferences to review applications for therapy and counselling and one in-person meeting each year. The Committee is supported by the Policy Department.

Core Activities & Statistics

Administering Funding for Therapy and Counselling

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

[1] Three new physician appointments are to be made at the December Council meeting, and one current physician member of the Committee will be resigning. These appointments will bring the Committee up to its full complement of members.

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]

Ontario regulation 50/94[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.

On May 1, 2018, the amendments to the eligibility criteria for the funding for therapy and counselling program were proclaimed.[5] These amendments specify that a person is eligible for funding for therapy and counselling if it is alleged, in a complaint or report, that the person was sexually abused by a member while the person was a patient of a physician. The alternative eligibility requirements which are set out in regulation under the *Medicine Act, 1991* have been retained.

The following provisions were also proclaimed on May 1, 2018; however, the regulations that would enable these provisions have not yet been developed by the Government:

- Expanding the purposes for which funding can be provided (e.g. for medication, child care and travel costs) and the ability for Colleges to pay other persons/classes of persons (other than the therapist/counsellor); and
- Expanding the Patient Relations Program to perform other functions.

The PRC has approved 218 applications since its inception (1994-2018), and has denied 21 applications.[6] The total amount awarded over this period is $2,868,235.00. The total amount paid out to date is $1,481,333.14. 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. Applicants have 5 years to use their funding.

[2] Section 85.7(4).
[3] Section 42(2).
[4] Section 1(a).
[5] These amendments are the result of Bill 87, the *Protecting Patients Act, 2017*, which received Royal Assent on May 30, 2017.
[6] 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).

The following chart summarizes the funding for therapy and counselling that has been approved and used over the last ten years:

	2018 *(Jan-Nov)*	2017	2016	2015	2014	2013	2012	2011	2010	2009
Applications Approved	29 (31[7] were reviewed)	23 (25[8] were reviewed)	16 (22[9] were reviewed)	10 (13[10] were reviewed)	4 (5 were reviewed)	3 (4 were reviewed)	8	4 (5 were reviewed)	5	4 (5 were reviewed)
Funding Approved	$465,740	$401,500	$256,960	$160,060	$64,240	$48,180	$128,480	$63,120	$71,740	$56,800
Money Paid Out[11]	$141,914	$152,720	$108,176	$77,388	$46,090	$78,502	$53,583	$33,575	$51,870	$29,676

In 2012 and for the past four years (2015-2018), the PRC received a higher number of applications than in previous years. It is not clear what might have caused these increases, but it is possible that the increase in 2012 was a result of activity to increase awareness of the funding for therapy and counselling program and to support potential applicants in the application process. The College has taken a number of steps 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, the #MeToo movement may have some effect on the numbers of applications received.

Because the Code specifies that the funding must only be used to pay for 'therapy or counselling', with some limited restrictions, the PRC determines 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 patients to select the therapist/counsellor that best meets their needs.

[7] Two of these applications were denied.
[8] Two of these applications were denied.
[9] One of these applications was deferred (was later approved in November 2017) and five of these applications were denied.
[10] One of these applications was deferred (and still remains deferred as of October 2018).
[11] To therapists/counsellors of approved applicants.

Other Activities

In 2018, the PRC focussed primarily on funding for therapy and counselling applications. The PRC's other two areas of focus were 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.

Looking forward to 2019, the PRC's main focus will continue to be reviewing funding applications. The Committee will assess the impact of the new eligibility provision. In addition, if regulations are made by Government related to the funding for therapy and counselling program, the PRC will make any necessary changes to its processes.

To facilitate and ensure succession planning, there will be some changes in committee membership in the upcoming year. The Committee looks forward to welcoming new committee members later this year.

The PRC will also continue to assist in the review of the College's Maintaining Appropriate Boundaries and Preventing Sexual Abuse policy review.

The PRC continues to be involved in raising and providing feedback on issues that affect patients, including:

- The challenges involved in patients/members of the public contacting the College i.e. difficulties arise by virtue of the fact that there is no live person answering the phone at first contact;
- Difficulties that patients/members of the public have in navigating the College's website.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Premises Inspection Committee

Annual Committee Report 2018

PREMISES INSPECTION COMMITTEE
2018 Annual Report to Council

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" or "fail";
(e) Delivering written reports as required under Ontario Regulation 114/94;
(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; and
(g) Reviewing adverse event reports from premises.

COMMITTEE ACTIVITIES

The Out-of-Hospital Premises Inspection Program (OHPIP) is overseen by the Premises Inspection Committee (PIC). 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). 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, interventional pain, obstetrics/gynecology, plastic/cosmetic surgery, and general surgery. For the 2018 program year, there will have been 38 individual committee panels to review inspection assessment reports, 3 adverse event subcommittee meetings, as well as three (3) policy meetings to give overall direction to the program. Below is a list of the 2018 committee activities and milestones.

STRATEGIC ACTIVITIES

The mandate of the Premises Inspection Committee is aligned with and supports two of the College's strategic priorities in the 2015-18 Strategic Plan; specifically assuring and enhancing physician competence and ensuring accountability of physicians and demonstration of the profession's commitment to protect the public via self-regulation. As part of the College's ultimate goal of public protection the Committee is focused on responding to risks in order to ensure safety.

In support of improving the knowledge and skills of assessors a biannual assessor meeting was held. We continue to work with the Ministry of Health and Long-Term Care regarding the potential inclusion of

fertility services in the quality and inspection mandate of the College. We have ongoing collaboration with Public Health Ontario to enhance the OHPIP's capacity and the knowledge and compliance of physicians with respect to infection prevention and control. And following royal assent of the *Strengthening Quality and Accountability for Patients Act,* we actively worked with the Ministry on development of regulations in support of the Act that would lead to a consolidation of the College's two inspection programs under a single quality regime that would enhance our ability to protect the public. More details about these activities can be found below.

COMMITTEE FINANCIAL ACCOUNTABILITY

Starting in 2016, in an effort to reduce costs, Council directed staff and committee chairs to include financial reporting and budget forecasts in the annual reports from member-specific committees, to consider the use of technology and to be more fiscally-minded.

Currently all PIC panel meetings to review inspection-assessment reports are conducted by teleconference. As well, the adverse events subcommittee meetings are held via teleconference. Only the day long policy meetings (3 per year) are conducted in person. And unless there are technical issues, Committee materials are distributed electronically, for example, via secure file transfer. This has eliminated the cost of USB drives and courier.

The quorum for Committee meetings is set out in the College by-laws – three members, including one public member. When planning meetings generally four members are scheduled due to potential conflicts of interest and ensuring quorum if a member becomes unavailable, i.e. minimizing cancellations.

In 2018 a number of initiatives were undertaken to improve overall committee efficiency; in particular reducing the number of low risk items brought to the Committee for review. Low risk items include those where evidence of compliance does not require clinical knowledge; evidence of compliance can be determined at the program level with support from a College Medical Advisor (MA); or evidence of compliance is straightforward based on the submission of completed certification for a course or other requirement outlined in the OHPIP Standards.

Staff are currently in the process of implementing the initiatives with support of the Committee. Data will be collected to evaluate the impact of the initiatives. It is expected that in 2019 Committee meetings will be shorter and/or there will be fewer meetings required to review reports.

OTHER ACTIVITIES AND STAKEHOLD ENGAGEMENT

Assessor Meeting

In April 2018, in conjunction with the College's biannual Assessor Meeting, a one-day pre-meeting was held for assessors in the OHP program along with Independent Health Facility (IHF). There were 86 assessors and committee members who attended this OHP/IHF pre-meeting. The second day was open to all College assessors; of the more than 460 attendees approximately 50 were assessors for the OHP program.

Presentations at the OHP/IHF assessor meeting included: infection control, the report submission process for the OHP and IHF programs, changing landscape of assessment including community health facilities

legislation and assessor network. The content of this meeting is informed by the Committee and our assessors. Evaluations of the day were very positive with feedback on sessions for future meetings.

Fertility Services – Standards Development/Regulation Submission

In 2015 the Ministry requested the College's participation in establishing a quality and inspections framework for the fertility services sector, including Out-of-Hospital Premises (OHPs) and hospital settings.

In 2017, 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".

In order to fulfill the Ministry's request, the College needs regulatory authority to enter and inspect the premises where fertility services are performed. In 2017 Council approved a draft regulation amendment to *Ontario Regulation 114/94, Part XI (Inspection of premises where certain procedures are performed)* made under the *Medicine Act, 1991.*

In April 2018 the Ministry reached out to the College with a number of questions about the draft regulation, including the potential financial impact of the draft regulation. In July the Ministry proposed a number of changes to the draft regulation. The Executive Committee approved a response to the Ministry in August 2018. Subsequently, the Ministry has had follow-up questions. The government has not indicated when the regulation would be enacted.

Ongoing Collaboration with Public Health Ontario

The CPSO is involved in a variety of initiatives with system stakeholders to improve infection prevention and control (IPAC) practices among physicians, and to develop consistent approaches to managing IPAC lapses in out-of-hospital premises. This work supports PIC as IPAC recommendations are a frequent issue in inspection-assessment reports reviewed by the committee.

PIC continues to be involved with conducting joint IPAC inspection-assessments with regional public health units across the province. Public Health Ontario (PHO) continues to provide ongoing support with training initiatives and evidence for concerns identified by OHPIP assessors. In November PHO finalized updates to the IPAC checklists used in facility assessments. Educational sessions are planned for December with OHP assessors regarding the changes. As well as updating IPAC information on the OHPIP website, the changes will be communicated to OHP medical directors and the Committee.

In 2017 OHPs were encouraged to use the PHO checklists as a self-assessment tool to support their ongoing compliance with IPAC requirements. Beginning in the summer of 2018, premises were required to submit their completed IPAC self-assessments as part of the pre-visit questionnaire in preparation for scheduled inspection-assessments.

Quality Management Partnership (the Partnership)

In December 2015 the Ministry of Health and Long-Term Care mandated that the College's Quality Management Partnership (the Partnership), a joint initiative between the College and Cancer Care Ontario, 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's quality activities, as endoscopy represents a major component of the out-of-hospital premises inspection program. This past year the Partnership program provided updates on colonoscopy quality management reports which are distributed to facilities, regions and physicians, as well some of the supports to foster use of the reports for quality improvement.

Oversight of Health Facilities

In May 2016, the Health Minister, endorsed recommendations in Health Quality Ontario (HQO) report *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 2017 the Minister of Health and Long-Term Care, introduced the *Strengthening Quality and Accountability for Patients Act, 2017.* The bill received royal assent in December 2017.
In the first half of 2018 program staff continued to engage in discussions and collaboration with the Ministry in the development of regulations to support the enactment of various aspects of the Act. Following the election of the new government and appointment of a new Minister in June 2018 work has been paused.

Education

A number of education opportunities and presentation at conferences/meetings 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 and quality assurance rounds, assessor meeting, Ontario Association of Medical Radiation Sciences and presentations at regional public health units, 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 2018

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 (under reconsideration)
   - Determining whether College interventions produce change
   - Ensuring policies improve quality of care/safety

   As noted in previous annual reports, the Research and Evaluation Department is leading a multi- year project under the Assessment Revisioning mandate to redesign the protocols/tools used for peer assessment. Under the direction of a dedicated RED staff lead, the following activity / targets have occurred in 2018:

   - In the first quarter, family medicine became the first specialty to fully implement new peer assessments tools into all assessments. Across the year, six additional specialties have been fully implemented (Walk in Clinic, Medical Psychotherapy , Psychiatry, Hospitalist, Emergency Medicine, Cardiology,), and an additional three specialties (Dermatology, , Endocrinology and Rheumatology) continue to be piloted. There are 9 handbooks and assessment tools publicly available on the CPSO website and, as of October 2018, 655 assessments have been conducted using the new Peer Redesign protocols/tools.

- Three assessor network groups (Diagnostic Radiology, Anesthesia, and General Surgery) have completed creation of draft assessment protocols positioned to implement in 2019 following internal/external review processes. Four additional disciplines continue to develop draft peer assessment protocols (Pathology, Hematology/Oncology, Long Term Care, and Chronic Pain Management).

- A program evaluation has accompanied implementation of the new program, through which regular feedback has been collected from PA&E staff, assessors, QAC members, and assessed physicians. Overall, the results have been very positive: assessors, staff, and QAC prefer the new report formats for facilitating their decision-making and assessed physicians report that their assessments were valuable and educational experiences. Lastly, an evaluation of assessor expense submissions ("SSRs") attributed to the redesigned assessment protocol was initiated in the third quarter of 2018 and will conclude in the first quarter of 2019.

- With the full implementation of new peer assessment protocols, a sustainable process was required for ensuring assessment protocols and resources remain up to date (e.g., reflecting changes to clinical guidelines). Development of this review/updating process began in the third quarter and currently focuses on 41 Quality Improvement Resources (QIR) on specific topics (e.g., prescribing for chronic non-cancer pain, management of Diabetes mellitus type 2, etc.) contained across 10 assessment handbooks. The review/updating process has begun as a shared responsibility of RED and the program area, but will ultimately be carried out by the Practice Assessment and Enhancement department in collaboration with medical advisors and College assessors.

- Engagement of additional assessor networks in peer redesign is being reconsidered in light of where the greatest need for assessment resources will be following the implementation of our revised selection for peer assessment in 2019 (i.e. the disciplines more likely to be selected for peer assessment will be prioritized for assessment protocol/tool development in the future).

2. Assessment Revisioning – "Physician Factors"

Staff are working to develop a Quality Improvement and Quality Assurance model including a suite of self-directed quality improvement tools as part of modernizing our approach to ensure physician quality. Based on the evidence that identifies risk and support factors to physician practice two tools are under development; a Self-Guided Chart Review based upon the redesigned peer assessment handbooks described above and an individualized Physician Practice Profile. This will be an online tool that provides information and resources to physicians based on the information they input concerning their personal risk and support factors in practice. Finally, RED is working on an algorithm to incorporate evidence and data to appropriately stratify physicians for QI activities to

make available to them various support resources they can access across their practice career. The content for each of these products will be complete at the end of 2018 with piloting occurring in early 2019.

COMMITTEE FINANCIAL ACCOUNTABILITY

Starting in 2016, in an effort to reduce costs, Council directed staff and committee chairs to include financial reporting and budget forecasts in the annual reports from member-specific committees, to consider the use of technology and to be more fiscally-minded. Staff implemented a process to monitor MSI caseload volumes 6-8 weeks in advance of a scheduled meeting to assess the feasibility of converting an in-person meeting to a teleconference if no interviews were scheduled. For 2018, 3 in-person meetings were cancelled because of small caseloads and which were reassigned to existing meetings resulting in cost savings of over $50,000. Three in-person meetings were converted to teleconferences resulting in an additional cost saving of $35,000 for a total of $85,000 in savings.

As of April 2018, the QAC began receiving electronic dissemination of meeting materials via Secure File Transfer which eliminated all courier and USB costs. Consideration was also given to incorporating these process changes into financial projections for the 2019 budget eliminating the need to budget for either courier or USB costs.

3. **OTHER ACTIVITIES**

QAC Education Day

A fourth successful Education Day was held in May addressing the ongoing work of the Peer Redesign project, providing an introduction to a systems based approach to right touch regulation, an update on education as strategic initiative and education on Compliance Monitoring & Supervision processes. The day was attended by 17 committee members and feedback was that the information provided was very helpful in informing attendees about the direction of assessment for the College, improving their understanding of the QA regulation and College policies.

QAC Working Group

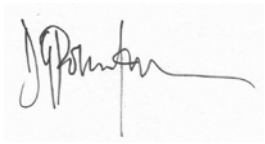
Formed in late 2015 this subset of QAC members meets monthly to review Peer Redesign cases and to provide feedback and advice on a variety of staff initiatives in advance of them possibly being presented to the larger QAC. The working group have developed significant expertise in supporting staff in their work and in the efficient review of Redesign cases allowing them to act in a “train the trainer” capacity for the broader committee when those cases begin to come to regular member specific panel meetings.

Ongoing QAC Training
The Committee continues to receive education and training as part of the quarterly Policy meetings based on identified topics of interest and to keep them up to date with work occurring in other areas of the College which intersects with their mandate.

Process Improvements – Decision Guide and Tip Sheets
The Committee has continued to be involved in streamlining processes to improve the efficiency of meetings and to continue to improve consistency in decision making. Led by the PA&E Decision Administrators a Decision Guide with Tip Sheets has been developed that supports members in making consistent informed decisions in accordance with the Committee's regulatory authority with regards to physician assessment outcomes. Feedback from the Committee on the merit and use of those resources has been resoundingly positive.

QAC Member Interviews
Committee co-chairs agreed as part of their role to ensure they speak directly with all members of the Committee annually to review member's goals and to give and get feedback on the member's work on the Committee. All members were contacted in the first half of 2018. .

Methadone Committee Transition
As of January this year the work of the former Methadone Committee was formally transitioned to be a Specialty Panel under the QAC. This panel met quarterly to review assessments. QAC members attended these meetings for a better understanding the methadone assessment process. Plans are underway to integrate this panel into regular member specific panel meetings in 2019.



Dr. Brenda Copps and
Co-Chair
Quality Assurance Committee

Dr. Deborah Robertson
Co-Chair

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Registration Committee
Annual Report 2018

REGISTRATION COMMITTEE

MANDATE

The Registration Committee's mandate is described in the *Health Professions Procedural Code*, to consider applications for a 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 in Ontario.

The Registration Committee continues to collaborate with external stakeholders to identify alternative ways to evaluate the competence and performance of physicians. External stakeholders include provincial medical 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. The increase is the result of an increase in applications as a direct result of the College's commitment to reduce barriers to registration for qualified individuals by approving alternate 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 2019 report.

Committee Efficiencies

The Committee and staff are continuously 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 Committee in-person meeting days.

How we did it:

- A truncated presentation of material.
- 10 additional Panel meetings were held by teleconference.
- Re-organized the panel meeting agendas to cover complex cases first, increasing the efficiency of the meeting and a better utilization of time

- Restructured the Committee into panels of 4 members containing both new and seasoned members. This change in structure significantly reduced Committee time at meetings and has ensured cross training among members to build succession planning.
- Reviewed Committee member preparation time to better calibrate member billing expenses
- Centralization of Decision Administrators has cut down on the duplication of work, and improved staff competency and consistency in writing of Orders.

Timeliness of Review of Applications and Issuance of Decisions

The amount of time taken to review applications for licensure is reported on the Council dashboard, and performance on this metric has remained on-target for the entire year. In addition a benchmark of 7 business days was established for issuing a decision letter to applicants, following the Committee's consideration of a matter. 100% of decisions were issued within this timeline for 2018 even while complex cases continue to rise.

HPARB APPEALS

There were 11 appeals initiated with 8 being withdrawn, and 2 decisions confirmed by HPARB. Six appeals remain active from previous years with no disposition.

Registration Committee Goals and Objectives

At the beginning of 2018, 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 2018 shows that for the 13th year in a row there has been an increase in the number of certificates of registration being issued 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 policies are still relevant and if further changes are warranted.
- As a result of this review, the Registration Committee recommended the following revisions:
    - Directives were issued to the Registrar regarding certain registration requirements which, if fully satisfied would allow the Registrar to issue certificates of registration without requiring the Registration Committee's review. We anticipate a 20% reduction in memo cases which would otherwise go to committee in 2019.

- **Council Policy**
  - **Changing Scope of Practice and Re-entry** Policies were updated and amalgamated into one policy - Ensuring Competence Changing Scope of Practice and/or Re-entering Practice.
  - **Practice Ready Assessments for Family Medicine** In 2017 we completed the operational framework for the launch of this program; however, we have yet to consider applications under this alternate route as the Ministry has temporarily placed the initiative on hold.

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.
- Last year the Committee processed 50 supernumerary First Year Residency applications for underserviced areas that were mandated by the MOH. This involved creating a process to review the applications and ensure that applicants were ready to start their residency training on July 1st without delay.
- Implementation of the new expedited review fee for assessment of applications was well received and saw a significant increase in requests for this service. In 2018 there was a two-fold increase in requests from 2017

Objective #3: Web-based registration improvements

- The College is participating, through FMRAC, in the development of an on-line national application process for Independent Practice Certificates. Ontario's commitment to this mandate is in phase one, which allows for first time registered independent practice applicants to apply for registration using this new service. This application was launched in October 2018.
- The CPSO website has been updated to reflect the new process and timelines to ensure transparency and facilitate better understanding of Registration and the Registration Committee's process.
- The Creation of a Record of Qualifications was rolled out to pre-screen and better match applicants with appropriate pathways and application types, and to provide an optimal customer service experience.

Objective # 4 **–** Proactively regulate the profession

- 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 by Council will facilitate onboarding physicians in self-regulation with tools and expectations around professional medical

practice in Ontario. The Content of the Modules is anticipated to be completed at the end of 2018.

- In 2018, the Applications and Credentials department was subject to a full assessment by the Office of the Fairness Commissioner (OFC) to determine our compliance with our registration mandate to be fair, impartial and transparent.
- We anticipate receiving a favourable outcome to this audit from the OFC by December 2018.

UPDATE ON OTHER ACTIVITIES

Significant changes to process and staffing structure resulted in more effective process efficiencies in 2018. This 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 need for additional resources. Change of Scope and Re-entry applicants are now captured in the application tracking system and have a real time status view, additionally this program area has been assigned a dedicated compliance monitor resulting in a more robust monitoring program by combining two separate systems and programs into one.

Respectfully submitted,

Akbar Panju
Chair, Registration Committee

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 2018

TOPIC: Report of the Finance and Audit Committee

FOR DECISION

ISSUE:

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

- Recommendations from the Physician Compensation Working Group
- 2019 Budget
- Proposed by-law amendment to the General By-Law

BACKGROUND:

The Finance and Audit Committee met on October 16, 2018. At that meeting the following motions were made:

> It was moved by Mr. Giroux, seconded by Dr. Bodley, and **CARRIED**. *That the Finance & Audit Committee recommends to Council that:*
>
> - *The compensation rate is recommended to remain at $972 per day (or $162 per hour reflecting the current 2018 rates for physician Council and Committee members.), with cost of living adjustments to continue in the annual budget process.*
> - *Travel time should be compensated at a percentage of the per diem rate, and the PCWG recommends that this be 75% of the annual daily per diem rate.*
> - *Preparation time should be further standardized based on the nature of the work of Committees. This requires additional review by MSI Committee Chairs to develop and implement a standardized approach.*
> - *The College should rescind differential per diem rates for the President (currently $1242 per day) and Vice President (currently $1020 per day). Both the President and VP will continue to submit claims for work performed on various College Committees at the current rate for members. In addition, the*

President will receive an annual stipend of $30,000.00, which will be adjusted annually with the cost of living increase as approved by Council.

- *Committee Chairs should include, in their Annual Report to Council, information about how their Committee has addressed, in the previous year, efficiencies in the performance of their committee responsibilities. This will be completed in consultation with the respective Committee staff support manager. Finance Department will provide a template in order to assist with the reporting.*

It was moved by Dr. Poldre, seconded by Dr. Rosenblum, and **CARRIED.** *That the Finance & Audit Committee recommends to Council that the budget for 2019 be approved as presented.*

It was moved by Dr. Bertoia, seconded by Mr. Giroux, and **CARRIED.** *That the Finance & Audit Committee recommends to Council that per diems be increased by approximately 2.2% effective January 1, 2019*

It was moved by Mr. Giroux, seconded by Dr. Rosenblum, and **CARRIED.** *That the Finance & Audit Committee recommends to Council the proposed amendment to the General By-law.*

DECISION/DISCUSSION FOR COUNCIL:

Does Council approve the motions as detailed above?

Contact: Peter Pielsticker, Chair Finance and Audit Committee
Douglas Anderson, Corporate Services Officer, ext. 607
Leslee Frampton, Manager Finance and Business Services

Date: November 8, 2018

Attachments:

Appendix A: 2019 Budget Material

Appendix B: Council and Committee Remuneration By-Law

Appendix C: General By-Law

Appendix D: Finance and Audit Committee Annual Report 2018

Appendix A

BUDGET

2019

Statement of Operations Input Template

College of Physicians and Surgeons of Ontario

	ACTUALS			BUDGET				
	ACTUALS 2015	ACTUALS 2016	ACTUALS 2017	BUDGET 2018	NUMBERS	FEES	BUDGET 2019	% INCREASE OVER 2018 BUDGET
REVENUE NET OF CRCC'S								
MEMBERSHIP FEES								
Independent Practice								
3110 - Renewal Independent Prac Lic - First 5 months	50,062,063	51,507,896	53,641,622	56,782,073	33,538	1,725	24,105,438	
3110 - Renewal Independent Prac Lic - Last 7 months					34,309	1,725	34,523,431	3%
3111 - New Independent Practice Lic	2,660,466	2,925,616	2,817,923	3,108,625	1,813	1,725	3,127,425	1%
3465 - Credit Card Service Charges	-1,204,105	-1,253,249	-1,335,698	-1,276,870			-1,451,188	14%
3120 - Renewal - Postgraduate Cert.	1,356,707	1,565,894	1,216,943	966,875	4,930	345	1,700,850	76%
3121 - New Post Graduate Certificate	666,347	719,839	698,503	430,300	2,025	345	698,625	62%
3198 - Late Payment Penalty	371,501	348,906	256,662	355,866			384,935	8%
TOTAL MEMBERSHIP FEES	**53,912,980**	**55,814,902**	**57,295,956**	**60,366,869**			**63,089,516**	**5%**
APPLICATION FEES								
General								
3210 - App Fee - New IPL Rate	1,633,303	1,655,975	1,856,535	1,874,740	2,043	1,035	2,114,505	13%
3280 - A. F. - Short Duration	3,828	6,146	8,520	6,305			6,165	-2%
3245 - IP - Expedited Review Fee	0	0	62,246	95,912			76,000	-21%
3255 - SD - Expedited Review Fee	0	0	647				800	0%
3220 - App Fee - New PG Rate	463,320	494,438	1,120,749	537,875	2,775	431	1,196,719	122%
3230 - App Fee - Reg Comm Modify	20,028	41,226	46,271					0%
3250 - PG - Expedited Review Fee	0	0	58,056	96,415			77,000	-20%
3325 - CPC - Paid by Physician (Mem.)	410,800	378,525	576,000	600,000	12,650	50	632,500	5%
3326 - CPC - Paid by Hospital	9,000	8,550	7,450		50	50	2,500	0%
Certificates of Incorporation								
3340 - New - Cert of Incorporation	571,150	515,500	434,700	560,000	725	400	290,000	-48%
3341 - Renewal-Cert of Incorporation	2,165,025	2,383,375	3,486,275	3,438,225	20,700	175	3,622,500	5%
TOTAL APPLICATION FEES	**5,276,453**	**5,483,734**	**7,657,450**	**7,209,472**			**8,018,688**	**11%**
OTHER								
Miscellaneous Services								
3305 - Embassy Letters	27,190	22,560	15,770	18,000	270	40	10,800	-40%
3310 - Wall Diploma	23,695	18,975	19,575	20,625	265	75	19,875	-4%
3990 - Miscellaneous	17,708	26,228	13,296	22,919			19,077	-17%
3370 - OHPIP - Application Fee	10,000	7,000	5,500	35,921			7,500	-79%
3385 - OHPIP - Affliliation Fee	34,200	29,400	39,225				34,275	0%
3197 - OHP Late Payment Penalty	17,190	11,610	3,131	27,825			10,644	-62%
3199 - IHF Late Payment Penalty	17,229	23,675	16,613				19,172	0%
3825 - Survivor Fund Charge Backs	45,620	20,418	16,952	29,563				-100%
3830 - Discipline Costs Recovered	442,488	374,551	260,124	261,092			359,054	38%
3835 - Court Costs Awarded	15,000	0	97,250				37,417	0%
3880 - Prior Year Items	133,881	14,216	-33,751				38,116	0%

	ACTUALS			BUDGET				
	ACTUALS 2015	ACTUALS 2016	ACTUALS 2017	BUDGET 2018	NUMBERS	FEES	BUDGET 2019	% INCREASE OVER 2018 BUDGET
Investment Income								
3520 - Investments - Long Term	992,566	613,405	686,421	676,000			649,913	-4%
3530 - Bank Account Interest	436,367	401,600	479,071	392,489			439,013	12%
TOTAL OTHER	**2,213,134**	**1,563,638**	**1,619,176**	**1,484,434**			**1,644,855**	**11%**
TOTAL REVENUE (BEFORE CRCC'S)	**61,402,567**	**62,862,274**	**66,572,582**	**69,060,775**			**72,753,059**	**5%**
EXPENDITURES NET OF CRCC'S								
Executive Division	2,948,457	3,146,782	3,683,112	3,330,549			3,137,434	-6%
Information Technology Division	3,786,597	4,498,282	4,750,053	5,284,835			5,087,487	-4%
Research and Evaluation Division	1,170,039	1,588,278	1,408,592	1,573,385			1,482,539	-6%
Policy and Communications Division	4,833,262	5,168,000	5,146,684	5,604,182			5,606,871	0%
Legal Services Division	3,965,469	4,320,300	4,931,400	5,239,599			5,154,157	-2%
Corporate Services Division	7,248,162	8,061,714	8,655,137	8,418,846			8,304,665	-1%
Quality Management Division	12,569,552	13,819,124	12,779,218	14,477,663			14,270,269	-1%
Investigations and Resolutions Division	21,176,453	23,176,820	23,428,738	24,954,822			23,959,555	-4%
TOTAL EXPENDITURES (BEFORE CRCC`S)	**57,697,992**	**63,779,300**	**64,782,934**	**68,883,881**			**67,002,979**	**-3%**
EXCESS REVENUE OVER EXPENDITURES (BEFORE CRCC`S)	**3,704,575**	**-917,026**	**1,789,648**	**176,894**			**5,750,080**	
69								
CAPITAL AND NEW REQUESTS								
ADDED:								
Increase in Membership Fee (i.e. 7 months of the New Year at the increased rate)					34,309	0	0	
LESS:								
Per diem rate increase - Operating							184,701	
HST increase (Due to per diem rate increase) - Operating							11,045	
COLA							776,377	
Salary Increases							109,379	
Benefit increase due to change in salaries - Operating							127,549	
Pension increase (Due to salary increase) - Operating							79,718	
New Requests - Positions							1,615,339	
Therapy Funding Reserve							900,000	
Workplace Strategy							1,000,000	
Lean Facilitation							500,000	
TOTAL NET SURPLUS/(DEFICIT)							**445,972**	

EXPENDITURES BY COST CENTRE (BEFORE CRCC'S)

College of Physicians and Surgeons of Ontario

	ACTUALS			BUDGET					
	ACTUALS 2015	ACTUALS 2016	ACTUALS 2017	BUDGET 2018	BUDGET 2019	CHANGE $	CHANGES %	TARGET FOR 2019	DIFFERENCE
EXECUTIVE DIVISION									
Council	524,946	545,471	522,088	491,007	535,466	44,459	9%	481,187	54,279
Strategic Planning Project				101,067	40,000	(61,067)	-60%	99,046	(59,046)
Executive Committee	65,378	83,029	168,004	84,977	106,863	21,886	26%	83,277	23,586
President's Expenses	108,062	101,165	66,111	80,464	84,695	4,231	5%	78,855	5,841
FMRAC	489,933	497,641	490,620	433,900	440,408	6,508	1%	425,222	15,186
Executive Department	1,760,139	1,919,476	2,436,289	2,139,134	1,930,003	(209,131)	-10%	2,096,351	(166,349)
TOTAL EXECUTIVE DIVISION	**2,948,457**	**3,146,782**	**3,683,112**	**3,330,549**	**3,137,434**	**(193,115)**	**-6%**	**3,263,938.02**	**(126,504)**
INFORMATION TECHNOLOGY DIVISION									
Technical Services	359,745	-	-			-	0%	0	-
IT Department	2,815,633	3,616,351	3,726,040	3,757,144	3,636,806	(120,338)	-3%	3,682,001	(45,195)
Infrastructure	611,219	881,931	1,024,013	1,527,691	1,450,681	(77,010)	-5%	1,497,137	(46,456)
TOTAL INFORMATION TECHNOLOGY DIVISION	**3,786,597**	**4,498,282**	**4,750,053**	**5,284,835**	**5,087,487**	**(197,348)**	**-4%**	**5,179,138.30**	**(91,651)**
RESEARCH AND EVALUATION DIVISION									
Education Program Development	33,133	70,076	59,200	83,500	79,200	(4,300)	-5%	81,830	(2,630)
Research & Evaluation Projects	158,538	273,340	159,337	208,073	154,443	(53,630)	-26%	203,912	(49,469)
Research & Evaluation Departme	978,368	1,244,863	1,190,055	1,281,812	1,248,896	(32,916)	-3%	1,256,176	(7,280)
TOTAL RESEARCH AND EVALUATION DIVISION	**1,170,039**	**1,588,278**	**1,408,592**	**1,573,385**	**1,482,539**	**(90,846)**	**-6%**	**1,541,917.30**	**(59,378)**
POLICY AND COMMUNICATIONS DIVISION									
Governance Committee	32,037	32,083	33,901	45,271	49,438	4,167	9%	44,366	5,073
District Elections	9,721	5,385	7,998	7,864	6,000	(1,864)	-24%	7,707	(1,707)
Outreach Program	65,468	45,748	34,651	41,383	53,398	12,015	29%	40,555	12,843
Policy Working Group	78,253	76,386	68,546	102,377	96,380	(5,997)	-6%	100,329	(3,949)
Patient Relations Program	110,240	134,427	168,080	128,349	372,963	244,614	191%	125,782	247,181
Policy Department	995,410	1,041,386	1,052,083	1,266,950	1,143,954	(122,996)	-10%	1,241,611	(97,657)
Communications Department	2,247,134	2,491,426	2,396,558	2,568,543	2,463,176	(105,367)	-4%	2,517,172	(53,996)
Advisory Services Department	1,295,000	1,341,158	1,384,867	1,443,445	1,421,562	(21,883)	-2%	1,414,576	6,986
TOTAL POLICY AND COMMUNICATIONS DIVISION	**4,833,262**	**5,168,000**	**5,146,684**	**5,604,182**	**5,606,871**	**2,689**	**0%**	**5,492,098.36**	**114,773**
LEGAL DIVISION									
Legal Services	3,965,469	4,320,300	4,931,400	5,239,599	5,154,157	(85,442)	-2%	5,134,807	19,350
TOTAL LEGAL DIVISION	**3,965,469**	**4,320,300**	**4,931,400**	**5,239,599**	**5,154,157**	**(85,442)**	**-2%**	**5,134,807.02**	**19,350**
CORPORATE DIVISION									
Finance Committee	55,215	53,133	65,166	65,245	68,610	3,365	5%	63,940	4,670
Human Resources Department	823,415	1,140,737	1,095,444	963,317	1,001,027	37,710	4%	944,051	56,976
Council Services			-			-	0%	0	-
Facility Services	838,982	923,249	1,061,877	966,492	898,407	(68,085)	-7%	947,162	(48,755)
Records Management	897,020	905,324	944,970	977,786	918,282	(59,504)	-6%	958,230	(39,948)
Business Services	197,425	248,385	264,412	259,583	268,907	9,324	4%	254,391	14,515
Finance Department	1,780,836	2,027,614	1,972,241	2,045,367	2,101,345	55,978	3%	2,004,460	96,885
Occupancy	2,207,524	2,331,520	2,576,179	2,409,422	2,328,948	(80,474)	-3%	2,361,234	(32,286)
800 Bay Street	447,746	431,753	674,849	731,634	719,140	(12,494)	-2%	717,001	2,139
TOTAL CORPORATE DIVISION	**7,248,162**	**8,061,714**	**8,655,137**	**8,418,846**	**8,304,665**	**(114,181)**	**-1%**	**8,250,469.08**	**54,196**

	ACTUALS			BUDGET					
	ACTUALS 2015	ACTUALS 2016	ACTUALS 2017	BUDGET 2018	BUDGET 2019	CHANGE $	CHANGES %	TARGET FOR 2019	DIFFERENCE
QUALITY MANAGEMENT DIVISION									
Education Committee	39,438	45,815	44,938	51,008	47,971	(3,037)	-6%	49,988	(2,017)
Changing Scope Working Group	3,873	22,556	35,228	41,597	37,657	(3,940)	-9%	40,765	(3,108)
Registration Pathways Evaluati	248,906	119,923	31,023	96,000	96,000	0	0%	94,080	1,920
Registration Committee	231,206	229,084	216,728	235,777	172,833	(62,944)	-27%	231,061	(58,229)
Quality Assurance Committee	937,099	954,741	910,348	1,044,027	1,084,032	40,005	4%	1,023,146	60,885
Peer Assessment Program	2,865,054	2,964,399	2,488,853	2,166,224	1,422,941	(743,283)	-34%	2,122,900	(699,958)
Peer Redesign Assessment			132,697	1,291,856	1,901,443	609,587	47%	1,266,019	635,425
Assessor Bi-Annual Meeting	14,947	167,225	1,369	183,891		(183,891)	-100%	180,213	(180,213)
Assessor Training	88,701	39,935	43,796	149,901	123,559	(26,342)	-18%	146,903	(23,344)
Assessor Networks	63,194	68,873	91,655	124,786	146,895	22,109	18%	122,290	24,605
Annual Membership Survey	53,338	52,071	53,485	44,800	22,250	(22,550)	-50%	43,904	(21,654)
Methadone Committee	98,236	95,088	75,357			-	0%	0	-
Quality Management Department	1,122,268	1,419,668	1,390,598	1,559,630	1,523,452	(36,178)	-2%	1,528,437	(4,986)
Quality Assurance Program	2,638,168	3,077,774	2,819,711	2,953,783	3,227,810	274,027	9%	2,894,707	333,102
Applications and Credentials	2,559,862	2,802,790	2,752,415	2,889,269	2,885,898	(3,371)	0%	2,831,484	54,414
Membership Department	677,278	769,168	710,698	671,361	648,480	(22,881)	-3%	657,934	(9,454)
Corporations Department	927,983	990,013	980,321	973,753	929,048	(44,705)	-5%	954,278	(25,230)
TOTAL QUATLITY MANAGMENT DIVISION	**12,569,552**	**13,819,124**	**12,779,218**	**14,477,663**	**14,270,269**	**(207,394)**	**-1%**	**14,188,109.74**	**82,159**
INVESTIGATIONS AND RESOLUTIONS DIVISION									
Caution Panels	103,825	87,994	113,897	105,516	105,513	(3)	0%	103,406	2,107
Business, Leadership, Training	236,397	193,847	184,631	220,273	208,672	(11,601)	-5%	215,868	(7,196)
General, Fast & Medium Track	973,615	1,208,014	1,400,030	1,299,027	1,172,089	(126,938)	-10%	1,273,046	(100,957)
ICRC - Specialty Panels	784,783	882,279	1,060,003	987,227	990,849	3,622	0%	967,482	23,367
ICRC - Health Inquiry Panels	104,897	114,028	90,935	90,691	70,005	(20,686)	-23%	88,877	(18,872)
Training - Non-Staff	36,322	0	6,937	12,500	25,000	12,500	100%	12,250	12,750
Discipline Committee Hearings	1,698,344	2,080,129	1,925,953	2,385,135	1,981,161	(403,974)	-17%	2,337,432	(356,271)
Discipline Committee Case Mana	146,205	235,282	266,798	266,080	294,881	28,801	11%	260,758	34,123
Discipline Committee Policy/Tr	220,058	235,330	249,352	258,279	297,408	39,129	15%	253,113	44,294
Fitness to Practice Committee	26,714	50,306	46,261	83,167	71,083	(12,084)	-15%	81,504	(10,420)
Health Assessments	140,491	94,835	65,399	83,475	122,871	39,396	47%	81,806	41,065
Medical Assessors (MIs)	1,136,847	1,155,815	1,611,889	1,072,610	1,016,407	(56,203)	-5%	1,051,158	(34,751)
Peer Opinions (IOs)	353,519	288,393	213,528	189,441	185,876	(3,565)	-2%	185,652	224
I&R Administration	2,158,843	1,994,330	2,188,267	2,408,715	2,362,903	(45,812)	-2%	2,360,541	2,362
ICR Committee Support	1,799,139	2,000,790	1,901,149	2,353,396	2,317,163	(36,233)	-2%	2,306,328	10,835
Compliance Monitoring	1,425,276	1,478,427	1,568,818	1,847,157	1,915,815	68,658	4%	1,810,214	105,601
Public Complaints Resolutions	1,005,948	1,164,434	1,104,378	1,570,662	1,292,947	(277,715)	-18%	1,539,249	(246,302)
Sexual Impropriety Investigati	971,347	1,326,293	1,358,107	1,257,126	1,046,983	(210,143)	-17%	1,231,983	(185,000)
Public Compaints Investigation	4,103,162	4,550,766	4,237,045	4,415,553	4,289,047	(126,506)	-3%	4,327,242	(38,195)
Registrar's Invest. Preliminar	682,968	690,371	0			-	0%	0	-
Registrar's Investigations	2,210,273	2,300,774	2,813,274	2,789,382	2,906,852	117,470	4%	2,733,594	173,257
Reinspections	21,016	5,580	(0)			-	0%	0	-
Incapacity Preliminary	93,480	114,320	0			-	0%	0	-
Incapacity Investigations	222,036	338,978	479,404	578,612	583,720	5,108	1%	567,040	16,680
Hearings Office	520,951	585,506	542,683	680,798	702,310	21,512	3%	667,182	35,128
TOTAL INVESTIGATIONS AND RESOLUTIONS DIVISION	**21,176,453**	**23,176,820**	**23,428,738**	**24,954,822**	**23,959,555**	**(995,267)**	**-4%**	**24,455,725.56**	**(496,170)**
TOTAL EXPENDITURES (BEFORE CRCC`S)	**57,697,992**	**63,779,300**	**64,782,934**	**68,883,881**	**67,002,979**	**(1,880,902)**	**-3%**	**67,506,203**	**(503,225)**

EXPENDITURES BY ACCOUNT (BEFORE CRCC'S)

College of Physicians and Surgeons of Ontario

	ACTUALS			BUDGET					
	ACTUALS 2015	ACTUALS 2016	ACTUALS 2017	BUDGET 2018	BUDGET 2019	CHANGE $	CHANGES %	TARGET FOR 2019	DIFFERENCE
COMMITTEE COSTS									
Attendance	2,894,007	3,156,669	2,902,656	3,440,244	3,228,880	(211,364)	-6%	3,371,439	(142,559)
Preparation Time	2,390,553	2,612,977	2,734,861	2,945,407	2,563,616	(381,791)	-13%	2,886,499	(322,883)
Decision Writing	647,788	712,767	690,424	127,694	744,491	616,797	483%	125,140	619,351
Expert/Peer Opinions	1,569,749	1,480,952	1,827,805	1,213,706	1,184,713	(28,993)	-2%	1,189,432	(4,719)
Assessors	932	3,419	-			-	0%	0	-
Travel Time	1,344,157	1,349,543	1,291,672	2,051,477	1,427,542	(623,935)	-30%	2,010,447	(582,905)
HST on Per Diems	415,309	500,780	559,794	537,793	547,125	9,332	2%	527,037	20,088
Legal Fees	1,397,637	1,498,452	1,956,780	1,572,792	1,474,626	(98,166)	-6%	1,541,336	(66,710)
Audit Fees	35,719	38,092	44,526	40,000	45,000	5,000	13%	39,200	5,800
Sustenance	233,342	311,518	232,711	346,625	308,425	(38,200)	-11%	339,693	(31,267)
Meals and Accommodations	273,255	326,015	304,734	457,304	372,925	(84,379)	-18%	448,158	(75,233)
Travel Expenses	624,838	683,977	610,271	722,025	662,060	(59,965)	-8%	707,585	(45,525)
Witness Expenses	55,800	30,300	40,429	66,600	51,000	(15,600)	-23%	65,268	(14,268)
TOTAL COMMITTEE COSTS	**11,883,087**	**12,705,462**	**13,196,664**	**13,521,667**	**12,610,402**	**(911,265)**	**-7%**	**13,251,234**	**(640,831)**
STAFFING COSTS									
Salaries	30,351,024	33,623,510	33,771,156	35,904,546	35,273,297	(631,249)	-2%	35,186,455	86,842
Part Time Help	361,979	231,089	206,846	415,940	283,400	(132,540)	-32%	407,621	(124,221)
Benefits	3,768,466	4,464,739	4,380,323	5,088,082	5,147,355	59,273	1%	4,986,320	161,034
Pension	2,869,696	3,100,349	3,213,787	3,477,505	3,374,597	(102,908)	-3%	3,407,955	(33,358)
Personnel, Consultant, etc.	270,292	336,164	301,915	238,135	212,300	(25,835)	-11%	233,372	(21,072)
Placement	59,546	255,354	237,940	107,839	39,500	(68,339)	-63%	105,682	(66,182)
Training and Conferences	377,426	437,204	497,357	600,535	657,049	56,514	9%	588,524	68,525
Employee Engagement	178,861	227,680	183,265	243,346	274,184	30,838	13%	238,479	35,705
TOTAL STAFFING COSTS	**38,237,290**	**42,676,088**	**42,792,589**	**46,075,928**	**45,261,681**	**(814,247)**	**-2%**	**45,154,409**	**107,272**
DEPARTMENT COSTS									
Consultant Fees	939,689	1,490,956	1,682,397	1,667,340	1,706,363	39,023	2%	1,633,993	72,370
Software Costs	162,793	265,693	363,809	770,000	567,391	(202,609)	-26%	754,600	(187,209)
Office Supplies	336,480	331,191	307,298	356,841	306,610	(50,231)	-14%	349,704	(43,094)
Equipment Leasing	71,554	110,894	10,796	26,480	30,500	4,020	15%	25,950	4,550
Equipment Maintenance	104,295	39,937	55,711	48,500	42,911	(5,589)	-12%	47,530	(4,619)
Miscellaneous	92,690	118,862	104,878	235,800	214,000	(21,800)	-9%	231,084	(17,084)
Photocopying	414,910	356,565	348,567	248,500	352,450	103,950	42%	243,530	108,920
Printing	52,637	37,341	22,828	32,300	7,700	(24,600)	-76%	31,654	(23,954)
Member's Dialogue	399,265	380,297	339,522	420,000	350,000	(70,000)	-17%	411,600	(61,600)
Postage	296,108	288,440	275,329	280,370	235,959	(44,411)	-16%	274,763	(38,804)
Courier	117,743	111,448	64,943	70,050	53,925	(16,125)	-23%	68,649	(14,724)
Telephone	265,557	310,443	322,302	305,916	309,797	3,881	1%	299,798	9,999
Reporting and Transcripts	255,864	353,184	453,629	297,212	401,727	104,515	35%	291,268	110,459
Internal Charges	(365,627)	(311,463)	(417,892)	(318,913)	(479,569)	(160,656)	50%	-312,535	(167,034)
Professional Fees - Staff	92,002	82,039	91,324	135,261	132,645	(2,616)	-2%	132,556	89
FMRAC Fees	469,860	471,000	490,620	433,900	440,408	6,508	1%	425,222	15,186
Publications and Subscriptions	200,710	191,780	193,784	184,023	204,488	20,465	11%	180,343	24,145
Travel and Other	367,678	437,610	232,420	397,750	438,031	40,281	10%	389,795	48,236
Grants	74,000	74,000	94,000	125,000	75,000	(50,000)	-40%	122,500	(47,500)
Survivors Fund	87,517	107,017	140,223	90,000	345,000	255,000	283%	88,200	256,800

	ACTUALS			BUDGET					
	ACTUALS 2015	ACTUALS 2016	ACTUALS 2017	BUDGET 2018	BUDGET 2019	CHANGE $	CHANGES %	TARGET FOR 2019	DIFFERENCE
Offsite Storage Fees	201,296	203,143	188,552	215,000	205,500	(9,500)	-4%	210,700	(5,200)
Bad Debt Expense	108,590	5,742	47,648			-	0%	0	-
TOTAL DEPARTMENT COSTS	**4,745,610**	**5,456,117**	**5,412,687**	**6,021,330**	**5,940,836**	**(80,494)**	**-1%**	**5,900,903.40**	**39,933**
OCCUPANCY COSTS									
Electrical	42,610	48,079	107,108	50,200	23,800	(26,400)	-53%	49,196	(25,396)
Plumbing	16,170	43,765	57,400	53,400	24,700	(28,700)	-54%	52,332	(27,632)
Building Consultants	34,560	49,836	153,998	23,400	23,750	350	1%	22,932	818
Mechanical	72,724	78,440	96,205	83,000	91,696	8,696	10%	81,340	10,356
Depreciation	1,289,327	1,270,931	1,236,585	1,286,456	1,195,877	(90,579)	-7%	1,260,727	(64,850)
Housekeeping	209,680	209,930	201,523	204,000	219,420	15,420	8%	199,920	19,500
Other Building Costs	50,478	35,143	64,792	45,000	33,900	(11,100)	-25%	44,100	(10,200)
Offsite Leasing	371,917	384,653	627,325	692,000	719,140	27,140	4%	678,160	40,980
Insurance	449,721	496,566	500,276	500,000	532,000	32,000	6%	490,000	42,000
Realty Taxes	78,486	78,236	87,457	80,000	93,331	13,331	17%	78,400	14,931
Hydro	181,392	214,015	216,016	212,000	197,137	(14,863)	-7%	207,760	(10,623)
Natural Gas	15,789	13,190	14,021	15,000	16,582	1,582	11%	14,700	1,882
Water and Other Utilities	19,151	18,850	18,288	20,500	18,726	(1,774)	-9%	20,090	(1,364)
TOTAL OCCUPANCY COSTS	**2,832,005**	**2,941,633**	**3,380,994**	**3,264,956**	**3,190,059**	**(74,897)**	**-2%**	**3,199,656.88**	**(9,598)**
TOTAL EXPENDITURES (BEFORE CRCC`S)	**57,697,992**	**63,779,300**	**64,782,934**	**68,883,881**	**67,002,979**	**(1,880,902)**	**-3%**	**67,506,203**	**(503,225)**

Appendix B

COUNCIL AND COMMITTEE REMUNERATION

20. (1) In this section, "committee" includes a special committee, task force or other similar body established by the council or the executive committee by resolution.

(2) Nothing in this section applies to a person appointed to the council by the Lieutenant Governor in Council or to an employee of the College.

(3) The amount payable to members of the council and a committee is, subject to subsections (4) and (8),

(a) for attendance at, ~~travel to,~~ and preparation for, meetings to transact College business, $497 per half day, and

~~(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~~

(b) for transacting College committee business by telephone or electronic means of which minutes are taken, the corresponding hourly rate ~~(i.e. President, Vice President, Member)~~ for one hour and then the corresponding half hour rate for the half hour or major part thereof after the first hour.

(4) The amount payable to members of the council and a committee for travel to or from home, or both, is a maximum of three hours per one way trip at a rate equal to 75% of the hourly rate corresponding to the rate set out in subsection 20(3)(a). ~~, and n~~No member shall charge the College for the first hour travelled on each portion of the trip.

(5) *[revoked: December 5, 2013]*

(6) The amount payable to members of the council and a committee in reimbursement of expenses incurred in the conduct of the council's or committee's business is,

(a) for travel by common carrier, the member's actual cost for economy air fare ~~,~~and ~~currently when booking with Air Canada, this is Tango or Tango Plus,~~ transportation to and from the airports, stations or other terminals, or

(b) for travel by VIA 1 if the train fare does not exceed the economy air fare or, if travelling the evening before conducting College business, if the cost of the train fare plus the hotel room does not exceed the economy air fare, or

(c) for overnight accommodation and related maintenance (including meals) away from home, the actual amount reasonably spent up to ~~a~~such maximum ~~of $300 per~~amount set by the College from time to time, for each day away from home for both accommodation and maintenance.

(7) No person shall be paid under this section except in accordance with properly submitted vouchers or receipts.

(8) The amount payable to the president under subsection 20(3)(a) applies to the following

College business:

(a) Council meetings,

(b) meetings of committees which the president is required to attend,

(c) policy working groups,

(d) outreach and other speaking engagements coordinated by the College, but not including stakeholder meetings outside the College and government relations meetings, and

(e) conference attendance.

For all other College business conducted by the president (including but not limited to, stakeholder meetings outside the College and government relations meetings), the College shall pay the president a stipend at the rate of $30,000 per year, or if the president is unable or unwilling to serve any part of the term as president, a pro rata amount for the time served.

Appendix C

Proposed Amendment to General By-law

Subsection 7(1) of the General By-law is revoked and the following is substituted:

Indemnification

7. (1) Every councillor, and his or her heirs, executors and administrators, and estate and effects, shall from time to time and at all times be indemnified and saved harmless ~~out of the funds of~~ by the College from and against,

(a) all costs, charges and expenses whatsoever that he or she sustains or incurs in or about any action, suit or proceeding that is brought, commenced or prosecuted against him or her, for or in respect of any act, deed, matter or thing whatsoever made, done or permitted by him or her, in or about the execution of the duties of his or her office; and

(b) all other costs, charges and expenses that he or she sustains or incurs in or about or in relation to the affairs thereof,

except such costs, charges or expenses as are occasioned by his or her own wilful neglect or default.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Appendix D

Finance and Audit Committee Annual Report 2018

REPORT OF THE FINANCE AND AUDIT COMMITTEE

The Finance and Audit Committee met on January 23, 2018 (Orientation/Education), April 3, 2018 and October 16, 2018.

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 23, 2018
    - Insurance and Risk
    - Cost Efficiencies
    - Cost Awards
    - Space

- April 3, 2018
    - Auditor's Report and Year-end Financial Statement
    - Internal Controls
    - Appointment of Auditor
    - In-Camera Session with the Auditor
    - Budget objectives for 2018
    - Physician Compensation Working Group
    - Administrative Purchasing Practices Review Group
    - Amendment to the Budget Motion
    - Business Continuity Plan

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

The October 16, 2018 Finance Committee focused on the following items:

- Audit Engagement and Planning Letter for 2019
- 2017 Financial Statements for both the closed Defined Benefit Pension Plan and the Employees Retirement Saving Plan
- Physician Compensation Working Group
- 2019 Budget
- Amendment to the General By-Law
- Change in the policy for recording capital items
- Agreement with the Bank of Nova Scotia
- Work Place Strategy Presentation

Further details on a number of these items follow.

Audit Engagement and Planning Letter for 2019

The College's external auditor, Mr. Dale Tinkham, from Tinkham LLP reviewed the Audit Engagement and Planning Letter for the Committee. The Engagement Letter details the objective and scope of the audits that Tinkham conducts for the College. These include:

- Financial Statements of the College of Physicians and Surgeons of Ontario
- Financial Statements for the Employees' Retirement Savings Plan for the College
- Financial Statements for the Designated Employees' Retirement Plan for the College
- Statement of Operations of the Methadone Program administered by the College

The Audit Planning letter addresses the responsibilities as independent auditors and provides information about the planned scope and timing of the audits. It also speaks to a request to respond to some audit questions and any additional information that could be relevant to the audits.

Physician Compensation Working Group

The Physician Compensation Working Group (PCWG) was established by the Finance and Audit Committee as a sub group in April 2017. The Finance and Audit Committee had not conducted a review of the overall approach to compensating physician members of Council and Committees in approximately 25 years.

The PCWG was directed to review and develop recommendations for a sustainable and transparent compensation model that will *manage the growth* of Committee and Council member compensation costs. The work of PCWG is restricted to *physician members* of Committees and Council only.[1]

The PCWG met 5 times from June 2017 – August 2018 and considered a number of things including:

- An environmental scan of health regulators, medical regulators, and major medical organizations.
- Internal cost analysis and trends of Council and Committee compensation
- A survey of all Council and Committee members in January 2018 receiving a significant 79.5% response rate.

The Finance and Audit Committee determined to make the following recommendations to Council:

> It was moved by Mr. Giroux, seconded by Dr. Bodley, and **CARRIED**. *That the Finance & Audit Committee recommends to Council that:*
>
> - *The compensation rate is recommended to remain at $972 per day (or $162 per hour reflecting the current 2018 rates for physician Council and Committee members.), with cost of living adjustments to continue in the annual budget process.*

[1] The recommendations will not apply to the following groups: (1) public members of Council because their compensation rules are set out by the Provincial Government, and (2) physicians who fulfill expert roles (eg. Assessors, independent opinion providers, etc.) as further analysis is required as their work differs from Council/Committee responsibilities.

- *Travel time should be compensated at a percentage of the per diem rate, and the PCWG recommends that this be 75% of the annual daily per diem rate.*
- *Preparation time should be further standardized based on the nature of the work of Committees. This requires additional review by MSI Committee Chairs to develop and implement a standardized approach.*
- *The College should rescind differential per diem rates for the President (currently $1242 per day) and Vice President (currently $1020 per day). Both the President and VP will continue to submit claims for work performed on various College Committees at the current rate for members. In addition, the President will receive an annual stipend of $30,000.00, which will be adjusted annually with the cost of living increase as approved by Council.*
- *Committee Chairs should include, in their Annual Report to Council, information about how their Committee has addressed, in the previous year, efficiencies in the performance of their committee responsibilities. This will be completed in consultation with the respective Committee staff support manager. Finance Department will provide a template in order to assist with the reporting.*

In addition, the Finance and Audit Committee will consider whether further review of a differential payment system should exist for Council/Committee members that may have varied practice circumstances at upcoming meetings.

2019 Budget

The College is accountable for $67M expense budget, and regularly demonstrates – through detailed reports to the Finance Committee, Council, physicians and the public – fiscal accountability, optimal resource use and delivery of effective and efficient programs.

In the drafting of the budget for 2018, Senior Management at the College was tasked with finding efficiencies and reducing their base budgets by 2%. This direction was continued for the 2019 budget and the base budget has been reduced by a further 2.73%, a savings of $1.8M

Revenue is predicted to be $72.7M; an increase of 5% due to the fee increase of $100 and some additional application revenue of $0.6M not previously budgeted. The increase to revenue and the reduction of the 2.73% in the base budget results in a surplus of $5.7M. Requests for new items including an increase to the per diem, staff salary increases and related costs, new positions, therapy funding, work place strategy and lean facilitation total $5.3M leaving a modest surplus of $0.5M with no increase to membership fees.

2019 Budget		
Revenues	$72,753,059	
Base Budget (Expenses)	$67,002.979	
New Requests		
Per Diems & HST		$ 195,746
Salary & related benefits		$1,093,023
Staffing Requests		$1,615,339
Therapy Funding		$ 900,000
Workplace Strategy		$1,000,000
Lean Facilitation		$ 500,000
Total New Requests		$5,304,108
Surplus (Deficit)		**$445,972**

The Finance Committee approved the following motions and Council will be asked to consider related motions with respect to the 2019 proposed budget and fee increase:

The Finance and Audit Committee approved the following motions:

It was moved by Dr. Poldre, seconded by Dr. Rosenblum, and **CARRIED.** *That the Finance & Audit Committee recommends to Council that the budget for 2019 be approved as presented.*

It was moved by Dr. Bertoia, seconded by Mr. Giroux, and **CARRIED.** *That the Finance & Audit Committee recommends to Council that per diems be increased by approximately 2.2% effective January 1, 2019.*

The new rate for a half day per diem is $497.

The Finance and Audit Committee is recommending that the Membership Fee for a Certificate of Independent Practice remain at $1,725.

Proposed Amendment to the General By-Law - Indemnity

Subsection 7 (1) of the General By-law currently states that:

Every councillor, and his or her heirs, executors and administrators, and estate and effects, shall from time to time and at all times be indemnified and saved harmless out of the funds of the College.

This by-law was written before the College had the current insurance coverage that it has now in place. Therefore, the wording of the General By-Law needs to be changed to reflect this. Please see attached for new

The Finance and Audit Committee proposed the following motion:

It was moved by Mr. Giroux, seconded by Dr. Rosenblum, and **CARRIED.** *That the Finance & Audit Committee recommends to Council the proposed amendment to the General By-law.*

Change in Policy for Recording Capital Items

The Finance and Audit Committee approved the move to increase the limit for recording capital items to $5,000. This change was made with guidance from our external auditors.

Agreement with the Bank of Nova Scotia

The College has been able to secure an agreement with the Bank of Nova Scotia for an additional three years with no service fees.

Financial Integrity

The Finance and Audit Committee, on a continual basis, look for ways to use technology to conduct meetings. On occasion, the Committee has members who teleconference/video conference in. The Finance and Audit Committee distributes its meeting material in electronic format.

Financial Statement Review

Quarterly the Financial Statements together with comments and variance analysis are circulated to the members of the Finance and Audit Committee for review and comment. This keeps the Finance and Audit Committee current on the financial results for the year to date.

MRA	2013	2014	2015	2016	2017	2018	2019	CHANGE FROM 2013 TO 2019
Alberta	$1,960	$1,960	$1,960	$1,960	$1,960	$1,960	$1,960	0.0%
PEI	$1,665	$1,865	$1,865	$1,900	$1,900	$1,900	$1,950	2.4%
Nova Scotia	$1,555	$1,555	$1,555	$1,750	$1,750	$1,850	$1,950	3.6%
Saskatchewan	$1,600	$1,700	$1,800	$1,880	$1,880	$1,880	$1,880	2.5%
NFLD & Labrador	$1,650	$1,750	$1,750	$1,750	$1,750	$1,850	$1,850	1.7%
Manitoba	$1,650	$1,700	$1,700	$1,700	$1,780	$1,780	$1,816	1.4%
Ontario	**$1,550**	**$1,570**	**$1,570**	**$1,595**	$1,625	$1,725	$1,725	1.6%
British Columbia	$1,500	$1,542	$1,590	$1,625	$1,670	$1,685	$1,700	1.9%
Quebec	$1,320	$1,345	$1,380	$1,420	$1,420	$1,520	$1,595	3.0%
New Brunswick	$500	$540	$600	$600	$600	$600	$600	2.9%
Average								2.1%

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 2018

TOPIC: Governance Committee Report

FOR DISCUSSION:

1. **2018 Council Performance Assessment Results**

FOR DECISION:

2. **Proposed By-law Amendments to Facilitate Public Member presidents**

NOMINATIONS:

3. **2018-2019 Governance Committee Election**
4. **Committee Membership Appointments for 2018-2019**

FOR INFORMATION:

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

FOR DISCUSSION:

1. 2018 Council Performance Assessment Results

Background:

- Council's 2018 performance assessment was distributed to all members of Council with the meeting materials for the September Council meeting.
- The results overall are quite positive.
- The goals of the performance assessment are as follows:
  - 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.
- Twenty-three Council members (64%) responded.
- Number of years on Council:
  - 1 year < – 22%
  - 1-2 years – 22%
  - 3-4 years – 30%
  - 5-6 years – 13%
  - >7 years – 9%
  - No response – 4%

A. VISION AND MANDATE

QUESTIONS	RATING			
	Yes	Somewhat	No	Don't Know
1. I understand the vision and the mandate of the College.	**96%**	**4%**		
2. The Council formally reviews its vision.	**87%**	**9%**		**4%**

Summary:

- The College vision and mandate is understood by Council.
- Members of Council may feel that the upcoming strategic planning work will provide the opportunity to review the College vision.

Comments:

- *The definition of the college which is embedded in the Vision, is great, communication of this to the Members and Public should be a priority.*

B. STRATEGIC PLAN AND PRIORITIES

QUESTIONS	RATING			
	Yes	Somewhat	No	Don't Know
1. The College's strategic plan is documented	**100%**			
2. The Council creates a set of key priorities that must be implemented in support of the strategic plan of the College	**91%**	**9%**		
3. The Council establishes a small number of strategic initiatives to focus attention and resources to help achieve the College vision.	**83%**	**17%**		
4. The dashboard report presented by the Registrar clearly reports progress on College priorities.	**83%**	**13%**		**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 is perceived to be clear and is viewed positively.
- There may be some uncertainty regarding the creation of a set of strategic initiatives to focus resources and help achieve the College's vision.
- The development of a new strategic plan is timely.
- The respondent who answered "don't know" to the fourth question is a new member of Council.

Comments:

- *As yet, I have not seen a formal discussion around Council setting priorities to support the mission vs its approval of what the College is doing – I suspect the question required differentiation between the two bodies. Most of what comes before Council, from what I have seen, seems to be discussions of policies or actions that have already been taken or prioritized. I am still unclear about the difference in roles between the Executive and the Council in identifying priorities. The presentations from the Registrar have always been linked to the strategic plan.*
- *The Registrar's report clearly shows the dashboard with an easy snapshot that is colour coded and easy to read. There are a reasonable number of strategic initiatives although some are very large in scope. (2 positive comments)*
- *Dashboard has too many categories. New less busy dashboard will be helpful. Dashboard presentation has become stale (3 negative comments)*
- *It is good that the plan for Strategic renewals is underway. I look forward to the discussion (3 positive comments about the development of a new strategic plan)*

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.	**78%**	**22%**		
2. The Council effectively develops and approves principles and policies that fulfill its duty to protect the public interest.	**96%**	**4%**		
3. The Council effectively discharges its statutory functions.	**83%**	**17%**		
4. The Council periodically monitors and assesses its performance against its strategic direction and goals.	**83%**		**9%**	**9%**
5. The College has an effective system of financial oversight.	**91%**		**4%**	**4%**

6. The Council meets with external auditors, reviews their reports and recommendations and, ensures any deficiencies are corrected.	**96%**			**4%**

Summary:

- Most Council members are familiar with College governance practices and policies.
- Respondents feel that the Council develops and approves policies that fulfill its public interest mandate.

Comments:

- *I am not sure of the distinction between the College's assessing its performance vs the Council. I am unsure of the metrics by which the Council measures itself. The College has presented reports about its metrics.*
- *The discussion on Governance change is difficult, however, necessary. It is critical to stay the course. It is smart to start with the plan developed by the CNO and work on changes from there. I am available to support at any time.*
- *Re #3 – effective perhaps but not efficient.*
- *Re #5 – up until now, the system for reviewing registrar remuneration has been informal, poorly understood and not transparent, this has been addressed.*
- *Re #3 – effectiveness limited by research.*
- *Council has sufficient oversight re finance and strategic goals.*

D. GOVERNANCE OPERATIONS

QUESTIONS	**RATING**			
	Yes	**Somewhat**	**No**	**Don't Know**
1. As a Council member I understand my fiduciary obligations.	**100%**			
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 Council members:
    - understand their fiduciary obligations;
    - know and understand the Code of Conduct;
    - understand the COI policy;
    - declare conflicts.
- The results in this section are the best ever!

Comments:

- *Re #5 – the system of committee submission, "Statement of Services Rendered" is extremely cumbersome. By the same token, I believe committee members should be given some feedback about their expenses relative to the mean.*

E. COUNCIL OPERATIONS

QUESTIONS	RATING			
	Yes	Somewhat	No	Don't Know
1. I receive appropriate information for Council meetings.	**100%**			
2. I receive information for Council meetings on a timely basis.	**100%**			
3. Council's meetings are effective and efficient.	**61%**	**39%**		
4. The President chairs Council meetings in a manner which enhances performance and decision-making.	**91%**	**9%**		
5. I feel comfortable participating in Council discussions.	**78%**	**22%**		
6. Council has a formal written orientation package for Council members.	**74%**	**22%**		**4%**
7. My orientation to the College Council was effective.	**61%**	**35%**		**4%**
8. I am aware that Council has a mentorship program.	**96%**	**4%**		
9. Council's mentorship program is helpful.	**61%**	**35%**	**4%**	

10. I find Council's continuing education activities useful.	**74%**	**22%**		**4%**

Summary:

- All respondents feel that they receive appropriate and timely information for Council meetings.
- Council feels that meetings are well chaired by the President, yet there appears to be a perception amongst some that meetings could be more effective and efficient.
- There is a high level of satisfaction with the quality of Council meeting materials.
- Notwithstanding the positive comments about mentorship below, there is an opportunity to improve the effectiveness of the mentorship program and consolidate orientation materials.

Comments:

- *Staff's help with preparation for meetings has been great. The meetings seem fairly efficient given the amount of material that is covered each time.*
- *There is a very detailed orientation to Council and the various committee work. It would be useful to have all the orientation information in one document for each committee. It would also be helpful to have more direction around the process for completing and submitting expenses.*
- *Meetings could reduce the amount of time reviewing background material that is in the briefing notes.*
- *The mentorship program is excellent. The mentor is not only responsive but instructive regarding most activities of Council.*
- *The mentorship program was highly appreciated. There is so much to learn at the CPSO considering its complexity and roles. Education is beneficial.*
- *Dr. Bodley should be commended for keeping the meeting on time and focused, it's a challenging role.*
- *Have not had access to continuing education – too new?*
- *Chair very effective in running an effective and productive meeting.*
- *Orientation – could be broader, more explanation of day to day operations on all committees - DC/ICRC and committees such as policy committees statutory committees.*
- *Better explanation of how government and Council functions overlap and how they deal with each other.*

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.	**83%**	**9%**		**9%**
2. The President asks Council for feedback which informs the Registrar's performance review and advised Council of the outcome of the review.	**74%**	**9%**		**17%**
3. The Council maintains a collegial working relationship with the Registrar.	**100%**			
4. The Council does not get involved in day-to-day operational matters.	**78%**	**22%**		
5. Committees do not get involved in day-to-day operational matters.	**78%**	**22%**		

Summary:

- All respondents feel that Council maintains a collegial working relationship with the Registrar (100%).
- Further orientation is required for new members of Council to ensure awareness of the Council role.

Comments:

- *I have been impressed with the Registrar's reports to Council which are very helpful to understand the College's operations.*
- *Re # 1 – only because I am currently on the executive. I am concerned this is poorly understood and has not historically been well executed due to the short term of the presiding (president figure prominently in this "committee").*
- *There is some overlap with operations.*
- *Council & committees are providing oversight and members are involved with operations of ICRC & DC – hard to answer.*

STRENGTHS AND DEVELOPMENTAL NEEDS

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

- *Very good representation of public and physician constituents*
- *Representation from community and academic centres across the province*
- *Very well supported by staff in communications, legal, policy writing, data collection etc.*
- *Collegial support of new members is exemplary*
- *Staff assistance is always available*
- *Has an excellent support staff*
- *Staff preparation is excellent and efficient*
- *Collegial – allows for members to disagree*
- *Collegial, esp. relationship between public members and physicians*
- *Respectful – non-confrontational atmosphere*
- *Council members are committed to their role*
- *Council members are informative and prepared*
- *The council members are committed to the CPSO. The members are very supportive and enhance the learning process. The public members are amazing, knowledgeable, communicative, and provide more of the patient focus.*
- *Aware of how essential the work of the CPSO is*
- *Cognizant of medical practice in Ontario*
- *Commitment to the mandate of protecting the public*
- *Members' commitment to College mandate*
- *A group of very passionate and dedicated however disjointed folks*
- *Members' conscientiousness*
- *Leadership is exemplary*
- *Good, frank discussion and participation by most members*
- *Well researched and documented materials and presentations*
- *I often like presentations regarding issue of current importance – such as the presenter regarding opioids*
- *Presentations (esp from outside guests) are generally excellent*
- *Time management*
- *Commitment*
- *Diligence*
- *Generally engages in fulsome and nuanced discussion*
- *Engaged. Great discussion*
- *Conversation is encouraged at the meeting and even better dialogue happens over coffee and lunch*
- *Look ahead and trying to be pro-active about government actions*
- *Diversity*
- *Enthusiasm*
- *Meetings well run*
- *Public members listened to and included*

2. **List two ways Council could be improved.**

Governance related comments:

- *Council members could be more diverse in age, gender, race to better reflect the membership*
- *Younger members*
- *Smaller size (3 comments)*
- *Probably somewhat smaller would be better but I do not see a big problem here*
- *Large group – so consider shrinking it (already in discussion) or have multiple break out small group sessions*
- *Become more "nimble" (proposed governance change will help achieve this)*
- *Now being driven by new governance changes*
- *With limited experience of Council, my suggestions may be somewhat uninformed compared to others with longer tenures on Council. However, I agree with decreasing the size of Council to make it more efficient. I would reconsider how physicians are appointed to Council since I do not believe the elected and university members are really representing a constituency. Therefore, if they are representing the public, then the public should somehow have more say in their appointment.*
  It is somewhat challenging to hear updates from the work of committees without having specific, directed questions for Council to consider. I suspect, however, the committees have probably vetted most of the questions in their deliberations so it might be counterproductive to revisit all of these major issues. With such a large Council, it is difficult to get everyone's input on the questions at hand for the committee as they are developing policy. There are votes, but I am not convinced that everyone has been asked to weigh in on the discussion so the voting may be more superficially driven without much depth of understanding of the policy issues.
- *Clearer delineation of roles – of board members- what are board members expected to do outside of statutory committees? Eg as a member of sex abuse/boundary policy committee/group was told to provide ideas, tell committee "where it should be going" – shouldn't staff members be presenting a list of suggestions to be considered by all committee members? What is the expectation here? Sometimes not clear…*

Council Meetings:

- *Focus Council meetings around decision making and less repetition of background material. New council members can read the background information in the written material.*
- *Perhaps more time for controversial discussions*
- *Perhaps anticipate need for discussion and adjust timing of items on the agenda*
- *More time spent standing (rather than sitting) during Council meetings*
- *It would be nice to have one speaker at every Council meeting.*
- *Since Public members are roughly 50% of council, perhaps they should be involved in 50% of presentations regarding policy presentations, etc.*
- *Earlier start (8:30am) and earlier finish (15:30)*
- *Enhance being informed by individuals with specific expertise. Guest speakers (eg. H Cayton, individuals with expertise in boundary issues, disabilities, etc)*

Council meeting materials:

- *More understanding of the executive process and the flow of information between council and the executive. I would still appreciate the utilization of the powerpoints prior to the meeting as they provide a more focused understanding than reading the complete documents. Also available afterwards to review.*

- *Less voluminous briefing packages*
- *The staff does and amazing job of providing timely and comprehensive material. I look forward to even more concise Executive summaries as briefing memos, supported by appendix style "deep five" materials*

Other:

- *Improved orientation about employees for Council members, their role and how will they interact with Council members.*
- *Enhanced government relations identifying a plan including tactics required.*
- *It will be important to ensure that council feels involved in development of new strategic plans and changes in governance*

ADDITIONAL COMMENTS:

- *Well run!*
- *I find that meeting materials are comprehensive, well organized and delivered in a timely fashion.*
- *I continue to be frustrated by the lag between proposed committee appointments, their council approval and ultimate GO LIVE date; i.e. December. This was a particular issue in my role as a committee chair. Too long – can be disrespectful (i.e. informing committee members re: reappointment).*
- *Council and committees are provided oversight and members are involved with operations of ICRC & DC – hard to answer.*

OPPORTUNITIES AND Next Steps:

- There appears to be considerable support for the governance review including a move to a smaller and more diverse Council.
- Continue the work that is underway to consolidate orientation materials and strengthen programming. Additional strategies are required to meet the needs of new Council members as the annual orientation/education day in 2019 will be replaced with a strategic planning session. Strategies to ensure effective orientation and education include the following:
    - provide orientation in December for new members of Council;
    - review and consolidate orientation materials;
    - orientation/education element built into each meeting of Council (e.g. truth and reconciliation/cultural awareness in Dec. 2018);
    - facilitate administrative training for new public members and the Health Board Secretariat which processes claims;
- Continue work to update the dashboard and develop a new strategic plan.
- Consider each of the suggestions that have been made to improve Council meetings (more standing etc.).

QUESTIONS FOR CONSIDERATION:

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

FOR DECISION:

2. Proposed By-Law Amendments to Facilitate Public member Presidents

ISSUE:

In 2017, Council approved in principle the concept of opening up the College president and vice-president positions to public Council members. In order to facilitate this, the College General By-law needs to be amended. The Council is asked to review the proposed by-law amendments.

BACKGROUND:

- Council supported the concept of a public member president (and vice-president) at its meeting on September 8, 2017.
- Council decided that the first president / vice-president election that will be open to public members would be in May 2019 for the 2019/2020 Council year.
- In order to facilitate this, certain amendments need to be made to the College General By-law. This includes amending the composition of the Executive Committee to have a minimum of 2 public members and a minimum of 2 physician members.
- Bringing in the by-law amendments in December 2018 will offer some time for communication of the new process and conventions that are not expressed or mandated in the by-laws for transparency.

NEW PROCESS:

- Executive Committee will have six members, with a minimum of two public members and a minimum of two physician members.
    - Currently, the committee is required to have one or two public members.
    - Starting in the 2019/2020 Council year, the composition of the Executive Committee may change depending on whether the president and/or the vice-president are public members or physicians.
    - The possible composition of the Executive Committee could consist of (a) four physician members and two public members; (b) four public members and two physician members, or (c) three each of public and physician members.

- The then current vice-president will automatically progress to the president position for the following Council year.

  - As is currently the case, this will occur by convention or expectation and will not be mandated in the By-laws.

- The then non-officer "physician" member on the Executive Committee will no longer automatically progress to the vice-president position.

- The past president will continue to automatically be on the Executive Committee unless he or she is unwilling or unable to serve, in which case a Council member will be elected to the Executive Committee in place of the past president. This person may be a physician or a public member.

- The vice-president for the following Council year will be selected from among current members of the Executive Committee (whether a public or physician member) or from a Council member who has been on Council during their current or recent Council term.
  - The purpose of this is to ensure that the vice-president has sufficient recent Executive Committee experience.
  - This will occur by convention or expectation and will not be mandated in the By-laws.

- It is the intention to be fully transparent about the expected conventions.

- The proposed by-laws will establish a new election process for the five positions on Executive Committee other than the president position.
  - In order to ensure there are at least two physicians on the Executive Committee (in any position), an election will be held (if needed):
    - for one physician member if only one of the current president and vice-president (who will become past president and president, respectively) is a physician; or
    - for two physician members if neither of the current president and vice-president are physicians.
  - In order to ensure there are at least two public members on the Executive Committee (in any position), an election will be held (if needed):
    - for one public member if only one of the current president and vice-president is a public member; or
    - for two public members if neither of the current president and vice-president are public members.

- For any remaining positions on the Executive Committee not filled after the above elections, an election will be held for the remaining number of positions. The nominees for the remaining position(s) may be public members or physicians.

NEXT STEPS:

- If approved by Council, the new process will be in place for the Executive Committee elections held in May 2019 for the 2019/2020 Council year. The proposed by-law amendments are attached at Appendix 1.

DECISION FOR COUNCIL:

1. Does Council have any feedback on the proposed by-law amendments?
2. Does Council approve the proposed by-law amendments?

Attachments:
Appendix 1 - Proposed By-law Amendments

APPENDIX 1

Proposed Amendments to the General By-law

Council Meetings

28. (1) The council shall hold,

(a) an annual general meeting, which shall be called by the president between November 1st and December 14th of each year,

(b) an annual financial meeting, which shall be called by the president between March 1st and June 30th of each year,

(c) regular meetings other than the annual general meeting and the annual financial meeting, which shall be called by the president from time to time, and

(d) special meetings, which may be called by the president or by any 12 councillors if the president or 12 councillors deposit with the registrar a written requisition for the meeting containing the matter or matters for decision at the meeting.

(1.1) In this Section 28, councillors appointed to council by the Lieutenant Governor in Council are referred to as "public councillors", and physician members of council are referred to as "physician councillors".

(2) The council shall ~~at each annual general meeting~~,

(a) annually elect a president and vice-president to hold office starting upon the adjournment of the next annual general meeting (or if elected at an annual general meeting, starting upon the adjournment of that meeting) until the ~~next~~ following annual general meeting and, if an election is not so held, the president and vice-president shall continue in office until their successors are elected;

(b) annually appoint the Executive Member Representatives (as defined in subsection 39(1)) to the executive committee. The Executive Member Representatives shall be determined in accordance with the following: ~~a member of the College who is a councillor to serve on the executive committee ("Executive Member Representative").~~

(i) If one or both of the president-elect and the past president-to-be are not physician councillors, or the then current president is unwilling or unable to serve on the executive committee as the past president in the following year, the council shall ~~there is more than one nominee, the council shall determine such member by first have~~ing hold an election of nominees for the remaining number of physician councillor positions required in order to have a minimum of two physician councillors on the executive committee, as required by subsection 39(1);~~this position, which election shall be in accordance with the procedure set out in subsection 3.1.~~

(ii) If one or both of the president-elect and the past president-to-be are not public councillors, or the then current president is unwilling or unable to serve on the executive committee as the past president in the following year, the council shall hold an election of nominees for the remaining number of public councillor positions required in order to have a minimum of two public councillors on the executive committee as required by subsection 39(1);

(iii) The council shall then hold an election of nominees for the number of unfilled Executive Member Representative positions. The nominees for this election may be physician councillors and /or public councillors;

(iv) All of the elections contemplated under this subsection 28(2)(b) shall be in accordance with the procedure set out in subsection 28(3.1); and

~~(i)~~(v) Following such elections, the council shall consider a motion to appoint the successful nominees to serve as the Executive Member Representatives starting upon the adjournment of the next annual general meeting (or if appointed at an annual general meeting, starting upon the adjournment of that meeting) until the following annual general meeting; and

~~(b)~~(c) at the annual general meeting, approve a budget authorizing expenditures for the benefit of the College during the following fiscal year.

(3) ~~Council shall annually elect a President and a Vice President in accordance with the procedure set out in subsection 3.1.~~

(3.1) The procedure for election of the president, vice-president and ~~determination of the member to be appointed as~~ the Executive Member Representatives ~~(as defined in subsection 28(2)(b))~~ shall be as follows:

(a) If there is only one nominee for an office or position, the presiding officer shall declare the nominee elected by acclamation; or

(b) If there are two or more nominees for an office or position,

(i) prior to the first vote, each of these nominees shall be given an opportunity to speak to the council for a maximum of two minutes about his/her candidacy for the office or position;

(ii) that office or position shall be selected by voting by secret ballot, using generally accepted democratic procedures;

(iii) the nominee who receives a majority of the votes cast for that office or position shall be declared the successful nominee;

(iv) if no nominee receives a majority of the votes cast, the nominee who receives the lowest number of votes shall be deleted from the nomination (subject to

clause (v)), and another vote by secret ballot shall be taken. This procedure shall be followed until one nominee receives a majority of the votes cast;

(v) if a tie vote occurs between two or more nominees having the lowest number of votes and no nominee receives a majority of the votes cast:

i. if there is only one nominee other than the tied nominees, a vote by secret ballot shall be taken to determine which of the tied nominees shall be deleted from the nomination. If the nominees again receive an equal number of votes, the presiding officer shall break the tie by lot; or

ii. if there are two or more nominees other than the tied nominees, all of the tied nominees shall be deleted from the nomination; and

(vi) if the nominees that remain have an equal number of votes, each of these nominees shall be given an opportunity to speak to the council for a maximum of two minutes about his/her candidacy for the office or position, and then another vote by secret ballot shall be taken. If the nominees again receive an equal number of votes, the presiding officer shall break the tie by lot.

Vacancies in Presidential Offices

32. (1) The office of president or vice-president becomes vacant if the holder of the office dies, resigns, stops being a councillor or is removed from office by a vote of council at a special meeting called for that purpose and, in the case of the vice-president, in accordance with clause (2)(b).

(2) If the office of the president becomes vacant,

(a) the vice-president becomes the president for the unexpired term of the office;

(b) the office of vice-president thereby becomes vacant; and

(c) the council shall fill any vacancy in the office of vice-president at a special meeting which the president shall call for that purpose as soon as practicable after the vacancy occurs.

(3) If the offices of the president and of the vice-president become vacant concurrently,

(a) the longest-serving member of the executive committee who is (i) a member of the College if the president was a member of the College, or (ii) a public councillor (as defined in subsection 28(1.1)) if the president was appointed to council by the Lieutenant Governor in Council, -becomes the president *pro tempore* until the council fills the vacancies;

(b) the council shall fill both vacancies at a special meeting which the president *pro tempore* shall call for that purpose as soon as practicable after the vacancies occur.

Executive Committee

39. (1) The executive committee shall be composed of the following six members,

(a) the president and the vice-president;

(b) the past president, subject to clause (c) ~~and one member of the college who is a councillor or, if the past president is unwilling or unable to serve on the executive committee, two members of the College one or both of whom are councillors~~; and

(c) three or, if the past president is unwilling or unable to serve on the executive committee, four ~~one or two~~ councillors (each, an "Executive Member Representative"). ~~appointed to the council by the Lieutenant Governor in Council~~.

A minimum of two members of the executive committee (regardless of their position on the executive committee) shall be members of the College. A minimum of two members of the executive committee (regardless of their position on the executive committee) shall be councillors appointed to the council by the Lieutenant Governor in Council.

(2) The president is the chair of the executive committee.

(3) In addition to the duties of the executive committee set out in section 30 of this by-law and section 12 (1) of the Health Professions Procedural Code under the *Regulated Health Professions Act*, the executive committee shall review the performance of the registrar and shall set the compensation of the registrar.

(4) In order to fulfill its duties under subsection (3), the executive committee shall,

(a) consult with Council in respect of the performance of the registrar and with respect to setting performance objectives in accordance with a process approved from time to time by Council;

(b) ensure that the appointment and re-appointment of the registrar are approved by Council; and approve a written agreement setting out the terms of employment of the registrar.

FOR DECISION:

Nominations:

3. 2018- 2019 Governance Committee Election

ISSUE:

- There will be an election for one physician member and two public members for the 2018-2019 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 2.

DECISION FOR COUNCIL:

1. Vote for elected positions for 2018-2019 Governance Committee; 1 physician member and 2 public members on the Council.

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4. Committee Membership Appointments for 2018-2019

- 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[1]
- 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.

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

- The proposed committee membership rosters (as Appendix 3) 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.

DECISION FOR COUNCIL:

1. Election of nominated committee members to committees as set out in Appendix 3.

FOR INFORMATION:

5. Completion of Annual Declaration of Adherence Form for 2018-2019

- Council members are asked to read, and then sign and submit your completed annual Declaration of Adherence Form for 2018-2019. Please provide staff with your Declaration form by the adjournment of the Council meeting on December 7, 2018.
- 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 4).
- 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 4) at the December Council meeting.

Contact: David Rouselle, Chair, Governance Committee
Marcia Cooper, ext. 546
Debbie McLaren, ext. 371
Suzanne Mascarenhas, ext. 843
Louise Verity, ext. 466

Date: November 16, 2018

Attachments:

Appendix 2: Nomination/Election Process for 2018-2019 Governance Committee Vote at Council meeting; includes *Nomination Statements for*: Dr. Haidar Mahmoud, Dr. Jerry Rosenblum, Mr. John Langs, Ms. Joan Powell
Appendix 3: Proposed 2018-2019 Committee Membership Roster
Appendix 4: Declaration of Adherence Form

APPENDIX 2

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

MEMORANDUM

To: All Council Members

From: Dr. David Rouselle, Chair, Governance Committee

Date: October 16, 2018

Subject: **Nomination/Election Process for vote at the December Council Meeting for Elected positions on the 2018-2019 Governance Committee**

At the upcoming Council meeting in December, there will be a vote for the three elected positions on the 2018-2019 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 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. All voting members of Council are eligible to nominate or second a candidate's nomination. A Council Contact list will be provided for you to facilitate your communication with Council members.

If you wish to be nominated for a 2018-2019 Governance Committee position, please contact Debbie McLaren at dmclaren@cpso.on.ca Debbie will provide you with a personalized template to fill in your 200 words (or less) statement.

For your reference, a list of the current composition of the 2018 Governance Committee, a list of the proposed non-elected 2018-2019 Governance Committee members, as per the General By-Law, and a list of the 2018-2019 Executive Committee membership are attached.

1. **The deadline for submission of your completed Nomination Statement is: Monday, November 5, 2018 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, December 6, 2018, prior to the commencement of the Council meeting.**
3. **The vote (if applicable) will take place at the Council meeting on Friday, December 7, 2018.**

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. 2018-2019 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,

David A. Rouselle, MD, FRCSC
Chair, Governance Committee

att.

2018 (current) Governance Committee:

Dr. David Rouselle, (Past President), Chair ♦×
Dr. Steven Bodley, (President) ♦
Dr. Peeter Poldre, (Vice President) ♦
Dr. Jerry Rosenblum (has served for 1 year)
Mr. John Langs (has served for 2 years)
Ms. Joan Powell (has served for 2 years)

Proposed 2018-2019 Governance Committee:

Dr. Steven Bodley, (Past President), Chair ♦×
Dr. Peeter Poldre (President)♦
Dr. Brenda Copps (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)*

2018-2019 Executive Committee:
(appointed by Council at the May 2018 Council meeting)

(Physician member and two public members who are members on the 2018-2019 Executive Committee are not eligible for the 2018-2019 Governance Committee)

Dr. Peeter Poldre, (President)
Dr. Brenda Copps, (Vice President)
Dr. Akbar Panju, (Physician Member)
Ms. Lynne Cram, (Public Member)
Mr. Peter Pielsticker, (Public Member)
Dr. Steven Bodley, (Past President)

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

GOVERNANCE COMMITTEE NOMINATION FORM

FOR PHYSICIAN MEMBER ON THE GOVERNANCE COMMITTEE:

I_____**am willing to be**

Print name here

nominated for Physician Member on the Governance Committee.

Signed by: _____ _____

Signature of Nominee ***Date***

Nominated by: _____ _____

Signature ***Date***

Seconded by: _____ _____

Signature ***Date***

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

GOVERNANCE COMMITTEE NOMINATION FORM

FOR 2 PUBLIC MEMBERS ON THE GOVERNANCE COMMITTEE:
(You may nominate 1 or 2)

I_____**am willing to be**
Print name here

nominated for Public Member on the Governance Committee.

Signed by: _____ _____
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 Public Member on the Governance Committee.

Signed by: _____ _____
Signature of Nominee *Date*

Nominated by: _____ _____
Signature *Date*

Seconded by: _____ _____
Signature *Date*

NOMINATION STATEMENT
CANDIDATE FOR PHYSICIAN MEMBER, GOVERNANCE COMMITTEE

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 – 2018
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.

NOMINATION STATEMENT
CANDIDATE FOR PHYSICIAN MEMBER, 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 and Audit Committee	2014 – 2018
Governance Committee	2017 – 2018
Inquiries, Complaints and Reports Committee	2013 – 2018 2010 – 2013 (as non-council member)
Outreach Committee	2014 – 2018
Premises Inspection Committee	2017 – 2018
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:

I am asking for your support in my quest to remain on the Governance Committee for one more year. As predicted in my submission last December, this past year has been eventful: there are major changes coming in governance at the College, and in how we staff committees. We are in the middle of this evolution and for that reason; we need continuity in the membership of the Governance Committee.

I am still uniquely qualified to sit on this committee. I have been contributing to the College since 1996. I am currently in my fifth year on Council. In addition to Governance, I sit on four other committees (one of which as Chair) and two working groups. Previously, I was a peer assessor for six years and I also have sat on MRC (2001-2004) and Patient Relations Committee (1996-2000). My experience and knowledge of this College and this Committee is a definite and unrivalled asset and will be needed to manage the challenges ahead of us. As well, my organizational, communication and analytical skills and my passion for governance make me the ideal candidate for this position.

It will be an honour and privilege to serve on the Governance Committee in 2019.

NOMINATION STATEMENT
CANDIDATE FOR PUBLIC MEMBER, 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:	2014-2018
Governance Committee	2016-2018
Outreach Committee:	2015-2018
Quality Assurance Committee:	2014-2018
Policy Working Group : *Accepting New Patients / Ending the Physician-Patient Relationship*	2015- present

NOMINATION STATEMENT:

I am now in my second year as a member of the Governance Committee and I would very much appreciate your support for my nomination for the coming year.

As Council is aware, professional regulation is under review across Canada and in particular in Ontario - and the timetable is tight. The Governance Committee and the Executive Committee are fully engaged in the review process, and I would very much welcome the opportunity to continue to participate as a member of the Governance Committee.

I believe my past experiences, not only on the College's Governance Committee but in my professional and volunteer life, have helped me to gain an understanding of both the challenges and the benefits of change.

Again, I would very much appreciate your support.

NOMINATION STATEMENT
CANDIDATE FOR PUBLIC MEMBER, GOVERNANCE COMMITTEE

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	2016-2018
Governance Committee	2017-2018 *(1 year and 9 months)*
Inquiries, Complaints and Reports Committee:	2015-2018
Registration Committee:	2015-2018
Policy Working Group : *Continuity of Care* and *Test Results Management*	October 2016 - present

NOMINATION STATEMENT:

In 2017, I served 9 months on the Governance Committee, stepping into a position that was made vacant by a public member who resigned for medical reasons. I found the Governance work to be very interesting and rewarding and, with Council support, I continued on the Committee in 2018.

As many of you know, my career was spent in education. I began as a classroom teacher, then worked as Vice-Principal, Principal, Superintendent of Schools, and finally, 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, as well as my involvement over the past two years, will serve me well during a third and final year on the Governance Committee. With Council support, I will be happy to remain on the Committee in 2019.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO — Appendix 3
PROPOSED 2018-2019 COMMITTEE MEMBERSHIP — *Rev. 2018-11-19*

COUNCIL AWARD SELECTION COMMITTEE:

COUNCIL MEMBERS:	
Ms. Lynne Cram	
Dr. Peeter Poldre	
Dr. David Rouselle	
NON-COUNCIL MEMBERS:	
Dr. Steven Bodley	Chair/ Past President
Dr. Joel Kirsh	

DISCIPLINE COMMITTEE:

COUNCIL MEMBERS:	
Dr. Philip Berger	
Dr. Michael Franklyn	
Mr. Pierre Giroux	
Dr. Deborah Hellyer	
Dr. Paul Hendry	
Mr. Mehdi Kanji	
Major Abdul Khalifa	
Mr. John Langs	
Mr. Paul Malette	
Ms. Ellen Mary Mills	
Mr. Peter Pielsticker	
Dr. John Rapin	
Dr. Patrick Safieh	
Dr. Elizabeth Samson	
Dr. Bob Smith	
Ms. Gerry Sparrow	
Dr. Andrew Turner	
Dr. Scott Wooder	
NON-COUNCIL MEMBERS:	
Dr. Ida Ackerman	
Dr. Vinita Bindlish	
Dr. Steven Bodley	
Dr. Paul Casola	
Dr. Pamela Chart	
Dr. Carole Clapperton	
Dr. Melinda Davie	Co-chair
Dr. Paul Garfinkel	

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
PROPOSED 2018-2019 COMMITTEE MEMBERSHIP

DISCIPLINE COMMITTEE: (continued)

Dr. Kristen Hallett	
Dr. William L.M. King	
Dr. Barbara Lent	
Dr. Bill McCready	
Dr. Veronica Mohr	
Dr. Tracey Moriarity	
Dr. Joanne Nicholson	
Dr. Terri Paul	
Dr. Dennis Pitt	
Dr. Harvey Schipper	
Dr. Robert Sheppard	
Dr. Fay Sliwin	
Dr. Eric Stanton	Co-chair
Dr. Yvonne Verbeeten	
Dr. James Watters	
Dr. Susanna Yanivker	
Dr. Sheila-Mae Young	
Dr. Paul Ziter	

EDUCATION COMMITTEE:

COUNCIL MEMBERS:	
Dr. Paul Hendry	
Dr. Akbar Panju	Chair
Ms. Joan Powell	
Dr. Sarah Reid	
Dr. Robert Smith	
NON-COUNCIL MEMBERS:	
Dr. Mary Jane Bell	
Dr. Terri Paul	
Dr. Suzan Schneeweiss	CPD:COFM
Dr. Janet van Vlymen	

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
PROPOSED 2018-2019 COMMITTEE MEMBERSHIP

EXECUTIVE COMMITTEE:

COUNCIL MEMBERS:	
Dr. Brenda Copps	Vice President
Ms. Lynne Cram	
Mr. Peter Pielsticker	
Dr. Akbar Panju	
Dr. Peeter Poldre	Chair/President
NON-COUNCIL MEMBER:	
Dr. Steven Bodley	Past President

FINANCE AND AUDIT COMMITTEE:

COUNCIL MEMBERS:	
Dr. Brenda Copps	
Mr. Harry Erlichman	
Mr. Pierre Giroux	
Dr. Rob Gratton	
Mr. Peter Pielsticker	Chair
Dr. Peeter Poldre	
NON-COUNCIL MEMBER:	
Dr. Thomas Bertoia	

FITNESS TO PRACTISE COMMITTEE:

COUNCIL MEMBERS:	
Dr. Deborah Hellyer	
Major Abdul Khalifa	
Mr. John Langs	
NON-COUNCIL MEMBERS:	
Dr. Steven Bodley	Chair
Dr. Pamela Chart	
Dr. Carole Clapperton	
Dr. Melinda Davie	
Dr. Paul Garfinkel	
Dr. William L.M. King	
Dr. Barbara Lent	
Dr. Bill McCready	
Dr. Tracey Moriarity	

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
PROPOSED 2018-2019 COMMITTEE MEMBERSHIP

FITNESS TO PRACTISE COMMITTEE (continued):

Dr. Dennis Pitt	
Dr. Robert Sheppard	
Dr. Eric Stanton	
Dr. Paul Ziter	

GOVERNANCE COMMITTEE:

COUNCIL MEMBERS:	
Dr. Brenda Copps	Vice President
Dr. Peeter Poldre	President
Physician member of Council	Vote – Dec 7-18
Public member of Council	Vote – Dec 7-18
Public member of Council	Vote – Dec 7-18

NON-COUNCIL MEMBER:	
Dr. Steven Bodley	Chair/ Past President

INQUIRIES, COMPLAINTS AND REPORTS COMMITTEE:

COUNCIL MEMBERS:	
Dr. Brenda Copps	
Ms. Lynne Cram	Co-Vice Chair, General Panels
Mr. Harry Erlichman	Co-Vice Chair, General Panels
Ms. Joan Fisk	
Dr. Rob Gratton	
Ms. Catherine Kerr	
Dr. Haidar Mahmoud	
Ms. Judy Mintz	
Dr. Akbar Panju	Vice Chair, Internal Medicine
Dr. Judith Plante	
Ms. Joan Powell	
Dr. Jerry Rosenblum	
Dr. David Rouselle	Chair

NON-COUNCIL MEMBERS:
Dr. George Arnold
Dr. Haig Basmajian

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
PROPOSED 2018-2019 COMMITTEE MEMBERSHIP

INQUIRIES, COMPLAINTS AND REPORTS COMMITTEE (continued):

Dr. George Beiko	
Dr. Mary Jane 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. Mary Jean Duncan	
Dr. William Dunlop	
Dr. James Edwards	**Co-Vice Chair, Settlement Panels**
Dr. Gil Faclier	
Dr. Thomas Faulds	
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	**Co-Vice Chair, Settlement Panels**
Dr. Edith Linkenheil	**Vice Chair, Obstetrical**
Dr. Jack Mandel	
Dr. Edward Margolin	
Dr. Bill McCauley	
Dr. Robert McMurtry	
Dr. Dale Mercer	**Vice Chair, Surgical**
Dr. Robert Myers	
Dr. Sadhana Prasad	
Dr. Peter Prendergast	
Dr. Anita Rachlis	
Dr. Val Rachlis	
Dr. Michael Rogelstad	
Dr. Nathan Roth	
Dr. Dori Seccareccia	

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
PROPOSED 2018-2019 COMMITTEE MEMBERSHIP

INQUIRIES, COMPLAINTS AND REPORTS COMMITTEE: (continued)

Dr. Ken Shulman	
Dr. Wayne Spotswood	
Dr. Michael Szul	
Dr. Lynne Thurling	
Dr. Anne Walsh	
Dr. Donald Wasylenki	
Dr. Stephen White	
Dr. Stephen Whittaker	Vice Chair, Family Practice
Dr. Lesley Wiesenfeld	
Dr. Jim Wilson	

OUTREACH COMMITTEE:

COUNCIL MEMBERS:	
Dr. Brenda Copps	
Ms. Lynne Cram	
Mr. Pierre Giroux	
Mr. John Langs	
Dr. Peeter Poldre	
Dr. Jerry Rosenblum	Chair
Ms. Gerry Sparrow	

NON-COUNCIL MEMBER:
Dr. Steven Bodley

PATIENT RELATIONS COMMITTEE:

NON-COUNCIL MEMBERS:	
Dr. Rajiv Bhatla	
Ms. Julie Kirkpatrick	
Ms. Lisa McCool-Philbin	Chair
Dr. Heather Sylvester	
Dr. Angela Wang	
Dr. Jennifer Wyman	

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
PROPOSED 2018-2019 COMMITTEE MEMBERSHIP

PREMISES INSPECTION COMMITTEE:

COUNCIL MEMBERS:	
Ms. Ellen Mary Mills	
Mr. Peter Pielsticker	
Dr. Jerry Rosenblum	
Dr. Andrew Turner	
NON-COUNCIL MEMBERS:	
Dr. El-Tantawy Attia, PhD	
Dr. Steven Bodley	
Dr. Andrew Browning	
Dr. Bob Byrick	
Dr. John Davidson	
Dr. Bill Dixon	
Dr. Marjorie Dixon	
Dr. Mark Mensour	
Dr. Gillian Oliver	
Dr. Dennis Pitt	**Chair**
Mr. Ron Pratt	
Dr. James Watson	

QUALITY ASSURANCE COMMITTEE:

COUNCIL MEMBERS:	
Dr. Michael Franklyn	***Methadone Specialty Panel***
Mr. Pierre Giroux	
Dr. Deborah Hellyer	
Mr. John Langs	
Mr. Peter Pielsticker	
Dr. Patrick Safieh	
Dr. Robert Smith	
Dr. Scott Wooder	

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
PROPOSED 2018-2019 COMMITTEE MEMBERSHIP

QUALITY ASSURANCE COMMITTEE: (continued)

NON-COUNCIL MEMBERS:	
Dr. Steven Bodley	
Dr. Jacques Dostaler	
Dr. Miriam Ghali Eskander	
Dr. Hugh Kendall	Co-Chair
Dr. Bill McCready	
Dr. Deborah Robertson	Co-Chair
Dr. Ashraf Sefin	
Dr. Bernard Seguin	
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. Barbara Lent	*Methadone Specialty Panel*

REGISTRATION COMMITTEE:

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

NON-COUNCIL MEMBERS:
Dr. Bob Byrick
Dr. John Jeffrey
Dr. Barbara Lent
Dr. Kim Turner

Appendix 4

Please submit your completed Declaration of Adherence Form to Debbie McLaren or Ellen Spiegel on Friday, December 7, 2018.

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[1]

- 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: _____

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

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

MEMBER TOPICS

No Meeting Materials

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 2018

TOPIC: **Cycle Three Assessment: Office of the Fairness Commissioner Report**

FOR INFORMATION

ISSUE:

- The Office of the Fairness Commissioner (OFC) has provided its initial report to the College concerning the College's Cycle 3 Assessment outcome regarding our compliance with the Fair Access to Regulated Professions Act. The Act outlines the broad, general duty of regulatory bodies to have transparent, objective, impartial and fair registration practices.

BACKGROUND:

- Established by provincial legislation (Fair Access to Regulated Professions Act, 2006), the Office of the Fairness Commissioner (OFC) assesses the registration practices of 40 regulated professions to make sure that they are transparent, objective, impartial, and fair for anyone applying to practise his or her profession in Ontario.
- The OFC requires the bodies that regulate the professions to review their own registration processes, submit reports about them, and undergo compliance audits. With these audits, the office ensures that the regulatory bodies are meeting their legislated obligations.
- The College of Physicians and Surgeons is in its third Cycle of reporting.
- The College has since been responding to bi-annual mini assessments focused in the area of Fairness and Transparency.
- 2018 is the second full assessment since the auditors initiation of the program in 2009.
- Full assessments are scheduled every 4 years with bi-annual assessments in between. The OFC has cycled through the regulatory bodies, 3 times in its schedule.

CURRENT STATUS:

- For a description of the full Assessment process, please see the link below: http://www.fairnesscommissioner.ca/index_en.php?page=about/current_projects/assessment_of_registration_summary

- Currently the College is in step 4 of 5 whereby the OFC is producing a revised assessment report based on our feedback. This revised report could result in us only being required to complete a general-duty self-assessment submission. There is strong potential that if the final submissions of the revisions are accepted, no further action will be needed and the College will have a complete pass without recommendations. This has never happened in any assessment/audit.

CONSIDERATIONS:

- Appendix A is a physical copy of our report that will be available at the meeting for review of the questions and material submitted to satisfy the audit's mandate.

- As of this briefing note there are only 3 recommendations and 2 suggestions for continuous improvement in the report. The College has responded to the recommendations and is awaiting an updated report that would demonstrate our compliance with these recommendations based on additional information that we have provided.

- Of all the assessments completed by the OFC of the CPSO, Cycle 3 is by far the most positive to date. It is anticipated that further training will be suggested of the Registration Committee and Council related to considering the Ontario Human Rights Code when making decisions and making sure everyone understands what constitutes a basis for discrimination and bias.

- It is anticipated that in the near future the College will be asked/mandated to provide all services to applicants and the membership in French.

NEXT STEPS:

- Meet with the OFC to complete final recommendations.

This Item is for information only.

Contact: Nathalie Novak - ext. 432

Date: November 13th, 2018

Note: Physical Binders of Submitted Cycle 3 report and evidence are available for reference upon request.

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 2018

TOPIC: **2019 Council Award Recipients**

FOR INFORMATION

ISSUE: To inform the Council of the four 2019 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 2019 Award:

- Dr. Marie Alison Gear, Teeswater
- Dr. Michelle Adrienne Hladunewich, Toronto
- Dr. Rayfel Schneider, Toronto
- Dr. Mark Arthur Spiller, Kirkland Lake

This item is for information.

Contact: Tracey Sobers, Ext. 402
Date: November 13, 2018

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 2018

TOPIC: **Adding Non-Binary Gender Identification in the Register**

FOR INFORMATION

ISSUE:

- Adding a non-binary gender option in the register for members' gender identification.

  We are adding a non-binary gender option to keep in step with a societal trend toward less binary (male/female) gender based requirements and get ahead of possible requests.

BACKGROUND:

- The College's General By-law requires that a member's gender be recorded in the register and be publicly available in the College's website.

- Historically, gender has always been recorded in the College's registration database, and this information has been available online since launch of the College's website in 1998.

- To date, the register has provided for entry of gender as "male" or "female" only. Similarly, in the College's registration application form, applicants are required to identify their gender as either male or female.

- However, there has been increasing policy and legislative change around the world, including in Canada and Ontario, towards recognition of "non-binary" gender identification. That is, an option for persons to identify their gender as non-binary or gender-neutral, rather than as male or female. This change is a reflection of the societal view that gender identification is a fundamentally personal choice, and that there should be accommodation and recognition for people who do not identify as either male or female.

- Increasingly, government-issued documents are allowing for non-binary gender identification. In Ontario, for example, health cards, drivers' licences and birth certificates may now be issued with non-binary gender identification. Instead of showing gender only as "M" or "F," the document may also show gender as "X." Canadian passports also now offer a gender-neutral option.

CURRENT STATUS:

Canadian MRA/MCC Developments:

- Thus far, among the Canadian medical regulatory authorities and the Medical Council of Canada, only the MCC is taking active steps towards inclusion of a non-binary option for gender identification.

- A recent FMRAC survey of the MRAs shows that none are yet providing an option for non-binary gender identification. Further, many do not include gender at all in their public register information. See Appendix A.

- As for the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada, neither of them display gender information in their public directory on their website. However, in their membership applications, both organizations ask for male/female gender identification and, in addition, the Royal College includes "unspecified" as a gender option.

- Meanwhile, the MCC intends to move forward with providing a gender-neutral option for physicians applying for MCC examinations or registering for MCC's credentials verification and national application services ("physiciansapply.ca"). It is expected to be operational beginning in 2020. The MCC adopted the following policy statement earlier this year:

  "For candidates who do not identify exclusively as male or female, the MCC will:
  - introduce gender-neutral provisions on all forms and systems as follows: "M", "F"and "X" *,
  - continue to collect information about gender, and
  - report on identifier "X" * in an aggregate format.

  * For the purposes of this policy the identifier "X" will mean that gender is unspecified."

- In future, there will be increasing data flow from MCC to the College as more of our applicants begin to use MCC's national application service to start their CPSO registration. As MCC starts to forward non-binary gender data to us, and as government documents displaying gender-neutral options proliferate, there will be increasing need and expectation for the College's register and its application material to accommodate non-binary gender identification.

CONSIDERATIONS:

- As we proceed with adding non-binary gender identification in the College's register and registration application forms, a number of operational considerations will be addressed, including the following:

Terminology and Definition:

- For each member in the public register, the gender field will display one of Male, Female or Non-Binary.

- A definition of non-binary will be provided in our application material so that this new data field is used by applicants as designed. As well, the definition will appear in the glossary in our website. It will explain that gender is part of a person's personal and social identity, and will define "non-binary" as the gender term to be used by those individuals who identify their gender as being neither exclusively male nor female.

CPSO Membership Data: Non-Binary Gender

- The addition of the non-binary gender option will require some minor modification to the College's systems, including the registration database.

- Once the non-binary gender field begins to populate with data, College membership reports and statistics will need to reflect this new data. External organizations such as OPHRDC, OHIP, e-health and FSMB which use College membership data will be given advance notice so that they can accommodate this new data element.

- At present, every one of the College's members (almost 43000) is entered in the register as either male or female. While we cannot know at this point how many applicants or members will identify as non-binary, we can assume it will be a low number.

- Estimates of the general population who identify as non-binary range from 0.05% (1 in 2000) to 0.025% (1 in 4000). This suggests that perhaps about 15 of the College's current membership and about 2 of our 5000 new applicants reach year might identify as non-binary. We will start our implementation of the non-binary gender option with our new applicants and will make note of the actual number who identify as non-binary. This will inform subsequent steps with respect to implementing the non-binary gender option for the general membership.

Registration Credentialing:

- Initially, during registration credentialing, applicants' selection of the non-binary gender option in the College's application form may not be supported by their identification

documents. For example, they may select non-binary in our application form, but their passport or academic transcripts may show male or female.

- In the event of such discrepancies the applicants will be contacted for clarification, but because gender is self-reported identification data, selection of the non-binary gender option will not necessarily require that it be verified and matched to the applicant's identification documents.

- In future, these discrepancies should decrease as the non-binary gender option becomes a common feature in all identity documents.

By-Law Amendment Not Required:

- The addition of the non-binary gender field in the public register will not require amendment to the College's by-laws.

- With respect to gender, the by-law requires that members identify their gender and that members' gender be put on the public register. However, the by-law does not define gender or specify that gender must be male or female only.

- Therefore, as it stands, the current by-law allows for non-binary as a third gender option for the public register, without need for amendment. Only if we were proposing to allow members not to identify their gender at all would a by-law amendment be required because, as noted above, the current by-law requires that each member identify their gender.

This item is for information only.

Contact: Wade Hillier, Ext. 636
James Stratford, Ext. 210

Date: November 20, 2018

Appendices:

Appendix A: FMRAC Survey of MRAs: Gender Identification – June 2018

(Appendix A)

FMRAC Survey - Gender Identification
June 2018

Request sent by Fleur-Ange Lefebvre to the Registration Working Group on 4 June 2018 (with responses requested by end-of-day on 20 June 2018):

The CPSO is requesting information about gender identification on your register. What options does the physician have when applying for or renewing their license with your medical regulatory authority?

_____ Male
_____ Female
_____ Unspecified
_____ Non-binary
_____ Other

Please feel free to add any comments you may have.

Gender→ MRA ↓	Male	Female	Unspecified	Non-binary	Other	Comments
CPSBC	√	√				We publicly display male/ female. We do not have other options. We are considering options. We don't have to disclose gender on the web, but we see this as an important patient-focused bit of information.
CPSA	√	√			√ undisclosed √ unknown	"Unknown" is historic from when a candidate did not answer the question.
CPSS	√	√				Saskatchewan currently gives options to identify as Male or Female. This is likely an artifact of historical practice and CPSS would consider broadening the options.
CPSM						We do <u>not</u> ask for gender when renewing a licence or on an application. We do record male or female in our database (for statistical purposes). This information is not public information on any of our Registers. However, under Regulation 104/2005 we are required to maintain a public Physician Profile website for members on the Manitoba Medical Register. 4(1) Each profile must contain the following information about the member and his or her practice in Manitoba... (b) subject to subsection (2), the member's sex; Information re member's sex not to be included on request

						4(2) The council must not include a member's sex in his or her profile under clause (1)(b) if the member requests, in writing, that this information not be included. If the member opts to display the member's sex on the Profile, it is currently identified as Male or Female.
CPSO	√	√				At present, CPSO options for gender identification are Male or Female only, but we're moving towards other options.
CMQ	√	√				The Code des professions requires gender identification to be the same as that registered with the office of the Directeur de l'Etat civil. If a physician or candidate wishes to indicate anything other than male or female, they must first make the change with that office, in keeping with the legally available options. If no information is provided, while registration or renewal can still proceed, ideally this would be resolved as soon as possible by communicating with the physician. For physicians applying from outside the province, the CMQ will most likely rely on the information on the birth certificate.
CPSNB	√	√				
CPSPEI	√	√				PEI records it in the data base, but not on any public document, register or web site. I wonder if it is necessary to record it at all.
CPSNS						Nova Scotia is revisiting our approach to gender identification. At present, our thinking is: 1. We are not convinced of the need for candidates to identify by gender; 2. If it is decided they must, candidates should be asked an open-ended question to self-identify; 3. Ideally, we support a voluntary disclosure in response to an open-ended question; 4. We do not support the use of the term "unspecified". The gender identity of individuals can be quite specific, without being male or female; 5. We do not support the

						designation X, feeling it is rife with negative connotation; 6. We are not sure about the meaning of non-binary; 7. We would support collaborative input from organizations representing LGBQT community and academic input from the discipline of Gender Studies.
CPSNL	√	√				CPSNL is revisiting its approach as well. Can we have a common approach to this issue?
Yukon	√	√			√	In Yukon, we record it in the database. The information may have been used for statistical reasons in the past, but is not currently used.
NWT						
Nunavut						No gender information is requested.
Medical Council of Canada	√	√			√ X (beginning in FY 2021)	During the period from January to June 2017, the MCC conducted an environmental scan to help define a policy statement with regards to gender-neutral identification as it relates to MCC candidates. In addition to reviewing related information from the federal, provincial and territorial governments and the International Civil Aviation Organization (ICAO) a UN specialized agency and other organizations, the MCC consulted: • Ontario Ministry of Government & Consumer Services • CaRMS • CAPER • MINC • ECFMG • Wabano Centre for Aboriginal Health • Gowlings (legal counsel) • Management across MCC All consultation were very helpful. However, the meeting with the Ontario Ministry of Government & Consumer Services was very informative. Their own consultation extended to other partners within the Ontario government, other provinces and the federal government. The MCC Executive Team examined the proposed gender-neutral policy options for its candidates and approved the following policy statement:

						"For candidates who do not identify exclusively as male or female, the MCC will: • Introduce gender-neutral provisions on all forms and systems as follows: "M", "F", and "X"*; • Continue to collect information about gender; and • Report on identifier "X"* in an aggregate format. For the purposes of this policy, the identifier "X" will mean that gender is unspecified." The intent is for MCC to identify all of the requirements that will impact its systems during the period April 2019 to March 2020 and implement the changes during the period April 2020 to March 2021.

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 2018

TOPIC: **Government Relations Report**

FOR INFORMATION

Items:

1. Ontario's Political Environment
2. Issues of Interest
3. Interactions with Government

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1. ONTARIO'S POLITICAL ENVIRONMENT:

- Following the June election, changeover and reorganization continues within the ranks of both elected and appointed officials.
- The Legislature has sat continuously throughout the fall and there have been a number of policy announcements of interest relating to the health sector.
- There have also been signals from the government around longer-term priorities, particularly relating to measures designed to bring down the 2017-18 deficit of $15B.
- Many of these signals can be found in a **report released by EY Canada** to the Treasury Board in September. The report reviewed government expenditures between 2002-03 and 2017-18 in order to identify programs and operations that could be targeted for efficiencies.
    - Health care spending, and hospital funding in particular, was a major focus.
    - High-level recommendations relating to the health sector included optimizing the workforce to reduce overtime premiums, reducing administration costs by consolidating transfer payment agreements and service providers, and consolidating procurement to increase purchasing power (e.g. for consumables and specialized clinical materials).
    - The general themes of the report and recommendations echo the Minister of Health's opening address at the Ontario Hospital Association's Health Care

Leadership Summit in early September, which highlighted the need for innovation, efficiency, and system transformation in the face of "difficult financial times".

- The **Fall Economic Statement (FES)**, a provincial "mini-budget", was released on November 15 and set out more details regarding spending cuts and strategic changes to service delivery.
- In line with the above recommendations, the FES committed to a comprehensive review of all provincial agencies to ensure that they are relevant, efficient, effective, and providing good value for money.
    - The government has assembled a task force charged with, among other things, identifying immediate opportunities to enable efficiencies and aligning agencies with current government priorities.
    - Each year, the government makes appointments to many hundreds of provincial agencies, with almost 100 of these falling under the purview of the Ministry of Health and Long-Term Care.
    - We anticipate that the agency review may affect health sector partners, including potentially the LHINs or smaller health units, as the government seeks to consolidate services and service providers.
- The FES also made a number of commitments relating to compensation in the broader public service.
    - In order to better manage the estimated $2.6 billion that provincial agencies spend each year on compensation, as of December 31, 2018 agencies will be required to obtain approval of their bargaining mandates and ratification of collective agreements.
    - All broader public sector executive compensation increases (including for hospital and provincial agency employees) have been suspended. This is an interim measure as the government develops a long-term approach to broader public-sector executive compensation.
    - Again, these changes will be felt in the health sector as the government looks to control spending and optimize the workforce across the broader public service.
- Both the agency review and the changes to compensation announced in the FES are introductory initiatives, designed to lay groundwork for more significant changes to come.
- Finally, in October the **Ministry of Health and Long-Term Care was reorganized** to clarify and simplify lines of accountability, with a number of divisions being merged together.

- Notably, the Health Workforce Regulatory Oversight Branch, formerly reporting to ADM Denise Cole, will now report into the Strategic Policy and Planning division Patrick Dicerni (ADM). Allison Henry remains director of the branch.
- Denise Cole has been assigned the task of leading an expedited review of legislation and regulation to identify barriers to the effectiveness and efficiency of the health system and ministry oversight.
- A new Secretariat for Ending Hallway Medicine has been created, reporting to the Deputy Minister.
- Population and public health oversight has been aligned under the Chief Medical Officer of Health.

ISSUES OF INTEREST:

- As the new government's agenda takes shape, it has signaled changes to priorities in line with its renewed focus on system transformation and health sector efficiencies.
- As anticipated, regulatory development under Bill 87 (*Protecting Patients Act, 2017*) and Bill 160 (Community Health Facilities) has slowed.
    - In the meantime, the College continues to work with the Ministry to finalize regulatory changes to bring fertility services within the scope of the College's Out-of-Hospital Premises Inspection Program.
- The College's CEO-led work focusing on organizational process improvements and efficiencies in the complaints process is timely, and fits nicely within the framework of the EY Canada recommendations.
- The CPSO Governance Review also reflects the same priorities around efficiency, as Council looks to consider recommendations for governance reform at this December meeting.

Public Appointments

- In addition to the current public member vacancy on College Council, four more public member appointments are due to expire at the end of 2018.
- These public members are serving in leadership positions at the College and are invaluable to the work of College committees, including Discipline and ICR.
- Ensuring prompt appointments in anticipation of these vacancies is critical to ensuring the proper functioning of College committees.
- We have actively continued both formal and informal outreach on this issue to political and Ministry staff, and have been in regular contact with the new Minister's Office on this file.

- We have escalated this activity to ensure we are taking all necessary steps to have 15 qualified public members on the Council.

INTERACTIONS WITH GOVERNMENT:

- The College's government relations activities have strongly focused on (re)establishing relationships with the new government and the opposition parties.
- In particular, we have had (and continue to set up) meetings with key staff and elected officials including new MPPs.
- We anticipate regular contact between the College and MPPs/staff as we build out our relationships with the new government and staff. Our MPP contact program is an active area of attention and a core component of our government relations activity.

Contact: Louise Verity, Ext. 466
Heather Webb, Ext. 557

Date: November 16, 2018

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 2018

TOPIC: 2018 District Council Elections

FOR INFORMATION

ISSUE:

- The 2018 district election results.

BACKGROUND:

- An election was held in District 7 (Counties of Dundas, Glengarry, Lanark, Prescott, Renfrew, Russell and Stormont, and the Regional Municipality of Ottawa-Carleton).

- Candidates in District 6 (Counties of Frontenac, Haliburton, Hastings, Leeds and Grenville, Lennox and Addington, Northumberland, Peterborough, Prince Edward and Victoria); District 8 (Territorial districts of Algoma, Cochrane, Manitoulin, Nipissing, Parry Sound, Sudbury, and Timiskaming); and District 9 (Territorial districts of Kenora, Rainy River and Thunder Bay) were acclaimed.

- Ballots were distributed to eligible voters in District 7 on September 18. The election was open through to October 9 at 4:00 p.m. Reminders were sent to voters who had not voted throughout the election period.

- Five candidates ran for two District 7 positions:
    - Dr. Patricia Horsham
    - Dr. Atul Kapur
    - Dr. Judith Plante
    - Dr. Sarah Reid
    - Dr. Sunil Varghese

RESULTS – District 7:

- Drs. Reid and Plante were elected in District 7. Dr. Plante was re-elected as she currently sits on Council.

RESULTS – Districts 6, 8 and 9:

- Dr. John Rapin was acclaimed in District 6
- Dr. Michael Franklyn was acclaimed in District 8
- Dr. Andrew Turner was acclaimed in District 9

See Appendix A for the complete results of the District 7 election.

Contact: Louise Verity, ext. 466

Date: November 16, 2018

Attachments:

Appendix A: District 7 Election Results

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

MEMORANDUM

DATE: October 10, 2018

TO: Dr. Nancy Whitmore, Registrar and Chief Executive Officer

FROM: Ms Lisa Brownstone, Returning Officer

RE: Results of 2018 Election of Councillors to the College – District 7
(Ballots received by 4:00pm October 9th, 2018)

Number of ballots cast: 1287

Number of votes for each candidate:

Patricia Horsham	240
Atul Kapur	370
Judith Plante	531
Sarah Reid	783
Sunil Varghese	308

Certificate of Returning Officer for District No. 7

I declare: Sarah Reid and Judith Plante elected as the members of Council for District 7 for the ensuing term of Council.

Respectfully submitted,

Ms Lisa Brownstone
Returning Officer

10 OCT '18
Date

Discipline Committee
Report of Completed Cases – December 2018

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, 2018 and November 16, 2018. The decisions are organized according to category, and then listed alphabetically by physician last name.

Sexual Abuse – 2 cases

1. Dr. V.C. Dao

Name:	Dr. Viet Cuong Dao
Practice:	Independent Practice
Practice Location:	Toronto
Hearing:	Uncontested Facts and Joint Penalty
Finding/Penalty Decision Date:	September 10, 2018
Written Decision Date:	November 9, 2018

Allegations and Findings

- Sexual abuse of a patient – **proved**
- Disgraceful, dishonourable or unprofessional conduct – **proved**

Summary

Dr. Dao is a physician, practising in a Clinic in Toronto. He received his certificate of registration authorizing independent practice from the College on July 5, 2011. Dr. Dao has practised exclusively in chronic pain medicine since 2014.

Dr. Dao's Comments of a Sexual Nature

Dr. Dao saw and treated Patient A on four occasions at the Clinic in January and February, 2017. Patient A was referred to Dr. Dao for treatment of chronic pain, in particular, chronic back pain and fibromyalgia. On each of Patient A's visits, Dr. Dao administered injections in Patient A's lumbar spine, sacroiliac joints, sciatic nerves, and sacroiliac fascia and massaged numbing anesthetic into the sites of injection, during which Patient A's bare buttocks were exposed.

At the first visit Patient A was accompanied by a friend. Dr. Dao commented to Patient A's friend about a tattoo that Patient A has on her lower back. Patient A commented that she would not have gotten the tattoo on her lower back if she had known it was called a "tramp stamp". Dr. Dao commented that it was a sexy place to put a tattoo.

At the second visit, which Patient A attended alone, Dr. Dao asked, when Patient A moaned from the pain of the injections, whether "it hurt". Patient A confirmed it did. Dr. Dao then said: "It's going to feel good." Patient A responded by saying: "Yeah, it's one of those things that feels good." Dr. Dao commented it was "kind of like S&M" and asked: "Do you know what S&M is?" Patient A indicated she knew what it was, and Dr. Dao asked: "Do you like S&M?"

At the third visit, which Patient A attended alone, Dr. Dao asked Patient A if she knew what a sugar daddy is. Patient A confirmed she did. Dr. Dao asked if sugar daddies take care of women's children. Patient A responded: "Well, I guess if the mother's taken care of, then I guess the kids are taken care of too." Dr. Dao responded that that was true. Later at the same appointment, Dr. Dao asked her if she knew what a "rub and tug" is. Patient A indicated she did and commented: "You probably go there every day on your lunch hour, and that's inappropriate, you shouldn't be talking to me like that." When Dr. Dao chuckled, Patient A told Dr. Dao that was enough, and got up and left.

At the fourth visit on February 13, 2017, Patient A attended with another friend. About ten minutes into this appointment, Dr. Dao asked: "So, the…rub and tug is for guys? Is anything equivalent like that for women?" Patient A responded she could not say, adding that she does not go to "those places." Dr. Dao commented that he has two family friends who work as massage therapists and that they do not do "those things."

Disposition

On September 10, 2018, the Discipline Committee ordered and directed that:

- the Registrar suspend Dr. Dao's certificate of registration for a period of three (3) months effective October 1, 2018.
- Dr. Dao attend before the panel to be reprimanded.
- the Registrar impose the following terms, conditions and limitations on Dr. Dao's certificate of registration:
    - Dr. Dao will successfully complete one-on-one instruction in Communication Education by an instructor approved by the College, at his own expense, and shall provide proof of completion to the College;
    - Dr. Dao will successfully complete the PROBE course in ethics and professionalism by obtaining an unconditional pass, at his own expense, or any alternate course in ethics and professionalism approved by the College. Dr. Dao will provide proof of completion to the College.

Practice Monitor

- Dr. Dao shall not engage in any professional encounters, in person or otherwise ("Professional Encounters)"), with patients of any age, in any jurisdiction, unless the Professional Encounter takes place in the continuous presence and under the continuous observation of a monitor who is a regulated health professional acceptable to the College (the "Practice Monitor").
- At all times, Dr. Dao shall ensure that the Practice Monitor shall:
    - provide reports (as described in the Practice Monitor's undertaking attached hereto as Appendix "A" to the Order) to the College on at least a monthly basis;
    - remain present at all times during all Professional Encounters with all patients;

  - carefully observe all of his Professional Encounters with patients, including but not limited to physical and internal examinations. Dr. Dao shall ensure the Practice Monitor's view of all of his Professional Encounters with patients, including physical and internal examinations, is unobstructed at all times;
  - refrain from performing any other functions, except those required in the Practice Monitor's undertaking attached as Appendix "A", while observing Dr. Dao in all of his Professional Encounters with patients;
  - maintain a log of all Professional Encounters with patients in the form attached to this Order as Appendix "B" (the "Log");
  - initial all corresponding entries in the records of patients noted in the Log; and
  - submit the on final Log to the College on a monthly basis.
- Dr. Dao shall maintain an up to date copy of the Log, by ensuring a copy is made at the end of each business day, and to make it available to the College upon request.
- Dr. Dao, shall inform the College of each and every location where he practises or has privileges including, but not limited to, hospital(s), clinics) and office(s), in any jurisdiction (collectively my "Practice Locations") within five (5) days of commencing practice at that location.

Posting a Sign

- Dr. Dao, shall post a sign in all waiting rooms, examination rooms and consulting rooms, in all of his Practice Locations, in a clearly visible and secure location, in the form set out in Appendix "C" to the Order that states: "Dr. Viet Cuong Dao has agreed not to have professional encounters, in person or otherwise, with patients, of any age, unless in the continuous presence and under the continuous observation of a practice monitor acceptable to the College of Physicians and Surgeons of Ontario. Dr. Viet Cuong Dao must not be alone during any professional encounter with any patient. Further information may be found on the College website at www.cpso.on.ca".
- Dr. Dao shall post a certified translations) in any languages) in which he provides services, of the sign described in section (vii), in all waiting rooms, examination rooms and consulting rooms, in all of his Practice Locations, in a clearly visible and secure location, in the form set out at Appendix "C" to the Order.
- Dr. Dao shall ensure that each patient with whom he has a Professional Encounter is directly notified, prior to the Professional Encounter, that he has agreed not to have professional encounters, in person or otherwise, with patients of any age, unless in the continuous presence of a practice monitor acceptable to the College of Physicians and Surgeons of Ontario.
- With respect to patients with whom Dr. Dao has appointments that are scheduled at least seven (7) days in advance, Dr. Dao, shall ensure that each

patient is directly notified, within seven (7) days after the appointment is scheduled, of the details of the restriction described in section 4(iii) above.
  - The requirement to practise with a practice monitor as set out in clauses 4(iii)-(x) above, shall remain in place until the College has received proof of successful completion of the Communication Education and the PROBE course, as set out in 4(i) and (ii) above.
  - Dr. Dao shall be responsible for any and all costs associated with implementing the terms of this Order.
- Dr. Dao 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 (30) days of the date of this Order, in the amount of $16,060.00.
- Dr. Dao pay the College costs in the amount of $6,000 within thirty (30) days from the date of this Order.

2. Dr. M.L. Iscove

Name:	Dr. Melvyn Lawrence Iscove
Practice:	Psychiatry
Practice Location:	Toronto
Hearing:	Contested Allegations and Contested Non-mandatory penalty and Costs
Finding/Written Decision Date:	March 8, 2018
Penalty/Written Decision Date:	October 5, 2018

Allegations and Findings

- Sexual abuse of patients – **proved**
- Disgraceful, dishonourable or unprofessional conduct – **proved**

Summary

Dr. Iscove is a psychiatrist who practises psycho-analysis in Toronto.

Dr. Iscove has a special interest in the treatment of patients with problems related to homosexuality, to which he applies the theories of Dr. Edmund Bergler; these theories treat homosexuality as a condition dating to infancy, which is amenable to therapy. Although Dr. Bergler's theories and Dr. Iscove's use of these theories in his practice are controversial, there was no allegation in this case that Dr. Iscove failed to maintain the standard of practice of the profession, and the Committee's findings in this case are not

related to any views that the members of the Committee may have with respect to Dr. Bergler's teachings.

The case was about allegations of sexual abuse that arose from the complaints of two men, Patient A and Patient B, who had each been long-term patients of Dr. Iscove. In addition, it was alleged that Dr. Iscove engaged in disgraceful, dishonourable or unprofessional conduct in relation to boundary violations of a financial and social nature with Patient A and Patient B.

Patient A

Patient A first became a patient of Dr. Iscove when he was in his early twenties and continued to see Dr. Iscove as a patient for about eighteen years. He was referred to Dr. Iscove by a psychologist to whom he had presented with depression and anxiety associated with fears that he was gay. From the outset of treatment, he was introduced by Dr. Iscove to the concepts of Dr. Edmund Bergler. Patient A understood that homosexuality, according to Dr. Bergler, was a clinically curable condition through psychoanalytic treatment, with excellent chances of cure.

Patient A's appointments were initially two or sometimes three times per week, and at each appointment, he would discuss major events in his life, and feelings about other people and about Dr. Iscove. At almost every appointment, there were discussions about Patient A's dreams and fantasies, including any fantasies that he might have had about Dr. Iscove. Even if Patient A did not spontaneously refer to fantasies about Dr. Iscove, Dr. Iscove would ask directly about fantasies specifically involving Dr. Iscove.

Patient A understood from Dr. Iscove that he was the only psychiatrist who was available to discuss and treat these fantasies and that Dr. Iscove was the only available source for this sort of help. Dr. Iscove also cautioned Patient A that he should not talk to other people about the therapy, because they would be unable to understand the basis for it.

During their doctor-patient relationship, Patient A admired Dr. Iscove and considered him as a father figure. He felt free to call him at any point and felt he could rely on Dr. Iscove's advice about almost every aspect of his life. However, Dr. Iscove's enquiries about his fantasies about Dr. Iscove made him feel uncomfortable, and talking about his sexual fantasies was associated with a lot of shame. Patient A at times felt pressure to respond in a way that he thought Dr. Iscove expected and would say what he thought Dr. Iscove wanted to hear.

On a date between the end of 2001 and the beginning of 2002, Dr. Iscove offered Patient A a hug at the end of an appointment. Patient A accepted and Dr. Iscove walked round his desk and they embraced. This recurred on two or three appointments, during which Dr. Iscove would ask "what are you thinking you want to do?" and subsequently said "you may touch me if you like." Patient A then touched Dr. Iscove's erect penis

through Dr. Iscove's trousers. The sexual activity subsequently progressed to Dr. Iscove removing his penis from his trousers, then Patient A doing the same. This progressed on later occasions to mutual masturbation and oral sex. Patient A estimated that such activity occurred on between 10 and 20 occasions with oral sex occurring on one-third of the episodes. On one occasion only, Patient A remembered removing his clothes. Patient A was uncertain about how and when the sexual activity ended. He believes it ended when he told Dr. Iscove that he did not want it to continue. Patient A continued to see Dr. Iscove as a patient after the sexual activity ended.

A number of interactions between Patient A and Dr. Iscove extended beyond the conventional physician-patient psycho-therapeutic relationship. One day Patient A awoke with pain and called Dr. Iscove, who took him to the hospital where Patient A had surgery. In addition, emails between Dr. Iscove and Patient A referred to other subjects, including:

- photographs of a trundle bed owned by Dr. Iscove, sent at a time when Patient A needed to buy a bed for his family member, although he did not recall receiving such a bed from Dr. Iscove.
- a series of photographs of "Oriental" rugs, including comments from Dr. Iscove such as "Let me know if the colours suit your tastes" and "Does this sort of size and pattern suit your purposes? I would need to know the width of your space", sent at a time when Patient A needed a rug, although he did not receive one from Dr. Iscove.
- an e-mail in which Patient A asks about the availability of an apartment in another city owned by the Bergler Foundation, at which Patient A and a friend stayed for a weekend. This was arranged by Dr. Iscove in his role on the board of the foundation.
- a series of e-mails about operatic productions. In one of these e-mails Dr. Iscove invited Patient A and a friend to a working rehearsal of the opera as Dr. Iscove's guest as a President's Council member. Patient A attended the rehearsal, sitting with several other guests of Dr. Iscove, including another psychiatrist. When Patient A expressed concern about disclosing that he was a patient of Dr. Iscove, Dr. Iscove suggested that he could lie about that fact.

With respect to the occasion on which Dr. Iscove drove Patient A to the hospital because he had an acute medical condition, the Committee did not want to suggest that there is anything wrong in coming to the aid of a patient requiring medical assistance. The Committee noted, however, that Dr. Iscove is a psychiatrist and this was not a psychiatric issue. The fact that Patient A chose to call Dr. Iscove when he had an acute physical condition and the fact that Dr. Iscove responded by driving Patient A to the hospital is reflective of the extent to which Patient A had come to rely on Dr. Iscove and that the boundaries within this doctor-patient relationship were significantly eroded.

The rental of the apartment in another city was claimed to be at a low rate which went to the Foundation rather than directly to Dr. Iscove; however, Dr. Iscove's position on the Foundation board placed him in a clear conflict of interest with respect to financial dealings of this nature and must be considered unprofessional.

The invitations to opera rehearsals not only violated social boundaries but placed Patient A in a position of dependency to Dr. Iscove and created the potential for violation of Patient A's confidentiality, demonstrated by Dr. Iscove's caution that not only should Patient A not disclose that he was a patient of Dr. Iscove, but that Dr. Iscove would deny the doctor-patient relationship if needed.

The Committee concluded that the e-mails regarding the trundle bed and the carpets must be viewed as offers to sell these items to Patient A. The fact that Patient A may not have actually purchased any of the items does not mean that this was not a boundary violation. Attempting to sell personal items to your patients is unprofessional.

The Committee found that Dr. Iscove engaged in conduct that would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional in that he:

- tried to sell Patient A personal items;
- invited Patient A to attend the opera as his guest;
- arranged for him to rent the Bergler Foundation's apartment in another city.

Patient B

Patient B became a patient of Dr. Iscove in his late teenage years and saw Dr. Iscove as a patient for over 20 years. His parents had recommended that he see Dr. Iscove for his feelings of depression and anxiety. Patient B denied having any concerns about his own sexuality before seeing Dr. Iscove.

Throughout his therapy with Dr. Iscove, Patient B was encouraged to read material by Dr. Bergler and was aware that this was the basis for his treatment by Dr. Iscove. According to Patient B, Dr. Iscove raised the issue of Patient B's feelings about homosexuality at every appointment, even though he did not think of himself as gay and had no physical relationships with other men.

Patient B developed a trusting relationship with Dr. Iscove. He relied on Dr. Iscove to make decisions for him and found Dr. Iscove to be helpful in advising him, for example, in avoiding self-destructive behavior with alcohol. Patient B also felt that Dr. Iscove was supportive and helpful in his desire to further his career. As a consequence, he wanted to impress Dr. Iscove and show himself to be a "good patient." Although he was reluctant to disclose details at first, he concluded that it was easier to respond to these requests from Dr. Iscove and fully engaged in analysis of his fantasies.

Dr. Iscove would ask at almost every appointment whether Patient B was having fantasies about Dr. Iscove himself. Patient B replied that he did have fantasies about Dr. Iscove and that these made Patient B feel uncomfortable. He expressed this discomfort to Dr. Iscove without taking any other action. He felt that he needed to continue to see Dr. Iscove because of an emotional dependence on Dr. Iscove as his therapist.

At some point in 2007, Patient B and Dr. Iscove began engaging in sexual activity; there were about 12 episodes of sexual contact. When Patient B started to believe that he was homosexual and discussed with Dr. Iscove his thoughts of beginning a homosexual affair with an unspecified male, Dr. Iscove persuaded him that a random partner was undesirable and made it known that he, himself, would be available. Patient B described Dr. Iscove coming around his desk to the patient's side and initiating mutual handling of each other's penis through their clothes. On subsequent occasions, the contact progressed to mutual oral sex with both parties ejaculating; on one or two occasions, they removed their shirts. On one visit, Patient B brought a condom with him, and asked Dr. Iscove to penetrate him anally, which Dr. Iscove did. The final three episodes occurred at Dr. Iscove's house, after Dr. Iscove suggested that they meet there.

After patient B ended the sexual activity with Dr. Iscove, there was a gap of several years in the doctor-patient relationship but Patient B went back again to Dr. Iscove with concerns about his response to the death of a family member.

During their physician-patient relationship, Patient B and Dr. Iscove exchanged emails, which related to activities of a non-sexual nature that extended beyond physician-patient relationship, including:

- e-mails regarding an apartment in another city owned by the Bergler Foundation and administered by Dr. Iscove, at which Patient B had stayed for a small amount of money.
- e-mails regarding the treatment of a medical condition at a time when Patient B’s family member was ill. These included complimentary medicine therapy for the medical condition, the removal of dental amalgams for ameliorating the condition, and referral of Patient B’s family member to an experimental treatment centre. According to Patient B, Dr. Iscove sold him an electromagnetic device for the treatment of his family member’s medical condition for $4000. Dr. Iscove also sold him a juicer.
- e-mails with photographs of Dr. Iscove's grandchild.
- e-mails from Patient B to Dr. Iscove detailing Patient B’s various experiences when on holiday, including details of sexual activities and fantasies.

The Committee found that Dr. Iscove engaged in boundary violations that members of the profession would find disgraceful, dishonourable or unprofessional, in that he:

- sold equipment to Patient B, for the use of Patient B's family member, in an area of medicine in which Dr. Iscove had no expertise;
- arranged for Patient B to rent the Bergler foundation’s apartment in another city; and
- sold a juicer to Patient B.

These boundary violations further eroded the appropriate professional boundaries in a doctor-patient relationship. Given the level of dependence that Patient B had on him, Dr. Iscove should not have engaged in any commercial transactions with Patient B.

Finding

On March 8, 2018, the Discipline Committee found that Dr. Iscove committed an act of professional misconduct in that:

- he has engaged in the sexual abuse of two patients: Patient A and Patient B; and

- he has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional. In particular:

    - he sexually abused two patients;
    - he sold equipment to Patient B for the use of Patient B's family member in an area of medicine in which he had no expertise;
    - he arranged for Patient B and Patient A to each rent the Bergler Foundation's apartment in another city;
    - he sold a juicer to Patient B;
    - he tried to sell Patient A personal items; and
    - he invited Patient A to attend a working rehearsal of the opera as his guest.

Immediate Interim Suspension

Given the Committee's findings, the Committee made an immediate interim order suspending Dr. Iscove's certificate of registration pursuant to subsection 51(4.2) of the Health Professions Procedural Code, until such time as the Committee makes a penalty order under subsection (5) or (5.2) of the Code.

Disposition

On October 5, 2018, the Discipline Committee ordered that:

- The Registrar revoke Dr. Iscove's certificate of registration, effective immediately.
- Dr. Iscove reimburse the College for funding provided for patients 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 (30) days from the date of this Order, in the amount of $32,120.00.
- Dr. Iscove appear before the panel to be reprimanded.
- Dr. Iscove pay to the College its costs of this proceeding, in the amount of $91,620.00 within thirty (30) days from the date of this Order.

Failed to Maintain the Standard of Practice - 3 cases

3. Dr. A.H. Laity

Name:	Dr. Alan Howard Laity
Practice:	Family Physician
Practice Location:	London
Hearing:	Agreed Facts and Joint Penalty
Finding/Penalty Decision Date:	October 15, 2018
Written Decision Date:	October 19, 2018

Allegations and Findings

- failed to maintain the standard of practice of the profession - **proved**
- disgraceful, dishonourable or unprofessional conduct – **proved**
- sexual abuse of a patient - **withdrawn**
- incompetence - **withdrawn**

Summary

Dr. Dr. Laity is a family physician who had a practice in London, Ontario until September 30, 2016 at which time he closed his practice. On June 26, 2017, he resigned his certificate of registration with the College.

In January 2016, the College received a complaint from Patient A, who had been a patient of Dr. Laity's since July 2007. An expert retained by the College to provide an opinion with respect to the standard of practice of the profession, reviewed Dr. Laity's patient chart for Patient A and identified deficiencies in Dr. Laity's record-keeping and prescribing.

Record-keeping Deficiencies

The Expert noted the following deficiencies in Dr. Laity’s record-keeping with respect to Patient A:

- The cumulative patient profile in Dr. Laity's chart for Patient A was difficult to read and follow due to Dr. Laity's handwriting and adjustments to the cumulative patient profile;
- The medication list on Patient A's cumulative patient profile was not current and did not include all medications Patient A was taking, such as methadone;
- At his first appointment with Patient A, Dr. Laity prescribed clonazepam with no documentation of dosing so or the amount of pills prescribed;

- Dr. Laity started Patient A on an antidepressant medication without documenting any depression anxiety symptoms or risk of self-harm, and benzodiazepines were renewed regularly with little documentation.

Prescribing Deficiencies

Dr. Laity prescribed escalating doses of benzodiazepines to Patient A throughout the 8.5-year doctor-patient relationship, despite multiple warning signs that Patient A was addicted to and/or abusing the medication he prescribed.

Dr. Laity acceded to numerous requests for early refills of benzodiazepines. In the period between December 2007 and August 2009, Patient A claimed she required early refills of medication because she was assaulted and had trouble sleeping, because her pills were stolen on four separate occasions, because her pills were lost on two occasions, because she said she was entering a residential treatment program for post-traumatic stress disorder, amongst other reasons. These requests were warning signs of benzodiazepine abuse. On each occasion, Dr. Laity provided early refills of Patient A's benzodiazepines, on at least one occasion as little as two days after the last prescription.

When Patient A told Dr. Laity that she was taking extra medications, Dr. Laity continued prescribing clonazepam and other medications to her without properly addressing this.

While Dr. Laity first prescribed Patient A clonazepam in 2007 on a dose of 0.5 mg twice a day, by 2014 he was prescribing 2 mg of clonazepam three times a day with 180 tablets every two months. In May 2015, he again increased Patient A's prescription to 300 tablets of clonazepam 2 mg three times a day every two months. In August 2015, Dr. Laity replaced Patient A's pills because she told him she "knocked" two bottles of pills into the toilet.

In September 2015, Patient A was admitted to hospital for lithium overdose and remained in hospital for several months for several reasons, including severe anxiety and benzodiazepine addiction.

On January 4, 2016, Dr. Laity's office received a consultation note from a hospital physician, which indicated that Patient A had been weaned off of diazepam and was no longer taking clonazepam or any benzodiazepines. The physician wrote in the consultation notes:

> Benzodiazepine withdrawal is a significant concern, though not likely to be severe. Her risk for relapse if discharged at this time would be extremely high, and she will need to be monitored to ensure she has been successfully managed through the initial withdrawal symptoms. If she does require a return of benzodiazepine administration, my recommendation is to

> backtrack a single step (in this case to 2.5 mg of diazepam) and likely would be best administered at night so that she can become accustomed to the lowering blood levels during the day.

Three days later, on January 7, 2016, at his first appointment with Patient A since she had been admitted to hospital in September 2015, Dr. Laity prescribed Patient A clonazepam 1 mg three times a day, down from 2 mg three times a day prior to her hospital admission, but much higher than recommended by the hospital physician.

The expert opined in his report that the first visit post hospital discharge in January 2016 was very concerning, noting that according to the notes from the hospital physician, there was concern for the patient to relapse and return to benzodiazepine use and Dr. Laity was advised if a drug is needed to use diazepam at 2.5 mg. However, on January 7, 2016, Dr. Laity prescribed clonazepam 1 mg and gave the patient 90 tablets.

The expert concluded that Patient A presents as a very high risk for abuse, and addiction. The escalating use, and lost prescriptions and withdrawal symptoms, of benzodiazepines and specialist notes indicating abuse raised many red flags that Dr. Laity appeared to miss, or ignore. The expert noted that Dr. Laity ignoring the warnings of the hospital physician, post a three-month hospital admission for benzodiazepine abuse, is very concerning.

The expert opined that Dr. Laity has not met the standard of care of the profession in his care of Patient A. Based on the review of this chart, and the notes provided, the expert opined that Dr. Laity exposed Patient A to harm, and based on her last visit, may have exposed Patient A to future harm.

Undertaking

Dr. Laity resigned his certificate of registration in June 2017. Dr. Laity was referred to the Discipline Committee on allegations of professional misconduct in July 2017. In the face of these allegations, Dr. Laity has entered into an Undertaking with the College wherein he agreed never to apply or reapply for registration as a physician in Ontario or any other jurisdiction.

Disposition

On October 15, 2018, the Discipline Committee ordered and directed that:

- Dr. Laity attend before the panel to be reprimanded.
- Dr. Laity pay costs to the College in the amount of $10,180.00 within thirty (30) days from the date of this Order.

4. Dr. D.C. Leduc

Name:	Dr. Dean Carey Leduc
Practice:	General Practitioner
Practice Location:	Orleans
Hearing:	Agreed Facts and Joint Penalty
Finding/Penalty Decision Date:	September 17, 2018
Written Decision Date:	November 15, 2018

Allegations and Findings

- failed to maintain the standard of practice of the profession - **proved**
- disgraceful, dishonourable or unprofessional conduct – **proved**
- sexual abuse of a patient - **withdrawn**

Summary

Dr. Leduc is a general practitioner, with a practice in Orleans, Ontario. At all materials times, Dr. Leduc practised in a clinic setting that also operates as a walk-in clinic with 12 physicians.

Patient A became a patient of Dr. Leduc in the late 1990s, when she was a teenager. Between approximately September 2003 and September 2013, Patient A saw Dr. Leduc for a variety of physical issues, including pain associated with ankle and humerus fractures and a dislocating shoulder, for which she eventually received disability insurance. Patient A also saw Dr.
Leduc for a range of psychiatric issues, including an eating disorder, depression, anxiety, addiction to alcohol, addiction to narcotics and benzodiazepines, chronic pain and PTSD.

Standard of Practice with Respect to Patient A

After receiving information in September 2013, the College conducted an investigation into the allegations regarding Dr. Leduc's conduct and clinical care with respect to Patient A. An expert retained by the College reviewed Dr. Leduc's care of Patient A, including his prescribing of narcotics and related substances and opined, in part, that Dr. Leduc’s care of Patient A demonstrates:

- a significant lack of knowledge regarding safe prescribing habits for narcotics and benzodiazepines;
- a significant lack of skill in managing Patient A’s numerous aberrant behaviors; and
- a staggering lack of judgment in his continuing prescriptions of medications to Patient A, while being aware of the risk of addiction and harm to this patient.

The expert noted that while he cannot say with certainty that Dr. Leduc's clinical practice, behaviour, or conduct expose or are likely to expose other patients to harm or injury, there are a number of indicators that raise concern.

Boundary Violations with respect to Patient A

In 2011, Patient A experienced a traumatic personal event and confided in Dr. Leduc. After discussing the events in some detail, and providing counselling, Dr. Leduc hugged Patient A in his office. Over the next two years, Dr. Leduc and Patient A would often hug at the end of an appointment.

About a year later, criminal proceedings regarding the events of 2011 took place. During the proceedings, Dr. Leduc called Patient A from his cell phone and asked if she wanted to meet and talk. They arranged a time and place to meet and, once they had met, they went to a restaurant.
Despite his knowledge that Patient A struggled with alcohol addiction, and the fact that she was on medications that he had prescribed to her, Dr. Leduc did not object to Patient A ordering wine, which he paid for in addition to her meal. Dr. Leduc disclosed personal information to Patient A during their discussion and, at the end of the encounter, Dr. Leduc drove Patient A home. Patient A continued to see Dr. Leduc after this meeting for regular follow up care and for supportive counselling. At this time, Dr. Leduc was prescribing Patient A large doses of Demerol by tablet and by injection, as well as benzodiazepines.

A couple of months later, in 2012, Patient A experienced further physical trauma and, as a result of her injuries, Dr. Leduc assisted with her application for disability coverage. In late September 2012, Dr. Leduc contacted Patient A again and offered to meet outside the office to talk. They met at a coffee shop during the day and talked for about one hour. At the end of the encounter they walked to Dr. Leduc's car and he drove Patient A home. Between June and September 2012, Dr. Leduc called Patient A on a few occasions from his cell phone. Patient A continued to see Dr. Leduc after the encounter in late September for regular follow up care, including her pain and mood medications, and for supportive counselling.

In the spring of 2013, Dr. Leduc and Patient A met for a third time outside of his office. On this occasion, they met outside Patient A's apartment and walked from there to a restaurant, where Dr. Leduc again paid for Patient A's lunch and alcoholic drink. Dr. Leduc hugged Patient A and/or they exchanged kisses on the cheek during one or more than one of the three out of office encounters.

Dr. Leduc recognizes that his conduct was inappropriate conduct for a physician towards his patient and that it breached physician-patient boundaries, especially in the context of Patient A's vulnerabilities. Dr. Leduc knew that Patient A had very few people

she trusted or could turn to for support and, during this time, she endured significant physical and emotional trauma.

Registrar's Investigation

In July 2015, as a result of the concerns regarding Dr. Leduc's prescribing to Patient A raised in the expert's report, the Inquiries, Complaints and Reports Committee (ICRC) approved an appointment of investigators in order to conduct a broader investigation into Dr. Leduc's prescribing practices. Another expert was retained by the College to provide an opinion with respect to Dr. Leduc's standard of care, including his prescribing of narcotics and benzodiazepines. This expert reviewed ten patient charts and conducted an interview with Dr. Leduc, during which Dr. Leduc advised that after receiving notice of the public complaint, he completed the three-part Safe Opioid Prescribing program at the University of Toronto in January 2014.

Upon the College's request, the expert provided an addendum report, dated February 21, 2017, with respect to the standard of care provided by Dr. Leduc *before* he took the Safe Opioid Prescribing program and made changes to his practice. The expert opined that prior to January 2014, Dr. Leduc:

- did not meet the standard of practice of the profession in six out of ten charts;
- displayed a lack of knowledge, skill or judgment in seven out of ten charts; and
- in five out of ten charts, Dr. Leduc's clinical practice exposed patients to harm or injury.

Relevant Remediation and Education

At the conclusion of the Registrar's Investigation, the ICRC reviewed and considered the material and ordered Dr. Leduc to participate in a Specified Continuing Education and Remediation Program (SCERP), which required Dr. Leduc, among other things, to:

- practise under the guidance of a clinical supervisor for a period of six months;
- re-take all three webinars and the workshop that comprise the Safe Opioid Prescribing program at the University of Toronto; and
- have biweekly meetings with the supervisor for two months and monthly meetings for four months.

Dr. Leduc registered in and successfully completed the three-part series from March to May 2018, and completed the workshop component in June 2018. Dr. Leduc's clinical supervisor conducted the supervision between December 2017 and May 2018, and provided a total of eight reports to the College's Compliance Case Manager. Dr. Leduc has completed all aspects of the SCERP with the exception of the reassessment, which was directed to occur approximately six months following the completion of the remediation.

In addition, Dr. Leduc enrolled in and successfully completed a boundaries course at the Schulich School of Medicine at the University of Western Ontario on March 21 to 22, 2014.

Disposition

On September 17, 2018, the Discipline Committee ordered and directed that:

- the Registrar suspend Dr. Leduc's certificate of registration for a period of six (6) months, effective immediately.
- Dr. Leduc attend before the panel to be reprimanded.
- Dr. Leduc pay to the College costs in the amount of $16,012.00, within thirty (30) days of the date of this Order.

5. Dr. H.S. Pasternak

Name:	Dr. Harvey Stephen Pasternak
Practice:	Family Physician
Practice Location:	Toronto
Hearing:	Agreed Facts and Joint Penalty
Finding/Penalty Decision Date:	July 25, 2018
Written Decision Date:	September 21, 2018

Allegations and Findings

- failed to maintain the standard of practice of the profession - **proved**
- disgraceful, dishonourable or unprofessional conduct – **withdrawn**
- incompetence **- withdrawn**

Summary

Dr. Pasternak is a family physician practising medicine in Toronto. He received his medical degree at the University of Toronto in 1973 and his certificate of registration authorizing independent practice in Ontario in 1974.

Failure to Maintain the Standard of Practice - Patient A

The College investigation began after receipt of information from an Emergency Room physician, practising in a hospital outside Toronto, that an adult female patient (“Patient A”) had been transported to the hospital by ambulance after a family member became concerned about a possible narcotics overdose. The Emergency Room physician

expressed concern to the College regarding the amounts of narcotics in the possession of Patient A, which had been prescribed by Dr. Pasternak.

An expert retained by the College to provide an opinion on the care provided by Dr. Pasternak to Patient A, concluded that Dr. Pasternak not meet the standard of practice in his care of Patient A, including in the following ways:

- The patient was provided large doses of opioid and benzodiazepine medication from along with dose escalations and changes to medication in the absence of a physical assessment and in the absence of any documentation in the medical record.
- Dr. Pasternak did not re-assess the patient to determine the effectiveness of the dose increases and medication changes in order to support the ongoing prescribing of such large doses of opioids with concurrent benzodiazepine medication.
- Dr. Pasternak failed to assess the reasons for repeated early prescription refills of opioid medication and by failing to do so did not fully assess for the possibility of drug diversion, overuse and/or misuse.
- Dr. Pasternak failed to maintain adequate medical records for the patient

In the expert's opinion, Dr. Pasternak's clinical care of Patient A potentially exposed the patient to harm or injury.

Failure to Maintain the Standard of Practice – 15 Patients

Following receipt the expert report, the College conducted a broader investigation of Dr. Pasternak's prescribing practice. The expert reviewed fifteen patient charts and opined that the care provided by Dr. Pasternak did not meet the standard of practice in relation to the fifteen patients. In fourteen of the fifteen patients, Dr. Pasternak's care potentially exposed the patient to harm or injury. In reviewing the fifteen patient charts, the expert noted amongst other things, that Dr. Pasternak failed to meet the standard of practice as follows:

- Failing to document rationale for prescribing;
- Failing to assess reasons for repeated early prescription refills and failure to fully assess the possibility of diversion, overuse or misuse;
- Failing to assess or re-assess, patients for potential adverse risks associated with big doses of opioids and benzodiazepines including the risk of sedation, cognitive impairments and overdose;
- Providing large doses of opioid in the absence of physical assessments; and
- Failure to maintain adequate medical records.

Dr. Pasternak's Conduct since the College's Investigation

Dr. Pasternak has no discipline history with the College. Since the College investigation began, Dr. Pasternak completed two full-day interactive courses offered by the University of Toronto's Faculty of Medicine as follows:

- In May 2016, he completed the Medical Record Keeping Workshop.
- In May 2017, he completed the Challenging Cases in Opioid Use and Misuse Workshop.

On May 25, 2017, Dr. Pasternak voluntarily entered into an Undertaking, pending the disposition of this matter by the Discipline Committee. Dr. Pasternak undertook to practice under the guidance of a Clinical Supervisor, who reviews the charts for patients to whom Dr. Pasternak prescribes narcotics or controlled substances and makes regular reports to the College. Pursuant to the Undertaking, Dr. Pasternak retained a Clinical Supervisor who reported to the College confirming that Dr. Pasternak's prescribing practices have improved and currently adhere to the Canadian Guideline for Opioids for Chronic Non-Cancer Pain. Specifically, the Clinical Supervisor has noted Dr. Pasternak's use of the following practices which meet the standard of practice for prescribing:

- Recording patient identifiers;
- Completing the functional pain scale at visits;
- Using a pain scale to track patients' complaints of pain;
- Having patients sign opioid treatment agreements and reviewing the agreements with them;
- Completing opioid risk assessment tools;
- Reviewing non-pharmacological approaches to pain control with patients;
- Documenting discussions of side effects;
- Recording morphine equivalents;
- Prescribing small/limited quantities;
- Documenting discussions about tapering to reduce dosage; and
- Booking follow up visits to assess pain control.

Since the commencement of the investigations into Dr. Pasternak's prescribing practices, the College has published a number of articles in *Dialogue* magazine about opioid prescribing with an aim to alerting the profession to the current opioid crisis and working with physicians to ensure appropriate and safe prescribing of opioids to patients who need them. The College has also published several articles regarding investigations into information about high prescribers received from the Narcotics Monitoring System and the remedial approach taken in the majority of cases.

Disposition

On July 25, 2018, the Discipline Committee ordered that:

- The Registrar to impose the following terms, conditions and limitations on Dr. Pasternak's certificate of registration:

Clinical Supervision

- Within twenty (20) days of this Order, Dr. Pasternak shall retain a College-approved clinical supervisor or supervisors (the "Clinical Supervisor") with respect to his prescribing of narcotics and controlled substances, who will sign an undertaking in the form attached as Schedule "A" [to the Order]**.**
- Dr. Pasternak shall practise under the guidance of the Clinical Supervisor for a period of twelve (12) months, commencing on the date that the Clinical Supervisor is approved by the College ("Clinical Supervision").
- Clinical Supervision of Dr. Pasternak's prescribing of narcotics and controlled substances shall contain the following elements:
- Throughout the entire period of Clinical Supervision, Dr. Pasternak shall maintain a log of all prescriptions ("Prescribing Log") for:
  - **Narcotic Drugs** (from the Narcotic Control Regulations made under the *Controlled Drugs and Substances Act,* S.C., 1996, c. 19);
  - **Narcotic Preparations** (from the Narcotic Control Regulations made under the *Controlled Drugs and Substances Act,* S.C., 1996, c. 19);
  - **Controlled Drugs** (from Schedule G of the Regulations under the *Food and Drugs Act,* S.C., 1985, c. F-27);
  - **Benzodiazepines and Other Targeted Substances** (from the Benzodiazepines and Other Targeted Substances Regulations made under the *Controlled Drugs and Substances Act.,* S.C., 1996, c. 19);
  - (A summary of the above-named drugs [from Appendix I to the Compendium of Pharmaceuticals and Specialties] is attached as Schedule "B" [to the Order]; and the current regulatory lists are attached as Schedule "C" [to the Order])
  - **All other Monitored Drugs** (as defined under the *Narcotics Safety and Awareness Act*, *2010,* S.O. 2010, c. 22 as noted in Schedule "D" [to the Order]).
- The Prescribing Log shall be in the form set out at Schedule "E" [to the Order], which will include at least the following information:
  - the date of the prescription;
  - patient identifier;
  - the medication, dose, direction, number of tablets to be dispensed and frequency (if applicable);
  - the clinical indication for use;
  - whether it is a new prescription; and
  - physician initials.

- For an initial period of at least six (6) months, the Clinical Supervisor will engage in a period of moderate-level supervision, during which time the Clinical Supervisor will, at minimum:
  - review materials and have an initial in-person meeting with Dr. Pasternak to discuss issues and practice recommendations;
  - meet with Dr. Pasternak at his Practice Location, or another location approved by the College, once every two (2) months thereafter;
  - review charts and prescriptions for at least twenty (20) of Dr. Pasternak's patients at every meeting, which shall be selected from the Prescribing Log at the sole discretion of the Clinical Supervisor. If the Prescribing Log contains fewer than twenty (20) patients, the Clinical Supervisor shall review all charts and prescriptions contained in the Prescribing Log;
  - review charts and prescriptions for any new patient(s) to whom Dr. Pasternak prescribed a Narcotic Drug, Narcotic Preparation, Controlled Drug, Benzodiazepine and Other Targeted Substance or other Monitored Drug at the next meeting with the Clinical Supervisor following any such prescribing;
  - keep a log of all charts reviewed with patient identifiers and sign and date the Prescribing Log to confirm the charts that the Clinical Supervisor has reviewed and discussed with Dr. Pasternak;
  - evaluate whether the assessment, clinical examination, risk assessment for addiction and on-going management and follow up is appropriate in all cases reviewed;
  - discuss with Dr. Pasternak any concerns the Clinical Supervisor may have arising from the chart review and make recommendations for practice improvements or ongoing professional development;
  - perform any other duties, such as reviewing other documents or conducting interviews with staff or colleagues, that the Clinical Supervisor deems necessary to Dr. Pasternak's Clinical Supervision; and
  - submit written reports to the College at least once every two (2) months, or more frequently if the Clinical Supervisor has concerns about Dr. Pasternak's standard of practice;
- After a minimum of six (6) months, and only upon recommendation by the Clinical Supervisor and approval of the College, the level of supervision may be reduced for the balance of the period of Clinical Supervision.
- Once permission is received from the College, Clinical Supervision shall continue as described in paragraph (3)(f) above for the balance of the period of Clinical Supervision, subject to the following two modifications: meetings between Dr. Pasternak and his Clinical Supervisor shall occur once every three (3) months, and written reports from the Clinical Supervisor shall be submitted to the College at least once every three (3) months, or more frequently if the Clinical Supervisor has concerns about Dr. Pasternak's standard of practice.

Other Elements of Clinical Supervision

- Throughout the period of Clinical Supervision, Dr. Pasternak shall abide by all recommendations of his Clinical Supervisor.
- If a person who has given an undertaking in Schedule "A" to the Order is unable or unwilling to continue to fulfill its provisions, Dr. Pasternak shall, within twenty (20) days of receiving notice of same, obtain an executed undertaking in the same form from a similarly qualified person who is acceptable to the College and ensure that it is delivered to the College within that time.
- If Dr. Pasternak is unable to obtain a Clinical Supervisor as set out in this Order, he will cease prescribing Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines and Other Targeted Substances and other Monitored Drugs until such time as he has obtained a Clinical Supervisor acceptable to the College.
- If Dr. Pasternak is required to cease prescribing as a result of paragraph (3)(k) above, this will constitute a term, condition or limitation on his certificate of registration and that term, condition or limitation will be included on the public register until such time as he has obtained a Clinical Supervisor acceptable to the College.

Reassessment of Practice

- Approximately six (6) months after completion of the Clinical Supervision, Dr. Pasternak shall undergo a reassessment of his practice by a College-appointed assessor or assessors (the "Assessor"). The Assessor shall report the results of the reassessment to the College.
- The reassessment may include (at the College's discretion) a review of a minimum of twenty (20) of Dr. Pasternak's patient charts, direct observation of Dr. Pasternak's practice, an interview with Dr. Pasternak, interviews with colleagues and co-workers, and any other tools deemed necessary by the College. Dr. Pasternak shall abide by all recommendations made by the Assessor.
- Dr. Pasternak shall consent to the sharing of information among the Assessor, the Clinical Supervisor and the College, as any of them deem necessary or desirable in order to fulfill their respective obligations.

Monitoring

- Dr. Pasternak shall inform the College of each and every location where he practices, in any jurisdiction (his "Practice Location(s)") within fifteen (15) days of this Order and shall inform the College of any and all new Practice Locations within fifteen (15) days of commencing practice at that location.
- Dr. Pasternak shall cooperate with unannounced inspections of his Practice Location(s) and patient charts and to any other activity the College deems necessary in order to monitor his compliance with the provisions of this Order.

  - Dr. Pasternak shall consent to the College making appropriate enquiries of the Ontario Health Insurance Plan, the Narcotics Monitoring System and/or any person or institution that may have relevant information, in order for the College to monitor and enforce his compliance with the terms of this Order.
  - Dr. Pasternak shall be responsible for any and all costs associated with implementing the terms of this Order.

- Dr. Pasternak attend before the panel to be reprimanded.
- Dr. Pasternak pay to the College its costs of this proceeding in the amount of $10,180 within thirty (30) days from the date of this Order.

Disgraceful, Dishonourable or Unprofessional Conduct – 7 cases

6. Dr. W.A. Botros

Name:	Dr. Wagdy Abdalla Botros
Practice:	Psychiatrist, Sleep Medicine
Practice Location:	Kitchener, London, Cambridge
Hearing:	Self-represented, did not attend hearing Contested Allegations and Penalty
Finding/Written Decision Date:	May 20, 2018
Penalty/Written Decision Date:	September 21, 2018

Allegation and Finding

- disgraceful, dishonourable or unprofessional conduct – **proved**

Summary

Dr. Botros is a psychiatrist who practised sleep medicine. During the period from May of 2014 to December of 2015, he was practising sleep medicine at three licensed independent health facilities known as Sleep Clinic Kitchener, Sleep Clinic London and Sleep Clinic Cambridge. Dr. Botros resigned his membership on January 4, 2018.

Breach of Undertaking

As a result of an assessment by the College as directed by the Director, Independent Health Facilities at the Ministry of Health and Long Term Care, Dr. Botros entered into an undertaking with the College on May 14, 2014, which provided in part that Dr. Botros practise under the guidance of a clinical supervisor acceptable to the College, who will meet with Dr. Botros at least once a week to review and discuss any issues or concerns arising from the review and /or observations of his practice.

Two successive compliance monitors were assigned to monitor Dr. Botros' compliance with the undertaking. Dr. X was Dr. Botros' Clinical Supervisor from May 14, 2014 to December 16, 2015.

The Discipline Committee found that there was a consistent pattern of missing meetings throughout the period of clinical supervision. This occurred despite the fact that the College repeatedly reminded Dr. Botros' Clinical Supervisor and Dr. Botros of the need to comply with the terms and conditions of the Undertaking.

During the first six weeks of supervision, only one appointment was missed due to Dr. Botros attending a funeral. Between June 30, 2014 and December 20, 2014, however, 12 of 27 meetings were missed. The reasons for the missed meetings were a combination of illness (Dr. Botros), vacation (Dr. Botros and Clinical Supervisor) and simply that “Dr. Botros unavailable”.

Between December 20, 2014 and March 28, 2015, 9 of 14 weekly meetings were missed. The Clinical Supervisor was away on vacation for four weeks, there were additional holidays for another two weeks and Dr. Botros was “unavailable” for three weeks.

Between July 1 and October 1, 2015, 11 of 13 meetings were missed. The Clinical Supervisor was away for five appointments, including four consecutive weeks. There was a computer issue that prevented meeting on one week. Four other missed meetings were allegedly the result of Dr. Botros’ ankle injury. On another date, Dr. Botros was “unavailable.”

Then finally, between November 16 and December 16, 2015, 3 of 5 weekly meetings were missed. Of these, the Clinical Supervisor was away for two and Dr. Botros was “unavailable” for one other.

It may be that the terms and conditions of the Undertaking were onerous, but this was an Undertaking which Dr. Botros had entered into in May of 2014 to allow him to continue to practise sleep medicine until the College completed reassessments of each of Dr. Botros’ clinics and reported to the Director of the IHF that the results were satisfactory. If his chosen Clinical Supervisor was not able to meet more frequently due to his vacation schedule or other reasons, Dr. Botros should have looked for an alternative Clinical Supervisor, as had been recommended by his compliance monitor. Further, many of the missed meetings were the result of Dr. Botros’ own unavailability and were not related to the Clinical Supervisor.

It was clear from the express wording of the Undertaking that a change in the terms and conditions could only be made with the approval of the College. As submitted by College counsel, it was not the role of Clinical Supervisor to determine the extent to which the Undertaking was being complied with, that was the responsibility of the compliance monitors. Further, neither the Clinical Supervisor nor Dr. Botros could unilaterally change or relax any of the conditions in the Undertaking.

After Dr. Botros’ ankle injury in June 2015, the College accepted that there would be problems with compliance due to Dr. Botros’ injury. The Committee concluded, however, that if Dr. Botros could see 383 patients and travel to two of his clinics one month after sustaining his ankle injury, he should have been able to meet with Clinical Supervisor during that time. If he was well enough to see his patients, he should have been well enough to meet with his Clinical Supervisor.

Further, even if a number of the missed meetings were the result of Clinical Supervisor's vacation schedule, it was Dr. Botros' responsibility to ensure that he was complying with the terms of the Undertaking. Given the repeated warnings from the compliance monitors, he should have taken steps to provide for an alternative clinical supervision.

The Committee found that Dr. Botros breached the terms of his Undertaking by failing on repeated occasions to meet on a weekly basis with his Clinical Supervisor. In particular, the Committee found that his failure to meet with his Clinical Supervisor during the month of July 2015, when he was able to see 383 patients, was a flagrant breach of the Undertaking.

The Committee found that Dr. Botros' breach of the Undertaking is clearly an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional. The Committee stated that undertakings are to be treated seriously and are not to be entered into lightly. They are not to be complied with simply at the convenience of the member. It was Dr. Botros' obligation to ensure he was complying with the Undertaking. The in-person meetings were important because they protect the public and provide remediation or assistance to the physician in improving his practice. Without the meetings, the Clinical Supervisor could not provide feedback to the physician on concerns and recommendations, as contemplated by the Undertaking.

Failure to Co-operate with College Investigation

In January, 2016, the College commenced an investigation into Dr. Botros' compliance with his undertaking. Dr. Botros failed to co-operate fully with the College investigation by refusing to provide information sought by the College investigator, taking the position that there was no reasonable basis for the inquiries. Despite the Investigator's follow-up to remind Dr. Botros of his duty to co-operate, he refused, through his legal counsel, to provide the requested information and again took the position that there was no reasonable basis for the request.

The Committee found that the College investigator's inquiries were relevant to an investigation into whether or not Dr. Botros had been compliant with his undertaking. The Committee further found that Dr. Botros' failure to respond to those inquiries constituted a failure to co-operate fully with the College investigation.

Disposition

On September 21, 2018, the Discipline Committee ordered and directed that:

- The Registrar revoke Dr. Botros' certificate of registration, effective immediately.
- Dr. Botros pay costs to the College in the amount of $39,948.71, within 30 days of the date that this order becomes final.

7. Dr. E.S.L. Guirguis

Name:	Dr. Emad Samir Luka Guirguis
Practice:	Family Physician
Practice Location:	Mississauga, Oakville
Hearing:	Uncontested Facts and Contested Penalty
Finding Date:	January 18, 2018
Finding/Penalty Decision Date:	August 24, 2018

Allegation and Finding

- disgraceful, dishonourable or unprofessional conduct – **proved**

Summary

Dr. Guirguis is a family physician practising in Mississauga and in Oakville. He received his certificate of registration authorizing independent practice from the College of Physicians and Surgeons of Ontario (the "College') in May 2007. At all relevant times, Dr. Guirguis practised in a group family medicine practice.

Incapacity Investigation

In May 2014, the College received information from a pharmacist and from a physician that Dr. Guirguis had been forging prescriptions for Percocet for himself using the College registration number and signature of a colleague with whom he shared an office.

The College made preliminary inquiries into Dr. Guirguis' capacity to practice medicine, which later became a full incapacity investigation. In response to receiving notice of the College's intent to conduct an incapacity investigation, Dr. Guirguis provided information to the College regarding his self-prescribing and admitted that he had written prescriptions to himself under another physician's name, explaining that he takes Percocet in order to treat a men's health related issue.

Percocet is brand name of a narcotic medication. The generic name for the opiate pain reliever in Percocet is oxycodone hydrochloride. Oxycodone is a narcotic medication.

A College retained independent specialist (the Assessor), who assessed Dr. Guirguis' capacity to practise, did not conclude that Dr. Guirguis suffers from any disorder related to substance use or substance abuse, noting that there were no reports of Dr. Guirguis presenting under the influence of opioids while at work and no complaints from patients, colleagues or coworkers. The Assessor reported that Dr. Guirguis openly described his

history, motivation and pattern of self-prescribing Percocet in 2013 and 2014, by writing prescriptions for himself under one colleague's name.

Section 75(1)(a) Investigation regarding Prescribing

Self-prescribing

The College conducted investigation into Dr. Guirguis' conduct, including his self-prescribing.
The information requested and obtained by the College from the Ontario Ministry of Health and Long Term Care's Narcotics Monitoring System ("NMS") regarding all prescriptions for monitored drugs issued to Dr. Guirguis between April, 2012 and February, 2015 showed a total of 27 prescriptions from two prescribers. One prescriber was the physician who was previously known to the College from the initial report. The second prescriber was another physician with whom Dr. Guirguis shared an office. Both of these physicians worked with Dr. Guirguis at the Clinic during this period and all three names appear at the top of the Clinic's printed prescription pads. Through its investigation the College learned that in addition to Percocet, the 27 prescriptions forged by Dr. Guirguis included additional medications, such as Benzodiazepines, statins and nonsteroidal anti-inflammatories.

Prescribing to Family

The College also requested and obtained data regarding NMS prescriptions written by Dr. Guirguis for all patients between May, 2012 and May, 2016, which indicated that on several occasions during this period Dr. Guirguis wrote prescriptions for controlled/monitored drugs for at least 3 members of his family. Dr. Guirguis billed the Ontario Health Insurance Program for his treatment of these 3 family members; however, he does not have any medical records reflecting his prescriptions of controlled drugs or any other treatment of these family members.

Dr. Guirguis' conduct is not consistent with his professional obligations, including those set out in the College's policies regarding physicians' treatment of self or family members or others close to them.

Disposition

On August 24, 2018 the Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Guirguis' certificate of registration for a period of six (6) months, effective immediately.
- The Registrar impose the following terms, conditions and limitations on Dr. Guirguis' certificate of registration upon his return to practice at the conclusion of his suspension:

Restrictions

- Dr. Guirguis shall keep a log, for a period of one year from the date of this Order, of all prescriptions for any of the following (the "Prescription Log for Controlled Drugs"):
  - Narcotic Drugs (from the Narcotic Control Regulations made under the Controlled Drugs and Substances Act, S.C., 1996, c. 19);
  - Narcotic Preparations (from the Narcotic Control Regulations made under the *Controlled Dugs and Substances Act*, S.C., 1996, c. 19);
  - Controlled Drugs (from Part (i) of the Food and Drug Regulations under the *Food and Drugs Act*, S.C., 1985, c. F-27);
  - Benzodiazepines and Other Targeted Substances (from the Benzodiazepines and Other Targeted Substances Regulations made under the *Controlled Drugs and Substances Act*, S.C., 1996, c. 19); and
  - All other Monitored Drugs (as defined under the *Narcotics Safety and Awareness Act*, 2010, S.O. 2010, c. 22).
- The Prescription Log for Controlled Drugs shall be in a form acceptable to the College, but shall include the following:
  - the date of the appointment;
  - the name of the patient and chart/file number;
  - the name of the medication prescribed, dose, direction, number of tablets to be dispensed and frequency;
  - the clinical indication;
  - whether the prescription is for a new medication and/or different dose or frequency than currently prescribed to the patient (Y/N);
  - Dr. Guirguis' signature; and
  - Dr. Guirguis is to keep a copy of all prescriptions he writes for Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines and Other Targeted Substances and all other Monitored Drugs, in the corresponding patient chart.
- Dr. Guirguis shall not issue any new prescriptions or renew existing prescriptions for any member of his family or others close to him for any medication. Dr. Guirguis shall abide by the College's Policy on "Physician Treatment of Self, Family Members, or Others Close to Them", and any future versions of this Policy, a copy of which is attached to this Order as Schedule "A".

Education

- At his own expense, Dr. Guirguis shall participate in and successfully complete, within six (6) months of the date of this Order, individualized instruction in medical ethics satisfactory to the College, with an instructor approved by the College. The instruction is to include an in-depth review of the College policy on "Physician Treatment of Self, Family Members or Others Close to Them" and its underlying rationale. The instructor shall provide a summative report to the College including his or her conclusion about whether the instruction was completed successfully by Dr. Guirguis.

Drug Screening

- For a period of two years following his return to practice, Dr. Guirguis shall participate in a random urine drug screening process which will include attending a facility that will facilitate random, witnessed urine drug testing at a rate of twelve (12) times per year.
- Dr. Guirguis shall engage a regulated health professional approved by the College to act as a monitor for the purpose of facilitating the random urine drug screening process ("Monitor"). The Monitor shall have available to him or her all relevant information in the College's possession.
- The Monitor shall execute an undertaking in the form attached to this Order as Schedule “B”, which includes a duty to report to the College regarding any positive test result, any missed tests and any concern that Dr. Guirguis may not be in compliance with the terms of this Order.
- Notification regarding the dates for tests will take place according to the discretion of the Monitor. Dr. Guirguis will be required to proceed to a facility approved by the Monitor before closing time on the same day of notification to provide a specimen. He will provide a specimen in the fashion required by the Monitor and will consent to the provision of the specimen under a proper chain of-custody protocol. Failure to adhere to this procedure will be considered a missed test.
- Dr. Guirguis shall submit to urine screening at any time upon the request of the Monitor and/or the College. Any missed tests that have not been excused by the Monitor will be considered a breach of this Order.
- Dr. Guirguis shall not ingest any Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines/Other Targeted Substances and all other Monitored Drugs as set out in the following legislation except within the conditions as noted in section (x) (the “Controlled Drugs”).
    - Narcotic Drugs (from the Narcotic Control Regulations made under the *Controlled Drugs and Substances Act*, S.C., 1996, c. 19);
    - Narcotic Preparations (from the Narcotic Control Regulations made under the *Controlled Dugs and Substances Act*, S.C., 1996, c. 19);
    - Controlled Drugs (from Part (i) of the Food and Drug Regulations under the *Food and Drugs Act,* S.C., 1985, c. F-27);
    - Benzodiazepines and Other Targeted Substances (from the Benzodiazepines and Other Targeted Substances Regulations made under the *Controlled Drugs and Substances Act*, S.C., 1996, c. 19); and
    - All other Monitored Drugs (as defined under the *Narcotics Safety and Awareness Act, 2010*, S.O. 2010, c. 22).
- Dr. Guirguis shall not consume any Controlled Drugs unless legitimately prescribed for him by a practitioner who has knowledge of the Discipline Committee's Decision and Reasons for Decision and with the prior approval of the Monitor. If Dr. Guirguis consumes one or more Controlled Drugs, the Monitor shall notify the College, in writing, at the earliest

opportunity.

Compliance

- Dr. Guirguis shall inform the College of each and every location where he practises, in any jurisdiction ("Practice Locations") within fifteen (15) days of this Order and shall inform the College of any and all new Practice Locations within fifteen (15) days of commencing practice at that location.
- Dr. Guirguis shall cooperate with unannounced inspections of his practice, Prescription Log and patient charts by College representatives for the purpose of monitoring and enforcing his compliance with the terms of this Order.
- Dr. Guirguis shall consent to the College providing any Chiefs of Staff or a colleague with similar responsibilities, such as a medical director, at any location where he practises ("Chief(s) of Staff") with any information the College has that led to this Order and/or any information arising from the monitoring of his compliance with this Order.
- Dr. Guirguis shall provide his irrevocable consent to the College to make enquiries of the Ontario Health Insurance Plan ("OHIP"), the Drug Program Services Branch, the Narcotics Monitoring System implemented under the *Narcotics Safety and Awareness Act, 2010*, S.O. 2010, c. 22, as amended ("NMS"), and/or any person who or institution that may have relevant information, in order for the College to monitor and enforce his compliance with the terms of this Order and any terms, conditions or limitations on Dr. Guirguis' certificate of registration.
- Dr. Guirguis shall be responsible for any and all costs, including all laboratory services, associated with implementing the terms of this Order.

- Dr. Guirguis attend before the panel to be reprimanded, within 90 days of the date this Order becomes final.
- Dr. Guirguis shall pay to the College costs in the amount of $5,500.00, within thirty (30) days of the date of this Order.

8. Dr. A. Mossanen

Name:	Dr. Ayoob Mossanen
Practice:	Family Physician
Practice Location:	Toronto
Hearing:	Agreed Facts and Joint Penalty
Finding/Penalty Decision Date:	August 9, 2018
Written Decision Date:	October 9, 2018

Allegations and Findings

- Sexual abuse of a patient – **withdrawn**
- disgraceful, dishonourable or unprofessional conduct – **proved**
- contravened a term, condition or limitation on certificate of registration - **proved**
- Incompetence - **withdrawn**

Summary

Allegations referred by Notices of Hearing of November 23, 2016, November 15, 2017, and March 20, 2018 were dealt with in one hearing.

Dr. Mossanen received his certificate of registration authorizing independent practice from the College in 1970; he holds RCPSC certification in neurology and practised at the Clinic in Toronto, until his resignation on October 26, 2017.

Patient A

In the fall of 2006, Patient A sustained injuries in a motor vehicle accident. Dr. Mossanen was retained by Patient A's legal counsel to conduct an independent medical examination. Patient A attended Dr. Mossanen's office in the fall of 2007. She reported headache, neck pain, mid and lower back pain and lower abdominal pain. Patient A was in her mid-30s.

After interviewing Patient A, Dr. Mossanen instructed her to remove her top and provided her with a gown. Patient A followed his instructions. Dr. Mossanen examined Patient A's nervous system, cranial nerves, motor system, gait, neck, back, facet joints, shoulders, lower extremities, sacro-iliac joint and lower abdominal area. Dr. Mossanen's examination included straight leg raising (including hip flexion), and bending each of Patient A's knees toward the chest. In examining Patient A's fundi, Dr. Mossanen placed his face very close to hers. She could feel his breath. Patient A recalls Dr. Mossanen touched her face.

Dr. Mossanen asked Patient A to remove her pants. Patient A was upset and cold and did not wish to remove her pants. As Patient A recalled, Dr. Mossanen assisted her in removing her pants during the course of the examination. Without an adequate explanation to Patient A, Dr. Mossanen manipulated Patient A's legs as part of his examination. In doing so, he came close to Patient A's symphysis pubis, causing her discomfort. Without an adequate explanation, Dr. Mossanen palpated Patient A's lower abdomen, including near her symphysis pubis. To do so, Dr. Mossanen rolled down Patient A's underwear exposing her lower abdomen and the upper part of her pubic area. Patient A became increasingly upset and uncomfortable, and was crying extensively. She found Dr. Mossanen sharp and impatient and did not understand why

he was palpating her near her pelvic area, and why he was pushing and pulling on her legs, as part of his examination. She forced her legs shut.

Dr. Mossanen terminated the IME and advised Patient A he could not complete the examination. Dr. Mossanen failed to explain to Patient A the steps of his examination, failed to explain that he would be palpating a sensitive area of her anatomy, and failed to obtain Patient A's informed consent, causing Patient A considerable distress. Dr. Mossanen failed to show adequate sensitivity and respect for Patient A's comfort, which was unprofessional.

In November 2015, Patient A complained to the College regarding her experience with Dr. Mossanen.

Patient B

In the fall of 2016, Patient B sustained injuries in a motor vehicle accident. Dr. Mossanen was retained by Patient B's legal counsel to provide an IME. Patient B attended Dr. Mossanen's office in the summer of 2017. She reported neck pain, chest pain, interscapular, lower and whole back pain, right groin pain, post-nose fracture, vague cracking sensation in the toes without any pain, right and left upper extremity stiffness and intermittent tingling of the hands and feet. Patient B was in her mid-30s at the time.

Dr. Mossanen's physical examination included investigation of Patient B's nervous system (including cranial nerves, fundi and visual fields, and hearing), musculoskeletal, motor, and sensory systems as well as an examination of the left and right side of her groin. As part of the examination of Patient B's cranial nerves, Dr. Mossanen examined Patient B's eyes. This involved coming in very close to Patient B's face, which made Patient B very uncomfortable. Dr. Mossanen failed to adequately explain the steps of his examination and the purpose of his examination, making Patient B uncomfortable. Further to Patient B's complaint of right groin pain, without an adequate explanation to Patient B, Dr. Mossanen palpated Patient B's right and left inguinal ligament. Without an adequate explanation to Patient B, the examination was performed with Patient B's pubic hair and the top of her vulva exposed. In palpating the area, Dr. Mossanen incidentally touched the area of Patient B's pubic bone. The examination caused Patient B considerable distress.

At the time of Patient B's IME, Dr. Mossanen was required to have a College-approved practice monitor present during the entirety of the encounter. The practice monitor, a registered nurse, who observed Dr. Mossanen's entire examination of Patient B, did not consider any touching inappropriate.

Dr. Mossanen failed to explain the steps of his examination, failed to explain that he would be palpating a sensitive area of Patient B's anatomy, and failed to obtain her

informed consent, causing Patient B considerable distress. Dr. Mossanen failed to show adequate sensitivity and respect for Patient B's comfort which was unprofessional.

Breach of the Section 37 Order

On January 6, 2017, the Inquiries Complaints and Reports Committee made an Order prohibiting Dr. Mossanen from engaging in professional encounters with female patients of any age, unless the patient encounter took place in the presence of an approved practice monitor. Dr. Mossanen was required to ensure that the practice monitor remained in the examination room or consultation room and carefully observed all physical examinations. The terms of the Order required, among other things, that:

- Dr. Mossanen ensure that each patient scheduled for an appointment with him was directly notified, prior to the appointment, of the details of the practice restriction
- Dr. Mossanen ensure that each practice monitor maintain a patient log of all in-person professional encounters with female patients and that Dr. Mossanen ensure the practice monitor submit the original Log to the College on a monthly basis.

Dr. Mossanen contravened the terms, conditions and limitations on his certificate of registration by failing to notify several of his patients, including Patient B, that he was required to have a practice monitor present for all professional encounters with female patients, and by failing to ensure that all three College–approved practice monitors submitted their patient logs to the College on a monthly basis as required.

2018 Undertaking

On August 7, 2018, Dr. Mossanen entered into an Undertaking with the College, wherein he acknowledged that he resigned from the College and undertook not to apply or re-apply for registration as a physician to practise medicine in Ontario or any other jurisdiction.

Disposition

On August 10, 2018, the Discipline Committee ordered and directed that:

- Dr. Mossanen attend before the panel to be reprimanded.
- Dr. Mossanen pay costs to the College in the amount of $6,000.00 within thirty (30) days from the date this Order becomes final, or in accordance with a payment plan approved by the College.

9. Dr. G.W. Otto

Name:	Dr. George Williams Otto
Practice:	Family Physician
Practice Location:	Toronto
Hearing:	Agreed Facts and Contested Penalty
Finding Decision Date:	April 23, 2018
Penalty/Written Decision Date:	August 24, 2018

Allegations and Findings

- disgraceful, dishonourable or unprofessional conduct – **proved**

Summary

Dr. Otto received a certificate of independent practice in 1988. He practises family medicine in Toronto. Dr. Otto failed to provide records in a timely manner when requested on behalf of three patients.

Patient A

On April 13, 2016, a lawyer for Patient A sent a letter by fax to Dr. Otto's office, requesting Patient A's complete client file and enclosing an executed authorization and direction. The fax was received by Dr. Otto's office. Dr. Otto failed to respond to the request.

On August 15, 2016, Patient A's lawyer sent another letter to Dr. Otto's office by fax and by regular mail. He repeated his request for Patient A's file and noted that time was of the essence. The letter was received by Dr. Otto's office. Dr. Otto failed to respond to the request.

On September 28, 2016, Patient A's lawyer contacted the College regarding Dr. Otto's ongoing failure to provide Patient A's file as requested. The College investigator requested Dr. Otto's response by letters dated October 3, 2016 and November 14, 2016.

On December 9, 2016, Dr. Otto submitted a letter of response to the College. In his letter, Dr. Otto advised that he had provided the records to Patient A's counsel on October 1, 2016.

Patient B

On November 16, 2015, counsel for Patient B sent a letter by regular mail to Dr. Otto's office, requesting Patient B's complete client file and enclosing an executed authorization and direction. The letter was received by Dr. Otto's office. Dr. Otto failed to respond to the request.

Counsel for Patient B sent two further letters to Dr. Otto's office by regular mail on January 18, 2016 and June 14, 2016, repeating his request for Patient B's file. Both letters were received by Dr. Otto's office. The final letter stated in bold that the matter had become urgent. Dr. Otto failed to respond to these requests.

On August 24, 2016, counsel for Patient B contacted the College regarding Dr. Otto's ongoing failure to provide Patient B's file as requested. The College investigator requested Dr. Otto's response by letters dated August 30, 2016 and October 25, 2016.

On December 9, 2016, Dr. Otto submitted a letter of response to the College. In his letter, Dr. Otto advised that he had provided the records to Patient B's counsel on October 19, 2016.

Patient C

On January 4, 2017, the College received a letter from counsel for Patient C requesting assistance in obtaining copies of her client's records from Dr. Otto. As advised in her letter, Patient C's counsel had sent four requests to Dr. Otto for Patient C's records by letters dated February 12, March 12, April 14 and May 14, 2014. The final three request letters included the following statement in bold font: "If you have not seen this patient, please confirm in writing." Dr. Otto failed to respond to these requests.

In his response to the College, dated February 16, 2017, Dr. Otto stated that he had no record of receiving the requests from Patient C's counsel and apologized if the letters were received and missed by an administrative error. Dr. Otto also noted that Patient C's first name was spelled inconsistently, in that a single letter in the middle of Patient C's first name was different in counsel's letter and in the four request letters. Dr. Otto stated that he did have records related to a patient with the name indicated on the request letters and would provide them upon receipt of an executed consent form. Patient C's surname was spelled correctly throughout, and her birthdate was included in the four request letters.

Relevant College History

Dr. Otto has been the subject of a number of prior investigations, cautions and disciplinary decisions by the College.

In responding to the investigations regarding the complaints made on behalf of Patients A and B, Dr. Otto advised the College investigator on December 8, 2016 that in order to prevent similar oversights and delays, he has directed that all requests for patient records received by his office be logged into a journal, that each week, he personally reviews the journal to ensure requests have been attended to in a timely manner, and that if they are not, he personally ensures his office staff immediately attends to the request. Dr. Otto indicated that he is confident that the system now implemented at his office will assist in responding to patient record requests in a timely and appropriate manner.

Dr. Otto's previous involvement with the College includes the following:

- In November 2012, the Inquiries, Complaints and Reports Committee (the ICRC) cautioned Dr. Otto in person and accepted his undertaking in resolution of an investigation into issues regarding his practice, including his use of a physician assistant and his inadequate record-keeping. Among other things, Dr. Otto undertook to complete a medical record-keeping course.
- On May 1, 2013, the ICRC advised and cautioned Dr. Otto in two separate cases to respond promptly and properly to requests for patient records. In one case, counsel for the patient advised that he had written four letters to Dr. Otto requesting a copy of the patient's records and had telephoned on numerous occasions. In the other case, counsel for the patient advised that he had written three letters requesting records on the patient's behalf and had called numerous times. In both cases, Dr. Otto advised the College that he had since set up a binder to record patient record requests, which he reviewed weekly.
- In a decision dated October 5, 2015, relating to his completion of Special Diet Allowance forms, the Discipline Committee made findings of professional misconduct. Dr. Otto admitted that his record-keeping did not meet the standard of practice. The Committee administered a public reprimand, suspended Dr. Otto's registration for two months, ordered he pay a $10,000 fine and imposed a number of other terms. The Committee noted that Dr. Otto had since completed the medical record-keeping course in accordance with his previous undertaking, and ordered that he also complete an educational program in ethics.

Disposition

On April 23, 2018, the Committee ordered and directed that:

- the Registrar suspend Dr. Otto’s Certificate of Registration for period of 3 months, to commence on May 7, 2018;

- the Registrar impose the following terms, conditions and limitations on Dr. Otto's Certificate of Registration:

Records Log

(a) Dr. Otto shall maintain a log of all requests for the release of Personal Health Information ("PHI"), which shall include a copy of the requests received, the date such requests were received, and the date of Dr. Otto's response (the "Log"). Dr. Otto shall also include a copy of the request and his response in the relevant patient's clinical record;
(b) Dr. Otto shall submit a copy of the Log to the College thirty (30), sixty (60) and ninety (90) days following the date of this Order, and every two (2) months thereafter, for a total period of twenty-four (24) months;

Education

(c) Dr. Otto shall complete a physician practice management course acceptable to the College within six (6) months of the date of this Order;

Preceptorship

(d) Within thirty (30) days of the conclusion of the suspension of his Certificate of Registration described above in paragraph 3, Dr. Otto shall retain, at his own expense, a College-approved clinical supervisor or supervisors (the "Preceptor") with respect to effective office administration, and in particular the timely response to requests for PHI. The Preceptor will sign an undertaking in the form attached as Schedule "A" to the Order, dated April 23, 2018;
(e) Dr. Otto shall meet with the Preceptor a total of six (6) times over a period of twelve (12) months (the "Preceptorship"): an initial meeting, then once after one (1) month, once after a further two (2) months; and once every three (3) months thereafter until the conclusion of the Preceptorship;
(f) The meetings shall include a review of the Log and related correspondence, including the requests received, the responses by Dr. Otto and the associated records and patient charts to ensure appropriate documentation. The Preceptor may conduct an additional review of any records or documents deemed necessary for the purposes of the Preceptorship. The Preceptor may also make inquiries of relevant individuals, including staff or colleagues;
(g) Dr. Otto shall cooperate fully with the Preceptor and shall abide by the recommendations of the Preceptor, including but not limited to, any recommended practice improvements and professional development;
(h) The Preceptor shall submit quarterly reports to the College;
(i) If a person who has given an undertaking in Schedule "A" to this Order dated April 23, 2018 is unable or unwilling to continue to fulfill its provisions, Dr. Otto shall, within twenty (20) days of receiving notice of same, obtain an executed undertaking in the same form from a similarly qualified person who is acceptable to the College and ensure that it is delivered to the College within that time;

(j) If Dr. Otto is unable to obtain a Preceptor in accordance with this Order, he shall cease to practice until such time as he has obtained a Preceptor acceptable to the College;
(k) If Dr. Otto is required to cease practice as a result of paragraph (4)(j) above, this will constitute a term, condition or limitation on his Certificate of Registration and that term, condition or limitation will be included on the public register;
(l) Dr. Otto shall consent to the disclosure by his Preceptor to the College, and by the College to his Preceptor, of all information the Preceptor or the College deems necessary or desirable in order to fulfill the Preceptor's undertaking and Dr. Otto's compliance with this Order;

Reassessment
(m) Within six (6) months of completing the Preceptorship required above, Dr. Otto shall undergo a reassessment with regard to effective office administration by a College-appointed Assessor;
(n) The reassessment may include (at the College's discretion) a review of Dr. Otto's Log and related documentation; an interview with Dr. Otto, interviews with colleagues and staff, and any other tools deemed necessary by the College;
(o) The results of this assessment shall be reported to the College;
(p) Dr. Otto shall abide by all recommendations with regard to practice management made by the College-appointed Assessor;
(q) If Dr. Otto is of the view that any of the Assessor's recommendations are unreasonable, he shall have thirty (30) days following receipt of the recommendation within which to provide the College with his submissions in this regard. Thereafter, the Inquiries, Complaints and Reports Committee (the "ICRC") will consider his submissions and make a determination regarding whether or not the recommendations, or any of them, are reasonable and if so, whether they, or any of them, constitute limitations or restrictions on his practice, and that decision will be provided to Dr. Otto;
(r) Following the decision referenced in paragraph (4)(q) above, Dr. Otto shall abide by those recommendations of the Assessor that the ICRC has determined are reasonable.

Other
(s) Dr. Otto shall inform the College of each and every location where he practices, in any jurisdiction (his "Practice Location(s)") within fifteen 15 days of this Order and shall inform the College of any and all new Practice Locations within fifteen (15) days of commencing practice at that location;
(t) Dr. Otto shall submit to, and not interfere with, unannounced inspections of his Practice Location(s) and patient records for the purposes of monitoring and enforcing his compliance with the terms of this Order;
(u) Dr. Otto shall consent to the College making appropriate enquiries of the Ontario Health Insurance Plan and/or any person who or institution that may

have relevant information, in order for the College to monitor his compliance with this Order.

(v) Dr. Otto shall consent to the sharing of information among the Preceptor, the Assessor and the College, as any of them deem necessary or desirable in order to fulfill their respective obligations;

(w) Dr. Otto shall be responsible for any and all costs associated with implementing the terms of this Order.

- Dr. Otto attend before the panel to be reprimanded;

- Dr. Otto pay costs to the College for one half-day hearing in the amount of $6,000 within sixty (60) days from the date of this Order.

On May 4, 2018, Dr. Otto appealed the decision on penalty of the Discipline Committee to the Ontario Superior Court of Justice (Divisional Court). Pursuant to s. 25(1) of the *Statutory Powers Procedure Act*, the appeal operates as a stay of the decision pending the outcome of the appeal. Therefore, the decision of the Discipline Committee is not in effect.

10. Dr. W.W.H. Rudd

Name:	Dr. William Warren Heatherington Rudd
Practice:	Colorectal Surgeon (retired)
Practice Location:	Toronto
Hearing:	Agreed Facts and Joint Penalty
Finding/Penalty Decision Date:	August 10, 2018
Written Decision Date:	August 22, 2018

Allegations and Findings

- disgraceful, dishonourable or unprofessional conduct – **proved**
- sexual abuse of a patient **– withdrawn**

Summary

Dr. Rudd is a retired colorectal surgeon, who received his certificate of registration authorizing independent practice from the College in July 1960 and permanently retired from the practice of medicine on May 25, 2018. Prior to his retirement, Dr. Rudd practised in Toronto at an outpatient clinic where he performed anorectal surgery and colonoscopy.

Patient A

Patient A was first seen by Dr. Rudd in September 2013 for a complete anorectal examination which involved a sigmoidoscopy. She returned to see Dr. Rudd one year later, in September 2014. At that appointment, Dr. Rudd performed a medically-indicated anorectal examination, including an anoscopy, which is less invasive than a sigmoidoscopy. When the examination was complete, Dr. Rudd did not take sufficient care to maintain Patient A's privacy and spatial boundaries. This included touching one side of Patient A's buttocks indicating the end of the examination, removing the paper drape and helping Patient A pull up her trousers. Dr. Rudd was accompanied by a nurse throughout the patient encounter.

Patient A found the appointment distressing and continues to be affected by Dr. Rudd's conduct. After the appointment, she expressed her concerns to her family doctor. She did not return to see Dr. Rudd following her appointment.

Patient B

Patient B was seen by Dr. Rudd in November 2017 for an anorectal examination which involved an anoscopy and sigmoidoscopy. Patient B was diagnosed with an anal fissure. On the way to the examination room, Dr. Rudd made an unprofessional comment to Patient B and another patient. During the course of the encounter, Dr. Rudd also made inappropriate comments about Patient B's appearance and inquired about her personal life.

During the appointment, Dr. Rudd did not obtain consent in an appropriate manner and did not take sufficient care to ensure privacy and appropriate coverage of Patient B. After his examination, Dr. Rudd instructed her on how to keep the affected area clean and dry and suggested certain treatments. As part of this process Dr. Rudd demonstrated proper ano-rectal self-care by placing his gloved hand on Patient B's hands to guide her, without first ensuring she consented to him doing so. Dr. Rudd was accompanied by a nurse throughout the patient encounter.

Patient B was distraught after the appointment and expressed her concerns to her husband and her family doctor. Patient B did not return to see Dr. Rudd following this appointment.

Relevant College History

In response to a public complaint from a patient, Dr. Rudd signed an undertaking to the College in 1992, which included the term that Dr. Rudd "must adopt/take all reasonable measures to continue to ensure to the extent practicable the comfort and dignity of his patients".

In January 1995, Dr. Rudd was cautioned by the Complaints Committee regarding sensitivity around assisting patients to pull up their undergarments and trousers following anorectal examinations. Dr. Rudd was directed to ask patients if they want help and, if so, to offer to have his nurse provide assistance.

In March 2012, after reviewing materials from the investigation of a public complaint, the Inquiries Complaints and Reports Committee took no further action on the complaint. However, in its Decision and Reasons, the Committee indicated that, "…Dr. Rudd could probably have been a lot more sensitive in his communications with a young and anxious patient who was likely undergoing an anal/rectal examination with a scope for the first time. The Committee expects that Dr. Rudd will keep in mind the importance of sensitivity and patience in his communications in the future."

Undertaking to the College

Dr. Rudd entered into an undertaking to the College on May 7, 2018, by which he agreed to resign his certificate of registration, effective May 25, 2018

Disposition

On August 10, 2018, the Discipline Committee ordered and directed that:

- Dr. Rudd attend before the panel to be reprimanded.
- Dr. Rudd pay costs to the College in the amount of $6,000.00 within thirty (30) days of the date of this Order.

11. Dr. J.D. Strang

Name:	Dr. John Douglas Strang
Practice:	Family Physician
Practice Location:	Burlington
Hearing:	Agreed Facts and Joint Penalty
Finding/Penalty Decision Date:	September 10, 2018
Written Decision Date:	October 4, 2018

Allegations and Findings

- disgraceful, dishonourable or unprofessional conduct – **proved**

Summary

Dr. Strang is a family physician practising at a Clinic in Burlington. Dr. Strang received his Independent Practice Certificate in 1991.

The 2013 SCERP

In August of 2013, the Inquiries, Complaints and Reports Committee (the "ICRC") considered two public complaints against Dr. Strang and directed in each case that Dr. Strang complete a specified continuing education or remediation program (SCERP), including attending and successfully completing a Medical Record-Keeping Course and undergoing a reassessment, approximately 6 months following completion of the course, consisting of a chart review of 15-20 charts. On March 4, 2015, Dr. Strang provided the College with the certificate of completion of the Apri128, 2014 Medical Record-Keeping Course.

A reassessment of Dr. Strang's practice was completed in November 2015. The assessor concluded that Dr. Strang did not meet the standard of practice for medical record-keeping in 15 of the 16 charts reviewed.

The 2016 SCERP

In August of 2016, the ICRC considered the results of the reassessment. The ICRC ordered a verbal caution with respect to medical record-keeping, clinical care regarding test results and professionalism in failing repeatedly to respond to the College. The ICRC also issued a SCERP consisting of clinical supervision for a period of 6 months followed by a reassessment. Dr. Strang was informed of the ICRC's disposition on October 6, 2016. The decision sets out the requirements that Dr. Strang recruit a Clinical Supervisor acceptable to the College and that the Clinical Supervisor sign an undertaking with the College within 30 days of Dr. Strand's receipt of the decision.

On October 13, 2016, the College’s Compliance Case Manager wrote to Dr. Strang setting out Dr. Strang's obligations flowing from the ICRC's decision and requesting that a Clinical Supervisor be proposed immediately. On December 6, 2016, Dr. Strang proposed a physician to be his Clinical Supervisor. Dr. Strang was advised by the Compliance Case Manager that the proposed Supervisor would need to be approved by the College and to provide the proposed Supervisor with the SCERP document for his review. The Compliance Case Manager advised Dr. Strang to ensure that the proposed Supervisor contact the Compliance Case Manager to discuss the SCERP.

On January 6, 2017, the Compliance Case Manager advised Dr. Strang that the proposed Supervisor had not contacted the College. Dr. Strang responded the same day indicating that the proposed Supervisor was away over the holidays and that he would be contacting him.

On February 15, 2017, the proposed Supervisor contacted the Compliance Case Manager inquiring as to what the clinical supervision would entail. On February 22, 2017, the Compliance Case Manager responded to the proposed Supervisor, providing him with the relevant details of the clinical supervision including the SCERP and Individual Education Plan documents for his review. The proposed Supervisor then declined to be the Clinical Supervisor.

On March 15, 2017, the Compliance Case Manager informed Dr. Strang that the proposed Supervisor declined to be his Clinical Supervisor and advised that a new supervisor was required for approval by March 31, 2017, or the matter would be returned to ICRC. On March 24, 2017, the Compliance Case Manager sent a reminder email to Dr. Strang about obtaining a Clinical Supervisor. Dr. Strang responded to the email inquiring as to whether the College has any suggestions for supervisors. The Compliance Case Manager responded that the College did not maintain a list of clinical supervisors and offered that Dr. Strang speak with one of the College's medical advisors. On April 25, 2017, College Compliance Case Manager informed Dr. Strang that the ICRC would consider the matter on May 16, 2017.

On May 16, 2017 the ICRC met to consider Dr. Strang's non-compliance with the SCERP. The ICRC directed an undertaking be signed in lieu of completion of the SCERP.

On May 23, 2017, a registered letter was sent to Dr. Strang containing the draft undertaking for his review. The letter states that the College would return the matter to the ICRC if Dr. Strang was unwilling to sign the undertaking. The letter also specified that the ICRC might refer allegations of professional misconduct to the Discipline Committee with respect to non-compliance with the SCERP. No response to proposed undertaking was received from Dr. Strang.
On June 13, 2017, allegations of professional misconduct were referred to the Discipline Committee. Dr. Strang retained counsel in March of 2018. On June 22, 2018, an undertaking executed by Dr. Strang reflective of the terms of the SCERP, together with the Clinical Supervisor's undertaking, was received by the College.

Disposition

On September 10, 2018, the Discipline Committee ordered and directed that:

- the Registrar suspend Dr. Strang's certificate of registration for a period of one (1) month, commencing immediately.
- Dr. Strang appear before the panel to be reprimanded.
- Dr. Strang pay to the College its costs of this proceeding in the amount of $6,000 within thirty (30) days from the date of this Order.

12. Dr. G.A. Heymans

Name:	Dr. Gerry Adrianes Heymans
Practice:	Family Physician
Practice Location:	Russell
Hearing:	Agreed Facts and Joint Penalty
Finding/Penalty Decision Date:	October 12, 2018
Written Decision Date:	November 9, 2018

Allegations and Findings

- disgraceful, dishonourable or unprofessional conduct – **proved**
- sexual abuse of a patient – **withdrawn**

Summary

Dr. Heymans is a physician, practising family medicine in Russell. He received his certificate of registration authorizing independent practice from the College of Physicians and Surgeons of Ontario in 1980. At all relevant times, Dr. Heymans held privileges at a Hospital. Dr. Heymans resigned his hospital privileges on October 5, 2018 and currently practises at Russell Meadows Retirement Community.

Patient A: Disgraceful, dishonourable or unprofessional conduct

In early 2015, around noon, Patient A arrived by ambulance at the Hospital Emergency Department. She had been suffering from severe abdominal pain for around twenty-four hours. Patient A was put into an Emergency room. She underwent x-rays and a CT scan. A physician, who was a member of the surgical team, later attended the Emergency room, examined Patient A's abdomen and told her that she had a bowel obstruction and would be staying in the hospital overnight.
Later that evening, Dr. Heymans, attended on Patient A for further examination. As the patient's family physician did not have privileges at the hospital, Dr. Heymans was assigned as the most responsible physician (MRP) for the admission. This was Patient A's first encounter with Dr. Heymans that day. According to Patient A, she had never been treated by Dr. Heymans in the past.

When Dr. Heymans came into the emergency cubicle, Patient A was lying in a hospital bed, wearing only a hospital gown on her upper body, tied at the neck, and wearing underwear on her lower body. She had a hospital blanket covering her legs and lower body, which pulled up above her waist. Dr. Heymans introduced himself to Patient A and advised her that she would be admitted to hospital due to a bowel obstruction. He was standing up, leaning against a wall. While he was speaking to Patient A, and while still standing, Dr. Heymans fell asleep. After a short period of time, he woke up and

continued talking to Patient A. According to Dr. Heymans, he apologized to Patient A and told her that it had been a long day. Shortly thereafter, Dr. Heymans went over to Patient A and sat down on the side of the bed. He asked Patient A about her medical history. He appeared to fall asleep again during this encounter. Dr. Heymans told Patient A he was going to examine her and lowered the hospital blanket that was covering Patient A and lifted the hospital gown. After examining Patient A's abdomen, Dr. Heymans then proceeded to examine Patient A's breasts. Dr. Heymans documented the breast examination in Patient A's medical records.

Prior to examining Patient A's breasts, Dr. Heymans did not explain to Patient A what he was doing and why he was conducting the exam; did not explain the steps involved did not Ascertain whether Patient A was comfortable with the steps involved; and did not ascertain whether Patient A consented to the exam. According to Patient A, she felt violated and confused, responded to Dr. Heymans by saying "my breasts are just fine," and pulled the hospital gown down.

Dr. Heymans explained to Patient A that she was going to be moved from Emergency to a room on a ward upstairs. He then left.

The next day, Patient A learned that Dr. Heymans would continue to provide care to her. She was very upset by this and told a nurse that she did not want Dr. Heymans to continue to provide her care. The nurse told Patient A she did not have the ability to choose her physician while admitted at the hospital. Prior to Patient A's discharge, Dr. Heymans was not informed of this information.

Patient A was discharged from the Hospital four days later. Dr. Heymans saw Patient A on each day she was admitted, except for the day she was discharged.

Relevant Undertakings

On October 16, 2017, Dr. Heymans entered into a voluntary undertaking in lieu of the ICRC interim order. Dr. Heymans entered into the undertaking after the College received the complaint that is the subject matter of these proceedings. He is also subject to a prior undertaking with the College, entered into on March 8, 2013, which arose from an inquiry that was initiated after the College received reports from colleagues who expressed concerns that Dr. Heymans appeared overly tired and had a tendency to experience drowsiness while seeing patients. Dr. Heymans entered into the undertaking, which certified (among other things) that he would not engage in direct patient care for more than forty five (45) hours per week, and would not work any overnight shifts.

Prior History

In December 2011, a patient alleged that Dr. Heymans had given her a hug while in the examining room. The ICRC issued a written caution and directed a Specified Continuing

Education or Remediation Program (a "SCERP") under which Dr. Heymans was to complete the Understanding Boundaries Course. Dr. Heymans successfully completed the course on October 18 and 19, 2013.

In May 2015, following the patient encounter that gave rise to these proceedings, the College conducted inquiries relating to Dr. Heymans' sleep disorder. Dr. Heymans had been diagnosed with obstructive sleep apnea in 2001. In November 2015, as part of the College inquiries, Dr. Heymans agreed to undergo a sleep study that resulted in enhanced measures to assist Dr. Heymans with his sleep disorder. Since that time, Dr. Heymans and his sleep specialist have reported, to the College's satisfaction, that Dr. Heymans' sleep disorder has been well managed since the enhanced measures are in place.

Dr. Heymans has no prior history with the Discipline Committee.

Changes to Practice

In the Spring of 2015, following the complaint that gives rise to these proceedings, Dr. Heymans elected to cease responsibility as the Most Responsible Physician for orphan patients at the Hospital. In 2017, Dr. Heymans elected to take a leave of absence from the Hospital, including shifts in the Emergency Department, the skin clinic and ceased to follow his own patients who were admitted to hospital. In May 2018, Dr. Heymans decided to further limit his practice by closing his primary care practice. On October 15, 2018, Dr. Heymans resigned his hospital privileges at the Hospital. Dr. Heymans' current practice is limited to the provision of care in retirement homes and long-term care facilities as set out in the Agreed Statement of Facts on Liability.

Disposition

On October 12, 2018, the Discipline Committee ordered and directed that:

- the Registrar suspend Dr. Heymans' Certificate of Registration for a three (3) month period effective 12:01 a.m. on November 17, 2018.
- the Registrar impose the following terms, conditions and limitations on Dr. Heymans' Certificate of Registration:
    - Dr. Heymans shall only practice medicine in facilities designated as Retirement Homes and/or Long-term Care Homes, as defined in the *Retirement Homes Act*, 2010, S.O. 2010 c.11 and the *Long-Term Care Homes Act*, 2007, S.O. 2007, c.8, and associated Regulations, unless otherwise approved of in writing by the College;
    - Dr. Heymans shall engage in direct patient care no more than thirty (30) hours per week, and this restriction supersedes Dr. Heymans' undertaking signed on March 8, 2013, in so far as the maximum number of hours he is permitted to work per week;

- Dr. Heymans shall not engage in any professional encounters, in person or otherwise ("Professional Encounter(s)"), with patients of any age, unless in the continuous presence and under the direct observation of a monitor (the "Monitor") who is a regulated health professional and employed at the facility where Dr. Heymans provides care;
- Dr. Heymans shall maintain a log ("the Log") of all Professional Encounters with patients. Dr. Heymans shall ensure that the Monitor initials each entry on the Log for each patient seen in the Professional Encounter and shall make this Log available to the College upon request;
- Dr. Heymans shall annually submit to the College, a report prepared by his sleep disorder specialist or his family physician, regarding Dr. Heymans sleep disorder, commencing within one year of the date of this Order;
- Dr. Heymans shall inform the College of each and every location where he practices, in any jurisdiction (collectively my "Practice Location(s)") within fifteen (15) days of commencing practice at that location;
- Dr. Heymans shall be responsible for any and all fees, costs, and expenses, associated with implementing and fulfilling the terms of this Order; and
- Dr. Heymans shall provide irrevocable consent to the College to make appropriate enquiries of OHIP and/or any person or institution that may have relevant information, in order for the College to monitor compliance with this Order.
- Dr. Heymans appear before the panel to be reprimanded.
- Dr. Heymans pay costs to the College in the amount of $6,000.00 within thirty (30) days of the date of this Order.

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 2018

TOPIC: **Independent Legal Advice Program for Complainants/ Witnesses in Discipline Hearings Relating to Sexual Misconduct**

FOR INFORMATION

ISSUE:

- The Executive Committee was asked for direction on whether to indefinitely extend the pilot project it approved in June of 2016 and September of 2017 to provide independent legal advice (ILA) to complainants/witnesses involved in discipline hearings in which the allegations relate to sexual misconduct.

- On November 6, 2018, the Executive Committee approved the infinite extension of the program.

BACKGROUND:

- In June of 2016, As part of Council's ongoing initiative to ensure it is doing all it can to eliminate sexual abuse by physicians and support those who are victims of sexual misconduct by physicians, the College proceeded with a pilot project to provide up to three hours of independent legal advice to complainants/witnesses who are expected to be involved in a College discipline hearing.

  Who is eligible for the program?

  The program is offered to all witnesses who are likely to testify in a College discipline hearing where that testimony would relate to sexual misconduct by the physician.

  What does independent legal advice cover?

  The aspects that can be covered would include:

- basic information about the administrative law system and specifically the College discipline hearing proceeding;
- information about the relationship (or lack of relationship) between the College's process and other aspects of the justice system such as criminal and civil courts, the Criminal Injuries Compensation Board, the College's Patient Relations Committee, and others;
- any questions the witness has about the College, the proceeding, and his or her rights;
- basic information about testifying in an adversarial process, including the need to be truthful and forthcoming with relevant evidence; and
- information about resources/support available to victims of sexual abuse.

EVALUATION

- In 2018, the program was evaluated by the College's Research and Evaluation Department (RED), to facilitate a decision on whether to either extend the pilot or make it a permanent program.

- After two years, there have been twenty-five witnesses who were eligible and could have benefitted from the ILA program. Of twenty-five, seven took advantage of the program and received legal advice.

- 6 witnesses were invited to participate in the evaluation; 3 people agreed to be interviewed.

- The 3 interviews were conducted by RED between August 2017 and September 2018.

Summary of Findings

- The participants interviewed who accessed ILA reported that the program was a very important resource that helped them understand what to expect at the upcoming discipline hearing.

- The participants who accessed the program stated that the reason they utilized the program was to get non-biased advice and to be able to ask questions confidentially.

- One participant expressed appreciation for the program and stated that she would not have known how to get this type of legal advice had the College not offered it.

- Overall, participants found the ILA program very supportive and impactful.

Suggestions for improvement

- Enhance communication of the ILA program:
    - Ensure all victims/witnesses are made aware of the ILA program; repeat the information as necessary as there is a lot of information that is provided initially and this piece may be forgotten.
    - Provide more information about what ILA entails, what the potential benefits are, why someone would want to access it, what kinds of questions they can ask, etc.
    - Provide an information sheet to victims/witness with a description of all the steps in the process, what everyone's role is, and how ILA might be useful.
    - The distinction between ILA lawyers and CPSO lawyers should also be clarified.

- Timing of the ILA program:
    - ILA should be offered at least 6-8 weeks prior to a hearing. The two participants who accessed ILA mentioned that they felt it came a little too late in the process, and that they would have benefitted from it earlier on.

CURRENT STATUS:

- On November 6, 2018, the Executive Committee approved the infinite extension of the program.

FOR INFORMATION

Contact: Alice Cranker, ext. 780
Kathryn Hodwitz, ext. 522

Date: November 20, 2018

Attachments:

Appendix A: June 2016 Executive Committee Briefing Note

June 2016

EXECUTIVE COMMITTEE BRIEFING NOTE

TOPIC: Pilot Project for Independent Legal Advice to Complainants/Witnesses in Discipline Hearings Relating to Sexual Misconduct

FOR DECISION

ISSUE:

The Executive Committee is asked for direction on whether to proceed with a pilot project to provide independent legal advice to complainants/witnesses involved in discipline hearings in which the allegations relate to sexual misconduct.

BACKGROUND:

As part of Council's ongoing initiative to ensure it is doing all it can to eliminate sexual abuse by physicians and support those who are victims of sexual misconduct by physicians, it is recommended that the College proceed with a 12-month pilot project to provide independent legal advice to complainants/witnesses who are expected to be involved in a College discipline hearing.

What is the purpose of the pilot program?

Witnesses who testify in sexual misconduct hearings often say that the experience is harrowing, akin to re-living the abuse they experienced. One theme that is repeated among many witnesses is that they feel as though there is no one involved in the legal side of the process who is looking out for their interests. In College proceedings, they note that the physician has his/her own counsel (usually more than one), and the College prosecutor is there on behalf of the College, but there is no one there advocating specifically for them. This perception may have contributed to the challenge the College has faced in a number of recent discipline hearings where the College could not proceed with allegations as a result of witnesses refusing to participate and testify in the proceedings. There is some concern that witnesses are increasingly reluctant to testify, which severely impairs the College's ability to discharge its duty to the public.

In addition, many witnesses do not fully understand the way in which the adversarial legal system at the College works. They may inadvertently, and

through a lack of understanding, make decisions that undermine the quality of the evidence that they can provide to the Discipline Committee.

Providing witnesses with a maximum of three hours of legal advice, once it appears likely that a discipline hearing will occur, may help in the following ways:

- witnesses may feel less anxious and more supported regarding the process;
- independent legal advice may improve the quality of evidence provided by a witness, as a result of the witness better understanding the process and how it may unfold; and
- witnesses can ask questions they do not feel they can direct to the College prosecutor, and under the protection of solicitor-client privilege. There would be no duty of disclosure imposed upon the lawyer providing independent legal advice.

Note that this program would be in addition to, not instead of, the current program offered by the College to provide support to witnesses in the form of a Witness Support person – currently a position held by Pam Greenberg. This role is not a legal function, but is a supportive one. The Witness Support person attempts to act as a liaison and facilitator on behalf of the witness while he or she is at the College or meeting with College representatives, but does not provide legal advice. It is an extremely important part of the College's efforts to help witnesses, but it cannot cover some aspects about which the witness may need assistance. In addition, there is no privilege associated with the communications between the witness and the College's support person.

A similar pilot project to provide independent legal advice has recently been announced by the provincial government for victims of sexual assault. At this point, it is not clear precisely who will be eligible for the legal advice being provided by the province. It appears that the program is specifically targeted to victims of criminal sexual assault, and is not intended to cover those who may be testifying in an administrative, as opposed to a criminal, process. In accordance with the Executive Committee's direction, the College has started efforts to lobby the provincial government to expand its program to cover witnesses in the College's proceedings. However, it is not expected that such an expansion is likely. Further, the College's legal department would be concerned if witnesses were provided advice by lawyers who may not be familiar with the College process. Controlling the pool of lawyers who provide independent legal advice, by managing the program internally, may be of significant benefit to the College.

Who would be eligible for the program?

The proposed program would be offered to all witnesses who are likely to testify in a College discipline hearing where that testimony would relate to sexual misconduct by the physician.[1]

What would independent legal advice cover?

The aspects that could be covered would include:

- basic information about the administrative law system and specifically the College discipline hearing proceeding;
- information about the relationship (or lack of relationship) between the College's process and other aspects of the justice system such as criminal and civil courts, the Criminal Injuries Compensation Board, the College's Patient Relations Committee, and others;
- any questions the witness has about the College, the proceeding, and his or her rights;
- basic information about testifying in an adversarial process, including the need to be truthful and forthcoming with relevant evidence; and
- information about resources/support available to victims of sexual abuse.

While all of this information could also be conveyed by the prosecutor – and indeed is – the reality is that witnesses may not fully trust the prosecutor, whose role is to act in the public interest, not in the interest of the witness. In addition, given the stress of being involved in this process, it may be that a witness needs to hear a similar message from different voices, and one whose sole responsibility is to provide advice to the witness, in order to fully understand and appreciate the information being conveyed.

What are the potential risks and benefits of the program?

If successful, the program could achieve multiple goals:

- improve the experience of testifying in sexual misconduct hearings for witnesses;
- improve the quality of evidence provided by witnesses in sexual misconduct hearings;
- demonstrate to the public that the College is committed to doing all it can to support victims of sexual abuse by physicians, which could

[1] If the provincial program was expanded and one of our witnesses had benefited from the provincial program, the College could consider excluding them or reducing the amount of time offered.

increase the likelihood of other victims coming forward in the future, or decrease the number of times the College is unable to proceed with sexual misconduct prosecutions as a result of witnesses refusing to participate.

Risks of the process include the following:

- the legal advice could dissuade the witness from testifying (this risk could be mitigated by the manner in which the College will select a small pool of lawyers to provide independent legal advice to witnesses, and sets the parameters of the program);
- the prosecution will never be in a position to know what has been said by the independent counsel to the witness;
- there will be a cost associated with the program (we would propose to control this risk by only offering legal advice after a case has been referred to the Discipline Committee, and only if it does not appear that the matter is likely to settle);
- although the proposal is only for a 1-year pilot project, the project could create an expectation that it will continue, or criticism of the College if it does not; and
- the witness could ask questions of the independent legal counsel instead of the prosecution, impairing the relationship and trust between the witness and the prosecutor (this risk could be mitigated by the prosecutor continuing with the current practice of providing the same type of general legal advice that it is anticipated independent counsel will provide, which could actually reinforce/strengthen the relationship between the prosecution and the witness).

In order to reduce the risk that the witness discloses or discusses important aspects of the actual allegations to someone who is not the prosecutor, the parameters of the program will clearly and explicitly exclude the specific facts of the case. Independent legal counsel will not be provided with any of the material relevant to the allegations, and will be told that if the witness wants to discuss that kind of detail, he or she should speak with the prosecutor.

How much would the pilot program cost?

It is impossible to know precisely how much the program would cost, as it would depend upon how many potential sexual misconduct witnesses there would be during the 12-month pilot who wanted to take advantage of the program. (Alternatively, if the Executive Committee prefers a hard cap on the money spent on the program, the pilot could extend to a specified number of witnesses, regardless of the time period). If it was to run as a 12-month pilot, a very rough estimate, based on the number of sexual misconduct witnesses who have

testified in previous years, and the increase in such referrals recently, is that the program could cost the College approximately $17,500 to $20,000.[2] [3]

In terms of the College resources required to run the program, this should be fairly minimal. The legal office already has a relationship with several lawyers who provide independent legal advice for witnesses whose records are the subject of a third party records motion, who could be approached for this purpose as well. It is expected that there would be an initial investment of time from the legal office to identify the small roster of lawyers to whom witnesses could be referred for independent legal advice, and to define the parameters of the legal advice to be provided, but thereafter would not take significant time.

There would also be some time required, likely of the legal office and Research & Evaluation Department ("RED") staff, for the evaluation component of the project, discussed below.

How will the College know whether the program is worthy of continuing at the end of the year?

The legal office has met with members of the College's RED department to seek assistance in developing a means of evaluating the program (if approved) to help answer this question. RED staff are interested in supporting this evaluation and will have a greater understanding of the scope and methods that may be employed once further detailed information about the program is provided. A full evaluation plan, including expected RED staff resourcing, will be undertaken as part of this project.

One potential challenge with the evaluation is that the number of witnesses involved in a 12-month period may be too low to provide any meaningful information. Accordingly, one possibility at the end of the 12-month period is that the legal office seeks approval for an extension of the pilot program, prior to any formal evaluation results being presented.

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[2] This estimate is based on an estimate of the cost to the College of the legal advice (roughly estimated to be $1,000 per witness, if all three hours are used), and an analysis of the Notices of Hearing for discipline cases between 2010 and 2015 in which there were allegations of sexual misconduct and individual patients/witnesses were referred to in the schedule to the Notice of Hearing. While the estimate exceeds the average number of witnesses based on that calculation, I have also presumed (for the purpose of this estimate) that there will be an increase in the number of potential sexual abuse witnesses, based on the very preliminary data from 2015-2016 and the trend of referrals at ICRC. While many of the witnesses ultimately did not testify in the hearings analyzed between 2010 and 2015, it is likely that many of them would have been eligible for this pilot program since settlements occur in such close proximity to the hearing that there is a reasonable possibility that the witness may have to testify and should benefit from legal advice.

[3] It is anticipated that any costs associated with this pilot project in 2016 would be supported through the legal department's current budget. Costs in 2017 could be included within the department's annual budget.

DECISION FOR EXECUTIVE COMMITTEE:

(1) Does the Executive Committee support a 12-month pilot project to provide independent legal advice to complainants/witnesses who are expected to testify in a College discipline hearing?

CONTACT: Vicki White, ext. 433

DATE: June 9, 2016

Council Committee Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 2018

TOPIC: Policy Report

FOR INFORMATION

Updates:

1. Consultation Response: Ontario College of Pharmacists' draft *Opioid Policy*
2. New Requirements for Practitioners who Dispense Opioids: Updates to the College's *Dispensing Drugs* Policy
3. Cannabis Update: Housekeeping Amendments to the College's *Marijuana for Medical Purposes* Policy
4. Policy Consultation Update:
    I. Continuity of Care
    II. Disclosure of Harm
    III. Joint Consultation on Three Policies
5. Policy Status Table

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1. Consultation Response: Ontario College of Pharmacists' draft *Opioid Policy*

- The Ontario College of Pharmacists (OCP) released a draft *Opioid Policy* for external consultation on September 10th, 2018.
- This policy set out expectations for pharmacists regarding prescription opioids, and addresses topics including the assessment of prescriptions, communicating with patients and caregivers, and documentation.
- The draft policy was reviewed by policy staff, with additional feedback provided by Nanci Harris (Manager, QMD), Maureen Boon, Dr. Angela Carol, Dr. Nancy Whitmore, and Dr. Steven Bodley.

- While the draft policy was generally supported, several minor issues were identified that may benefit from further clarification and/or consideration.

- A formal response was prepared outlining the College's feedback and submitted to the OCP following final approval from Dr. Bodley (see **Appendix A** for a copy of the response).

2. New Requirements for Practitioners who Dispense Opioids: Updates to the College's *Dispensing Drugs* Policy

- New legislation is now in effect[1] which requires practitioners who dispense opioids[2] to include a warning label and information sheet with each prescription.

- This requirement must be met for all new prescriptions as well as subsequent refills, but not in circumstances where the prescription is being administered to the patient under the supervision of a practitioner (e.g. a physician or nurse).

- The objective of these new requirements is to help ensure that patients receive consistent and relevant information to help mitigate the risks associated with prescription opioid use.

- While relatively few physicians in Ontario dispense opioids, these new requirements necessitate a minor housekeeping amendment to the College's *Dispensing Drugs* policy:

    1. Where the current policy requires that physicians "provide appropriate packaging, labeling and patient related material for the drugs they dispense," the following footnote will be added (which includes a number of active hyperlinks):

        > "Under the Food and Drug Regulations, physicians who dispense Class A opioids are required to apply a warning sticker to the prescription bottle, container, or package, and provide a patient information handout to accompany the drug. A sticker or handout is not required if the prescription is being administered under the supervision of a practitioner (for example, a physician or a nurse). For more information about these requirements, and to access digital copies of the materials, please visit Health Canada's website."

[1] Regulations Amending the Food and Drug Regulations (Opioids): SOR/2018-77.
[2] A list of the specific opioids that are subject to the prescription labeling provisions can be viewed on Health Canada's website.

3. Cannabis Update: Housekeeping Amendments to the College's *Marijuana for Medical Purposes Policy*

- As Council is aware, the federal *Cannabis Act, 2018* legalizes the production, distribution, sale, and possession of cannabis for recreational purposes in Canada.

- Given the introduction of this legislation, minor housekeeping amendments are being undertaken to update the College's *Marijuana for Medical Purposes* policy:

    1. The policy is being revised to use the term "cannabis" instead of the more colloquial term "marijuana". This change is being undertaken to align the language of the policy more closely with the language of the legislation, as well as to reflect the fact that "cannabis" is a formal scientific designation, whereas "marijuana" is a colloquial or slang term.
    2. A footnote is also being added to clarify that the recreational use of cannabis is governed by separate legislation from medical use, and is not contemplated by the policy.

4. Policy Consultation Update

I. Continuity of Care Draft Policies

- Council approved a set of draft *Continuity of Care* policies for external consultation at its May 2018 meeting. An extended consultation period is underway and will continue until December 9, 2018.

- The tone and content of the feedback has remained consistent since Council was last updated in September 2018. Broadly speaking, respondents are supportive of the idea of continuity of care, but many have expressed concern about how the policies aim to achieve this objective.

- Additional engagement activities have also been undertaken, including seeking input from the Citizen Advisory Group, conducting public opinion polling, and engaging with key stakeholders at two Stakeholder Summits where physicians, organizations, and members of the public had an opportunity to discuss key issues and provide feedback.

II. Disclosure of Harm Policy

- The preliminary consultation on the Disclosure of Harm policy has now closed. The consultation garnered a total of 63 responses: 5 through the online discussion page, 4 via email, and 54 via online survey.

- Written feedback was generally brief and supportive of the current policy's content.

- Survey responses suggested a need for refinement of the policy's scope and expectations, as well as more guidance for physicians and patients around how to conduct the disclosure discussion.

- All feedback is currently being reviewed in detail to inform recommended next steps for this policy.

III. Joint Consultation on Three Policies

- A preliminary consultation on the *Anabolic Steroids, Substances and Methods Prohibited in Sport* policy*, Female Genital Cutting (Mutilation)* policy*, and Fetal Ultrasound for Non-Medical Reasons* policy was carried out in order to assess whether these policies are useful to physicians and members of the public. The consultation received 52 responses via the online discussion page, survey, and e-mail.

- A summary of the feedback is captured in a separate briefing note, *Approval to Rescind Three Policies* included in the Council materials for December, 2018.

5. Policy Status Table

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

- For further information about the status of any policy issue, please contact Craig Roxborough, Interim Manager, Policy, at extension 339.

For information only

Contact: Craig Roxborough, Ext. 339

Date: November 16, 2018

Appendices:

Appendix A: Consultation Response
Appendix B: Policy Status Table

Appendix A

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

From the Office of the President
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Toll free: (800) 268-7096

October 31, 2018

Via Email

Nancy Lum-Wilson
Registrar
Ontario College of Pharmacists
483 Huron Street
Toronto, ON M5R 2R4

Dear Ms. Lum-Wilson:

Re: Draft Opioid Policy

On behalf of the College of Physicians and Surgeons of Ontario (CPSO), I would like to thank you for the opportunity to comment on the Ontario College of Pharmacists' (OCP) draft *Opioid Policy*.

The CPSO commends the OCP on its efforts to clarify expectations for pharmacists with respect to prescription opioids. It is the view of the CPSO that this policy represents an important opportunity to further improve patient care and safety, and to reinforce the importance of professional collaboration between pharmacists and prescribers.

The CPSO is supportive of the draft policy; however, two areas have been identified that may benefit from further clarification and/or consideration. These areas are outlined below:

Section B: Assessment

The draft policy requires that pharmacists assess, within their scope, whether the prescribed opioid therapy is appropriate given the clinical status of the patient, and further specifies the steps that must be undertaken for each assessment.

As drafted, the policy appears to require that pharmacists will assess every opioid prescription they receive, and that every assessment will entail the specific steps outlined in the policy (these include, as examples: a complete patient history, a monitoring plan, and an assessment of the patient's risk for opioid use disorder).

While physicians rely on pharmacists to review new prescriptions and flag concerns as they arise, requiring pharmacists to undertake a full assessment for every prescription may prove burdensome, and result in the duplication of tasks that have already undertaken by the prescriber. Alternatively, there may be value in permitting pharmacists some latitude to determine whether a full assessment is needed for every prescription, or whether there are circumstances in which a partial assessment (or no assessment) would be more appropriate (for example, in response to a prescription refill, or in response to a prescription for a patient that is well known to the pharmacist and who has a stable history of opioid use).

Section C: Communication

The draft policy states that "patients/caregivers of patients prescribed opioids should be educated" on a number of specific topics.

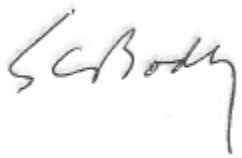
As drafted, the policy is not clear whether pharmacists are expected to provide this education themselves, or whether they are permitted to rely on education that has already been provided by another healthcare provider (e.g. the prescriber).

Additionally, while the draft policy contains general recommendations for communicating with prescribers, it stops short of requiring that pharmacists communicate important information (for example, evidence of opioid abuse and/or diversion).

The CPSO recommends that the final policy more strongly require that pharmacists proactively communicate important information to prescribers, such as suspected drug therapy problems, suspected substance use disorder, and relevant NMS alerts. The CPSO further recommends that the final policy more strongly reinforce the principle that pharmacists to be responsive to physician inquiries.

We trust that the above comments will be of assistance to you in finalizing the draft policy, and thank you again for the opportunity to comment on this important consultation.

Yours truly,



S.C. Bodley MD, FRCPC
President

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

Appendix B

POLICY STATUS REPORT – DECEMBER 2018 COUNCIL

POLICY REVIEWS

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
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. A Working Group has been struck to undertake this review and a preliminary consultation on the current policy has been undertaken. Further updates with respect to the status of this review will be provided at future meetings of Council.	2019
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 physician-patient relationship, after the physician-patient relationship ends, and with respect to persons closely associated with patients.	A Working Group has been struck to undertake thee review of this policy and a preliminary consultation on the current policy has been undertaken. Revisions to the current policy based on the feedback received and research undertaken are being made and a draft policy will be brought to a future Council meeting.	2019
Practice Management Considerations for Physicians Who Cease to	This policy explains the practice management measures physicians should take when they	This policy is currently under review. A newly titled *Closing a Medical Practice* draft policy was approved for external consultation by	2019

POLICY STATUS REPORT – DECEMBER 2018 COUNCIL

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
Practise, Take an Extended Leave of Absence or Close Their Practice Due to Relocation	cease to practise or will not be practising for an extended period of time.	Council in February 2018. A consultation on the draft policy took place between February and April 2018. The draft policy is being revised in light of the feedback received. The timeline for this review has been adjusted to align with the development of the new *Continuity of Care* draft policies. Further updates with respect to the status of this review will be provided at a future meeting.	
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. Following Council approval in May 2018, the draft Managing Tests policy was released for external consultation.	2018
Continuity of Care	The College does not currently have a policy on *Continuity of Care*.	A joint Working Group has been struck to oversee the development of new *Continuity of Care* policies alongside the review of the current *Test Results Management* policy. In May 2018, Council approved a set of draft *Continuity of Care* policies for external consultation which will continue until December 9, 2018.	2018

Appendix B

POLICY STATUS REPORT – DECEMBER 2018 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. A Working Group has been struck to assist with this policy review and provided direction on the expectations to be included in the draft policy in November 2018. Revisions to the current policy are being made in light of the Working Group's feedback and a draft policy will be brought to a future Council meeting.	2019
Medical Records	This policy sets out the essentials of maintaining medical records.	This policy is currently under review. A working group has been struck to assist with this review and is providing direction on the expectations to be included in the draft policy. Further updates with respect to the status of this review will be provided at a future meeting.	2019
Disclosure of Harm	This policy sets out the expectations of physicians in situations where patients experience harm in the course of medical treatment.	This policy is currently under review. A preliminary consultation was held between September and November 2018. Stakeholder feedback is currently being reviewed to inform potential recommendations regarding this policy.	2019
Fetal Ultrasound for Non-Medical Reasons	The purpose of this policy is to clarify physician obligations with respect to ordering and performing fetal ultrasounds.	This policy is currently under review. A joint consultation was conducted to evaluate the value and usefulness of this policy. Further information is available in the *Approval to*	2018

POLICY STATUS REPORT – DECEMBER 2018 COUNCIL

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
		Rescind Three Policies briefing note included in your Council materials.	
Female Genital Cutting (Mutilation)	This policy sets out physicians' obligations with respect to female genital cutting/mutilation.	This policy is currently under review. A joint consultation was conducted to evaluate the value and usefulness of this policy. Further information is available in the *Approval to Rescind Three Policies* briefing note included in your Council materials.	2018
Anabolic Steroids, Substances and Methods Prohibited in Sport	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).	This policy is currently under review. A joint consultation was conducted to evaluate the value and usefulness of this policy. Further information is available in the *Approval to Rescind Three Policies* briefing note included in your Council materials.	2018

POLICY STATUS REPORT – DECEMBER 2018 COUNCIL

POLICIES SCHEDULED TO BE REVIEWED

POLICY	TARGET FOR REVIEW	SUMMARY
Complementary/Alternative Medicine	2016/17	This policy articulates expectations relating to complementary and alternative medicine. The review of this policy has been deferred, due to competing priorities.
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.
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.
Social Media – Appropriate Use by	2018/19	This document provides guidance to physicians about how to engage in social

POLICY STATUS REPORT – DECEMBER 2018 COUNCIL

POLICY	TARGET FOR REVIEW	SUMMARY
Physicians (Statement)		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: Recruitment of Subjects for Research Studies and MDs Relations with Drug Companies)	2019/20	The draft policy sets out the College's expectations for physicians who interact with industry in a number of key areas. Council approved the Physicians' Relationships with Industry: Practice, Education and Research policy at its September 2014 Meeting. The policy was posted on the College's website, and published in *Dialogue*, Volume 10, Issue 3, 2014.
Telemedicine	2019/20	The policy sets expectations for physicians using telecommunications technologies to interact with patients in different locations, in actual or stored time.
Marijuana for Medical Purposes	2020/21	The policy sets expectations for physicians relating to the prescribing of dried marijuana for medical purposes.
Professional Obligations and Human Rights	2020/21	The policy articulates physicians' existing legal obligations under the Ontario *Human Rights Code*, and the College's expectation that physicians will respect the fundamental rights of those who seek their medical services.
Consent to Treatment	2020/21	The policy sets out expectations of physicians regarding consent to treatment.
Planning for and Providing Quality End-of-Life Care (formerly Decision-Making	2020/21	This policy sets out expectations of physicians regarding planning for and providing quality care at the end of life.

POLICY STATUS REPORT – DECEMBER 2018 COUNCIL

POLICY	TARGET FOR REVIEW	SUMMARY
for 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 Members	2021/22	This policy sets out the circumstances in which it may be acceptable for physicians to provide treatment for themselves, family members, or others close to them.
Physician Behaviour in the Professional Environment	2021/22	This policy provides specific guidance about the profession's expectations of physician behaviour in the professional environment.
Medical Assistance in Dying	2021/22	This policy articulates the legal obligations and professional expectations for physicians with respect to medical assistance in dying, as set out in the federal legislation, provincial legislation, and relevant College policies.
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.

POLICY STATUS REPORT – DECEMBER 2018 COUNCIL

POLICY	TARGET FOR REVIEW	SUMMARY
Uninsured Services: Billing and Block Fees	2022/23	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.
Ensuring Competence: Changing Scope of Practice and Re-entering Practice	2023/2024	This policy sets out the College's expectations related to reporting and demonstrating competence prior to changing scope of practice and/or re-entering practice. It also outlines the College review process for ensuring competence when physicians change their scope of practice and/or re-enter practice.
Public Health Emergencies	2023/2024	This policy sets out the College's expectations of physicians during public health emergencies, and affirms the commitment of the profession to responding to public health emergencies by providing physician services.