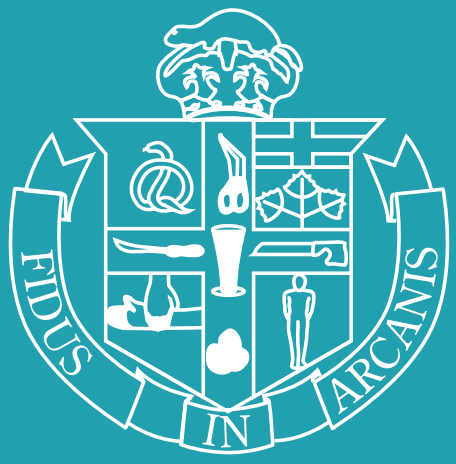
The College of Physicians and Surgeons of Ontario

Annual Financial Meeting of Council



May 24 and 25, 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 May 24 and Friday May 25, 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 May 24, 2018.

Daniel Faulkner, HBSc., MBA
Interim Registrar

April 30, 2018

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

MEETING OF COUNCIL
May 24 and 25, 2018
Council Chamber, 3rd Floor, 80 College Street, Toronto

May 24, 2018

CALL TO ORDER

9:00 President's Announcements

Council Meeting Minutes of February 23, 2018 ..... **1**

Executive Committee's Report to Council, March – April 2018 ..... **9**

9:10 INTERIM REGISTRAR'S REPORT

1. Corporate Report **15**
2. Dashboard 2018 – Q1 ..... **29**
3. Risk Management Report – Q1 ..... **34**
4. Registrar's Update **36**

Divisional Reports:

1. Corporate Services **40**
2. Information Technology **51**
3. Investigations, ICR Committee Support, Hearings, Compliance Monitoring and Supervision **63**
4. Legal Office **94**
5. Policy and Communications **98**
6. Quality Management **113**
7. Research and Evaluation **124**

GOVERNANCE REVIEW

10:00 Governance Review – Part 1 131

Council supported a review of the CPSO's governance structure in February. The review is being overseen by a working group that consists of members of the College's Governance and Executive Committees.

The Governance Review Working Group (GRWG) established the goal and objectives of the review and has had some initial discussion regarding governance best practices and preliminary principles of a high performing board and governance structure.

Council is asked to consider the work of the GRWG to date with a focus on the jurisdictional summaries and literature review that are highlighted in the material, and provide feedback on the themes that have emerged from the GRWG's initial discussions, to help direct the CPSO Governance Review going forward.

11:00 Bill 87: Psychotherapy Regulation Proposal 154

- ***For Decision***

Bill 87 provides Colleges with the ability to develop a regulation relating to the duration of the physician-patient relationship for the purposes of sexual abuse.

A proposed draft regulation has been developed for Council's consideration. The draft regulation specifically addresses physician-patient relationships that have involved psychotherapy. It is consistent with the College's current position regarding the unique nature of psychotherapeutic relationships and the need for additional caution in that context.

Council is asked whether it approves the draft regulation and whether it supports delaying consultation of the regulation until the government's timing is clear.

COUNCIL AWARD PRESENTATION

11:30 Council Award Recipient: Dr. Sarah Reid, Ottawa, Ontario **168**

12:00 ***Lunch***

1:00 2017 Audited Financial Statements and Appointment of the Auditor for 2019 169

- ***For Decision***

At the Annual Financial Meeting of Council, the College's auditor presents the Audit Report along with the Audited Financial Statements for the year 2017. Council is asked to appoint the external auditors for the upcoming year.

1:30-4:30 CONTINUITY OF CARE

1:30 Continuity of Care 186

- ***For Decision***

Council is presented with a 'suite' of new policies relating to a number of Continuity of Care issues as well as revisions to the current Test Results Management policy. Council is provided with an overview of the development and review process to date and is asked whether each of the draft policies comprising the Continuity of Care 'Suite' can be released for external consultation.

2:30 Annual Fire Drill and Evacuation Procedures 242

The College is required to complete annual testing of fire drill procedures. Council will be participating in this evacuation process during the meeting.

4:30 ADJOURN

May 25, 2018 – Day 2

CALL TO ORDER

9:00 President's Announcements

GOVERNANCE REVIEW

9:15 Governance Review – Part 2

Small group discussions will take place consider the following questions:

i. What are the characteristics of a high functioning modern board?
ii. Thinking ahead to identifying the core principles that should underpin CPSO's governance structure, what are your early suggestions?
iii. What changes to the College's governance structure would improve the College's effectiveness?

10:30 ***Break***

PRESENTATIONS

10:45 Opioid Strategy: Update..... 246

- ***For Discussion***

11:00 Proposed General By-Law Amendments – Methadone Committee 253

- ***For Decision***

Council is being asked to approve amendments to the General By-Law that will amend Section 41 to remove reference to the Methadone Committee and revoke Section 45 describing the functions of the current Methadone Committee.

11:30 Motion to go In Camera

IN CAMERA

12:15 – 1:15 ***Lunch***

1:15 Governance Committee Report 259

2019 Executive Committee Election

- ***For Decision***

Appointments:

- Public Member Reappointments
- Committee Appointments

- ***For Information***

Completion of 2019 Committee Interest Forms (for submission at Council Meeting)

MEMBER TOPICS

INFORMATION ITEMS

1. Government Relations Report **295**
2. Policy Report **298**
3. Physician Assistants **314**
4. *Immunization of School Pupils Act* (ISPA): Government Amendments **325**
5. Quality Management Partnership Report: Advancing Quality: Progress on Key Priorities in Colonoscopy, Mammography and Pathology **330**
6. Discipline Committee Report of Completed Cases, May 2018 ..... **353**

ADJOURN

DRAFT **PROCEEDINGS OF THE**
MEETING OF COUNCIL
OF
THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
FEBRUARY 23, 2018

Attendees:

Dr. Steven Bodley (President)
Dr. Philip Berger
Dr. Brenda Copps
Ms. Lynne Cram
Mr. Harry Erlichman
Ms. Joan Fisk
Dr. Rob Gratton
Dr. Deborah Hellyer
Dr. Paul Hendry
Ms. Catherine Kerr
Major A. Khalifa
Mr. Mehdi Kanji
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
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 and Dr. Janet van Vlymen

Regrets: Ms. Debbie Giampietri, Mr. Pierre Giroux, Dr. Barbara Lent, Ms. Joan Powell and Dr. Robert (Bob) Smith

CALL TO ORDER

President's Announcements

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

Council Meeting Minutes of November 30 and December 1, 2017

01-C-02-2018

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

The Council accepts the minutes of the meeting of the Council held on November 30/December 1, 2017.

CARRIED

Special Council Teleconference of February 6, 2018

Council reviewed the following two motions passed at its February 6, 2018 in-camera meeting:

The Selection Committee - Outcome

02-IC-02-2018

It is moved by Dr. Dave Rouselle and seconded by Ms. Lynne Cram that:
The Council appoint Dr. Nancy Whitmore as Registrar effective June 4, 2018.

CARRIED

Appointment of Registrar on Interim Basis

03-IC-02-2018

It is moved by Dr. Peeter Poldre and seconded by Dr. Akbar Panju that:
The Council appoints Dan Faulkner as Registrar on an interim basis, from March 1, 2018 to June 3, 2018.

CARRIED

Executive Committee's Report to Council from December 2017 to February 2018

Received with no comments.

FOR DECISION

Closing a Medical Practice – Draft for Consultation

02-C-02-2018

It is moved by Dr. Elizabeth Samson and seconded by Dr. Akbar Panju that:

The College engage in the consultation process in respect of the draft policy "Closing a Medical Practice" (a copy of which forms **Appendix "A"** to the minutes of this meeting).

CARRIED

Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice – Consultation Report and Revised Draft Policy

03-C-02-2018

It is moved by Dr. Deborah Hellyer and seconded by Mr. John Langs that:

The Council approves the revised policy "Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice", formerly titled "Changing Scope of Practice" and "Re-entering Practice", (a copy of which forms **Appendix "B"** to the minutes of this meeting).

CARRIED

Public Health Emergencies – Consultation Report and Revised Draft Policy

04-C-02-2018

It is moved by Dr. Philip Berger and seconded by Mr. John Langs that:

The Council approves the revised policy "Public Health Emergencies", (a copy of which forms **Appendix "C"** to the minutes of this meeting).

CARRIED

FINANCE COMMITTEE REPORT

2018 Membership Fee

05-C-02-2018

It is moved by Mr. John Langs and seconded by Dr. Dave Rouselle that:

The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 116, after circulation to stakeholders:

By-law No. 116

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

Annual Fees

4. Annual fees for the year beginning June 1, 2018, are as follows:

   (a) $1,725 for holders of a certificate of registration other than a certificate of registration authorizing postgraduate education and other than a certificate of registration authorizing supervised practice of a short duration; and

CARRIED

Tariff Rate Increase for Discipline Hearings

06-C-02-2018

It is moved by Major Khalifa and seconded by Mr. Paul Malette that:

The Council of the College of Physicians and Surgeons of Ontario amends the Discipline Committee's Tariff Rate for Costs and Expenses for the College to Conduct a Day of Hearing, increasing the Tariff Rate to $10,180, effective February 23, 2018.

CARRIED

PRESENTATIONS

Education Strategic Initiative Update

Council was provided with an update on the status of the Education Strategic Initiative and related activities planned for 2018-2020 (a copy of which forms **Appendix "D"** to the minutes of this meeting).

Opioid Strategy - Update

Council was provided with an update on the Opioid Project (a copy of which forms **Appendix "E"** to the minutes of this meeting).

COUNCIL AWARD WINNER

Dr. Jerry Rosenblum presented the Council Award to Dr. Bill I. Wong of Toronto, Ontario.

Motion to Go In Camera

07-C-02-2018

It is moved by Mr. Peter Pielsticker and seconded by Dr. Elizabeth Samson 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 11:55 a.m. and returned to open session at 12:20 p.m.

PRESENTATION

Continuity of Care and Test Results Management Policy Development Update

Council was provided with an update on the current policy development activities and an overview of the issues that will be addressed in the policies including planned next steps (a copy of which forms **Appendix "F"** to the minutes of this meeting).

GOVERNANCE COMMITTEE REPORT

District Election Dates

08-C-02-2018

It is moved by Dr. Jerry Rosenblum and seconded by Ms. Lynne Cram that:

The Council approves the 2019-2021 district election dates set out below:

Districts 1, 2, 3 and 4:	October 15, 2019
Districts 5 and 10:	October 13, 2020
Districts 6, 7, 8 and 9:	October 12, 2021

CARRIED

Committee Appointments for New Council Members, Mr. Mehdi Kanji and Ms. Catherine Kerr

09-C-02-2018

It is moved by Dr. Judith Plante and seconded by Dr. Elizabeth Samson that:

The Council appoints Mr. Mehdi Kanji to the Discipline Committee and Ms. Catherine Kerr to the Inquiries, Complaints and Reports Committee for the balance of the 2018 Council session.

CARRIED

New Public Members of Council

Three new public members have been appointed to the College Council for three-year appointments; Paul Malette from Toronto, was appointed to Council on January 8th, 2018 and Mehdi Kanji from Richmond Hill, and Catherine Kerr from Stevensville were both appointed to Council on February 8th, 2018.

Committee Appointments

At the January 19, 2018 Executive Committee meeting, the Committee appointed Paul Malette to the Discipline Committee. At the January 22, 2018 Executive Committee meeting, the Committee appointed two non-council public members to the Premises Inspection Committee, El-Tantawy Attia and Ron Pratt, both have previously served on the College Council and meet defined rationale and criteria developed to inform these appointments.

Current Committee Vacancies

There are some vacancies on 2018 committees for non-council physician specialists

Information regarding committees and the time commitment to participate on committees is available on the College's website. The Governance Committee continues to look at ways to improve our recruitment processes and is working to fill all vacant positions as soon as possible.

Non-LGIC Public Members on Committees: Premises Inspection Committee (PIC)

Recruiting public members who are not members of the College Council to serve on designated and College committees is something Council has already determined should be part of the College's strategy to manage its workload. As a result of the time sensitive and urgent needs of PIC, the Executive Committee approved, on the advice and recommendation of the Governance Committee, the concept of appointing non-LGIC public members who are former public members of Council to PIC according to specified criteria set out by the Governance and the Executive Committee that includes:

- Proven record of achievement while serving as a member of the College Council (contribution, dependability, quality of work);
- Commitment to the public interest;
- Availability – meets needs of committee;
- Integrity;
- Capacity (able to perform work, manage technology, possesses necessary skillset to review, reflect on inspection reports);
- Served on Council for the "maximum" years of eligibility.

Based upon the criteria, the Governance Committee recommended the appointment to PIC for two former public members of Council; El-Tantawy Attia and Ron Pratt to ensure that PIC can continue its work.

Development of a broader process to recruit and retain public members who are not on the College Council, to help manage the College workload, is on the Governance Committee's priority list this year. Further work needs to be done to develop an approach to non-LGIC public member appointments in the future for PIC and other committees.
Council will consider these issues further at a future meeting.

Governance Review

At its January 19th meeting, the Governance Committee considered its priorities for the next year with a focus on one of the elements of the Corporate Plan – Regulatory Governance: Modernization.

The purpose of this review is to build on the governance work completed by the College in 2017 and ensuring Council engagement in governance discussion. This includes building on Council support for greater independence of the Discipline Committee and, support of a process and timeline to facilitate the election of a public member of Council as President.

The initial activity will include the collection of information about existing governance models, best practices and work being done by other organizations. Concrete objectives and a work plan will be developed to support this work.

MEMBER TOPICS

There were no member topics brought forward.

REGISTRAR'S REPORT

Strategic Initiatives Including Dashboard Update was provided by Mr. Dan Faulkner, Interim Registrar (a copy of which forms **Appendix "G"** to the minutes of this meeting).

TOPICS FOR INFORMATION

1. Government Relations Report

2. Policy Report

3. Quality Management Partnership: Draft Progress Report on Quality in Colonoscopy, Mammography and Pathology

4. Discipline Committee – February 2018 Report of Completed Cases

ADJOURNMENT

As there was no further business, the President adjourned the meeting at 3:40 p.m.

_____
Dr. Steven Bodley, President

_____
Franca Mancini, Recording Secretary

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May 2018

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

FOR INFORMATION

January 18, 2018 Executive Committee Meeting

1. Appointment of New Public Member

The Executive Committee appointed Joseph Paul Malette to the Discipline Committee.

2. Blood Borne Viruses Policy: Housekeeping Amendments

One of the questions on the 2018 Annual Renewal Survey relating to blood borne viruses has been revised to clarify that a positive blood test for the Hepatitis C Virus (HCV) includes either a positive blood test for HCV antibody or HCV RNA. Housekeeping amendments were made to the current Blood Borne Viruses policy so that the policy aligns with the new wording in the Annual Renewal Survey.

January 22, 2018 Executive Committee Meeting

1. Non-LGIC Public Members on Committees: 2018 Premises Inspection Committee (PIC)

The Premises Inspection Committee has had to cancel some 2018 panels because of a lack of availability of public Council members. While PIC is required to have a public member on each panel, this public member does not need to be an LGIC (Lieutenant Governor in Council) appointment.

The Executive Committee approved a proposal from the Governance Committee to appoint non-LGIC public members to PIC according to specified criteria. These criteria include:

- Proven record of achievement while serving as a member of the College Council (contribution, dependability, quality of work)
- Commitment to the public interest
- Availability – meets needs of committee
- Integrity
- Capacity (able to perform work, manage technology, possesses necessary skillset to review, reflect on inspection reports)
- Served on Council for the 'maximum' years of eligibility

The Executive Committee then approved the appointment for 2018 of 2 non-LGIC public members who met the criteria – Mr. Ron Pratt and Dr. el-Tantawy Attia – to PIC in order to ensure the Committee can continue its work.

This decision is specific to PIC for 2018. Further work will be done to develop an approach to non-LGIC public member appointments for other committees, in order to ensure that LGIC public members are available for those committees that require them.

March 20, 2018 Executive Committee Meeting

1. Proposed Regulations under the *Health Sector Payment Transparency Act, 2017*

The Ministry of Health and Long-Term Care is seeking comments on a new regulation proposal to support the implementation of the reporting scheme established under the *Health Sector Payment Transparency Act (HSPTA), 2017*. Once proclaimed into force, the HSPTA will require the medical industry, including pharmaceutical manufacturers and medical device companies ("payors"), to report annually to the Minister of Health and Long- Term Care all transfers of value (TOV) provided to certain categories of individuals and organizations involved in the health care sector ("recipients").

The two specific provisions of the regulation that would apply to physicians, health regulatory colleges and other recipients are: record retention and correction of reported information.

The Executive Committee directed staff to provide comments to the Ministry on the regulation proposal. It is unclear how useful the published data will be to the public given the amount of data that will be generated, particularly when no context is given. In addition, as recipients are required to keep records, information is needed around how recipients are to note transactions.

2. Bill 87: Regulation Proposal and Draft Submission

The Executive Committee reviewed the College's draft submission on new regulation proposals intended to support the implementation of some provisions contained as part of Bill 87, the *Protecting Patients Act, 2017*. The regulation proposals relate to three issues: definition of patient for the purposes of sexual abuse, contents of the public register, and offences that result in mandatory revocation.

The draft submission expresses the CPSO's support for the intention to prohibit sexual relationships between regulated health professionals and former patients while the power imbalance forged during the relationship may remain in place.

The College made suggestions for amendments to the language in the regulation regarding the criteria for individuals who are deemed to be patients for the purpose of sexual abuse.

Contact: Steven Bodley, President
Vicki White, ext. 433

Date: May 2, 2018

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

TOPIC: Interim Registrar's Report

DATE: May 2018
For Information

ISSUE:

The College's work is guided by its Strategic Plan (Appendix A) which charts the course to our vision: Quality Professionals - Healthy System - Public Trust.

College activities are focused on this framework targeted toward 4 high level priorities (Registration, Physician Competence, Investigations, Discipline & Monitoring and Operations) and 4 strategic initiatives (Quality Management Partnership, Education, Transparency and Data/Analytics).

The CPSO is nearing the end of its current strategic plan, which extends until 2018. 2018 is an interim reporting year as the organization transitions to the new Registrar and begins preparations for a new strategic plan.

This Q1 Registrar's report includes 4 elements:

1. Corporate Report

The 2018 Corporate Plan guides the College's strategic and operational activities. The Corporate Plan is an internal document that supports annual performance objectives for the Registrar and enables monitoring of significant initiatives across all levels of the College. It sets out what the focus will be in 2018, recognizing the importance of the Strategic Plan and other issues that have arisen. Progress towards the 2018 objectives is set out in the Q1 corporate report. (Appendix B)

2. Dashboard

The Q1 Dashboard sets out the status of strategic and operational targets connected to the strategic plan. The dashboard will need to be revised and updated to align with both the existing corporate plan and future strategic plan. (Appendix C)

3. Risk Management Report

The Risk Management Report sets out the current risks facing the organization from either a strategic or operational perspective. It also captures public risk, if it exists. The report also sets out the current proposed response to the risk, including any mitigation strategies. (Appendix D)

4. Registrar's Update

The Registrar's Update includes recent developments of note, as well as reports on stakeholder engagement and finance/operations. (Appendix E)

DECISION FOR COUNCIL: For information only

Contact: Dan Faulkner
Maureen Boon, ext 276

Date: May 4, 2018

Appendices:
A: Strategic Framework
B: Corporate Report – Q1
C: Dashboard – Q1
D: Risk Management Report – Q1
E: Registrar's Update

CPSO Strategic Framework 2015-2018

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

VISION

QUALITY PROFESSIONALS, HEALTHY SYSTEM, PUBLIC TRUST

PRIORITIES

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

STRATEGIC INITIATIVES

- QUALITY MANAGEMENT PARTNERSHIP
- EDUCATION
- TRANSPARENCY
- INFORMATION MANAGEMENT

PRINCIPLES

- INTEGRITY
- ACCOUNTABILITY
- LEADERSHIP
- COLLABORATION

APPENDIX B

2018 Corporate Report Q1 - COUNCIL

Strategic

- Education
- Data & Analytics
- Transparency

Regulatory

- Facilities[R]
  - QMP
- Investigations/Hearings/Monitoring
  - Bill 87[R]
- Registration
- Assessment (Physician Factors)

Operations

- Corporate Planning
- Financial Integrity
- Workplace Planning
- Workforce Planning[R]
- Modernized Business Practices

Risk

- Opioids
- Regulatory Modernization: Governance[R]
- Regulatory Modernization: Oversight/Accountability

[R]Items include a specific identified risk.

Strategic

Initiative	Objectives	Deliverables – 2018[1]	Status
1. Education	To support the CPSO's regulatory priorities so that Ontario physicians are engaged in life-long learning and continuing professional development.	1. Education Strategy Complete and Communicated 2. Begin implementation of Education Strategy a) Education data mapping complete by Q3 2018 b) New member orientation product development c) Remediation framework for opioid cases	Education Strategy communicated – Feb 2018. Implementation: a) Education data compiled Dec 2018 d) New member orientation pilot Dec 2018 e) Remediation framework for opioid cases developed Fall 2018
2. Data & Analytics	To implement Data and Analytics Strategy to support evidence-based decisions, College initiatives, operations and business.	1. Create requirements and a framework document for a data and analytic repository; extract and clean routinely collected data for analytics 2. Provide a report to each department regarding its data assets and make suggestions to eliminate redundancies and streamline data collection & integration 3. Develop a data governance framework	Data inventory and recommendations to departments will be complete by fall 2018. Central data repository design and governance framework will be complete by end of 2018. Report re physician demographic trends and projections complete Fall 2018

[1] Unless specified, all deliverables will be completed by the end of 2018.

Initiative	Objectives	Deliverables – 2018[1]	Status
		4. Complete a project to routinely estimate the number and demographic composition of physician members over time	
3. Transparency	1. Improving transparency of process, outcome and member information. 2. Website improvements to FindaDoc and Premises Register	1. Development of reports on effectiveness/outcomes as part of annual reporting for each regulatory process 2. Complete a) accessibility audit (AODA) b) follow-up public site usability review 3. Implementation of improved public reporting relating to Facilities/Bill 160 and completion of outstanding transparency work.	Effectiveness/outcomes will be included in the 2018 annual report. Accessibility audit completed. Website usability review will be done Q2. Improvements to facilities reporting on hold pending development of CHF transparency requirements.

Regulatory

Initiative	Objectives	Deliverables – 2018	Status
1. **Facilities**	Implementation of oversight of community health facilities (CHF)	1. Work with MOH on regulations required to enact our role in CHF legislation (Bill 160 - Strengthening Quality and Accountability for Patients), as well as governance and implementation. 2. Align program and processes with new CHF legislative requirements. **NOTE: This area has an additional identified risk relating to the size/scope of the implementation and current uncertainty re reg development/proclamation**	Schedule 9 – Oversight of Health Facilities and Devices Act has not yet been proclaimed pending development of regulations. Reg developments moving slowly given impending election. Work continues internally to prepare for implementation once regulations in place.
2. Facilities - Quality Management Partnership (Partnership)	1. Increase the consistency in the quality of care provided across facilities. 2. Fulfill CPSO mandate to act in the public interest and to developing and maintaining professional	1. Implement Partnership operational processes within CPSO a) Complete 2018 funding agreement 2. Develop a plan to implement and monitor pathology standards 3. Continue work on system consistency a) Revise, consult and implement standards identified by expert	Operational integration is proceeding. Quality work has focused on pathology standards. Future work includes public reporting.

Initiative	Objectives	Deliverables – 2018	Status
	competencies 3. Identification and provision of resources, tools and opportunities to support quality improvement for the Partnership's clinical stakeholders.	advisory panels. b) Work with Practice Assessment & Enhancement (PA&E) on any changes required based on CHF legislation regulations 4. Define public reporting and the roles of HQO, CPSO and CCO 5. Design and implement a strategy to facilitate engagement and promote QI skills and knowledge. 6. Develop evaluation plan for Partnership operational improvements 7. Evaluate annual facility, regional and provincial reports (and physician reports in colonoscopy)	
3. Investigations Hearings and Monitoring	Improve investigative, monitoring and discipline processes	1) Process and Timeline Improvement: a. Regression analysis to assess changes in timelines related to individual investigative actions and overall time of investigation process resulting from changes in technology and staffing	Multiple initiatives in progress relating to improvements in process. Evaluations of impact on timelines will be available at the end of the year. Discussions about risk-based streaming of investigations are ongoing.

Initiative	Objectives	Deliverables – 2018	Status
		b. Modernize and enhance the hearings process (ie. possible use of digital audio recording (DAR). c. Complete analysis of Compliance Monitoring workload sustainability (Note: this relates to Workforce Planning). 2) Risk-based streaming of Investigations: a. Determine ability to identify level of concern and required attention of a new matter based on risk screen tool. b. Decide whether Physician & Public Advisory (PPAS) can take on specific low-risk complaints. If yes, develop plan and implement. 3) Committee resourcing: track availability of panel members/public members and impact on scheduling of Investigations, Complaints and Reports Committee (ICRC) and Discipline panels.	

Initiative	Objectives	Deliverables – 2018	Status
4. Bill 87 – Protecting Patients Act	1. Implementation 2. Improve regulatory processes. Leadership at Federation of Health Regulatory Colleges of Ontario (FHRCO) to ensure success.	1. Influence regulation development (i.e. sexual abuse related regulations, statutory committee related regulations), consistent with Bill 87 submissions. **2.** Secure FHRCO support for CPSO response to regulations **NOTE: This area has an additional identified financial risk relating to increased PRC funding.**	Considerable input into regulation development, which is not yet complete. Chairing FHRCO Bill 87 Working Group. Proclamation of several elements of Bill 87 on May 1.
5. Registration	1. Modernization of Registration Regulation 2. Improve Registration Process	1. Complete an overview analysis of the current state of the registration regulation and risk to College of status quo. A recommendation to be made by June 2018 re whether to do further work and nature of work to be done. 2. Development of future process vision (e.g. moving away from a paper based registration system)	Preliminary work has begun but other matters have had to take priority. Further information to be provided in fall.
6. Assessments (Physician Factors)	To develop evidence-based assessment programs and to develop a broader model for physician assessment, based on	1. Create an overarching model for using data and evidence to support effective assessment programming 2. Phase in use of CPSO full member	Operational model for using data and evidence to inform effective assessment programming in place by summer 2018 A new assessment program for low risk matters proposed and supports in place

Initiative	Objectives	Deliverables – 2018	Status
	risk and support factors	data to identify risks, based on factors analyses for priority cohorts (Factors) 3. Develop a new assessment program for low risk matters based on evidence and create a plan to test its effectiveness 4. Continued roll out of peer re design assessments; evaluation complete and implementation of refinement based on evaluation 5. Use complaints recidivism study results to: a)better understand physicians with 7 or more complaints, b) develop a 'score' (risk profile) that identifies physicians at higher risk of recurrent complaints	to test by end of 2018

Operations

Area	Objective	Deliverables - 2018	Status
1. Corporate Planning	To develop an effective, transparent and sustainable internal planning process and annual Corporate Plans.	1. Establish a Corporate Planning Development Group to support all of the development and implementation work in 2018 2. Complete all deliverables in the terms of reference by December 31, 2018	Group has been established. Work ongoing to develop and integrated planning, budget and reporting structure including key performance indicators.
2. Financial Integrity	1. Responsible management of financial resources in the short and long term 2. Identification of cost savings, efficiencies and potential revenue generating initiatives.	1. Develop the 2019 base budget – before new requests – that is 2% less than the 2018 base budget 2. Implement Council-approved recommendations from the Finance Committee, to modernize the physician compensation model for Council and Committee participation 3. Engage staff in the identification of cost savings and efficiency ideas, and use the Administrative & Purchasing Practice Review Working Group to prioritize ideas, effectively implement, and measure specific cost impact.	2019 budget will be developed with 2% reduction. Group reviewing physician compensation anticipated to report recommendations to Council at end of 2018 and administrative and purchasing practice group is reviewing and modifying practices on an ongoing basis.
3. Workplace Planning	Ensure we have sufficient and appropriate space for CPSO staff	Receive final workplace strategy report from Deloitte and develop implementation plan, that addresses short, medium and long term needs	Strategy expected in June.

Area	Objective	Deliverables - 2018	Status
4. Workforce Planning	Ensure human resource sustainability so that key regulatory functions are supported	Development of a workforce management plan to align resources to key regulatory processes a. Develop cross training, job shadowing and pooling programs to improve capacity across departments/divisions b. Review use of temporary replacement workers c. Develop and provide reports to help managers better understand their short and long term departmental staffing needs. **NOTE: This area has been identified as an additional risk given workload.**	Multiple strategies being considered to address resourcing issues. 2 positions have been trained to provide a staff pooling/support function. Maintaining appropriate staffing levels is a challenge, with 28 recruitments in the past 90 days (new staff, internal moves and maternity leaves).
5. Modernized Business Practices	Develop and implement a sustainable approach to continuously improve the efficiency and timeliness of regulatory processes	1. Development of Key Performance Indicators (KPIs) for each regulatory process 2. Develop a systematic, transparent approach to review and improvement of key regulatory processes. Work in 2018 will focus on investigations and legal. a) Improve management of investigation and compliance files in an electronic environment and facilitate the disclosure process.	KPIs will be developed by the end of the year. Work to improve I&R and legal processes is ongoing. Further analysis will be provided in the 2019 budget, pursuant to the 2 council motions relating to #3 and #4.

Area	Objective	Deliverables - 2018	Status
		b) LEAN Legal review. 3. 2019 budget will include additional analysis connecting financial reporting and budget requests to quantitative measures of volume and complexity in member-specific committees. 4. Member-specific committee annual reports will include commentary on financial reporting and budget forecasts with respect to Committee activities. 5. Recommend a process for evaluation of the impact of committee decision-making on operations.	

Risk

Initiative	Objectives	Deliverables – 2018	Status
1. Opioids	1. Improve ability to identify and respond to inappropriate opioid prescribing 2. Facilitate safe/appropriate opioid prescribing 3. Protect patient access to care 4. Reduce risk to patients and the public.	1. Prescribing Drugs policy – full review 2. Complete an overarching model for using data and evidence to support effective opioid assessment programming using external and internal data inputs 3. Modify existing assessment process to identify/address prescribing issues 4. Communicate approach, regulatory results and best practices - Includes collaboration on delivery of educational opioid sessions for profession 5. Complete OneID integration to facilitate access to prescribing reports – Q2 2018 6. Narcotics Monitoring System (NMS) evaluation – results & recommendations for application to investigation work and future College programming	An operational model for integrating data and evidence to support effective opioid assessment programming using external and internal data inputs complete by summer 2018 Ongoing work to modify existing investigative and assessment processes. Physicians now able to sign up for OneID via CPSO portal.

Initiative	Objectives	Deliverables – 2018	Status
2. Regulatory Modernization: Governance	1. Governance proposals to ensure key regulatory functions are supported: a) Separate DC and Council b) Quorum Changes 2. Position CPSO for future by proposing a streamlined and purpose-driven governance structure.	1. Develop, advocate for and implement strategies to ensure regulatory work supported. For example: a) Appointment of a full complement of qualified public members b) Appoint new pool of public members to defined statutory committees c) New regulations/statutory change 2. With Council direction, develop good governance proposals for the future, potentially including the following: a) Reduction in size of council b) Competency based appointments (possible elimination of elections) c) 50/50 public/member committees d) Separation between council and statutory committees **NOTE: This area has an additional identified financial risk relating to Public Member Payment.**	Full complement of public members in place. Council Governance Review to be discussed at May meeting.

Initiative	Objectives	Deliverables – 2018	Status
3. Regulatory Modernization: Oversight/ Accountability	Develop strategy to anticipate and respond to proposals relating to oversight body and other oversight mechanisms	Discussion paper/analysis to incorporate key regulatory research/development and support strategic planning process	To be incorporated into Council Governance review.

APPENDIX C

Dashboard – 2018 – Q1

Strategic Priority	Objective	Measure/Target	Q1	Q2	Q3	Q4	Comments
Optimize Registration	Meets processing time for Registration Applicants	90% of applicants meet processing time of a) 3 wks b) 4 wks					Credentials Applications 1065 of 1065 applications is 100% Registration Committee Applications 340 of 344 applications is 98%
Assure/Enhance Physician Competence	Every physician assessed every 10 years (EDEX)	2600 assessments/year **NOTE**: this target has been adjusted to **2475** to redirect resources to peer redesign.					269 assessments completed = 43% of quarterly target Methadone assessments not initiated until March due to QAC transition IHF assessments delayed due to inability to bring together review panels Staff shortages
	Quality Management Partnership implementation: physicians receive information about quality	% of physicians in each program receiving quality reports 1 colonoscopy 2 mammography 3 pathology					Data not available Reports provided to physicians later in 2018
	Increase input in policy	130 responses/policy					Two policy consultations undertaken in Q1 2018: Prescribing Drugs – preliminary consultation (77 responses), and Closing a Medical Practice (99 responses). Average number of responses: 88.

APPENDIX C

Strategic Priority	Objective	Measure/Target	Q1	Q2	Q3	Q4	Comments
	Existing policies[1] current/relevant	80% of policies have been reviewed within 5 years					Many policy reviews have been deferred to enable the Policy Department to respond to urgent or competing priorities of the College including strategic projects and initiatives.
Optimize Investigations, Discipline and Monitoring	Reduce time for completion of high risk investigations	90% of high risk investigations completed in 243 days. *(old)*					January 1st – March 31st , 2018: 90% of high risk investigations were completed in an average of 208 days, (48 investigations involving 40 unique physicians).
	Reduce time to mitigate risk for high risk investigations	**<u>New</u>** **90% of high risk investigations had risk mitigated in an average of 150 days.**					**<u>New</u>** 90% of high risk investigations had risk mitigated in an average of 170 days (48 investigations involving 40 unique physicians).
	Schedule discipline hearings more quickly	Time from referral to hearing date is 1 year					January 1st – March 31st , 2018: 90% of hearings (9) began on average, 310.6 days (10.2 months) from the NOH date.
	Reduce decision release time	Time from hearing date to decision release date <u>2 months for uncontested (UC)</u>					January 1st – March 31st , 2018: 90% of uncontested decisions (9) were released , 40.4 days (1.3 months) from the last hearing date.
		<u>6 months for contested (C)</u>					January 1st – March 31st , 2018: 90% of contested decisions (4) were released 154.3 days (5.1 months) from the last hearing date.

[1] Does not include registration policies

APPENDIX C

Strategic Priority	Objective	Measure/Target	Q1	Q2	Q3	Q4	Comments
Operational Excellence	Improve service level targets	85% live answer (PPAS, A&C)					A&C: 86% (5,795 of 6,732) calls managed live PPAS: 83% (10,378 of 12,484) calls managed live Combined: 85% (16,173 of 19,216) live response rate
	Improve service level targets	10% call abandonment					A&C 621 calls abandoned 10% PPAS 1203 calls abandoned 10% Combined: 10% call abandonment rate
	Media coverage	80-100% positive or neutral					86% positive or neutral articles (total 300) Positive: 109 (36%) Neutral: 151 (50%) Negative: 40 (13%)

LEGEND

APPENDIX C

	Objective	Measure	Target	On Track	Approaching Target	Attention Required
Optimize Registration	Reduce processing time for Registration Applications	Time from application received by College to (a) first application contact for non-registration committee cases; (b) first applicant contact for registration committee cases	90% of applications meet processing time of (a) 3 weeks (b) 4 weeks	= > 90%	70-89%	<70%
Assure and Enhance Physician Competence	Every physician assessed every 10 years	# of physician assessments in College programs	2600 assessments/year **NOTE**: target has been adjusted to 2475 for Q3 and Q4.	Tracking to >= 2475	Tracking to 2300-2474	Tracking to <2300
	Quality Management Program – implementation	% of physicians in each program receiving quality reports 1 colonoscopy 2 mammography 3 pathology	80% of physicians receiving reports	80%+ receiving reports	50-79%	<50%
	Increase participation in development of policy	Average # of responses/policy	130 responses/policy	>130 responses	100-129 responses	<100 responses
	Existing policies are current & relevant	Policies reviewed and updated regularly	80% of policies reviewed within 5 years	80%+ reviewed within 5 years	60-79%	<60%
Optimize Investigations, Discipline and Monitoring Processes	Reduce time for completion of high risk investigations	# days to complete investigation	90% of High Risk investigations completed in ***243 days or less*.** **New** ***90% High Risk Investigations had risk mitigated in 150 days of less***	90% High Risk investigations done in <=***243d*.** ***New*** ***90% Time to mitigate risk in high risk investigations done in <=150 days***	90% High Risk investigations done ***244-256 d***. ***New*** ***90% Time to mitigate risk for high risk investigations done 151 to 170 days***	90% High Risk investigations done in ***257d+***. ***New*** ***90% Time to mitigate risk for high risk investigations done 171d+***
	Schedule discipline hearings more quickly	Time from referral (notice of hearing) to hearing date	Hearings begin within 1 year	90% began within 365 days (1 yr)	90% began w/i 366-457 days (12-15 mos)	90% began more than 457 days (15 mos)
	Reduce discipline decision release times	Time from hearing date to decision release date	Uncontested (UC): 2 months Contested (C): 6 months	90% released <= 2 mos (UC)	90% released 2-4 mos (UC)	90% released > 4 mos (UC)

APPENDIX C

	Objective	Measure	Target	On Track	Approaching Target	Attention Required
				<= 6 mos (C)	6-8 mos (C)	> 6 mos (C)
Operational Excellence	Improve service level targets	Live answer for PPAS and A&C	85% live answer	85% or greater	75-85%	Less than 75%
	Improve service level targets	Call abandonment rate	10% call abandonment	10% or less	11-15%	Greater than 15%
	Media coverage	Positive or neutral media coverage	80% positive/neutral media coverage	80-100%	60-80%	<60%

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Risk Management Report – Q1

To Council

From Dan Faulkner, Interim Registrar and CEO

Date May 8, 2018

This report sets out potential issues/risks for Q1 that are not already included on the Corporate Report.

1. Physician Assistant Regulation **MEDIUM**

Description: Government would like PAs to be regulated. While there are multiple potential approaches, the CPSO has recommended full regulation under the RHPA.
Risk: The regulation of PAs will be a significant multi-year project for the CPSO, with operational, governance and program impacts.
Plan: CPSO has indicated its willingness to participate in discussions with government relating to full PA regulation. There will be no further discussions on this issue or process until after the provincial election.

2. Physician Incorporation **LOW**

Description: Federal government could dramatically alter the tax benefits of small business incorporations (including physician incorporation) as part of planned income tax changes.
Risk: Decreases in incorporation could have significant financial impact.
Plan: Monitor. Although Q1 2018 new incorporations (170) are lower than Q1 2017 (309), the revised tax proposal may have reduced the risk of decreased incorporations. Monitoring will continue as federal rules are finalized.

3. Sexual Abuse **MEDIUM**

Description: Scrutiny of Discipline Decisions relating to sexual abuse continues.
Risk: The MOH expert advisor recommendations could result in direction to create an independent body to adjudicate sexual abuse cases, which would be a significant undertaking.
Plan: Monitor. Wait for recommendations. Prepare a sexual abuse progress status report by the end of 2018.

4. Wettlaufer Inquiry **LOW**

Description: Ministry inquiry into nurse murders at LTC homes could raise issues re legislation and oversight.
Risk: Recommendations could include enhanced oversight or other changes. If accepted by government, could be embedded into legislation.
Plan: Monitor. The focus of phase one of the inquiry appears to be on specific issues relating to the case, not on bigger issues of legislation and oversight. If necessary, CPSO can seek to participate at a later date.

5. Public Member Payment **LOW**

Description: Current work to include non-council public members on committees and to advocate for equal pay will have financial implications for the CPSO.
Risk: Costs could be significant.
Plan: Continue to raise the issue as part of gov'ts management of the public appointments process.

6. Transparency **HIGH**

Description: Recent media articles have criticized current approach to transparency of physician information and the movement of physician information between jurisdictions.
Risk: Government is likely to either ask or require Colleges to make more information available on the public register.
Plan: Current work to ensure effective jurisdictional flow of information, to identify potential improvements to transparency, and to participate in discussions at FMRAC about a national approach.

APPENDIX E

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Registrar's Update

To	Council
From	Dan Faulkner, Interim Registrar and CEO
Date	May 8, 2018

College Assessor Event, April 9, 2018

The College held a successful meeting in Toronto for over 500 physicians and non-physicians who perform physician and facility assessments and medical inspections. Presentations included a dive into continuing competence, risk-based program approaches of the CMPA and the CPSO, as well as a variety of practical workshops for the assessors.

Physician Health Program (PHP): Program Enhancement Review

The PHP, a program of the Ontario Medical Association (OMA), will be conducting a review to address its effectiveness, accountability, gaps in practices, and long term sustainability. As a significant stakeholder, the College has contributed to the development of the terms of reference and scope of the review. Dr. Peter Prendergast, Medical Advisor, will be the College staff liaison to the review with support from Legal, Investigations & Resolutions and the Executive Office. The review will be conducted by an external reviewer and the College will participate in the process and receive the full report upon completion.

Meetings with Ministry of Health and Long Term Care Officials

Regular meetings between senior management of the College and the Deputy Minister are critical to understanding MOHLTC directions and ensuring advancement of our objectives. In April, a meeting was held and the following were discussed:

- Possible regulation solutions to increase access to public members by using new sections of the RHPA that permit changes to the Discipline Committee composition;
- CPSO's position on the legislative oversight of Physician Assistants and the intent to develop and submit a regulation to further define 'patient' in the context of psychotherapeutic relationships;
- Progress on the proposed amendments to the Premises Inspection regulation (inclusion of fertility clinics) submitted by the CPSO in 2017.

Media

The CPSO is always of great interest to the media because of the nature of our work. We field inquiries from reporters on a daily basis and we are actively engaged in several social media platforms. The week of April 30 – May 4 was a particularly demanding period with the release of a three-part series on transparency and flow of information between Canadian and US regulatory bodies, the Peirovy appeals decision was released by the Ontario Court of Appeal, and the MOHLTC released two reports by Stephen Goudge about College investigations and

medical malpractice. Notwithstanding the extremely negative tone of the transparency series, the College fully cooperated with the reporters by providing answers to all of their questions over a 12 – 18 month period, and we agreed to a sit-down interview to ensure that our leadership in transparency to the public and our practices of regulatory information exchange were fully explained. We will continue to look for improvement opportunities internally and there have been several discussions with some Canadian medical regulators about a national approach.

Ontario Medical Association (OMA): Task Force on CPSO Investigations

The OMA has established a short term Task Force to focus on several key areas related to the College's investigation processes: stressors impacting physicians; methods to mitigate the stressors; and the identification of ways to improve the process including previous recommendations of the OMA and CMPA. The CEO of the OMA is committed to using the most current and accurate information about our processes and the CPSO will inform their work. The report produced by Stephen Goudge will be another source of information. The CPSO will consider any outcome that will support our mandate of public protection, fair and objective investigations, and compliance with our statutory obligations.

Employee Engagement in Workplace Values

Our management team has held full day quarterly meetings for the past year, to identify and enhance leadership skills, communication, and planning. One outcome has been the creation of value statements to guide our work on a day-to-day basis with each other, with staff, and between all staff. From February – April, almost all of our 400 staff participated in engaging activities to practically define what the following means to us in our daily work: trust, respect, communications & understanding, collaboration, accountability and excellence. Our focus is beyond words on paper, and the management team continues to provide leadership by framing actions and accountabilities to support a common set of values to guide how we do our important work.

Federation of Medical Regulatory Authorities of Canada (FMRAC)

The CPSO is very active in our federation to support a national voice in medical regulation. Some of the highlights from the past few months include:

- Most of the provincial regulators are experiencing similar attention to regulatory governance and health system oversight of regulators. In early May, some of the provincial Colleges discussed their unique jurisdictional pressures, and agreed to bring this issue to FMRAC for further discussion with the full group of Registrars.
- The CMA is revising its Code of Ethics. The Board of FMRAC (all the Registrars in Canada) expressed concern with the direction of the Code. The apparent move towards more non-specific language will not be helpful to regulators in defining physician expectations, and in some cases will conflict with regulatory expectations. The FMRAC President and CEO continue to consult with the CMA as the Code of Ethics has not yet been finalized.

- For the first time, , there will be a meeting with the Registrars and Presidents of all provincial and territorial Colleges of Physicians and Surgeons at the FMRAC Annual General Meeting. This half-day meeting will be attended by Dr. Stephen Bodley (President); Dr. Nancy Whitmore (Registrar & CEO) and Mr. Dan Faulkner (Deputy Registrar).

Change in Scope of Practice: Emergency Medicine in a Rural Environment

In March, the CPSO released its operational document entitled *Expectations of Physicians Not Certified in Emergency Medicine (EM) Intending to Include EM as Part of their Rural Practice*. This document was prepared to ensure a consistent approach by staff and the Quality Assurance Committee in applying expectations to physicians who wish to change their scope of practice. The final document was prepared following extensive consultation with rural groups and medical organizations. Its release initially led to lots of concern and in some cases, the distribution of misleading and incorrect information across social media channels. Contact was made with a number of groups including LHIN EM Committees, Rural Societies, and Health Force Ontario. I am pleased that many of the concerns have been addressed. CPSO staff continues to work with the College of Family Physicians of Canada and its Ontario Chapter to ensure a common understanding of how this document fits with new graduates of its postgraduate training program in Family Medicine.

Divisional/Program Updates

The following are brief updates about issues related to CPSO's operations:

- All of the College Divisions and Departments have submitted their 2017 annual reports to coincide with the year-end review of the audited financial statements. You have been provided with extensive information about service, timelines and outcomes from all areas of the College. I hope that you are as proud as I am of the tremendous work by all staff to support Council's goals and legislative mandate. These annual reports provide a great source of information for Council in considering strategic planning and key performance indicators later in the year.
- Our annual renewal process was initiated on April 16 for all practising physicians and on April 23 for all postgraduate renewals.
- Our Finance Department has acquired new software (BI360) that permits authorized individuals (eg. Directors, Managers, Supervisors) to have daily, self-serve access to ongoing expenditures which enhances regular, cross-College financial accountability.
- The Human Resources area has actively engaged in 52 staff recruitments since the beginning of the year. We continue to pursue solutions to ensure full capacity of staff in key risk areas, including the Investigations & Resolutions Division where case files continue to increase and the staff turnover rate is higher than we would like it to be.
- Legal continues to explore technology solutions with our IT area to ensure timely and full disclosure of case materials and internal document management.
- The Quality Management Division is preparing – through staffing and project management support - for rapid development and implementation of the Community

Health Facilities Program (created through Bill 160). This requires a delicate approach given the uncertainty of timing due to the provincial election and the unknown priorities of the next Government of Ontario.

- I want to acknowledge the incredible work of Ms. Julie Stabile, Manager, Records Management and Archives, who will retire from the College in June after more than 11 years of service. She has raised the quality of our policies and practices in paper and electronic document management with expertise and an inclusive approach. Thank you Julie!
- And finally, all staff is excited for the arrival of Dr. Nancy Whitmore as Registrar & CEO on June 4, 2018. Staff will have an opportunity to meet her informally throughout the building in her first weeks and a formal introduction will occur at a full staff meeting on June 7.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Corporate Services
Annual Divisional Report
2017

Corporate Services Division
Report to Council – 2017

Corporate Services Division includes the Following Departments:

A. Human Resources:

- HR strategic alignment, recruitment, annual performance, total rewards, legislative compliance, workforce planning, employee engagement and retention, benefits, training, development and orientation, health and wellness, HR online services and employee relations.

B. Records Management and Archives:

- Services include: development of policies and procedures which provide direction to staff on the effective management of records and provision of training in these best practices; organization of departmental shared drives to facilitate retrieval of information; creation of records retention schedules to improve accountability and record availability; management of all College contracts and agreements; file retrieval from on-site and off-site (including PC, MIF, Evidence records & Registration files), library reference and retrieval, and general assistance in locating information across the College.

C. Facilities & Building Operations:

- Maintenance Services
  - Facilities helpdesk is a central maintenance service that manages all building-related maintenance items such as temperature issues, plumbing, lighting, custodial duties, offices moves, meeting room arrangements, life safety testing and ergonomics installations.

- Meeting & Event Services
  - Services include: all aspects of on-site meetings for committees, council and other College-related business. This includes teleconferencing equipment/set-up, projection equipment, video conferencing, food and beverage service and all lunches.
  - Extensive planning for meetings and events that take place in the building. Many events now include external organization planning with which the College is connected to improve relations with external stakeholders.

- This department continues to fulfill event planning responsibilities both on and off-site for organizing external conferences. Many departments now work with the support and guidance from Meetings and Events Services.

- Security Services
  - Services include: reception screening; issuing security ID; communicate security procedures; coordinate parking requests for meetings and staff; answer inquiries from the membership regarding application processes; provide assistance in all emergencies whether medical, fire safety or building.

D. Finance and Business Services:

- Financial Services
  - Financial Services include: Budgeting, Investments, Accounts Payable, Accounts Receivable, Payroll, Financial Statements, Pensions, Audit, Financial Information and Purchasing.

- Business Services – Print Shop
  - Print Shop services include: photocopying, scanning and fax machines, point of contact for floor photocopiers and the delivery of paper.

- Document and Cash Management Services
  - Ensures cash management of negotiable instruments and PCI compliance of hard paper credit card remittances
  - Services include: the delivery and pick-up of mail and tracking courier packages and hand-delivered items that arrive at the front desk.
  - Scanning of I&R incoming mail for entry into the New CATS

A. HUMAN RESOURCES

To support College core business to protect the public by providing innovative, cost effective and value added HR programs and services that align to College goals and priorities.

Employee value proposition

CPSO employees do important work - they protect the public. To this end, our people are attracted and retained because they want to utilize their skills and experience to fulfill this important mandate. Human Resources contributes to the success of our people by providing effective policies and programs that create a healthy and supportive work environment where employees feel fully supported and engaged in the important work they do.

Head Count

	2013	2014	2015	2016	2017
Total including contract	**343.3**	**345.23**	**374.6**	**383.0**	**405.0**
% Change	**9.20%**	**0.50%**	**8.7%**	**2.1%**	**5.7%**

Employee Turnover

	2015		2016		2017	
Voluntary	16	4.4%	23	5.8%	14	3.4%
Involuntary	3	0.8%	9	2.3%	10	2.5%
Retirements	0	0.0%	7	1.8%	3	0.7%
TOTAL	**19**	**5.3%**	**39**	**9.8%**	**27**	**6.7%**

Average time to hire (days)

	2015	2016	2017
# positions recruited	53	58	64
Time to Fill	29.50	29.5	27.5

Average Number of Sick/Personal Days

	2015	2016		2017	
	Avg.	**Days**	**Avg.**	**Days**	**Avg.**
Personal	n/a	762	2.1	696	1.7
Sick	n/a	1302	3.5	1441	3.6

Total	**5.6**	**2064**	**5.6**	**2137**	**5.3**

Short Term Disability Claims

	2015	2016	2017
Number of new claims	23	17	25
Number of closed claims	19	5	24
All claims - days at full pay	644	429	762
Average days per claim	36.6	29.4	31.1

Performance Results

	2015	2016	2017
Unsatisfactory Developmental (2015)	1%	0%	.3%
Developing role/performance Low meets (2015)	4%	8%	3%
Good performance Meets (2015)	30%	70%	68%
Excellent performance High meets (2015)	42%	21%	24%
Outstanding performance Exceeds (2015)	23%	2%	4%

Training costs

2015	2016	2017
$494,639	$434,448	$600,676

B. RECORDS MANAGEMENT AND ARCHIVES (RMA)

RMA objectives and activities are directed by the CPSO's 4th strategic priority: "maintain ongoing operations and continuous quality improvement". Within this strategic priority, the specific mandate for the RMA department is to develop and implement a

comprehensive management program for all College records with the purpose of realizing the following objectives:

a. Support College accountability and efficiency,
b. Ensure that all legal and business requirements with regards to record keeping are met,
c. Mitigate legal risks by development of records management policies and best practices,
d. Provide staff with timely access to records within RMA custody, and to published information on relevant issues.

The components of this comprehensive records program and the program activities undertaken and completed by the RMA department in 2017 are as follows:

1. Develop and implement strong corporate records policies and practices for the management of College information:
    - Implemented new TAB Enterprise software to facilitate management of college contracts; software enabled the downloading of a PDF of each contract for easy access to relevant staff.
        - **Number of contracts/agreements managed and tracked: 1585**
    - Coordinated with RED in the implementation of the data inventory (first activity in the Data and Information Strategy).
        - **Conducted 80 meetings with staff and inventoried 103 datasets**
    - Conducted an audit of Council and Executive Committee records on the shared drive to ensure completeness and accuracy and added a scanned copy of all council and executive committee records back to 2005 for easy staff access.
    - Increased by 28% the number of schedules which have electronic record as the authoritative record, thus again rendering efficient access to these records,
    - Implemented the process for confirming that retired council and/or committee members and assessors have destroyed or deleted all CPSO information in their possession, thus ensuring confidentiality of CPSO information.
        - **Number of people contacted: 56**
    - Continued working on classification of departmental shared drives on the W drive in order to improve retrieval of information and to enable compliance with business, legal and retention requirements.
    - Implemented our annual process for destruction according to approved retention schedules of off-site paper records, of in-office paper files and electronic College files on shared drives as well as destruction according to signed data sharing agreements of electronic data received from, or shared with external sources.
        - **Number of boxes destroyed in compliance with our records retention schedules: 245 boxes**
        - **Number of records groups for which the eligible electronic documents were deleted: 87 record groups**

2. Facilitate access to, and retrieval of, information found in external journals, newspapers, databases and other external sources to support College activities and decision-making:
    - Populated and maintained the CPSO virtual library which at the end of 2017 provided staff access to **40 journals, 12 databases** and corporate subscriptions to the New York Times.
    - Answered **232 research and reference requests**.
    - Conducted **17 training sessions** on use of CPSO virtual library.
    - Published a bi-weekly newsletter on relevant publications and disseminated it to **100 stakeholders**.
    - Sent out table of Contents e-alerts for 45 key healthcare research and policy journals.

3. Provide staff timely access to all on-site and off-site records required to execute business functions and take measures to ensure that all files in RMA custody are accounted for:
    - Provided staff with registration files as required 3 times daily.
        - **Number of transactions in the first floor file room: 92,033.**
    - Provided staff with on-site investigative files and evidence files as required twice a week.
        - **The number of transactions for these files was 10,442**
    - Provided staff with off-site files as required at least once a week.
        - **The number of retrievals of off-site files: 1727.**
    - Conducted an audit of evidence records, both off site and on site, to ensure all were accounted for.

4. Conducted outreach activities to communicate records management awareness to internal and external stakeholders:
    - Developed an exhibit showcasing the members' participation in space travel
    - Organized and attended the annual Records Management Special Interest group at the FMRAC 2017 Annual General Meeting.
    - Participated in the annual FHRCO annual records management meeting.

C. FACILITIES

Mission Statement

To be a partner to our stakeholders and deliver professional services including planning, operations, maintenance, infrastructure and stewardship that support core business programs in a well-maintained physical environment.

Vision Statement

To inspire trust with our partners through dedication to solution-focused planning, commitment to positive change/innovation and consistency of service and support.

Strategies for Facilities & Building Operations:

Provide a Safe Physical Working Environment

- Security staff monitor all people entering the building throughout the day. All guests and staff are required to wear ID badges while on the premises and guests are escorted to and from meetings to ensure they leave by the appropriate exit.
- Security Services is engaged to support any threats against staff, guests, committee members and other professionals that work for the College.
- Increased security camera coverage at front entrance and in the garage levels. Storage capacity for CCTV footage increased to ensure we have a minimum of 1 month for reference.
- Environmental Management: Regular sampling of cooling tower and humidifier pans for legionella. This sampling takes place 3 times per year for the safety of staff and guests. As well, indoor air quality testing is conducted triennially.
- Meet requirements for Accessibility for Ontarians with Disabilities Act.
- Meet requirements for Occupational Health and Safety Act.

Mitigate Risk

- Continued to test emergency evacuation procedures and annual testing. Completed all annual life safety testing required by code.
- Developing Business Continuity plan in conjunction with other operational areas in Corporate Services and IT.

Key Performance Indicators

Maintenance

	2017
Work Orders	3718
Average Time to Complete Work Orders	1.95 days
Excluding emergency work and capital projects, the Maintenance area responded to over 3,718 work orders last year in various areas of building maintenance including, lighting, plumbing, mechanical, environmental controls, moves, custodial and equipment maintenance. This represents an increase of 3.5%. Conversely, the completion time has decreased by around 22%.	

Meeting and Events Services

-	2016 YR	2017 YR
Meetings in Conference Rooms	3,720	3,716
People Served in Conference Rooms	31,427	29,058
Notes: 2017 overall shows a stable comparison to 2016 for the number of meetings taking place. The meetings continue to take place on site but the roughly 7% decrease in people attending may indicate the increased use of telecommunications. About 80% of meetings require some sort of A/V equipment. Sustenance costs also indicated a similar decrease in line with these numbers.		

	2016 YR	2017 YR
People Requiring Assistance at Security Services	6,826	27,563
Notes: Though the data gathered shows an increase of more than double of assistance provided by security services staff in 2017, this is the first complete year that the data is all being measured in the same manner. In previous years, there was not compliance with the method of capturing the data.		

Planned Capital Projects

- Significant work was required to meet NFPA code for the sprinkler systems. As well, maintenance coordinated repairs to cracked piping in the basement levels serving the sanitary lines and handled water main repairs (5 year cycle).
- Installed additional heating for the front entrance and lobby. Consistently cold winter temperatures in the lobby entrance resulted in temperatures well below specifications that are recommended by the Canadian Centre for Occupational Health and Safety.
- Initiated project to replace front entrance interlocking stones. This project was heavily impacted due to the site condition of the deck – the concrete surface was not bonded properly from the original installation 35 years ago and required extensive repairs. As a result of the increased scope of work, delays prevailed due to weather conditions. It became necessary to shift the completion of the work to the spring to save costs of curing concrete over the winter period. Project will be completed in the spring 2018.
- There were several larger scale projects recommended by the building engineer that connect to the regular maintenance of an aging building. These were connected to life cycle replacement of equipment.

Keep property Clean and Well-Maintained

- Housekeeping and maintenance staff continued to sanitize "hand-touch points" throughout the building during the epidemic and flu season.
- Annual preventative maintenance for the building's humidification, air handling, heating and cooling systems.
- All public areas are clean and well maintained. Snow removal annually to handle exterior challenges in winter. Potential hazards are identified by building staff or health and safety committee members and dealt with quickly.
- Interior parking garage is swept regularly and cleaned twice per year.
- Exterior property is swept and reviewed on regularly (i.e. daily/weekly)

Find Ways to Reduce Our Carbon Footprint

- HVAC system and lighting adjusts based on occupancy load and reduces energy outside regular business hours.
- In conjunction with Toronto Hydro, maintenance initiated a cost recovery project to replace all fluorescent fixtures and other ceiling lights with LEDs throughout the building. The payback period is projected to be less than 7 months.

Accommodate Variety of On-Site Meetings

- There are a variety of meetings that take place on-site including: business meetings, interviews, committee meetings, council meetings, discipline hearings, FHRCO events and other external groups. As well, 2017 saw many educational/seminar style meetings that were able to be held on property.
- There continues to be a trend of technology requirements for on-site meetings. Most meetings require presentation capabilities, teleconference equipment and/or video conference technology.
- Meeting & Event Services has also established relationships with nearby institutions for off-site space when required.

Public & Physicians

- Continued to manage high profile hearings, which require additional staffing and security screening protocols.
- Continued cross-departmental training with departments that directly support the public and physicians to handle many inquiries immediately in the lobby.

D. Finance and Business Services

Finance Department

The underlying purpose of the Finance Department is to provide financial information that is needed by management to help them plan and monitor the activities of the College.

Business Services

The Business Services Area exists to support the College with coping, scanning and binding requests.

Finance

- Annual external audit was completed and it was a clean audit
- Budget for 2018 was approved by Council
- Implementation of new financial management reporting system – BI360
- Continued our core functions – Accounts Payable, Accounts Receivable, Payroll and Financial reporting
- Pension Administration
- Scanning of incoming mail and documents for I&R in support of the new CATS

Business Services

- Continued with our core functions – photocopying, scanning, binding and electronic generation of agendas and committee material

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

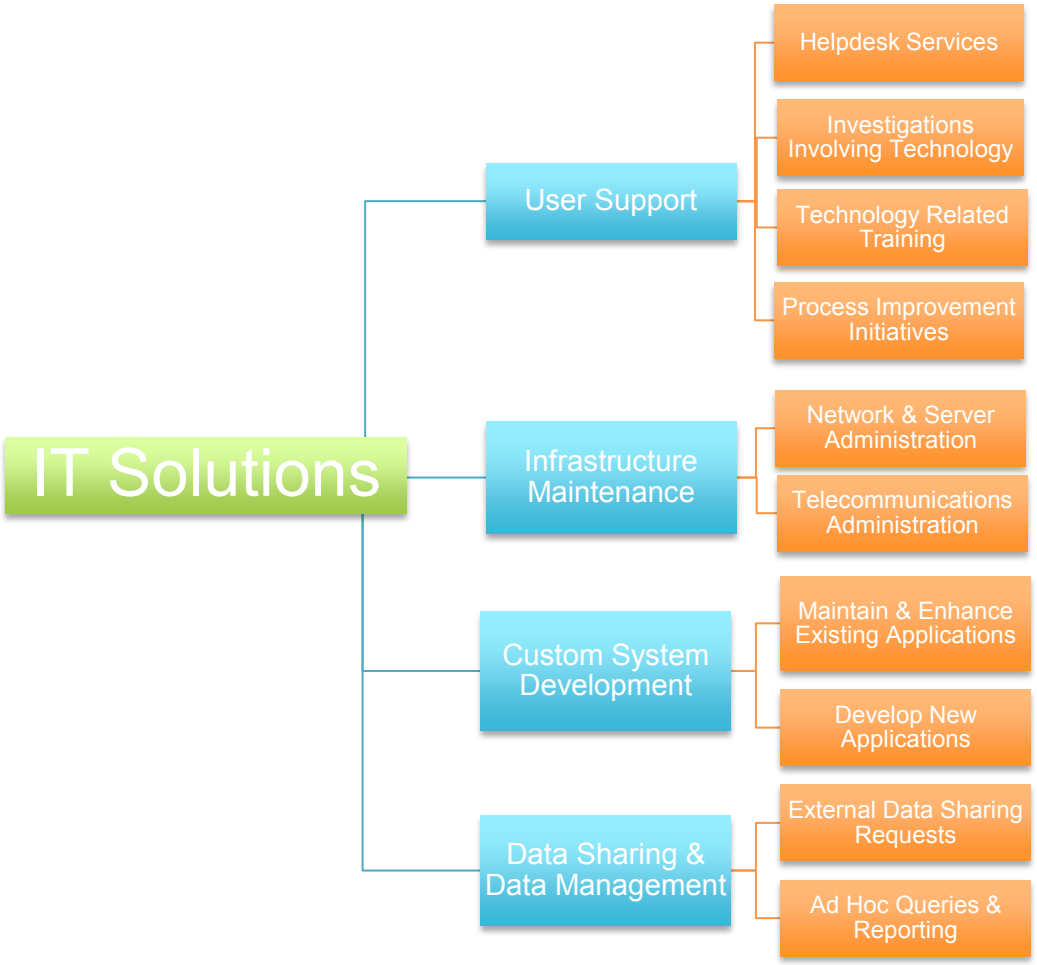
IT

Annual Divisional Report

2017

Information Technology Solutions
2017 Departmental Report

WHAT WE DO



The IT Team offers a wide range of services that establish, manage, secure and support the technology and communications infrastructure (networks, PCs, phones) and systems used to support the business of the College. More information on these services are as follows:

- **User support –** Through the Helpdesk we manage immediate technology and telecommunication issues, assist in the acquisition and installation of new software and equipment and manage system access rights. We also develop and provide training and information related to technology and its use to support business processes.

- **Custom system development and Process Improvement–** We create new custom systems, maintain and enhance existing systems and partner with external consultants to deliver technology tools designed to support and improve business processes. Larger development projects are prioritized based on direction of the IT Steering Committee.
- **Data Sharing and Data Management** – We co-ordinate the Data Sharing Request and Approval process for all external requests for data and respond to internal requests for queries and reports relating to the data captured in our College systems.
- **Infrastructure Management** – We implement and maintain the CPSO technology infrastructure that provides various services: email, secure file transfer, file access and storage, backup, phone and telecommunication, Internet, IT Security, Wi-Fi, remote and network access, copying, and scanning. We make sure that our infrastructure is secure and performing as expected by installing regular software and security updates and monitoring for issues.

OUR STRATEGY

Our strategy for 2017 was based on four key assumptions:

1. Technology will evolve – we need to keep up to date and consistently re-invest so that we do not fall behind
2. We standardize on a Microsoft platform – not because it is the best, but because it is supportable and mainstream – we will always be able to find resources that are familiar with it
3. Our project priorities are set by the IT Steering Committee – based on the overall strategic and operational priorities of the organization
4. Where necessary, and in areas where we are lacking expertise, we will bring in experts to work with us.

We support the College's strategic and operating plan by:

- Improving and maintaining infrastructure
- Standardizing equipment and software where possible
- Ensuring that appropriate security and data protection is in place
- Developing, enhancing, and supporting enterprise or program-specific systems

Our process for prioritizing new projects involves input from College functional areas.

The IT Steering Committee meets monthly to ensure that:

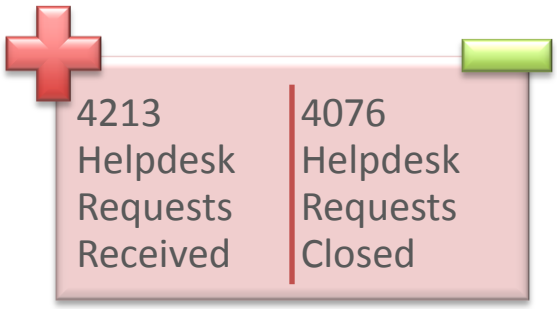
- IT strategy is aligned with the strategic and business goals of the College
- There is full participation by functional areas of the College in decisions about major IT projects and their potential impact on operational processes
- IT project decisions are regularly reviewed, monitored, prioritized and approved

SUPPORT

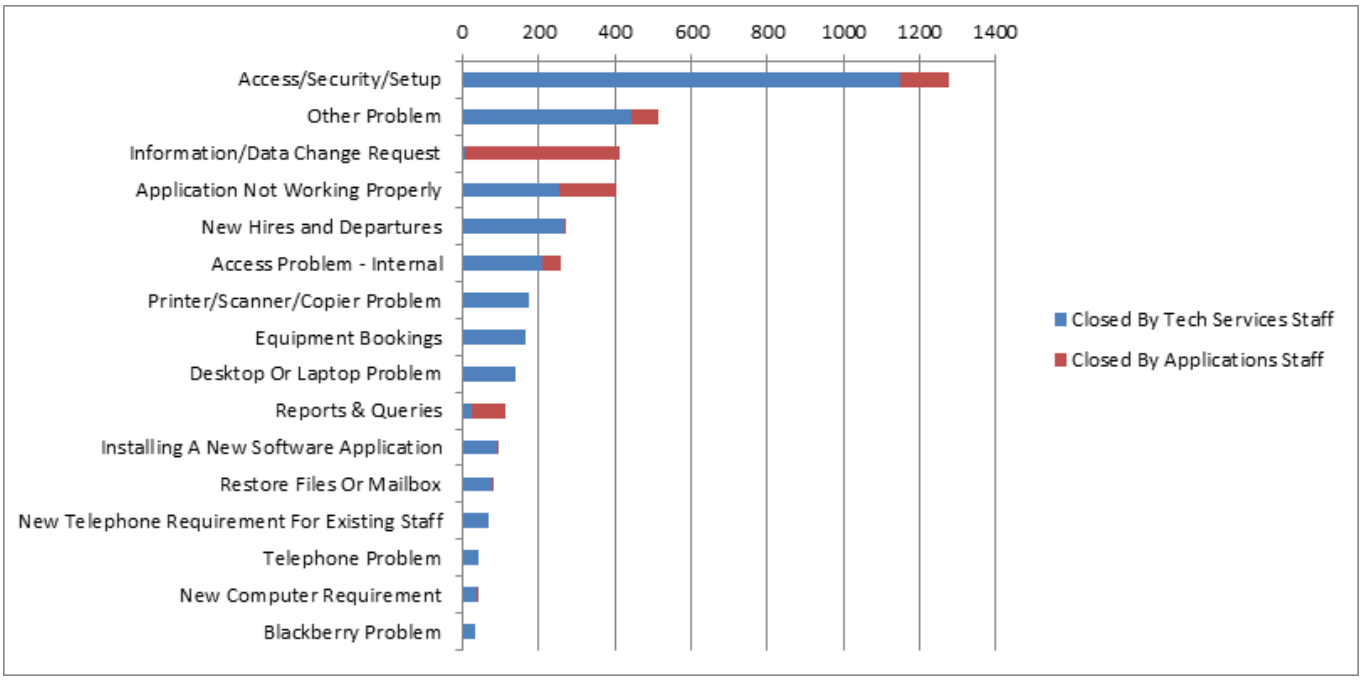
We offer a variety of support services. Helpdesk, the "first line" of support, is the most widely used. Requests for problem resolution or services are submitted online, by phone or email. We also provide support to users of technology tools in various ways; by developing and providing customized in-house training and guides for processes and applications. We also provide assistance in process improvement techniques, along with support for investigations using electronic records.

Helpdesk

Helpdesk is committed to ensuring that its stakeholders, both internal and external to the College, are provided with efficient and effective support.



In 2017, we had a total of ***4213 Helpdesk requests*** of which ***4076 were closed***—a 97% closure rate, which was consistent with 2016. Over the year, the team managed a workload that closed an average of 320 tickets every month. The quantity and types of requests are described below:

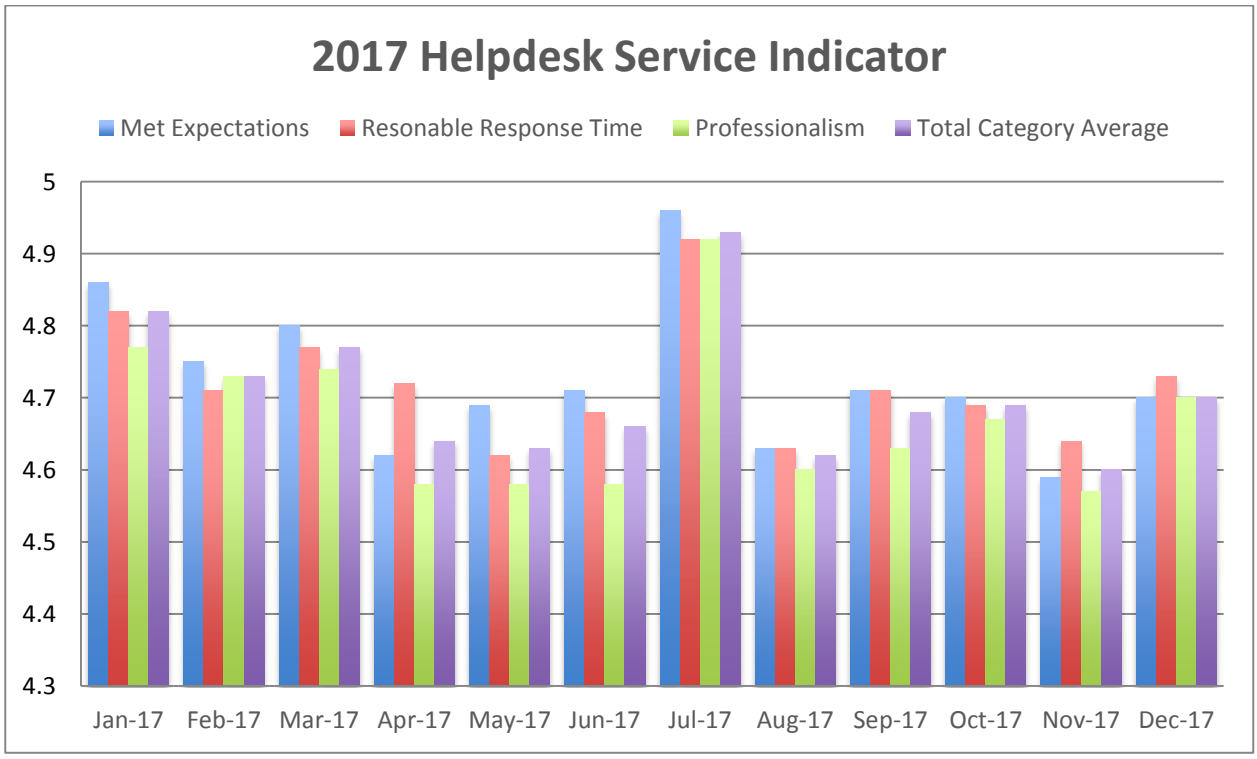


Customer Service

Good customer service is extremely important – we measure our success through an indicator calculated based on responses to a survey presented upon resolution of a Helpdesk request. The survey asks respondents to rank (on a 5 point scale where 5 is most positive) their experience relating to three aspects of service:

1. *Meeting Expectations* -"The request resolution met my expectations"
2. *Appropriate Response Time* -*"*My request completed in a timely manner"
3. *Professionalism* -"I was kept up to date on what was happening"

Below are the results of our 2017 Helpdesk Survey:



Overall, for 2017 we had high scores in all of the components of our Customer Service Indicator; scoring an aggregate expectations average of 4.7, a response time average of 4.7, and a professionalism average of 4.7. Our goal for 2018 is to increase our ratings to 4.8 in an effort for continuous improvement to be aligned with our strategic priorities for 2018.

Interesting Security Facts:

Our Web Filtering appliance blocked over 530,800 malicious Web addresses in 2017

Our Email Gateway allowed over 1,617,700 external emails to be delivered to and from CPSO in 2017 while blocking more than 86,700 that were deemed spam and malicious and blocking more than 110 that contained viruses

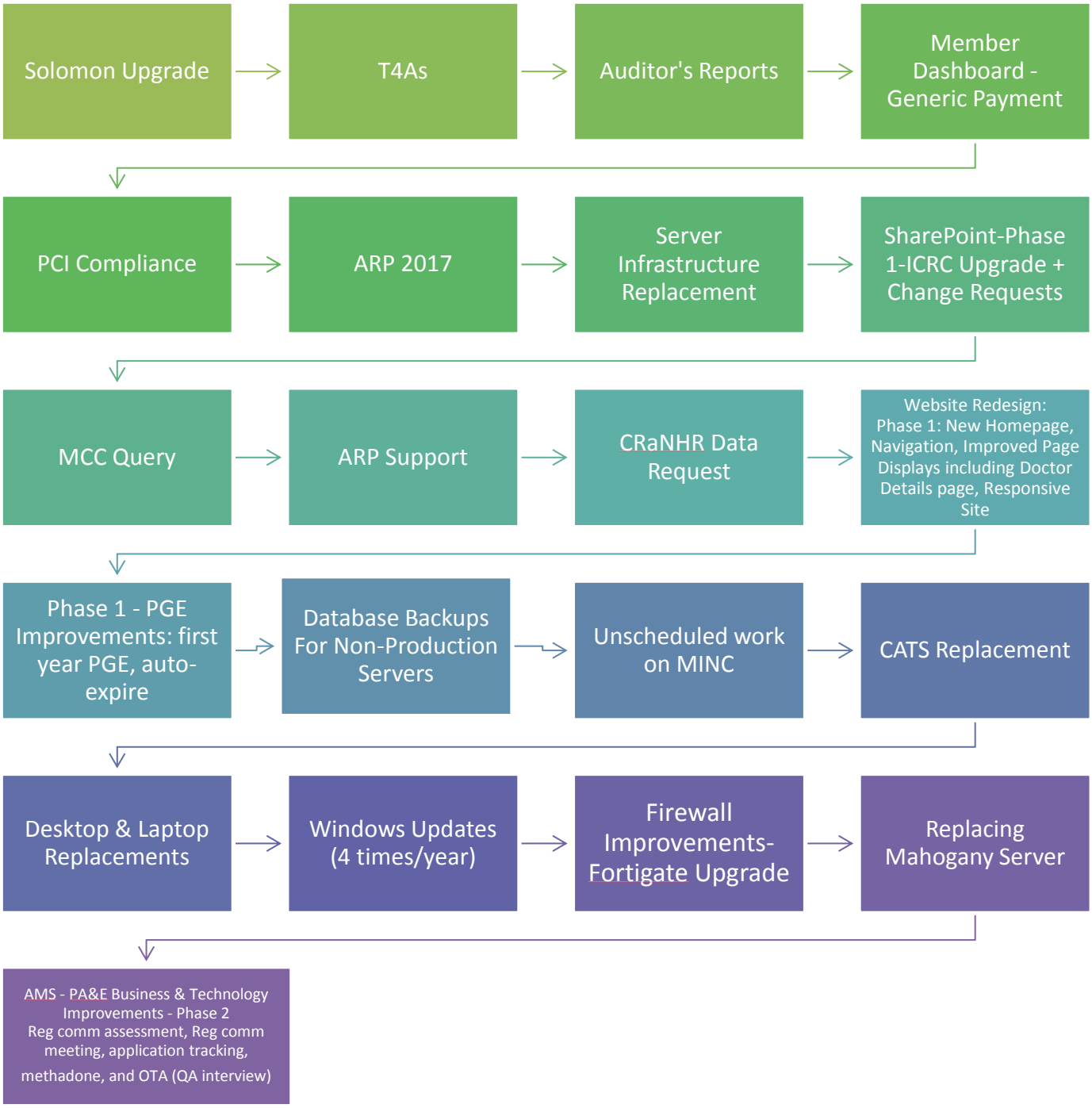
Our Anti-Virus software has detected, blocked and removed over 340 viruses on our PCs in 2017

Hardware Support - By the Numbers:

APPLICATION DEVELOPMENT- IT PROJECTS

Our Applications Development group builds and maintains custom software applications. We often work with external partners who bring specific technical expertise to our project teams. The projects we work on are prioritized by the IT Steering Committee, ensuring that our efforts are aligned to the strategic and operational needs of the College. Much of the work that we do stems from, and is in support of, process Improvement initiatives.

Below is a listing of the projects we successfully completed in 2017…



DATA SHARING & DATA MANAGEMENT

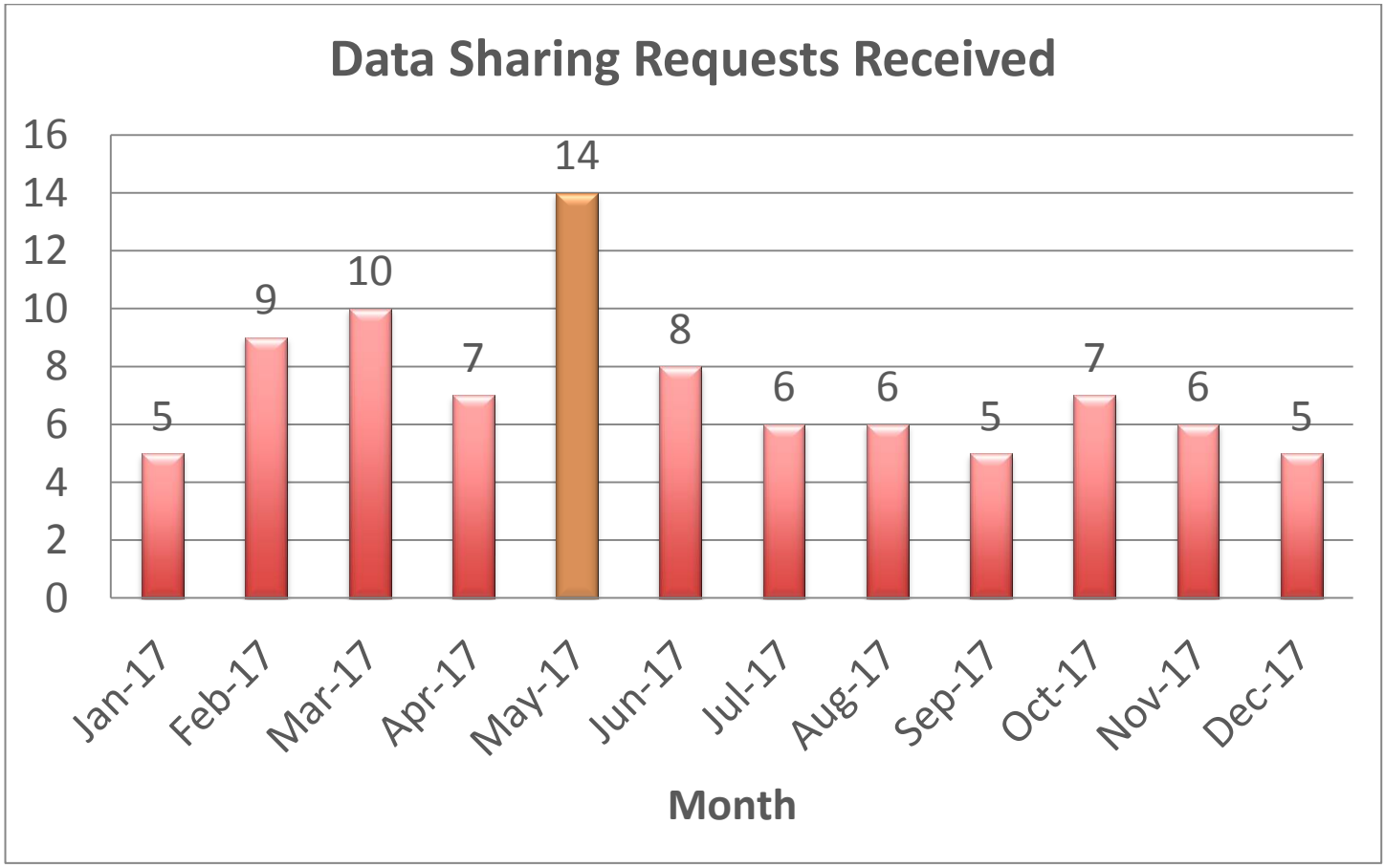
In addition to supporting internal requests for information, we accept requests from external groups, wanting to use our data for a variety of purposes. Data is available on a "one-time" basis, annually or quarterly for a fee that covers our costs. Once a request is submitted, it is assessed by the Data Sharing Working Group (DSWG) – an internal committee. Requests are reviewed using a decision framework that incorporates a risk and resource impact assessment and also considers whether the use of the data relates to the Objects of the College. IT manages the relationship with the requestor, facilitating the request process through the working group, communicating with the stakeholders of this process, and ultimately fulfilling approved requests.

External Data Sharing Requests:

In 2017, we received a total of 88 new requests. From these requests 43 were approved in alignment with College objects, 34 were denied, and 10 requests were withdrawn.

In addition to new requests received in 2017, we also extract data from ongoing quarterly or annual requests from previous years. As a result, in 2017 we sent a total 75 data extracts to external requestors.

The majority of our approved requests for data sharing in 2017 came from hospitals. Approved requests were primary related to research and health human resource planning.



LOOKING FORWARD….

Our upcoming project work for 2018 includes a wide variety of project types, below are the key areas which determine the types of projects where we focus our time and effort:

Enabling The Corporate Plan

- ***These initiatives are supportive of Strategic, Regulatory, Risk, and Operations categories of the Corporate plan and are foundational to organizational change.***

Technology & Workplace Evolution

- ***These initiatives keep up with the evolution of technology, allowing us to provide services and solutions in a reliable, secure, and supportable technical environment.***
- ***They relate to the Operations categories in the Corporate Plan.***
- ***They also support the evolution of the way we work, and our assumption that the strategic use of technology and technical tools can improve process and mitigate risk.***
- ***They primarily support the Operations categories in the Corporate Plan.***

Enhancing Quality & Improving Stakeholder Satisfaction

- ***These initiatives contribute to improved IT Department and College-wide processes and move us towards our goal of "partnership" with our stakeholders.***

A preview of 2018 projects that enable our corporate plan…

- Annual Renewal Processes
- Assessment Process Improvement
- Enhancements To Improve Investigations & Legal Process
- Case Administration Tracking Post Production Support
- Community Health Facilities
- Data and Info Management Strategy (Opioid Data, Data Inventory & Governance)
- eHealth Provider Registry

- ***Member Portal Improvement:***
- A) eHealth ONEID
- B) MemberPortal Usability Redesign
- C) Physician Profile Review

- ***Modernization of Registration Process:***
- A) New Member Orientation
- B) Application for Medical Registration Integration
- C) Vision for Registration of the Future

- ***Operational Efficiency and Financial Integrity:***
- A) Accounts Receivable Process Review

- Practice Assessment & Enhancement Reporting
- Public Site Usability Review
- Website Accessibility Audit

A preview of 2018 projects that foster technology & workplace evolution…

Collaboration Tools:

- A) SharePoint For Committees & Internal Sites
- B) Project Management Software
- Core Switch Replacement
- Desktop & Laptop Replacements
- Windows 10 and Office Suite Upgrade
- Development of Cloud Adoption Criteria and Implementation
- Disaster Recovery (Business Continuity) Improvements
- Mobile Device Management and Device Strategy
- Register Database Server Upgrades
- Replacement For Admin File Tracking
- Records Management Nightly History Download
- Security Improvements (Windows Upgrades)
- Wifi Replacement

A preview of 2018 projects that enhance quality & stakeholder satisfaction

- Activity Management System Simplification Program
- Helpdesk Service/Application Maintenance & Enhancement Request Process Improvement
- IT Online Improvements (redesign and repurpose site)
- Enhance project-related processes
- Security & Risk Review
- Data Sharing Process Improvements

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Investigations, ICR Committee Support, Hearings Office, Compliance Monitoring and Supervision Division

Annual Divisional Report 2017

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Mandate

- Support the College's efforts to enhance quality of medical care and ensure patient safety.
- Conduct comprehensive and timely investigations and hearings.
- Monitor compliance with Orders, Undertakings, and Specified Education and Remediation plans.
- Compile and analyze aggregate case data about care, conduct, capacity, and system delivery issues.
- Provide information to the profession to assist in minimizing complaints.

Structure

- An Investigations department:
  - An Intake/Triage area that assesses all member-specific information, streams cases, and directs specific investigative action. The area also follows up on positive responses to the questions on the annual renewal, which include jurisdictional issues, civil litigation issues, criminal charges, and members' status regarding blood-borne pathogens if they perform exposure-prone procedures.
  - Four specialized investigation teams that carry out investigations on behalf of the Inquiries, Complaints and Reports Committee (ICRC).
- A Committee Support unit that continues to coordinate all aspects of ICR Committee meetings and supports the Committee in its case review and quality assurance activities.
- A Hearings Office that supports the two adjudication committees: Discipline and Fitness to Practise. The Office also prepares notices of suspension, revocation and restrictions.
- A central Compliance Monitoring and Supervision department that ensures members fulfill agreements, undertakings, Orders and remediation programs required by the College ICR, Discipline, Fitness to Practise, Quality Assurance, and Registration Committees.
- A Statistics unit that codes and conducts analyses of operational processes and closed investigative files to identify and assess factors that were influential in investigation outcomes. The analysis of these data helps to identify trends in physician practices and guides policy initiatives.

Objectives

The Division's work supports Council's Strategic Priorities by optimizing the fairness, effectiveness and efficiency of the Investigations, Discipline and Monitoring processes.

The Division's objectives are to reduce risk, support physicians to enhance their knowledge and skills, and improve health care. Its goals are to ensure fairness and eliminate unreasonable delay in its processes and to release clear and complete decisions.

In 2017, the Division focused on:

- developing training program content for practice monitors/physician supervisors and launch
- creating protocols for Interim Orders
- revising risk and case weighting levels for assessing and streaming investigations
- analyzing individual investigative actions against time
- restructuring Intake/Triage
- implementing a new case management system for investigations and committee support
- reducing time to release committee decisions
- recruiting to fill vacancies for investigators (20%) and compliance case managers (50%).

Investigations and Committee Support – ICR Committee

The ICR Committee oversees all investigations into and makes decisions about physician care, conduct, and capacity. The Committee conducts Public Complaint Investigations, broader practice (Registrar's) Investigations, and inquiries into a member's capacity.

Registrar's Investigations and Incapacity Investigations remain small in number proportionate to public complaints. They are, however, often more intricate than most patient-related complaints, which require looking at the individual patient record and relevant information related to the patient's (complainant's) concerns. Registrar's Investigations include review of up to 25 patient charts by an external assessor, interviews, and often observation. Incapacity Investigations include various types of external health assessments, interviews, and review of records. Both types are often more complex investigations that can result in more serious outcomes.

Nature of Issues

Summary of Investigations - 2016

In 2017, the ICR Committee analyzed investigations completed in 2016 to identify the nature of the issues based on panels' review and decisions.

In total 2,767 investigations met this criterion, involving 2,339 physicians. Thirteen percent of physicians accounted for 26% of all investigations.

- Physicians with 1 completed investigation accounted for 87% of investigations.
- Physicians with 2 -9 completed investigations accounted for 13%.

The ICR Committee took some form of action in 40.2 % of all investigations.

Clinical and Professionalism Issues

Tables 1 and 2 describe the clinical and professionalism issues identified in the investigation. The number and percentage of investigations and the ICR Committee outcome pertaining to each issue are shown. Percentages sum to greater than 100 as one investigation may contain more than one issue.

Seventy-seven percent of investigations addressed clinical aspects of care. Common clinical concerns were:

- incomplete history taking and/or examination of the patient (17.4%)
- inadequate investigation of the presenting concerns, including improper diagnostic testing (12.4%)
  - often resulting in additional concerns; misdiagnosis (7.6%); delayed or lack of a referral to a specialist (10.1%); lack of appropriate treatment (13.5%)
- procedural mishaps, which occurred predominantly during surgical procedures (8.6%)
- prescription of non-monitored drugs (14.9%)
- inadequate medical records (18.2%).

Forty-seven percent of investigations addressed the physician's conduct or behavior. Common professionalism concerns were:

- unprofessional communication involving patients, colleagues or other health professionals (53.5%)
- breach of patient confidentiality (5.3%)
- inappropriate termination of the physician-patient relationship (4.9%)
- boundary violations and/or sexual impropriety (6.9%).

Physician Demographics

Table 3 provides physician demographics.

- 71% of the doctors investigated were male
- 52% were general practice/family medicine
- 12% were surgeons
- 11% were internists
- 27% of investigations involved physicians age 40-49; 26% involved physicians age 50-59
- 37% of the incidents took place in a hospital; 31% in a family practice based setting; 15% in a specialist's office-based practice.

Physicians with the specialty of family medicine/general practice or psychiatry were significantly over-represented amongst physicians investigated in 2016 ($p<0.05$). Conversely, internists, anesthesiologists, and pediatricians were significantly under-represented when compared to all practising physicians.

Younger practitioners, between the ages of 20 and 29 years, were significantly over-represented when compared to all practising physicians ($p<0.01$).

Please refer to tables 1-3 below.

Table 1 Clinical issues identified in 2,767 investigations

Clinical issues	Issues (N)	Issues %	Issues that the ICRC took action (N)	Percentage of time the ICRC took action (%)
Communication - Patients				
Not explained	105	3.8	47	44.8
Not listened to	242	8.8	64	26.4
Side effects/Complications	161	5.8	85	52.8
Diagnosis	44	1.6	14	31.8
Other	51	1.8	9	17.6
Communication - HCP	131	4.7	66	50.4
Documentation	502	18.2	374	74.5
Consent	229	8.3	90	39.3
History/Examination				
Lack of privacy and/or chaperone	30	1.1	14	46.7
Not done/Incomplete	479	17.4	224	46.8
Delay	26	0.9	13	50.0
Technique - painful	45	1.6	12	26.7
Third party reports	176	6.4	57	32.4
Investigation				
Not done/Incomplete	104	3.8	47	45.2
Delay	15	0.5	6	40.0
Referrals - not done/inappropriate	279	10.1	114	40.9
Diagnostic testing				
Not done	211	7.6	102	48.3
Wrong test	28	1.0	15	53.6
Diagnosis				
Failed to diagnose	121	4.4	39	32.2
Misdiagnosis	210	7.6	92	43.8
Delayed	47	1.7	30	63.8
Treatment				
Lack of/incomplete treatment	373	13.5	111	29.8
Delayed	75	2.7	39	52.0
Mishap/adverse event	238	8.6	94	39.5
Discharge - Premature	88	3.2	37	42.0
Transfer of Care	27	1.0	14	51.9
Prescribing - Monitored drugs	303	11.0	131	43.2
Prescribing - Other drugs	411	14.9	155	37.7

Follow-up and Monitoring				
Follow-up appt	75	2.7	39	52.0
Observation following procedure	86	3.1	38	44.2
Test Results Mgmt				
Communicate with HCP	14	0.5	12	85.7
Communicate with Patient	116	4.2	66	56.9
Interpretation of the results	85	3.1	44	51.8
Inappropriate response	73	2.6	43	58.9

Table 3 Professionalism and other issues identified in 2,767 investigations

Issue identified	**Issues (N)**	**Issues (%)**	**Issues that the ICRC took action (N)**	**Percentage of time the ICRC took action (%)**
Communication - Unprofessional				
Inappropriate - patients	426	15.4	129	30.3
Inappropriate - colleagues	37	1.3	19	51.4
Rude - patients	282	10.2	96	34.0
Rude - colleagues	15	0.5	8	53.3
Breach of Confidentiality	146	5.3	70	47.9
Breach of Undertaking/Discipline Order	31	1.1	28	90.3
Conflict of interest	115	4.2	40	34.8
Falsify medical records	67	2.4	27	40.3
Billing issues - Block and service fees	121	4.4	51	42.1
Billing issues - OHIP	27	1.0	18	66.7
Ungovernability	45	1.6	39	86.7
Termination of patient	136	4.9	58	42.6
Accepting new patients	34	1.2	15	44.1
Scope of practice	25	0.9	13	52.0
Boundary violation and/or sexual abuse	191	6.9	146	76.4
Other issues				
Capacity concerns	64	2.3	53	82.8
Infection control	117	4.2	78	66.7

Table 3. Physicians named in 2,767 investigations

Characteristic	N	% of Sample	Number of Practicing Physicians+	Percentage of Practicing Physicians
Male*	1965	71.0	17,407	60.4
Female**	802	29.0	11,398	39.6
Specialty				
Family/General Medicine*	1438	52.0	13,441	46.7
Psychiatry*	260	9.4	2,136	7.4
Internal Medicine**	302	10.9	4,137	14.4
Surgery (all subspecialties)	325	11.7	3,566	12.4
Obstetrics and Gynecology	139	5.0	1,002	3.5
Anesthesiology**	53	1.9	1,282	4.5
Ophthalmology	52	1.9	448	1.6
Pediatrics**	43	1.6	1,448	5.0
Radiology**	39	1.4	1,002	3.5
Other	116	4.2	343	1.2
Age				
20-29 years*	70	2.5	398	1.4
30-39 years	518	18.7	5,972	20.7
40-49 years	734	26.5	7,775	27.0
50-59 years	716	25.9	7,257	25.2
60-69 years	557	20.1	5,550	19.3
70+ years	172	6.2	1,853	6.4
Practice Location				
Family practice - office based	866	31.3		
Hospital	1045	37.8		
Specialist, office-based	415	15.0		
Walk-in clinic	164	5.9		
Clinic-OHP/IHF	140	5.1		
Other	137	5.0		
Medical School Graduation				
Canada**	1832	66.2	20,624	71.6
Other*	935	33.8	8,181	28.4

++Number of practising physicians was obtained from Physicians in Ontario 2015 report created by The Ontario Physician Human Resources Data Centre

*p<0.05 over-represented in the study sample when compared to all practising physicians

**p<0.05 under-represented in the study sample when compared to practising physicians

2017 Investigation Issues

Prescribing Investigations

Eighty-four physicians were investigated as a result of information received from the Narcotics Monitoring System. The majority of these were disposed of in 2017.

These investigations were managed consistent with the College's Opioid Strategy, which aims to facilitate safe and appropriate opioid prescribing while avoiding abrupt cessation of prescribing, thus reducing risk to both patients and the public. During the investigations, physicians were encouraged to proactively seek education and remediation and were provided with resources to assist with this.

A designated ICR panel reviewed all investigations and any proposed education plans.

Marijuana Investigations

Investigations began to receive concerns of overprescribing of marijuana and/or related billing issues and anticipates these concerns will continue.

Infection Control Investigations

Investigations continue to receive complaints and reports about improper infection control practices from various sources. Some investigations exposed high-risk issues affecting patient safety.

Over-Utilization Investigations

Investigations saw an increase in the number of reports concerning "over-utilization" of various interventions/investigations that are costly to the system and may be of questionable benefit to patients, e.g. frequency of cardiac ultrasounds, X-ray studies, urine drug screens and paravertebral nerve blocks. These investigations require close scrutiny of OHIP data and patient charts. Such investigations are challenging given varying community opinions.

Illegal Practitioner Investigations

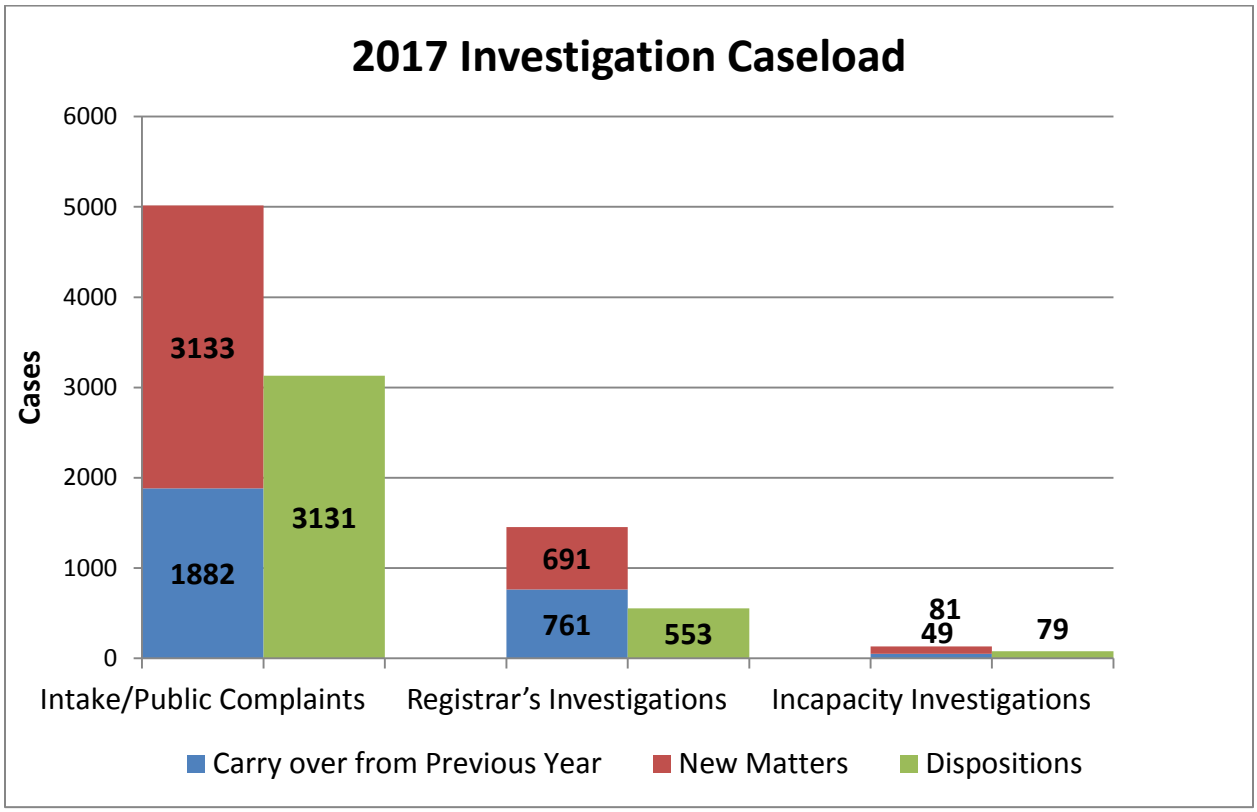
In 2017, investigations of illegal practitioners involving controlled acts have been more fulsome. Cease-and-desist letters are sent to unlicensed practitioners improperly using the title "Dr." with follow-up.

Interim Orders

The amendments to the *Regulated Health Professions Act* in May 2017 expanded the ICR Committee's powers to impose Interim Orders earlier than at the time of referral where the ICR Committee identifies a risk of harm to patients by directing the Registrar to suspend, or to impose terms, conditions or limitations on, a physician's certificate.

Investigations must assess cases to determine if the s.25.4 threshold might be met. If met, the investigations must be expedited, in particular when the ICR Committee gives notice to issue an Interim Order. Since the amendments in 2017, 19 Interim Orders were issued, and it is anticipated this number will rise in 2018.

2017 – Investigations Caseload

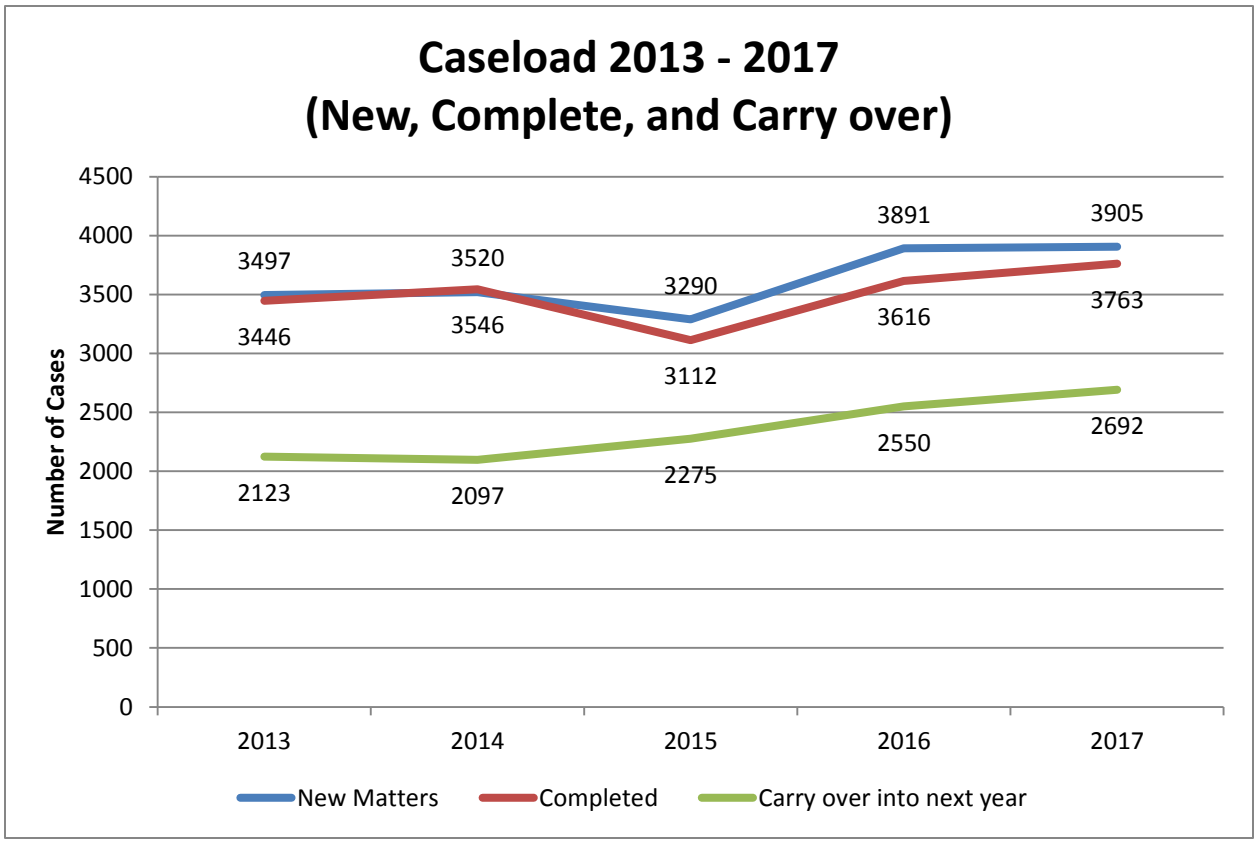


Carry over from previous year as of December 31st, 2017

- New Public Complaint Investigations remained constant (2,682). Sixty-two percent of Public Complaint Investigations (new and carryover from 2016) were disposed.
- New Registrar's Investigations increased by 20% (691). Thirty-eight percent of Registrar's Investigations (new and carryover from 2016) were disposed.
- New Incapacity Investigations remained at similar levels to those seen in 2016 (81). Sixty-one percent of Incapacity Investigations (new and carryover from 2016) were disposed.

2013 – 2017 Trends

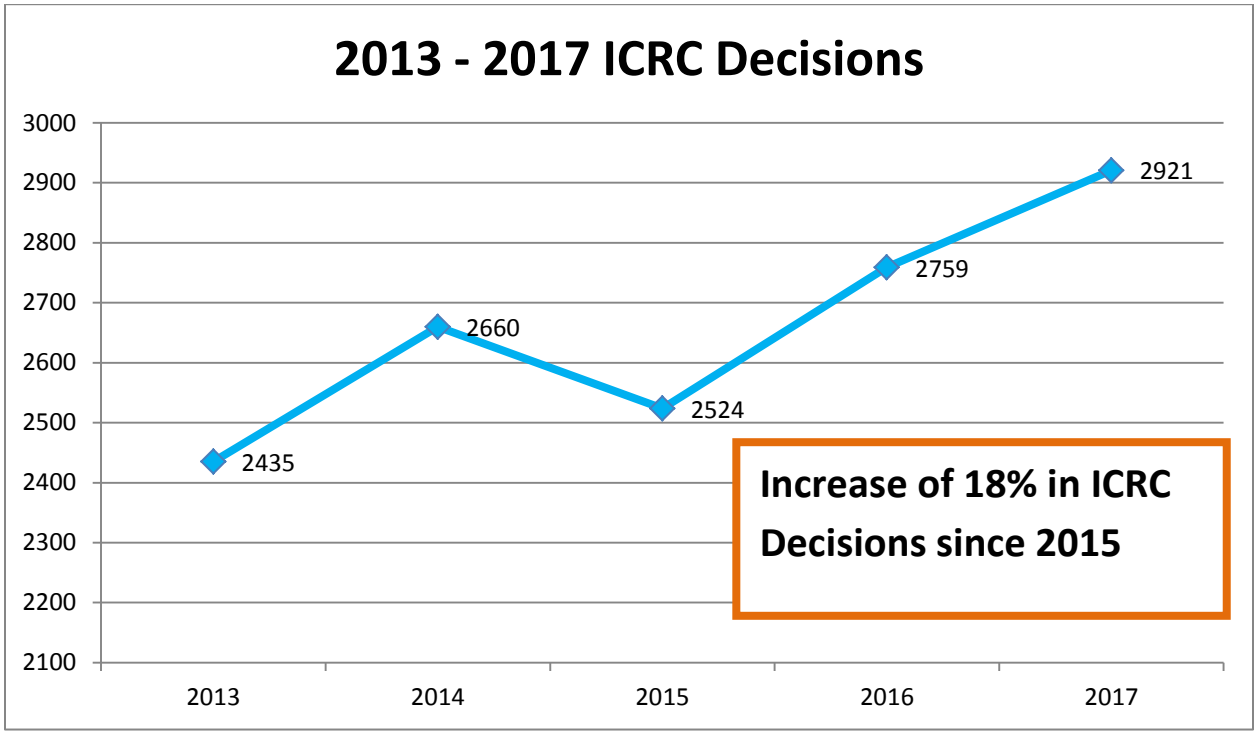
Investigations Caseload



As of December 31st, 2017

- Since 2015, new matters increased by 19% and completed investigations increased by 21%. However, in each of the last three calendar years more matters were opened than completed; therefore, the carryover has continued to increase each year since 2015. Reasons for carryover include:
  - ICR Committee practice review of concurrent investigations about a physician at single panel meeting can extend open caseloads. As of December 31st, 2017, 35% of open investigations involved a physician with more than one active investigation
  - ICR Committee deferrals for legal input, further investigation, additional responses from members and clarification from assessors
  - increased complexity of investigative issues
  - turnover in investigator resources
  - focused attention on expediting investigations where notice of Interim Order has been issued

2013 -2017 ICR Committee Decisions



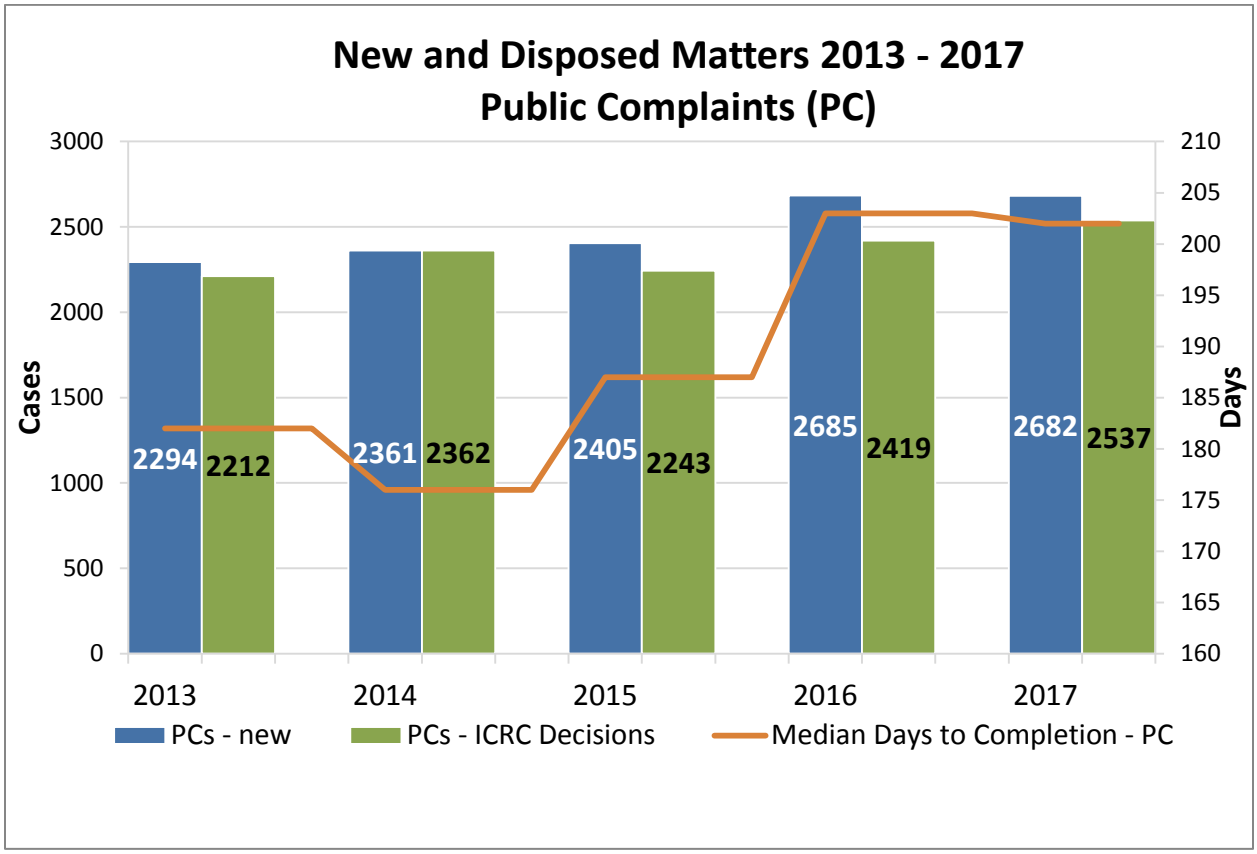
As of December 31st, 2017

- ICR Committee has reviewed a growing number of matters each year.
- To manage the growing workload, ICR Committee has increased the number of panels.

	2013	2014	2015	2016	2017
Number of Panels	189	191	200	222	261
Matters Reviewed	3652	4206	3809	4298	4490

2013-2017 Caseload

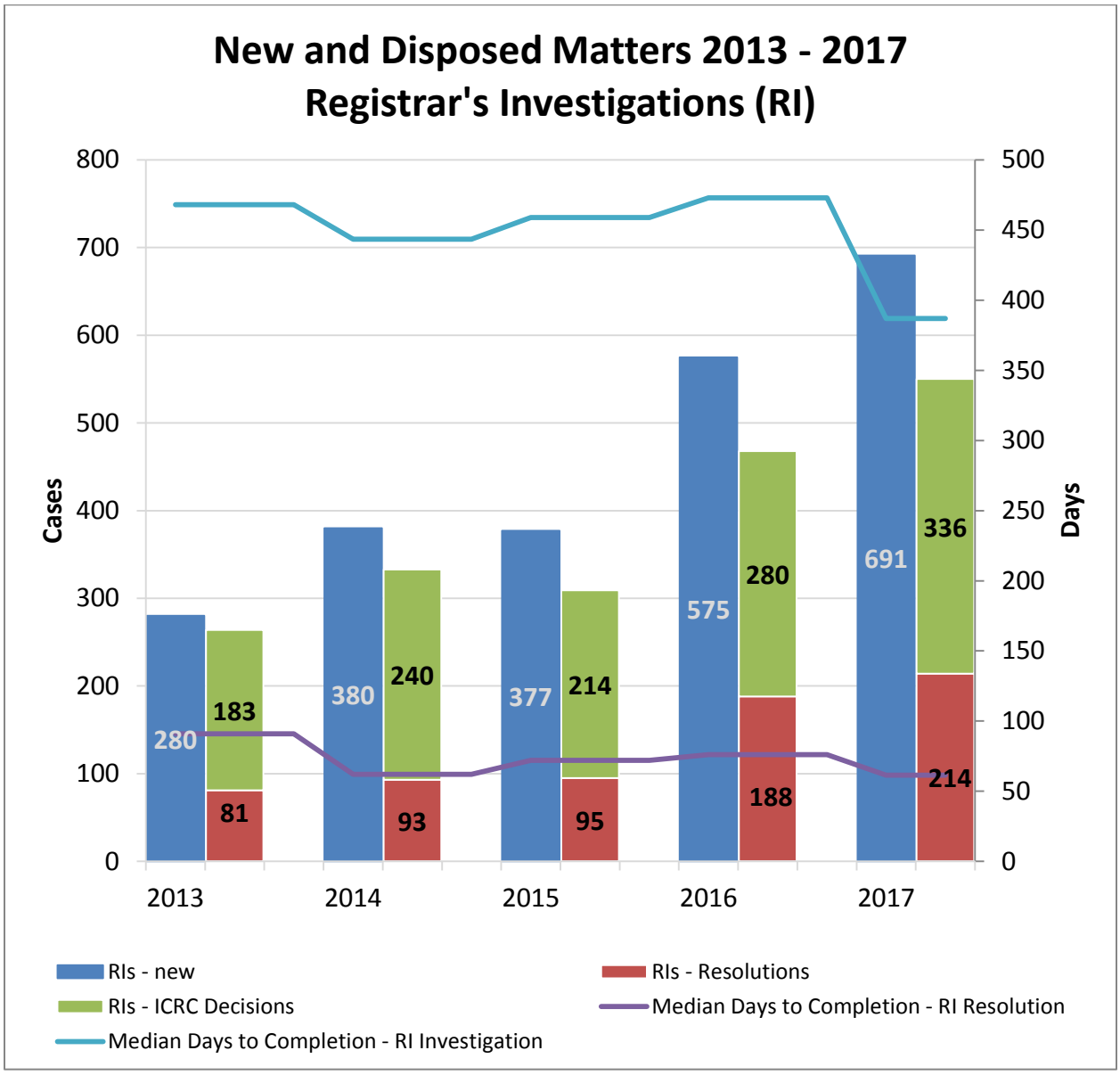
Public Complaints



As of December 31st, 2017

- Public Complaints increased by 12% since 2015.
- ICR Committee Decisions increased by 13% since 2015.
- Number of median days to decision has risen by 9% since 2015. There was no difference between 2016 and 2017.

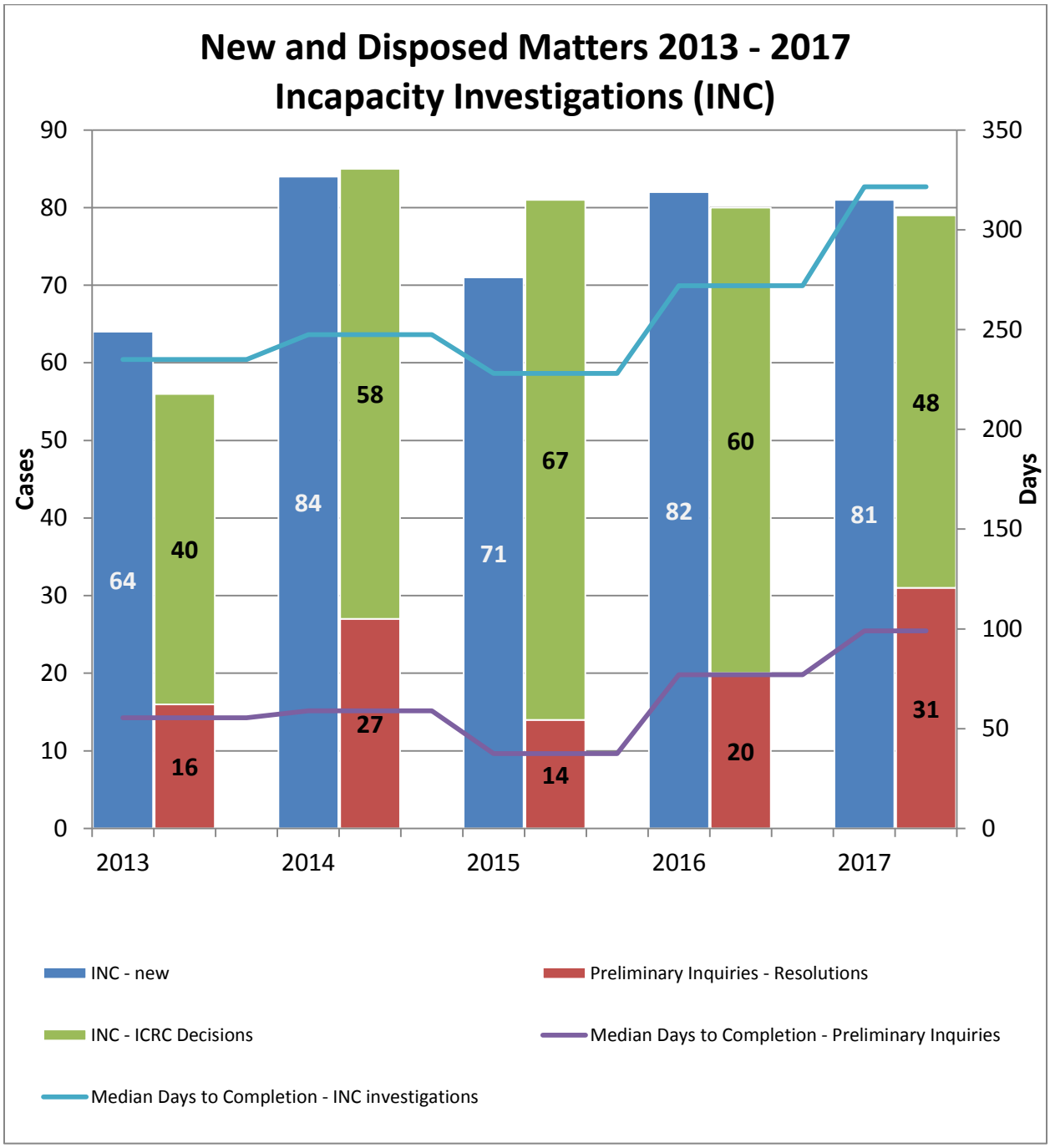
Registrar's Investigations



As of December 31st, 2017

- Number of RIs has increased by 83% since 2015.
- RI resolutions (preliminary Registrar's investigations) have increased by 125%.
- Median days to complete RI Investigations –ICRC Decisions has declined by 16% since 2015 and by 18% in 2017 over 2016.

Incapacity Investigations



As of December 31st, 2017

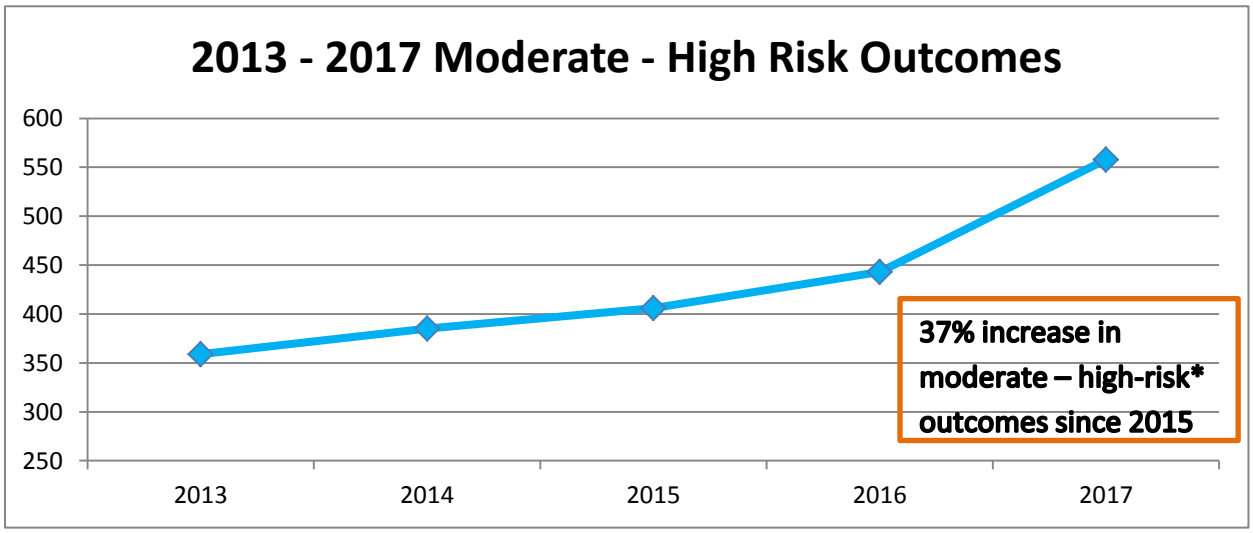
- Number of Incapacity Investigations has remained relatively stable except for 2015.
- Median days for ICR Committee decisions have steadily increased (by 41% since 2015) due to ICR Committee's direction to obtain multiple assessments from different professionals.

2013 -2017 Aggregate Timelines

From 2013 to 2017, 14,999 investigations were completed. The aggregate and median timelines were:

	2013-2017	
	Average Days Open	Median Days Open
PC	234.5	184.0
RI	388.2	313.5
INC	260.5	173.0
ALL	**260.8**	**191.0**

2013-2017 ICR Committee Outcomes

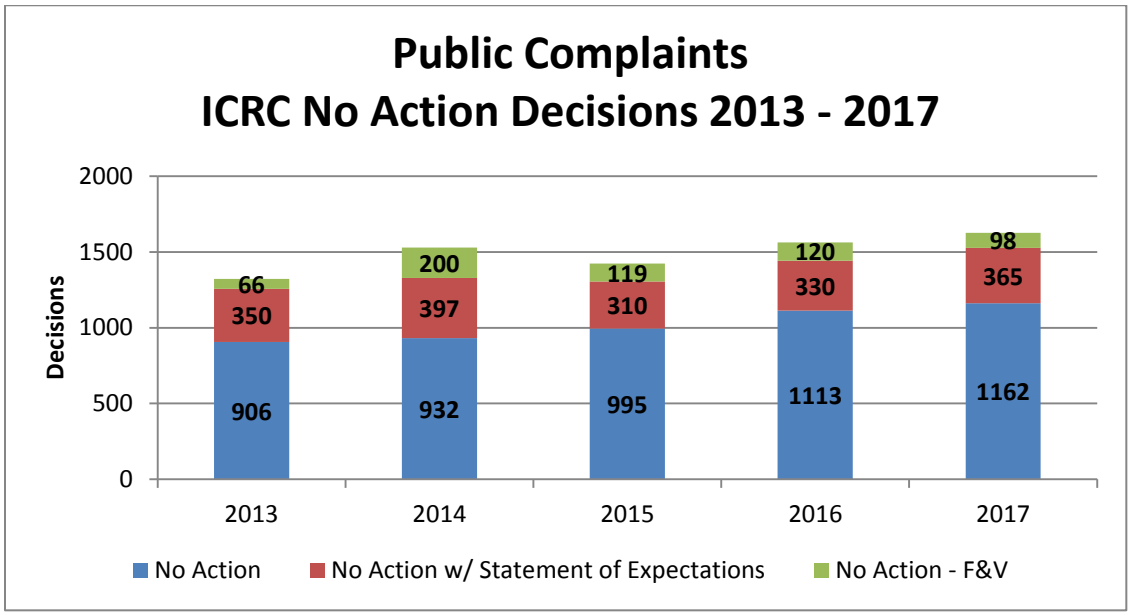


As of December 31st, 2017

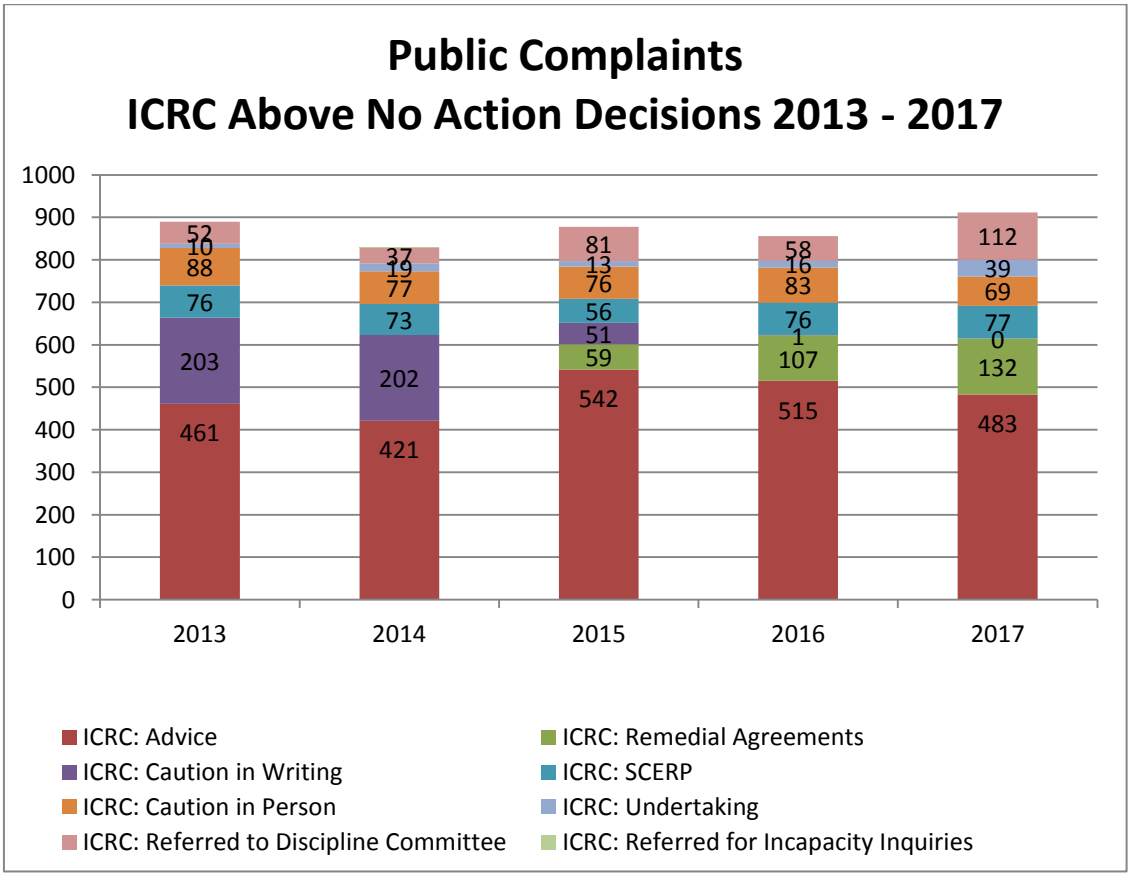
*Moderate to High-Risk outcomes include: Cautions in person, Specified Continuing Education and Remediation Programs (SCERPS), Undertakings, Restrictions, referrals to Discipline and Fitness to Practise.

- In 2017 Committee Support assisted ICR Committee to expedite decisions for sec.25.4 orders and prescribing investigations.
- Committee Support continues to write case summaries for the public register for caution-in-person and Specified Continuing Education or Remediation Program ("SCERP") outcomes.

Public Complaints

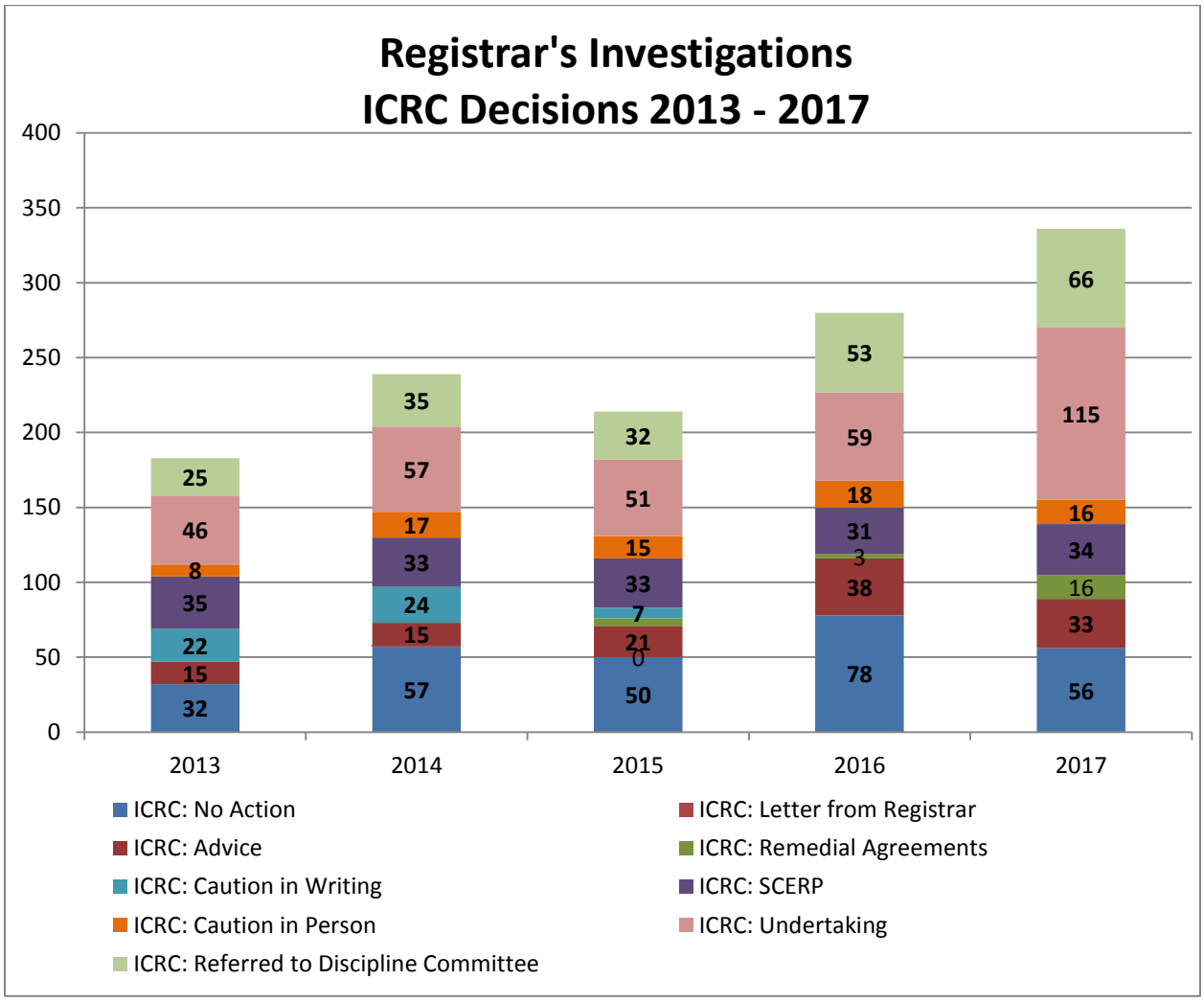


As of December 31st, 2017



As of December 31st, 2017

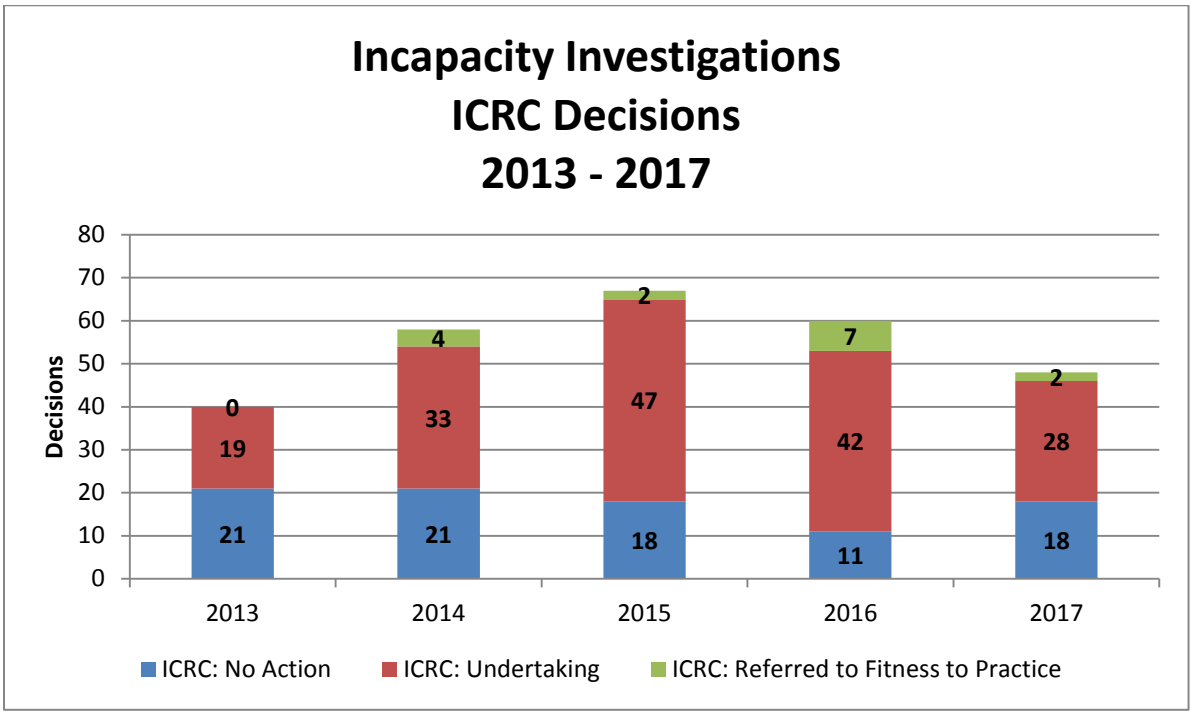
Registrar's Investigations



As of December 31st, 2017

- In 2017, ICRC referred 178 cases to the Discipline Committee, involving 78 Notices of Hearings.
  - Since 2016 this is a 55% increase in the number of cases referred
  - 5 of the 78 Notices of Hearings involving Compliance matters

Incapacity Investigations



As of December 31st, 2017

Hearings Office: Discipline and Fitness to Practise Committees

The Hearings Office supports the two adjudicative committees of the College:

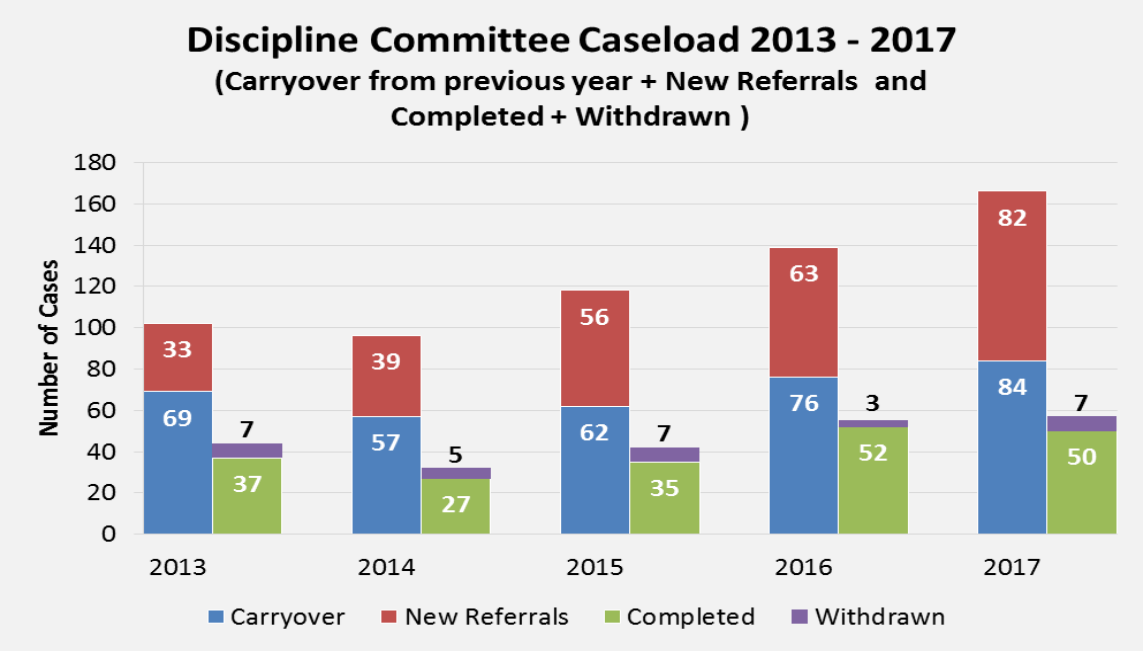
- the Discipline Committee
  - hears allegations of professional misconduct and/or incompetence
- the Fitness to Practise Committee
  - hears allegations of incapacity

The Discipline Committee manages each case through all stages of the hearings process:

- referral of allegations by the ICR Committee
- disclosure – the College and the physician exchange documents/information
- case management conferences to manage case progress
- a pre-hearing conference aimed at case resolution and scheduling
- hearing
- written Decision and Reasons for Decision

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

Caseload – Referrals, Completed Cases and Withdrawals



As of December 31st, 2017

- 2017 year-end caseload: 109 (the highest on record). These came from:
  - 2017 referrals: 82
  - 2016 referrals: 63
- In 2017 the College withdrew all allegations in seven cases.
- Increase since 2013:
  - Referrals: ↑ 110%
  - Completed cases: ↑ 85%
  - Year-end caseload: ↑ 74%
- There were 1 case in 2013, 2 cases in 2014, and 1 case in 2017 that did not proceed because the physician died.

Case Management – Pre-hearing Conferences and Case Management Conferences

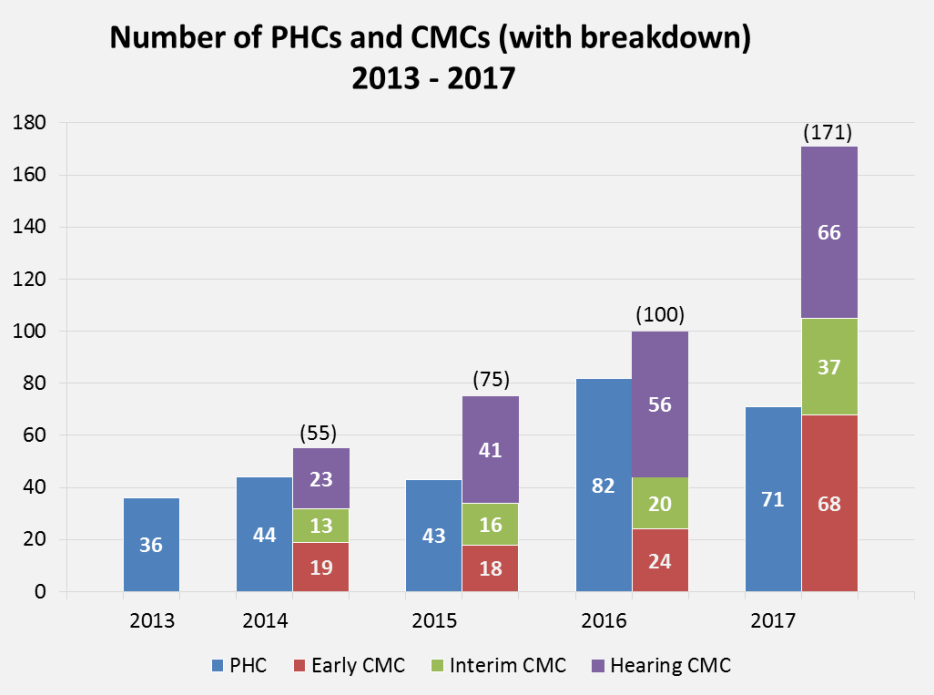
The Discipline Committee conducts pre-hearing conferences and case management conferences to manage cases in accordance with its Practice Direction on Case Management.

Pre-hearing conferences (PHCs) have

- a case resolution function, to narrow issues and negotiate potential settlements, and
- a case management function, including the scheduling of hearing dates.

There are three types of Case Management Conferences (CMCs):

- 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.



As of December 31st, 2017

- Since 2013, the number of CMCs has increased by 210%; early CMCs have increased by 258%.

Cases currently before the Committee:

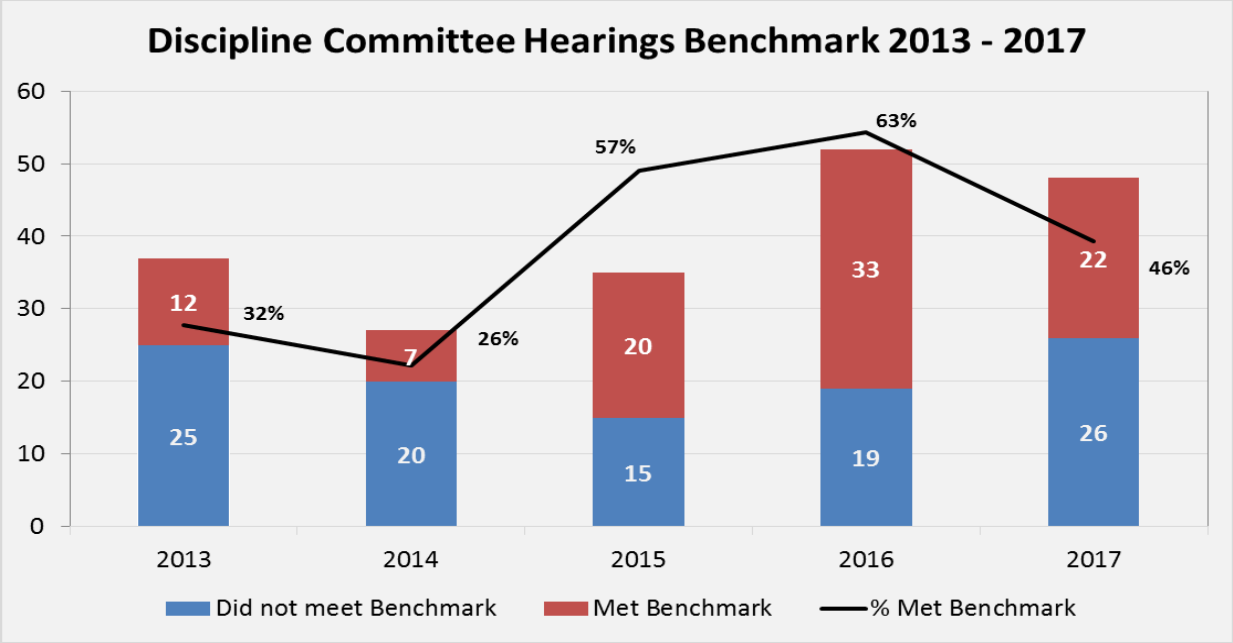
- 93% were referred in 2016 or a subsequent year
- 14% are in the disclosure stage
- 19% are in the PHC stage
- 43% are in the hearing stage
- 16% are in the decision stage
- 8% are adjourned or on hold pending concurrent proceedings.

Hearings and Decision Benchmarks

The Committee reviews its performance against the hearings and decision benchmarks.

Hearings Benchmark

The Discipline Committee has a hearings benchmark to commence and, if possible, complete hearings within 1 year of referral.



As of December 31st, 2017

- The decrease in 2017 in cases that met the benchmark relates to the increased number of referrals from 2015 to 2017.

Reasons for variance over benchmark:

- Factors external to the Committee:
  - the parties' readiness for a pre-hearing conference
  - concurrent proceedings which add to case complexity
    - discipline or fitness referral, criminal proceeding, judicial review or appeal
  - postponements due to further investigation and the referral of additional allegations
  - ongoing case negotiations.
- Factors internal to the Committee:
  - availability of dates
  - availability of panel.

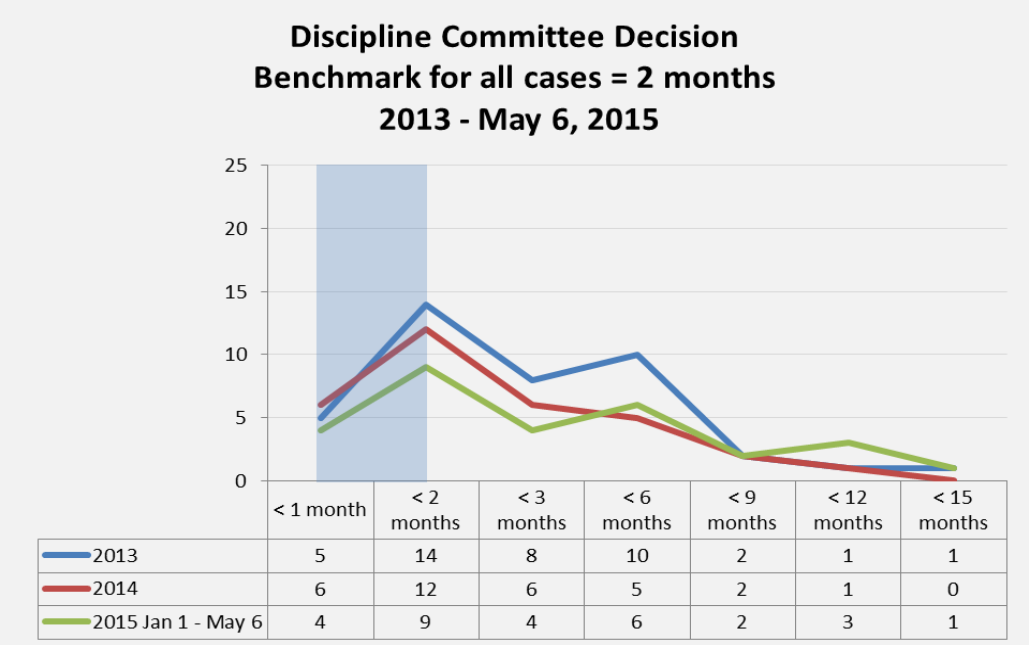
Approximately 70% of cases referred to discipline proceed on an uncontested basis, where the College and the physician agree on the facts, or the physician does not contest the facts, and the physician admits to one, some or all of the allegations. The parties also make a joint penalty proposal. In law, the Committee must accept a jointly proposed penalty unless it would bring the administration of justice into disrepute or it is otherwise contrary to the public interest. Uncontested hearings typically complete in one day.

In approximately 30% of cases, discipline hearings proceed on a contested basis with the allegations and the penalty in dispute, and the College and the physician call witnesses and other evidence. A contested hearing may take several days or one to several weeks.

The Discipline Committee continually considers ways to resolve cases earlier and maximize resources. When possible, the Committee schedules two uncontested cases before the same panel in one day.

Decision Benchmark

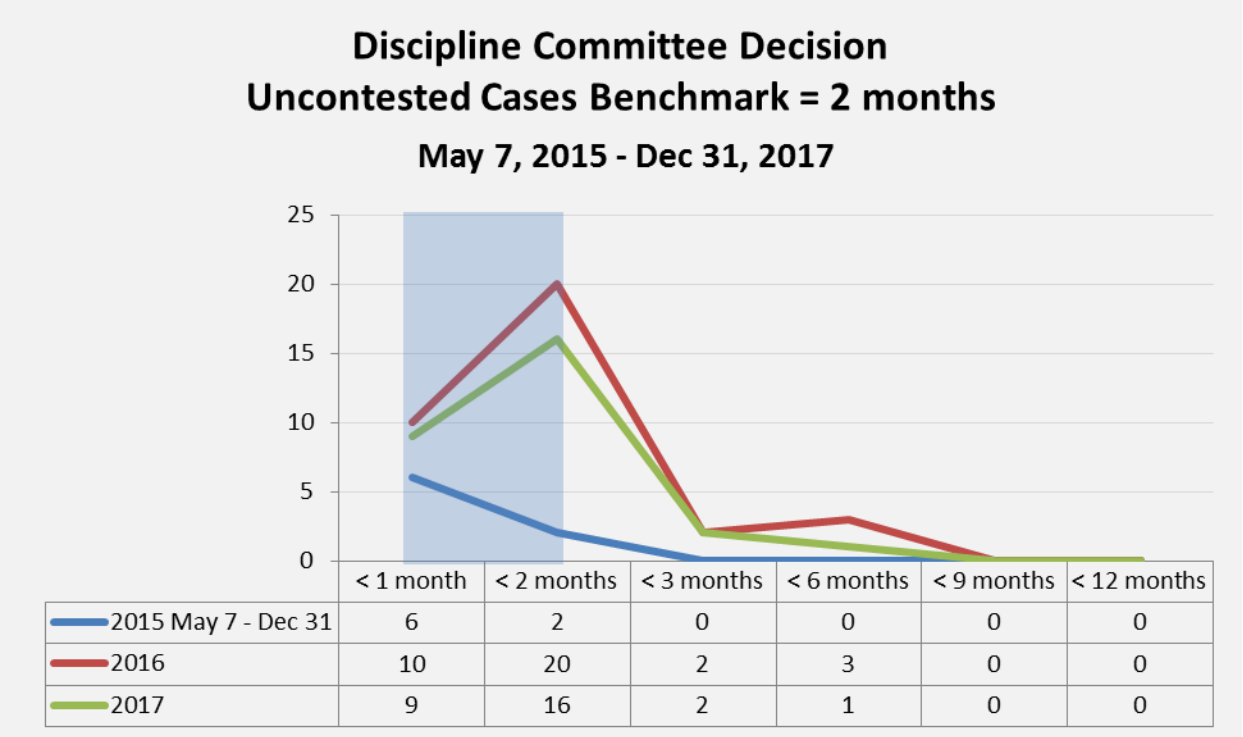
As of May 2015, the Discipline Committee has two decision-release benchmarks to acknowledge differences in case complexity: two months for uncontested cases, and six months for contested cases, absent extenuating circumstances. Prior to that, it had one 2-month benchmark.



	< 1 month	< 2 months	< 3 months	< 6 months	< 9 months	< 12 months	< 15 months
2013	5	14	8	10	2	1	1
2014	6	12	6	5	2	1	0
2015 Jan 1 - May 6	4	9	4	6	2	3	1

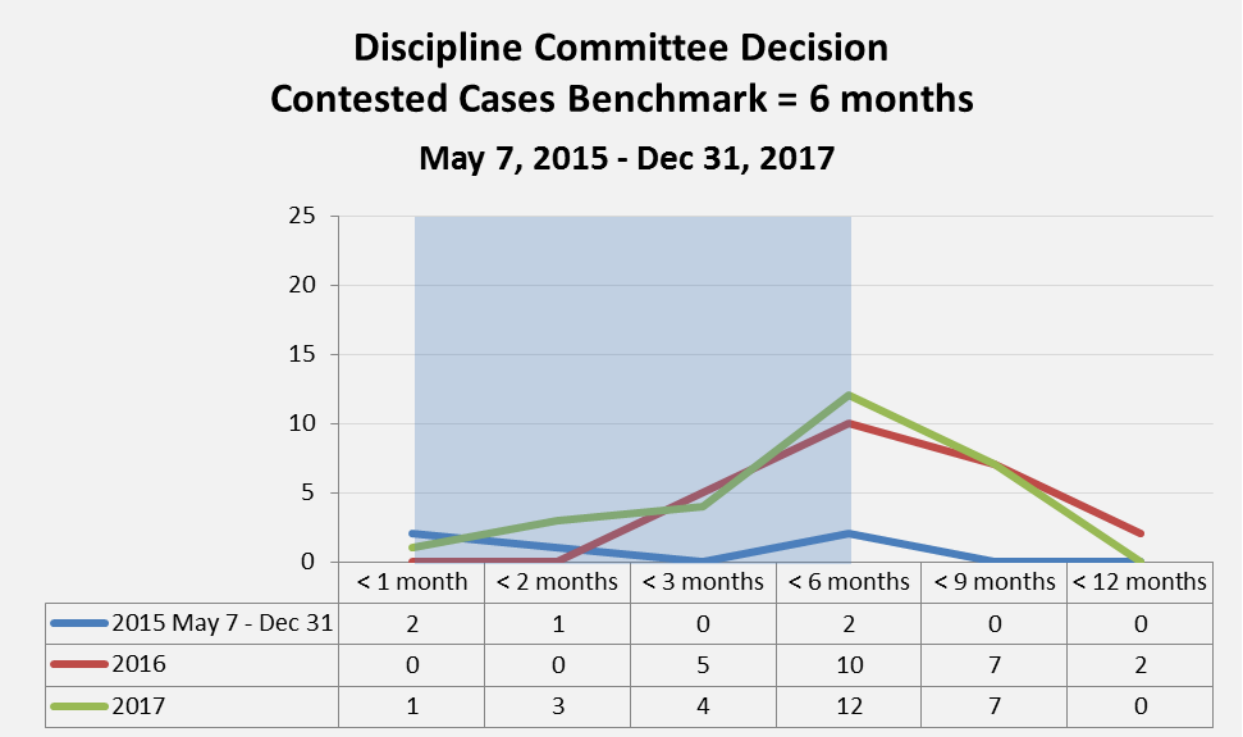
The timeliness of decisions has improved:

- Prior to May 2015: 49% of all decisions met the 2-month benchmark
- May 2015 to 2017: 89% (uncontested) and 71% (contested) met their respective benchmarks.



	< 1 month	< 2 months	< 3 months	< 6 months	< 9 months	< 12 months
2015 May 7 - Dec 31	6	2	0	0	0	0
2016	10	20	2	3	0	0
2017	9	16	2	1	0	0

As of December 31st, 2017

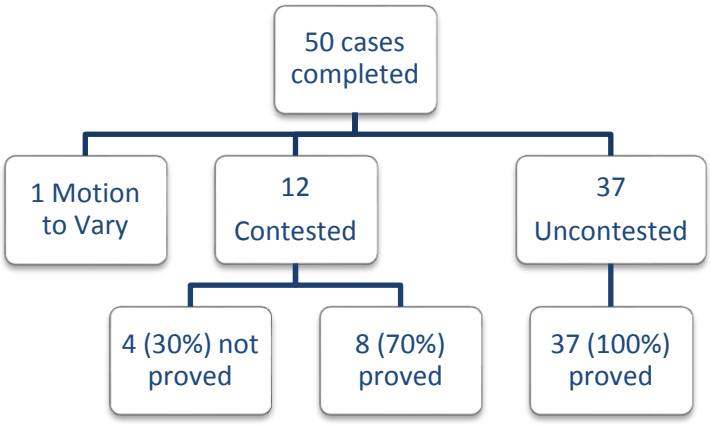


	< 1 month	< 2 months	< 3 months	< 6 months	< 9 months	< 12 months
2015 May 7 - Dec 31	2	1	0	2	0	0
2016	0	0	5	10	7	2
2017	1	3	4	12	7	0

As of December 31st, 2017

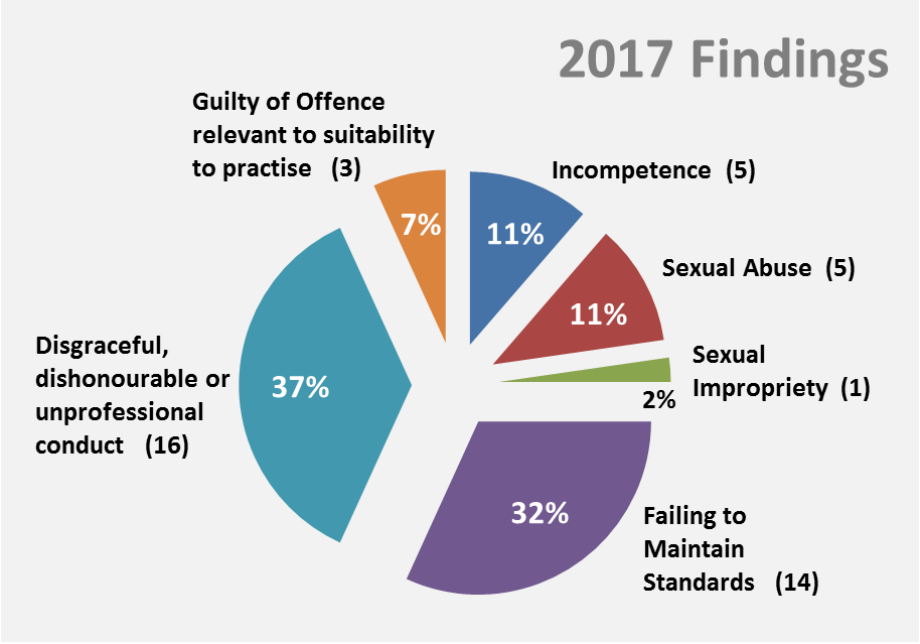
Discipline Outcomes – Findings and Orders

In 2017, the Discipline Committee completed 50 cases.



8 proved contested cases + 37 proved uncontested cases = 45 cases or 92% where some or all allegations were proved.

Findings in 45 Proved Cases:

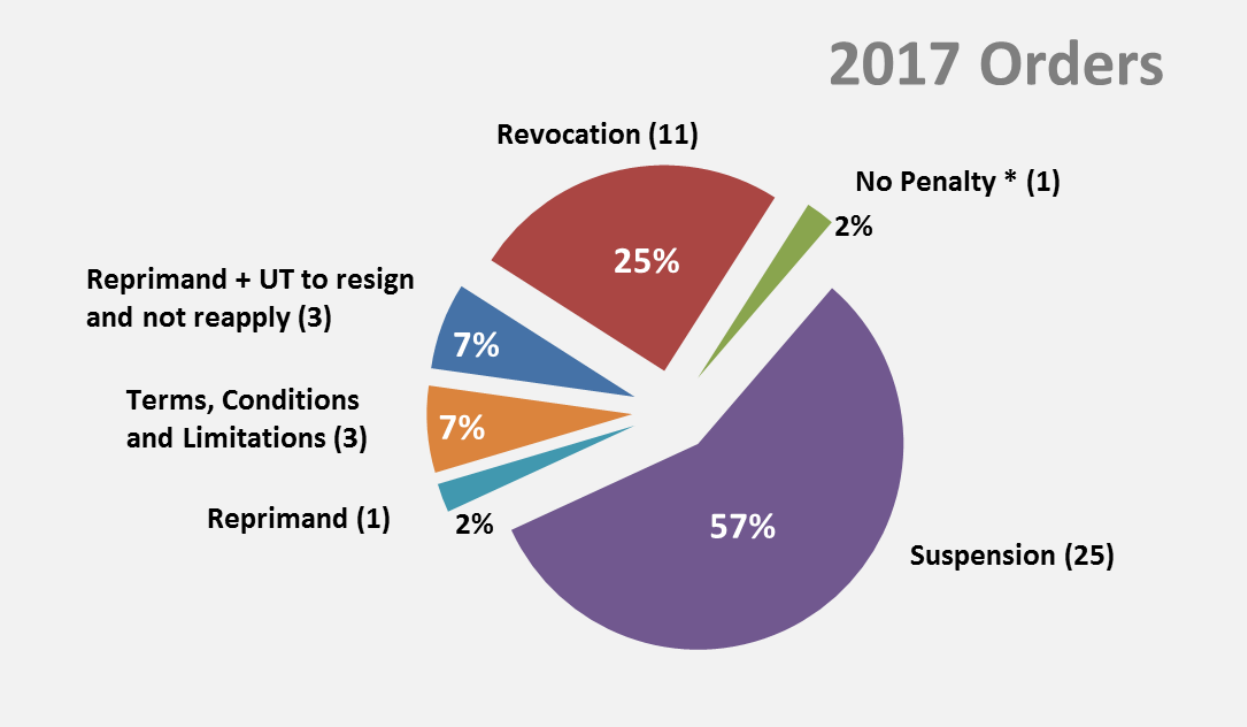


As of December 31st, 2017

Note: *2 of the 45 proved cases were joined into one hearing and therefore the chart shows 44 findings.*

Orders in 45 Proved Cases:

An Order of the Discipline Committee may have one or multiple components. For example, the Committee may order revocation and a reprimand, or a suspension, the imposition of terms, conditions and limitation and a reprimand. The following is based on the most serious component of the Order in each case:



Finding	Revocations	Suspensions	TCL	Reprimand + UT	Reprimand	No Penalty *
Sexual Abuse	3	2				
Sexual Impropriety	1					
Incompetence	2	2		1		
Fail to maintain standards	1	10	2	1		
Guilty of Offence	1	1				1
DDU	3	10	1	1	1	

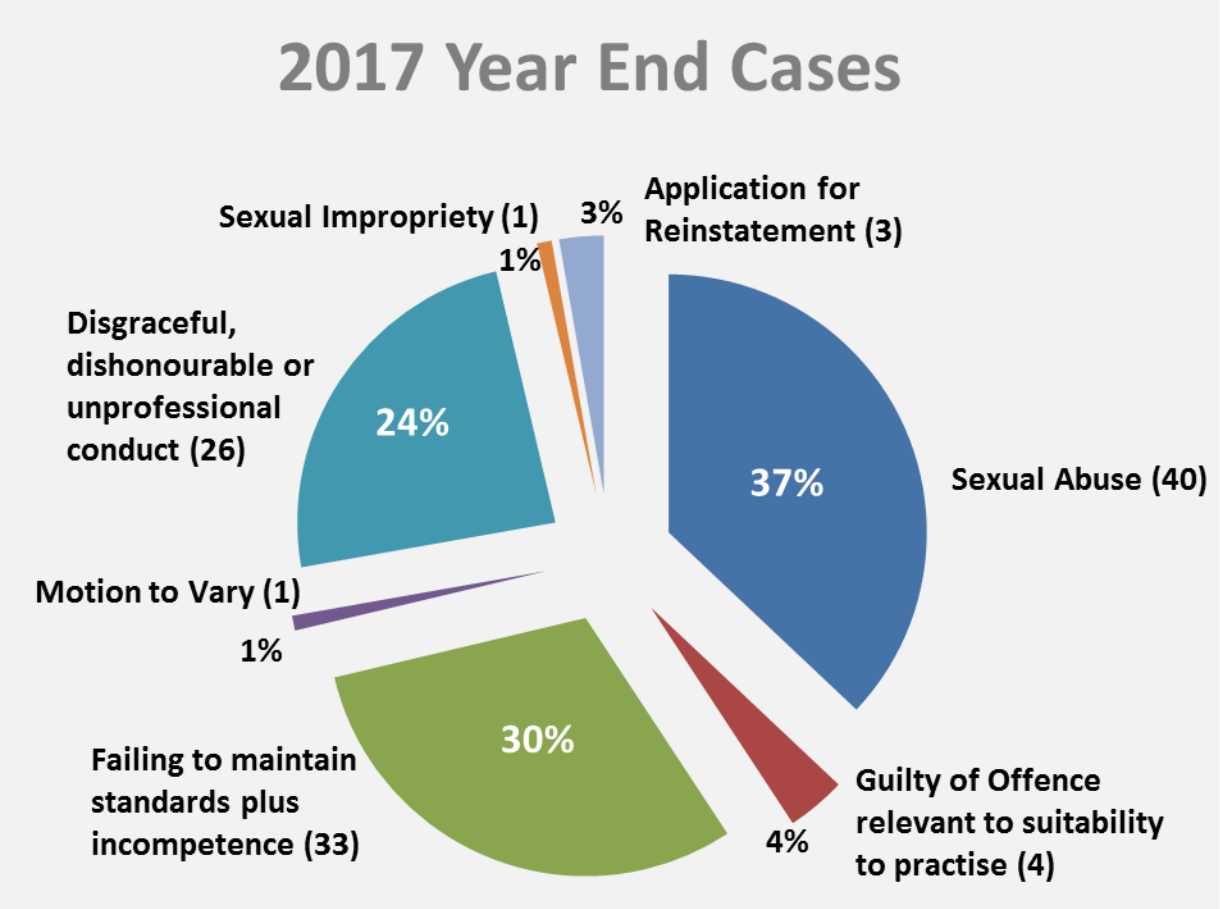
As of December 31st, 2017

** the physician had grave health issues and resigned with an undertaking to never reapply in Ontario or any other jurisdiction*

Note: *2 of the 45 proved cases were joined into one hearing and therefore the chart shows 44 penalties.*

Carryover - 2017 Year End Cases

At the end of 2017, there were 108 cases before the Committee.



As of December 31st, 2017

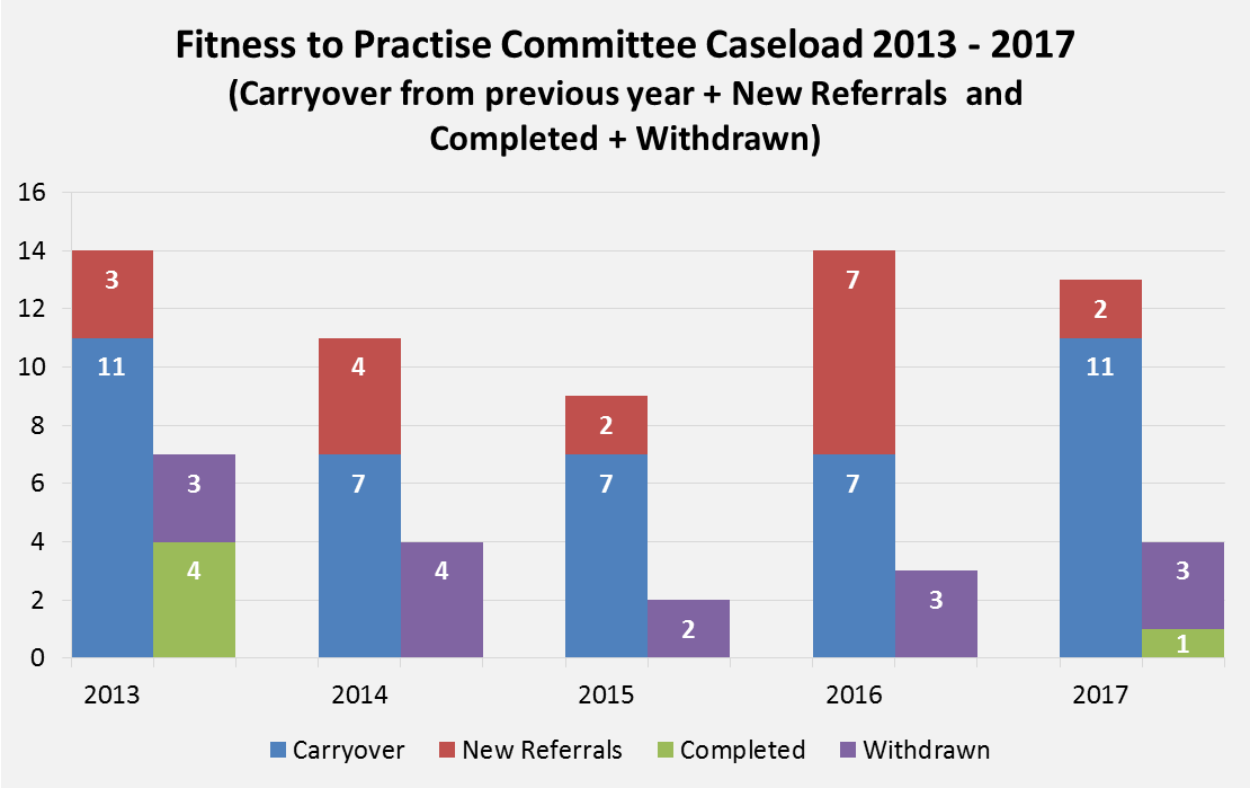
Appeals

In 2017, the Divisional Court dismissed three appeals by physicians, and one physician abandoned his appeal. Currently, there are appeals pending in 10 cases.

Fitness to Practise Committee

The Fitness to Practise (FTP) Committee rarely hears cases, as matters of incapacity tend to resolve through health monitoring agreements with the Ontario Medical Association's Physician Health Program.

Caseload – Referrals, Completed Cases and Withdrawals



As of December 31st, 2017

When incapacity matters resolve through monitoring agreements, the allegation of incapacity before the Committee is withdrawn.

The FTP Committee referrals and caseload have been decreasing since 2013. Consequently, pre-hearing and hearing activity are decreasing. Since 2013, there have been 2 to 6 PHCs per year.

There were no hearings in 2014, 2015 and 2016. There were two referrals and one hearing in 2017.

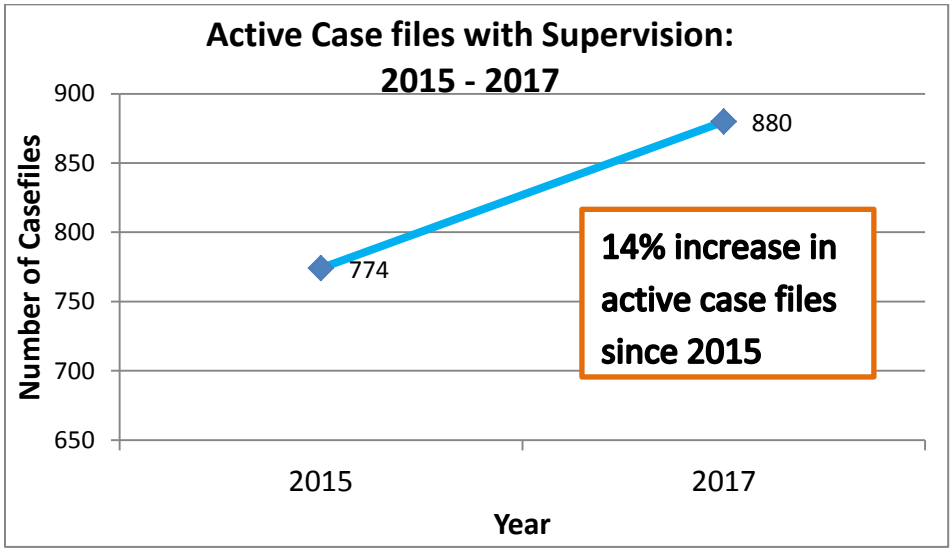
Compliance Monitoring and Supervision

The College's Compliance, Monitoring and Supervision Department (CMS) monitors all Committee decisions, undertakings and Orders (outcomes) for which there is an education, remediation and/or restriction requirement.

Key Measures

Volume: CMS monitors over 1600 active files.

Complexity: the total number of education, remediation or restriction requirements in each of the various outcomes appears to be increasing. This layering of outcomes increases the complexity of the files. Also, Committees are increasingly issuing outcomes, such as clinical supervision, which are often complex in and of themselves. Since 2015, there has been a 14% increase in the number of active files with supervision issued by a variety of Committees.



As of December 31st, 2017

Risk: From 2012-2017, the number of moderate and high-risk outcomes (for example, matters for which the deciding committee issued a specified continuing education or remediation program, an undertaking or an Order), issued by the ICR Committee increased by 45%. It is anticipated that this number will continue to increase in 2018.

With the amendments to the *Regulated Health Professions Act* in May 2017, the ICR Committee has the power to impose Interim Orders earlier than at the time of referral where the Committee where the ICR Committee identifies a risk of harm to patients by directing the Registrar to suspend, or to impose terms, conditions or limitations on, a physician's certificate. Nineteen Interim Orders were issued in 2017 and it is anticipated this number will only rise.

Projects

- The content of a training program for Practice Monitors and physician supervisors has been completed and will be launched in 2018.
- CMS continues to work closely with other members of the Investigations and Resolutions Division, Medical Advisors, and Legal Division to plan for and respond to a cohort of Narcotics Monitoring System investigations by the College. This work is continuing throughout 2018.

Staff

I would like to both commend and thank the staff and managers for their continual efforts and solid work in the face of many challenges, ever-increasing volume and complexity, and a changing environment.

Sandy McCulloch

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Legal Office
Annual Divisional Report
2017

2017 ANNUAL REPORT TO COUNCIL FROM THE COLLEGE LEGAL OFFICE

Mandate and Objectives

The Legal Office's mandate is to conduct substantially all of the College's litigation[1] and to provide the bulk of the legal advice to the Council, committees, working groups and departments.

Core Activities & Statistics

Information about the civil proceedings, discipline prosecutions and appeals is presented, as usual, in separate documents. Other statistical information on discipline hearings is presented in the hearings office report.

Ongoing Activities

Staffing

In 2017 the Legal Office had a complement of fourteen full-time counsel and eleven administrative staff. One of the lawyers is a corporate lawyer, the others litigators. The office continues to run under the co-director model adopted in January, 2009, with Vicki White and Lisa Brownstone sharing the director duties.

Legislation/ Regulations

In 2017 the Office spent a fair bit of time on legislative initiatives, largely on work related to Bill 87 and its regulations, and the draft Community Health Facilities legislation.

Bill 87 brought significant changes to the governing legislation, which has required work at the stages of analysis, advice and implementation including the following:

- giving the College a new power to suspend or restrict a physician's licence while investigations are ongoing (previously, interim restrictions were only possible once a physician was referred to the Discipline or Fitness to Practise Committees). This required review of all of the high risk cases in the system at any stage of investigation, consideration of the application of the provision to the case, providing advice to ICRC about the use of the power, and responding to challenges to its use;
- mandating that physicians found to have committed acts of misconduct for which licence revocation is mandatory are immediately suspended pending the Discipline Committee's final penalty order (previously, physicians could continue to practise, sometimes for months, while awaiting a penalty hearing). This has been implemented in a number of cases; and
- expanding the scope of physical acts of sexual abuse that result in mandatory revocation of a physician's licence. This has resulted in, among other things, arguments before the Discipline

[1] We are not involved in the College's employment law issues. As well, outside counsel is retained by the insurer when we are sued civilly for claims for which we have insurance coverage.

Committee (and soon to be the courts on appeal) about when these provisions take effect (there is a difference between prospective, retrospective and retroactive legislation).

Other provisions have come into effect in 2018 and are resulting in similar activity by the Legal office (legislation governing third party records applications and regulations, expanding further the type of conduct that will result in mandatory revocation). More will be reported on these in 2018.

Litigation

The number of discipline referrals continued to increase yet again in 2017. As of December 2017, there were 97 outstanding discipline referrals at various stages of proceeding, as compared to 89 in December 2016, 71 in December 2015, and 56 in December 2014. Of the 52 Discipline decisions released in 2017, CPSO lawyers were successful in proving one or more of the allegations advanced in 48 (or 92%) of those cases. In 10 of those cases, the physician's certificate of registration was revoked.

As mentioned above, the new legislation (the amendments to the governing legislation made by Bill 87) has affected the discipline hearings. For example in three cases in 2017, the College argued for the retrospective application of various aspects of the new legislation to ongoing cases.

The office also successfully argued two interesting issues at HPARB in 2017. First, in *C.J.H. v J.S.*, 2017 CanLII 78875 (ON HPARB), HPARB adopted the submissions of CPSO counsel in defence of the constitutionality of regulations governing permissible advertising by physicians. HPARB confirmed that the ICRC's interpretation of the regulation struck an appropriate balance between protection of the public and the physician's right to freedom of expression, in light of public safety concerns arising from advertising by professional members.

Second, in the registration context, the legal office successfully defended before HPARB the College's decision to require an applicant who had been diagnosed with drug and alcohol dependence and a delusional disorder to have terms, conditions and limitations imposed on his certification of registration. The applicant challenged this decision, alleging that he had been discriminated against on the basis of his disability. In upholding the denial, HPARB accepted the CPSO lawyers' argument that the conditions the CPSO had proposed were reasonable and *bona fide*, and did not constitute a human rights violation. The Board agreed with the CPSO that a regulator's duty to accommodate an applicant differs from that of an employer to an employee, and what constitutes "undue hardship" in accommodating an applicant must be assessed within the context of membership in a self-governing health profession and the regulator's duty of public protection.

Further, the office had a busy year in Court. The office successfully represented the College in two applications challenging the constitutionality of the College's Human Rights and MAiD Policies, focusing in particular on their requirement for an effective referral to be made by objecting physicians. These were argued in June 2017 (decisions released January 2018).

The College also appeared on a number of other Court matters, including an appeal at the Court of Appeal for Ontario.

The legal office continues to be involved in cases involving the suspected performance of controlled acts by non-members. In 2017, this involved, among other things, securing a court order against an unlicensed practitioner for contempt of court, for failing to follow a court order the College had previously obtained

against her. The 2017 order required her to pay a substantial fine and court costs, and run a prominent notice in a major newspaper advising members of the public as to her finding of contempt.
Much work was also done by the office in working on various aspects of the opioid issue, both at a general and a member-specific level.

Other Matters of Significance

As always, the Legal Office continues to be involved in many of the College's ongoing initiatives, such as the opioid initiative, the development of a new mechanism for the regulation of community health facilities, transparency initiatives, and training for College committees and members of College staff.

The Legal Office also continues to support regular College activities, programmes and policies, such as the Premises Inspection Committee, registration initiatives, the QA Committee, the annual renewal process, and governance processes and related by-laws.

In addition, this is the second full year in which Marcia Cooper, counsel, has acted as the College's Privacy Officer. In this role, Marcia leads the management of all reported CPSO privacy breaches and consults on privacy issues arising in member-specific files. In addition, she provides input on privacy-related issues in CPSO policies, and participates as a lead member of the Privacy and Security Working Group. In 2017, Marcia also participated in meetings with representatives of the OMA, OMD, CMPA and IPC on privacy matters for the implementation of Ontario electronic health record systems and other health system-related privacy matters. Data sharing, confidentiality agreements and consents for information sharing also fall within the Privacy Officer's role. In 2017, there were 39 privacy breaches reported.

Process Review; Looking Forward

Given the increased number of discipline cases and other matters requiring legal input, the Office prepared a budget submission seeking additional resources for 2018. In so doing, the Office gathered such information as was available about the use of legal resources college-wide. In addition, with the assistance of a consultant, the Office undertook a "lean process review" related to the discipline process. These exercises underscored the need for, among other things,

- Better capture of the use of legal resources among different areas of the College
- Determination of whether the right legal resources are being used for the right matters
- Greater efficiency in the legal processes
- Better reporting on the use of legal resources

Work is underway to move forward in these areas. That work includes a process working group between the Legal office and the I and R department, focusing on the current use of shared technology and exploration of other tools that might assist in achieving the above-noted goals. Planning for and ultimate implementation of these initiatives will be a priority for the Office moving forward.

Respectfully submitted

Lisa Brownstone
Vicki White

4 May 2018

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Policy and Communications
2017 Annual Report

Policy and Communications 2016 Annual Report

Overview

The Policy and Communications Division provides strategic and operational support in a number of areas including policy development, internal and external communications, issue management, public and government relations and governance. The Division coordinates and supports the work of four College committees: Patient Relations, Outreach, Governance and Council Awards. Committee support and coordination also extends to policy-specific working groups.

Major Functions

Policy

- Develop and review policies to provide guidance to physicians about legislative/ regulatory requirements and the expectations of the medical profession
- Coordinate and manage consultations
- Research and analysis of issues related to medical regulation
- Develop submissions to government, agencies and external stakeholders
- Support for corporate initiatives and projects

Communications

- Manage all media relations activity
- Strategic communications (internal and external)
- Website development and maintenance, management of social media presence
- Publications including Dialogue, Patient Compass, specialty newsletters (OHP/IHF, medical students), Annual Report
- Editorial and design support for a range of products
- Coordinate external outreach activities
- Public and physician inquiries
- Manage Council Award program
- Manage public relations activities

Government Relations

- Manage relationships with government
- Strategic oversight and support for all activities with government
- Monitor legislative initiatives of interest to the College
- Coordinate and oversee the development of government submissions

Governance*

- Coordinate and support the Governance Committee including:
  - all nominations activity
  - Council, committee and committee chair performance assessment/feedback process
  - Strategic support for College leadership
  - Development and review of governance policies (together with legal counsel)
  - Coordinate and support the district election process

**** Note: Governance activity is reported as part of the annual report of the Governance Committee.***

2017 HIGHLIGHTS

1. Policy

Policy review and development are core activities of the Policy Department.

The goal of policy review is to ensure that College policies fulfill the College's public interest mandate, and provide clear, current and useful guidance to the profession and public. Development of new policies is undertaken in accordance with the direction of the Executive Committee and Council to respond to emerging trends or issues.

In addition to policy review and development, Policy performs a number of other core functions including project support, legislative monitoring and issue support and management. Approximately 50-60% of the work of the department falls within this category. This includes the following:

External Consultation Requests or Initiatives: This includes reviewing, assessing and developing responses to external consultation requests that come to the College. These requests are from a broad range of stakeholders including government, medical regulatory authorities, Ontario health regulatory colleges and health-related organizations on matters relevant to the College and its mandate.

Submissions & Legislative Monitoring: Legislative monitoring includes regular review of the Legislative Assembly of Ontario, Ontario Gazette and other sources for emerging legislative developments that have relevance to the College and the health regulatory landscape. Where applicable, pertinent draft legislation is reviewed and analyzed and submissions are developed on matters relevant to the College, either in response to draft legislation, initiatives or other relevant issues.

Support of College Projects and Initiatives: Policy provides ongoing support to a broad range of College projects and initiatives. This has included support in relation to legislative submissions on Bill 87 and Bill 160, Community Health Facilities, New Member Orientation, the Peer Redesign project, Medical Assistance in Dying and Outreach events.

Committee Support: Support is provided to College Committees, including Registration, Education, Quality Assurance, Methadone, Premises Inspection and Investigations Complaints and Reports Committees.

Patient Relations Program: The department manages and supports the College's Patient Relations Program. This involves managing the ongoing activities related to the Patient Relations Program; and supporting the Patient Relations Committee.

Professionalism in Undergraduate Medical Education: The 'Professionalism and Practice Program: Undergraduate Medical Education' was launched in 2013, and Policy currently has central responsibility for its ongoing development and administration. It was developed to fulfill Council's objective to engage medical students on issues of self-regulation, professionalism and ethics.

2017 Highlights


POLICY MATTERS

What to consider before ending the physician-patient relationship

Clinical judgment, compassion key to determining course of action

EXTERNAL CONSULTATION

DATES HELD: December 12th, 2016 – February 10th, 2017

OF RESPONDENTS: 104

BREAKDOWN OF RESPONDENTS:

77% PHYSICIANS
13% PUBLIC
6% UNIDENTIFIED
4% ORGANIZATIONS

CHANGES MADE IN RESPONSE TO FEEDBACK: YES NO

ISSUE 2, 2017 DIALOGUE 31

In 2017, work on the Continuity of Care project was a key area of focus. Under the guidance of a Council Working Group, extensive research was conducted and a broad, preliminary consultation with the profession, the public and organizational stakeholders was undertaken. On the basis of the research and stakeholder feedback, the Working Group directed the development of a 'suite' of policies, to address priority issues identified by Council. Work on this project has continued into 2018.

Other highlights from 2017 include the approval of three policies: Accepting New Patients, Ending the Physician-Patient Relationship and Uninsured Services and Block Fees. Policy amendments were also made to the Prescribing Drugs policy, in accordance with the commitments the College made in the Joint Statement of Action to Address the Opioid Epidemic, arising out of the Opioid Conference and Summit in late 2016. Ten policies were under active review in 2017 including Medical Records, Maintaining Appropriate Boundaries and Preventing Sexual Abuse, and Physicians and Health Emergencies.

In addition, Policy was extensively involved in supporting litigation where the College was defending the 'effective referral' requirement contained within the Medical Assistance in Dying and Professional Obligations and Human Rights policies.

New Policies/ Statements	**4**	• Accepting New Patients: May 2017 • Ending the Physician-Patient Relationship: May 2017 • Prescribing Drugs (Opioid Content): September 2017 • Uninsured Services and Block Fees: December 2017
Policies under Review or Development	**10**	• Block Fees and Uninsured Services • Change in Scope • Re-entering Practice • Test Results Management • Continuity of Care
Active Policy Working Groups	**3**	• Medical Assistance in Dying • Accepting New Patients/ Ending the Physician-Patient Relationship • Continuity of Care/Test Results Management

Legislation/ Regulation Development or Response	**5**	• Bill 87 (two submissions: March and April 2017) • Bill 84-Medical Assistance in Dying • Bill 160: Submission on Schedules 1 and 9 (CHF, Ambulance Act) • Bill 163, Protecting a Woman's Right to Access Abortion Services Act, 2017 • Medical Assistance in Dying: Submission to the Council of Canadian Academies
Consultation Responses to External Stakeholders	**15**	Stakeholders included the following: • Ministry of Health and Long-Term Care • Ministry of the Attorney-General • Ontario College of Pharmacists • Ministry of Transportation • Health Canada • College of Massage Therapists
Support: Initiatives and Projects	**5**	The support provided has included the following: • Sexual Abuse Initiative/Task Force • Peer Redesign • Community Health Facilities • Opioids • Educational Strategic Initiative

CONTINUOUS IMPROVEMENT

The Policy Team strives for excellence in all the work it does and as such, maintains a critical eye toward opportunities for improvements to our process and products.


WE WANT YOUR FEEDBACK

Closing a Medical Practice Policy – Consultation

A draft of the **Closing a Medical Practice** policy has been approved by Council for external consultation. This draft policy is an update to the current policy and sets out expectations for physicians when permanently closing a medical practice.

We are now inviting feedback on the draft policy from all stakeholders, including members of the medical profession, the public, health-system organizations, and other health professionals. Visit the dedicated consultation page at **www.cpso.on.ca** to view further information and provide your feedback.

You can also email your thoughts to: **practicemanagement@cpso.on.ca**

In 2017, these efforts have focused on making policy documents more readable, accessible and inclusive. Executive Summaries have been added to policies, on a go-forward basis, to assist readers in obtaining a quick sense of the content contained within the document. A new policy structure is being piloted in the Continuity of Care project: a foundational umbrella policy, with companion policies on specific sub-topics. The goal is that through this approach, policy content will be more accessible for readers. In 2018, efforts will focus on the language used in policy with a particular emphasis on employing a plain language approach, using gender neutral pronouns, and developing case examples that are inclusive.

Improvements continue to be made to the policy consultation process. The consultation process is an essential part of the policy development process. It employs a number of tools and is inclusive and transparent. Invitations are sent electronically to all College members, and to a broad range of other stakeholders including patient and physician organizations and all feedback received is posted online.

Efforts in 2017 have focused on improvements to the look and format of the web pages developed for each policy consultation, the avenues through which we collect feedback and how we report on feedback. Extending into 2018, Policy and Communications will continue to explore ways to enhance engagement with the profession, the public and key organizational stakeholders.

An overview of the policy consultations undertaken in 2017 together with the response rates are captured below. Rate of response for consultations vary significantly depending on the subject matter of the policy, and whether the consultation is a preliminary consultation on an existing policy or a consultation on a new draft policy. A breakdown of the consultation responses received in 2017 is as follows:

Total number of responses received in 2017: 594

Average number of responses received per consultation: 66

Consultation-specific breakdown:

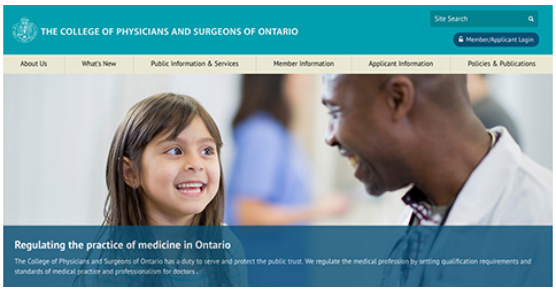
1. Ending the Physician-Patient Relationship: **85** – *reflects only the feedback received in 2017*
2. Accepting New Patients: **87** – *reflects only the feedback received in 2017*
3. Uninsured Services: Billing & Block Fees **118**
4. Confidentiality of Personal Health Information: **121**
5. Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice: **40**
6. Physician Services During Disasters and Public Health Emergencies: **36**
7. Maintaining Appropriate Boundaries and Preventing Sexual Abuse: **40**
8. Medical Records: **58**
9. Prescribing Drugs: **9** – *reflects only the feedback received in 2017*

Public opinion polling is used to inform the policy development and review process. Polling results provide Council with valuable perspective about the views and perspectives of the public. Public expectations and perceptions help inform sound decision-making in the public interest.

Social media tools (namely, Facebook and Twitter) have been used extensively to promote policy consultations to help us reach a different and broader audience. This practice continues to be used to complement the consultation process.

Top 5 policies visited on the website for 2017	**Unique Page Views: Jan 1 – Dec 31, 2017**	**Avg. Unique Page Views Per Month**
Medical Records	57, 839	4,820
Confidentiality of Personal Health Information	23, 654	1971
Prescribing Drugs	19, 637	1,636
Mandatory and Permissive Reporting	17, 573	1,464
Consent to Medical Treatment	14, 761	1,230

2. Communications



The Communications team strives to develop timely and effective internal and external communications. The department also coordinates and supports the public affairs and media relations functions. The communications team develops and supports a broad spectrum of communications products in support of College decisions and programs. We work to ensure that stakeholders, members and the public are informed about and engaged in College work.

COLLEGE WEBSITE & SOCIAL MEDIA

CPSO.on.ca is the primary communication vehicle for all aspects of the College's work. From our expanding public register to our dynamic consultation feature, it is how the majority of the profession and the public access information about the College. Improvements are always being made to content and navigation to ensure that information is up-to-date and relevant. There were a number of major projects associated with the website this year, including:

- **The revamping of the website overall to improve usability/transparency.** This revamp, the culmination of work we did with a group of usability experts called Mitrebox, launched in September 2017. It included a refreshed homepage, a more usable and intuitive search functionality for the public register, an entire new section called "Public Information & Services," an update to the colour scheme to match our new corporate palette, and other enhancements.

- **A new whiteboard video.** In November, we launched a new animated whiteboard video, called "Getting Communication Right with Your Patients," narrated by deputy register Dan Faulkner. This video identifies communication problems between doctors and patients as a leading cause of complaints to the College, provides tips to physicians on how they can improve their communication skills, and outlines other College-related resources on the matter. Video is available for viewing at www.cpso.on.ca/communication or on our YouTube channel.

- **The introduction of paid Facebook ad campaigns.** Taking our lead from our counterparts at the College of Pharmacists, this year we began launching paid advertising campaigns on our Facebook page for key CPSO website content. These campaigns have proven to exceed our expectations: each campaign costs only about $50 per ad, and the rate of return – in terms of impressions, likes and shares, and click-throughs – has averaged between 15 to 20 times what we get for non-paid-for content. The types of content we've advertised has included job postings, CPSO policy consultations, and the whiteboard video on good patient communication.

2017 WEBSITE STATISTICS

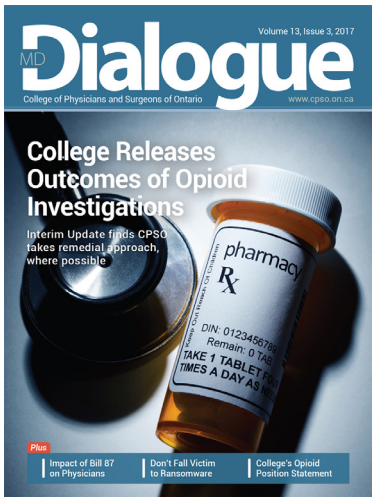
+2.7 million visitors
(2.6 million in 2016)

+9.6 million visits
(9.3 million in 2016)

+52.3 million page views
(51.6 million in 2016)

Most Visited pages:
1. The Public Register/Doc Search
2. The Homepage
3. Members' login
4. Medical Records policy
5. About Us page

DIALOGUE AND ANNUAL REPORT



The College's magazine *Dialogue* is one of our most important communications products. It is published four times each year following meetings of Council. It conveys the work of the College and includes College expectations for the profession. In addition, every issue of Dialogue includes summaries of the College's discipline decisions to ensure the profession is aware of the outcome, the rationale and the expectations of the profession. Dialogue is sent to the entire profession and many key decision-makers and stakeholders including MPPs, health care leaders, and other groups and organizations.

Dialogue has been critical to the College's communications of our opioid strategy to the profession and our efforts to encourage appropriate prescribing practices. In 2017, we published more than 20 articles, letters and infographics about opioids. We interviewed guideline experts, patients, assessors, pain specialists and doctors who have inherited opioid-intense practices in an effort to approach the issue from as many different angles as possible. In each issue, we explain the dangers of abrupt cessation and extreme tapering. Significant coverage of this important issue will continue into 2018 as we continue our efforts to promote safe prescribing.

In addition to regular columns and features, we highlighted, over the previous year, such issues as Bill 87's impact on physicians, the College's Peer Assessment Redesign and the Uninsured Services policy. With each policy-related article, we emphasize the importance of feedback from the profession to our consultation process and direct readers to the website to share their thoughts and opinions.

We also use Dialogue to consistently drive the conversation online as often as possible, whether it pertains to the development of a policy or an important undertaking. Significantly, we began conversations in 2017 about the process of digitalizing Dialogue and discontinuing our print run of the publication. The debut of the digital Dialogue is slated for 2019, after we consult with the profession and other stakeholders about how to best optimize the reading experience.

To augment our 2016 annual report, we developed a compelling infographic to highlight the College's areas of focus and results for the year. Our online infographic allowed readers to click onto any one of several "read more" icons to obtain specific information contained in the report.

NEWSLETTERS AND COUNCIL AWARD


PATIENT COMPASS
Help chart the course for medical care in Ontario
THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
Special Issue: The Opioid Crisis
Advice and Information for Patients
www.cpso.on.ca
The CPSO's Role and Approach: Our Opioid Strategy
Are You Currently Using Opioid Therapy?
Safe Opioid Usage: Find out all you can
New CPSO Opioid Web Hub
Current Policy Consultations
Dialogue
Our quarterly magazine contains important updates on policies, topics of interest, as well as a summary of recent disciplinary findings.
Read the latest issue here.
Like all Canadians, we are deeply concerned about the devastating impact the current opioid crisis is having on patients and communities. As we face escalating opioid overdose deaths across the country and the second highest rate of opioid prescribing/use per capita in the world, we are working with our health care partners on system-wide solutions to ensure patient well-being and public safety.
While there are many factors that have contributed to the opioid crisis, we recognize that well-meaning prescribing by physicians has also contributed to the problem and, therefore, improvements to physicians' prescribing practices must be part of the solution. Prescribing opioids under the right conditions is critical for good patient care and we are taking steps to ensure we give physicians the resources, information and guidance they need to appropriately prescribe opioids to their patients.
In this special issue of *Patient Compass*, we highlight our Opioid Strategy with particular attention to supports and information for patients and their families.

E-NEWSLETTERS

In addition to Dialogue magazine, Communications produces several e-newsletters targeted to specific stakeholders:

Medical Student Update is produced three times a year and each issue contains information developed specifically for the medical student audience. We use video content, vibrant images and infographics to help students better engage with our content. In 2017, articles covered a range of topics including: physician bullying, professional conduct on social media, and the CPSO Opioid Strategy. Students are encouraged to participate in policy consultations in each issue.

Patient Compass: Patient Compass is directed to our health care consumers and advocates. In 2017, Patient Compass covered a range of current health care and regulatory issues of interest to the public, such as Bill 87, medical marijuana, improvements to our website, new patient information communication tools, , and invitations to participate in our policy consultations. In step with the College's opioid strategy, Patient Compass included several articles about opioids throughout the year, and a special issue in October focussed entirely on our strategy, with particular emphasis on supports and information for patients and their families.

IHF/OHP News is produced twice a year for physicians working in independent health facilities and out-of-hospital premises. In 2017, articles provided practical advice on maintaining regulatory obligations infection control issues, and information on significant changes to facility standards. The new regulatory framework for IHF/OHP facilities was highlighted in the November issue.

Assessor News: Assessor News is produced four times a year for the physicians, nurses and other health care professionals who conduct physician and facility inspections/assessments on behalf of the College. Peer Redesign continued to be a significant focus in 2017, with several articles reporting on the integration of new program assessment tools and procedures into various assessor networks. .

Council Update: Council Update is produced four times a year immediately following each Council meeting to share the decisions and areas of focus and discussion from the meeting. It is also our first opportunity to encourage participation/feedback on consultations on a variety of issues.


COUNCIL AWARD
An advocate for culturally sensitive mental health
Dr. Kenneth Fung honoured for work

COUNCIL AWARD

Each year we receive many nominations for the Council Award from communities, patients and colleagues. The Council Award Committee selected the following worthy recipients in in 2017: Drs. Kenneth Fung, Shazia Ambreen, Michael Stephenson and Gary Smith.

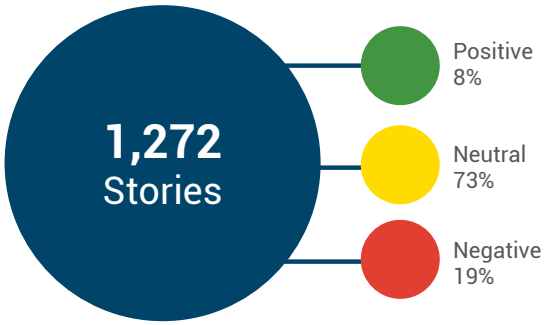
MEDIA RELATIONS

The work of the College is closely followed and scrutinized by the media. Each year, the College receives hundreds of inquiries about physicians who are under investigation or before the Discipline Committee, and, about our policies and initiatives. Responses to daily requests for information are developed on a wide variety of topics. We also actively reach out to media on a range of issues, and respond promptly to media inquiries.

As we've seen in years past, our discipline cases attracted the greatest interest, with 527 of 1,272 stories – or 41% of all stories – about various physicians who were the subject of proceedings.

We use the Media Relations Rating Points (MRP) system to measure all media activity related to the College. The MRP system measures coverage by any type of media (print; radio; online; television) and each media is scored up to 10 points based on the following:

- Tone of the story can earn 5 points for Positive; 3 for Neutral; and 0 for Negative;
- Each one of a set of predetermined criteria present in the story earns one additional point. The criteria are: CPSO mentioned; spokesperson quoted; key message included; mandate mentioned or evident; accuracy.



Looking at the volume of coverage in 2017, although there was a slight decrease in the overall number of stories (94 fewer in 2017 vs 2016), the overall volume continues to be significant. There was sustained interest from media on discipline cases, investigations, and CPSO policies and programs, with almost four news items about the College on average per day. The College was also the subject of focused attention from faith-based media on policies that set requirements for conscientious objectors.

Overall, the tone of the coverage was 8% (261 stories) positive; 73% (790 stories) neutral; and 19% (221 stories) negative. In comparing the 2016 and 2017 results, we saw an increase in the percentage of negative stories from 13% to 19%, and an increase in the percentage of neutral stories from 70% to 73%. The increase in negative stories is largely related the effective referral requirement and the Medical Assistance in Dying policy.

We always look for opportunities to generate accurate and balanced coverage of our high profile initiatives and of the decisions made by our College Committees.

OUTREACH PROGRAM

The CPSO's Outreach Program reaches out to members of the public and Ontario's physicians on key College issues. The program proactively targets specific areas of the province with organized education sessions, meetings, events, and presentations. Key CPSO spokespeople also participate in a variety of medical student and resident milestone events.

HIGHLIGHTS

- **Increased opportunities for intra-professional collaboration**
  - The CPSO continues to be a sought after regulatory resource internationally. In 2017, policy staff met with representatives from Denmark's Ministry of Health, and the Ministry Agriculture of Denmark to discuss our Marijuana for Medical Purposes Policy.

- **Produced 3 issues of Medical Student Update: e-newsletter**
  - Each issue contained critical information about self-regulation, professionalism and ethics geared towards medical students.

- **Coordinated education sessions on the CPSO Opioid Strategy**
  - Several CPSO spokespeople were equipped and dispatched to speak on the CPSO Opioid Strategy. **6** sessions were delivered across the province.

- **Sponsored Ontario Medical Student Weekend (OMSW)**
  - 450+ Ontario medical students in attendance at OMSW hosted by The Northern Ontario School of Medicine, Sudbury, Ontario.
  - Students had an opportunity to ask questions at an interactive CPSO booth.

- **Continued regular engagement at medical school milestones**
  - Registrar, President, Academic Council Representatives and Medical Advisors gave welcome and congratulatory remarks at medical class orientation sessions and convocation ceremonies across the province.

- **Most frequently requested CPSO topics:**
  - Boundaries and Sexual Abuse
  - The CPSO's Opioid Strategy
  - Medical Assistance in Dying
  - Medical Regulation

2017 Outreach by the Numbers	
15	Member outreach meetings with the profession including: Academies of Medicine, medical staff associations, hospital rounds
19	Meetings with members of the public and other healthcare stakeholders: Dying with Dignity (Kingston Chapter), Toronto Public Health, Ontario Pharmacists Association, Ontario Health Informatics Standards Council
6	Resident education sessions on: Relationships with Industry, Boundaries, End of Life, Registration
17	Medical student engagements including: Convocation addresses, orientation week sessions, Ontario Medical Student Weekend
57	Total outreach meetings with key CPSO target audiences

3. Government Relations

The role of the College, as well as our authority and powers, are set out in provincial legislation including the Regulated Health Professions Act (RHPA), the Health Professions Procedural Code, and the Medicine Act. The government has entrusted the regulatory function of regulating the medical profession in the public interest to the College. Given the scope and nature of College work we are regularly called upon by government decision-makers to inform policy and program development and potential legislative changes. We work to contribute to the public discourse in areas that touch on medical regulation and matters of patient safety. We also respond to legislation that has implications for medical regulation and patient protection, develop and maintain productive relationships with government decision-makers and MPPs from all three parties, and are active participants in the legislative process.
The following outlines some of the main initiatives underway in 2017.

LEGISLATIVE WORK

2017 was a very busy year with respect to government relations activities. This was in large part due to the heavy legislative agenda at Queen's Park. In 2017, we saw the passage of three Bills that were particularly relevant to the College: Bill 84, Medical Assistance in Dying Statute Law Amendment Act, 2017; Bill 87, Protecting Patients Act, 2017; and Bill 160, Strengthening Quality and Accountability for Patients Act, 2017.

Bill 84, Medical Assistance in Dying Statute Law Amendment Act, 2017 brought forward a series of amendments related to medical assistance in dying (MAID), following the passage of federal MAID legislation in 2016. Bill 84 secured protections from civil liability for physicians, nurse practitioners, and those assisting them, who had lawfully provided MAID; clarified that the Coroner of Ontario would be notified of a MAID-related death, but would have discretion over whether to initiate an investigation into the circumstances of the death; and safeguarded that entitlements, including insurance payouts and workplace safety benefits, could not be denied only because of a medically-assisted death. College President David Rouselle appeared before the Standing Committee on March 30th and expressed strong support for passage of Bill 84. A written submission was also provided.

Bill 87, the Protecting Patients Act, 2017 was an omnibus health bill that among other measures contains the government's response to recommendations made by the Minister's Sexual Abuse Task Force and the Goudge review. The objectives of the Bill were to strengthen the sexual abuse and transparency provisions of the RHPA and to improve the complaints, investigation and discipline processes at Regulatory Colleges. Notable changes included new powers for the ICRC to order interim suspensions at the investigative stage; expansion of mandatory revocation; changes to the Colleges' public registers; and creating a definition of "patient". The College made multiple written submissions on Bill 87 and the President appeared before the Standing Committee.

Bill 160, Strengthening Quality and Accountability for Patients Act, 2017 was an omnibus health bill that among other measures contained the government's plan to consolidate the oversight of out-of-hospital premises and independent health facilities – now called "community health facilities". The College was supportive of the overall design of this new system but had concerns and suggestions for clarifying certain aspects of the legislation. The College President appeared before the Standing Committee and a detailed written submission was also provided. These efforts contributed to an excellent outcome as almost all of the substantive amendments the College requested in our submission were made to the Bill in Committee.

The College also continued to work closely with government on a number of files of shared interest including the government's management of the public appointment process, issues surrounding opioids and medication management, MAID, and issues surrounding the prevention of sexual abuse of patients.

GR OUTREACH

The College reaches out to and builds relationships with elected officials from all three political parties and their staff. These interactions with elected officials aim to build awareness of the College role in medical regulation and protecting the public, keep decision-makers informed about our policy and program work, and allow us the opportunity to influence legislation, regulation and policy directions of government.

Public and Physician Advisory Services

The Public and Physician Advisory Service serves as the initial contact for members of the public and the profession. Advisors provide information about CPSO policies and assist with a wide variety of questions about physician practice. Advisory staff are the initial contact for complaints. They also assist physicians with all aspects of the annual renewal process. They respond to thousands of inquiries annually, via phone, e-mail, and written correspondence.

GENERAL OVERVIEW

In 2017, a total of 52,937 calls were placed to our frontline areas- Public Advisory and Physician Advisory Service (PPAS), reflecting a 2% decrease from 2016. The decrease in call volume is partially attributed to the increased success of the annual renewal process. Physicians are now more familiar with the online process and require less assistance. 88% percent of incoming calls were answered live in 2017 reflecting a 4% decrease from 2016, but exceeded the established target of 85%.

Live call rates and abandoned call rates are part of the College's strategic dashboard under operational excellence. Our live answer target in 2017 was 85% and our call abandonment target was 10%. These targets were achieved or surpassed in all four quarters of 2017. The Advisors continue to serve as the primary contact for all annual renewal related inquiries, including Post Graduate inquiries. PPAS continues to manage all clinical related complaint calls and subsequent follow up, which account for approximately 33% of all complaint calls.

2017 Annual Call Volumes (All Queues)

Year	Calls Incoming	Answered Live	To Voicemail	Abandoned
2017	**52,937**	**46,575 (88%)**	**2,274 (4%)**	**4,088 (8%)**
2016	53,803	49,330 (92%)	1,705 (3%)	2,768 (5%)
2015	55,647	50,230 (90%)	1,751(3%)	3,666 (7%)
2014	60,850	51,247 (84%)	3,019 (5%)	6,584 (11%)
2013	66,671	46,841 (70%)	9,003 (14%)	10,823 (16%)

Public Advisory Service

- We continue trying to merge the telephone queues so that there is one contact number for both the public and physicians. As a result, more physicians are calling the number that was previously designated solely for members of the public. However, many continue to use the physician advisory line as noted below. The total incoming call volume for 2017 decreased by 4% from 2016, which reflects the lower call volume from members during the annual renewal process.

- **Most frequently asked questions from the public**
  - How do I access a copy of medical records?
  - Are physicians permitted to charge block fees?
  - How can I find a family physician?
  - How do I file a complaint against a physician?
  - Can my physician terminate me as a patient?

Year	Calls Incoming	Answered Live	To Voicemail	Abandoned
2017	**47,815**	**42,086 (88%)**	**1,938 (4%)**	**3,791 (8%)**
2016	50,131	45,937 (92%)	1,572 (3%)	2,622 (5%)
2015	51,815	46,724 (90%)	1,593 (3%)	3,498 (7%)
2014	56,419	47,537 (84%)	2,363 (5%)	6,246 (11%)
2013	59,615	41,958 (70%)	7,844 (13%)	9,811 (16%)

Physician Advisory Service

- The total incoming call volume for 2017 increased by 40% compared to 2016, but reflects only an additional 1,450 actual calls. This is a result of more physicians using the dedicated physician advisory extension or selecting the option from the main voice mail menu. The live call response rate of 88% exceeded the established target of 85%.

Year	Calls Incoming	Answered Live	To Voicemail	Abandoned 2016
2017	**5,122**	**4,489 (88%)**	**336 (7%)**	**297 (6%)**
2016	3,672	3,393 (92%)	133 (4%)	146 (4%)
2015	3,832	3,506 (91%)	158 (4%)	168 (4%)
2014	4,431	3,710 (84%)	383 (9%)	338 (8%)
2013	7,056	4,883 (69%)	1,159 (16%)	1,012 (14%)

Emails

- PPAS reviews and either replies to or forwards all emails sent to Feedback, the College's main address on its website for general inquiries.
- 6,237 e-mails were received in 2017, representing a 10% increase over 2016.
- Advisory Services responded to 67% of these e-mails. Thirty-three percent were directed to other departments.
- 17% of the e-mails received related to the annual renewal process.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Quality Management
Annual Divisional Report
2017

The Quality Management Division (QMD) consists of three operational units and one project unit:

- Applications and Credentials
- Membership, Corporations and Physician Register
- Practice Assessment and Enhancement
- Quality Management Partnership

Activities, achievements and outcomes within these four areas for 2017 are summarized below.

APPLICATIONS AND CREDENTIALS

(Processes activities for individuals who want to become members)

MAJOR FUNCTIONS:

- Assess applications for a certificate of registration for all physicians in Ontario
- Issue, renew or terminate certificates of registration
- Provide guidance for applicants through the assessment, training and examination systems in Ontario and Canada
- Provide guidance for applicants for all CPSO registration policies and pathways
- Direct compliance and supervision for restricted certificates of registration, such as supervision and assessment
- Facilitate the Changing Scope of Practice and Re-entry into Practice for all registrants and members
- Facilitate and implement initiatives and policies that increase access to CPSO registration for qualified candidates
- Support Registration Committee to fulfill their decision making authority
- Fulfill the reporting mandate to the Office of the Fairness Commissioner

ACHIEVEMENTS:

- 1.7% increase in the total number of new issuance of certificates
- 97% of certificates in all classes were issued well within the benchmark service standard of 3 to 5 weeks
- The expedited review fee was launched and 438 applicants used the service
- The department was restructured to better utilize resources and therefore not require additional staffing budget
- HPARB appeals have decreased for the 6th consecutive year
- For the 14th consecutive year more certificates were issued to IMGs than to Ontario graduates
- The outcomes of the Pathways project were communicated, results were positive
- Successful completion of the registration process for the Invitcus Games
- Registration Committee projects a 40% savings by moving to committee panel meetings instead of full committee meetings

- Meetings continue in our work with stakeholder engagement at the Post Graduate offices, Ministry of Health, CaRM's symposium, Touchstone Institute, and Office of the Fairness Commissioner

OUTCOMES AND DATA HIGHLIGHTS:

Registration Committee Decisions

Applications Considered	2015	2016	2017
Total applications approved	1,247	1,154	1,261
Total applications refused	12	19	19
Total applications deferred	16	36	41
Total applications withdrawn	5	5	3
Total Applications Considered	1,275	1,214	1,279

HPARB Activity

Status of Appeals to HPARB	2015	2016	2017
HPARB confirmed the Reg. Comm. Decision	0	0	2
HPARB returned the case to the Reg. Comm. for reconsideration	0	0	2
Appeals withdrawn	2	1	6
Appeals outstanding	4	7	4

Inquiries of Applicants Serviced	2015	2016	2017
Calls Received	30,127	32,772	27,784
Calls Answered	26,005	28,261	23,004
Service Standard	86%	86%	82%
Written Correspondence	6,261	7,229	7,886
Customized application packages	2,508	2,636	2,872
Letters of Eligibility	1,306	1,188	1,242

Certificates of Registration Issued	2015	2016	2017
Independent Practice	1,624	1,593	1,671
Postgraduate Ed.	2,794	2,949	2,935
Restricted	551	361	384
All Other	24	23	16
Total Applications Processed	4,993	4,926	5,011

MEMBERSHIP SERVICES, CORPORATIONS AND PHYSICIAN REGISTER

(Processes a variety of activities for existing members)

MAJOR FUNCTIONS:

- Maintain the College Register and carry out various member services
- Assess applications for the authorization of medicine professional corporations and issue, renew or terminate certificates of authorization
- Issue Certificates of Professional conduct
- Ensure the annual renewal of general membership by collecting annual fees and facilitating completion of the mandatory annual renewal form
- Ensure the most effective and efficient administrative processes to successfully renew the registration of 38,481 members (33,903 general membership; 4,575 PGEs)
- Ensure adequate follow-up by specific departments related to individual physician responses to the annual survey, including follow-up with physicians not enrolled in CPD
- Process applications from 4,575 Ontario postgraduate trainee certificates applying for renewal of their PGE certificate

ACHIEVEMENTS:

- Certificates of Professional Conduct: Achieved issuance of 7,728 certificates. Over 90% issued within service standard of 5 days or less
- PGE Annual Renewal: The 2017 renewal process for Postgraduate Education certificates was completed faster than in any previous year. Only 10 out of 4,575 renewals missed their renewal due date of July 1, 2017. By comparison, in 2016 and 2015, there were 24 and 47 late renewals, respectively
- Annual renewal for General Membership: The process of renewing 33,903 members was carried out on schedule with no major issues or obstacles
- Late Renewals: Conducted successful follow-up of the 1,405 members who missed the June 1 due date. Only 58 suspensions for non-renewal were carried out
- CPD Non-complier follow up: successfully followed up with 230 CPD non-compliant members to ensure they enrolled in CPD or signed a cease-to-practise undertaking. Only one member was suspended for failure to comply
- Certificates of Authorization: Processed record high 19,993 renewals of certificates held by medicine corporations. Processed 1,076 new issuances
- Physician Register Activities: Continued to process large volumes of activity related to member resignations, undertakings, Registrar's notices, discipline entries, name changes, address changes. See figures in table below
- Online Member Portal: There was continued heavy usage by members of the self-serve options in the online member portal. Members made 20,313 online address and email updates in 2017, close to the record-high total seen in 2016

- The number of Registrar's Notices sent to other jurisdictions continued to increase in 2017. The increase is largely due to the College's Transparency Initiative and includes such matters as SCERPS, cautions-in-person, criminal charges and discipline findings in other jurisdictions

OUTCOMES AND DATA HIGHLIGHTS:
Certificates of Authorization

Medicine Professional Corporations	2015	2016	2017
New Issuances of Certificates of Authorization	1,643	1,484	1,076
Renewals Certificates of Authorization	17,529	18,848	19,993

Certificates of Professional Conduct

	2015	2016	2017
CPCs Issued	8443	7,241	7,728

Renewals and Extensions of Postgraduate Education Certificates

	2015	2016	2017
Postgraduate Renewals and Extensions	5,362	5,254	5,373

Physician Register

Total Membership	2015 (as of Jan 1)	2016 (as of Jan 1)	2017 (as of Jan 1)
All Registration Classes	40,243	41,146	41,920
Independent Practice Class only	31,803	32,405	32,987

Total Physicians in Active Practice in Ontario (excluding PG trainees, retired, out-of-province, etc.)	2015	2016	2017
	28,805	29,933	31,000 (estimated)

Physician Register – Related Activities

Physician Register – Related Activities	2014	2015	2016	2017
Address Changes Entered by Staff (new & edits)	28,914	25,707	24,674	24,389
Address Changes –Entered Online by Members	10,710	16,518	19,367	18,129

Email Address Changes – Entered by Staff	896	1,659	1,665	1,591
Email Changes – Entered Online by Members	2012	2147	2,098	2,184
Resignations from Membership	780	965	907	861
Legal Name Changes	68	60	57	56
Foreign Embassy Letters[1]	578	640	564	394
Registrar's Notices	153	236	430	650

PRACTICE ASSESSMENT AND ENHANCEMENT

(Coordinate all assessments in the Quality Management Division)

MAJOR FUNCTIONS:

- Conduct Peer Assessments generally comprised of an onsite records review and an interview with feedback to the physician
- Support and contribute to Peer Redesign which is developing an evidence based approach to assessment of physicians that will map onto all scopes of practice for which physicians are assessed
- Conduct Change of Scope and Re-entry Assessments of physicians changing their scope of practice, re-entering practice, and comprehensive peer and practice reassessments including observation and interviews with colleagues and co-workers
- Conduct Out-of-Hospital Assessments of new premises as they notify to become operational, as well as existing premises on a 5-year cycle
- Conduct Assessments of Physicians wishing to maintain an exemption from Health Canada to prescribe methadone (process will change as of May 19th, 2018 when the exemption is removed)
- Conduct Methadone Delegation exemption assessments in collaboration with Ontario College of Pharmacists which allows for the administration of methadone from community clinics
- Conduct Independent Health Facilities (IHF) assessments and reassessments as requested by the Ministry of Health Director of IHF. IHFs are assessed on a 5 year cycle
- Update Clinical Practice Parameters (CPPs) used in IHF assessments on a 5 year cycle
- Conduct Registration Assessments on behalf of the Registration Committee to determine if a physician should obtain an independent practice certificate
- Conduct Assessments of CPSO members providing anesthesia procedures in dental clinics. These assessments are conducted in collaboration with the Royal College of Dental Surgeons of Ontario
- Coordinate Assessor Network, providing support through administration of the Assessor Governance Framework, ensuring a consistent approach to recruitment, orientation and training of Assessors for QMD, including the Biannual Assessor Meeting

[1] Foreign Embassy letters are a service for persons travelling abroad with medical forms requiring certification that the physician who prepared the form is registered with the College

- Ongoing collaboration with Public Health Ontario and regional public health units in the review and investigation of infection control lapses in regulated clinics (IHFs/OHPs)
- Committee Support unit oversees the administration of five College Committees

ACHIEVEMENTS:

- Began planning for the 2018 Assessor Meeting
- Continued implementation of a new administrative process for peer assessment to address gaps in data reporting requirements and solutions to streamline work
- In conjunction with OntarioMD developed and launched the Oscar, QHR and Acuro Training Videos for assessors to access electronic medical records
- Conducted an RFP and selected a company to develop additional training modules for assessors on report writing and conducting a post chart interview
- Updated and expanded a Decision Guide to support QAC member's standardization in decision making. Training provided to staff contributed to the development of the work being done to develop "New Member Orientation"
- Continued work with the Quality Assurance Committee Working Group to support the launch of Peer Redesign assessments
- Continued collaboration on the development of new Peer Assessment tools and procedures as part of Peer Redesign initiative
- Currently 9 disciplines are using peer redesign tools, 3 more disciplines will be developed in 2018 with the remaining eleven including a generic format in 2019 or 2020
- Committee education being offered at all QAC policy meetings – in addition to the annual QAC Education day
- Participated as a key stakeholder in development of the annual Methadone Prescribers Conference offered by Centre for Addiction and Mental Health (CAMH)
- Lead department coordinating a QA response to physicians identified through NMS data, addressing issues related to both assessment of opioid prescribing and changes to the governance of methadone prescriber assessments
- Facilitated transition of the Methadone committee to be a specialty panel under the Quality Assurance Committee
- Updated the Independent Health Facilities (IHF) Clinical Practice Parameters and Facility Standards for Nuclear Medicine, Diagnostic Imaging and Dialysis in collaboration with the corresponding IHF Task Force
- Began coordination with Public Health Ontario for the delivery of Infection Prevention and Control training for IHF assessors. This included the development of training materials and a full day wrap-up component with all participants
- Successful inaugural Medical Director Education Day providing program updates and support to over 250 stakeholder attendees in the Out-of-Hospital Premises Inspection Program
- Updated the Out of Hospital Premises Inspection Program (OHPIP) Standards to increase the responsibilities and duties of the Medical Director role in Out-of Hospital Premises (OHPs)

- Initiated and finalized a Changing Scope of Practice Working Group to develop a framework to guide physicians not certified in Emergency Medicine, who wish to practice EM in a Rural Setting
- Collaboration with Ministry of Health and Long Term Care in the drafting of Bill 160 (Schedule 9 – Oversight of Health Facilities and Devices Act). The Bill received royal assent in December 2017. Involved in providing a considerable amount of submissions to the Legislative Standing Committee conducting hearings on Bill 160
- Initial discussions and transition planning internally regarding the impact of the implementation of Bill 160 on existing facility assessment programs in QMD
- QMD Committee Support area was responsible for the coordination of the five QMD Committees (including member specific and policy meetings) resulting in over 145 committee meetings in 2017. Decision Administrators completed just under 1,631 decision letters to communicate Committee decisions

OUTCOMES AND DATA HIGHLIGHTS:

Type of Physician Assessment	2015	2016	2017
QA Peer Assessments	1,048	1,295	1,341
Change in Scope of Practice Assessments	32	36	50
Re-entry to Practice Assessments (through QAC)	3	3	5
Peer & Practice Reassessment (Comprehensive)	13	9	1
Methadone Assessments	87	98	87
IHF Physicians Assessed	298	465	321
OHP Physicians Assessed	111	382	250
Assessments for Registration Decisions	193	107	129
Pathways Assessments	612	422	33
TOTAL	2,384	2,817	2,216

Peer Assessment Outcomes

2017 saw significant changes made part way through the year with respect to how assessment outcomes were reported and classified. These changes included upgrades and version changes to the Activity Management System (AMS) that records the data. As a result there were changes to the data capture in the two different versions and therefore an annual comparative summation of the data is not possible. However, these changes will result in better data capture on assessment outcomes for all assessment types including Peer Redesign in subsequent reports

Data available upon AMS upgrade:

- 78% of assessments were No Further Action (Satisfactory)
- 4% of assessments resulted in reassessment in one year
- 2.3% of assessments resulted in an enhanced interview
- 1.6% of assessments resulted in some type of undertaking
- .2% of assessments resulted in a SCERP

- 13.9% of assessments remain without an outcome as of Dec. 31, 2017

Targeted Assessments: (70+)

- 15% of targeted assessments were reassessments directed by QAC in 2016
- 16% of targeted assessments done in 2017 were age 70
- 15% of assessments done in 2017 were age 70+
- 0.2% of targeted assessments done in 2017 were Change of Scope

Methadone Prescriber Assessment Outcomes

Methadone	Satisfactory Assessment			Re-Assessment or Interview		
	2015	2016	2017	2015	2016	2017
1st Year Assessment	60%	72%	68%	40%	28%	32%
3rd Year Assessment	76%	75%	84%	24%	25%	16%
5th Year Assessments	75%	73%	71%	25%	27%	29%
Re-assessments	79%	64%	78%	21%	36%	22%

Facility Based Assessment Outcomes

Type of Assessment	2015	2016	2017
IHF	199	171	130
OHP	67	117	111
TOTAL	266	288	241

Independent Health Facilities Outcomes

	Satisfactory Assessment			Licensing Action Required by MOHLTC		
	2015	2016	2017	2015	2016	2017
All IHFs	97 %	99%	98%	3%	1%	2%

Out of Hospital Assessment Outcomes

	Pass			Pass with Conditions			Fail		
	2015	2016	2017	2015	2016	2017	2015	2016	2017
All OHPs	34%	38%	36%	39%	40%	44%	3%	8%	5%

Note: In addition to Pass/Pass with Conditions/or Fail – 15 % of 2017 total Assessments were categorized as: Deferred or Not Rated.

QUALITY MANAGEMENT PARTNERSHIP

(Formal partnership created by the Ministry of Health between Cancer Care Ontario and the CPSO to develop provincial quality management programs for colonoscopy, mammography and pathology services)

MAJOR FUNCTIONS:

- Development of facility standards and guidelines to improve the consistency of care provided across all facilities
- Quality reporting at the provincial, regional, facility and provider levels
- A supportive three-tiered clinical leadership structure to foster continuous quality improvement and accountability
- Resources and opportunities to support quality improvement
- Monitor and evaluate Partnership programs
- Link to health system stakeholders to leverage opportunities for implementing and championing the Partnership and its quality management programs
- Determine legislative and/or regulatory supports and strategies to support the Partnership and its quality management programs

ACHIEVEMENTS:

Operations:

- Defined and streamlined practices for sharing facility business information between College and CCO
- Tested unsuccessfully methodology to assign OHP location to OHIP colonoscopy claims in order to provide more fulsome reports to OHPs
- Streamlined funding agreement processes between CPSO/CCO to foster ease of renewal each year

Clinical leadership structure:

- Two Provincial Leads meetings were held focusing on collaboration, engaging non-physician members in the work of Provincial Quality Committees (PQC), evaluation and quality improvement resources

Quality Improvement Resources:

- Launched a learning management system (LearnQMP) to support training, communities of practice, and information sharing
- Posted tools, resources and links to literature for colonoscopy and pathology
- 198 facility leads were registered, colonoscopy (145) and pathology (53) in the LMS by end of December
- Conducted two train-the-trainer sessions, identified six trainers (two in each health service area and provided two training sessions

- Collaborated with IDEAS (Improving & Driving Excellence Across Sectors) to develop training plans for foundations in quality improvement skills and methods
- Coordinated the development of brief guidance documents with RCPSC for clinicians participating in the training to claim CPD
- Developed physician and facility improvement plan templates to support QI initiatives related to the QMP reports in each HSA

QMP (Quality Management Program) Reports
Facility, Regional and Provincial Reports:

- Generated one report for 524 recipients (colonoscopy 179, mammography 290, pathology 55)
- Hosted three webcasts, one for each service area (colonoscopy, mammography and pathology) to orient recipients to reports prior to distribution
- Created a supplementary information package for dissemination with reports for each of colonoscopy, mammography, and pathology
- Held a total of seven technical briefings in follow-up to distribution of the reports

Colonoscopy physician level quality management reports:

- 905 physicians received individual performance reports
- Held two technical briefings to support physician recipients post report release
- Provided a list of resources to support colonoscopy performance, a physician learning plan template and contact information for Regional Leads

QMP Standards Integration:

- Work continues to adapt the colonoscopy facility standards for integration into key system stakeholders' programs, e.g., Quality Based Procedures (QBP), Canadian Association of Gastroenterology (CAG)
- Embedded additional colonoscopy and mammography QMP standards for Facility Leads into the OHPIP standards and IHF Diagnostic CPPs
- Revised the language of 10 of the 28 pathology standards for additional clarity and ease of adoption by laboratories in Ontario
- Conducted a targeted consultation about the revised pathology standards to confirm clarity and acceptance by pathologists and laboratories

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Research and Evaluation

Annual Divisional Report

2017

Research and Evaluation Department 2017 Annual Report

The Research & Evaluation Department (RED) promotes the use of evidence for decision making, continuous quality improvement and member education at the strategic and operational levels of the College. We integrate data collected by CPSO through our large data systems, information that we have collected directly from stakeholders and systematic reviews of the published literature. We collaborate and interact with our system partners to leverage excellent quality remedial and education programs for our members. Through our multi-disciplinary expertise we apply qualitative, quantitative, and mixed- methods approaches toward informed decision making in our medical regulatory environment.

RED continues to guide the College toward a continuous physician practice quality and improvement system based on CPSO mandate. With continuous collaboration and consultation, RED developed the framework draft below to guide our work over the next few years:

RED leads two CPSO strategic initiatives:

- Education Strategic Initiative: To promote and support life-long learning for physician practice competence and public safety
- Data and Analytic Strategy: To develop quality data to inform decisions, support programs, improve practice and maintain member and public trust.

Both were approved by Council and are currently being implemented across the College.

RED Achievements for 2017

A. Understanding the risk and support factors associated with physician performance and practice outcomes

1. Pan Canadian Physician Factors Steering Committee

The RED team is a key contributor to this national initiative. In June 2017, we co-led the National Factors meeting which developed a white paper document to move the National work forward. In particular, CPSO RED collated the research projects from across the country into a "state of the science" synthesis which will be presented this year at FMRAC.

RED also presented this national work at IAMRA in London, 2017. This work is deemed to be seminal, spurring worldwide discussion and impact.

2. Evaluation of the CPSO's Registration Pathways and Policies

The full analysis of the three "Pathways" outcome components were presented at Council in December 2017. Peer reviewed articles outlining this work is underway.

3. Examination of full member data to understand factors associated with CPSO public advisory calls and complaints

Specifically, the purpose of this project is to determine:

- the nature and frequency of advisory calls for the Ontario physician membership in 2010 for the subsequent 5 years - 2011-2015
- the demographic and practice factors associated with a) receiving an advisory call, and b) receiving a complaint in Ontario between 2011 – 2015 for the 2010 cohort of College members
- the full utility of CPSO administrative data for analytics

The methodology developed from the project supports:

- using data to identify member-related risk and supports which underpin the proposed corporate operational approach for quality assurance programming
- the methodology that underpins the "triage" approach for the opioid strategy

An abstract has been accepted to CPE and submitted to IAMRA. A full written report is underway

4. A qualitative study of the experiential knowledge of College assessors regarding physician risk and support factors

- College assessors have a wealth of experiential knowledge regarding the risk and support factors of physician performance.

- The purpose of the qualitative study is to interview assessors in Ontario, Alberta and Manitoba regarding these factors in order to supplement our knowledge of risk and support factors.

  In collaboration with Alberta and Manitoba, a final manuscript for peer review publication is complete.

5. **Collaboration study with MCC:**
   - Are exam scores associated with downstream peer assessment outcomes?
   - Third party de identified data linkage
   - REB approved
   - Analysis at MCC

B. Program development and evaluation

1. Assessment Re-visioning: Peer Assessment Redesign

- Peer Assessment "Handbooks" (comprising newly developed assessment tools) have been implemented into 10 disciplines to date. These 10 disciplines (including family medicine) account for over 50% of the annual volume of peer assessments conducted by the College.
- An evaluation of the new program is currently underway to monitor the impact of the new tools and processes on program operations (affecting committee, staff, and assessors) and assessing the impact of the program on physician practice.
- New disciplines (including the surgical specialities) have begun a streamlined process of developing their own quality-improvement focused peer assessment tools.

2. Evaluation of Multi-Source Feedback (MSF)

Evaluation is complete and was delivered to Council in May 2017. The further use of MSF at CPSO is under discussion.

C. Supporting Physician Education and CPD

- New Education Lead hired in September - replacement
- Education Strategy presented and approved at Council in February
- Implementation of Strategy initiated
- Ongoing support for Education Committee
- Implementation of a New Member Orientation modules – requirement for new members

- Implementation of evaluation of outcomes of 2016/17 opioid cases
- Ongoing stakeholder engagement relating to supportive and remediation resources for physicians (CPD Ontario; CPD-COFM; CFPC, RCPSC, OCFP etc)
- Opioid remediation and program environmental scan for members
- Continued internal and external collaboration to align physician needs, committee decisions and programs

D. Opioid Strategy

1. **Opioid Strategy Education Working Group**

   - Co-leading Working Group and supported the development of remedial and supervisory processes for the 2016/17 NMS cohort
   - Developed (and continuing to develop) a resource compendium and evaluation of programs and resources for members – updated on website
   - Stakeholder engagement for appropriate programs relating to opioid prescribing
   - Evaluation of outcomes of supervision and remediation of NMS cases
   - Developed and implementing a remediation model to ensure standardized committee decision making (Hauer model) – focusing on opioid cases

2. **Opioid data and evaluation working group – Lead**

   Developing an approach that would integrate our College Knowledge with de-identified ICES output and identified NMS data from the MOHLTC (if we have the ability to collect it). This supports the development of risk-informed programming at the College.

3. **Funded by the Ministry of Health and Long-term Care Applied Health Research Question**, ICES submitted the final analyses to CPSO that describes the magnitude and intensity of opioid prescribing by Family Physicians in Ontario. This output supports the CPSO opioid strategy and the broader system that is focused on opioid prescribing. HQO has participated in the project development (and funding) over the year.

4. **Evaluation by Optimus** focusing on the internal processes for investigating 102 NMS cases in I&R over 2016/2017. Report delivered January 2018.

E. Data strategy and support

- Hired new Research Data Analyst to support data strategy activities and College-wide analyses - replacement

- Implementation of Data Inventory
    a. Summer student hired
    b. Education sessions for all College depts.
    c. Deployment of data inventory in each department across the College
    d. Begin to report and provide feedback to departments
- Plan for Central Data Repository for analytics
- Proposal for data use governance – data sharing working group
- Develop longitudinal data for analytics
- Article in College Pulse
- Rocco's blog

- Project: Member demographics, practice characteristics shift over time: project underway – report Fall 2018

F. College data, evaluation and presentation support

- Evaluation of Legal pilot project: Provision of independent legal advice for complainants/witnesses in discipline hearings relating to sexual misconduct
- Rapid analytic response for staff and Council members
- Evaluation development and analysis for finance committee survey
- Support for staff presentations – power point and data visualization needs
- Support for data collection - Qualtrics
- Analytic support for presentations

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

GOVERNANCE REVIEW - PART 1

Council Briefing Note

May 2018

TOPIC: CPSO Governance Review

FOR DISCUSSION

ISSUE:

- Council supported a review of the CPSO's governance structure in February. The review is being overseen by a working group that consists of members of the College's Governance and Executive Committees.
- The Governance Review Working Group (GRWG) established the goal and objectives of the review and has had some initial discussion regarding governance best practices and preliminary principles of a high performing board and governance structure.
- Council is asked to consider the work of the GRWG to date with a focus on the jurisdictional summaries and literature review that are highlighted in the following material, and provide feedback on the themes that have emerged from the GRWG's initial discussions, to help direct the CPSO Governance Review going forward.
- The governance review discussion at Council will take place in two parts:

    1. Day 1: After reviewing the materials, Council will be asked to consider the following questions:
        i. What are the strengths and weaknesses of the current governance structure?
        ii. What elements of other governance models do you find most appealing?

    2. Day 2: Small group discussions will take place and the following questions will be considered:
        i. What are the characteristics of a high functioning modern board?
        ii. Thinking ahead to identifying the core principles that should underpin CPSO's governance structure, what are your early suggestions?
        iii. What changes to the College's governance structure would improve the College's effectiveness?

BACKGROUND:

A. CPSO Governance Review

- The working group has established the approach, goal and objectives of the CPSO Governance Review. These are set out below.

Approach

- The approach for the review includes the following:
    - Utilize resources that have been developed. This includes literature reviews, research, best practices (CNO, Law Society).
    - Review to focus on structure as opposed to detailed consideration of processes.
    - Education of oversight mechanisms with a focus on the UK's PSA model.
    - Working group membership includes members of the Governance and Executive Committees. Working group meetings will take place in conjunction with existing Executive Committee and Governance Committee meetings.
    - Governance education sessions will be a focus of every Council meeting in 2018.

Goal and Objectives of the Review

- The goal of the review is to identify governance principles and best practice structural changes to update and strengthen the integrity of the regulatory system and mandate to ensure public protection.
- The objectives of the review include the following:
    1. Education- build awareness and understanding of:
        a) governance structures of similar organizations;
        b) governance best practices, including characteristics of high performing boards and committees;
        c) external environment, including an assessment of current pressure for change;
        d) regulatory oversight mechanisms, with a focus on the UK's PSA model
    2. Position organization to effectively influence and respond to anticipated activity in the external environment (development of governance related regulations)
    3. Adopt principles re a high performing board, governance structure
    4. Identify recommendations where indicated in support of governance reform.

B. External Environment

- An overview of the current regulatory governance landscape is set out below.

1) Government of Ontario and the McMaster Health Forum

- The governance structure created through the *Regulated Health Professions Act* (*RHPA*) 25 years ago is perceived as out of date.

- Ministry leaders have stated that there are too many health Colleges and that the *RHPA* structure of having a single college for each health profession is dated.
- The Liberal government expressed a commitment to medical workforce modernization.
- Bill 87 lays important groundwork for modernization and includes the most comprehensive changes to the *RHPA* since it was put in place 25 years ago.
- For example, government now has the ability to establish the composition and functions of all College statutory committees.
- The Ministry contracted with the McMaster Health Forum to consider modernizing the oversight of the health workforce in Ontario in 2017.
- As part of this work, the McMaster Health Forum prepared an extensive evidence brief, and convened three citizen panels on the subject of modernizing the oversight of the health workforce in Ontario, followed by a stakeholder dialogue that was informed by the insights captured through the panels.
- The evidence brief served as the basis for discussions by the panels and identified the following as the problems with the current governance model:
    1. Oversight is out of sync with the health care system
    2. Regulation of individual professions, not groups and do not include everyone
    3. Oversight is out of sync with education and training
    4. Funding of oversight bodies doesn't optimize public protection efforts
    5. It is difficult to find information on how health workforce and oversight bodies are performing
    6. Citizens are not consistently engaged in oversight
- Citizens panels reviewed the brief and identified additional challenges that warrant modernizing the oversight of the health workforce in Ontario:
    1. Oversight bodies have not adapted to changes in the delivery of care;
    2. Having many bodies responsible for the oversight of the health workforce makes navigating the oversight system challenging and may be inefficient;
    3. The oversight framework doesn't put enough emphasis on the soft skills and personalization required to provide high-quality patient-centred care;
    4. Oversight bodies have not been set up in a way that prioritizes the interests of patients;
    5. Finding information about health workers and their oversight bodies is difficult and there are limited opportunities for patients to contribute to oversight efforts; and
    6. Risk of harm needs to be identified and addressed across a patient's entire care pathway.
- Stakeholder participants also generally agreed that there is a compelling set of factors that suggest the need to modernize the oversight of the health workforce in Ontario, particularly:
    - The existing oversight framework is no longer fit for purpose
    - The media frequently draws attention to issues that may not warrant it
    - Politicians typically react to every issue regardless of its importance to the system as a whole

  - Some professional associations are not advancing their members' understanding of the importance of protecting the public.
- The final reports from the Forum are available here.

2) Minister's Technical Advisor

- The Minister appointed a technical advisor (Deanna Williams) in mid-2017 following the release of the Minister's sexual abuse task force report.
- Her mandate includes providing advice on issues that flow from the regulations relating to Bill 87.
- Her mandate also includes consideration of best practices in Ontario and other jurisdictions in college governance and college committee membership and review and analysis of the Sexual Abuse Task Force recommendations.

3) College of Nurses of Ontario

- The College of Nurses of Ontario has completed a comprehensive governance review. They created a Task force in 2014 with a mandate to review all aspects of its governance structure and operations. The CNO task force reviewed global governance trends, best practices and expert advice.
- The resulting report, Final Report: A vision for the future is comprehensive, recommending everything from the elimination of elections, a much smaller Council (down to 12 from 35), an even split of public and professional members, competency-based appointments and no overlap in membership between Council and college committees.
- CNO work includes significant literature and jurisdictional reviews.
- CNO is focused on implementing changes for 2020. They are working on developing a plan for implementation and identifying advancements that can occur without legislative change.
- Comprehensive information about the CNO governance review including a literature review and recommendations can be found here.

4) Law Society of Upper Canada

- Looking outside of the health sector, the Law Society of Upper Canada also initiated a Governance Task Force in 2016.
- It has the mandate to review the Law society's corporate governance, including practical process issues and governance structure issues, engage in research and consultation and make recommendations to Convocation (the Law Society's large board) to improve corporate governance through greater transparency, inclusiveness, effectiveness, efficiency and cost-effectiveness.
- The Law Society governance structure has some significant differences from that of the CPSO and CNO (i.e., 95 benchers/board members) however, initial results of the review reported at Feb 2018 Convocation appear to have some consistency with the overall direction of the CNO work.

- To achieve greater effectiveness for governance at the Law Society, the Task Force has proposed to focus on:
    a. Models for an appropriate smaller size for the Law Society's board
    b. The appropriate board structure;
    c. Changes to the composition of the board;
    d. The appropriate terms for the Treasurer and benchers (board members);
    e. Committee structure and membership, and conduct of board and committee meetings; and
    f. Governance and conduct policies for board members.
- Changes are meant to occur by 2023.
- More information about the Law Society's governance review can be found here. Information about the extensive jurisdictional review undertaken as part of this work is set out below.

C. CPSO's Preliminary Work

- Council has been considering and discussing governance issues for the past three years:
    - **Feb, 2016:** Council heard a presentation from Bob Bell, Overview of regulatory models/jurisdiction summary and from Robert Lapper at the Law Society, Regulatory Models and an Overview of the Law Society of Upper Canada.
    - **Feb, 2017:** Council recommended creating greater independence of the Discipline Committee and put forward amendments as part of Bill 87 submissions. The College recommended changes to prevent overlap in membership between Council and discipline to strengthen, modernize and ensure the integrity of the discipline/adjudicative process.
    - **Sept, 2017:** Council endorsed a process to facilitate the election of a public president. Council also heard a presentation from Anne Coghlan at the CNO regarding their Governance Vision 2020.
    - **Feb, 2018:** Council supported the concept of a governance review working group.

D. Jurisdictional and Literature Reviews

- The GRWG considered governance structures of organizations with similar mandates and literature related to board best practices for board effectiveness. An overview of the material considered is set out below.

1) CPSO Jurisdictional Review

- Preliminary background research about the governance structures in other jurisdictions was presented at the February 2016 meeting of Council.

- This included review of medical regulatory governance structures in Quebec, UK, Australia and New Zealand and, review of the governing structure of the Law Society of Upper Canada.

- The following items were compared across jurisdictions:
    - o Governance
    - o Elected physicians/members
    - o Physician/public ratios
    - o Hearings
    - o Separation between board and tribunal
    - o Location of hearings
    - o Involvement of lawyers on discipline panels and boards
    - o Oversight Body

- In summary, some of the reforms and findings or areas of difference when compared to the CPSO include the following:
    - o A move to smaller boards (though there are considerable differences);
    - o A move to separate or create more independence between board and adjudicative functions;
    - o A variety of oversight models – the UK's Professional Standards Authority is seen as the gold standard by many;
    - o For some regulators a move away from "electing" board members from amongst membership.
- Geographic representation on the board is common in Canadian organizations in the comparator group. In other jurisdictions, directors are elected to represent fields within the practice or other non-geographic constituencies within the profession (this is particularly common among Australian organizations).
- A detailed comparison of these topics across jurisdictions is set out in Appendix A.

2) Law Society Jurisdictional Review

- As part of the Law Society's governance review a comprehensive jurisdictional review was undertaken of 33 self-regulated organizations from Canada, the United Kingdom, Australia and New Zealand including lawyers, accountants, engineers, teachers, doctors, nurses and dentists. The review compared the following governance issues:
    - o Board Function and Size
    - o How Directors are Selected
    - o Director Terms
    - o Director Term Limits
    - o Committee Structure
    - o How Board Officers are Selected
    - o Adjudication

- The results of the jurisdictional comparison can be found here.

Literature on Board Best Practices

- There is a considerable body of literature that addresses board best practices for board effectiveness.
- Both the CNO and the UK's Council for Healthcare Regulatory Excellence have reports that detail literature related to board best practices.[1]
- In light of the direction of the GRWG to utilize existing resources, a summary of key literature that has been prepared by the CNO and UK's Council for Healthcare Regulatory Excellence is provided below.

Board functions and roles

- Literature suggests that boards across sectors generally have similar core functions:

1) **Strategic leadership and strategic decision making**
   - setting an organization's overall goals and high level policies; defining its mission and values and shaping a positive culture
2) **Stewardship, including holding the executive to account**
   - ensuring legal, ethical and financial probity and integrity and taking care of organizational resources
3) **External relations and accountability**
   - maintaining relations with important stakeholders; ensuring obligations to stakeholders are understood and met, representing the organization externally
4) **Board maintenance**
   - responsibility for sustaining, checking and repairing the ways in which the board functions; recruiting members, reviewing and evaluating their performance and developing their capacity to work effectively.[2]

- The roles described above align with the role of Council set out in the CPSO's Governance Process Manual.

Optimal Board Size for Board Effectiveness

- There is a range of literature and research that considers the optimal size of boards.

[1] These documents include the CNO's Governance Literature Review and Trends in Regulatory Governance and the UK's Council for Healthcare Regulatory Excellence's report, Board size and effectiveness: advice to the Department of Health.

[2] Cornforth, C, 1996. *Governing Non-profit organisations: Heroic Myths and Human Tales* (As cited in Council for Healthcare Regulatory Excellence. (2011). *Board size and effectiveness: advice to the Department of Health regarding health professional regulators.*)

- Both the CNO's Governance Literature Review and the UK's Council for Healthcare Regulatory Excellence report, highlight a range of literature that supports that smaller boards are considered best practice for board effectiveness.
- Generally recommendations for size range from 8-12 members and do not exceed 15 members.
- The literature details the rationale for smaller boards. This is set out below.

Behaviour and Board Size – Larger Boards

- Research suggests that large boards have inherent difficulties, including:
    - "As groups increase in size they become less effective because the coordination and process problems overwhelm the advantages gained from having more people to draw on."[3]
    - "As team size increases, it becomes more difficult for team members to contribute their knowledge, skills and experience to their full potential."[4]
    - "Increasing a team's size can hamper its coordination, diminish its members' motivation, and increase conflict among other team members."[5]
    - Problems of fragmentation – "In meetings of large boards, a small number of individuals often dominate and it is almost inevitable that a sub-group emerges to take on a disproportionate share of the power and governance role."[6]
    - "Individuals decrease their efforts as the number of people in the group increases, which results in social loafing phenomenon" or 'free riding'.[7]
    - Large boards require greater resources to support and administer.

Behaviour and Board Size – Smaller Boards

- Smaller boards have been found to promote effectiveness in the following ways:
    - *Satisfying mission:* "Boards consisting of about 10-12 members are more efficient in serving their clients and better able to satisfy their outreach mission".[8]

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[3] Jensen, M. C., 1993. *The Modern Industrial Revolution, Exit and the Failure of Internal Control Systems*. The Journal of Finance, pp 831-880, at p.865 (As cited in Council for Healthcare Regulatory Excellence. (2011). *Board size and effectiveness: advice to the Department of Health regarding health professional regulators*.)

[4] Hoegl, M. (2005). *Smaller teams–better teamwork: How to keep project teams small. Business Horizons*, 48(3), 209-214. http://dx.doi.org/10.1016/j.bushor.2004.10.013 (As cited in College of Nurses of Ontario. (2016). *Governance Literature Review*)

[5] Staats, B. R., Milkman, K. L., & Fox, C. R. (2012). *The team scaling fallacy: Underestimating the declining efficiency of larger teams.* Organizational Behavior and Human Decision Processes, 118(2), 132-142. http://dx.doi.org/10.1016/j.obhdp.2012.03.002 (As cited in College of Nurses of Ontario. (2016). *Governance Literature Review*)

[6] Framjee. P., *When less is more*, March 2008 (As cited in Council for Healthcare Regulatory Excellence. (2011). *Board size and effectiveness: advice to the Department of Health regarding health professional regulators*.)

[7] Hoegl, M. (2005). *Smaller teams–better teamwork: How to keep project teams small.* Business Horizons, 48(3), 209-214. http://dx.doi.org/10.1016/j.bushor.2004.10.013 (As cited in College of Nurses of Ontario. (2016). *Governance Literature Review*)

- *Teamwork*: "Smaller boards have efficient communication, greater efforts by all team members and a better utilization of all team members' potential".[9]
- *Participation*: "Smaller board sizes are more easily able to create an environment with active participation in meetings."[10]
- *Communication and Decision Making*: "Smaller sized groups are able to communicate more effectively and reach decisions more quickly than larger ones."[11]
- *Flexibility: "*Small size is more associated with organic and flexible structure and large size with more bureaucracy."[12]

Board composition: Diversity and Performance

- Research suggests that board member diversity is associated with better-performing organizations.[13]
- Diversity is seen as beneficial because "it expands views on issues, options and solutions."[14]
- Having board members with similar educational and occupational career paths can lead to "groupthink" and loss of cognitive diversity. Research has shown that the closer board members are in outlook, the less likely they are to raise questions that might break their cohesion.[15]

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[8] Hartarska, V., & Nadolnyak, D. (2012). *Board size and diversity as governance mechanisms in community development loan funds in the USA*. *Applied Economics*, 44(33), 4313-4329. http://dx.doi.org/10.1080/00036846.2011.589812 (As cited in College of Nurses of Ontario. (2016). *Governance Literature Review*)

[9] Hoegl, M. (2005). *Smaller teams–better teamwork: How to keep project teams small.* Business Horizons, 48(3), 209-214. http://dx.doi.org/10.1016/j.bushor.2004.10.013 (As cited in College of Nurses of Ontario. (2016). *Governance Literature Review*)

[10] Barry, Jean, International Council of Nurses. (2014a). *Regulatory Board Governance Toolkit*, page 36 (As cited in College of Nurses of Ontario. (2016). *Trends in Regulatory Governance*)

[11] Crowe Horwath, *Organization Review Recommendations to Nursing and Midwifery Board of Ireland*, December 2015, page 10 (As cited in College of Nurses of Ontario. (2016). *Trends in Regulatory Governance*)

[12] Bradshaw, P. (2009). *A contingency approach to nonprofit governance*. Nonprofit Management and Leadership, 20(1), 61-82. http://dx.doi.org/10.1002/nml.241 (As cited in College of Nurses of Ontario. (2016). *Governance Literature Review*)

[13] Harris, E. E. (2014). *The impact of board diversity and expertise on nonprofit performance*. Nonprofit Management and Leadership, 25(2), 113-130. http://dx.doi.org/10.1002/nml.21115 (As cited in College of Nurses of Ontario. (2016). *Governance Literature Review*)

[14] Spencer Stuart, 2010. *Cornerstone of the Board: Lessons on creating or rebuilding a board*. http://www.spencerstuart.com/research/articles/1429/ (As cited in Council for Healthcare Regulatory Excellence. (2011). *Board size and effectiveness: advice to the Department of Health regarding health professional regulators*.)

[15] Hemphill, T.A, Laurence G.J. (2014). *The case for professional boards: an assessment of Pozen's corporate governance model*. International Journal of Law & Management, 56(3), 197-214. http://dx.doi.org/10.1108/IJLMA-07-2012-0023 (As cited in College of Nurses of Ontario. (2016). *Governance Literature Review*)

Elections and Appointments

- The literature cites the inherent complexities with the use of elections in forming regulatory boards:
- *Confusion for Membership and the Public:*
    - "Board members often believe they were elected to represent the interests of the members who elected them"[16]
    - "The election process may, incorrectly, suggest the Parliamentary model where representatives are elected to act on behalf of their *constituents*"[17]
- *Potential Conflicts:*
    - "General concern for reputation of the profession can present conflicts"[18]
    - "Professionals, bring practitioners' perspective: professional empathy may overtake sensitivity to patient needs"[19]
    - "Re-election can become a concern for some Council or Board members if a controversial regulatory issue arises during their term"[20]
- *Perceived Conflicts:*
    - "For patients and the public, who do not participate in this democratic process (elections), the perception will remain that their own interests are at risk of being given less weight. The perception of independence is undermined as a result and the effectiveness of the regulators is significantly diminished."[21]
    - "Perceptions of conflict of interest are as important to public confidence as actual conflicts of interest"
- Literature suggests that "councils that regulate health professions have, as a minimum, parity of membership between lay and professional members, to ensure that purely profession concerns are not thought to dominate their work".[22]
- The independent appointment of Council members is suggested to dispel the perception that councils are overly sympathetic to the professionals they regulate.[23]

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[16] Steinecke, R (2003, July). *Will the Real Public Interest Please Stand Up?* Grey Areas, 65. page 1 (As cited in College of Nurses of Ontario. (2016). *Trends in Regulatory Governance*)
[17] Ibid.
[18] Institute on Governance/Ministry of Health and Long-Term Care (November 2015) *Governance Training for Public Appointees to Health Regulatory College Councils*, slide 45 (As cited in College of Nurses of Ontario. (2016). *Trends in Regulatory Governance*)
[19] Ibid.
[20] Steinecke, R (2003, July*). Will the Real Public Interest Please Stand Up?* Grey Areas, 65. page 1 (As cited in College of Nurses of Ontario. (2016). *Trends in Regulatory Governance*)
[21] Hewitt, P. (2007). *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century.* page 26 (As cited in College of Nurses of Ontario. (2016). *Trends in Regulatory Governance*)
[22] Hewitt, P. (2007). *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*. page 5 (As cited in College of Nurses of Ontario. (2016). *Trends in Regulatory Governance*)
[23] Ibid.

Recruitment and Board Competencies

- The literature sets out recommendations related to recruitment and board competencies.
- There is a general recommendation that recruitment procedures should focus on the competencies required for the membership of the particular board and consider whether an applicant has the capacity to contribute fully to the work of the board.[24]
- It is suggested that Councils should draw up a competency framework to help determine the existing mix of skills and expertise on the council, and try to fill any gaps that exist.[25]
- Desirable competencies of board members include both specific skills and characteristics of board members.
    - Characteristics include qualities such as being well-informed, strategic, energized and engaged.
    - Skills include competencies in areas such as governance and organizational effectiveness, policy development, regulation and the public interest and specific fields (e.g., communications, finance, HR, law, etc.)[26]
- Training from scratch is considered insufficient.[27]

Committee Roles/Oversight

- The CNO report on trends in regulatory governance highlights literature that focuses on committee roles and oversight.
- The literature generally suggests that:
    - The role of committees is to serve the Board and not vice versa; [28]
    - There is merit in adopting an entirely independent adjudication process as this promotes wider confidence and clarity of roles;[29]
    - Separation of the adjudication process allows Council to focus on the elements of good governance: strategic direction, holding the executive to account, and the proper use of resources.[30]

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[24] Professional Standards Authority. (2013a). *Fit and Proper? Governance in the Public Interest*. (As cited in College of Nurses of Ontario. (2016). *Trends in Regulatory Governance*)
[25] Professional Standards Authority. (2014a). *Good Practice in Making Council Appointments: Guidance for regulators making appointments which are subject to section 25C scrutiny*. (As cited in College of Nurses of Ontario. (2016). *Trends in Regulatory Governance*)
[26] Steinecke, R. (2017, May) *The Ontario Context: Anticipating and Shaping Governance Direction*
[27] Ibid.
[28] Steinecke, R. (2009, June). *Governance 101*. Grey Areas, 136. page 2 (As cited in College of Nurses of Ontario. (2016). *Trends in Regulatory Governance*)
[29] Dickson, Naill (2007), Department of Health. Implementing the White Paper *Trust, Assurance and Safety:* Enhancing confidence in healthcare professional regulators. (As cited in College of Nurses of Ontario. (2016). *Trends in Regulatory Governance*)
[30] Council for Health Care Regulatory Excellence (2012) *A review conducted for the Nursing Council of New Zealand* p. 8 (As cited in College of Nurses of Ontario. (2016). *Trends in Regulatory Governance*)

CURRENT STATUS:

- The GRWG has had an opportunity to review background materials relating to the current environment, developments in other jurisdictions and governance changes proposed by other regulators in Ontario. These discussions occurred on March 29 and April 24, 2018 and focussed on a number of themes, which are set out below.

1. Governance change is coming – although the timing and type of change are not yet clear.

2. This does not mean that the current Council members or Council as a group are not doing a good job.

3. The GRWG and Council have an opportunity to consider what kind of change would best enable the CPSO to fulfil its mandate.

4. There is general agreement that:
    a. The Council should be smaller
    b. There should be equal representation of public and physician members. (The composition of Council is not far off from this currently with 44% of the Council comprised of public members).

5. Council and Committees should be separated (particularly the Discipline Committee), as should the discussions about structure and composition.

6. The GRWG had the following comments/concerns about the research and models in other jurisdictions:
    a. The evidence for best practice in governance is more anecdotal than scientific. There is not much research or evaluation on the effectiveness of particular models proposed as best practice.
    b. Although a competency-based board is desirable, it is not clear what competencies are being considered and who gets to decide.
    c. One competency that must be present at Council is the physician perspective.
    d. It's important to avoid a council made up of professional/career board members, who are disconnected from the public and the profession.
    e. Whether referred to as physician buy-in or engagement, physicians must believe in the legitimacy of the board and committee structure.
    f. It can be challenging to get both diversity and competency, particularly if the board is smaller.

7. The GRWG identified the following as the most important qualities of council, no matter what size it is:
    a. Including physicians 'at the coalface' (a diverse group of physicians).
    b. Geographical diversity

c. Diversity of perspective/opinion (GRWG emphasized the importance of having multiple views and new ideas around the table)
d. Diversity of age and career stage (which would likely require changes to the way council operates - meetings may have to be in the evenings)

8. The existing Council selection mechanisms – election and public appointments – have pros and cons. Elections, in addition to ensuring geographical representation, provide an element of randomness and also give physicians choice. However, neither the election nor appointment process is competency based. It was noted that the physicians are chosen for *committees* based on skills, not election.

9. Focussed discussion is required to provide more clarity around board diversity, competencies.

10. The concept of equal compensation for public members of Council was identified.

11. It is useful to separate the discussion about the ideal structure and composition of council from the mechanism used to select the members.

12. A smaller Council could mean the elimination of the Executive Committee.

NEXT STEPS:

- Council member survey regarding perceptions of board effectiveness/areas of good governance in support of developing governance principles of a high performing board and governance structure.
- September, 2018: Council to consider governance principles of a high performing board and governance structure
- December, 2018: Council to consider recommendations where indicated in support of governance reform.
- Review to be completed by the end of the year so it can inform the development of the College's new strategic plan.

DISCUSSION FOR COUNCIL:

1. Day 1: After reviewing the materials, Council will be asked to consider the following questions:
    i. What are the strengths and weaknesses of the current governance structure?
    ii. What elements of other governance models do you find most appealing?

2. Day 2: Small group discussions will take place and the following questions will be considered:
    i. What are the characteristics of a high functioning modern board?
    ii. Thinking ahead to identifying the core principles that should underpin CPSO's governance structure, what are your early suggestions?
    iii. What changes to the College's governance structure would improve the College's effectiveness?

Contact: Louise Verity, Ext. 466
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Date: May 8, 2018

Attachments:

Appendix A: Jurisdictional Review

GOVERNING BODY						
	Ontario (Doctors)	**Ontario (Lawyers)**	**Quebec (Doctors)**	**UK (Doctors)**	**Australia (Doctors)**	**New Zealand (Doctors)**
Background:						
Name	College of Physicians and Surgeons of Ontario (CPSO)	Law Society of Upper Canada	Collège des Médecins du Québec (the "Collège")	General Medical Council (the "GMC")	National governing body: • Medical Board NSW governing body: • Medical Council	Medical Council
Composition:						
Members	Council: up to **34 members** including: • 16 physicians elected by their peers on a geographical basis every three years; • three physicians appointed from among the six faculties of medicine • no fewer than 13 and no more than 15 members appointed by the Lieutenant Governor in Council	Benchers run the affairs of the Law Society. They include: • Honorary benchers o Honorary benchers before 1970 o all former Treasurers o everyone who has held position of elected bencher for 12 or more years • Benchers by virtue of their office o Minister of Justice o Attorney and Solicitor Generals of Canada o current and all previous Attorney Generals of Ontario o longstanding elected benchers • Elected benchers o **40 lawyers**	Board of Directors: • **28 directors** (including a president) Of these: • 4 are laypersons • 24 are physicians	The GMC is governed by **12 individuals:** • 1 Chair (who is a doctor) • 5 doctors • 6 laypersons	Medical Board: • 1 chair (who is a doctor) • at least 50% of the remaining are doctors but no more than 2/3 of Board can be doctors • at least 2 community members Medical Council: • **19 members** Of these: • 1 is a lawyer • 12 are doctors nominated by various organizations • 5 are persons nominated by the Minister • 1 is a doctor nominated by the Minister	The Medical Council is comprised of **12 members**: • 8 doctors • 4 laypersons

		○ **5 paralegals** • Lay benchers ○ 8 persons				
Selection Process for Members	• **16 physicians elected** by their peers on a geographical basis; • **3 physicians appointed** (elected by Council) • **LGIC appointment process (political)**.	Honorary benchers and benchers by virtue of the office: • **appointed by government** • **years of service** Elected benchers: • **elected** by lawyers or paralegals (depending on profession) • elected at large and by region Lay benchers: • **appointed** by the Lieutenant Governor	• **20 are elected doctors**, chosen by doctors on a regional basis • 4 are appointed by the Office des Professions du Québec • 4 are appointed by the faculties of medicine in Québec	• **appointed** by the Privy Council	Medical Board: • **appointed** by the Ministerial Council Medical Council: • appointed by the Governor ○ but many members nominated by various organizations or the Minister	• 4 doctors **elected** by doctors • 4 doctors **appointed** by the Minister of Health • 4 laypersons **appointed** by the Minister of Health
Special Categories of Representation	• regional representation • medical faculty representation	• regional representation • representation by profession (lawyer, paralegal, layperson, government officer etc.)	• regional representation • medical faculty representation	• regional representation	Medical Board: • regional representation Medical Council: • representation of specialties • representation of some organizations, such as: ○ the Australian Medical Association ○ Multicultural NSW	• majority of Council must be doctors

DISCIPLINE BODY						
	Ontario (Doctors)	**Ontario (Lawyers)**	**Quebec (Doctors)**	**UK (Doctors)**	**Australia (Doctors)**	**New Zealand (Doctors)**
Background:						
Name	Discipline Committee	Law Society Tribunal (consists of two divisions: Hearing Division and Appeal Division)	Disciplinary Council	Medical Practitioner Tribunal Service ("MPTS")	Civil and Administrative Tribunal	Health Practitioners Disciplinary Tribunal (for conduct/competence issues) *Medical Council (for competence/capacity issues)*
Hearing Panels:						
Composition of Body	• 24 members • Quorum requirement for 2 LGIC members, 1 professional member of Council on every DC panel	Hearing Division: • Chair of the Law Society Tribunal o a lawyer but not a bencher • 1 Vice-Chair o an elected bencher • 90 individuals o laypersons and lawyers o over half are benchers	• 1 President/Chair o a lawyer • 7 Substitute Chairs o lawyers • 51 doctors	280 laypersons and doctors ewer doctors than laypersons Panel members: • cannot be members of the GMC governing body • cannot take part in the investigation process	N/A (see composition of panels)	• 1 Chairperson • 2 Deputy Chairpersons
Selection Process	Chairs: • appointed by Council, on recommendation by GC. Members of each committee: • appointed by Council. Panel:	Chairs: • appointed by benchers Members of the Hearing Division: • appointed by benchers	Chairs: • appointed by the government Other members: • appointed by the Collège's Board of Directors	MPTS appoints: • lay members • registrant members • makes a list of eligible Chairs from the lay and registrant members	Judges: • judges of the Supreme Court or District Court Medical Practitioners: • selected by the Medical Council Layperson: • selected by the Medical Council from a panel	The Minister of Health appoints all members of the Tribunal

	• Chair of the Discipline Committee selects a panel from among the members of the committee.				nominated by Minister	
Composition of Individual Panels	• A discipline panel is comprised of **at least 3 members – 2 must be public members (appointed)** and one must be a physician member of Council. • Panels are usually made up of **4 or 5** members.	Panels have three members If person subject to proceeding is a lawyer: • at least 1 elected lawyer bencher • at least 1 lay bencher or a person approved by the Attorney General of Ontario If person subject to proceeding is a paralegal: • 1 paralegal • 1 lawyer • 1 lay bencher or a person approved by the Attorney General of Ontario Chair or Vice-Chair appoints members to each panel	Panels have 3 members: • a chair o designated by the President • 2 doctors o selected by the Council secretary	Panels have 3 members, including a Chair, at least one of whom is: • a lay member • a registrant member	Panels have 4 members: • 1 judge • 2 doctors • 1 layperson For an appeal restricted to a point of law, the panel is one judge	Panels have 5 members: • the Chairperson of the Tribunal or a deputy Chairperson of the Tribunal • 4 persons selected by the Chairperson or the deputy Chairperson from the panel maintained by the Minister of Health, of whom: o 3 are doctors o 1 is a layperson
Role of Lawyers	N/A	At least one lawyer sits on each Hearing Panel	8 members of the Council are lawyers 1 lawyer sits on each panel	Each hearing will have either: • a legal assessor; or • a legally qualified Chair	Each panel includes a judge and for appeals of points of law, only a single judge decides the matter *Also: one member of the Medical Council is a lawyer*	The Tribunal's Chairperson and two deputy Chairpersons are lawyers Either the Chairperson or a deputy Chairpersons sits on each hearing panel
Independence Mechanisms:						

Separate hearing location	No	Yes	Yes	Yes	Yes	[information not available']
Governing body appoints majority of members:	Yes	Yes	No	No	Yes (except for appeal of point of law alone)	No
Majority of adjudicators part of governing body:	Yes	Yes	No	No	No	No
Other		• Tribunal Chair is not a bencher • Tribunal members must apply to be members of the Tribunal (merit based selection process) • Chair reviews performance of all adjudicators, and determines reappointments	• Chair and Substitute Chairs are not doctors • No members of the Disciplinary Council can sit on the Board of Directors	• the GMC and the MPTS are separate bodies • no membership cross-over except for the Chair of the MPTS, who is a member of the GMC by virtue of appointment as Chair • MPTS tracks private interests of members	• Every panel includes a judge • No members of the Medical Council can sit on the Tribunal • The Tribunal is completely separate and adjudicates a wide range of matters in the state	• hears cases from all regulated health professions • two individuals out of five on a hearing panels are not doctors
Appeals:						
Body	Divisional Court	Law Society Tribunal: Appeal Division	Professional Tribunal (hears cases for all Professions)	relevant Court	• Civil and Administrative Tribunal • relevant Court (questions of law)	High Court
Composition	A proceeding is usually heard and decided by a panel of three judges, but may be heard by a single judge in some circumstances.	• Chair of the Tribunal • Vice-Chair o a bencher appointed by benchers • 22 members o vast majority are	11 judges	Judges presiding	As described above	Judges presiding

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

OVERSIGHT BODY						
	Ontario (Doctors)	**Ontario (Lawyers)**	**Quebec (Doctors)**	**UK (Doctors)**	**Australia (Doctors)**	**New Zealand (Doctors)**
Background:						
Name	Fragmented: Minister of Health and Long-Term Care; HPARB; Fairness Commissioner; Divisional Court	• Advisory Council • Attorney General of Ontario	• the Office des Professions du Québec • the Commissioner for Complaints Concerning Mechanisms for the Recognition of Professional Competence • the Interprofessional Council	• Privy Council • Professional Standards Authority for Health and Social Care ("PSA")	• Advisory Council	There is no oversight body for the Medical Council. However, the New Zealand Parliament (the Minister of Health) plays an oversight role (see below)
Composition	N/A	Advisory Council: • the chair and vice-chair of each standing committee • the president of each county or district law association (or a nominee) • one person who is a lawyer in an Ontario law school and who is also a full-time teacher at an Ontario and who is appointed by law school faculty	Office: • four members of a regulated profession o chosen by the Council, from a list furnished by the government • one non-professional Commissioner: • nominated by the Office Council: • Presidents (or other delegate) from each regulated profession in Québec, including the Collège	Privy Council: • senior politicians, who are present or former members of the House of Commons or the House of Lords PSA: • has a staff and board of directors	• 7 members, including: o chair who is not a health practitioner o of 6 others, 3 have expertise in health and/or education Members are appointed by Ministerial Council	

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

RELATIONSHIP TO GOVERNMENT AND INDEPENDENCE

	Ontario (Doctors)	Ontario (Lawyers)	Quebec (Doctors)	UK (Doctors)	Australia (Doctors)	New Zealand (Doctors)
Relationship to government	• The government has entrusted the regulatory function of regulating the medical profession in the public interest to the CPSO. • 26 health colleges regulating 29 health professions in Ontario • CPSO is required to report to the Minister annually (through Annual Report). • Government has the power to appoint a supervisor. • Government appoints public members to Council.	The benchers have a standing committee dedicated to working with government • the mandate is to develop and maintain an effective working relationship with the government	Disciplinary Council Chairs are appointed by government The Collège reports annual to the Office, who sends the report to the relevant Minister The Minister of Justice oversees the application of the *Professional Code* and the *Medicine Act* • The Minister can direct the profession or convene the Interprofessional Council	The Privy Council: • sets the number of registrant versus lay members of the GMC • appoints members to the GMC • reviews the conduct of the GMC and can assume the powers of the GMC, where the GMC fails to fulfil its mandate	Australian Health Workforce Ministerial Council: • comprised of health ministers of participating jurisdictions and commonwealth • provides high level decision-making and ministerial oversight	The Medical Council is required to report annually to the Minister of Health The Minister of Health may: • request statistical information from the Medical Council • audit the Medical Council on compliance with legislation • convene a conciliation conference to address concerns in the audit • address jurisdictional disputes between different regulated professions

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May 2018

TOPIC: Bill 87: Psychotherapy Regulation Proposal

FOR DECISION

ISSUE:

- Bill 87 provides Colleges with the ability to develop a regulation relating to the duration of the physician-patient relationship for the purposes of sexual abuse.

- A proposed draft regulation has been developed for Council's consideration. The draft regulation specifically addresses physician-patient relationships that have involved psychotherapy. It is consistent with the College's current position regarding the unique nature of psychotherapeutic relationships and the need for additional caution in that context.

- Council is asked whether it approves the draft regulation and whether it supports delaying consultation of the regulation to coordinate with the government's timing.

BACKGROUND:

- As of May 1st 2018, three new government regulations related to Bill 87 were proclaimed, and a number of provisions in Bill 87 were proclaimed into the *Regulated Health Professions Act, 1991* (RHPA).

- The Government Relations Report included in Council's materials provides more information on these regulations and their enactment.

- Included in statutory provisions that have been proclaimed is a definition of patient, which addresses the period of time an individual will be deemed to be a patient for the purpose of sexual abuse. One of the three regulations introduced sets out criteria for when a physician-patient relationship has been created. For Council's reference, the statutory definition of

patient, and the regulation are attached as **Appendix A**.

- As Council will note, the statutory definition of patient explicitly states that an individual will be a patient for one year after the termination of the physician-patient relationship. It means that a physician who engages in a sexual relationship with a former patient within one year of terminating the relationship will be considered to have engaged in sexual abuse, and will be subject to mandatory revocation.

- The definition of patient is worded in a way that allows Colleges to create a regulation to extend the physician-patient relationship for a period longer than one year.

- At its March 2018 meeting, the Executive Committee considered whether the College should propose a regulation that would extend the physician-patient relationship in situations where the treating relationship involved psychotherapy.

- The Committee directed that the College pursue a regulation proposal. This direction was included in the College`s March 2018 response to the Ministry (attached as **Appendix B**).

CURRENT STATUS:

- In accordance with direction from the Executive Committee, draft regulation language has been developed. The proposed regulation is as follows:

> ***Where the treatment provided by the member to the individual involves psychotherapy that is more than minor or insubstantial, an individual will be deemed to be a member's patient for five years after the date on which the individual ceased to be the member's patient.***

- The enactment of this regulation would mean that if a physician has a sexual relationship with a former psychotherapy patient within five years of termination, the physician would be subject to mandatory revocation.

- The Discipline Committee would also retain the *discretion* to impose revocation in other instances where the sexual relationship commenced more than five years after termination. This would be based on the specific facts of the case – it would be discretionary, not mandatory.

- For example, should the Discipline Committee find a physician engaged in a sexual relationship with a former psychotherapeutic patient six years after termination, the Committee would have the discretion to order revocation of the physician's certificate of registration. It could also choose to order a different penalty.

- The proposed regulation focuses on psychotherapeutic relationships in recognition of the fact that those relationships can result in unique power imbalances between physicians and patients and can give rise to unique vulnerabilities for patients.

- This sentiment is captured in the College's *Maintaining Appropriate Boundaries and Preventing Sexual Abuse* policy, which indicates that a sexual relationship with a former psychotherapeutic patient may never be appropriate.

- The 2015 Discipline Committee decision involving Dr. Peter John Brown contains the Committee's observations about the unique nature of the psychotherapeutic relationship and its duration:

  > *Psychotherapy practice is unique particularly in regard to the depth and nature of the dependency and the degree of trust involved. This may include frequent visits, disclosure of highly personal or intimate information and protracted care. Emotional dependence on the physician is significant. Risk of harm is substantial if boundary violations occur. Those choosing to practice psychotherapy are expected to understand the inherent risks of such therapy such as transference and countertransference and to be able to respond appropriately.*
  > *…*
  > *In general, it may be said the duration of the professional relationship will depend on the potential for the physician to exploit the trust or emotions of the patient or otherwise use the influence of their previous physician patient relationship. Simply put, in such circumstances, the physician patient relationship endures and the physician remains accountable, whether or not the service provided has ended.*

- A limited ban (five years) on sexual relationships with former patients is proposed in the regulation as opposed to an indefinite ban. A five-year ban would achieve important patient protections, as it would allow a significant period of time to elapse during which the power imbalance between the physician and former patient could resolve. Given the wide range of circumstances in which a physician may provide psychotherapy to a patient, including on a short-term and limited basis, retaining discretion for the Discipline Committee to determine the appropriate penalty in cases beyond the five-year period was seen to be an important means of ensuring the legislative scheme is fair and defensible.

CONSIDERATIONS: MINISTRY PROCESS AND TIMING

- Although Bill 87, under the *Health Professions Procedural Code,* provides Colleges with the ability to develop a regulation relating to the definition of patient, the enactment of the regulation requires government participation and approval.

- There are a number of stages and formal requirements that a regulation proposal must pass through prior to becoming law. This process includes the College posting the regulation for consultation on its website and the Ministry posting the regulation for consultation on the Regulatory Registry (government) website. Typically, these two consultations are concurrent as the College is expected to receive the feedback submitted via both consultations.

- Given that we are currently in an election period the work of the government/Ministry is on hold pending the formation of a new government.

- Following the June 7th 2018 vote, and after a new government has been sworn in, the College can work with government to assess support for the regulation proposal and the potential timelines for the formal regulation approval process.

- The Executive Committee recommended that Council approve the draft regulation and hold releasing the draft regulation for consultation until additional information about government timing and support is known.

- This approach would allow the College to be on record with its support for the proposed regulation and would streamline the next steps of the approval process.

NEXT STEPS:

- Following the election, College staff will reach out to government regarding the regulation proposal and will assess government's support for the regulation proposal along with the timelines on which we may expect the government will act.

- The draft regulation will then be circulated for external consultation in conjunction with the Ministry's posting of the regulation.

- Following the consultation, the regulation will be brought back to Council for approval and the draft regulation will be submitted to government for their approval.

DECISIONS FOR COUNCIL:

1. Does Council approve the draft regulation?

2. Does Council agree that consultation on the regulation can be delayed to coordinate with the government`s timing, post-election?

CONTACT: Vicki White, Andréa Foti, Louise Verity

DATE: May 4, 2018

Attachments:

Appendix A: Statutory definition of patient, and regulation

Appendix B: CPSO response to Ministry Bill 87 regulations, March 2018

Appendix A

I. Statutory Provision : Definition of Patient

REGULATED HEALTH PROFESSIONS ACT, 1991

Section 1(6)

(6) For the purposes of subsections (3) and (5),

"patient", without restricting the ordinary meaning of the term, includes,

(a) an individual who was a member's patient within one year or such longer period of time as may be prescribed from the date on which the individual ceased to be the member's patient, and

(b) an individual who is determined to be a patient in accordance with the criteria in any regulations made under clause 43 (1) (o) of the *Regulated Health Professions Act, 1991*; ("patient")

II. Regulation: Patient Criteria

ONTARIO REGULATION 260/18

made under the

REGULATED HEALTH PROFESSIONS ACT, 1991

Made: April 10, 2018
Approved: April 18, 2018
Filed: April 20, 2018
Published on e-Laws: April 20, 2018
Printed in *The Ontario Gazette*: May 5, 2018

PATIENT CRITERIA UNDER SUBSECTION 1 (6) OF THE HEALTH PROFESSIONS PROCEDURAL CODE

1. The following criteria are prescribed criteria for the purposes of determining whether an individual is a patient of a member for the purposes of subsection 1 (6) of the Health Professions Procedural Code in Schedule 2 to the Act:

1. An individual is a patient of a member if there is direct interaction between the member and the individual and any of the following conditions are satisfied:
   i. The member has, in respect of a health care service provided by the member to the individual, charged or received payment from the individual or a third party on behalf of the individual.
   ii. The member has contributed to a health record or file for the individual.
   iii. The individual has consented to the health care service recommended by the member.
   iv. The member prescribed a drug for which a prescription is needed to the individual.
2. Despite paragraph 1, an individual is not a patient of a member if all of the following conditions are satisfied:
   i. There is, at the time the member provides the health care services, a sexual relationship between the individual and the member.
   ii. The member provided the health care service to the individual in emergency circumstances or in circumstances where the service is minor in nature.
   iii. The member has taken reasonable steps to transfer the care of the individual to another member or there is no reasonable opportunity to transfer care to another member.

Commencement

2. This Regulation comes into force on the latest of,

(a) the day section 6 of Schedule 5 to the *Protecting Patients Act, 2017* comes into force;

(b) May 1, 2018; and

(c) the day this Regulation is filed.

Made by:
Pris par :

La ministre de la Santé et des Soins de longue durée,

HELENA JACZEK
Minister of Health and Long-Term Care

Date made: April 10, 2018
Pris le : 10 avril 2018

APPENDIX B

March 22, 2018

Ministry of Health and Long-Term Care
Health Workforce Planning and Regulatory Affairs Division
12th Floor, 56 Wellesley Street West
Toronto, ON
M5S 3R9

Re: New Regulations under the *Regulated Health Professions Act*, 1991

The College of Physicians and Surgeons of Ontario (the "College") appreciates the opportunity to comment on the Ministry of Health and Long-Term Care's proposed regulations under the *Regulated Health Professions Act, 1991* (RHPA).

The College is strongly supportive of strengthening the sexual abuse and transparency provisions in the RHPA. Our response to the draft regulations is grounded in the College's commitment to improve the regulatory framework so that we have the tools needed to protect the public. Below, comments are offered on the three proposed regulations. The College has extensive expertise and experience in the areas which are the subject of the proposed regulations and urges the Ministry to carefully consider our feedback.

The focus of the College's feedback is regarding the criteria to support the definition of patient. Less substantial comments are made on the regulation expanding the College register and no further suggestions are offered with respect to the regulation concerning Criminal Code Offences. The comments, and where possible the proposed solutions, are put forward to strengthen the proposed regulations and avoid negative unintended consequences.

1. **Regulation prescribing criteria defining who is a patient, for the purpose of sexual abuse**

The College is fully supportive of the government's objective to prohibit sexual relationships between physicians and former patients, while the power imbalance forged during the physician-patient relationship may remain in place. However, the College has significant concerns about the criteria for individuals who are deemed to be patients for the purpose of sexual abuse. These concerns relate to the specific language used in the regulation and the exclusion of incidental or minor care from the exemption to the criteria.

In order to better protect vulnerable patients, the College will be proposing an additional regulation be developed that would prescribe a longer period of time that an individual would be considered a member's patient where the treating relationship involves psychotherapy. The College would respectfully request that the government support the development of this regulation and expedite the proposal in order to minimize any gaps between the proclamation of the government's statutory amendments and regulations and the College's proposed additional regulation.

The criteria, contained in section 1.1 of the regulation, for determining whether an individual is a patient requires a "direct interaction" between the member and this individual. However, it is unclear what would constitute a direct interaction. The College recommends that the regulation clarify that a direct interaction need not be in person but also could occur via telemedicine or other virtual forms of care, which are being used increasingly in practice. It is, in our view, essential that the language used in the regulation be clear and inclusive.

The third condition (1.1.iii) for determining the existence of a treating relationship is dependent upon whether an individual has "consented to the health care service recommended by the member". The College has a number of concerns regarding this condition.

Under the *Health Care Consent Act* section 11(4), consent to treatment may be express or implied. The College recommends that the regulation be clear that either would constitute consent for the purposes of this element of the criteria. In its *Consent to Treatment* policy, the College recommends that physicians always document in the patient's record information regarding consent to treatment,[1] but does not require documentation of consent in every instance. The College recommends that the regulation clarify that consent need not be recorded in order for this criteria to be met. There are also instances where the patient may not provide consent, for instance when a substitute decision-maker provides consent on behalf of an incapable patient. It is unclear whether the condition in 1.1.iii would be satisfied in these instances.

The fourth condition (1.1.iv) for determining the existence of a treating relationship is where "the member prescribed a drug for which a prescription is needed" to the individual. The College is concerned that the criteria is too narrow. There may be instances where a member prescribes a drug for which a prescription is not required (for example, in order for a drug to be covered by extended health benefits). Whether a prescription is technically required seems immaterial to the purpose of the provision. The College recommends removing the words "for which a prescription is needed" from this condition.

[1] See the College's policy Consent to Treatment

In addition to specifying criteria for when an individual is considered to be a patient, this draft regulation includes an exemption from the definition. In order for the exemption to be met, three conditions must be satisfied. The first condition (1.2.i) states that the individual is not a patient of the member if "there is, at the time the member provides the health care services, a sexual relationship between the individual and the member". The College is concerned that the language in this condition may cause confusion as it is unclear how to interpret "at the time". We presume that it is the government's intention to capture situations where there is a concurrent or pre-existing sexual relationship, which might be better captured by including the word "pre-existing" in the regulation, such as: "there is, at the time the member provides the health care services, a *pre-existing* sexual relationship between the individual and the member".

Without this addition, we believe there is a risk that arguments would be made that the sexual interaction must be taking place at the time the care is provided, which we do not understand to be the government's intention.

The second condition for the exemption (1.2.ii) states that an individual must receive a health care service from the member in an emergency situation. However, this condition does not include an exemption for incidental or minor care. The failure to include this additional element is inconsistent with existing case law.[2] In previous court challenges to the constitutionality of the mandatory revocation scheme for sexual abuse, the courts have noted that the provision of incidental medical care between spouses should not be characterized as sexual abuse and that it would be unreasonable to suggest that a physician-patient relationship is created when a physician provides incidental care to his or her spouse.

Consistent with case law, the College's Physician Treating of Self, Family Members, or Others Close to Them policy states that physicians must not provide treatment for themselves or family members except for a minor condition or in an emergency situation **and** when another qualified health-care professional is not readily available. The College is concerned that the draft regulation departs from this case law and urges the government to include incidental or minor care in this exemption. We suggest the government could word this second condition along the following lines; "the health care service provided by the member to the individual was minor or was provided in emergency circumstances."

The third element of the exemption requires (1.2.iii) the member to have taken "reasonable steps to transfer the care" or "there is no reasonable opportunity" to transfer care. The language in this

[2] See Mussani v. College of Physicians and Surgeons of Ontario, 2004 CanLII 48653 (ON CA); Rosenberg v. College of Physicians and Surgeons of Ontario, 2006 CanLII 37118 (ON CA); and Leering v. College of Chiropractors of Ontario, 2010 ONCA 87.

condition is unclear as it seems to imply that a member must only make efforts to transfer this care but is not obliged to do so. Clarifying the language of this exemption would be helpful.

Additional regulation extending the duration of the relationship where treatment includes psychotherapy

The definition of patient for the purposes of sexual abuse included in Bill 87, which is now in the RHPA and which we understand the government intends to proclaim together with these regulations, provides Colleges with the ability to specify in regulation a period of time, beyond one year, during which the provider-patient relationship will be extended. This extends the period during which any sexual relationship between the regulated health professional and the patient would constitute sexual abuse. This College intends to put forward a proposed regulation that would provide for this extension. This additional regulation would supplement the three regulation proposals currently out for consultation, and would offer additional protections for patients.

A full proposal from the College will be forthcoming but a draft of the proposed regulation is set out below. The College proposes that the regulation would specify that when the treating relationship involves psychotherapy, the treating relationship continues for a period of 5 years after the relationship ceases.

The proposed regulation would reflect the current policy expectations of the College for members providing care to the most vulnerable patients. It also ensures that the regulations currently proposed by the government do not make it more difficult for a College to establish that a member engaged in sexual abuse of a patient when the sexual relationship commences more than a year after the treatment ended.

The proposed regulation is consistent with the College's Maintaining Appropriate Boundaries and Preventing Sexual Abuse policy, which states that a sexual relationship is likely never appropriate following a treating relationship that involves a significant component of psychotherapy. The proposed regulation would also recognize the unique nature of a psychotherapeutic relationship, and the particular vulnerabilities patients undergoing psychotherapy may have.

Draft of suggested additional regulation:

> *Where the treatment provided by the member to the individual involves psychotherapy that is more than minor or insubstantial, an individual will be deemed to be a member's patient for five years after the date on which the individual ceased to be the member's patient.*

The College would welcome the opportunity to work closely with the Ministry to develop this regulation proposal and ensure its expedient passage, particularly in light of what we understand may be expedited timelines for the proclamation of the government's definition of patient for the purposes of sexual abuse.

2. Additional information required on the College register

The College has passed amendments to its By-law that requires its register contain most of the information the government proposes to require through its regulation. The College does have a few points of clarification in relation to this regulation.

i) Findings of guilt

The regulation requires the register reflect a finding of guilt under the *Criminal Code* (Canada) or the *Controlled Drugs and Substances Act* (Canada) where the person against whom the finding was made was a member at the time of the finding (and no pardon/record suspension has been ordered).

This is the language currently adopted by the College in its By-law. However, we have found the language to be problematic and would recommend changing it. The problem arises where a member's criminal charges had been posted on the register but the physician is no longer a member at the time the finding is made (whether because the member has resigned or been suspended or revoked before the charges are disposed of). The proposed wording of the regulation would mean Colleges could not post the guilty finding on the register. Once there is a finding of guilt, the charges must be removed, and in such cases, there would be no information on the website to indicate to the public that the member had in fact been found guilty on the previously posted charges. We do not think this is ideal from the perspective of transparency.

We recommend amending the regulation in a manner that would require the posting of findings made once a member is no longer a member, but not findings made before the member became a member in the first place. We note that any criminal convictions against a member before becoming registered would have been considered by the Registration Committee at the time of registration.

ii) Bail Conditions

The government's proposed regulation requires posting of any currently existing conditions of release following a charge for an offence under the *Criminal Code* or the *Controlled Drugs and Substances Act* or

subsequent to a finding of guilt and pending appeal or any variations to those conditions. Unlike the College By-law, the proposed regulation does not limit the posting of bail conditions to those relating to the practice of medicine. Many bail conditions are standard (for example, not to carry a weapon), and involve residing at a certain address and not going near or contacting certain persons. Other bail conditions risk violating privacy interests of third parties even if they are not named -- such as bail conditions requiring a member to attend a "Partner Assault Response Program", as the College has seen. Under current College practice, such bail conditions, addresses and anything that might identify third parties persons would not be included in the register posting. It is not clear how listing all bail conditions will be helpful or meaningful to the public, and will make the postings quite lengthy in many cases. Listing conditions but removing the operative portion for privacy purposes (such as addresses and names of third parties) seems cumbersome and unhelpful for the public. We recommend that the regulation be limited to bail conditions that relate to the member's practice, as follows:

> Any currently existing conditions of release following a charge for an offence under the *Criminal Code* (Canada) or the *Controlled Drugs and Substances Act* (Canada) or subsequent to a finding of guilt and pending appeal, that relate to the member's practice, or any variations to those conditions.

iii) Other Regulatory Disciplinary Findings

The proposed regulation requires information be posted if a member has been the subject of a disciplinary finding by another regulatory or licensing authority in any jurisdiction. Different regulatory authorities, particularly those not under the RHPA framework, have different processes and different language to describe what the RHPA refers to as disciplinary findings. This is the term the College used in our By-law, and we have found that there can be ambiguity as to whether the actions or findings of another regulatory authority constitute a disciplinary finding in the way in which we use these terms. Accordingly, there may be interpretation issues in determining what the regulation requires the College to post. We would suggest different language such as "action or finding of a disciplinary or significant remedial nature".

Section 85.6.3(2) of the Code, once in force, will obligate members to report "findings of professional misconduct or incompetence made against the member by another body that governs a profession inside or outside of Ontario". It is not entirely clear if "disciplinary findings" (in the proposed regulation) are the same or are intended to be the same as "findings of professional misconduct or incompetence"

(in the Code). If anything, “disciplinary findings” may be broader than the language in the Code. There is also a difference in the way the authoritative bodies are described in the regulation and the Code. It would be preferable for the regulation and the Code to use the same language unless there are intended differences. If there is an opportunity to amend the language in the Code Section 85.6.3(2) in this regard, the wording suggested in the paragraph above could be considered.

3. Prescribed offences

The draft regulation would require mandatory revocation of a member’s certificate of registration where a member is found guilty of the specified Criminal Code offences. The College is supportive of this regulation and the Criminal Code charges specified in it.

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

Yours truly,

S.C. Bodley MD, FRCPC
President

Daniel Faulkner, HBSc, MBA
Interim Registrar

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May 24, 2018

TOPIC: COUNCIL AWARD RECIPIENT

FOR INFORMATION

ISSUE:

At the May 24th meeting of Council, **Dr. Sarah Reid** of Ottawa will receive the Council Award.

BACKGROUND:

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

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

CURRENT STATUS:

Council member Dr. Judith Plante will present the award.

DECISION FOR COUNCIL:

No decisions required.

Contact: Tracey Sobers, Ext. 402
Date: April 27, 2018

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May 2018

TOPIC: 2017 AUDITED FINANCIAL STATEMENTS AND APPOINTMENT OF THE AUDITOR FOR 2018

FOR DECISION

ISSUE:

Annual audit and audited financial statements for 2017

BACKGROUND:

The spring meeting of Council is the Annual Financial Meeting of the College. At this meeting the external auditors present the audit report along with the audited financial statements.

As well, at this meeting, Council appoints the external auditors for the next year.

At the April 3, 2018 meeting of the Finance and Audit Committee, Mr. Tinkham reported that the financial statements are represented fairly and in accordance with Canadian accounting standards for not-for-profit organizations. The reports states:

> "In our opinion, the financial statements present fairly, in all material respects, the financial position of the College of Physicians and Surgeons of Ontario as at December 32, 2017 and the results of its operations and its cash flows for the year ended in accordance with Canadian accounting standards for not-for-profit organizations."

The Finance and Audit Committee noted that net of the actuarial remeasurement for pension (note 8) there was a surplus of $1,490,184 against a loss of $997,039 in 2016 for a net surplus of $493,145 over the two years. On an average budget of $65M for 2016 and 2017 this represents a surplus of .76%

In keeping with the direction of Council, the surplus was transferred to the Building Reserve. However, the Finance and Audit Committee did acknowledge that there were a number of issues including Bill 87, loss of incorporation revenue, Physicians Assistants and Workplace Strategy that we not included in the 2018 budget and may require resources.

The Finance and Audit Committee made the following motions:

> *The Finance and Audit Committee recommends to Council that the Audited Financial Statements for the year ended December 31, 2017, as presented by Tinkham LLP Chartered Professional Accountants be accepted as amended.*
>
> *The Finance and Audit Committee recommends to Council that the firm of Tinkham LLP Chartered Professional Accountants be appointed as the College's auditors or the fiscal year 2018.*

The auditor also stated that the College has excellent internal controls and they did not have any recommendations to improve internal controls or accounting procedures as a result of the application of their audit procedures.

DECISION FOR COUNCIL:

The Finance and Audit Committee recommends to Council that the audited financial statements for the year ended December 31, 2017 be approved as amended.

> Does Council approve the audited statements for 2017 as presented?

Contact: Mr. Peter Pielsticker, Chair Finance and Audit Committee
Mr. Douglas Anderson, Corporate Services Officer, ext. 607
Ms. Leslee Frampton, Manager, Finance and Business Services, ext. 311

Date: April 25, 2018

Attachments:

Appendix A: Audited Financial Statements for the year ended December 31, 2017

Financial statements of

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 31, 2017

TINKHAM LLP | CHARTERED PROFESSIONAL ACCOUNTANTS

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INDEPENDENT AUDITOR'S REPORT

To the Members of
The College of Physicians and Surgeons of Ontario

We have audited the accompanying financial statements of The College of Physicians and Surgeons of Ontario, which comprise the statement of financial position as at December 31, 2017 and the statements of operations and changes in net assets, and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian accounting standards for not-for-profit organizations, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of The College of Physicians and Surgeons of Ontario as at December 31, 2017 and the results of its operations and its cash flows for the year then ended in accordance with Canadian accounting standards for not-for-profit organizations.

TORONTO, Ontario
DATE

Licensed Public Accountants

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Statement of Financial Position

As at December 31	2017	2016
Assets		
Current		
Cash (note 2a)	**$ 30,587,647**	$ 27,333,907
Accounts receivable (note 3)	**435,235**	933,950
Prepaids	**777,460**	436,647
	31,800,342	28,704,504
Investments (note 4)	**50,886,488**	50,543,913
Capital assets (note 5)	**10,131,121**	10,737,540
	$ 92,817,951	$ 89,985,957
Liabilities		
Current		
Accounts payable and accrued liabilities	**$ 6,173,307**	$ 6,528,693
Administered programme (note 7)	**58,589**	64,497
Current portion of obligations under capital leases (note 9)	**422,981**	386,815
	6,654,877	6,980,005
Deferred revenue (note 6)	**28,933,972**	27,528,513
	35,588,849	34,508,518
Accrued pension cost (note 8)	**5,687,665**	5,472,074
Obligations under capital leases (note 9)	**537,087**	491,199
	41,813,601	40,471,791
Net assets (note 10)		
Invested in capital assets	**9,171,053**	9,859,526
Building fund	**41,833,297**	39,654,640
Unrestricted	**617,362**	312,159
Pension remeasurements (note 8)	**(617,362)**	(312,159)
	51,004,350	49,514,166
	$ 92,817,951	$ 89,985,957

Commitments and contingencies (notes 11 and 12, respectively)

Approved on behalf of the Council

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THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Statement of Operations and Changes in Net Assets

Year ended December 31	**2017**	2016
Revenue		
Membership fees		
General and educational (note 6)	**$ 58,374,991**	$ 56,719,244
Penalty fee	**256,662**	348,906
	58,631,653	57,068,150
Application fees	**7,657,450**	5,483,734
OHPIP annual and assessment fees (note 6)	**1,460,514**	1,215,732
IHF annual and assessment fees (note 6)	**1,053,893**	1,078,327
OHPIP, IHF application fees and penalties	**64,469**	71,685
Cost recoveries and other income	**1,775,172**	1,920,583
Investment income	**1,165,492**	1,015,005
	71,808,643	67,853,216
Expenses		
Committee costs (schedule I)	**15,581,175**	15,288,667
Staffing costs (schedule II)	**43,891,826**	43,485,099
Department costs (schedule III)	**7,159,261**	7,020,345
Depreciation of capital assets	**1,236,585**	1,270,931
Occupancy (schedule IV)	**2,144,409**	1,670,702
	70,013,256	68,735,744
Excess (deficiency) of revenue over expenses for the year	**1,795,387**	(882,528)
Net assets, beginning of year	**49,514,166**	50,511,205
Actuarial remeasurement for pension (note 8)	**(305,203)**	(114,511)
Net assets, end of year	**$ 51,004,350**	$ 49,514,166

See accompanying notes to the financial statements.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Statement of Cash Flows

Year ended December 31	2017	2016
Cash flows from operating activities:		
Excess (deficiency) of revenue over expenses for the year	**$ 1,795,387**	$ (882,528)
Depreciation of capital assets	**1,236,585**	1,270,931
	3,031,972	388,403
Net change in non-cash working capital items:		
Accounts receivable	**498,715**	77,458
Prepaids	**(340,813)**	(32,802)
Accrued interest receivable	**(342,575)**	(458,784)
Accounts payable and accrued liabilities	**(355,386)**	611,360
Due to Ministry of Health and Long Term Care	**-**	(1,288,849)
Administered programme	**(5,908)**	(88,481)
Deferred revenue	**1,405,460**	1,026,948
Pension cost	**(89,612)**	(87,465)
Cash provided by operating activities	**3,801,853**	147,788
Cash flows used by investing activities:		
Purchase of capital assets	**(57,501)**	(463,880)
Cash flows used by financing activities:		
Payment of capital lease obligations	**(490,612)**	(447,451)
Net increase (decrease) in cash	**3,253,740**	(763,543)
Cash, beginning of year	**27,333,907**	28,097,450
Cash, end of year	**$ 30,587,647**	$ 27,333,907

See accompanying notes to the financial statements.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Notes to the Financial Statements
December 31, 2017

1 Organization

The College of Physicians and Surgeons of Ontario ("the College") was incorporated without share capital as a not-for-profit organization under the laws of Ontario for the purpose of regulating the practice of medicine to protect and serve the public interest. Its authority under provincial law is set out in the Regulated Health Professions Act (RHPA), the Health Professions Procedural Code under RHPA and the Medicine Act.

The College is exempt from income taxes provided certain criteria are met.

2 Significant accounting policies

These financial statements have been prepared by management in accordance with Canadian accounting standards for not-for-profit organizations.

a) Cash

Cash includes cash deposits held in an interest bearing account at a major financial institution.

b) Investments

Guaranteed investment certificates are valued at amortized cost.

c) Capital assets

The cost of a capital asset includes its purchase price and any directly attributable cost of preparing the asset for its intended use.

A capital asset is tested for impairment whenever events or changes in circumstances indicate that its carrying amount may not be recoverable. An impairment loss is recognized in the statement of operations when the carrying amount of the asset exceeds the sum of the undiscounted cash flows resulting from its use and eventual disposition. The impairment loss is measured as the amount by which the carrying amount of the capital asset exceeds its fair value. An impairment loss is not reversed if the fair value of the capital asset subsequently increases. As at December 31, 2017, no such impairment exists.

Amortization is provided for on a straight-line basis over their estimated lives as follows:

Building	10 - 25 years	Computer and other equipment	3 - 5 years
Leasehold improvements	5 years	Computer equipment under capital lease	3 - 4 years
Furniture and fixtures	10 years		

d) Pension plans

The College recognizes its defined benefit obligations as the employees render services giving them right to earn the pension benefit. The defined benefit obligation at the statement of financial position date is determined using the most recent actuarial valuation report prepared for funding purposes. The measurement date of the plan assets and the defined benefit obligation is the College's statement of financial position date.

In its year-end statement of financial position, the College recognizes the defined benefit obligation, less the fair value of plan assets, adjusted for any valuation allowance in the case of a net defined benefit asset. The plan cost for the year is recognized in the excess of revenues over expenses for the year. Past service costs resulting from changes in the plan are recognized immediately in the excess of revenue over expenses for the year at the date of the changes.

Remeasurements and other items comprise the aggregate of the following: the difference between the actual return on plan assets and the return calculated using the discount rate; actuarial gains and losses; the effect of any valuation allowance in the case of a net defined pension asset; past service costs; and gains and losses arising from settlements or curtailments. Remeasurements are recognized as a direct charge (credit) to net assets.

2 Significant accounting policies continued

e) Revenue recognition

i) Members' fees and application fees

These fees are set annually by Council and are recognized as revenue proportionately over the fiscal year to which they relate. Fees received in advance are recorded as deferred revenue.

ii) Independent Health Facility (IHF) and Out of Hospital Premises Inspection Program (OHPIP) fees

IHF and OHPIP annual and assessment fees are recognized at the same rate as the related costs are expensed.

iii) Investment income

Investment income is comprised of interest from cash and cash equivalents, and guaranteed investment certificates. Interest and dividends are recognized when earned.

f) Financial instruments

i) Measurement

The College initially measures its financial assets and financial liabilities at fair value, adjusted by, in the case of a financial instrument that will not be measured subsequently at fair value, the amount of transaction costs directly attributable to the instrument.

The College subsequently measures its financial assets and liabilities at amortized cost. Transaction costs are recognized in income in the period incurred.

ii) Impairment

At the end of each reporting period, the College assesses whether there are any indications that a financial asset measured at amortized cost may be impaired. When there is an indication of impairment, the College determines whether a significant adverse change has occurred during the period in the expected timing or amount of future cash flows from the financial asset.

g) Management estimates

In preparing the College's financial statements, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and reported amounts of revenue and expenses during the period. Actual results may differ from these estimates, the impact of which would be recorded in future periods. Estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognized in the year in which the estimates are revised and in any future years affected.

h) Net assets invested in capital assets

Net assets invested in capital assets comprises the net book value of the capital assets less the related obligations under capital leases.

3 Cancer Care Ontario Quality Management Partnership

The College and Cancer Care Ontario (CCO), are jointly developing a provincial quality management program in three areas: mammography, colonoscopy and pathology. The program is fully funded by CCO. The program's expenses totaling $640,362 (2016 - $698,360) are excluded from the College's financial statements.

As at December 31, 2017, the College's account receivable arising from reimbursement of expenses incurred on behalf of CCO are $116,971 (2016 - $539,221). CCO has the right to audit the expenses charged to the program and adjustments, if any, to the accounts will be accounted for in the year of settlement.

4 Investments

As at December 31	**2017**	2016
Guaranteed Investment Certificates (GIC)		
Manulife Bank, 1.70%, due November 14, 2017	**$ -**	$ 10,000,000
Manulife Bank, 1.95%, due November 13, 2018	**10,000,000**	10,000,000
Manulife Bank, 2.20%, due November 16, 2020	**10,000,000**	-
CIBC, guaranteed growth, minimum 0.50% annual return, due November 13, 2019	**10,000,000**	10,000,000
CIBC, guaranteed growth, minimum 0.60% annual return, due November 13, 2020	**10,000,000**	10,000,000
National Bank, 2.01%, due November 22, 2022	**10,000,000**	10,000,000
Accrued interest	**886,488**	543,913
	$ 50,886,488	$ 50,543,913

The GIC investments are measured at amortized cost. Interest on the guaranteed growth investments held at CIBC will be determined at maturity based on the percentage change in price of an equally weighted portfolio of five Canadian bank's shares. Interest has been accrued at the minimum guaranteed rates.

5 Capital assets

As at December 31	**2017**		2016	
	Cost	**Accumulated Amortization**	Cost	Accumulated Amortization
Land	**$ 2,142,903**	**$ -**	$ 2,142,903	$ -
Building and building improvements	**20,779,959**	**14,637,816**	20,735,933	14,134,456
Furniture and fixtures	**4,380,871**	**3,540,453**	4,357,209	3,384,491
Computer and other equipment	**1,268,078**	**1,262,123**	1,266,212	1,236,255
Computer equipment under capital lease	**2,200,964**	**1,240,896**	1,804,569	932,986
Leasehold improvements	**396,339**	**356,705**	396,339	277,437
	$ 31,169,114	**$ 21,037,993**	$ 30,703,165	$ 19,965,625
Net book value		**$ 10,131,121**		$ 10,737,540

6 Deferred revenue

Deferred revenue consists of membership fees received in advance for the next year as well as unearned fees related to the Independent Health Facility program (IHF) and Out of Hospital Premises Inspection Program (OHPIP). The change in the deferred revenue accounts for the year is as follows:

	Membership Fees	IHF	OHPIP	2017 Total	2016 Total
Balance, beginning of year	**$ 24,282,912**	**$ 1,949,351**	**$ 1,296,250**	**$ 27,528,513**	$ 26,501,566
Amounts billed during the year	**59,677,262**	**1,433,136**	**1,184,459**	**62,294,857**	58,095,097
Less: Recognized as revenue	**(58,374,991)**	**(1,053,893)**	**(1,460,514)**	**(60,889,398)**	(57,068,150)
Balance, end of year	**$ 25,585,183**	**$ 2,328,594**	**$ 1,020,195**	**$ 28,933,972**	$ 27,528,513

The IHF and OHPIP Programs are budgeted and billed on a cost recovery basis.

7 Administered programme

The College administers the Methadone programme on behalf of the Ministry of Health and Long Term Care (MOHLTC). The revenues and expenses incurred for the programme are not included in the statement of operations of the College as they are the responsibility of the MOHLTC.

	2017	2016
Balance, opening	**$ 64,497**	$ 152,978
MOHLTC	**513,744**	322,158
Expenditures	**(519,652)**	(410,639)
Balance, closing	**$ 58,589**	$ 64,497

8 Pension Plans

i) Plan description

The College maintains a defined contribution pension plan for the benefit of its employees. The College also sponsors a supplementary defined contribution retirement plan for employees of the College in order to supplement the pension benefits payable to employees which are subject to the maximum contribution limitations under the Canadian Income Tax Act.

In addition, the College maintains a closed (1998) defined benefit pension plan for certain designated former employees. The retirement benefits of these designated employees are provided firstly through a funded plan and secondly through an unfunded supplementary plan.

ii) Reconciliation of funded status of the defined benefit pension plan to the amount recorded in the statement of financial position

Defined Benefit Plan	Funded Plan	Unfunded Plan	2017 Total	2016 Total
Plan assets at fair value	**$ 2,742,860**	**$ -**	**$ 2,742,860**	$ 2,929,387
Accrued pension obligations	**(3,980,411)**	**(4,450,114)**	**(8,430,525)**	(8,401,461)
Funded status - deficit	**$ (1,237,551)**	**$ (4,450,114)**	**$ (5,687,665)**	$ (5,472,074)

8 Pension plans continued

iii) Plan assets

Defined Benefit Plan	**Funded Plan**	**Unfunded Plan**	**2017 Total**	2016 Total
Fair value, beginning of year	**$ 2,929,387**	**$ -**	**$ 2,929,387**	$ 3,243,210
Interest income	**107,216**	**-**	**107,216**	121,620
Return on plan assets (excluding interest)	**48,797**	**-**	**48,797**	(113,692)
Employer contributions	**-**	**289,889**	**289,889**	291,654
Benefits paid	**(342,540)**	**(289,889)**	**(632,429)**	(613,405)
Fair value, end of year	**$ 2,742,860**	**$ -**	**$ 2,742,860**	$ 2,929,387

iv) Accrued pension obligations

Defined Benefit Plan	**Funded Plan**	**Unfunded Plan**	**2017 Total**	2016 Total
Balance, beginning of year	**$ 3,987,128**	**$ 4,414,333**	**$ 8,401,461**	$ 8,688,238
Interest cost on accrued pension obligations	**145,928**	**161,565**	**307,493**	325,809
Benefits paid	**(342,540)**	**(289,889)**	**(632,429)**	(613,405)
Actuarial (gains) losses	**189,895**	**164,105**	**354,000**	819
	$ 3,980,411	**$ 4,450,114**	**$ 8,430,525**	$ 8,401,461

The most recent actuarial valuation of the pension plan for funding and accounting purposes was made effective December 31, 2015. In accordance with that valuation, no payments have been made or are required under the funded plan. The next required actuarial valuation for funding purposes must be as of a date no later than December 31, 2018.

v) The net expense for the College's pension plans is as follows:

	2017	2016
Funded defined benefit plan	**$ 38,712**	$ 34,008
Unfunded supplementary defined benefit plan	**161,565**	170,181
Defined contribution plan	**2,849,219**	2,765,209
Supplementary defined contribution plan	**229,047**	193,179
	$ 3,278,543	$ 3,162,577

vi) The elements of the defined benefit pension expense recognized in the year are as follows:

Defined Benefit Plan	**Funded Plan**	**Unfunded Plan**	**2017 Total**	2016 Total
Interest cost on accrued pension obligations	**$ 145,928**	**$ 161,565**	**$ 307,493**	$ 325,809
Interest income on pension assets	**(107,216)**	**-**	**(107,216)**	(121,620)
Pension expense (recovery) recognized	**$ 38,712**	**$ 161,565**	**$ 200,277**	$ 204,189

8 Pension plans continued

vii) Remeasurements and other items recognized as a direct charge (credit) to net assets are as follows:

Defined Benefit Plan	**Funded Plan**	**Unfunded Plan**	**2017 Total**	2016 Total
Actuarial (gain) losses	**$ 189,895**	**$ 164,105**	**$ 354,000**	$ 819
Return on plan assets (excluding interest)	**(48,797)**	**-**	**(48,797)**	113,692
Charge (credit) to net assets	**$ 141,098**	**$ 164,105**	**$ 305,203**	$ 114,511

viii) Actuarial assumptions

The significant actuarial assumptions adopted in measuring the accrued pension obligations as at December 31 are as follows:

	2017	2016
Discount rate	**3.30 %**	3.66 %
Rate of compensation increase	**N/A**	N/A

9 Obligations under capital leases

The College has entered into several capital leases for computer equipment. The following is a schedule of the future minimum lease payments of the obligations under these leases expiring on various dates to April 2021:

2018	$ 422,981
2019	341,077
2020	160,013
2021	35,997
	960,068
Less: current portion	422,981
	$ 537,087

10 Net assets

2017	Invested in Capital Assets	Building Fund	Unrestricted	Pension Re-measurement	Total
Balance, January 1	**$ 9,859,526**	**$ 39,654,640**	**$ 312,159**	**$ (312,159)**	**$ 49,514,166**
Excess (deficiency) of revenue over expenses for the year	**(688,473)**	**-**	**2,483,860**	**-**	**1,795,387**
Actuarial remeasurement for pensions	**-**	**-**	**-**	**(305,203)**	**(305,203)**
Transfers	**-**	**2,178,657**	**(2,178,657)**	**-**	**-**
Balance, December 31	**$ 9,171,053**	**$ 41,833,297**	**$ 617,362**	**$ (617,362)**	**$ 51,004,350**

2016	Invested in Capital Assets	Building Fund	Unrestricted Net Assets	Pension Re-measurement	Total
Balance, January 1	$ 10,219,127	$ 40,292,078	$ 197,648	$ (197,648)	$ 50,511,205
Excess of revenue over expenses for the year	(359,601)	-	(522,927)	-	(882,528)
Actuarial remeasurement for pensions	-	-	-	(114,511)	(114,511)
Transfers	-	(637,438)	637,438	-	-
Balance, December 31	$ 9,859,526	$ 39,654,640	$ 312,159	$ (312,159)	$ 49,514,166

The College has transferred $2,178,657 to the building fund from unrestricted net assets (2016 - $637,438 transferred from the building fund to unrestricted net assets).

Net assets invested in capital assets is calculated as follows:

As at December 31	**2017**	2016
Net book value of capital assets	**$ 10,131,121**	$ 10,737,540
Less: obligations under capital leases	**(960,068)**	(878,014)
	$ 9,171,053	$ 9,859,526

11 Commitments

The College has a lease for additional office space which extends to December 31, 2021 with two options to renew for additional five year terms subsequent. Minimum payments for base rent and estimated maintenance, taxes and insurance in aggregate and for each of the next four years are estimated as follows:

2018	$ 691,587
2019	716,394
2020	724,475
2021	732,717
Total	$ 2,865,173

12 Contingencies

The College has been named as a defendant in lawsuits with respect to certain of its members or former members. The College denies any liability with respect to these actions and no amounts have been accrued in the financial statements. Should the College be unsuccessful in defending these claims, it is not anticipated that they will exceed the limits of the College's liability insurance coverage.

The College acknowledges that it has an obligation to provide funding to patients who are approved by the Patient Relations Committee.

13 Financial instruments

General objectives, policies and processes

Council has overall responsibility for the determination of the College's risk management objectives and policies.

Credit risk

Credit risk is the risk that one party to a financial instrument will cause a financial loss for the other party by failing to discharge an obligation. The College is exposed to credit risk through its cash, accounts receivable and investments.

Accounts receivable are generally unsecured. This risk is mitigated by the College's requirement for members to pay their fees in order to renew their annual license to practice medicine. The College also has collection policies in place.

Credit risk associated with cash and investments is mitigated by ensuring that these assets are invested in financial obligations of major financial institutions.

Liquidity risk

Liquidity risk is the risk that the College will not be able to meet a demand for cash or fund its obligations as they come due. The College meets its liquidity requirements and mitigates this risk by monitoring cash activities and expected outflows and holding assets that can be readily converted into cash, so as to meet all cash outflow obligations as they fall due.

Market risk

Market risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices. Market risk is comprised of currency risk, interest rate risk and equity risk.

i) Currency risk

Currency risk reflects the risk that the College's earnings will vary due to the fluctuations in foreign currency exchange rates. The College is not exposed to foreign exchange risk.

ii) Interest rate risk

Interest rate risk refers to the risk that the fair value of financial instruments or future cash flows associated with the instruments will fluctuate due to changes in market interest rates. The exposure of the College to interest rate risk arises from its interest bearing investments and cash. The primary objective of the College with respect to its fixed income investments ensures the security of principal amounts invested, provides for a high degree of liquidity, and achieves a satisfactory investment return giving consideration to risk. The College has mitigated exposure to interest rate risk.

iii) Equity risk

Equity risk is the uncertainty associated with the valuation of assets arising from changes in equity markets. The College is not exposed to this risk.

Changes in risk

There have been no significant changes in risk exposures from the prior year.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
Schedule I
Committee Costs

Year ended December 31	2017	2016
Attendance	**$ 3,683,250**	$ 4,011,557
Preparation time	**3,164,413**	3,031,900
Decision writing	**901,074**	978,582
Expert opinions	**1,838,289**	1,481,904
Assessors	**330,793**	342,309
Travel time	**1,616,670**	1,718,558
HST on per diems	**650,946**	601,856
Legal costs	**1,956,780**	1,498,452
Audit fees	**44,526**	38,092
Sustenance	**236,991**	316,577
Meals and accommodations	**366,523**	390,895
Travel expenses	**750,491**	847,685
Witness expenses	**40,429**	30,300
	$ 15,581,175	$ 15,288,667

Schedule II
Staffing Costs

Year ended December 31	2017	2016
Salaries	**$ 34,895,857**	$ 34,489,020
Employee benefits	**4,486,376**	4,571,881
Pension (note 8)	**3,278,543**	3,162,577
Training, conferences and employee engagement	**691,195**	670,103
Personnel, placement and pension consultants	**539,855**	591,518
	$ 43,891,826	$ 43,485,099

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
Schedule III
Department Costs

Year ended December 31	2017	2016
Consultant fees	**$ 1,292,550**	$ 1,069,231
Credit card service charges	**1,335,698**	1,253,249
IT Projects - external partners	**399,337**	424,475
Software	**367,590**	265,693
Equipment leasing	**10,796**	110,894
Equipment maintenance	**55,711**	39,937
Miscellaneous	**417,439**	393,576
Photocopying	**352,211**	357,756
Printing	**22,828**	37,341
Postage	**280,095**	294,698
Members dialogue	**339,522**	380,297
Courier	**68,669**	118,228
Telephone	**325,511**	315,305
Office supplies	**315,636**	340,251
Reporting and transcripts	**453,629**	353,184
Professional fees - staff	**91,324**	82,039
FMRAC Membership fee	**490,620**	471,000
Publications and subscriptions	**193,784**	191,780
Travel	**252,311**	447,411
Grants	**94,000**	74,000
	$ 7,159,261	$ 7,020,345

Schedule IV
Occupancy

Year ended December 31	2017	2016
Building maintenance and repairs	**$ 681,026**	$ 465,192
Insurance	**500,276**	496,566
Realty taxes	**87,457**	78,236
Utilities	**248,325**	246,055
Rent	**627,325**	384,653
	$ 2,144,409	$ 1,670,702

Council Briefing Note

May 2018

TOPIC: Continuity of Care – Draft for Consultation

FOR DECISION

ISSUE:

- Work is underway to develop new policies relating to a number of Continuity of Care issues and to revise the current Test Results Management policy. In response to the research undertaken and feedback received to date, a 'suite' of draft policies has been developed.

- Council is provided with an overview of the development and review process to date and is asked whether each of the draft policies comprising the Continuity of Care 'suite' can be released for external consultation.

- To support Council in this regard, the briefing note has the following structure. The 'Background' section provides a general overview of the project and policy development and review process to date and the 'Current Status' section is divided into separate sections relating to each draft policy. In these sections, specific background information pertaining to each draft policy is provided, along with an overview of the key positions that have been developed or the key revisions that have been made. The respective decision pertaining to each draft policy is presented at the end of each section.

BACKGROUND:

1. Project Genesis

- The College first began development of various policies related to Continuity of Care in 2000, but ultimately decided in 2004 not to approve this work.

- Since that time, continuity of care issues have been raised at Council, at member specific committees, and through calls to the College's Public and Physician Advisory Service (PPAS).

- Continuity of care also continues to receive significant attention among policy makers, the media, advocacy groups, and others.

    - Most notably, the death of Greg Price in Alberta and resulting Health Quality Council of Alberta report shone a spotlight on a number of continuity of care issues. The

report contained numerous recommendations to a number of entities including the College of Physicians and Surgeons of Alberta.

- Additionally, reports from the Commonwealth Fund[1] and from Health Quality Ontario[2] regularly draw attention to continuity of care issues including the availability of same-next day appointments, availability of after-hours care, and challenges with the referral/consultation process.

- In March 2014, the Executive Committee directed staff to undertake preliminary work on the issue of continuity of care, including providing analysis and recommendations regarding the development of a new policy.

- This work culminated in a presentation to Council in May 2016 where Council reviewed and discussed a Continuity of Care Planning and Proposal document which provided analysis and recommendations relating to the development of new policy content.

    - Included in the presentation to Council was jurisdictional research which indicated that a number of medical regulatory Colleges across Canada have already addressed continuity of care issues, and that by not having policies on this topic, this College is lagging behind.

    - The document and presentation also outlined the objective and scope of the proposed project: to develop new policy content relating to continuity of care and to revise the current test results management policy.

- Following the May 2016 Council meeting, a large Working Group with a diversity of perspectives was struck to oversee the policy development and review process.

    - The Working Group is comprised of Dr. Brenda Copps (Chair), Dr. Kevin Glasgow,[3] Dr. Barbara Lent, Dr. Peeter Poldre, Ms. Joan Powell, Mr. Ron Pratt, Mr. Arthur Ronald,[4] and Dr. David Rouselle. The Working Group is also supported by Alice Cranker (Legal Counsel) and Dr. Keith Hay (Medical Advisor), in addition to policy staff.

2. Policy Development and Review Process

- In accordance with the usual policy development and review processes, a comprehensive literature review was undertaken and preliminary external consultations relating to both to

[1] Commonwealth Fund data is regularly reported in the media, but a review of the data is also regularly provided by the Canadian Institute for Health Research and Canadian Institute for Health Information (see for example CIHR & CIHI, 2016 and CIHR & CIHI, 2017).
[2] Health Quality Ontario publishes reports on various health-system quality indicators. Reports addressing issues relating to continuity of care include: Measuring Up, 2016 and Experiencing Integrated Care, 2015.
[3] Dr. Glasgow is a College Assessor with expertise in walk-in clinics.
[4] Mr. Arthur Ronald left the College in December 2017 and will not be a part of the Working Group going forward.

the topic of Continuity of Care and the current Test Results Management policy were held between June and August 2016.

- The literature review included a review of scholarly articles, research papers, news media, as well as a jurisdictional review of medical regulatory Colleges across Canada.

- The College received 65 responses to the Continuity of Care preliminary consultation and another 103 responses to the Test Results Management preliminary consultation. A summary of the feedback received and specific demographic details regarding who participated in the consultation was provided to Council in September 2016 as part of the Policy Report. All written feedback and a report of the survey results can be found on the respective consultation pages hyperlinked above.

- Relevant decisions of the Inquiries, Complaints, and Reports Committee (ICRC) were also reviewed and relevant concerns or points of discussion at ICRC and Quality Assurance Committee (QAC) meetings were forwarded to Policy staff for consideration by Committee Support staff. Additionally, feedback was solicited from College staff representing the Investigations & Resolutions and PPAS departments.

- To supplement the consultation feedback, two public opinion polls were also conducted.[5] The surveys probed Ontarians on issues including the availability of their physicians (e.g., ease of getting an appointment), their preferences regarding accessing care when their physician is unavailable, their experiences and expectations regarding test results, and their perceptions of the importance of various continuity of care issues.

- To facilitate increased engagement in the process and to provide the Working Group with different perspectives on the issues, speakers representing primary care, hospitals, patients, and those developing and advocating for technological solutions to health systems problems made presentations to the Working Group.

- The Working Group also took the unusual step of giving the Executive Committee and Council a preview of their work while it was still being drafted, including a presentation at the February 2018 Council meeting. The Working Group felt that the scale and scope of the project warranted introducing key issues and messages to the Executive Committee and Council to give the Committee and Council an opportunity to discuss the issues and inform the work before being presented with draft policies.

- Specific background information pertaining to each draft policy is provided in the specific draft policy sections below.

[5] Online surveys were conducted July 13-26, 2016 and March 31 - April 10, 2017 with representative samples of 866 and 856 Ontarians, respectively. As the online panel was recruited randomly using an Interactive Voice Response system, results can be generalized to the online population of Ontario, which represents approximately 80% of the adult population. Findings are accurate to +3.5%, at the 95% level of confidence.

CURRENT STATUS:

- In response to the research, feedback, and public polling the Working Group has developed a suite of draft policies. The suite is comprised of four companion policies organized under an 'umbrella' Continuity of Care policy which sets out core principles and expectations.

- While continuity of care is a broad concept that could include a number of issues, the Working Group directed that four key areas be prioritized as the focus of this current work: Availability and Coverage; Managing Tests; Transitions in Care; and Walk-in Clinics.

    - These areas were prioritized by the Working Group as they were identified as areas of real or perceived risk, areas where the College was lagging behind other medical regulatory Colleges, or areas where the Working Group felt the College had reason for being proactive in order to protect patients.

    - Additionally, this project focuses on those issues where physicians have a role to play in facilitating continuity of care. The College's recommendations regarding broader systems issues that are beyond the control or influence of physicians will be set out in a 'white paper' and published at a later date.

- The Working Group has also been deliberate in setting out draft expectations that are nuanced, balanced, and practical. In particular, the Working Group routinely deliberated about whether the expectations being drafted should be mandatory (must or required) or permissive (advised or recommends).

    - As part of these deliberations, the Working Group was sensitive to whether the expectations being developed would contribute to physician burnout and whether they were feasible in practice. However, the Working Group was also committed to making sure that it addressed issues or situations that can lead to discontinuity and pose a risk to patient safety. It aimed to strike an appropriate balance.

- An overview of each draft policy within the suite is set out in each section below and is followed by the respective decision before Council in relation to each draft policy.

1. Continuity of Care – Draft Umbrella Policy

A. Summary of Research and Feedback

- A variety of definitions of continuity of care can be found in the literature, but common themes were often represented. This included the idea that patients should experience their care as being coordinated and connected, the importance of information flow throughout the health-care system, and the value of being provided care within a sustained physician-patient relationship. Stakeholder feedback echoed these sentiments.

- The role that patients play in facilitating continuity of care also emerged as a key theme. The invited speaker representing the patient perspective emphasized that informed and engaged patients who understand their role and responsibilities complement physicians' efforts to support continuity of care. Stakeholders also noted that patient choices regarding when and how to access care, their availability to receive test results, and their compliance with getting tests completed in a timely manner all impact continuity of care.

- Technology was regularly lauded by researchers and stakeholders as being an important facilitator of continuity of care. In particular, a province wide and fully integrated electronic medical record was often cited as a much needed development and invited speakers spoke about technological developments that can improve continuity of care (e.g., e-consult, Sunnybrook's MyChart, etc.).

B. Overview of Draft Policy

- The draft Continuity of Care umbrella policy is attached as **Appendix A**.

1) Purpose and Organization (*Lines 34 to 56*)

- The draft umbrella policy introduces the organizational structure of the suite. In particular, it explains that the suite is comprised of this foundational or umbrella policy, as well as a number of companion policies that set out expectations regarding specific elements of practice.

- The purpose of the draft umbrella policy is to set out principles of professionalism that underpin the suite of policies and to set out general expectations that have broad application.

2) Principles (*Lines 57 to 71*)

- College policies include a 'Principles' section in order to ground the policy content in the values and duties found in the *Practice Guide*. In order to reduce duplication and to retain an overarching perspective, the Working Group opted to set out principles in the draft umbrella policy only rather than developing principles in each draft companion policy. The principles in the draft umbrella policy apply to all draft companion policies across the suite.

- The principles focus on patients' best interests, communication and collaboration, public trust, physician competence, and participation in medical regulation.

3) General expectations

- The draft umbrella policy sets out general expectations pertaining to three key facilitators of continuity of care: physicians, patient engagement, and technology. It also indicates that

more specific expectations relating to these key facilitators are set out in the draft companion policies.

a. Physicians' role in facilitating continuity of care (*Lines 75 to 88*)

- With respect to the role of physicians, the draft umbrella policy identifies the importance of physicians seeing patient interactions with the health-care system as a set of interactions that require oversight and management over time, rather than discrete events.

- The draft umbrella policy also advises physicians, in their role as health advocates, to respond to and participate in opportunities to improve continuity of care within the health system.

b. Patient engagement as a means to facilitate continuity of care (*Lines 89 to 103*)

- In recognition of the important role that patients play in facilitating continuity of care, the draft umbrella policy advises physicians to support patient engagement in this regard. This includes helping patients to understand their role and how their actions facilitate continuity of care.

- Importantly, the draft umbrella policy clearly states that patient engagement is not meant to absolve physicians of their responsibilities with respect to continuity of care.

c. The role of technology in facilitating continuity of care (*Lines 104 to 114*)

- The draft umbrella policy strongly advises physicians to capitalize on advances in technology that may facilitate continuity of care. However, the draft umbrella policy is also clear that physicians' responsibilities with respect to continuity of care exist whether or not there are technological solutions and whether or not those solutions are adopted.

DECISION FOR COUNCIL:

1. Does Council have any feedback on the draft **Continuity of Care (umbrella)** policy?

2. Does Council recommend that the draft **Continuity of Care (umbrella)** policy be released for external consultation?

2. *Availability and Coverage Draft Policy*

A. Summary of Research and Feedback

- Research conducted by the Commonwealth Fund suggests that Ontario lags behind many jurisdictions, including international comparators, in relation to the availability of same/next day appointments, the availability of after-hours care, and the ability of elderly patients with chronic conditions to access their physician between appointments.[6] Public polling confirmed that some Ontarians may have difficulty getting same/next day appointments and that after-hours care is not widely available.[7]

- Some research suggests that the adoption of same/next day scheduling systems can reduce the incidence of missed appointments, improve practice efficiency, and can improve both patient and provider satisfaction.[8]

- The Health Quality Council of Alberta recommended that physicians improve their availability by telephone. In particular, they recommend that physicians have an office phone that is answered (or voicemail that is responded to the same day) for a minimum of seven hours every weekday. The consultation feedback, along with the experiences of PPAS staff and the Working Group, confirmed this was a problem area. For example, we heard about instances where physicians may sometimes leave their office phone unanswered, will not permit voicemails to be left, will not return voicemails in a timely manner, etc.

    - The Ontario Association of Medical Laboratories (OAML) stated that laboratories often have difficulty communicating critical results with physicians, especially after-hours. They noted that even if coverage information is provided, calls from laboratories may go unanswered.[9]

    - The College is also aware that other health-care providers can experience difficulty contacting physicians. For example, through calls to the College we are aware that sometimes pharmacists experience challenges contacting physicians to confirm prescription information, which may pose a significant risk to patient safety. Similarly, the Associate Medical Officer of Health for a South Eastern Ontario city contacted the College due to the inability of their office to reach primary care providers by phone.

[6] See for example Commonwealth Fund data reported in CIHR & CIHI, 2016 and the following Health Quality Ontario reports: Measuring Up, 2016; Experiencing Integrated Care, 2015.
[7] About half of Ontarians report being able to get same/next day appointments with their physicians and that their physicians have after-hours policies in place.
[8] See for example Hudec, MacDougall, and Rankin, 2010 for a review of the literature as well as details about different same-day practice models.
[9] The OAML has provided this feedback formally through the preliminary consultation (see their feedback here) and have reiterated these issues when communicating with Policy staff.

- The importance of after-hours care was confirmed by the research, stakeholder feedback, and the public opinion polling. However, concerns were often raised as well.

    - The Ontario Medical Association (OMA) and OMA Section on General and Family Practice (SGFP) have expressed concern that the College would develop expectations that would contribute to physician burnout. In particular, that the College would set expectations that would require physicians to provide continuous and on-demand (24/7) access to care in the absence of appropriate remuneration mechanisms and in a manner that would compromise physician health.

    - Concerns were also identified in the literature, with some writers arguing that continuity of care does not mean continuous access to care and that some regulatory Colleges have erred in effectively requiring physicians to provide continuous access to care.[10] Stakeholder feedback also identified practical limitations with requiring after-hours care, including the lack of access to laboratory or diagnostic facilities and limited physician resources to assist with providing coverage in some communities.

    - Some critics have also advanced the claim that after-hours care is not a priority area for patients. The College's own polling confirms that while Ontarians rate access to after-hours care as less important than other issues,[11] they still rate it as important overall.

- Some medical regulatory Colleges across Canada set out expectations relating to after-hours care. Most notably, the College in Alberta has taken the position that physicians must directly provide or arrange for continuous after-hours care to be provided. Saskatchewan, Nova Scotia, and the Yukon adopt positions that are the same as Alberta's in substance, but in some instances may be more permissive in nature.

- Coverage for vacation and other temporary absences from practice was also identified as an area of importance through the consultation feedback and the research literature noted that risks to patient safety arise when coverage arrangements are not made. The College's polling results indicate that coverage arrangements may not always being made, or at least patients are not always being made of coverage arrangements that are in place.[12]

B. Overview of Draft Policy

- The draft Availability and Coverage policy is attached as **Appendix B**.

[10] See for example Prince, 2016.
[11] Most notably, issues relating to transitions in care or test results management.
[12] Only around half of Ontarians indicated that their physician implements coverage arrangements during vacations.

1) Improving physician availability (*Lines 34 to 82*)

- The Working Group felt strongly that good communication is the cornerstone of continuity of care, but that this cannot be achieved if physicians are unreachable to both patients and other health-care providers. As such, the draft policy requires that:
    - Physicians have an office phone that is answered and/or a voicemail that allows messages to be left **during operating hours**;
    - Physicians have a voicemail that allows messages to be left **outside of operating hours,**;
    - Voicemail outgoing messages be accurate and provide up to date information; and
    - Voicemail messages be reviewed and responded to in a timely manner.
- Recognizing that it is ideal for patients to see physicians with whom they have a sustained relationship, the draft policy requires physicians to structure their practice in a manner that allows for appropriate triaging of patients with time-sensitive or urgent issues.
    - While the draft policy does not require physicians to implement a same-day scheduling system, it does identify this approach as one way in which physicians can satisfy their obligations under the draft policy.
- Delays in responding to other health-care providers pose specific risks to patients and so the draft policy requires physicians to respond to other health-care providers in a timely and professional manner and includes specific examples relating to tests and prescriptions.

2) Coordinating after-hours coverage for patients (*Lines 89 to 98*)

- The draft policy explicitly notes that the College does not expect individual physicians to personally provide on-demand and continuous (24/7) access to care.
    - Instead, the Working Group sought to strike a balance between setting an expectation that is both achievable and realistic, and that would advance the public interest while recognizing that there are limitations to what can be expected of any individual physician due, in part, to the nature of their practice and the health system resources available to them.
- Accordingly, the draft policy requires physicians who are providing care as part of a sustained physician-patient relationship to have a plan in place to coordinate care outside regular operating hours. The aim of the plan is to minimize uncoordinated access to care and the inappropriate usage of emergency rooms or walk-in clinics.

- The draft policy does not prescribe what the plan will look like, leaving it to the professional judgment of the physician. Instead, the draft policy identifies a number of factors that will influence what an appropriate plan will look like, including the time of day and type of day (i.e., weekday, weekend, and holiday), the needs of their patients, as well as on the health-care provider and/or health system resources in the community.

- Once the policy is finalized, the Working Group intends to develop a "Frequently Asked Questions" document which can provide additional support to physicians with regards to understanding what options may be appropriate (e.g., on-call rotations, after-hours call group, formal arrangement with another clinic or Emergency Room, utilizing non-physician staff for triaging, etc.).

3) Coordinating after-hours coverage for test results (*Lines 100 to 104*)

- Because of their connection to the issues of availability and coverage, policy expectations found in the current *Test Results Management* policy regarding after-hours coverage for test results has been refined and relocated in this draft policy.

  - In response to feedback, particularly from the OAML, the draft policy is explicit that physicians must ensure that critical test results can be received and responded to 24 hours a day, 7 days a week.

4) Coordinating coverage for temporary absences from practice (*Lines 106 to 125*)

- Expectations regarding extended leaves of absence are set out in the current *Practice Management Considerations*[13] policy. This policy is under review and a draft Closing a Medical Practice policy was approved by Council for external consultation in February 2018. At that meeting, Council was informed that the expectations regarding temporary absences from practice would be captured in the Continuity of Care project.

- The draft policy focuses on all temporary absences from practice including both vacations and leaves of absence (e.g., parental leave, educational leave, suspension of a physician's certificate of registration).

  - The draft policy requires that coverage arrangements be made for patient care during temporary absences from practice. Consistent with the expectation for after-hours coverage, the nature of the arrangement is left to the physician's discretion, but the draft policy identifies factors that will influence what an appropriate arrangement looks like. This includes, length of the absence, whether the absence is planned or not, the

[13] The full policy title is: Practice Management Considerations for Physicians Who Cease to Practise, Take an Extended Leave of Absence or Close Their Practice Due to Relocation.

needs of the physician's patients, and the health-care provider and/or health system resources in the community.

- Physicians are also required to make specific arrangements for test results to ensure they are received, reviewed and followed up appropriately. Physicians' coverage arrangements must also allow other health-care providers to communicate or request information pertaining to patients under their care.

DECISION FOR COUNCIL:

1. Does Council have any feedback on the draft **Availability and Coverage** policy?

2. Does Council recommend that the draft **Availability and Coverage** policy be released for external consultation?

3. Managing Tests Draft Policy

A. Summary of Research and Feedback

- Issues with respect to receiving, monitoring and following-up on test results were identified both in the research and the consultation feedback.

- The research reviewed shows that a large percentage of legal actions against physicians are related to diagnostic delays or missed diagnoses.[14] As well, communication failures in test result notification have been identified in the research as problematic.[15] Both the research[16] and the consultation feedback indicated that errors in the testing process often result in patient harm.

- The research also shows that physicians are dissatisfied with their methods for tracking test results with some physicians admitting to having no method at all.[17] These issues were confirmed by the consultation feedback.

- Various "points of breakage" in test results management systems were identified in the research, including patients' failing to attend their laboratory or follow-up appointment, or simply failing to book the necessary appointments.[18]

[14] This information was obtained from Canadian Healthcare Network.ca (June 2016).
[15] See for example, Gale et al., 2011.
[16] See for example, Kwan & Cram, 2015.
[17] See for example, Kwan & Cram, 2015.
[18] See for example, Litchfield et al., 2015.

- A review of the case law and guidance from the Canadian Medical Protective Association (CMPA) regarding test results management issues shows that there is a need to improve systems and prevent failures in follow-up.[19]

- With respect to patient preferences regarding the communication of test results, the research and consultation feedback indicated that preferences varied depending on the type of test and patient demographics.[20]

- While the polling indicated that patients do not think that every result needs to be communicated to them, it also showed that only around half of Ontarians are confident that 'no news is good news' strategies will ensure that abnormal results are communicated to them.

- Most of the public feedback received in the consultation, as well as feedback from a few physicians, on the issue of 'no news is good news' strategies, indicated a distrust of 'no news is good news' strategies. However, the feedback also indicated that this strategy is necessary for physicians to run an efficient practice.

- Substantive policy suggestions were offered by a number of stakeholders including: providing additional detail or guidance regarding appropriate follow-up; adding provisions with respect to patient portals; further clarifying physicians' obligations when they review, receive, or become aware of a clinically significant or time-sensitive result, even if for a test they did not order; and, clarifying whether test results have to be communicated in the context of an appointment.

B. Overview of Draft Policy

- The draft Managing Tests policy is attached as **Appendix C**.

- The purpose of this draft policy is to set out expectations for physicians regarding the ordering and management of all types of tests.

- The draft policy clarifies that the scope of the policy applies to all tests, not just laboratory tests, and provides additional guidance regarding challenging elements of the test results management process. This includes, for example, tracking tests, communicating results to patients, receiving results in error, and supporting patient engagement.

- Those sections of the draft policy which reflect provisions set out in the current *Test Results Management* policy but have been modified for clarity purposes are not highlighted in this briefing note.

[19] Please see CMPA, 2011.
[20] See for example, LaRocque et al., 2015, Zagami et al., 2015 and Giardina et al., 2015.

- While not stated explicitly in the overview of key additions and revisions provided below, overall the positions set out in the draft policy are well aligned with advice and recommendations offered by the CMPA.

1) Ordering and tracking tests (*Lines 56 to 80*)

- New expectations have been added with respect to ordering tests including: requiring physicians to use their clinical judgment in determining whether to order a test; providing contextual patient information to laboratories and/or diagnostic facilities; and, ensuring that primary care providers are informed with respect to tests ordered for a patient.

- Regarding tracking tests, the draft policy maintains the expectations set out in the current *Test Results Management* policy - that is, tests must be tracked for high risk patients. The draft policy also clarifies what it means to track tests.

- In order to address a gap in the current policy, the draft policy sets out expectations for physicians with respect to tracking tests for patients who are not high risk. Physicians must use their professional judgement to determine whether tests must be tracked for these patients and the draft policy includes factors for the physician to consider when making this determination.

2) Communication of test results (*Lines 92 to 120*)

- The draft policy clarifies that physicians must use their professional judgment to determine how best to communicate test results and sets out factors for physicians to consider in making this determination. The draft policy also clarifies that physicians may have other health care providers and/or non-medical staff communicate test results to patients.

3) 'No News is Good News' Strategies (*Lines 121 to 137)*

- Revisions have been made to the current policy given the feedback received during the consultation with respect to 'no news is good news strategies'. The draft policy sets out expectations requiring physicians to consider a number of factors when determining whether such a strategy is appropriate. As well, the draft policy requires physicians to inform patients of such a strategy and to give patients the option to contact the physician's office to get the result.

4) Contact Information *(Lines 138 to 149)*

- In response to stakeholder feedback, a number of expectations have been included in the draft policy with respect to confirmation of patient contact information. For example, the draft policy includes expectations for confirming patient contact information and confirming whether voice mail messages can be left on patients' phones.

- Accurate patient contact information will ensure that test results can be communicated to patients and that follow-up appointments can be booked.

5) Patient Portals *(Lines 150 to 155)*

- Provisions with respect to patient portals are included in the draft policy. Physicians are advised to inform patients of the availability of patient portals and are reminded that the availability of patient portals does not discharge their responsibilities to communicate test results.

6) Test Results Received in Error or Incidentally *(Lines 162 to 174)*

- In response to stakeholder feedback, the draft policy clarifies physician responsibilities relating to receiving critical or clinically significant test results in error. Physicians must inform the ordering health-care provider, the patient's primary care provider, or the patient of the test result and must inform the laboratory or diagnostic facility of the error.

- The draft policy also sets out expectations for physicians who become aware, even incidentally (e.g., the physician is cc'd on a report) of a critical or clinically significant result where they have reason to believe that the ordering health-care provider did not or will not get the result.

7) Patient Engagement *(Lines 189 to 200)*

- The draft policy sets out two specific ways to engage patients. First, physicians must inform patients of the significance of the test, the importance of getting the test done and complying with requisition form instructions. Second, physicians are advised to encourage patients to discuss test results with the physician.

DECISION FOR COUNCIL:

1. Does Council have any feedback on the draft **Managing Tests** policy?

2. Does Council recommend that the draft **Managing Tests** policy be released for external consultation?

4. Transitions in Care

A. Summary of Research and Feedback

- Public opinion polling confirmed that transitions in care are a priority area for Ontarians. More specifically, metrics relating to hospital discharges and the referral and consultation process were rated among the top 5 most important continuity of care issues that were included in the poll.[21]

- Concerns regarding patient handovers in hospital were identified both in the research and by stakeholders. Stakeholders commented on how hard it is for patients to know who is responsible for their care and the research spoke both to the inherent risks in these transitions and to best practices.

- Research suggests that while many primary care providers report always or often receiving notification when their patient is discharged from hospital, there is room for improvement.[22] Moreover, some primary care providers report waiting 15+ days for discharge information.[23] Stakeholder feedback echoed these findings. Some physician stakeholders reported instances where they never received a discharge summary despite a significant event occurring in relation to the patient's care or instances where there was a significant delay in receiving a discharge summary.

- Stakeholders were concerned about discharged patients who do not understand their care needs or do not understand when and from whom to seek care if complications arise. The literature included recommendations in this regard, setting out suggested information to share with patients prior to discharge.

- The current *Medical Records* policy sets out expectations regarding the content of discharge summaries and requires that a brief summary be provided to those assuming responsibility for care if a delay in the distribution of the discharge summary is anticipated.

    - A few medical regulatory Colleges across Canada set out expectations regarding discharge summaries. Often the requirement is simply that discharge summaries be completed, but in some instances the discharging physician is also required to directly contact the physician assuming responsibility for the patient's care when follow-up is needed within 2 weeks of discharge.

- Research reveals that only a minority of primary care physicians say they always get the information they need from specialists, and fewer say this information is shared in a timely manner.[24] Research also indicates that patients have experienced instances where their

[21] Public perceptions of importance were assessed on 70 metrics relating to a range of continuity of care issues.
[22] See for example Health Quality Ontario's Connecting the Dots for Patients, 2016
[23] See for example the Commonwealth Fund data reported in CIHR & CIHI, 2016
[24] See for example the Commonwealth Fund data reported in CIHR & CIHI, 2016.

primary care provider is not always informed about care they received from specialists,[25] a result that was confirmed through public opinion polling. On the other hand, research reveals that specialists often feel as though they lack basic information from referring physicians.[26]

- Consultation feedback echoed these concerns. Stakeholders identified instances where referrals or patient information were lost, where referrals went unanswered, or where there was poor information sharing between physicians. Stakeholders also worried that a lack of clarity regarding who is responsible for booking consultation appointments (i.e., the patient, the consultant, or referring physician) may cause breakdowns in continuity of care.

- The current *Medical Records* policy sets out expectations regarding the content of referral requests and consultation reports. The list of required information is robust, similar to the other jurisdictions, and consistent with best practices as identified through the literature.

- Other jurisdictions also include a number of expectations for referring and consultant physicians. For example, expectations that referrals be made in writing, that referring physicians track referrals, that consultant physicians respond to referral requests promptly (14 or 30 days), that consultant physicians recommend alternative providers if they decline the referral, and that consultation reports be sent in a timely manner (14 or 30 days).

  - Many stakeholders also expressed concern regarding how consultations are being arranged, the possibility for significant delays, breakdowns in communication between physicians, and a lack of clarity regarding who should be communicating appointment information with patients.

B. Overview of Draft Policy

- The draft Transitions in Care policy is attached as **Appendix D**.

1) Purpose and scope of the draft policy (*Lines 24 to 28*)

- Patients experience a number of different types of transitions in care as they move through the health-care system. The draft policy does not address all types of transitions in care, but rather focuses on a subset of transitions and related issues.

  - In particular, this policy sets out expectations in relation to keeping patients informed about who is responsible for their care in hospital and during the referral and consultation process, managing patient handovers in hospital, hospital discharges, and the referral and consultation process.

[25] See for example Health Quality Ontario's Experiencing Integrated Care, 2015.
[26] See for example survey data reported by the Canadian Medical Association, 2014.

- These transitions in care and related issues were identified as being important due to the risk they pose to patients when breakdowns occur and because they are instances where physicians have an essential and clear role to play. The research, feedback, and public polling also confirmed their importance.

2) Keeping patients informed (*Lines 38 to 59*)

- Within hospitals and healthcare institutions, the draft policy requires physicians to coordinate with other health-care providers to keep patients informed about who is their most responsible provider.[27] The draft policy also requires referring and consultant physicians to inform patients about the nature of their role and to keep patients updated if their role changes.

3) Managing patient handovers (*Lines 61 to 72*)

- The draft policy describes the elements of an effective patient handover and advises physicians to implement best practices. In particular, the draft policy advises physicians to approach handovers in a systematic manner (e.g., using standardized or structured communication approaches or tools) and to set time aside to exchange information through a personal and real-time encounter (e.g., in person, telephone, video conferencing), rather than, for example, simply leaving documents or notes for the health-care provider assuming responsibility for the patient.

4) Discharging patients from hospital (*Lines 74 to 146*)

- In order to help prepare and support patients during the discharge process, a number of expectations have been developed. In particular, the draft policy requires physicians to:

    - Ensure that a discussion is had with the patient and/or substitute decision-maker prior to discharge about, for example, symptoms that require monitoring and where to go if complications arise; this advice was adapted from recommendations set out by the CMPA.[28]

    - Take reasonable steps to involve the patient's family and/or caregivers in this discussion, where the patient wishes them to be involved.

    - Use their professional judgment to determine whether elements of this discussion should be captured in writing.

[27] The draft policy uses the term "most responsible provider" in recognition that the scopes of practice of health-care providers is constantly evolving and that in some instances a non-physician may actually have overall responsibility for a patient.
[28] See for example the CMPA's Discharging patients following day surgery, 2015.

- The draft policy requires that physicians complete a discharge summary for all in-patients in a timely manner and to direct that the discharge summary be sent to the patient's primary care provider. The draft policy also requires physicians to take reasonable steps to identify other health-care providers who would benefit from knowledge of the hospitalization, and direct that the discharge summary be sent to them as well.

    - When there is an anticipated delay in the distribution of the discharge summary, the draft policy requires physicians to send a brief summary of the hospitalization to those health-care providers responsible for care.

    - Expectations regarding the content of discharge summaries found in the current *Medical Records* policy have been refined and imported into this draft policy.

5) Coordinating the referral and consultation process (*Lines 148 to 278*)

- In order to reduce delays that arise in the referral and consultation process and to help streamline the process, the draft policy includes a number of expectations many of which were inspired by the positions taken by other medical regulatory Colleges.

    - Referring physicians must take reasonable steps to confirm that a referral is within the scope of practice of the physician to whom they are referring and that the physician is accepting referrals;

    - Referring physicians must also have a mechanism in place to track that a referral has been received and will be acknowledged;

    - Consultant physicians must acknowledge referral requests in a timely manner, but no later than 30 days;

    - Referrals must be made in writing (with specific provisions for urgent situations) and the draft policy sets out expectations regarding the content of referral requests. The expectations regarding the contents of referral requests have been imported from the *Medical Records* policy with some refinements. The aim is to ensure consultant physicians have the information they need.

    - Expectations regarding communicating appointment information with the patient (e.g., date, instructions, etc.) have also been set out in order to bring clarity to this process.

- The draft policy requires that consultation reports be distributed to the referring health-care provider and primary care provider in a timely manner, but no later than 30 days after an assessment or after a new finding or change in the patient's management plan. Consultant physicians are also required to take reasonable steps to identify other health-

care providers involved in the patient's care who would benefit from knowledge of the consultation and send the report to them as well.

- Regarding the content of consultation reports, expectations currently found in the *Medical Records* policy have been refined and imported into this draft policy.

DECISION FOR COUNCIL:

1. Does Council have any feedback on the draft **Transitions in Care** policy?

2. Does Council recommend that the draft **Transitions in Care** policy be released for external consultation?

5. Walk-in Clinics

A. Summary of Research and Feedback

- Walk-in clinics emerged in the health-care system as a convenient alternative to emergency rooms for patients requiring non-urgent care, usually after-hours and on weekends. The model of care has now evolved and walk-in clinics often operate during traditional business hours as well as after-hours and on weekends.
  - Research shows that patients visit walk-in clinics for a variety of reasons, including the inability to see their own physician and because walk-in-clinics are convenient.[29]
  - Estimates suggest that around 6% of Ontarians do not have a primary care provider, and that men aged 16-44, recent immigrants, and people with lower household incomes are overrepresented in this population.[30]
- Issues pertaining to the nature and quality of care being provided in walk-in clinics have been identified by QAC, ICRC, and have been raised at Council. This includes concerns about the follow-up care that is/is not being provided, questions regarding how walk-in clinics can better support patients without a primary care provider, and concerns about physicians practising in walk-in clinics who refuse to provide specific types or elements of care.
- The lack of coordination between walk-in clinics and primary care providers is also an area of concern. This was identified in the Greg Price case where care was provided by multiple walk-in clinics with no coordination or connection back to Greg's primary care provider.

[29] See for example the Ontario Auditor General Report, 2011 and Premji, 2015.
[30] See for example the Ministry of Health's Patient's First Action Plan for Health Care – Year One Results and Hay, Pacey, Bains, and Ardel, 2010.

- The research confirmed this as a problem area as well, with some authors identifying the lack of connection as leading to breakdowns in continuity of care.[31] Stakeholders felt it would be ideal for primary care providers to be kept apprised of the care their patients receive in walk-in clinics.

- Some medical regulatory Colleges across Canada have been explicit that the standard of practice of the profession applies equally to walk-in clinics. Some Colleges have also set out expectations to improve information flow from walk-in clinics to primary care providers.

- The College in British Columbia requires walk-in clinics to provide comprehensive primary care to patients who regularly attend the same clinic and do not have a primary care provider.

  - This position has been fairly controversial and no other jurisdiction has followed suit to date. Instead, other jurisdictions set out the expectation that physicians be clear upfront that the care being provided is not comprehensive primary care.

B. Overview of Draft Policy

- The draft Walk-in Clinics policy is attached as **Appendix E**.

1) Purpose and scope of the draft policy (*Lines 23 to 26*)

- The scope of the draft policy is focused on addressing those elements of walk-in clinic care that most closely relate to continuity of care. The draft policy does not address all issues that might arise in this practice environment, nor does it address issues that might arise in other contexts where episodic care is provided.

- Addressing issues that arise in the context of walk-in clinics has been a focus of this project since its inception. This was due, in part, to problems that have been identified at QAC and ICRC or been raised by Council Members at Council meetings.

2) Supporting patient understanding (*Lines 41 to 53*)

- The draft policy requires physicians to use their professional judgment to determine whether it would be appropriate to sensitively remind patients about the nature of walk-in clinic care, the benefits of seeing physicians with whom they have a long-standing relationship, and the benefits of having a primary care provider (if they do not have one).

  - Patients may choose to visit walk-in clinics for a variety of reasons, but may not fully understand the nature of care being provided in a walk-in clinic or may not fully

[31] See for example Izenberg & Buchanan, 2018; Brown et. al, 2002; and Born & Dhalla, 2012.

understand how their choices facilitate continuity of care. The draft policy seeks to help support patients in this regard.

3) Facilitating continuity of care through the provision of quality care (*Lines 55 to 101*)

- The draft policy states that physicians practising in a walk-in clinic must provide care in accordance with the standard of practice of the profession.
    - This means providing appropriate care in response to the presenting concern(s) or identified medical condition(s), including conducting necessary assessments, ordering necessary tests or investigations, and providing appropriate follow-up care.
    - The draft policy also emphasizes that, as with all physicians, physicians practising in a walk-in clinic who order at test or make a referral are responsible for follow-up care.
    - Similarly, as with all physicians, physicians practising in a walk-in clinic who order tests must ensure that critical test results can be received and responded to 24 hours a day, 7 days a week.
- Where physicians limit the scope of services they offer in a walk-in clinic due to the episodic nature of walk-in clinic care (e.g., limiting services where regular or ongoing care would be required), the draft policy requires that they do so in good faith, that they communicate limitations to patients, and that they communicate appropriate next steps.
- In order to improve the coordination of care, the draft policy requires physicians practising in a walk-in clinic to provide the patient's primary care provider with a record of the encounter. It also requires physicians to take reasonable steps to identify other health-care providers who would benefit from receipt of this information and send the record to them as well.

4) Providing comprehensive primary care (*Lines 103 to 124*)

- The draft policy advises physicians practising in a walk-in clinic to offer comprehensive primary care to unattached patients, when doing so is within their scope of practice. The draft policy notes that this may require coordinating with other physicians in the practice to ensure access to care throughout regular operating hours.
    - The Working Group felt that it was important to try to address the issue of unattached patients, but felt that requiring physicians to provide comprehensive care to unattached patients would be impractical and out of step with the true purpose of walk-in clinics.
    - The issue of unattached patients and how the system can best support them has also been flagged for potential inclusion in the white paper, recognizing that this may require a broader systems level solution.

DECISION FOR COUNCIL:

1. Does Council have any feedback on the draft **Walk-in Clinics** policy?

2. Does Council recommend that the draft **Walk-in Clinics** policy be released for external consultation?

CONSULTATION AND ENGAGEMENT:

- Subject to the Council's approval, a consultation on approved draft policies will be held following the May 2018 Council Meeting. In order to provide ample opportunity for stakeholders to engage with the suite of draft policies and to provide feedback, an extended consultation period of approximately 4 months is planned.

- A number of additional consultation and engagement activities are planned or in development in order to provide additional opportunities to solicit feedback. For example:

    - The Working Group is planning to host a discussion session with key external stakeholders during the consultation process. The goals of this session are to facilitate increased and meaningful engagement in this project and to ensure that the College's work is informed by the expertise that exists among these stakeholders.

    - A "Tweet Chat" is also under development to host a real-time and online Twitter conversation. A tweet chat allows any user on Twitter to participate in the discussion by following a predetermined hash tag, in this case #cpso_chat, and allows the College to pose direct questions to the audience and respond to questions as needed. Key social media influencers will also be invited to participate in the online discussion.

    - Work is also underway to explore additional methods to solicit feedback from individual members of the profession as well as members of the public through the use of, for example, focus groups or a Citizen Advisory Group.[32]

    - Finally, steps are being taken to identify existing resources or partner organizations that may assist physicians in implementing the draft policy expectations or

[32] The College of Physiotherapists of Ontario (CPO) originally developed a Citizen Advisory Group in order to offer informed public perspectives on a variety of regulatory issues within their College. The CPO has since developed a partnership model that permits other health-regulatory Colleges in Ontario to utilize this group of engaged and informed Ontarians. This College has joined that partnership and is currently assessing whether this resource could be used to inform the Continuity of Care project.

otherwise support the positions being drafted. For example, resources offered by the CMPA address some of the topics and issues in the suite and could assist physicians in determining how to implement policy expectations.

NEXT STEPS:

- Subject to the Council's approval, a consultation on approved draft policies will be held following the May 2018 Council Meeting.

- Feedback received through both the consultation and the stakeholder discussion session will be shared with the Executive Committee and Council in the fall of 2018.

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Date: May 4, 2018

Attachments:
Appendix A: Draft *Continuity of Care (Umbrella)* policy
Appendix B: Draft *Availability and Coverage* policy
Appendix C: Draft *Managing Tests* policy
Appendix D: Draft *Transitions in Care* policy
Appendix E: Draft *Walk-in Clinics* policy

Appendix A

Continuity of Care

Executive Summary

In order to set out expectations pertaining to continuity of care, the College has developed a 'suite' of policies. The suite is comprised of this foundational policy, referred to as the umbrella policy, as well as a number of companion policies that set out expectations regarding: Availability and Coverage; Managing Tests; Transitions in Care; and Walk-in Clinics.

This umbrella policy sets out general expectations relating to the important role that physicians, patient engagement, and the use of technology play in facilitating continuity of care. Key topics and expectations include:

- *Physicians:* As active participants in the oversight and management of patient care across interactions with the health-care system, physicians must collaborate and communicate effectively with other health-care providers. Discharging these obligations is context dependent and requires, in part, complying with expectations in the companion policies.
- *Patient Engagement:* Physicians are advised to facilitate and support patient engagement as part of facilitating continuity of care.
- *Technology:* Physicians are strongly advised to capitalize on advances in technology that can facilitate continuity of care.

Introduction

Continuity of care is an essential component of patient-centred care and is critical to patient safety. While continuity of care can be understood in a number of ways, central themes include the importance of connected and coordinated patient interactions within the health-care system and the need for information to be exchanged in a manner that allows for patient care decisions to be informed by prior interactions within the health-care system. Test results that are delayed or missed, limited physician availability and accessibility, receiving care in an uncoordinated manner, and transitions in care all create the potential for breakdowns in continuity of care that may negatively impact patient health outcomes and the quality of care provided.

The College recognizes that health system level factors that are beyond the control or influence of individual physicians may often influence whether or not continuity of care can be achieved. However, many continuity of care issues are within the control or influence of physicians. The College has focused on setting out policy expectations related to those elements of continuity of care where physicians have a role to play. The College's recommendations regarding broader

systems issues that can be a barrier to or facilitator of continuity of care will be set out in a separate 'white paper' at a later date.[1]

Purpose and Organization

In order to set out expectations pertaining to continuity of care, the College has developed a 'suite' of policies. The suite is comprised of this foundational policy, referred to as the umbrella policy, as well as a number of companion policies that set out expectations regarding specific elements of practice. The purpose and scope of each of these policies is as follows:

Continuity of Care: This umbrella policy sets out the principles of professionalism that underpin the suite of policies, as well as general expectations relating to the important role that physicians, patient engagement, and the use of technology play in facilitating continuity of care.

Availability and Coverage: This policy sets out the College's expectations of physicians regarding physician availability, after-hours coverage, and coverage during temporary absences from practice. Unless otherwise specified, this policy applies to all physicians regardless of practice area or specialty.

Managing Tests: This policy sets out the College's expectations for physicians regarding the management of all types of tests.

Transitions in Care: This policy sets out the College's expectations of physicians where patient care or an element of patient care is transferred between physicians, or between physicians and other health-care providers. This includes expectations in relation to keeping patients informed about who is responsible for their care, patient handovers within a hospital or health-care institution, discharges from hospital, and the referral and consultation process.

Walk-in Clinics: This policy sets out the College's expectations of physicians practising in walk-in clinics. This policy does not address all aspects of practising in a walk-in clinic setting; rather it focuses on those elements that most closely relate to continuity of care. This policy also does not address the provision of episodic care in other practice environments or settings.

Principles

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

1. Acting in the best interests of their patients;

[1] The white paper is under development and will be released at a later date. When it is released, it will be made available on the College's website alongside this suite of policies.

2. Communicating and collaborating effectively with patients, other physicians, and other health-care providers in order to facilitate continuity of care and minimize risks to patient safety;
3. Maintaining public trust in the profession by ensuring patients are not abandoned and by enabling access to coordinated care;
4. Demonstrating professional competence, which includes meeting the standard of practice of the profession and acting in accordance with all relevant legal and professional obligations to provide high quality patient care;
5. Participating in medical regulation by complying with the expectations set out in this suite of policies.

Policy

Physicians, patients, and technology all play a key role in facilitating continuity of care. This umbrella policy sets out general expectations relating to these important roles.

Physicians

Physicians hold a prominent and important role in the health-care system and in turn are key facilitators of continuity of care. Central to this role is the need for physicians to recognize that patient interactions with the health-care system are best viewed not as discrete events, but rather as a set of interactions that require oversight and management.

As active participants in this oversight and management, physicians must collaborate with other health-care providers and enable effective communication and information sharing with others. How physicians can discharge these responsibilities will be context dependent and will require, in part, that physicians comply with the specific expectations set out in the companion policies.

Additionally, as health advocates, physicians are advised to use their expertise and influence to help advance the health and well-being of their patients, their communities, and the broader populations they serve.[2] Physicians can do this, in part, by responding to and participating in opportunities to improve continuity of care in both the local and broader health systems within which they work.

Patient Engagement

Patients also have an important and growing role to play in facilitating continuity of care, as actions they take may contribute to or help prevent breakdowns in continuity of care. While patient engagement can supplement and support physicians' efforts to facilitate continuity of

[2] As set out by the CanMEDS framework, physicians have a role to play in improving patient care by being a health advocate.

care and is an important element of patient-centred care, patient engagement is not meant to absolve physicians of their responsibilities in this regard.

Physicians are advised to facilitate and support patient engagement, doing so in a professional manner that is sensitive to the knowledge, needs, and desires of their patients. Physicians can do this by, for example, helping patients understand their role in their healthcare, as well as how their actions or inaction can facilitate or disrupt continuity of care. Physicians are also advised to direct patients to the companion Patient Engagement document that the College has developed in order to assist patients in understanding how they can facilitate continuity of care.[3]

More specific expectations regarding patient engagement have been articulated, where relevant, in the companion policies.

Technology

While the use of technology is not required to achieve continuity of care, a growing number of technological advances may assist in doing so. For example, there are technological solutions that can assist with test results management, facilitating access and/or coverage, facilitating information exchange between health-care providers, and improving transitions in care, especially as it pertains to handovers within health-care institutions, hospital discharges, and the referral and consultation process.

Physicians are strongly advised to capitalize on advances in technology that can facilitate continuity of care.[4] However, physicians' responsibilities to facilitate continuity of care continue to exist whether or not there are technological solutions that can assist in this regard and whether or not those solutions are adopted.

[3] This document will be developed at a later date and made available on the College's website alongside this suite of policies.

[4] See also the College's statement on eHealth: http://www.cpso.on.ca/Policies-Publications/Positions-Initiatives/eHealth

Appendix B

Continuity of Care: Availability and Coverage

Executive Summary

This policy sets out the College's expectations of physicians regarding physician availability, after-hours coverage, and coverage during temporary absences from practice. Key topics and expectations include:

- *Being Available by Telephone*: Physicians must have an office telephone that is answered and/or a voicemail that allows messages to be left during operating hours and a voicemail that allows messages to be left outside of operating hours.
- *Facilitating Access to Appointments:* Physicians must structure their practice in a manner that allows for appropriate triaging of patients with time-sensitive or urgent issues.
- *Being Available and Responding to Other Health-Care Providers:* Physicians must respond in a timely and professional manner when contacted by physicians or other health-care providers who want to communicate or request information pertaining to a patient.
- *Coordinating After-Hours Coverage for Patients:* Physicians providing care as part of a sustained physician-patient relationship must have a plan in place to coordinate care for patients outside of regular operating hours. The nature of the plan will depend on a variety of factors.
- *Coordinating After-Hours Coverage for Test Results:* Physicians who order tests must ensure that critical test results can be received and responded to 24 hours a day, 7 days a week.
- *Coordinating Coverage for Temporary Absences from Practice:* During temporary absences from practice physicians providing care as part of a sustained physician-patient relationship must make coverage arrangements for patient care, the nature of which will depend on a variety of factors, and all physicians must make coverage arrangements for test results.

Purpose and Scope

This policy sets out the College's expectations of physicians regarding physician availability, after-hours coverage, and coverage during temporary absences from practice. Unless otherwise specified, this policy applies to all physicians regardless of practice area or specialty.

Policy

Continuity of care does not require individual physicians to personally provide on-demand and continuous access to care. Doing so would negatively impact the quality of care being provided

and compromise physician health.[1] Rather, continuity of care means being available and responsive to patients and health-care providers and making plans or coverage arrangements when physicians are unavailable.

Availability and Responsiveness

Physician availability to patients and other health-care providers is an essential element of continuity of care. Breakdowns in care that can negatively impact patient health outcomes may occur, for example, when patients or health-care providers are unable to contact physicians, when patients are unable to get appointments for time-sensitive or urgent issues, or when there are delays in responding to health-care providers trying to communicate or request information pertaining to a patient. Physicians have a responsibility to be available and responsive to both patients and other health-care providers.

Being Available by Telephone

Good communication and collaboration are fundamental components of high quality care, but are not possible if patients and health-care providers are unable to contact physicians.

To facilitate good communication and collaboration, physicians must have an office telephone that is answered and/or a voicemail that allows messages to be left during operating hours and a voicemail that allows messages to be left outside of operating hours. Physicians must ensure that voicemail messages are reviewed and responded to in a timely manner. What is timely will depend on a variety of factors including, but not limited to, the impact to patient safety that may be caused by a delay in responding and when the message was left (e.g., after-hours, weekend, holiday, etc.).[2] Physicians must also ensure that the voicemail outgoing message is up to date and accurate, indicating, for example, practice office hours, any closures, and any relevant coverage information.

Physicians who also use electronic means of secure communication[3] to communicate with patients and/or other health-care providers must ensure that messages they receive through these means are reviewed and responded to in a timely manner.

[1] Physician wellness is a critical component of the professional practice of medicine (see the Practice Guide). Evidence also suggests that when physicians are unwell, the performance of the health-care system suffers (see, for example, Ruzycki, S.M. & Lemaire, J.B., (2018) "Physician burnout" *CMAJ,* 190:E53 & Wallace, J.E., Lemaire, J.B., & Ghali, W.A. (2009) "Physician wellness: a missing quality indicator" *Lancet*, 374: 1714–21).

[2] See also the section of this policy titled "Being Available and Responding to Other Health-Care Providers".

[3] This may include, for example, e-mail or a messaging portal. Physicians are reminded that electronic means of communication must comply with privacy legislation, including, the *Personal Health Information Protection Act, 2004* S.O. 2004, c. 3 Sched. A. (hereinafter, *PHIPA*).

Facilitating Access to Appointments

Treating patients as part of a sustained physician-patient relationship facilitates continuity of care, which improves patient health outcomes. It is ideal for patients to see physicians with whom they have a sustained physician-patient relationship for care that is within their physician's scope of practice, rather than relying on walk-in clinics or emergency rooms.

In order to facilitate timely access to care and continuity of care, physicians must structure their practice in a manner that allows for appropriate triaging of patients with time-sensitive or urgent issues. This may include implementing a same-day scheduling system[4] or utilizing other physicians or health-care staff within or outside their practice.

Being Available and Responding to Other Health-Care Providers

Good communication and timely access between physicians and between physicians and other health-care providers is essential to ensuring patient safety and can help promote a connected and coordinated patient experience.

Physicians must respond in a timely and professional manner when contacted by physicians or other health-care providers who want to communicate or request information pertaining to a patient.[5] How quickly physicians must respond will depend on the degree to which the information may impact patient safety, including exposure to any adverse clinical outcomes. With respect to test results, this means physicians must be responsive in a timely manner, urgently if necessary, to health-care providers communicating critical and/or clinically significant results.[6] Similarly, physicians must respond in a timely manner, urgently if necessary, to pharmacists or other health-care providers seeking to verify a prescription or requesting information about the drug prescribed.[7]

To facilitate access and to enable communication with other health-care providers, physicians must include their professional contact information when ordering a test, writing a

[4] For example: advance access, open access, or easy access scheduling systems. See, for example, Health Quality Ontario's Quality Compass Regarding Timely Access and The College of Family Physicians of Canada's Timely Access to Appointments in Family Practice for more information.

[5] Under *PHIPA*, physicians can assume they have patient consent to share personal health information with those in the patient's circle of care unless the patient has expressly withdrawn their consent to do so.

[6] Additional expectations pertaining to coverage for test results are set out in the next section of this policy. See as well the Managing Tests policy for more information on ordering and managing tests.

[7] In accordance with the Prescribing Drugs policy.

prescription, or making a referral.[8] Physicians must also provide their relevant coverage contact information directly to other health-care providers where it is appropriate to do so.[9]

Coverage

Continuity of care does not require individual physicians to be personally and continuously available to patients and other health-care providers involved in their patients' care. It does, however, require that physicians establish coverage arrangements to facilitate access to coordinated care for patients and to enable effective and timely information exchange with other health-care providers when they are unavailable.

Coordinating After-Hours Coverage for Patients

Primary care physicians and specialists providing care as part of a sustained physician-patient relationship where care is actively managed over multiple encounters must have a plan in place to coordinate care for their patients outside of regular operating hours. This is often referred to as after-hours. The nature of the plan will depend on the time of day and type of day (i.e., weekday, weekend, and holiday), the needs of their patients, as well as on the health-care provider and/or health system resources in the community. Physicians must use their professional judgment to determine how best to structure their plan and must act in good faith, making a reasonable attempt to minimize uncoordinated access to care and the inappropriate utilization of emergency rooms or walk-in clinics.

Coordinating After-Hours Coverage for Test Results

All physicians who order tests[10] must ensure that critical test results[11] can be received and responded to 24 hours a day, 7 days a week. Unless physicians choose to be available themselves this will necessitate making coverage arrangements for those times when they are unavailable (e.g., participating in an after-hours call group, telephone triage, or making specific on-call arrangements with other physicians or practices).

Coordinating Coverage for Temporary Absences

Primary care physicians and specialists providing care as part of a sustained physician-patient relationship where care is actively managed over multiple encounters have a responsibility to

[8] See also the Managing Tests, Prescribing Drugs, and Transitions in Care policies for more information on ordering tests, writing prescriptions, or making referrals.
[9] Most notably, laboratories keep physician coverage information on file, but there may be other instances where it is appropriate for physicians to provide their coverage information as well.
[10] As per the Managing Tests policy, this includes tests performed at laboratories, diagnostic facilities (including imaging facilities), and in physicians' offices and also includes pathology results.
[11] The Managing Tests policy defines critical test results as results of such a serious nature that immediate patient management decisions may be required

coordinate care for their patients during temporary absences from practice.[12] This includes, vacations and leaves of absence (e.g., parental leave, educational leave, suspension of a physician's certificate of registration), but also includes unplanned absences due to, for example, illness or family emergency.

To discharge this responsibility, physicians must arrange for another health-care provider(s) to provide patient care during temporary absences from practice. The specific nature of the coverage arrangement will depend on the length of the absence, whether the absence is planned or not, the needs of the physician's patients (including the need for follow-up care during the absence), and the health-care provider and/or health system resources in the community. Physicians are also advised to proactively plan for how to manage unplanned temporary absences from practice.

All physicians who order tests must make specific coverage arrangements with another health-care provider(s) to provide coverage during temporary absences to ensure that all test results are received, reviewed, and followed up appropriately.

To facilitate information exchange with other health-care providers all physicians who are temporarily absent from practice must have a plan or coverage arrangement that allows other health-care providers to communicate or request information pertaining to patients under their care.[13]

Notifying Patients

Physicians must inform patients about the after-hours plan they have put in place.

Physicians must also inform patients of any coverage arrangements that have been made for a temporary absence from practice. Physicians must use their professional judgement to determine if advance notice of a temporary absence from practice and the coverage arrangements that have been made is warranted. In making this determination, physicians must consider a variety of factors including, but not necessarily limited to, the needs of their patients, the nature of the coverage arrangement, and the length of the temporary absence.

Sharing Patient Information

Coordinated care is best delivered when those providing coverage are informed about or have access to patient health information. Physicians are advised to grant access to patient health

[12] Expectations relating to physicians who are not returning to practice as set out in the Closing a Medical Practice policy (which is currently under review).

[13] Under the *PHIPA*, physicians can assume they have patient consent to share personal health information with those in the patient's circle of care unless the patient has expressly withdrawn their consent to do so.

information to those providing coverage where the nature of the coverage arrangement is such that it is possible to do so.[14]

Patient Engagement

Physicians are advised to engage and support patients by encouraging them to develop a list of important information pertaining to their health status or needs (e.g., medication list, diagnosis, treatment plan, expected complications, etc.), which they can bring with them when seeking care when their physicians are unavailable.

[14] See footnote 13. Additionally, physicians providing coverage are reminded to only access patient personal health information as needed and within the context of providing care. For more information about physicians obligations in regards to privacy, see the Confidentiality of Personal Health Information policy and *PHIPA*.

Continuity of Care: Managing Tests

Executive Summary:

This policy sets out the College's expectations for physicians regarding the management of all types of tests. Key topics and expectations include:

- *Test Result Management System:* Physicians must have an effective test results management system so that appropriate follow-up on test results occurs.
- *Tracking Tests:* Physicians must track test results for high-risk patients and must use their professional judgment to determine whether to track a test result for non-high-risk patients.
- *Communication of Test Results*: Physicians must always communicate clinically significant test results to patients and must do so in a timely fashion. Physicians must use their professional judgment to determine how best to communicate test results.
- *'No News is Good News' Strategies:* Physicians who want to use a 'no news is good news' strategy must follow the expectations set out in the policy and must inform patients that they can contact the physician's office for the test result.
- *Receiving Tests Results in Error or Incidentally*: Physicians who receive a critical or clinically significant test result in error or incidentally must contact the individuals set out in the policy.
- *Patient Engagement:* The policy sets out two ways in which physicians can provide opportunities for patient engagement.

Purpose

This policy sets out the College's expectations for physicians regarding the management of all types of tests.

Definitions

Test Result: Includes results for tests performed at laboratories, diagnostic facilities (including imaging facilities), and in physicians' offices, and also includes pathology results.

Critical Test Result: Results of such a serious nature that immediate patient management decisions may be required.[1]

Clinically Significant Test Result: A test result determined by a physician to be one which requires follow-up in a timely fashion, urgently if necessary. Physicians determine the clinical significance of a test result using their clinical judgment and knowledge of the patient's symptoms, previous test results, and/or diagnosis.

Follow-up: Communication of the test result to the patient in an appropriate manner and taking appropriate clinical action in response to the test result.

High-risk patients: Patients who present with serious clinical symptoms, who have been diagnosed with a life-threatening illness, or who have been identified as high-risk by their physicians.

Policy

Managing tests effectively is an essential part of continuity of care. It includes having a robust test management system, ordering and tracking of tests, following up with patients once test results are known, communicating and collaborating with other health-care providers, and providing opportunities for patients to engage in the test results management process.

Test Results Management System

Physicians must have an effective test results management system so that appropriate follow-up on test results can occur in all of their work environments. In order for a test results management system to be effective, the system (whether it is electronic or paper-based) must at a minimum enable physicians to:

- Record all tests they order;
- Record all test results received;
- Record that all test results received by physicians have been reviewed;
- Identify high risk patients and critical and/or clinically significant test results;
- Record that a patient has been informed of any clinically significant test results and the details of the follow-up taken by the physician.

If physicians are not responsible for choosing the test results management system, they must be satisfied that the system in place has the capabilities listed above.

[1] A FAQ will be developed once the policy is finalized setting out information about existing guidelines (e.g., Canadian Association of Radiologists, Ontario Association of Medical Laboratories) regarding reporting test results and findings as well as clinical practice guidelines related to reporting for Independent Health Facilities.

Ordering and Tracking Tests

Ordering

Physicians must use their clinical judgment in determining whether to order a test for a patient. When ordering a test, providing contextual patient information to laboratories and/or diagnostic facilities is important, as sometimes test results that fall within the normal range may actually be abnormal for a particular patient. Therefore, when ordering a test, physicians are advised to provide sufficient relevant patient health information on the test requisition form that will help with interpreting the test result.[2]

In addition, where ordering physicians are not the patient's primary care provider[3], they must copy a patient's primary care provider on the requisition form.[4]

Tracking

Tracking test results involves verifying that the patient has taken the test and ensuring that the laboratory and/or diagnostic facility has sent the test result to the physician.

Physicians must track test results for high-risk patients to ensure that their test results are not lost or missed. For example, if physicians do not receive a test result for a high-risk patient, they must follow-up with the patient to verify that the patient has had the test and/or follow-up with the laboratory and/or diagnostic facility to verify that the laboratory and/or diagnostic facility has the test result. For patients that are not high risk, physicians must use their professional judgment to determine whether to track a test result. In making this determination, physicians must consider the following factors:

- The nature of the test that was ordered;
- The patient's current health status;
- If the patient appears anxious or has expressed anxiety about the test; and
- The significance of the potential result.

Physicians must either personally track test results or assign[5] this task to others.

[2] Under the *Personal Health Information Protection Act, 2004* S.O. 2004, c. 3, Sched. A (PHIPA), physicians can assume they have patient consent to share relevant information with the laboratory and/or diagnostic facility unless the patient has expressly withdrawn their consent.

[3] This includes subspecialists where a patient has been referred to by a specialist.

[4] Under PHIPA, physicians can assume they have consent to share relevant information with the patient's primary care provider unless the patient has expressly withdrawn their consent.

[5] One of the controlled acts under the RHPA is "communicating a diagnosis". Specifically, the wording in the RHPA states: "Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the

Follow-up

Once physicians receive a patient's test results, they must ensure that appropriate follow-up occurs. Follow-up includes communicating test results to patients[6] and taking clinically appropriate action in response to the test results.

Physicians must either personally follow-up on test results or assign or delegate this task to others[7].

In certain health care environments, the physician who orders a test may not be the same physician who receives the test result (e.g., in an emergency room or a walk-in clinic). In these situations, the ordering physician must either delegate or assign[8] the task of follow-up to others or ensure that there is another person that is responsible for coordinating the follow-up or that there is a system in place to do so.

Communication of Test Results

When in receipt of a clinically significant test result, physicians must always communicate the test result to their patient and must do so in a timely fashion. The timeliness of the communication will depend on the degree to which the information may impact patient safety, including exposure to adverse clinical outcomes. For test results that are not clinically significant, physicians must use their professional judgment as to if and when to communicate the test result.

Physicians must also use their professional judgment to determine how to best communicate a test result, for example, over the phone, or at the next appointment. In determining how to best communicate a test result, there are a number of factors that physicians must consider, including but not limited to:

- The nature of the test;
- The significance of the test result;
- The complexity and implications of the result;
- The nature of the physician-patient relationship;

individual or his or her personal representative will rely on the diagnosis". If the task includes performance of this controlled act, then the physician must delegate it to another person. When delegating a controlled act, physicians must comply with the College of Physicians and Surgeons of Ontario's Delegation of Controlled Acts policy. If the task does not include a controlled act, the physician would be assigning the task to the other person.

[6] Test results do not need to be communicated to patients if the test result is not clinically significant and the physician has used their professional judgment to determine that the test result need not be communicated or the physician is utilizing a 'no news is good news' strategy and is following the provisions set out in this policy in regard to 'no news is good news' strategies.

[7] Please see footnote 5.

[8] Please see footnote 5.

- Patient preferences/needs; and,
- Whether the patient appears anxious or has expressed anxiety about the test.

Physicians must ensure that the communication of test results adheres to their legal[9] and professional obligations[10] to maintain patient confidentiality and privacy.

Physicians do not necessarily have to personally communicate test results to their patients. Physicians must use their professional judgment to determine the circumstances where it makes sense for other health-care providers and/or non-medical staff to do so. Factors physicians must consider in making this determination include, but are not limited to:

- The nature of the test;
- Whether the patient appears anxious or has expressed anxiety about the test;
- The significance or implications of the test result; and,
- Whether communicating the test result would mean communicating a diagnosis.[11]

If physicians rely on others to communicate test results, they must have a mechanism in place whereby physicians are able to respond to any follow-up questions that the patient may have.

'No News is Good News' Strategies

Physicians who want to use a 'no news is good news' strategy for test results management must be confident that the test result management system in place is sufficiently robust to ensure that no test results will be missed and that no news really means good news. That is, the absence of a call back to the patient means that the test result was received, reviewed and a determination was made that no follow-up was required.

Even with a robust test results management system, a 'no news is good news' strategy may not always be appropriate. Physicians must use their professional judgment to determine when a 'no news is good news' strategy is appropriate. Physicians must consider the following factors in making this determination:

- The nature of the test that was ordered;
- The patient's current health status;

[9] PHIPA sets out requirements with respect to collecting, using and disclosing a patient's personal health information.

[10] See the CPSO Medical Records and the Confidentiality of Personal Health Information policies for more information. The *Confidentiality of Personal Health Information* policy states that "the College advises physicians that messages left for patients on a voice mail that is not private or with a third party should not contain any personal health information of the patient, such as details about the patient's medical condition, test results or other personal matters".

[11] Please see Footnote 5.

- If the patient appears anxious or has expressed anxiety about the test; and,
- The significance or implications of the potential result.

Physicians must inform patients as to whether they are using a 'no news is good news' strategy and must tell patients that they have the option to personally contact the physician's office for the test result.

Contact Information

To ensure that test results can be communicated to patients and that follow-up appointments can be booked, physicians are advised to do the following:

- confirm, or have their staff confirm, patient contact information at each appointment;
- confirm, or have their staff confirm, whether patients are comfortable with voice mail messages being left on their phones especially if the voicemail can be accessed by other people[12]; and,
- note the patient's emergency contact information in the patient record.

If physicians attempt to contact a patient to carry out the required follow-up but have been unable to reach the patient, they must document in the patient's record all attempts that were made to either communicate the test result to the patient and/or to book a follow-up appointment to discuss a test result.

Patient Portals

Patient portals, where patients can access their test results electronically, are becoming increasingly common. As part of actively involving patients in their own care, physicians are advised to inform patients of the availability of patient portals.

Informing patients about getting their test results through a patient portal does not discharge physicians' obligations to communicate test results as set out in this section.

Clinically appropriate action following receipt of test results

When physicians receive a critical and/or clinically significant test result for a test that they have ordered, they must take clinically appropriate action. What may be considered a clinically appropriate action is case specific and will be based on a physician's clinical judgment.[13] The

[12] Please see Footnote 10.
[13] Some examples of clinically appropriate actions include having the patient take another test or making a referral to a specialist.

timeliness of these actions will depend on the significance of the test result. Physicians can take clinically appropriate actions personally or they can assign or delegate this task to others.[14]

Receiving Test Results in Error or Incidentally

If physicians receive a critical or clinically significant test result in error (i.e., they have not ordered the test and have received the result in error because they have the same or a similar name as the ordering physician or the same address as the ordering physician), they must inform the ordering health-care provider, the patient's primary care provider, or the patient of the test result. Physicians or those acting on their behalf must also inform the laboratory or diagnostic facility of the error.

Additionally, physicians who become aware, even incidentally (e.g., physicians who are cc'd on a report), of a critical or clinically significant test result where they have reason to believe that the ordering health-care provider did not or will not get the test result, must make reasonable efforts to inform the ordering health-care provider or the patient of the test result. The physician must also make reasonable efforts to contact the laboratory and/or diagnostic facility that sent the test result.

Communication and Collaboration with other Health-Care Providers

Physicians must use their professional judgment to determine if it is necessary to share a patient's test result with other relevant health-care providers whose ongoing care of the patient would benefit from that knowledge.[15] In situations where patient safety may be impacted, it may be necessary for physicians to contact the patient's other health-care providers in a more urgent manner than usual (e.g., when in receipt of a critical and/or clinically significant test result that may impact the care provided to the patient by the patient's other health-care providers). The timeliness of the communication will depend on the degree to which the information may impact patient safety, including exposure to adverse clinical outcomes.

In addition, physicians whose role is to interpret and report test results (e.g., a radiologist) can help to prevent failures in follow-up by contacting the health-provider who ordered the test when a potentially clinically significant test result is discovered to ensure that this information is communicated quickly and that it does not go astray. [16]

[14] Please see Footnote 5.

[15] Under PHIPA, physicians can assume they have consent to share relevant test results with those in the patient's circle of care unless consent to do so has been expressly withdrawn by the patient.

[16] For example, a physician interpreting a prenatal ultrasound where there is a risk to the fetus would phone the referring health-care provider in addition to generating a written report.

Patient Engagement

Involving patients in their own care is important in ensuring continuity of care. Physicians can provide opportunities for patient engagement in two ways. Physicians must inform patients of the significance of the test, the importance of getting the test done (in a timely manner, as appropriate), and the importance of complying with requisition form instructions. This is especially important when dealing with high risk patients. While doing this, physicians are advised to consider and address language and/or communication issues that may impede a patient's ability to comprehend the information provided by the physician.[17]

The College also advises physicians to encourage patients to discuss test results with the physician, to feel free to ask questions about the test results, and to follow up with the physician after receiving a test result if they continue to feel unwell, regardless of the test result.

Availability and Coverage

For expectations regarding availability and coverage with respect to test results, please see the Continuity of Care: Availability and Coverage policy.

[17] Physicians may want to consider using the following resources or tools to help overcome any language and/or communication issues:

- Family members or third party interpreters.
- Speech language pathologists.
- Occupational therapists.
- Communication techniques.
    - o Writing
    - o Typing
    - o Non-verbal communication

Also, please see the Consent to Treatment policy and Frequently Asked Questions document for guidance on addressing language and/or communication barriers.

Continuity of Care: Transitions in Care

Executive Summary

This policy sets out the College's expectations of physicians when patient care or an element of patient care is transferred between physicians, or between physicians and other health-care providers. Key topics and expectations include:

- *Keeping Patients Informed*: Within hospitals and health-care institutions physicians must coordinate with others to keep patients informed about who is their most responsible provider. When referrals are made, both referring and consultant physicians must inform patients about the nature of their role and keep patients updated if their role changes.
- *Managing Handovers in Hospitals and Health-Care Institutions:* Physicians are advised to approach patient handovers in a systematic manner and to set time aside to allow for a real-time and personal exchange of information between health-care providers.
- *Completing and Distributing Discharge Summaries:* The most responsible physician must complete a discharge summary for all in-patients in a timely manner. If a delay in distribution is anticipated, the most responsible physician must provide a brief summary directly to those health-care providers responsible for follow-up care.
- *Making and Acknowledging a Referral:* Referring physicians must make a referral in writing and consultant physicians must acknowledge a referral request in a timely manner, urgently if necessary, but no later than 30 days from the date of receipt.
- *Distributing Consultation Reports:* Consultation reports must distributed in a timely manner, but no later than 30 days, following an assessment of the patient or when there are new findings or changes in the management plan.

Purpose and Scope

This policy sets out the College's expectations of physicians when patient care or an element of patient care is transferred between physicians, or between physicians and other health-care providers. This includes expectations in relation to keeping patients informed about who is responsible for their care, patient handovers within a hospital or health-care institution, discharges from hospital, and the referral and consultation process.

Policy

When responsibility for patient care or an element of patient care is transferred between physicians, or between physicians and other health-care providers, breakdowns in continuity of care may occur that can negatively impact patient health outcomes and the quality of care provided. Physicians have a role to play in facilitating continuity of care during transitions by

helping to keep patients informed about who is responsible for their care, facilitating the timely exchange of information between health-care providers, and coordinating transitions by collaborating with both patients and other health-care providers.

Keeping Patients Informed

Patients are often provided care by a number of health-care providers and keeping patients informed about who is responsible for their care or an element of their care is an important component of quality care. How physicians support patients in this regard will depend on their practice setting and their role in managing patient care.

Hospitals and Health-care Institutions

In a hospital or health-care institution, patient care is often provided by a team of health-care providers, and who the most responsible provider[1] is may regularly change. In these instances it can be difficult for patients to know who is responsible for their care. Physicians must coordinate with other health-care providers to keep patients informed about who is their most responsible provider.

Referring and Consultant Physicians

Referring physicians must clearly communicate to patients what their anticipated role will be in managing care during the referral process. This includes how patient care and follow-up may be managed and by whom.

Consultant physicians[2] must also discuss with patients the nature of their role in providing care to patients. This includes explaining which elements of care they are responsible for, and the anticipated duration of care. When it is possible to do so, consultant physicians must also clearly communicate when their relationship has reached its natural conclusion or when it is anticipated that it will reach its natural conclusion to help patients understand when the treating relationship ends.[3]

If there are any changes in these responsibilities, both referring and consultant physicians must keep patients informed about their changing role.

[1] Recognizing that the scopes of practice of other health-care providers are evolving and that other health-care providers may have overall responsibility for managing patient care, this section of the policy has adopted the term "most responsible provider" as opposed to "most responsible physician" (see the Canadian Medical Protective Association's "The most responsible physician: a key link in the coordination of care" for more information).
[2] This policy uses the term "consultant physician" in order to capture any physician, including primary care physicians, who accept referrals.
[3] See also the Ending the Physician-Patient Relationship policy.

Managing Handovers in Hospitals and Health-Care Institutions

Effective patient handovers equip those assuming responsibility for patient care with the information they need to appropriately manage that care. In order for this to occur, there needs to be a timely exchange of information, where the information exchanged is accurate, complete, and unambiguous, and where the health-care provider assuming responsibility has understood the information that has been exchanged.[4] Physicians have an essential role to play in ensuring that patient handovers are effective.

Physicians handing over patient care to another health-care provider are strongly advised, wherever possible, to have a real-time and personal exchange of information that includes an opportunity for a discussion to occur and for questions to be asked.[5] Physicians are also advised to approach patient handovers in a systematic manner and to set time aside for the information exchange process. This may mean, for example, utilizing standardized or structured communication approaches or tools[6] that help focus information sharing practices.

Discharging patients from hospital

Transitions from hospital to the community present a number of challenges for both patients and health-care providers providing care in the community, and breakdowns in continuity of care may occur. While other health-care providers may play a role in the discharge process and the coordination of supports in the community, this policy will focus on the role physicians play in preparing patients for discharge from hospital,[7] as well as their role in completing and distributing discharge summaries.

Preparing Patients for Discharge

Prior to discharging a patient from hospital, physicians must ensure that they or a member of the health-care team has a discussion with the patient and/or substitute decision-maker about:[8]

[4] The Canadian Medical Protective Association provides advice on managing handovers as well (see their "Improving patient handovers").

[5] This may occur via an in-person exchange, but may also be achieved through a telephone call, video conferencing or other e-communication technology so long as doing so complies with physicians' legal and professional obligations to protect the privacy and confidentiality of the patient's personal health information (see the Confidentiality of Personal Health Information policy and *PHIPA*).

[6] A number of tools have been developed to standardize and systematize patient handovers. This includes, for example, SBAR, I-PASS, or I START-END. The College does not endorse any specific approach or tool, recognizing that a variety of methods can facilitate the same successful information exchange.

[7] This policy addresses only those issues that arise in relation to a discharge from hospital. Information on discharging of patients from, for example, an Out of Hospital Premise or Independent Health Facility (or what will soon be called Community Health Facilities) can be found the College's website.

[8] See also the Canadian Medical Protective Association's "Discharging patients following day surgery".

- Post treatment or hospitalization risks or complications;
- Signs and symptoms that need monitoring and when action is required;
- Whom to contact and where to go if complications arise;
- Instructions and recommendations to the patient and/or substitute decision-maker with respect to managing post-discharge care, including medications (e.g., frequency, dosage, duration); and
- Information about any follow-up appointments or outpatient investigations that have been or are being scheduled, or that the patient is responsible for arranging and a timeline for doing so.

Involving the patient's family and/or caregivers[9] in discharge discussions may benefit both the patient and those involved in managing the patient's post-discharge care. Physicians must take reasonable steps to facilitate the involvement of these individuals in the discharge discussion when patients or substitute decision-makers indicate that they would like them involved and provide consent to disclose personal health information.[10]

There may be instances where the patient and/or substitute decision-maker would benefit from having elements of the discharge discussion captured in writing in order to support their ability to recall and act on that information once discharged. Physicians must use their professional judgment to determine both whether this discussion should be accompanied by written reference materials and the specific nature of those materials. Factors that physicians must consider when making these determinations include, but are not limited to: the health status and needs of the patient; any post treatment risks or complications; the need to monitor signs or symptoms; whether follow-up care is required; any language and/or communication issues that may impact comprehension;[11] and whether the recipient of the information is experiencing stress or anxiety which may impair their ability to recall and act on the information shared.

Completing Discharge Summaries

The most responsible physician must complete a discharge summary for all in-patients. In order to facilitate continuity of care, physicians must complete the discharge summary in a timely

[9] Caregivers may be formal or informal, and may include, for example, family and/or others close to the patient.
[10] For more information on physicians obligations relating to the disclosure of personal health information, see the Confidentiality of Personal Health Information policy and *PHIPA*.
[11] See the Consent to Treatment policy and Frequently Asked Questions document for guidance on addressing language and/or communication barriers.

manner. What is timely will depend on the patient's condition and the urgency associated with their follow-up care needs.[12]

The purpose of the discharge summary is to equip those health-care providers responsible for post-discharge care with the information they need to understand the admission, the care provided, and the patient's health-care condition and needs. The discharge summary must be signed and dated by the most responsible physician and must include:

- Identifying information, including the most responsible physician's name, the author's name and status if different than the most responsible physician, the patient's name and health record number, and the admission and discharge dates;
- The reason(s) for the admission and the patient's discharge diagnosis;
- A brief summary of how each active medical problem was managed, including any major investigations, treatments, and outcomes;
- Details regarding any discharge medications (e.g., frequency, dosage, durations), any changes to ongoing medication, and the reasons for giving or altering medications; and
- Follow-up care needs and recommendations, as well as a list of scheduled appointments, any further outpatient investigations, and any outstanding test or investigation results or consultant reports.

Physicians must avoid using terminology, acronyms, or abbreviations in the discharge summary that are known to have more than one meaning in a clinical setting or that might cause confusion among those health-care providers receiving the discharge summary.[13]

Distributing Discharge Summaries

The timely distribution of a discharge summary is an essential element of continuity of care and delays in distribution may expose patients to adverse clinical outcomes. If a delay in distribution of the discharge summary is anticipated, the most responsible physician must provide a brief summary of the admission and discharge directly to those health-care providers responsible for follow-up care in a timely manner to ensure they have the information they need to provide post-discharge care. Additionally, when the required follow-up care is time-sensitive or the patient's health condition requires close monitoring, the most responsible physician must also consider whether direct communication with the health-care provider assuming responsibility is warranted.

[12] Physicians are reminded that they must complete the discharge summary within 48 hours of discharge in order to bill the Ontario Health Insurance Plan for a patient visit on the day of discharge.
[13] This is consistent and builds upon the general requirements set out in the Medical Records policy.

The most responsible physician must direct that the discharge summary be sent to the patient's primary care provider.[14] The most responsible physician must also take reasonable steps to identify other relevant health-care providers whose ongoing care of the patient would benefit from knowledge of the hospitalization and direct that the discharge summary be sent to them as well.[15]

Referring Patients and Consulting on Patient Care

Breakdowns in care may occur during the referral and consultation process when there are unnecessary delays in receiving the care the patient needs or where there is a breakdown in the information exchange and communication between health-care providers. As such, physicians have a role to play in coordinating these transitions to facilitate continuity of care.

Planning for a Referral

In order to minimize unnecessary delays that may compromise patient safety, referring physicians must take reasonable steps to confirm that the patient's condition(s) is (are) within the scope of practice of the consultant physician to whom they intend to refer the patient. This may involve, for example, being mindful of sub-specialties and/or areas of focus to which physicians may choose to limit their practice. Physicians are also advised to be mindful of whether the consultant physician is accepting patients and whether the consultant physician's practice is accessible to the patient (e.g., location, physical accessibility, etc.).

Making a Referral

Referrals[16] must be made in writing[17] and signed by the referring physician. If urgent, a verbal request may be appropriate, but must be followed by a written request. If the referring and consultant physician have access to a common medical record, the written request may be made and contained in that medical record. Otherwise, both the referring and consultant physicians must keep a copy of the written request in their respective medical records.

[14] Under *PHIPA*, physicians can assume they have patient consent to share personal health information with those in the patient's circle of care unless the patient has expressly withdrawn their consent to do so.
[15] See Footnote 13.
[16] The expectations set out in this policy apply broadly to all referrals with the exception of effective referrals that are made when physicians choose to limit the services they provide for reasons of conscience or religion. Specific expectations for effective referrals are set out in the Professional Obligations and Human Rights and Medical Assistance in Dying policies.
[17] A referral may be made electronically or in paper form.

All referrals must include:

- Identifying information, including the name and contact information of the referring physician, primary care provider (if different than the referring physician), consultant physician, and patient;
- Reason(s) for the consultation, as well as any information the referring physician is seeking and/or questions they would like answered;
- Where relevant, the referring physician's sense of the urgency of the consultation;
- Summary of relevant medical history, including current medications and copies or summaries of all relevant test and procedure results.

Where referring and consultant physicians have access to a common medical record, a brief summary of the relevant medical history may be appropriate provided that the referring physician clearly indicates which elements of the common medical record (e.g., medications, test results, etc.) must be reviewed.

Tracking a Referral

Referring physicians must have a mechanism in place to track that the referral has been received and that an acknowledgment of the referral will be provided. The urgency of the referral will determine the degree to which the referring physician must monitor the referral request. Referring physicians are also advised to engage patients in this process by, for example, informing patients that they may follow-up with the referring physician if they have not heard anything within a specific time frame.

Being Available to Consultant Physicians

When making a referral, physicians must also comply with relevant expectations set out in the Availability and Coverage policy. For example, referring physicians must respond in a timely and professional manner when contacted by a consultant physician who wants to communicate or request information pertaining to the patient (e.g., to clarify a referral request, urgently communicate findings). Additionally, when making a referral for the purposes of a test, referring physicians must ensure that critical test results can be received and responded to 24 hours a day, 7 days a week.

Acknowledging a Referral

Physicians who are asked to consult on a patient's care must acknowledge the referral in a timely manner, urgently if necessary, but no later than 30 days from the date of receipt. How quickly consultant physicians must acknowledge the request will depend on the patient's condition and their need for a consultation, including whether a delay in acknowledgement

may expose the patient to any adverse clinical outcomes. When acknowledging the referral, consultant physicians must indicate whether or not they are able to accept the referral.

If consultant physicians are able to accept the referral, they must provide an estimated or actual appointment date and time to the referring health-care provider. They must also indicate whether they have communicated an appointment date and time with the patient directly or intend to do so.

If consultant physicians are not able to accept the referral, they must communicate their reasons for declining the referral to the referring health-care provider.[18] Where a consultation is urgently needed, consultant physicians must provide suggestions to the referring health-care provider of alternative health-care provider(s) who may be able to accept the referral, and are advised to do so for non-urgent referrals as well.

Communicating with Patients

Referring physicians must communicate the estimated or actual appointment date and time to the patient unless the consultant physician has indicated that they have already done so or intend to do so.

Consultant physicians must communicate any instructions or information[19] to patients that they will need in advance of the appointment, unless the referring physician has agreed to assume this responsibility. Consultant physicians must also communicate any changes in the appointment date and time with the patient directly and must allow patients to make changes to the appointment date and time directly with them.

Preparing Consultation Reports

Following an assessment of the patient (which may take place over more than one visit), consultant physicians must prepare a consultation report.[20] The purpose of the consultation report is to ensure that those involved in the patient's care have the information they need to understand the patient's health status and needs and to facilitate the coordination of care among those involved. The consultation report must include:

[18] For example, because the consultant physician is not currently accepting referrals or because the referral is outside the consultant physician's clinical competence or scope of practice. See also the Accepting New Patients policy.

[19] For example, any preparation the patient must make in advance of the appointment (e.g., fasting, drinking water, etc.), directions to the physician's practice, how to cancel appointments and fees for missed appointments, etc.

[20] For information regarding what consultants must document in their own medical record, please see the Medical Records policy. This policy addresses only the content of the report that will be distributed to others involved in the patient's care.

- Identifying information, including the name and contact information of the consulting physician, referring health-care provider, primary care provider (if different than the referring health-care provider), and patient;
- The date(s) of the consultation;
- The purpose of the referral as understood by the consulting physician;
- A summary of the information considered, including the patient's medical history and relevant family or social history, a review of systems, examinations and physical findings, tests or investigations undertaken, their purpose and their results, and any other pertinent patient data;
- A summary of conclusions reached, including any diagnostic conclusions or differential diagnoses;
- Treatments or interventions initiated or recommended and their rationale, including any medications prescribed or changes to ongoing medications;
- Outstanding investigations and additional referrals and their purpose;
- Advice given to the patient, including risks that were disclosed regarding initiated or recommended treatment and information regarding follow-up care needs; and
- Recommendations regarding follow-up by the referring health-care provider and whether ongoing care by the consulting physician is required.

When consultant physicians are involved in the provision of ongoing care, they must also prepare follow-up consultation reports when there are new findings or changes are made to the management plan. The purpose of follow-up reports is to ensure that those involved in the patient's care have the information they need to understand the patient's ongoing health status and needs, and to facilitate the coordination of care among those involved. Follow-up consultation reports must include a summary of:

- The original problem and any response to treatment;
- Any subsequent physical examinations related to the system(s) or problem(s) and their results;
- Any laboratory or investigation results, consultation reports, and any other pertinent data received since the previous visit related to the system(s) or problem(s); and
- Conclusions, recommendations, and follow-up plan(s).

Distributing Consultation Reports

Consultant physicians must distribute the consultation report and any subsequent follow-up reports in a timely manner, urgently if necessary, but no later than 30 days after an assessment or after a new finding or change in the patient's management plan. What is timely will depend on the nature of the patient's condition and any risk to the patient if there is a delay in sharing

the report, including exposure to any adverse clinical outcomes. If urgent, a verbal report may be appropriate, but must be followed by a written consultation report.

Consultant physicians must send consultation reports to the referring health-care provider and the patient's primary care provider, if different.[21] Consultant physicians must also take reasonable steps to identify other relevant health-care providers whose ongoing care of the patient would benefit from awareness of the consultation and share consultation reports with them as well.[22]

A copy of the consultation report must be retained in both the referring and consultant physician's medical record for the patient. Where the referring and consultant physician have access to a common medical record, the consultation report may be contained in that medical record.

Using Technology

Making a referral or preparing and distributing consultation reports may be facilitated by technological solutions that, for example, automatically produce required content or transcribe notes. Physicians are responsible to ensure the accuracy of their referral requests or consultation reports. If a referral or consultation report is produced and distributed automatically and prior to physician review, physicians must review it as soon as possible after it is sent to ensure it is accurate. If there are any errors, physicians must follow-up in a timely manner with those to whom the referral or consultation report has been sent.

[21] Under *PHIPA*, physicians can assume they have patient consent to share personal health information with those in the patient's circle of care unless the patient has expressly withdrawn their consent to do so.
[22] See Footnote 21.

Appendix E

Continuity of Care: Walk-in Clinics

Executive Summary

This policy sets out the College's expectations of physicians practising in walk-in clinics, focusing on those elements that most closely relate to continuity of care. Key topics and expectations include:

- *Meeting the Standard of Practice of the Profession:* Physicians practising in a walk-in clinic must meet the standard of practice of the profession, which applies regardless of whether care is being provided in a sustained or episodic manner.
- *Providing Follow-Up Care:* Physicians practising in a walk-in clinic must provide or arrange for the provision of appropriate follow-up care when ordering a test or making a referral. Additional expectations set out in the Managing Tests policy also apply.
- *Being Available and Coordinating Coverage:* Physicians practising in a walk-in clinic must ensure that critical test results can be received and responded to 24 hours a day, 7 days a week. Additional expectations set out in the Availability and Coverage policy also apply.
- *Coordinating with Other Health-Care Providers:* Physicians practising in a walk-in clinic must provide the patient's primary care provider, if there is one, with a record of the encounter and take reasonable steps to identify other health-care providers who would benefit from knowledge of the encounter and provide a record of the encounter to them as well.
- *Providing Comprehensive Primary Care:* Physicians practising in a walk-in clinic are advised to offer, where their scope of practice permits, comprehensive primary care to patients without a primary care provider who visit the same clinic for all their primary care needs.

Purpose and Scope

This policy sets out the College's expectations of physicians practising in walk-in clinics. This policy does not address all aspects of practising in a walk-in clinic setting; rather it focuses on those elements that most closely relate to continuity of care. This policy also does not address the provision of episodic care in other practice environments or settings.

Definitions

Walk-in Clinic: Medical practices that provide care to patients where there may be no existing association with the practice, where there may be no requirement to book appointments, and where the care provided is generally, although not always, episodic in nature. This includes urgent care centres, but does not include hospital-based emergency rooms.

Policy

Physicians practising in walk-in clinics contribute to the health-care system by, for example, providing an alternative to crowding emergency departments with patients who are better treated in the community but either cannot access their primary care provider or do not have a primary care provider. The nature of walk-in clinic care may, however, lead to breakdowns in continuity of care that can negatively impact patient health outcomes. Physicians practising in walk-in clinics have a responsibility to ensure that patients are being provided with quality care that facilitates continuity of care.

Supporting Patients

Patients may not always be aware that there are limits to the types of care that can be provided in an episodic manner and may not know that receiving care as part of a sustained physician-patient relationship facilitates continuity of care. Recognizing that there are a variety of reasons why patients visit walk-in clinics, physicians practising in a walk-in clinic must use their professional judgement to determine whether it would be appropriate to sensitively:

- Remind patients that there are differences between episodic care and care that is provided as part of a sustained physician-patient relationship;
- Remind patients who have a primary care provider about the benefits of seeing their primary care provider for care within their scope of practice; and/or
- Remind patients without a primary care provider of the benefits of having one and encouraging them to seek one out.

If asked for assistance in finding a primary care provider, physicians practising in a walk-in clinic must be as helpful as possible in supporting the patient.[1]

Facilitating Continuity of Care

Physicians practising in a walk-in clinic can facilitate continuity of care by: providing care in accordance with the standard of practice of the profession; providing appropriate follow-up care; being available and making coverage arrangements in certain instances; and by keeping other health-care providers involved in a patient's care informed about the care provided.

[1] The help that a physician is able to provide will ultimately be case-specific but could include referring patients to an organization that may be able to assist them in finding a health care provider or to a colleague who may be accepting new patients. Patients may also benefit from calling the College's Physician and Public Advisory Service (1-800-268-7096, Ext. 603) which can provide general tips and advice to those seeking a new provider. See also the Ending the Physician Patient Relationship policy.

Meeting the Standard of Practice of the Profession

Physicians practising in a walk-in clinic must meet the standard of practice of the profession, which applies regardless of whether care is being provided in a sustained or episodic manner. This means, for example, conducting any assessments, tests, or investigations that are required in order to treat the presenting concern(s) or identified medical condition(s) and providing any follow-up care that may be required in accordance with the standard of practice of the profession.

If physicians practising in a walk-in clinic limit the care or services offered due to the episodic nature of walk-in clinic care, they must communicate these limitations to patients in a clear and straightforward manner. In these instances, physicians must also communicate appropriate next steps, considering factors such as the urgency of the patient's needs and whether other health-care providers are involved in the patient's care. Any decision to limit the care or services being provided due to the episodic nature of walk-in clinic care must be made in good faith.

Providing Follow-up Care

Physicians ordering tests within a walk-in clinic environment must comply with the expectations set out in the Managing Tests policy. This includes, but is not limited to, having a system in place to ensure that appropriate follow-up occurs for all tests that they order and ensuring that clinically appropriate actions are taken in response to results.[2] Similarly, physicians practising in a walk-in clinic who make referrals must provide or arrange for the provision of necessary follow-up care, including reviewing consultation reports.[3]

It is not appropriate to rely on the patient's primary care provider or another health-care provider involved in the patient's care to provide or coordinate appropriate follow-up for tests or referrals unless they have explicitly agreed to assume this responsibility.

Being Available and Coordinating Coverage

Physicians practising in a walk-in clinic must comply with relevant expectations set out in the Availability and Coverage policy. For example, physicians practising in a walk-in clinic must:

[2] See the Managing Tests policy for more information.
[3] See the Transitions in Care policy for more information about the referral and consultation process.

- Respond in a timely and professional manner when contacted by physicians or other health-care providers who want to communicate or request information pertaining to a patient.[4]
- Ensure that critical test results can be received and responded to 24 hours a day, 7 days a week. This will necessitate making coverage arrangements for those times where physicians are unavailable.

Coordinating with Other Health-Care Providers

Physicians practising in a walk-in clinic must provide the patient's primary care provider, if there is one, with a record of the encounter.[5] This may include, for example, a record of any tests ordered, diagnoses reached, any treatment and advice provided, any referrals that were made, and any follow-up care that was arranged or advised. Physicians practising in a walk-in clinic must also take reasonable steps to identify other relevant health-care providers whose ongoing care of the patient would benefit from knowledge of the encounter and provide them with a record of the encounter as well.[6] Physicians are advised to consider whether it would be appropriate to inform patients that a record of the encounter will be shared with others prior to doing so.

Providing Comprehensive Primary Care

Walk-in clinics are not intended to be a substitute or replacement to a sustained relationship between a primary care provider and a patient. Rather, walk-in clinic care is intended to be episodic where neither the patient nor the physician have an expectation of a sustained relationship beyond any follow-up care that is necessary to address the presenting concern(s) or identified medical condition(s).

Some patients may, however, experience difficulty finding a primary care provider and may regularly attend the same walk-in clinic for all their primary care needs. In these instances, physicians practising in a walk-in clinic are advised to offer, where their scope of practice permits and in coordination with other physicians in the practice, comprehensive primary care to the patient as an interim measure.

Additional expectations set out in this suite of policies and other College policies will apply to physicians who provide comprehensive primary care as an interim measure.[7] With respect to

[4] Under *PHIPA*, physicians can assume they have patient consent to share personal health information with those in the patient's circle of care unless the patient has expressly withdrawn their consent to do so.
[5] See footnote 4
[6] See Footnote 4.
[7] For example, Medical Records, Ending the Physician-Patient Relationship, and Closing a Medical Practice (which is currently under review).

continuity of care and in accordance with the Availability and Coverage policy, when offering comprehensive primary care as an interim measure physicians practising in a walk-in clinic must have a plan in place to coordinate patient care outside regular operating hours (i.e., after-hours). Similarly, in these instances physicians must make or ensure arrangements are made with another health-care provider(s) to provide patient care during temporary absences from practice.[8] In both cases the specific nature of the plan or coverage arrangement will depend on a variety of factors, as set out in the Availability and Coverage policy.

Physicians practising in a walk-in clinic who do not offer comprehensive primary care as an interim measure may still offer to provide elements of care related to the management or monitoring of chronic diseases.[9]

[8] Periods of time where physicians are absent from their practice. This includes vacations and leaves of absence (e.g., parental leave, educational leave, suspension of a physician's certificate of registration), but also includes unplanned absences due to, for example, illness or family emergency.

[9] Physicians practising in a walk-in clinic may not be able to offer comprehensive primary care, but may be able to help patients without a primary care provider manage, for example, their hypertension over an extended period of time.

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May 2018

TOPIC: Annual Fire Drill and Evacuation

FOR INFORMATION

ISSUE:

- **The College is required to hold a fire drill and building evacuation annually. This event will take place during the May meeting of Council.**

BACKGROUND:

- The College is required by law to ensure that all fire safety devices are tested and operational. This includes ringing of the fire alarms and a mandatory planned evacuation of the building.
- Staff and Council members are required to participate in the fire drill at the May meeting.

CONSIDERATIONS:

- Council members are frequently in the building for meetings and many have not participated in evacuation procedures. This opportunity will allow councilors to review the evacuation procedures and participate in a fire drill.

NEXT STEPS:

- Participate in the fire drill: evacuate the building and meet at checkpoint

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Contact: Krista Waaler, Ext. 384

Date: May 8, 2018

Appendix: Emergency Procedures for Council & Committee Members

EMERGENCY PROCEDURES
COUNCIL & COMMITTEE MEMBERS

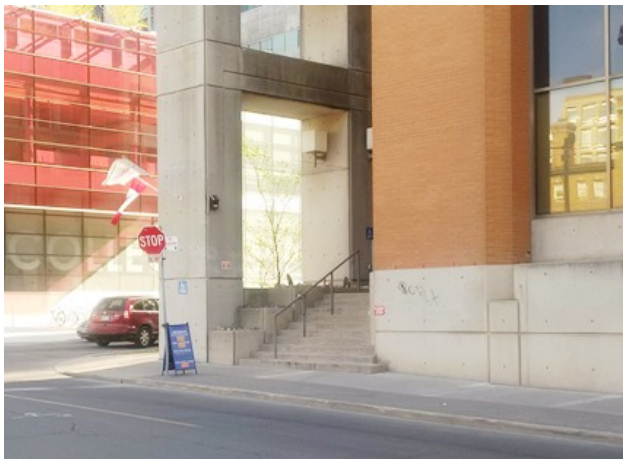
Upon hearing a fire alarm, the Committee Chair will stop the meeting.

With the back of your hand, test the door handle for heat and follow these steps:

- Door/handle is cool to touch
  - Brace yourself against the door and open slightly.
  - If you do not feel a resistance when you open the door, you are safe to leave the room.
  - Take the meeting role call with you to use as attendance
  - Exit with your group and close the door behind you.
  - Proceed to your nearest exit located near the washroom entrances. Do not use elevators.
  - Follow instructions provided by Fire Safety Team leaders and the Fire Department.
  - Once outside the building go to meeting check point (as seen below) and take attendance of your Committee members. If anyone is missing, report to the fire team (green hard hats).
  - Do not return to the building until it is declared safe to do so by the Fire Department or CPSO fire team.

- Door handle is hot or you have difficulty opening the door due to pressure:
  - Close the door and remain in the room.
  - Call the Fire Department at 9-911 and alert them of the address of the building (80 College Street) and your location (i.e. 3rd floor).
  - Call Security at extension 612 with the same information.
  - Seal off all openings, which may admit smoke.
  - Crouch low to the floor if smoke enters the room.
  - Wait for assistance from the fire department.

CHECK POINT – ONA Building



THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

GOVERNANCE REVIEW - PART 2

PRESENTATIONS

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May 2018

TOPIC: Opioid Strategy: Update

FOR INFORMATION/DISCUSSION

ISSUE:

- This briefing note provides an update on progress against the Opioid Strategy, and sets out some issues for consideration as we determine next steps relating to Narcotics Monitoring Data in 2018.

CURRENT STATUS:

- The Opioid Strategy, attached as Appendix A, was approved by Council at its May 2017 meeting. A status update on all elements of the strategy is set out below.

	Elements	Status
1 Guide	Review Prescribing Drugs policy to include updated guidelines and new expectations, as required	A full review of the policy will be conducted in 2018.
	Facilitate review of MMT guidelines	This work is currently on hold, pending resolution of the s56 methadone exemption changes.

	Elements	Status
2 Assess	Continue focused methadone assessments via methadone program	Methadone assessments are continuing. See update below.
	Expand focus on assessments to opioid prescribing via QAC	Work is underway to incorporate an opioid prescribing review into the existing random assessments.
	Identify & assess moderate opioid prescribing risk, avoiding need for investigations	Planning is underway to explore an alternate approach to responding to moderate opioid prescribing risk.

	Elements	Status
3 Investigate	Identify, investigate and monitor high risk (problem) opioid prescribing	Majority of investigations concluded. Status update was released post February Council. http://www.cpso.on.ca/CPSO/media/documents/Positions%20and%20Initiatives/Opioids/Opioid-Investigations-Backgrounder.pdf. A further update may be available at the May Council meeting. Work is underway to identify high risk prescribing, within the context of work already being done by other partners (ICES and HQO).

	Elements	Status
4 Facilitate Education	Work with partners to: Ensure multiple educational offerings, targeted at multiple stages of practice: general education, awareness and remediation	Regular communication with education providers, medical schools, and CPD programs is occurring to maintain an up-to-date list of resources.
	Work with partners to: Develop an Opioid Prescriber's Education Series, focused on the fundamentals of appropriate prescribing as well as particular areas of focus to be determined	CPSO participated in 2 educational sessions in collaboration with the Ontario College of Family Physicians (OCFP) - March 23 in Collingwood and March 29 in Kitchener. The focus was on College policy, use of guidelines and the importance of slow tapering.

ENABLING ACTIVITIES

	Elements	**Status**
A Communicate	Continue Dialogue coverage from multiple perspectives, including patients and families	20+ articles, letters, and infographics in Dialogue in 2017. Coverage continuing in 2018.
	Compile all Dialogue articles into a resource for other educational initiatives	COMPLETE All Dialogue articles relating to opioids have been consolidated on the web hub. These will also be incorporated into the Opioid Prescriber's Education Series, currently in development.

	Communicate directly with patients and the public	COMPLETE A message to patients was released September 8, 2017.
	Develop an Opioids Statement that clearly sets out the role of the College, physicians and system partners.	COMPLETE Opioids Position Statement released September 8, 2017.

	Elements	**Status**
B Use Data and Analytics	Accessing, analyzing and acting on prescribing data are key enablers of the strategy framework	Collaboration with ICES to develop an opioid prescribing risk score.
	Physicians need information to prescribe appropriately	Physicians who have access to one of the regional connecting hubs can access the Digital Health Drug Repository. Advocacy on this issue is continuing.
	The CPSO needs data to fulfill its regulatory responsibilities and to identify factors that support appropriate prescribing.	CPSO is working with ICES to receive de-identified information in order to determine next steps.

	Elements	**Status**
C Collaborate	For activities that are not the CPSO's primary responsibility, collaborate with key stakeholders – Health Quality Ontario, the MOH, eHealth Ontario, and others – to promote safe prescribing and access to information for physicians	Ongoing work with HQO and education providers to identify the supports that will be offered to physicians. Ongoing work with the MOH and the Prescription Monitoring Leadership Roundtable to establish algorithms and data transfer processes.

OTHER UPDATES

PROVINCIAL

Minister/Ministry of Health

- The Opioid Emergency Task Force created in October of 2017 is intended to advise the government on various opioid issues. The group includes front line workers in harm reduction, addiction medicine and community-based mental health and addiction services as well as representatives from multiple organizations.

- The CPSO was invited to participate at the beginning of 2018 and we recently presented to the group on the methadone program, the opioid strategy and our plans for reviewing the Prescribing Drugs policy. These presentations were well received.
- This group will not be meeting until after the election.

Prescription Monitoring Leadership Roundtable (PMLR)

- The PMLR's stated purpose is to ensure that NMS data is used by the MOHLTC in a consistent and evidence-based manner to ensure that potentially inappropriate prescribing and dispensing practices are identified and handled appropriately.
- Theoretically, the group is intended to deal with the development of algorithms to identify areas of highest risk and appropriate intervention methods when potentially questionable prescribing and dispensing behaviour is identified.
- The group has received a summary/overview of prescription monitoring programs across the country.

Health Quality Ontario (HQO)

- The CPSO continues to participate at the Opioid Partnered Supports Table (OPST). The OPST is a multi-year concerted effort to improve pain management for the people of Ontario by coordinating services and supports for clinicians. These services include
  - OntarioMD's EMR Dashboard and Peer Leader Program,
  - University of Toronto's Continuing Practice Development Webinars and Workshops,
  - the Ontario College of Family Physicians MMAP Program and Peer/Group Mentorship Networks,
  - the CAMH De-Implementation Model and Opioid Courses,
  - ECHO's Chronic Pain and Opioid Sessions and
  - the Center for Effective Practice's Academic Detailing program.

METHADONE

- The oversight of methadone prescribing is part of the College's overall Opioid Strategy. The Strategy contemplated a review of the MMT guidelines and continued methadone assessments under the new specialty panel of the QAC (see separate Briefing Note relating to the dissolution of the Methadone Committee by-law).
- The s56 methadone exemption requirement will be eliminated on May 19. As of that date, physicians will no longer require an exemption to prescribe methadone. The federal government considered the exemption requirement to be a barrier to methadone prescribing.
- The elimination of the exemption has implications for the CPSO's oversight of methadone prescribers. The exemption provided a mechanism to identify methadone prescribers as well as a way to ensure methadone prescribers had the necessary education, a preceptorship and more frequent assessments.
- While further discussion needs to occur at the QAC specialty panel and Executive Committee regarding the future approach to methadone oversight in the context of the CPSO's overall approach to opioid monitoring, the elimination of the exemption made it necessary to communicate our approach.
- In April, a notice was sent to all physicians indicating that the CPSO would continue to expect physicians to complete the Opioid Dependence Treatment course at CAMH, complete a preceptorship, give written

notice of their intention to begin prescribing methadone and be assessed one year after they begin prescribing.

PROPOSED APPROACH TO NMS DATA

In order to establish a new way of managing information from the NMS, the Executive Committee has been considering 3 key elements: development of a new algorithm to identify potentially inappropriate prescribing, development of new processes that would triage and enable identified physicians to be managed via QA and the current environment relating to opioids.

1. Algorithm

- The College has been working with ICES to develop a robust algorithm to identify prescribing risk.
- Risk scores will be comprised of multiple factors including things like how many patients are on high dose opioids, or on combinations of opioids and benzodiazepines, as well as new starts. At present, ICES will only be calculating risk scores for family physicians.
- This work is underway but at the moment the analysis is non-nominal. There are multiple details to be sorted out in order to identify particular physicians. We don't anticipate being in a position to make a further request for data until the end of the year, at the direction of the Executive Committee.

2. Triage and Assessment Process

- The College is considering ways to receive information about and manage potentially concerning opioid prescribing.
- The principles of the approach remain consistent: to use a regulatory process that addresses risk and achieves the goal of remediation wherever this is possible. We have been actively exploring the potential to manage some of these matters via the QM/QA process as an alternative to investigation.
- The benefits of this approach include an improved experience for physicians (via emphasizing the quality focus of assessment), and using the least invasive regulatory tool to achieve the appropriate outcome.
- Note that no matter how we approach a further request for NMS data, we have a continuing obligation to investigate matters that come to us via other sources.
- A triage model is currently being developed.

3. Current Environment

- While it appears that overall opioid prescribing declined slightly from 2015 to 2016 http://www.hqontario.ca/System-Performance/Specialized-Reports/Starting-on-Opioids-in-Ontario , opioid overdoses and deaths continue to rise.
- Ontario has reported **1,053** opioid-related deaths from January to October 2017, compared with **694** during the same time period in 2016. http://www.cbc.ca/news/canada/windsor/ontario-opiod-death-spike-free-nalaxone-1.4567224

- As a result, the MOH is focusing most of its efforts and resources on improvements to tracking overdoses and deaths, increasing access to naloxone and harm reduction initiatives including safe injection sites and other programs.
- While the MOH Strategy to Prevent Opioid Addiction and Overdose includes a commitment to modernizing opioid prescribing and monitoring, this has not been a priority, given the urgent problem of overdoses.
- We will continue to advocate for physician access to real time medication profiles, physician access to comparative prescribing information and a comprehensive prescription monitoring program in Ontario that clearly sets out objectives, data transfer authorities and the roles of various organizations.

NEXT STEPS:

Staff will continue to work on both the algorithm and process development, and monitor the environment for relevant developments. The matter will return to the Executive Committee prior to any decision to make a request for further information.

The CPSO will continue to advocate for a Prescription Monitoring Program (PMP), but this is a longer term policy objective, one that is unlikely to sustain attention over the election period.

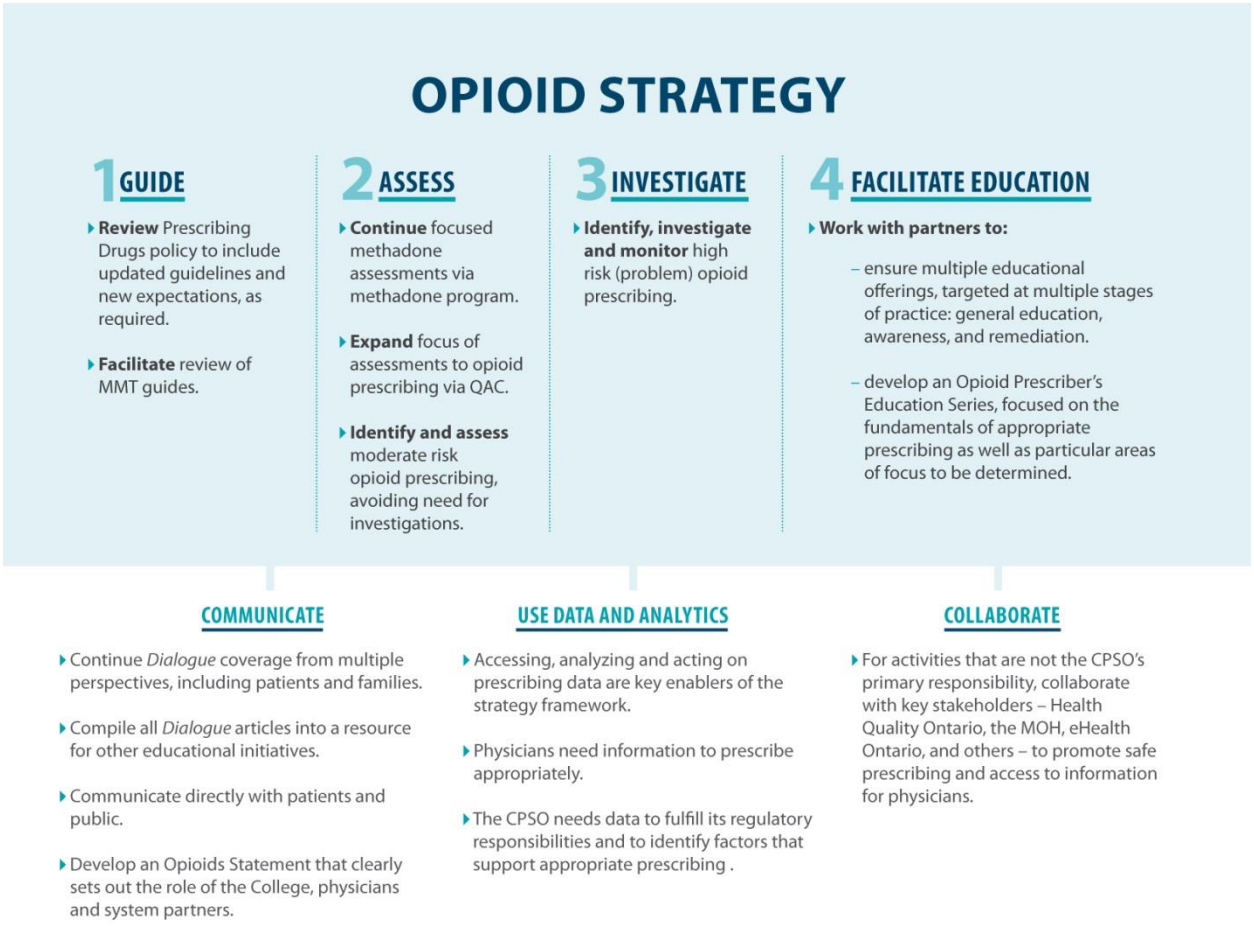
DECISION FOR COUNCIL: For information/discussion

Contact: Maureen Boon, extension 276

Date: May 7, 2018

Attachments:
Appendix A: Opioid Strategy

Appendix A: Opioid Strategy



Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

MAY 2018

TOPIC: PROPOSED GENERAL BY-LAW AMENDMENTS - METHADONE COMMITTEE

FOR DECISION

ISSUE:

- In May 2017, Council directed staff to proceed with the transition of the Methadone Committee from a by-law Committee to a specialty panel of the Quality Assurance Committee (QAC). This requires amending the CPSO General By-law.
- A number of operational process issues needed to be addressed with respect to transitioning the main elements of the program to be under the QAC prior to the bylaw being rescinded and these have now been addressed. Council is now being asked to give formal approval.
- Council is now being asked to amend Section 41 and revoke Section 45 of the CPSO General By-law for this purpose (see Appendix A).

BACKGROUND:

- In May 2017, the College presented to Council an Opioid Strategy to address its role in managing and responding to issues arising from problematic prescribing and providing direction on remediation and education needed by physicians.
- An element of this strategy includes transitioning the Methadone Committee to a specialty panel of the Quality Assurance Committee.
- The benefit of this transition is that the QAC has a full range of powers at its disposal under the *RHPA* that can be utilized when it determines that education and remediation for a prescriber are required. These powers include conducting more comprehensive assessments, directing SCERPs and, when necessary, using the authority of Section 80.2 of the Code to impose terms, limits and conditions or refer matters to the ICRC. This was approved at the May 2017 Council meeting.

- The College has had a financial agreement with the Ministry of Health and Long Term Care (MOHLTC) since 1996 for a program for methadone prescribing for the treatment of opioid use disorder.

- In 1999 the Methadone Committee was formed in by-law to oversee the assessments of physicians. (Appendix A)

- Council approved this direction in May 2017 but the rescindment was put on hold until the majority of methadone prescribers assessments initiated under the bylaw framework had been completed and opined on.

- Legal has advised that rescinding the Methadone Committee By-Law (section 45 of the General By-Law) does not require circulation to the membership under the Health Professions Procedural Code.

- As part of the Opioid Strategy a working group is identifying the relevant operational processes needing to be considered for the transition of the Methadone Committee under the QAC. This involves what processes under QAC will be applied to methadone prescriber assessments as well as a review of assessment frequency and focus.

CURRENT STATUS:

- To enable the transition, Legal advised that the CPSO General By-law must be changed however; circulation of this by-law amendment to the membership is not required. In October 2017, the Executive Committee reviewed the proposed changes to the CPSO General By-law, and recommended that they be forwarded to Council for consideration.

- Health Canada announced the Section 56 exemption required under the Controlled Drugs and Substances Act will be rescinded as of May 19th, 2018. In addition to the reasons identified above in support of rescinding Section 45 this announcement negates the need for any ongoing regulatory structure in support of the exemption itself.

- Information on the website has been updated to reflect the transition of methadone assessments to be under the Quality Assurance Committee.

CONSIDERATIONS:

- The role of the specialty panel of the QAC in overseeing the assessment of methadone prescribing physicians will remain essentially the same for the time being. Further

consideration will be given to how this panel might also be used to assess opioid prescribing. The additional powers of the QAC allows for a more formal program of assessment under statutory powers than was available to a committee formed in by-law.

- The dissolving of the Methadone Committee aligns with the broader College opioid strategy. It recognizes that in order for the College to better protect the public and to move away from oversight that is drug specific, we assess other forms of opioid prescribing as well as continuing to assess methadone prescribing, but that this be done under one statutory framework.

NEXT STEPS:

- Staff Working Groups under the College's Opioid Strategy will continue to work on identifying and implementing operational changes with input from the QAC and the new specialty panel as well as other stakeholders, to ensure a smooth transition of oversight.

DECISION FOR COUNCIL:

1. Does Council approve the proposed amendments (in Appendix A) to the General By-law to allow for the dissolution of the Methadone Committee whose activities are now part of a specialty panel of the QAC?

Contact: Nanci Harris, Ext. 325
Wade Hillier Ext. 636

Date: May 2, 2018

Attachments:

Appendix A: Proposed By-law Changes to Amend the General By-law

Appendix A

PROPOSED BY-LAW CHANGES TO AMEND THE GENERAL BY-LAW

General By-law Changes

A. Section 41 of the General By-Law is amended by revoking "4 Methadone Committee".

Establishment

1. The following committees are the standing committees.

1 Council Award Selection Committee
2 Education Committee
3 Finance Committee
3a Governance Committee
~~4 Methadone Committee~~
5 Nominating Committee *[repealed: May 2003]*
6 Outreach Committee
7 Premises Inspection Committee
8 Compensation Committee *[repealed: May 2017]*

B. Section 45 of the General By-Law is revoked.

~~45. The Methadone Committee shall,~~

~~(a) administer and govern the College's methadone program, including,~~

~~(i) brief programs of education in addiction medicine;~~

~~(ii) the establishment of guidelines or standards applicable generally to the use of methadone in the management of opioid dependence; and~~

~~(iii) a program to review the prescribing of methadone by members in the management of opioid dependence; and~~

~~(b) decide whether,~~

~~(i) to recommend to the Minister of National Health and Welfare the issuance, renewal or withdrawal of an authorization or exemption for a member to administer, prescribe, give or~~

~~otherwise furnish methadone for the management of opioid dependence; and~~

~~(ii) in accordance with any legislation enacted in Ontario, to issue, refuse to issue or withdraw a permit for a member to administer, prescribe, give or otherwise furnish methadone for the management of opioid dependence.~~

IN CAMERA

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Briefing Note

May 2018

TOPIC: Governance Committee Report:

For Decision:

1. 2019 Executive Committee Election

For Information:

2. Appointments

- **Public Member Reappointments**
- **Committee Appointments**

3. Completion of 2019 Committee Interest Forms
(for submission at Council meeting)

For Decision:

1. 2018 Executive Committee Election

ISSUE:

- Council will elect the members of the 2019 Executive Committee for President, Vice President, 1 Physician Member of Council and 2 Public Members of Council.
- Nomination Statements have been received to-date from the following candidates for these positions: (attached in Appendix A).

For President:	Dr. Peeter Poldre
For Vice President:	Dr. Brenda Copps
For Physician Member: *(1 position)*	Dr. Akbar Panju
For Public Members: *(2 positions)*	Ms. Lynne Cram Mr. Pierre Giroux Mr. Peter Pielsticker

- *Nomination Forms* with signature of nominee, mover and seconder are due at 12 noon on Thursday, May 24, 2018.
- Nominees will be given the opportunity to address Council, prior to the elections.

Decision:

1. Election of 2019 Executive Committee positions; President, Vice President, 1 physician member of Council and 2 public members of Council.

For Information:

2. Appointments

Public Member Reappointments:

- Given the pending election, public member reappointments coming up between March 10 and July 31, 2018, will be for a term ending December 31, 2018.
- Four public members have been reappointed to the Council by Order in Council:
    - Ms. Lynne Cram: May 2, 2018 – December 31, 2018
    - Major Abdul Khalifa: July 22, 2018 – December 31, 2018
    - Mr. Peter Pielsticker: March 18, 2018 – December 31, 2018
    - Ms. Joan Powell: July 22, 2018 – December 31, 2018
- The next government will consider reappointments of public members.

Committee Appointments:

- At the Executive Committee meeting, held on April 24, 2018, the following committee appointments were made:
    - Dr. Gil Faclier: Inquiries, Complaints and Reports Committee
    - Dr. Val Rachlis: Inquiries, Complaints and Reports Committee
    - Dr. Dori Seccareccia: Inquiries, Complaints and Reports Committee
    - Dr. Anne Walsh Inquiries, Complaints and Reports Committee
    - Dr. Mark Mensour Premises Inspection Committee

3. Completion of 2019 Committee Interest Forms

- All Council members are asked to complete the Committee Interest Form for 2019 committees. (see Appendix B)
- Appended to the form are a description of each committee, a chart that identifies the average time commitment for each committee and Council work, and a committee chair role description.
- Public members are asked to identify a preference for the Discipline Committee or the Inquiries, Complaints and Reports Committee.
- The completed form will inform the Governance Committee in its deliberations as it develops committee recommendations for the 2019 Council year.

- Council members are asked to complete the Committee Interest Form and submit their completed forms to Debbie McLaren by the end of the Council meeting on Friday, May 25.
- Council will make committee appointments at the December meeting.

Contact: David Rouselle, Chair, Governance Committee
Debbie McLaren, ext. 371
Suzanne Mascarenhas, ext. 873
Louise Verity, ext. 466

Date: May 3, 2018

Appendix A: Executive Committee Nomination Statements and Memo to Council
Appendix B: Committee Interest Form and attachments

Appendix A

NOMINATION STATEMENTS
FOR 2019 EXECUTIVE COMMITTEE VOTE

NOMINATION STATEMENT
CANDIDATE FOR PRESIDENT, 2018-2019 EXECUTIVE COMMITTEE

DR. PEETER POLDRE

District 10 Representative
Toronto, Ontario

Principal Area of Practice or Specialty/Occupation:
Haematology/Internal Medicine

Elected Council Terms:
2012-2014
2014-2017
2017-2020

CPSO Committees/Positions Held and Other CPSO Work:

Discipline Committee:	2012-2014, 2017-2018, Co-chair: 2014-2017
Executive Committee:	2016-2017, Vice President 2017-2018
Finance and Audit Committee:	2017-2018
Governance Committee:	2015-2016, 2017-2018
Outreach Committee:	2017-2018
Policy Working Group: *Physicians' Relationships with Industry, Practice, Education and Research*	Chair: 2013-2014
Policy Working Group: *Continuity of Care and Test Results Management*	2016 - Present

STATEMENT:

My almost two years on the Executive Committee have been eventful. We now await the arrival of our new Registrar, Dr. Whitmore, after celebrating the years of wise guidance from Dr. Gerace. Many challenges are ahead for the College, but our resolve to protect the public will always be our guiding lighthouse in the metaphorically turbulent seas.

In addition to serving on Council, Executive, Governance, Finance & Audit, and Outreach, I was recently the Co-Chair of Discipline for three years. I remain actively involved with the Discipline Committee this year. My participation in several Policy working groups has given me a valuable perspective on the issues facing the College. I am convinced that our policy work is incredibly educational and valuable to our members.

I have been fortunate to work with many dedicated staff, members of Council and Committee members to serve the public interest in our ever-evolving environment.

As President, and with the support of all of you, I will continue to listen, learn, synthesize and share the collective wisdom of the Council and the staff of the College in a constructive, positive and forward-thinking manner.

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NOMINATION STATEMENT
CANDIDATE FOR VICE PRESIDENT, 2018-2019 EXECUTIVE COMMITTEE

DR. BRENDA COPPS

District 4 Representative
Hamilton, Ontario

Principal Area of Practice or Specialty:
Family Medicine

Elected Council Terms:
2013-2016
2016-2019

CPSO Committees/Positions Held and Other CPSO Work:

Education Committee:	2015-2018
Executive Committee	2017-2018
Governance Committee:	2016-2017
Quality Assurance Committee:	2013-2015, Co-chair: 2015-2018
Quality Assurance Working Group member:	2016
Policy Working Group: *Accepting New Patients/Ending the Physician-Patient Relationship*	2015 - Present
Policy Working Group: *Continuity of Care and Test Results Management*	2016 – Present, Chair
FMRAC Annual Meeting Delegate:	2015

STATEMENT:

I come before you once again to ask for your support in my leadership journey. I have very much enjoyed my term as the physician member on the Executive and my continued climb up the steep learning curve of professional regulation. I hope to be able to bring my increasing expertise to the Executive in the role of Vice President, so that together, we can steward the board through the many upcoming changes and challenges.

My involvement in recent initiatives, including the new Registrar search and the development of the Registrar performance framework, has reinforced for me the importance of continuity in our governance structure.

I continue to have a clinical practise and consistently bring the important perspective of a generalist to college deliberations. I believe this lends relevance and relatability to our work for the public and the profession alike.

On a personal level, I like to think that I am viewed as principled and progressive; have a strong team and work ethic and utmost respect for our mandate to protect the public. I hope you will continue to demonstrate your confidence in me.

NOMINATION STATEMENT
CANDIDATE FOR PHYSICIAN MEMBER, 2018-2019 EXECUTIVE COMMITTEE

DR. AKBAR PANJU

University Representative – McMaster University
Hamilton, Ontario

Principal Area of Practice or Specialty/Occupation:
Internal Medicine

Appointed Council Terms:
2014-2018

CPSO Committees/Positions Held and Other CPSO Work:

Education Committee	2014-2017 *(non-voting academic member)* 2017-2018, Chair *(voting academic member)*
ICR Committee:	2014-2016 2016-2018, Vice Chair, Internal Medicine *(Dr. Panju has also served as non-council member of Complaints Committee 2008-2009 and ICR Committee 2009-2011)*
Registration Committee:	2014-2017 2017-2018, Chair

STATEMENT:

I have varied background and experiences. I was a family physician in Northern Ontario for 5 years prior to specializing in Internal Medicine and subsequently working in a teaching hospital. I am a clinician, educator and administrator, having been the Chief of Medicine at Hamilton Health Sciences (4 sites) and Chair of Medicine at McMaster University. I am the past president of The Canadian Society of Internal Medicine.

My CPSO experience has been in ICRC (Vice Chair), Education (Chair) and Registration (Chair). I have been a panel member of the Medical Record Policy writing.

We live in a changing environment. CPSO is involved in many exciting and innovative initiatives to meet the challenges and issues we are facing at all levels and to fulfill our mandate to protect the public. We also need to do our best to regain the trust of the public and all our stakeholders. I feel my previous experience working in non-academic and academic practices, working in rural and large settings, and my leadership roles in multiple levels would serve me in my work at the Executive Committee. I would do my best to fulfill my role.

NOMINATION STATEMENT
CANDIDATE FOR PUBLIC MEMBER, 2018-2019 EXECUTIVE COMMITTEE

MS. LYNNE CRAM

Public Member of Council
London, Ontario

Occupation:

I retired in 2007 as Executive Vice President with Windjammer Landing Resort in St. Lucia. Prior to Windjammer, I enjoyed challenging careers with Xerox, Four Seasons, Hyatt and offshore manufacturing.

I am most proud of my community involvement in London for over 25 years. I am currently Vice Chair of Goodwill Industries Great Lakes which has recently acquired expansion right into the GTA and surrounding area. I served on the Board of Kings University College for 13 years and was Chair 2013-1015.

Appointed Council Terms:
2012 – 2018

CPSO Committees/Positions Held and Other CPSO Work:

Council Award Selection Committee:	2016-2018
Executive Committee:	2016-2018
ICR Committee:	2012-2017, Co-Vice Chair, General Panels 2016-2018
ICR Committee-Settlement Panel:	2015-2018
Outreach Committee:	2013-2015, Chair: 2015-2018
Joint Policy Working Group: *MD Relations with Drug Companies/Conflict of Interest: Recruitment of Research Subjects*	2013-2014
Policy Working Group: *Blood Borne Viruses*	2014-2015
Policy Working Group: *Physician Assisted Death*	2015-2016
Policy Working Group: *Prescribing Drugs*	2018

STATEMENT:

I have really enjoyed working on the Executive Council for the last 1.5 years and I ask for your support for another year. I always find the work challenging as we, along with Senior Management, work through policy and legislative topics along with many emerging issues and concerns from government and the public which require urgent responses.

Being involved on the Registrar Selection Committee over the last year was demanding and ultimately very rewarding. The Executive is now working with a consultant to draft the CEO Performance Assessment Framework. This will be a strong document to guide Dr. Whitmore, Executive and Council through the initial year as well as the subsequent years. I would like to be involved in the first year of implementation.

The joint Executive/Governance Working Group has also commenced extensive research and generative thinking regarding the CPSO governance model. As we move forward, it will be essential to share our ideas and engage Council in this process. Over recent years, Council has approved policies on many difficult issues and I look forward to working with you as we challenge our governance model.

I ask you to support my re-election to the Executive for 2019.

Thank you.

Lynne

NOMINATION STATEMENT
CANDIDATE FOR PUBLIC MEMBER, 2018-2019 EXECUTIVE COMMITTEE

MR. PIERRE GIROUX

Public Member of Council
Toronto, Ontario

Occupation:
Sales and Marketing Executive

Appointed Council Terms:
2012-2016
2016-2019

CPSO Committees/Positions Held and Other CPSO Work:

Discipline Committee:	2013-2018
Executive Committee:	2015-2018
Finance Committee:	2013-2014, 2017-2018, Chair: 2014-2017
Outreach Committee:	2017-2018
Quality Assurance Committee:	2013-2018
Physician Compensation Working Group	2017-2018, Chair
Policy Working Group: *Prescribing Drugs*	2018

STATEMENT:

In a working career spanning over forty years, I held senior management and executive positions in industry, government and banking. Those roles required several domestic and foreign relocations, including lengthy periods in Mexico City, Rome, Paris and London. Throughout these postings, I learned the value of community, flexibility and self-reliance.

Since joining the College in 2012, I have been a vocal supporter of its mission; to ensure that the regulation and practice of medicine reflects and advances the interests, not only of those practising medicine, but also the public. I presently serve on four College Committees, Quality Assurance, Discipline, Finance and Outreach. I also chair the Physician Compensation Working Group, and I am a participating member of the Prescribing Drugs Policy Working Group.

Since the beginning of 2016, I have been on the Executive Committee which has been a great learning experience. I believe I have been an engaged participant, not only reflecting the views and interests of the public members of Council, but also ensuring that balance and thoughtfulness are provided on all matters brought before the Executive Committee.

I am asking for your support for my re-election to the Executive Committee.

NOMINATION STATEMENT
CANDIDATE FOR PUBLIC MEMBER, 2018-2019 EXECUTIVE COMMITTEE

MR. PETER PIELSTICKER, CA, CPA

Public Member of Council
Brampton, Ontario

Occupation:
Financial Consulting

Appointed Council Terms:
2015-2018

CPSO Committees/Positions Held and Other CPSO Work:

Discipline Committee:	2015-2018
Finance and Audit Committee:	2015-2017, Chair: 2017-2018
Premises Inspection Committee:	2015-2018
Quality Assurance Committee:	2015-2018
Staff Pension Committee:	2018

STATEMENT:

I was first appointed to CPSO in March 2015. I was retired and looking to keep my hand in something meaningful. I had no idea how exciting and challenging this post would be. The CPSO is an outstanding and meaningful organization with dedicated and able staff.

I thrive on the participation and would ask for your support in my nomination to the Executive Committee. I have just completed my first term and been reappointed for my second term. Unfortunately we are in the throes of an election so the appointment is just until December 2018 but I anticipate it will be renewed for the full term post-election.

My background is in Finance as a Chartered Professional Accountant where I carried the Chief Financial Officer roles in a number of different organizations for over 40 years. Since coming to the College I have been on Discipline Committee, Premises Inspection Committee, Quality Assurance Committee and Finance Committee where I am currently Chair. As part of the Chair role in Finance I am a member of the Pension Committee.

I have the time to commit to this important role and definitely the interest. I believe I can make a contribution and ask for your support.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Memorandum

To	All Council Members
From	Dr. David Rouselle, Chair, and Governance Committee
Date	April 10, 2018
Subject	Nomination/Election Process for the 2018-2019 Executive Committee Vote at the May Council Meeting

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At the May meeting of Council, an election will be held for the positions on the 2018-2019 Executive Committee. The Committee consists of the President, Vice President, Past President, one physician member and two public members of Council.

As per the General By-Law, s. 39(1)(b), the immediate Past President is a member of the Executive Committee without the need to be elected to that position. If the immediate Past President is unwilling or unable to serve, there would be a vote for two physician members for the Executive Committee as per the General By-Law.

All Council members who wish to be nominated for a position on the Executive Committee are invited to submit an optional **Nomination Statement.** The Statement should be limited to 200 words. In addition, **Nomination Statements** will also include brief biographical information and the candidate's picture. N**omination Statements** will be emailed to all Council members and circulated, as an attachment, to the Governance Committee Report to Council.

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

In addition, to a **Nomination Statement**, a completed **Nomination Form** is due on the first day of the Council meeting at noon. Each Nomination requires the signatures of a nominator, a seconder, and the agreement of the nominee. Please refer to the Governance Process Manual for role descriptions and key behavioural competencies that are necessary to fill the positions.
Governance Process Manual

A chart identifying the current Executive Committee members is attached. I have also attached the **Nomination Form(s)** for you to complete, should you wish to be nominated for a position on the 2018-2019 Executive Committee.

A separate Council Contact List is also provided for you to facilitate communications between Council members.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Timeframe and Process for Executive Committee Nominations:

1. **If you wish to submit a Nomination Statement, please forward your request for your *personalized template* to Debbie McLaren at dmclaren@cpso.on.ca**

2. **The deadline for submission of your completed Nomination Statement is Monday, April 30, 2018 at 5 p.m. Nominations Statements that are submitted by the deadline will be circulated to all Council members and included with the Governance Committee Report to Council. Submitted Nomination Statements will be reviewed by the Chair of the Governance Committee, prior to circulation to Council.**

3. **The deadline for your completed Nomination Form *(with signature of nominee and 2 nominators)* is Thursday, May 24, 2018 at 12 noon.**

4. **Nominations from the floor will also be accepted during the Governance Committee Report on the day that the vote takes place.**

5. **The Executive Committee that is voted in at this meeting, will officially take office at the adjournment of the annual meeting of Council on December 7, 2018.**

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

Thank you,

David Rouselle, MD, FRCSC
Chair, Governance Committee

att.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

2018 EXECUTIVE COMMITTEE MEMBERS:

This committee's composition is prescribed in the General By-Law. Council will vote for the President, Vice President, 1 physician member of Council and 2 public members for the 2019 Executive Committee at the May 2018 Council meeting.

Executive Committee Members	Length of Committee Appointment*	Current position and years on Committee
Dr. Steven Bodley - Chair	**3 years**	**President 17/18** Vice President 16/17 Physician Member 15/16
Dr. Brenda Copps	**1 year**	**Physician Member 17/18**
Ms. Lynne Cram	**2 years**	**Public Member 17/18,** 16/17
Mr. Pierre Giroux	**3 years**	**Public Member 17/18,** 16/17**,** 15/16
Dr. Peeter Poldre	**2 years**	**Vice President 17/18** Physician Member 16/17
Dr. David Rouselle	**4 years**	**Past President 17/18** President 16/17 Vice President 15/16 Physician Member 14/15

**[Length of Committee appointment reflects current term expiring on December 7, 2018]*

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

EXECUTIVE COMMITTEE
NOMINATION FORM

FOR PRESIDENT:

I _____ am
Print name here

willing to be nominated for President.

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

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

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

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

EXECUTIVE COMMITTEE
NOMINATION FORM

FOR VICE PRESIDENT:

I _____ am
Print name here

willing to be nominated for Vice-President.

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

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

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

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

EXECUTIVE COMMITTEE
NOMINATION FORM

FOR PHYSICIAN MEMBER:

I _____ am
Print name here

willing to be nominated for Physician Member on the Executive Committee.

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

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

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

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

EXECUTIVE COMMITTEE
NOMINATION FORM

FOR THE 2 PUBLIC MEMBERS ON THE EXECUTIVE COMMITTEE: (You may nominate 1 or 2)

I _____ am
Print name here
willing to be nominated for the Public Member on the Executive Committee.

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

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

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

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

I _____ am willing to be
Print name here

nominated for the Public Member on the Executive Committee.

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

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

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

Appendix B

2019 COMMITTEE INTEREST FORM
[2018-2019 COUNCIL TERM]

The Governance Committee follows Council's Nomination Guidelines in developing leadership and membership recommendations to Council. To assist the Governance Committee in its appointment of Councillors to committees for the 2018-2019 session of Council, please complete the form. A document entitled "College Committees" is attached to assist you in making your choices, as well as an Average Time Commitment Chart for Committee and Council Work.

In addition, please indicate whether you are interested in serving as Chair of that Committee in the column provided. The description of the role of a Committee Chair is attached for your information.

The Governance Committee reminds members of Council that it is often not possible to appoint members to every committee of their choice. In order to be considered for committee work, all Council members and committee members must sign the College's *Declaration of Adherence Form* that is contained in the Governance Process Manual. A *Criminal Record Check* must also be completed for all new Council members and all new non-Council committee members.

NAME: ☐

Please mark your committee selections in the column that best describes your interest level and available time commitment. [Public members are asked to identify a preference for the Discipline Committee or the Inquiries, Complaints and Reports Committee].

Committee Name	Prefer Not to Serve on	Interested	Very Interested	Interested in Chairing this committee
Statutory Committees				
Discipline*	☐	☐	☐	☐
Fitness to Practise*	☐	☐	☐	☐
ICR*	☐	☐	☐	☐
Quality Assurance*	☐	☐	☐	☐
Registration	☐	☐	☐	☐
By-Law Standing Committees				
Council Award**	☐	☐	☐	N/A
Education	☐	☐	☐	☐
Finance	☐	☐	☐	☐
Outreach	☐	☐	☐	☐
Premises Inspection	☐	☐	☐	☐

Potential Committee Conflicts:
ICR committee members will not be appointed to the Discipline Committee and/or Fitness to Practise Committee or the Quality Assurance Committee and vice versa.
It is recommended that whenever possible, Quality Assurance Committee members are not members of the Discipline and/or Fitness to Practise Committee and vice versa.
****Council Award Selection Committee is available to public members only, physician composition/chair selection is prescribed in the General By-Law.***
****Please complete the back of this form to outline your competencies to serve on the committees you have marked above, and if applicable, your competencies for chairing a committee.***

……continued on next page

Please note there is a nomination process and a council vote for the 2019 Executive Committee that will take place at the May 2018 Council meeting and a nomination process for the 2019 Governance Committee that will take place at the annual meeting of Council in December.

******COMMITTEE COMPETENCIES*:**

PLEASE STATE STRENGTHS, SKILLS, EXPERIENCE AND QUALITIES YOU WOULD BRING TO THE COMMITTEES YOU ARE INTERESTED IN SERVING ON.

******CHAIR COMPETENCIES*:**

PLEASE STATE THE STRENGTHS, SKILLS, EXPERIENCE AND LEADERSHIP QUALITIES YOU WOULD BRING TO THE POSITION OF CHAIR. IN WHAT DIRECTION WOULD YOU LEAD THE COMMITTEE?
PLEASE IDENTIFY ANY CURRENT PROBLEMS WITH THIS COMMITTEE AND YOUR IDEAS FOR SOLUTIONS.

GENERAL COMMENTS:

PRINT

COLLEGE COMMITTEES

Much of the work of the College is conducted through College committees. There are three types of committees. They include statutory committees, by-law committees and ad hoc committees and task forces.

Statutory committees are set out in the College's governing legislation, the Regulated Health Professions Act and the Medicine Act. They include:

- Discipline Committee
- Executive Committee
- Fitness to Practise Committee
- Inquiries, Complaints and Reports Committee
- Patient Relations Committee
- Quality Assurance Committee
- Registration Committee

Operating committees are set out in the College by-laws and are operational in nature. They include:

- Council Award Selection Committee
- Education Committee
- Finance Committee
- Governance Committee
- Methadone Committee
- Outreach Committee
- Premises Inspection Committee

Working groups/task forces are established to address specific issues. These groups are established by Council and are generally time limited and deal with a particular problem or issue.

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Committee Mandates

Discipline Committee

The Discipline Committee hears matters of professional misconduct or incompetence.

The Inquiries, Complaints and Reports Committee, after conducting an investigation, refer allegations to the Discipline Committee. A discipline panel is comprised of at least three members – two must be public members and one must be a physician member of Council. Panels are usually made up of four or five members.

If the panel finds that the physician has committed an act of professional misconduct or is incompetent, it can make an Order directing the Registrar to:

- revoke the physician's certificate of registration
- suspend the physician's certificate, and/or
- impose specified terms, conditions or limitations on the physician's certificate.

If the panel finds the physician has committed an act of professional misconduct, it can also make an Order:

- requiring the physician to appear before the panel to be reprimanded
- requiring the physician to pay a fine of not more than $35,000 to the Minister of Finance, and
- if the act of professional misconduct was the sexual abuse of a patient, requiring the physician to reimburse the College for funding provided for the patient for counselling and therapy, and requiring the physician to post security to guarantee payment.

If the panel finds the physician has committed an act of professional misconduct by sexually abusing a patient, the panel must:

- reprimand the physician, and
- revoke the physician's certificate if the sexual abuse consisted of or included certain acts.

In an appropriate case, the panel may also require the physician to pay all or part of the legal, investigation and hearing costs and expenses. The Discipline Committee also hears applications for reinstatement and motions to vary prior orders of the Committee.

Education Committee

The Education Committee reviews and makes recommendations to Council on matters of medical education in the province.

The Education Committee is responsible for:

- reviewing the undergraduate studies at faculties of medicine in Ontario and encouraging curriculum enhancement
- monitoring and sustaining the level and quality of Ontario postgraduate programs of medical education, and
- reviewing the Ontario continuing medical education programs.

Executive Committee
The mandate of the Executive Committee, as defined in the legislation, is to serve as the decision-making body of the College in between regular meetings of Council, and to report on these actions to the Council at subsequent Council meetings.
In acting on Council's behalf in between Council meetings, the Executive monitors and reviews policy issues under development and operational issues of significance.

Finance Committee
The Finance Committee is responsible for reviewing the financial affairs of the College and reporting directly to Council. It reviews such matters as investment policy, control of assets, the auditor's report, and the College's overall financial position.
The Finance Committee is directly and indirectly involved in reviewing and/or making recommendations to Council concerning any financial matter affecting the functioning of the College, including: the banking of the College's funds, investments, borrowing of monies, levels of approval and disbursement procedures relating to purchased goods and services, major items concerning the building, the findings of the external annual audit, the annual budget preparation and the remuneration paid to members of the College whole on College business. It also reviews the College's annual financial position.

Fitness to Practise Committee
The Fitness to Practise Committee conducts hearings of allegations concerning a physician's capacity to practise medicine that are referred by an incapacity inquiry panel of the Inquiries, Complaints and Reports Committee.

A Fitness to Practise panel is comprised of at least three members, and one member must be a public member of Council.

If the panel finds that the physician is incapacitated it can make an Order directing the Registrar to:

- revoke the physician's certificate of registration
- suspend the physician's certificate, and/or
- impose specified terms, conditions or limitations on the physician's certificate.

The College makes every effort to carefully balance the physician's rights with the protection of the public. The Fitness to Practise Committee also hears applications for reinstatement and motions to vary prior orders of the Committee.

Inquiries, Complaints and Reports Committee
The ICR Committee oversees all investigations into members' care, conduct and capacity, including complaints investigations, Registrar's investigations, and inquiries into members' capacity to practise.

The ICR Committee may be called upon to provide investigative direction to staff, and is required to dispose of investigations with a decision. Examples of decisions the ICR Committee may make include:

- requiring members to attend before a panel of the ICR Committee to be cautioned in person
- referring allegations of professional misconduct and/or incompetence to the Discipline Committee
- referring matters of incapacity to the Fitness to Practise Committee
- requiring members to complete a specified education or remediation program
- taking any other action which is not inconsistent with the legislation. (including taking no action and accepting members' undertakings)

A quorum of the ICR Committee consists of 3 members, including at least 1 member of Council appointed by the Lieutenant-Governor in Council. Panels of the ICR Committee may vary in size from 3 – 6 members. Several committee meetings are held monthly. These meetings consist primarily of reviewing documentary information relating to investigations, and by law are not open to members or the public.

Governance Committee
The Governance Committee monitors the governance process adopted by Council and develops Governance policies and practises to ensure an effective system of governance. It also recommends to Council changes to governance processes and oversees the nominations process. This includes making recommendations to Council regarding the membership and leadership of College committees. In addition, the Governance Committee nominates other officers, officials or other people acting on behalf of the College.

Methadone Committee
The Methadone Committee was established to oversee a program to improve the quality and accessibility of methadone maintenance treatment in the treatment of opioid dependence. The College actively manages the practise of methadone prescribing as a formal partner with the Mental Health & Addictions Branch of the Ministry of Health and Long-Term Care. The program receives full funding for all methadone registry, staff, physician assessments and other activities.

Outreach Committee
The Outreach Committee works with the Policy and Communications Division to help develop major communications and outreach initiatives to the profession and public. It also assists in the development of major communication and government relations strategies. In addition, it develops plans to deliver on each of the communications and outreach related components of the strategic direction.

Patient Relations Committee

The Patient Relations Committee advises Council with respect to the patient relations program. *The Regulated Health Professions Act* (RHPA) established that all Colleges must have a patient relations program that includes measures for preventing or dealing with sexual abuse of patients by members. The measures must include:

- educational requirements for members
- guidelines for the conduct of members with their patients
- training for the college's staff
- and the provision of information to the public. (The Health Professions Procedural Code, Schedule 2 to *The Regulated Health Professions Act* (S.84))

The committee is also responsible for administering a program of funding for therapy and counselling for persons who, while patients, were sexually abused by members.

Premises Inspection Committee

The Premises Inspection Committee is responsible for administering and governing the College's premises inspection program. The duties of the Committee are set out in the College's General By-law, and include:

- ensuring appropriate individuals are appointed to perform inspections and re-inspections;
- ensuring adequate inspections and re-inspections are undertaken and completed;
- reviewing premises inspection reports and other material and determining whether premises pass, pass with conditions or fail an inspection.

Quality Assurance Committee

The Quality Assurance Committee develops, establishes and maintains:

- programs and standards of practice to assure the quality of practice of the profession; and
- standards of knowledge and skill, and programs to promote continuing competence among physicians.

Registration Committee

The Registration Committee reviews the applications of physicians who wish to become members of this College, but do not fulfil the requirements for the issuance of a certificate of registration. After considering an application, the committee is charged with taking appropriate action within the powers granted to it under the law. The Registration Committee is also responsible for the development of policies and regulatory changes pertaining to registration requirements for entry to practice, whether they are for training programs or for independent registration.

AVERAGE TIME COMMITMENT FOR COMMITTEE AND COUNCIL WORK						*Revised: May 4, 2018*
Committee Name	**Number of meeting days/hearings days per year?**	**Preparation Time (per meeting/hearing)**	**Attendance at CPSO per meeting/hearing**	**Additional Teleconferences per year?**	**Decision/Report Writing Required for Committee Members?**	**Average approximate time commitment per meeting/hearing** *(includes prep and attendance at meeting)*
Council Award Selection Committee	1 (may be done by teleconference)	8 hours	¼ day	Not usual and rarely required	No	15 hours
Council Meetings ***(all Council members attend Council meetings)***	Two 2-day meetings Two 1-day meetings + 1-day *Annual Education Session for Council/committee members*	6 hours per 2-day meeting 3 hours per 1-day meeting	Two 2-day meetings Two 1-day meetings One day orientation = 7 days	Not usual, but sometimes required	No	18 hours per 2-day meeting 9 hours per 1-day meeting
Executive Committee	7	3 hours (additional 1-hour spent on emails prior to each Exec meeting)	1 day per meeting (6 hours)	As required	No	3 hours per Executive meeting + ? hours for teleconferences
Discipline Committee	20 to 80 hearing days 150 days scheduled that are cancelled due to settlement Payment for late cancellation (<10 business days' notice) 2 days of business meetings 2 to 3 days of education	0 to 4 hours for meetings 0 prep for most hearings 2 to 6 hours for motions 2 to 6 hours for closing submissions	1 day up to 5 to 10 days a month 70% of hearings proceed on an uncontested basis and complete in ½ day Contested hearings range from 2 days to several weeks Lengthy hearings are booked with 1 to 3 weeks in between in each hearing week There is an expectation that committee members commit to as many hearings panels as their schedules permit, including lengthy hearings. Active members commit to 70 to 80 days per year and, due to cancelled days, sit for 30 to 50 hearing days per year. Others commit to 8 to 18 days and sit for 5 to 15 days per year.	Case management conferences are conducted by teleconference Sometimes required for motions or panel deliberation	Yes One person on the 5-person panel writes the initial draft. The entire panel provides input and approves the final decision.	8 to 40 hours *(could be more depending on hearing)*

Education Committee	5	3 hours	3 half-day meetings 2 full-day meetings	No	No	9 hours
Finance Committee	3	2 hours	1 full-day	Not usual, but sometimes required	No	6 to 8 hours
Fitness to Practise Committee	Hearings rarely occur - 1 to 5 days for a hearing is possible 10 days scheduled that are cancelled due to late settlement Payment for late cancellation (<10 business days' notice) ½ day business education meeting	0 to 4 hours for meetings 0 prep for most hearings 2 to 6 hours for motions	Hearings rarely proceed as cases tend to resolve with health and practice monitoring agreements Uncontested hearings complete in ½ day Contested hearing when they occur, range from 3 to 5 days	Rare. Hearings are closed to the public, so may proceed by teleconference if uncontested.	Yes. One person on the 3-person panel writes the initial draft. The entire panel provides input and approves the final decision.	8 to 40 hours
Governance Committee	5	3 hours (8 hours for 1 nominations meeting)	½ day 1 full-day meeting for committee nominations	2 x 2 hours (as required)	No	4 to 11 hours
Inquiries, Complaints and Reports Committee ***(Note: Individual members are not required to participate in all ICRC meetings.)***	***For total committee:*** 24 General Panels (a non-panel Chair could attend on average 4 - 6 panels per year) 50 Specialty Panels (a non-panel Chair could attend on average 6-8 panels per year)	***Prep Per Meeting:*** General Panels Average 18 - 36 hours or 3 - 6 days prep (1 day = 6 hour periods) Varies depends on #cases Specialty Panels average 21 - 36 hours or 3.5 - 6 days prep (1 day = 6 hour periods) Varies depends on #cases	***Attendance Per Meeting:*** General Panel meetings: ½ day - 1 day (x 4 – 6 per year) Specialty Panels: ½ day (x 6-8 per year)	***Assignments rotated for a quorum of 3 members.*** Teleconferences 50 x 1 hour weekly Ad-Hoc as required 24 x 1 hour as needed Medium Track: 24 x 2 hours monthly. Fast Track: 24 x 1 hour twice a month Settlement: 24 x 2 hours twice a month	Need to review cases in advance of meeting and submit "written notes and decision reasoning"; Panel Chairs need to review and approve decisions from their assigned meetings.	General Panel Meeting: 21 - 39 hours Specialty panels: 24 - 39 hours Weekly Teleconferences: 6 hours Medium Track Panel: 12-15 hours Fast Track Panel: 3-6 hours Settlement Panel: 6 hours

Inquiries, Complaints and Reports Committee (continued)	50 Verbal Caution Panels (with attendance for 4-6 half days per year) 24 Health Inquiry Panel meetings (a non- panel Chair could attend 12 half days per year) 2 days yearly to discuss Business and Policy matters relating to member specific issues (with attendance at 2 days per year)	Verbal Caution Panels: Approx. 2 hours Health Inquiry Panels: Approx. 3-6 hours Business meetings: Approx. 2 hours	Verbal Caution Panels: ½ day = 3 hours (x 4 - 6 per year) Health Inquiry Panels: 2 hours (x 12 per year) Business/Policy meetings: 1 day= 6 hours (x 2 per year)			Verbal caution panels: 5 hours Health inquiry panels: 6-8 hours Business/Policy meeting: 8 hours
Methadone Committee	Participation in 1-day orientation session There are six 1-day meetings per year Attendance suggested at the *CPSO Annual Prescribers' Conference*	3 hours	Full Day	Not usual, but sometimes required *(max. of 3)*	No	9 hours
Outreach Committee	3 half-day meetings per year	Between 1 and 2 hours	½ day	No *(Note: The first meeting of the year will be in-person and the other two by teleconference.*	No	4 hours
Patient Relations Committee	1 meeting + 7 to 8 teleconference meetings	1.25 hours	1 day	7 to 8 1 hour to 1.25 hour teleconferences	No	1½ to 3 hours

Premises Inspection Committee	Estimate 3 full days business/policy meetings - Estimate 6 + panel meetings per year (by teleconference)	Up to 10+ hours to review premises reports and submissions	3 -full days for policy meetings	Possibly extra meetings held by teleconference for review of urgent cases	No (Completed by Program Decision Administrator)	Up to 12 hours
Quality Assurance Committee (meets in panels)	Participation in 1-day orientation session Five 1-day Policy meetings 1-day Education meeting Commitment to participate in a minimum of 5-6 additional member specific issue (MSI) meetings per year Methadone Specialty Panel – commitment to attend 4 Methadone specific MSI meetings annually	 9-12 hours for member-specific panel meetings 5-10 hours for MSI	Full Day Half Day – Full Day depending on caseload	Commitment to be available for teleconferences resulting from complex cases (# varies each year). Teleconferences generally scheduled for early morning or end of day. Same	No No	19 hours 15-19 hours
Registration Committee	10 days for MSI and 2 days for policy meetings - 12 panel meetings per year	12-16 hours	1 day	None	No	20 to 24 hours

Committee Chair

Reports to (Title): Council

Administratively to President

Updated: February 2010

Overview:

There are three types of committees that perform the work of the CPSO. These are comprised of statutory committees (i.e., Executive, Complaints, Discipline, Fitness to Practise, Registration, Patient Relations, and Quality Assurance), standing or operational committees (i.e., Education, Methadone, Governance, Outreach, Premises Inspection, and Finance) and ad hoc committees that are created by Council to undertake a particular project on behalf of the College on a time-specific basis. The role of the Committee Chair has some commonly held responsibilities that transcend specific committee mandates.

Chairs must be knowledgeable about the subject matter of the committee they lead and have the expertise necessary to fulfill its mandate. The Chair must understand the purpose of the committee, provide leadership to the committee to achieve its goals in a consistent, efficient, and balanced manner, and organize the committee's work so that action is taken in an orderly and timely manner. The Chair reports the work of the committee to Council and facilitates Council's understanding of this work. All Chairs are responsible for assessing whether their committee members have the resources and training to perform effectively in order to deliver on the mandate of the committee.

Major Responsibilities:

Leadership and Direction of the Committee

- Is knowledgeable and supportive of Council policy, and the work and responsibilities of the committee. Is knowledgeable about the regulatory and statutory obligations of the committee and CPSO.
- Read and become familiar with the College's By-laws and governance policies.
- Where applicable, works collaboratively with the other Chair to accomplish the work of the committee. If the other Chair is a non-Council committee member, they keep him or her informed of Council decisions and changes that occur.
- Adhere to, respect and model behaviour described in the Statement on Public Interest, Council Code of Conduct, Conflict of Interest Policy, Apprehension of Bias Policy and Confidentiality Policy.
- Works with the Committee and College staff to establish, monitor, and execute annual committee goals.
- Prepares for committee meetings by reviewing materials. Works with assigned staff in support of the successful fulfillment of the committee's mandate.

- Conducts meetings in a timely and cost effective manner, and facilitates the meeting process so that all members have the opportunity to participate and accept tasks that best meet their skills and interests.

- Facilitates dialogue at committee meetings in a manner that welcomes all members' perspectives on issues, encourages independent thinking, promotes alignment on decisions that are balanced and demonstrate good judgment for the successful fulfillment of the committee's purpose.

- Manages conflict effectively. When necessary, brings matters to the attention of the Registrar and President.

- Demonstrates cultural sensitivity in policy development, policy implementation, and communications, and personally models behaviours described in the Council's Code of Conduct.

- Obtains appropriate expertise pertinent to the committee's work to provide a synthesis of information that identifies important issues for discussion or requiring action to efficiently expedite the committee's work.

- Understands the relationship of the various activities of the College committees to facilitate decision-making and to provide clarity around responsibility.

- Ensures new committee members understand the purpose and functions of the committee. Helps to facilitate the succession process by working with the Governance Committee to recruit new committee members and subsequent committee Chairs.

- Evaluates the committee's performance of its duties and works to implement improvements to ensure its continued effectiveness. Provides feedback to the Governance Committee on the performance of committee members annually.

- Enforces attendance guidelines with committee members to ensure that if more than three consecutive meetings are missed or if one third of all meetings within the year are missed that a member's continued involvement with the committee is reviewed.

- Ensures that the committee provides feedback to the Governance Committee on the Chair's performance. Participates in self-evaluation with the President to obtain feedback on own and committee's performance.

Collaborative Linkage between the Committee and the College Management Staff

- Works in cooperation with College management and staff to ensure appropriate utilization of College resources in support of the committee's work.

- Works in cooperation with College management in the development of the committee's annual budget to allocate costs and expenses in a fiscally responsible manner.

Key Representative of the Committee

- Is the spokesperson for the committee to Council and within the College and ensures that Council is informed and understands the rationale for decisions made by the committee in the fulfillment of its mandate.

Role Outcomes:

- Uphold policies and standards of the College in the fulfillment of committee duties.
- Decisions comply with appropriate legislation and CPSO policies.
- Reports to the College Council are made, as required, representing committee activities.
- Risk as it relates to the committee's mandate is managed, and Council is alerted to pertinent issues in a timely manner.
- New policies are recommended to the Council, as required.
- Committee members are evaluated to support and promote the improvement of committee effectiveness.
- Interaction with College staff occurs by provision of information regarding the committee's work. Interaction with staff is managed in a respectful, collegial manner.

How far in advance must this position plan/execute its work? (i.e., daily, weekly, monthly, annually or longer)

- Preparation and attendance time is dependent on the nature and tasks of the committee (see Committee descriptions for more details).

Principle Interfaces:

Internal:	Council Committee Chair Committee members College staff Council
External:	Dependent on the mandate of the Committee

Desirable Behavioural Competencies

Key behavioural competencies that are essential for successfully performing this role:

Continuous Learning – Involves taking actions to improve personal capability, and includes the ability to quickly understand and apply information, concepts, and strategies. Demonstrates an interest in continuous personal learning.

Creativity – Is generating new solutions, developing creative approaches and implementing new approaches that lead to improved performance. It requires the ability to anticipate and lead change that contributes to organizational success.

Effective Communication – Is willing and able to see things from another person's perspective. Demonstrates the ability for accurate insight into other people's/group's behaviour and motivation, and responds appropriately. It is the ability to accurately listen, understand, and respond effectively with individuals and groups.

Leadership – Is the ability to take a role as leader of the Council or Committee. Creates strong morale and spirit in his/her team. Shares wins and successes. It includes demonstrating a positive attitude, energy, resilience, stamina and the courage to take risks. Integrity is recognized as a basic trait required.

Planning & Initiative - Recognizes and acts upon present opportunities or addresses problems. Displays effective use of time management skills. Is able to plan and organize workflow and meetings in an efficient manner to address the opportunity or problem.

Relationship Building – Is working to build or maintain ethical relationships or networks of contacts with people who are important in achieving Council-related goals and the College mission.

Results Oriented – Makes specific changes in own work methods or systems to improve performance beyond agreed standards (i.e., does something faster, at lower cost, more efficiently; improves quality, stakeholder satisfaction; revenues; etc.).

Stakeholder Focused – Desires to help or serve others, meets the organization's goals and objectives. It means focusing one's efforts on building relationships, and discovering and meeting the stakeholders' needs. Partnerships between internal colleagues within the College are essential to meet external stakeholders needs.

Strategic Thinking – Understands the implications of decisions and strives to improve organizational performance. It requires an awareness of organizational issues, processes, and outcomes as they impact key stakeholders and the organization's strategic direction.

Teamwork – Demonstrates cooperation within and beyond the Council or the College. Is actively involved and "rolls up sleeves". Supports group decisions, even when different from one's own stated point of view. Is a "good team player", does his/her share of work. Compromises and applies rules flexibly, and adapts tactics to situations or to others' response. Can accept set-backs and change own immediate behaviour or approach to suit the situation. Is candid about opinions and raises justified concerns.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

MEMBER TOPICS

No Meeting Materials

INFORMATION ITEMS

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May 2018

TOPIC: **GOVERNMENT RELATIONS REPORT**

FOR INFORMATION

Items:

1. Ontario's Political Environment
2. Issues of Interest
3. Interactions with Government

ONTARIO'S POLITICAL ENVIRONMENT:

- The provincial election will be held on June 7th.
- Going into the election, and at the time this note was written, the PCs continued to lead in the polls. However, given the broader political environment, the outcome of the June election is far from certain.
- PC Leader Doug Ford will be running for his first seat in the Legislature in the riding of Etobicoke North. The seat has been held by Liberal Shafiq Qaadri since 2003.
- There are 17 new seats up for grabs in the 2018 election due to the redistribution of federal boundaries and two new districts in the far north.
- As of today, 18 incumbent or recently resigned MPPs were not running for re-election. With over 30 seats without an incumbent, this could certainly have an impact on the outcome.

ISSUES OF INTEREST:

- The election comes on the heels of a very busy time for the College in our work with government. This work includes the following:
    - Community Health Facilities (CHF) – Since the passage of Bill 160, work has been underway at the College to ensure that we are ready for the new CHF regime, once

it is up and running. The College has worked closely with government to try and ensure a stream-lined approach to the implementation of this new regime.
- Physician Assistants – The College has been asked by government to put together an implementation plan for the direct oversight of PAs.
- CPSO Governance Review – Following Council's decision in February to proceed with a governance review, information about this review has been shared with government.

Significant work is continues on Bill 87 and public member appointment issues. More information is provided below.

Bill 87, Protecting Patients Act 2017

- Bill 87 received Royal Assent on May 30, 2017. Among other things, it contains a series of amendments to the *Regulated Health Professions Act, 1991* (RHPA) responding partially to the Sexual Abuse Task Force report and the Goudge review.
- Some provisions in the Bill came into effect immediately upon the passage of Bill 87 including the new power to restrict/suspend a member prior to referral, the expanded list of acts to which mandatory revocation applies, and the elimination of gender-based restrictions.
- Other provisions were delayed in terms of enactment and some require the development of regulations.
- In early March, the Ministry of Health posted draft regulations for consultation under the authority contained in Bill 87. These regulations will do the following:
    a) Identify criteria defining who is a patient, for the purposes of sexual abuse;
    b) Specify additional information as the minimum required to be posted on college registers; and
    c) Set out criminal offences that would result in mandatory revocation.
- The College responded in March. The College's response included our intention to put forward a regulation proposal that would extend the Ministry's definition of patient for the purposes of sexual abuse. A separate briefing note details this issue and the proposed regulation.
- The government proclaimed the above-noted regulations along with certain sections of Bill 87 on May 1, 2018.
- Some of the College's suggestions for improving the draft regulations were taken into account in the development of the final regulations. Most notably, one of the College's suggestions regarding the regulation defining who is a patient, for the purposes of sexual abuse was adopted in the final version.
- The regulation defining patient for the purposes of sexual abuse includes three conditions that if met, would exempt an individual from the definition of patient. The draft regulation included an exemption for an individual who receives a health care service from the member in an emergency situation. The College was concerned that there was no exemption for incidental or minor care, making the draft regulation inconsistent with case

law and the College's Physician Treating of Self, Family Members, or Others Close to Them policy.

- The regulation now includes an exemption for the provision of a health care service "in emergency circumstances or in circumstances where the service is minor in nature".
- The recent Bill 87 proclamations include the provisions relating to the above-noted regulations as well as production orders for third party records and guaranteed standing to witnesses who are the subject of these orders and a number of changes relating to the Patient Relations Committee and timing of access to funding and other eligibility requirements.
- The College was given very short notice on the intended proclamation of these sections. Considerable activity is underway to facilitate implementation.
- The College also chairs FHRCO's Bill 87 working group to help support implementation across all health colleges.

Public Member Appointments

- The College continues to identify issues and propose solutions to issues with the public appointment process and system more generally.
- They will be a focus of College interaction with government following the election.
- The current system is unsustainable and that there are significant systemic problems including workload, legislative quorum requirements, and remuneration.

INTERACTIONS WITH GOVERNMENT:

- The College has a well-established and positive relationship with all three parties at Queen's Park.
- Following the election we will work to (re)establish a relationship with the next government and the opposition parties. Given the ongoing issues of shared interest, and the pressing priorities highlighted we anticipate an action-packed summer and Fall.

Contact: Louise Verity, Ext. 466

Date: May 4, 2018

Council Committee Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May 2018

TOPIC: Policy Report

FOR INFORMATION

Updates:

1. College Response to Proposed Regulations under the Health Sector Payment Transparency Act, 2017
2. Policy Consultation Update:
    I. Closing a Medical Practice Draft Policy
3. Policy Status Table

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1. College Response to Proposed Regulations under the *Health Sector Payment Transparency Act, 2017*

- In March 2018, the Ministry of Health and Long-Term Care sought comments on a new regulation proposal to support the implementation of the reporting scheme established under the *Health Sector Payment Transparency Act, 2017* (HSPTA).
- The HSPTA is new legislation intended to strengthen transparency about financial relationships that exist within Ontario's health system and to increase public trust and confidence.
- The HSPTA received Royal Assent on December 12, 2017. Once proclaimed into force, the HSPTA will require the medical industry, including pharmaceutical manufacturers and medical device companies ("payors"), to report annually to the Minister of Health and Long-Term Care all transfers of value (TOV) provided to certain categories of individuals and organizations involved in the health care sector ("recipients").

- The proposed regulation:
    - Specifies the categories of individuals and organizations that will be considered “recipients”: entities who receive a TOV either directly or indirectly from one of the payors listed in the Act;
    - Further specifies what constitutes a TOV;
    - Adds community pharmacies and laboratories to the list of payors[1];
    - Establishes exemptions to the reporting requirements;
    - Sets the value threshold for reporting;
    - Establishes the information, manner and frequency of reporting;
    - Outlines the process for requesting corrections of posted information; and,
    - Sets out record retention requirements.

- The following are included in the list of recipients in the proposed regulation:
    - Member of a health regulatory college;
    - Professional corporations holding a certificate of authorization under the RHPA;
    - Family health team;
    - Independent health facility and community health facility[2];
    - Health regulatory college;
    - Association that advocates for the interest of health care professionals or organizations;
    - A person fulfilling the requirements to become a member of a regulated health profession;
    - Anyone who is a board member[3], director, trustee, officer, appointee, employee or agent of the above; and,
    - An immediate family member of any individual outlined above[4], but not if the TOV is for reasons unrelated to the individual’s role in the health care system.

- The HSPTA defines “transfer of value” as “a transfer of value of any kind and includes a payment, benefit, gift, advantage, perquisite or any other prescribed

[1] Under the HSPTA, the following persons are included as payors for the purposes of the Act if the person provides a TOV to a recipient:
- A manufacturer that sells a medical product (a drug, medical device or any other prescribed product used in the health care system).
- A marketing firm or person who performs activities for the purposes of marketing or promoting a medical product.
- A person who organizes continuing education events for members of a health profession on behalf of a manufacturer described in paragraph 1.
- A prescribed person or entity.

[2] Community health facilities will be a broader category of facilities under the new *Oversight of Health Facilities and Devices Act, 2017*.

[3] E.g., A Public Member on the Council of a health regulatory College.

[4] E.g., The spouse of a physician, CPSO employee, or Council member.

benefit." A payor is required to report transactions that have a dollar value of more than $10 (the prescribed threshold).

- The Executive Committee reviewed a briefing note on this issue at their meeting in March and directed that a response be sent to the Ministry setting out the College's concerns with the proposed regulations. These concerns include implications of the low threshold for reporting and practical/clarifying questions with respect to the record retention requirements and the posting of personal information. The College's response is attached as **Appendix A**.

- Shortly before the response was due, the College learned that the Government was not proceeding to proclaim the HSPTA or regulations and that this work was being put on hold.

- Notwithstanding this fact, the response was submitted to the Ministry in order to have the College's comments on the record.

2. Policy Consultation Update

I. Closing a Medical Practice Draft Policy

- The Practice Management Considerations for Physicians Who Cease to Practise, Take an Extended Leave of Absence or Close Their Practice Due to Relocation policy is currently under review. The policy sets expectations for physicians with respect to the practice management measures they should take before they stop practising or will not be practising for an extended period of time due to retirement, relocation, leave of absence, or as a result of disciplinary action by the College.

- Council considered an updated and newly titled *Closing a Medical Practice* draft policy at its February meeting and approved it for external consultation.

- The College received a total of 100 responses to this consultation (84 physicians, 2 other health care professions, 4 organizations[5], and 1 respondent who selected the "prefer not to say" category. These include 33 comments on the College's online discussion page and 67 online surveys[6]

- All written feedback is posted on our website in keeping with regular consultation processes and posting guidelines. A report of the survey results will be available on the College's website once analysis is complete.

[5] The organizational respondents were the Information and Privacy Commissioner/Ontario, the Canadian Medical Protective Association (CMPA), the Professional Association of Resients of Ontario (PARO), and an un-named medical records storage company.
[6] 67 respondents started the survey, but of these, 3 did not complete any substantive questions. This leaves 64 for analysis.

- Stakeholders provided feedback covering a range of issues pertaining to closing a medical practice. A few of the key themes that have emerged in the consultation are described below.

i. General Comments

- Broadly speaking, there was general support for the draft policy and the expectations that physicians are required to provide notification of a practice closure to patients, colleagues, and the College, and that physicians must take steps to facilitate ongoing access to care.

- However, some respondents raised questions, concerns and provided suggestions for how the draft policy could be clearer and more comprehensive

ii. Specific Comments and Suggestions for Improvement

- **Planning for the unexpected:** Although the majority of respondents indicated their support for physicians taking steps to ensure their medical practice is appropriately managed in the event of an unexpected illness or death, including identifying a designate, a number of questions and concerns were raised about this expectation. A few respondents asked whether the designate would be legally bound to fulfill their role. Some respondents felt that it is too difficult to plan for an unexpected event. Others suggested that the policy include more detailed resources on how physicians could fulfill this expectation.

- **Notification:** The vast majority of respondents supported the general expectations related to notification of a practice closure. However, respondents raised questions and concerns about certain details. For instance, concerns were expressed about operationalizing a 90 day notification period and a few respondents suggested 60 days would be more reasonable. Several respondents were concerned that the expectation to notify patients to whom the physician is actively providing care cast the net too broadly, while others expressed that the focus on “active” patients was too narrow.

- **Facilitating continuity of care:** Although the majority of respondents supported the principles of the draft policy regarding physicians’ role in facilitating continuity of care, several expressed concern with certain aspects of this expectation. A number of respondents pointed to systems issues related to continuity of care and noted that individual physicians should not be responsible for bridging gaps in care due to these systemic issues. Others were concerned that the expectations in the draft policy would result in making physicians take sole responsibility for arranging ongoing care for their patients. It appears these respondents have misread the content of the draft policy, as the draft policy only requires for physicians to take “reasonable steps” to arrange for ongoing care and recognizes that this will not be possible in many circumstances.

- **Differentiating expectations by practice type and setting:** Several comments were made that the draft policy should set out different expectations depending on the practice type (i.e. primary care vs. specialist). Others noted that the practice setting (i.e. group vs. solo practice) should be taken into account.

iii. Next Steps:

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

- Once the draft policy has been revised, it will be presented together with a summary of the consultation feedback, to the Executive Committee and Council for consideration.

3. Policy Status Table

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

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

DECISIONS/DISCUSSION FOR COUNCIL:

For information only

Contact: Andréa Foti, Ext. 387

Date: May 3, 2018

Appendices:

Appendix A: Response to Ministry of Health and Long-Term Care on Proposed Regulations under the *Health Sector Payment Transparency Act, 2017*

Appendix B: Policy Status Table

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Daniel Faulkner, HBSc MBA
Interim Registrar
Executive Office
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April 3, 2018

Ministry of Health and Long-Term Care
8th Floor Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 1R3

Re: Proposed Regulation under the *Health Sector Payment Transparency Act*, 2017

The College of Physicians and Surgeons of Ontario (the "College") appreciates the opportunity to comment on the Ministry of Health and Long-Term Care's proposed regulation under the *Health Sector Payment Transparency Act, 2017* (HSPTA).

The College is strongly supportive of transparency and has been a leader in this regard. We therefore are supportive of this new legislation which is intended to strengthen transparency about financial relationships that exist within Ontario's health care system.

Our response focuses on two areas, the first being the implications of the low threshold for reporting a transfer of value (TOV), and the second being practical and or clarifying questions about the record retention requirements set out in the regulation and the fact that personal information is to be posted on the website.

1. Implications of the Low Threshold for Reporting

The trigger for reporting transfers of value to the Ministry is when the value amount of a transaction is $10 or more. These transactions will be posted on the website in reference to specific recipients, including physicians. In addition, compliance orders will be posted on the website when there are contraventions of the HSPTA or regulation.

The low threshold for reporting as well as the fact that compliance orders with respect to low value transactions will be posted may have unintended consequences. The mere fact that a physician has a number of low value transactions associated with their name may imply that there is some sort of wrongdoing. In addition, compliance orders about recipients may also infer that there is wrongdoing, when all that may have occurred is a recipient forgetting to record a low value transaction.

As Ministry staff have stated, the purpose of publishing this information is to "support transparency for transparency's sake", not to suggest that there is wrongdoing on the part of recipients. Recipients, including physicians, may have not done anything wrong or unethical. As well, one cannot draw conclusions from this information about patient safety and in particular that patient safety is being compromised.

These implications of wrongdoing may give rise to concerns amongst the public and lead to patient complaints and negative media coverage. As you are aware, the College must follow-up on every complaint, even if it is frivolous and vexatious. The College should be using its resources to follow-up on complaints that pertain to the College's mandate of protecting the public from harm. As well, in order to respond to negative media coverage, the College has to use its resources by way of, for example, speaking to the media, drafting responses, etc. Perhaps if more context was provided on the website about the meaning of these type of transactions, the inference of wrongdoing would lessen.

2. Practical/Clarifying Questions

The College would like to ask the Ministry for clarity about two issues. The first pertains to the record requirements set out in the regulation. Given that there is an obligation on recipients (as well as payors and intermediaries) to retain records with respect to transactions, information on how physicians (and other recipients) are to note these transactions is needed. Such detail is particularly needed for transactions where receipts would not normally be generated, such as a meal or a consumable gift, like a bottle of wine. In these instances, is the recipient intended to keep a log, write a memo to file, or some other mechanism?

We also question whether it is even necessary for recipients to have these record retention obligations when the payor also has the same obligations and it is the payor who is responsible for reporting these transactions to the Ministry.

The second issue which requires clarity is with respect to the posting of personal information. The information to be reported to the Ministry about recipients includes personal information. It appears that this personal information would be included on the Ministry website. Publicizing some of this personal information may raise privacy concerns. In particular:

- The information is to include information about the administrative contact for the business who is a party to the transaction (including the person's full legal name, job title, email address and phone number). If the Ministry is collecting this information for its own use to facilitate contacting the recipient, we do not have concerns with this. However, if this information is intended to be posted on the public website, we question the necessity and purpose of making an administrative individual's name and contact information public.

- Where the recipient is an individual, the full legal name of the individual, the name of their employer, job title and business address need to be reported. It seems unnecessary and inappropriate from a privacy perspective to post contact information about individuals on the website. This is particularly the case for those

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

individual recipients who do not have a business address separate from their home address as posting the home address may also raise privacy concerns.

It would be helpful to get clarity as to whether all or only some information reported to the Ministry will be made public. In addition, the Ministry should consider the usefulness to the public, and the necessity of the public to have access to all of this personal information.

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

Yours truly,

Daniel Faulkner, HBSc, MBA
Interim Registrar

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.	This policy is currently under review. The review will be informed by the College's Sexual Abuse Initiative, the Minister of Health and Long-Term Care's Task Force on the Prevention of Sexual Abuse of Patients, and Bill 87, the *Protecting Patients Act, 2017*. 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
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	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. Further information on the consultation results and next steps can be found in the Policy Report contained in your Council materials.	
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. The draft Managing Tests policy will be presented for consideration to consult externally at the May 2018 meeting of Council. For more information please refer to the Continuity of Care entry below.	2018
Continuity of Care	The College does not currently have a policy on *Continuity of Care*.	In May 2016, Council reviewed and discussed a *Continuity of Care Planning and Proposal* document providing analysis and recommendations relating to the development of a new policy. A joint Working Group has been struck to undertake this policy development process alongside the review of the *Test Results Management* policy. The Working Group has developed a 'suite' of draft policies addressing a range of continuity of	2018

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
		care issues. The suite of draft policies will be presented for consideration to consult externally at the May 2018 meeting of Council. Further information can be found in a Briefing Note included in your Council materials.	
Confidentiality of Personal Health Information	This policy sets out physicians' legal and ethical obligations to protect the privacy and confidentiality of patients' personal health information.	This policy is currently under review. Initial stages of the review are underway and a preliminary consultation was held between May and July 2017. A working Group has been struck to assist with the policy review. Further updates with respect to the status of this review will be provided at a future meeting.	2019
Medical Records	This policy sets out the essentials of maintaining medical records.	This policy is currently under review. Initial stages of the review are underway and a preliminary consultation was held between September and December 2017. A working group has been struck to assist with this review. Further updates with respect to the status of this review will be provided at a future meeting.	2019

POLICIES SCHEDULED TO BE REVIEWED

POLICY	TARGET FOR REVIEW	SUMMARY
Disclosure of Harm	2015/16	This policy provides guidance to physicians on disclosing harm to patients. The review of this policy has been deferred, due to competing priorities.
Fetal Ultrasound for Non-Medical Reasons	2015/16	The purpose of this policy is to clarify physician obligations with respect to ordering and performing fetal ultrasounds. The review of this policy has been deferred, due to competing priorities.
Female Genital Cutting (Mutilation)	2016/17	This policy sets out physicians' obligations with respect to female genital cutting/mutilation. The review of this policy has been deferred, due to competing priorities.
Complementary/Alternative Medicine	2016/17	This policy articulates expectations relating to complementary and alternative medicine. 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.

POLICY	TARGET FOR REVIEW	SUMMARY
Criminal Record Screening	2017/18	This policy sets out circumstances in which applicants for certificates of registration and existing physicians are required to submit to a criminal record screen.
Professional Responsibilities in Undergraduate Medical Education	2017/18	This policy sets out the roles and responsibilities of most responsible physicians and supervisors of medical students engaged in undergraduate medical programs.
Medical Expert: Reports and Testimony	2017/18	This policy sets out the College's expectations of physicians who act as medical experts.
Anabolic Steroids, Substances and Methods Prohibited in Sport	2015/16	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). The review of this policy has been deferred, due to competing priorities.
Social Media – Appropriate Use by Physicians (Statement)	2018/19	This document provides guidance to physicians about how to engage in social media while continuing to meet relevant legal and professional obligations.
Providing Physician Services During Job Actions (formerly Withdrawal of Physician Services During Job Actions)	2018/19	This policy sets out the College's expectations of physicians during job actions. Council approved the Providing Physician Services During Job Actions policy at its March 2014 meeting. The policy was posted on the College's website, and published in *Dialogue*, Volume 10, Issue 1, 2014.
Physicians' Relationships with Industry: Practice, Education and Research (formerly Conflict of Interest: Recruitment of Subjects for Research	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

POLICY	TARGET FOR REVIEW	SUMMARY
Studies and MDs Relations with Drug Companies)		published in *Dialogue*, Volume 10, Issue 3, 2014.
Telemedicine	2019/20	The policy sets expectations for physicians using telecommunications technologies to interact with patients in different locations, in actual or stored time.
Marijuana for Medical Purposes	2020/21	The policy sets expectations for physicians relating to the prescribing of dried marijuana for medical purposes.
Professional Obligations and Human Rights	2020/21	The policy articulates physicians' existing legal obligations under the Ontario *Human Rights Code*, and the College's expectation that physicians will respect the fundamental rights of those who seek their medical services.
Consent to Treatment	2020/21	The policy sets out expectations of physicians regarding consent to treatment.
Planning for and Providing Quality End-of-Life Care (formerly Decision-Making for the End of Life)	2020/21	This policy sets out expectations of physicians regarding planning for and providing quality care at the end of life.
Blood Borne Viruses	2020/21	This policy sets expectations with respect to reducing the risk of acquiring or transmitting a blood borne virus, as well as expectations for physicians if they are exposed to a blood borne virus, and lastly, if they are infected with a blood borne virus.
Physician Treatment of Self, Family Members, or Others Close to Them (formerly Treating Self and Family 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.

POLICY	TARGET FOR REVIEW	SUMMARY
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.
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

POLICY	TARGET FOR REVIEW	SUMMARY
		emergencies, and affirms the commitment of the profession to responding to public health emergencies by providing physician services.

Council Briefing Note

May 2018

TOPIC: Physician Assistants

FOR INFORMATION

ISSUE:

- The Minister of Health has directed the College to develop a proposal for the direct oversight of Physician Assistants (**Appendix A**). The Minister directed that this proposal should include the establishment of a new class of members, a PA registry, and any other "innovative" solutions. A response to the Minister was requested no later than April 30th, 2018.

- A draft response to the Minster was reviewed and approved by the Executive Committee at their April 24th meeting. A finalized letter was submitted to the Minister on April 27th, and is included for Council's information (**Appendix B**).

BACKGROUND:

- As Council has received information on PAs at several recent meetings, the extensive background that has previously been included for information is not be reproduced here.

- However; by way of a reminder, all PAs in Ontario work under the supervision of a physician (or physicians), and PAs are permitted to perform controlled acts under medical directives.

- The College's Delegation of Controlled Acts policy sets expectations for physicians about when and how they may delegate controlled acts. Importantly, responsibility for a delegated controlled act always remains with the delegating physician.

- Since the first introduction of PAs in 2006, their oversight mechanism has been the supervisory relationship between the PA and the physician who oversees their clinical practice.

Recent activity

- In March, 2017, the Ministry struck a PA Integration Working Group. The College is included in the Working Group along with practising PAs, the Ontario Chapter of Canadian Association of Physician Assistants (CAPA), physicians involved in working with and training PAs, Government representatives from the Health Workforce Branch, the Negotiations Branch, Health Force Ontario, and LHINs.

- The Working Group's purpose is to support the Ministry in developing and implementing initiatives that improve the integration of PAs into Ontario's health care system for the benefit of patients and the health system.

- The Working Group intends to meet regularly into 2019 with a focus on: clarity of role and accountability for PAs; recruitment and retention of PAs; and funding integration and sustainability.

Letter from the Minister: August, 2017

- In August, 2017, the former Minister of Health, Dr. Eric Hoskins, requested that the College work with the Ministry on an approach to provide appropriate regulatory oversight to PAs.

- In response, the College proposed a phased approach which involved the following:

    1. The development of a resource document for physicians to clarify the application of the Delegation of Controlled Acts policy to PAs; and

    2. The development of a prototype medical directive specific to physician assistants, similar to the *Emergency Department Medical Directives Implementation Kit*, jointly developed by the Ontario Hospital Association, the Ontario Medical Association and the Ministry of Health and Long-Term Care.

- Additionally, the College committed to continued participation on the PA Integration Working Group, and recommend that the Ministry collect comprehensive information about where PAs are practising and their range of activities.

- It was not proposed at this time that the College undertake full regulation of PAs.

CURRENT STATUS:

Letter from the Minister: March, 2018

- A response to the College's letter was received from the current Minister of Health, Dr. Helena Jaczek, in March, 2018 (**Appendix A**).

- In her letter, the Minister expressed doubt that the phased approach recommended by the College would be sufficient to ensure the effective oversight and accountability desired by the Ministry.

- Instead, the Minister directed the College to submit a proposal with an implementation plan for the direct oversight of PAs by the College. It was further directed that this include the establishment of a new class of members, the development of a PA registry, and any other "innovative" solutions.

- A response from the College was requested by April 30, 2018.

College's response

- A draft response was presented to the Executive Committee for consideration in April, where it received final approval. In order to meet the Minister's deadline of April 30th, the final letter was submitted to the Minister on April 27, 2018 (**Appendix B**).

- Given the Minister's direction and stated objective of achieving direct oversight and accountability of PAs, the final response provides key preliminary considerations for full regulation of PAs under the College.

- In particular, the 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;
    - Quality assurance oversight;
    - A professional misconduct regulation;
    - Complaints, reports, disciplinary and fitness to practise oversight;
    - Extensive policy development to articulate professional and ethical standards of practice; and

- Professional liability protection.

- Given the scope of the work that would be involved, the response emphasizes that such an undertaking would take several years, particularly in light of numerous competing priorities at the present time, and require both significant legislative change, as well as broad and ongoing stakeholder collaboration.

CONSIDERATIONS:

- As Council is aware, the issue of PAs has been steadily growing in terms of attention for years, and this request has been expected for some time.

- From a practical and policy perspective, it does not make sense to create a stand-alone College for the limited number of PAs currently in practice (approximately 400).

- The Minister has the authority to require that the College do any number of things, including regulate PAs or potentially another health profession (regulations, legislative authority may be required).

- With the provincial election on the horizon, the College will need the next government and Minister of Health and Long-Term Care to confirm that they wish to proceed prior to committing the considerable time and resources that will be necessary. The College will want to highlight areas of priority and places where we are currently working with government and obtain the government's ongoing commitment to these priorities.

NEXT STEPS:

- Ongoing commitment to regulatory oversight will be sought from the next government and/or new Minister of Health before undertaking additional work.

- Council will be kept apprised of any response from the Minister or further developments on this file.

FOR INFORMATION

Contact: Dan Faulkner, Ext. 228
Louise Verity, Ext. 466

Cameron Thompson, Ext. 246

Date: May 4, 2018

Attachments:

Appendix A: Letter from the Minister (March, 2018)

Appendix B: College Response (April, 2018)

Appendix A

Ministry of Health and Long-Term Care

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Ministère de la Santé et des Soins de longue durée

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Ontario

HLTC2968IT-2018-21

Dr. Steven Bodley
President
College of Physicians and Surgeons of Ontario
80 College Street
Toronto ON M5G 2E2

Dear Dr. Bodley:

Thank you for your letter of December 22, 2017 responding to the then Minister of Health and Long-Term Care's letter of August 18, 2017 in which he asked the College of Physicians and Surgeons of Ontario (the 'College') to work with the Ministry of Health and Long-Term Care (the 'ministry') on an approach to providing appropriate regulatory oversight of physician assistants (PAs).

The College recommends an approach involving an initial phase of work that would include:

- the College clarifying its Delegation Policy in relation to PAs;
- the continued development of prototype medical directives by the ministry's Physician Assistant Integration Working Group; and
- the ministry working to collect current information about where PAs are practicing and delegated acts and activities they perform.

While I agree that these activities would, in part, contribute to a better understanding of how PAs may deliver health care services safely and competently, I am not convinced that these activities alone are sufficient to bring about effective oversight and accountability of PAs practising in Ontario. I believe that the time is right to consider direct oversight of PAs.

To that end, I am requesting that the College develop and submit for my consideration, a proposal with an implementation plan for the direct oversight of PAs by the College. In bringing this proposal forward, I ask that you consider the various accountability frameworks that may be used to achieve that goal. This should include the establishment of a new class of members, the development of a registry upon which

Dr. Bodley

PAs must be enrolled and any other innovative solution that the College may wish to propose.

I ask that you submit the proposal to me no later than April 30, 2018.

Should you have questions, please contact Denise Cole, Assistant Deputy Minister, Health Workforce Planning and Regulatory Affairs Division at Denise.Cole@ontario.ca or at 416-212-7688.

Sincerely,

Dr. Helena Jaczek
Minister

c: Dr. Robert Bell, Deputy Minister, MOHL TC
Denise Cole, Assistant Deputy Minister, Health Workforce Planning and Regulatory Affairs Division, MOHL TC

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

April 27, 2018

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

Dear Minister,

Thank you for your letter of March 8, 2018 regarding Physician Assistants.

In your letter, you indicated that the proposals set out in our December 22, 2017 letter to the former Minister to strengthen the existing accountability framework for PAs do not achieve your objective.

You have asked the CPSO to submit a proposal with an implementation plan for the direct oversight of PAs which includes the establishment of a new class of members, a mandatory registry, and any other "innovative" solutions.

Background

The CPSO has provided feedback and proposals for the oversight of PAs to both HPRAC and the Ministry since PAs were introduced in 2006.

In 2012, the CPSO's submission to HPRAC proposed a number of options for regulation, including the establishment of an interim PA registry.

Subsequent to the Minister's receipt of the HPRAC report and decision to not regulate PAs, but pursue the Registry option, the CPSO had multiple discussions with Ministry staff about a possible PA Registry. It was clear from these discussions that a registry, particularly a voluntary one, was unlikely to achieve the level of oversight desired by the government.

Over this period of time, two primary factors relating to PAs have remained constant. First, PAs are overseen via the model of delegation by the supervisory relationship between the PA and the physician (or physicians) who oversee their clinical practice. Second, there continues to be a relatively small number of PAs in clinical practice (approximately 400).

In addition, the CPSO is aware that the Ministry does not consider full regulation under the *Regulated Health Professions Act, 1991* (RHPA) to be an appropriate model for other unregulated health professions. It is our view that there would be value in applying a consistent model to all of the unregulated professions, including PAs.

Proposal

Given this previous work, we suggest that the creation of a new class of membership and a mandatory registry would not be sufficient in themselves to achieve the direct level of oversight that you have requested. A comprehensive regulatory regime included under the RHPA requires all of the associated regulatory processes, including registration, assessment, and discipline, which assure the public that when they access the registry, they can be confident that the member is safe to practice in Ontario.

Accordingly, the CPSO proposal is that PAs be fully regulated by the CPSO under the RHPA. At this point, we are unaware of any other innovative solutions that would achieve the stated objective of direct oversight and accountability.

Full regulation, in our view, includes the following elements in addition to a new class of members and a mandatory registry:

- A clearly defined scope of practice;
- Title protection;
- Entry to practice (registration) requirements, including out of province requirements and criminal records checks;
- Continuing education requirements;
- Quality assurance oversight;
- A professional misconduct regulation;
- Complaints, reports, disciplinary and fitness to practise oversight;
- Extensive policy development to articulate professional and ethical standards of practice; and
- Professional liability protection.

These elements will ensure that PA regulation is consistent with that of other health care providers, including physicians, from whom PAs currently receive delegation in order to perform their professional activities.

Implementation Plan

The implementation of a full regulatory scheme for PAs, including all of the elements identified above, will be a significant undertaking, requiring the development of a comprehensive project plan, legislative change, and the development of associated regulations, by-laws and policy.

Legislative changes will need to address fundamental questions about the scope of practice of PAs, which requires further discussion and collaboration with multiple stakeholders. In addition, significant internal work will be required in order to integrate a new category of members, including the development of new or significantly modified processes (for example, for practice assessments), IT system changes, website modifications, and governance changes.

The CPSO estimates that the work required to implement a full regulatory scheme for PAs will take several years. More specific estimates can be provided once a timeline for legislative change is established.

It should be noted that this general and preliminary time estimate is reflective of multiple competing priorities at the present time, including the implementation of Bill 160 (*Strengthening Quality and Accountability for Patients Act, 2017*); the implementation of Bill 87 (*Protecting Patients Act, 2017*) along with the development of associated regulations; activities related to fertility oversight; and ongoing activities related to preventing and dealing with the sexual abuse of patients.

Other Issues

Careful consideration of the following issues will be necessary to ensure that the limited number of PAs currently in practice (as few as 400) are able to support the full regulatory infrastructure and processes that are necessary for integration into the CPSO.

- Costs: Physicians in Ontario currently pay an annual registration fee of $1,725 to support the cost of regulation. If incorporated as a fully regulated member under the CPSO, Physician Assistants will also have to bear annual fees, as well as additional costs associated with initial implementation. It is too early to estimate these costs.

- Governance structures: Consideration will also have to be given to the governance structure of the CPSO to incorporate PA members (e.g. Council and committee composition). Any changes to CPSO governance structures will also require legislative change.

Proposed Next Steps

The CPSO has been in contact with the regulatory branch of the MOHLTC on this matter and is pleased to work with the Ministry towards the objective of direct oversight of PAs.

We suggest the creation of a joint MOH/CPSO table, separate from the PA Integration Working Group, with confirmed objectives and an implementation timeline. We see the creation of this table together with the three steps we had identified in our earlier correspondence to the previous Minister as the logical starting point, and would want to see these elements built into any project plan. In the interim, we are also gathering information from other Colleges with relevant experience to help develop and inform this activity.

We anticipate ongoing discussion and collaboration on this file going forward, and look forward to your response.

Yours Truly,

S.C. Bodley MD, FRCPC
President

Daniel Faulkner, HBSc, MBA
Interim Registrar

C:
Dr. Bob Bell, Deputy Minister, Ministry of Health and Long-Term Care
Ms. Denise Cole, Assistant Deputy Minister, Health Workforce Planning & Regulatory Affairs Division, Ministry of Health and Long-Term Care

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May 2018

TOPIC: ***Immunization of School Pupils Act*** **(ISPA): Government Amendments**

FOR INFORMATION

ISSUE:

- The government has recently approved amendments *Immunization of School Pupils Act* (ISPA) and regulations under the ISPA.
- This briefing note will provide a brief overview, focusing specifically on provisions that will impose a new reporting obligation on physicians.
- This item is for information only.

BACKGROUND:

- On May 30, 2017, the *Protecting Patients Act, 2017* received Royal Assent including provisions in Schedule 2 that would amend the ISPA to:
    1. Require mandatory education sessions for parents who request a non-medical exemption – this requirement was effective as of September 1st, 2017.
    2. Require health care providers to report to their local medical officer of health the record(s) of immunizations administered to children that protect against the nine designated diseases in the ISPA.[1]
- Changes were also approved to the regulation under the ISPA to specify the requirements for health care providers to report immunizations. These amendments will come into force on **July 1st, 2018**. Physicians are only required to report immunizations that occur after July 1.
- There are three options for reporting immunizations:

[1] See section 10(1) and (2) of the ISPA, R.S.O. 1990, c.I.1.

1. Submission through Immunization Connect Ontario for Healthcare Providers (ICON HCP). **Physicians must have a One ID account for this option.**[2]
2. Submission through a secure transfer of immunization records from an electronic medical records system that is compatible with the system used by the medical officer of health.
3. Secure transfer of the form, `Health Care Provider Record of Administered Immunization'. The form will be available on the Government of Ontario Central Forms Repository.

- It is important to note that use of the form (option 3) is only permitted if the medical officer of health is of the opinion that there is a technical or administrative reason that prevents submission of the form by the two electronic means listed (options 1 and 2). This means that physicians who wish to use the form cannot do so without first getting permission from a Medical Officer of Health.

- CPSO staff have raised concerns with this approach, and it is our understanding that those concerns have been mirrored by the Medical Officers of Health.

- The intent of the regulation is to encourage physicians to report electronically via ICON HCP and efforts have been made to make this easy to do. For example, physicians will have automatic access to ICON HCP without an additional application or sign in process.

- At the moment, there is no way to easily report from an EMR to ICON. Work is underway at eHealth and OntarioMD to address this problem but timing is not yet clear.

- The regulations were filed on March 29th, 2018 and changes have been integrated into the ISPA and its regulations online. Proclamation of the *ISPA* was published in the Ontario Gazette issue no. 15 as of April 14, 2018.

CURRENT STATUS:

- Ministry staff have been in contact with the CPSO in relation to the implementation of the amendments described above.

- The Ministry has sent communications to the Medical Officers of Health. It has also prepared communications documents for health care providers in both English and French. Those documents are attached as **appendices A** and **B**.

[2] Council members who are not familiar with One ID can find more information on E Health Ontario's website.

- Physician members of Council will also know that the CPSO has worked with eHealth Ontario to streamline the process for physicians to register for OneID. Via the CPSO member portal, physicians can sign up easily for a OneID account with eHealth Ontario.

- An article will be developed for the next issue of Dialogue on the new legislative requirements reminding physicians how to sign up for OneID, a requirement for physicians to fulfill their reporting requirement via ICON HCP.

- The Ministry has committed to putting together a support document to assist CPSO staff, notably those in the Public and Physician Advisory Services Department to respond to any calls they may receive.

- Amendments will be made to the CPSO's *Mandatory and Permissive Reporting* policy to capture this new obligation.

- Policy amendments cannot be made right away; there are a number of new reporting obligations that have been introduced recently and so a more fulsome review of the policy is required. As an interim measure, a statement has been placed on the policy, indicating to physicians that it is not currently up to date and that they should consult relevant statutes directly and obtain assistance from their independent legal counsel.

DECISION FOR COUNCIL:

1. This item is for information only.

Contact: Andréa Foti & Maureen Boon

Date: May 10, 2018

Attachments:
Appendix A: ISPA Communication Product - English
Appendix B: ISPA Communication Product - French

Appendix A

Ministry of Health and Long-Term Care
Population and Public Health Division

New vaccine reporting requirements under the *Immunization of School Pupils Act* (ISPA)

Dear Health Care Provider,

As you may be aware, in May 2017, the *Protecting Patients Act* was passed. As part of this *Act*, amendments were made to the *Immunization of School Pupils Act* (ISPA).

What this means for you:

Starting July 1, 2018, the ISPA, and regulatory amendments under the ISPA, will require health care providers in Ontario to report to the local medical officer of health immunizations administered to all children for the designated diseases that are specified in the ISPA.

The vaccines you will be required to report are for the following diseases: tetanus, diphtheria, pertussis, poliomyelitis, measles, mumps, rubella, varicella and meningococcal disease.

The updated regulation prescribes the information, timelines and the following mechanisms of record transmission for health care provider reporting of ISPA immunizations:

- An online web application, Immunization Connect Ontario for Health Care Providers (ICON HCP), which provides a secure mechanism for health care providers to submit immunization records to their local medical officer of health.
- Submission of immunization records through a compatible electronic medical records system.
- If in the opinion of the local medical officer of health, there is a technical or administrative reason that prevents submission of the report, through a Form entitled “Health Care Provider Record of Administered Immunization” dated May 2018 available through the Government of Ontario Central Forms Repository (available at: www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf?opendatabase&ENV=WWE).

These changes reinforce the Ministry of Health and Long-Term Care’s commitment to *Immunization 2020*, and also support the government’s *Patients First: Action Plan for Health Care* by providing Ontarians the information they need to make informed decisions and enabling a sustainable health care system.

The ministry is working with provincial associations, colleges and organizations, frontline primary care delivery organizations and local public health units (i.e., your vaccine supply source) to assist in preparing for and meeting these new requirements. Additional details will follow, including implementation tools and FAQs.

Ontario

Appendix B

Ministère de la Santé et des Soins de longue durée
Division de la santé de la population et de la santé publique

Nouvelles exigences en matière de déclaration des vaccins en vertu de la *Loi sur l'immunisation des élèves* (LIE)

Cher fournisseur de soins de santé,

Comme vous le savez sans doute, la *Loi de 2017 sur la protection des patients* a été adoptée en mai 2017. En vertu de cette loi, des modifications ont été apportées à la *Loi sur l'immunisation des élèves* (LIE).

Ce que cela signifie pour vous :

À compter du 1er juillet 2018, des modifications réglementaires aux termes de la LIE exigeront des fournisseurs de soins de santé de l'Ontario qu'ils déclarent au médecin-hygiéniste local les vaccins contre les maladies précisées dans la LIE administrés à tous les enfants.

Les vaccins qui devront être déclarés sont ceux qui servent à enrayer les maladies suivantes : le tétanos, la diphtérie, la coqueluche, la poliomyélite, la rougeole, les oreillons, la rubéole, la varicelle et l'infection à méningocoques.

Le règlement modifié indique les renseignements, les calendriers et les mécanismes suivants de transmission des dossiers pour les fournisseurs de soins de santé qui doivent signaler les immunisations au sens de la LIE :

- Une application Web, Connexion immunisations Ontario pour les fournisseurs de soins de santé (CION FSS), qui leur offre un mécanisme fiable de soumission des dossiers d'immunisation au médecin-hygiéniste de leur région.
- Soumission des dossiers dans un système des dossiers médicaux électroniques compatible.
- À compter de mai 2018, le formulaire intitulé « Dossier du fournisseur de soins de santé sur les vaccins administrés » si, de l'avis du médecin-hygiéniste de la région, il y a une raison technique ou administrative qui empêche la présentation du rapport. Ce formulaire sera disponible dans le Répertoire central des formulaires du gouvernement de l'Ontario (à l'adresse suivante : http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/?OpenDatabase&ENV=WWF).

Ces modifications renforcent l'engagement du ministère de la Santé et des Soins de longue durée envers *Vaccination 2020* et soutiennent l'initiative « Priorité aux patients : Plan d'action en matière de soins de santé » du gouvernement de l'Ontario en fournissant aux Ontariennes et Ontariens les renseignements dont ils ont besoin pour prendre des décisions éclairées et en favorisant un système de soins de santé durable.

Le ministère collabore avec les associations, les collèges et les organismes provinciaux, les organismes de prestation de soins primaires de première ligne et les bureaux de santé publique locaux (c'est-à-dire votre source d'approvisionnement en vaccins) pour vous aider à vous préparer à satisfaire ces nouvelles exigences. D'autres précisions suivront, dont les outils de mise en œuvre et une foire aux questions.

Ontario

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May 24th, 2018

TOPIC: **Quality Management Partnership Report: Advancing Quality: Progress on Key Priorities in Colonoscopy, Mammography and Pathology**

FOR INFORMATION

ISSUE:

- This note informs Council about the Quality Management Partnership's (the Partnership) progress report entitled "Advancing Quality: Progress on Key Priorities in Colonoscopy, Mammography and Pathology".

BACKGROUND:

- The Partnership has a goal of improving public confidence through increased accountability and transparency. In support of this goal, in 2015 the Partnership released its inaugural report released "Building on Strong Foundations: Inaugural Report on Quality in Colonoscopy, Mammography and Pathology".
- This goal is aligned with the Patents First: Action Plan for Health Care (2015).
- The inaugural report showed that strong foundations for quality management programs (QMPs) already existed and that there were gaps to be filled in order to ensure consistent high quality care across the province for the three health service areas.
- This progress report builds on the inaugural report by providing an update about the implementation of quality management programs (QMPs) for colonoscopy, mammography and pathology against these specific measures:

    - evidence-based standards, guidelines and indicators;
    - a clinical leadership structure of provincial, regional and facility leads;
    - quality reporting at the provincial, regional and physician levels, and;
    - resources, tools and opportunities to support quality improvement.

CURRENT STATUS:

- The primary audience for this progress report is the health system. It has been distributed electronically to stakeholders including associations such as the OHA, OMA (and pertinent sections), OAG (Ontario Association of Gastroenterologists), OAR (Ontario Association of Radiologists), and OAP (Ontario Association of Pathologists), the Deputy Minister, Dr. Bob Bell and Assistant Deputy Minister, Lynn Guerriero, Ministry of Health and Long-Term Care, and other MOHLTC staff.
- These are stakeholders the Partnership has included in past distributions of reports, many of which are participating in our Partnership governance tables.
- The report is also publicly available on the Partnership's website (qmpontario.ca).
  In addition to reporting on specific measures, the progress report signals that public reporting is being developed with the Citizens Advisory Committee of the Partnership Health Quality Ontario and the MOHLTC.

CONSIDERATIONS:

- The report utilizes non-identifiable, aggregate provincial data to highlight successes and challenges to implementation. It is important to note that data related to colonoscopy and pathology standards is self-reported to the Partnership.
- Some of the colonoscopy standards are very similar to those of the OHPIP and data presented may appear to highlight inconsistencies with expectations of the OHP inspection program. These are a result of standards language not yet aligned between the Partnership and the OHPIP as well the self-report nature of the data. The Partnership is aware of these challenges and has inserted a note about these limitations in Table 5 of the progress report.
- As with the Partnership's inaugural report, the progress report highlights that variation in each of the various existing quality programs continues. As a result, it is evident that some service providers will have had experience reviewing and understanding quality reports while for some this will be a new experience.
- The progress report highlights that key data is not available to OHPs meaning that some quality indicators, such as inadequate bowel preparation, cannot be included in quality management reports to OHPs. The Partnership continues to explore mechanisms to gather this data and provide complete reports to OHPs.
- This progress report provides an important focus on these service areas and supports the need for the Partnership QMPs.

NEXT STEPS:

- The report Advancing Quality: Progress on Key Priorities in Colonoscopy, Mammography and Pathology will continue to be available publicly on the Partnership website (qmpontario.ca).

This is for Information only.

Contact: Robin Reece ext. 396
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Date: May 24th, 2018

Attachments:

Appendix A: Advancing Quality: Progress on Key Priorities in Colonoscopy, Mammography and Pathology

Advancing Quality:

Progress on Key Priorities in Colonoscopy, Mammography and Pathology

2018

Quality Management Partnership

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Ontario
Cancer Care Ontario

Advancing Quality:
Progress on Key Priorities in Colonoscopy, Mammography and Pathology

Published March 2018

Message from the Partnership Executive

The Quality Management Partnership is working to ensure that all Ontarians have access to consistent, high-quality colonoscopy, mammography and pathology services. Working closely with our stakeholders, we have been implementing quality management programs (QMPs) in these three health service areas. A key component of the QMPs is quality reporting, which provides insights into the quality of care at multiple levels: across the province, and by region, facility and physician. Reporting information about performance provides a clearer view of quality across the system and helps identify areas for continuous quality improvement.

This report provides an overview of the quality of colonoscopy, mammography and pathology services in Ontario, based on select measures. It highlights the progress that has been made since QMP implementation began in January 2016. While quality improvements have been made, variation remains in some aspects of quality across the province. Working closely with our stakeholders to reduce this variation, the Partnership can contribute to achieving consistent, high-quality care wherever the care is provided.

The Partnership is committed to improving transparency in the healthcare system, ensuring greater accountability to the public and fostering engagement with key stakeholders, in alignment with Patients First: Action Plan for Health Care (2015). In the coming years, we will continue to enhance the information available publicly in a manner that is meaningful to those who use these three health services.

Achieving our shared goal of improving the quality of care provided to Ontarians requires the collective contributions of everyone involved, including healthcare providers, health system leaders and patients. We thank everyone for their efforts to date and look forward to continuing our work together.

Daniel Faulkner, HBSc, MBA
Interim Registrar,
College of Physicians and
Surgeons of Ontario

Michael Sherar, PhD
President and CEO,
Cancer Care Ontario

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Introduction

Background

On March 28, 2013, the Ministry of Health and Long-Term Care announced the Quality Management Partnership (the Partnership), which brings together Cancer Care Ontario and the College of Physicians and Surgeons of Ontario (CPSO). Since then, the Partnership has been working closely with stakeholders to develop quality management programs (QMPs) for three health service areas: colonoscopy, mammography and pathology.

The Partnership established three goals for the QMPs:

- enhance the quality of care;
- increase the consistency in the quality of care provided across facilities; and
- improve public confidence by increasing accountability and transparency.

The QMPs were designed by three expert advisory panels chaired by three provincial clinical leads, one for each health service area. Panel members included physicians and other health professionals who practice in the health service area, administrators and patients/service users.[1] The panels' recommendations are detailed in the Partnership's report, Provincial Quality Management Programs for Colonoscopy, Mammography and Pathology in Ontario. A subsequent report, Building on Strong Foundations: Inaugural Report on Quality in Colonoscopy, Mammography and Pathology, provided summary information on:

- the health professionals and facilities that provide the three health services in Ontario;
- key provincial quality initiatives that currently exist in each health service area; and
- provincial performance, as measured by standards and indicators recommended by the expert advisory panels, where data are available.

The report referenced above, Building on Strong Foundations: Inaugural Report on Quality in Colonoscopy, Mammography and Pathology, showed that strong foundations for QMPs already exist in Ontario and also revealed gaps that need to be filled to ensure consistent, high-quality services across the province. This report details some of the progress that has been made in implementing QMPs in colonoscopy, mammography and pathology and provides a high-level update on provincial performance for select measures.

1 Many people who have medical procedures – colonoscopy and mammography, in particular – are not sick and are doing so for routine screening purposes only, leading some to argue that "service users" is a more appropriate label than "patients." To address this issue, this report uses the terminology patients/service users to refer to people who use these health services.

Progress on Key Priorities

The Partnership identified four components of a QMP which it has been working to implement. The components are:

- evidence-based standards, guidelines and indicators;
- a clinical leadership structure of provincial, regional and facility leads;
- quality reporting at the physician, facility, regional and provincial levels; and
- resources, tools and opportunities to support quality improvement.

Building on existing quality initiatives wherever possible will help enable success of the QMPs. Accordingly, each QMP has endorsed standards, indicators and guidelines that are recommended or implemented in Ontario and/or in other provincial, national or international programs or organizations. The Partnership works with key stakeholders to ensure that these best practice guidelines and standards are applied to all providers and facilities in Ontario.

The Partnership has established a clinical leadership structure for each of the three health service areas that consists of a network of clinical leads at the provincial, regional and facility levels who provide clinical guidance and oversight to the QMPs. To support their clinical leads, facilities designate QMP executive contacts, and hospitals and community (private) laboratories also select administrative contacts. These contacts have operational accountability for quality within their organizations and assist facility leads by facilitating the implementation of standards and identified quality improvement initiatives.

The Partnership has developed and released reports in order to promote transparency and accountability in the healthcare system. For each health service area, the reports provide an overview of quality measured by select standards and indicators at the facility, regional and provincial levels. Reports are distributed to facility leads and administrative and executive contacts at facilities, as well as to regional clinical leads and administrators in Regional Cancer Programs. Webcasts, teleconferences and written documentation are provided to support recipients in understanding their reports and using them to foster conversations about quality improvement in their facility and region. Physician-level reporting has been initiated for colonoscopy.

The Partnership has been developing resources to assist facility and regionals leads, as well as healthcare professionals and other personnel in facilities, in carrying out quality improvement initiatives. Examples include toolkits, training on providing peer performance feedback, and an online learning management system (LearnQMP) to provide access to relevant resources, foster communities of practice and promote resource sharing. Further supports have been put in place for endoscopists who were receiving physician-level reports from the Partnership for the first time.

The Partnership has continued to engage patients/service users through a variety of channels such as the establishment of a Citizens' Advisory Committee. The committee provides guidance from the patient/service user's perspective on overall design and implementation of the QMPs and specific topics such as patient engagement, patient experience indicators and public reporting. Members of the Citizens' Advisory Committee participate in the three provincial quality committees that the Partnership has set up to provide the QMPs with advice and guidance.

The Partnership recognizes the importance of evaluation and evidence-based program design. As the QMPs are being implemented, evaluation of various activities has been carried out, and the learnings have been used to improve and refine the Partnership's approach. For example, reports have been evaluated to assess, among other things, their reach and usability and were subsequently redesigned based on these findings. The evaluation of Partnership activities, and the Partnership's overall approach to quality and performance management, will be invaluable inputs that will inform future efforts.

Colonoscopy

Background

In Ontario, the majority of colonoscopies are performed by general surgeons and gastroenterologists. Colonoscopies are performed in hospitals and out-of-hospital premises (OHPs); in 2017, 168 facilities provided colonoscopy services in Ontario: 103 hospitals and 65 OHPs.

Progress on Key Priorities

CPSO's Out-of-Hospital Premises Inspection Program has embedded several of the Colonoscopy QMP's standards into its requirements for OHPs. In addition, the Colonoscopy QMP, the Gastrointestinal Endoscopy Quality Based Procedure, and ColonCancerCheck (the provincial colorectal screening program) have a number of standards and indicators in common. These three programs have aligned indicator methodologies, where appropriate, in order to ensure that reports developed by each initiative provide consistent information.

The clinical leadership structure for the Colonoscopy QMP has been established. To ensure alignment, the colonoscopy regional leads are responsible for supporting the Colonoscopy QMP, ColonCancerCheck and the Gastrointestinal Endoscopy Quality Based Procedure in their regions.

The Colonoscopy QMP first released reports at the facility, regional and provincial levels in 2016 to all facilities providing colonoscopy in Ontario. An evaluation of the reports showed that the majority of respondents found the reports useful in describing quality, and many used the reports to have conversations about quality. The evaluation also revealed that some stakeholders felt the amount of information in the reports could be overwhelming. To simplify the reports and help recipients focus their quality improvement efforts, a consultative process that included the Partnership's Citizens' Advisory Committee and the Colonoscopy Provincial Quality Committee was used to identify priority standards and indicators. Updated reports with more recent data, and with priority indicators and standards highlighted, were released in 2017.

A key Partnership milestone was met when the Colonoscopy QMP released physician-level reports in 2017. The QMP reports build on Dr. Jill Tinmouth's randomized controlled trial examining the effectiveness of physician-level audit and feedback reporting in improving colonoscopy quality. The Partnership's release of physician reports is the first time in Ontario that all physicians in a health service area have received a report about their performance from a mandatory provincial program with an established performance management mandate.

For the physician reports, this was operationalized by focusing on processes to support physicians in improving their performance. Regional leads are available to all endoscopists to help them interpret their report. In addition, regional leads actively engage a subset of endoscopists who may benefit from discussing their report and work with them to develop a personal learning plan. Follow up will assess progress on the actions documented in the plan, and the entire approach will be evaluated as it rolls out.

Other colonoscopy-specific quality improvement supports include a resource package created to encourage consistent best practice in the performance of endoscopies and the operation of endoscopy facilities. The content was developed by a clinical working group using a systematic, evidence-informed process and includes guidelines for bowel preparation selection, pre- and post-procedure guidelines and checklists, and standardized discharge guidelines. The resource package is posted on the Partnership website, and relevant elements are referenced in documents that are included in the report release materials.

Key Report Findings

Figure A compares OHP and hospital adherence to three prioritized standards: informing referring physicians of all procedure results, using the global rating scale (GRS) and providing patients with written information at discharge. Overall, performance for the prioritized standards was mixed, with hospitals and OHPs performing similarly; lowest performance was reported for using the GRS. Compared to 2016, facilities performed slightly better on informing physicians of procedure results and using the GRS, and slightly worse on providing patients with written information on discharge (data not shown).

Figure B shows hospital and OHP performance for the two prioritized indicators: inadequate bowel preparation and wait times from positive fecal occult blood test (FOBT) to colonoscopy.[3] The figure shows that performance for these indicators was stable in 2015 compared to the previous year. At a hospital level, the 75th percentile wait time from positive FOBT to colonoscopy ranges from 76 to 104 days, while inadequate bowel preparation ranges from 1.8% to 4.4% (data not shown).

Figure A: Prioritized standards: OHP, hospital and Ontario adherence, 20172

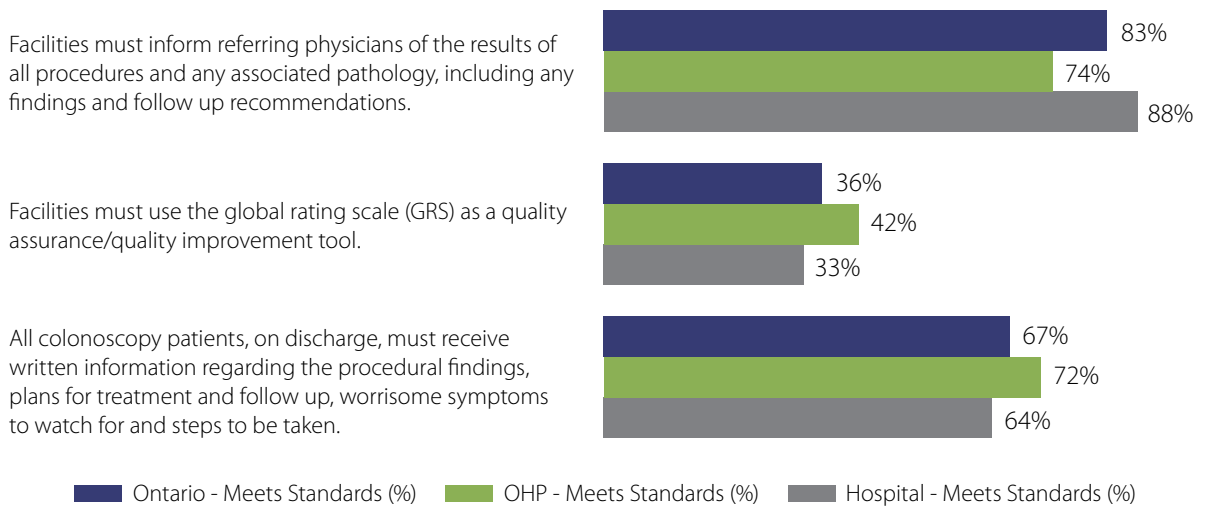


Figure B: Prioritized indicators: OHP, hospital and Ontario performance

Positive FOBT to Colonoscopy Wait Time	014 75th Percentile (Days)	2015 75th Percentile (Days)
Hospital total	79	83
OHP total	63	68
Total	**75**	**78**

Inadequate Bowel Preparation	2015 Indicator Value (%)	2016 Indicator Value (%)
Hospital total	3.3	3.0
OHP total	-	-
Total	**3.3**	**3.0**

2 Data are from a self-report facility survey for which the OHP response rate was 75% and the hospital response rate was 97%. The denominator for each standard is the total number of facilities (not the total number of survey respondents). As well, self-reported data are subject to respondent interpretation and assessment.

3 Inadequate bowel preparation is only reported for hospitals because the data are sourced from the ColonCancerCheck Colonoscopy Interim Reporting Tool which is a hospital-based data collection tool.

Figure C: Prioritized standards: regional summary

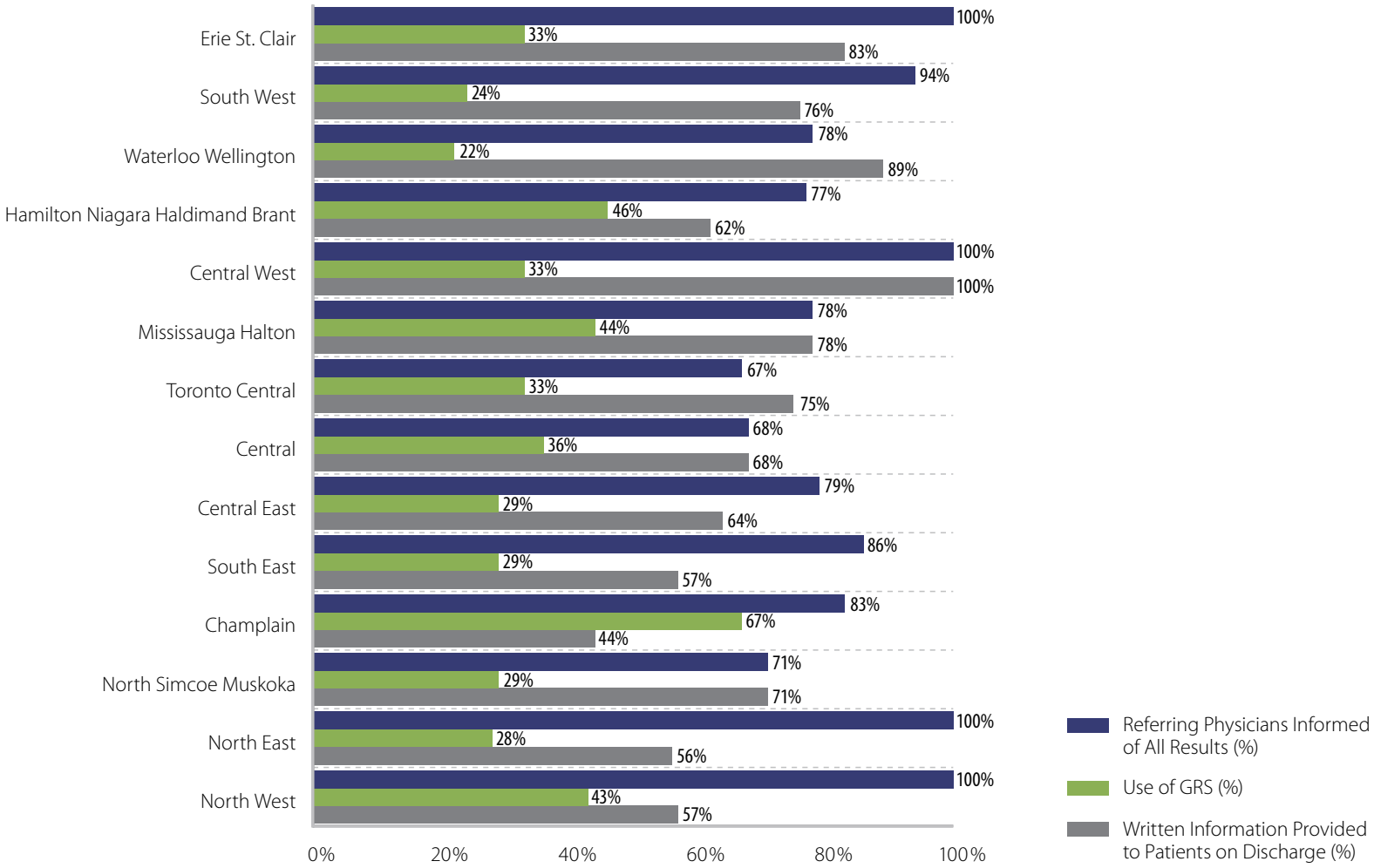
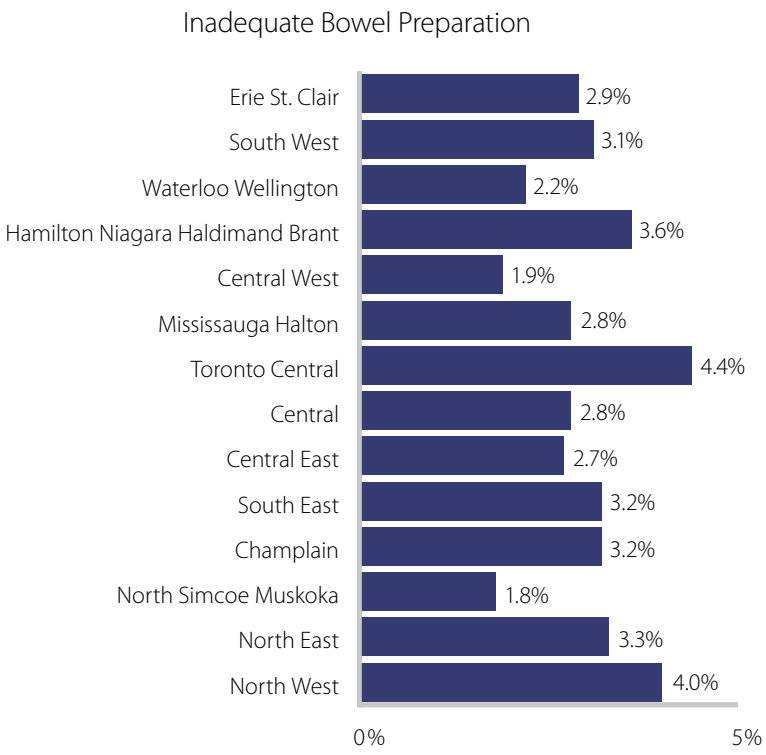
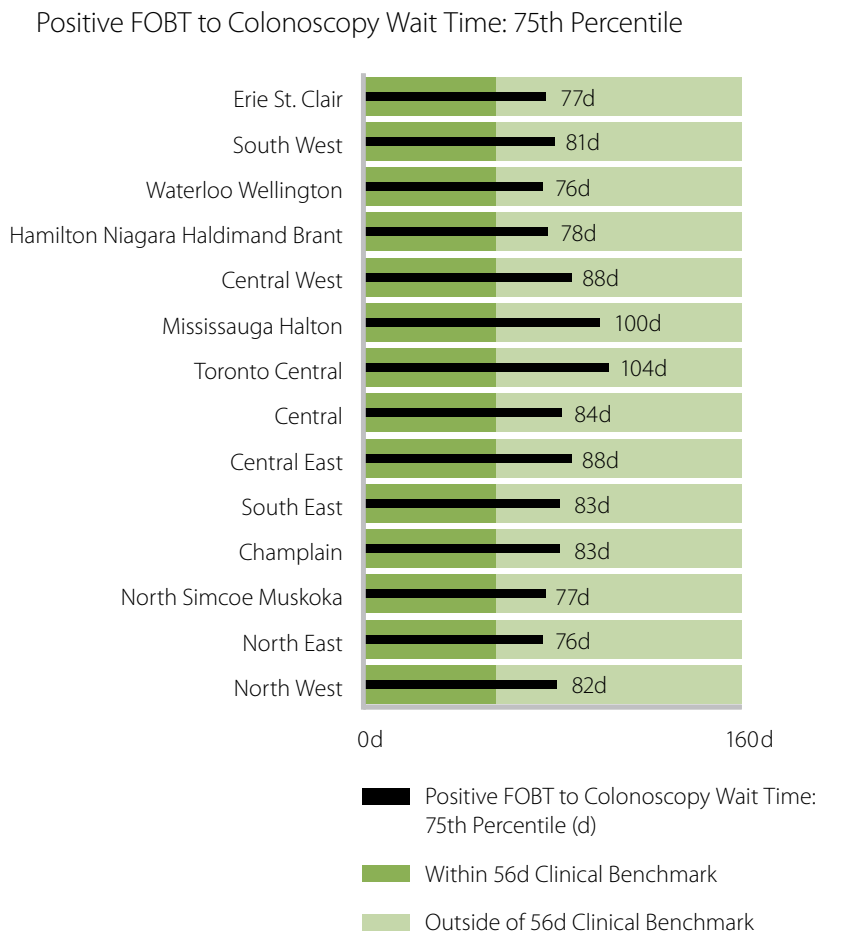


Figure C provides a regional summary of performance on the three prioritized standards (2017 data) and figure D provides a regional summary of performance on two prioritized indicators (2015 data). These figures show that there is substantial regional variation in adherence and performance. Based on the selected standards and indicators shown here, endoscopy performance in Ontario is good. However, there are regional and facility variations that need to be addressed.

Figure D: Prioritized indicators: regional summary





Mammography

Background

In Ontario, mammograms are performed by medical radiation technologists and interpreted by radiologists in hospitals and independent health facilities (IHFs). In 2017, 238 facilities provided mammography services in Ontario: 112 hospitals and 126 IHFs.

Progress on Key Priorities

The Mammography QMP continues to build on the excellent foundation for quality established by the Ontario Breast Screening Program (OBSP), as well as the CPSO's IHF Assessment Program and the Canadian Association of Radiology Mammography Accreditation Program (CAR MAP). The Mammography QMP recommends that all mammography facilities participate in the OBSP and made a number of other recommendations (e.g., that facilities be accredited by CAR MAP) that align with the OBSP and IHF assessment requirements. Like OBSP reports, Mammography QMP reports use established provincial, national and international indicators and targets.

The clinical leadership structure for the Mammography QMP has been established. To ensure alignment and reduce duplication, mammography regional clinical leads are responsible for supporting the Mammography QMP and the OBSP in their regions.

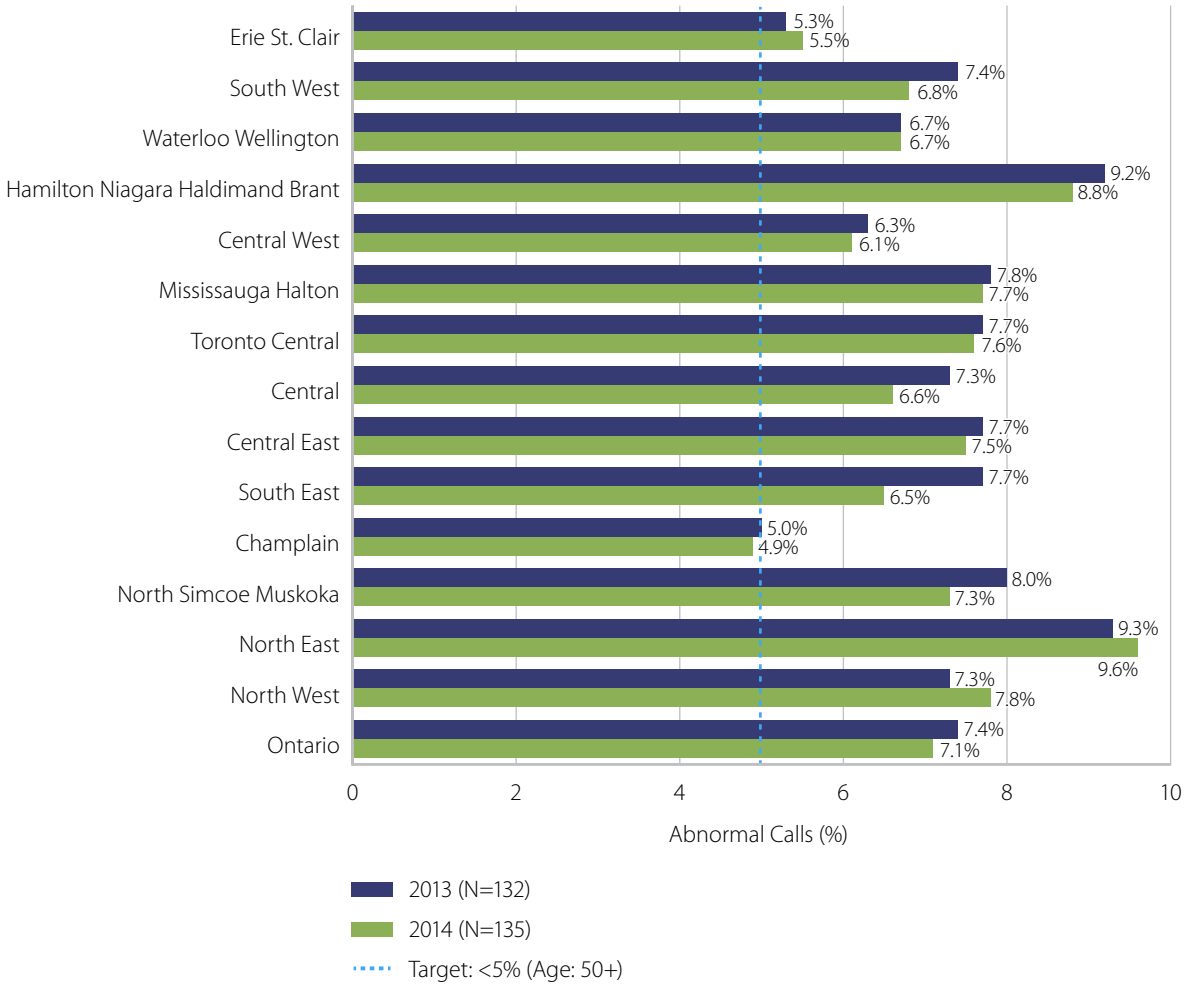
In 2016, the Mammography QMP released reports at the facility, regional and provincial levels that were sent to all facilities providing mammography in Ontario. Updated reports, with more recent data, were released in 2017. A recently completed evaluation found that there was good engagement with Mammography QMP reports, and that approximately half of respondents used the reports to initiate quality improvement activities in their facilities. However, the reports have some limitations. For example, the dataset currently available for mammography reporting is obtained from the OBSP, and it only includes data on women who are screened in the program. To be able to report on all mammography and associated breast imaging, the Mammography QMP has been exploring how to expand data collection beyond the screening program. Data expansion of this scope is a complex undertaking that must be carefully planned and must proceed with stakeholder support. The Mammography QMP has been working with the OBSP to define data needs for both programs and to explore options for data collection modernization and expansion.

The Partnership led an evaluation to determine if Mammography QMP facility leads need additional training, support and/or resources to perform their roles. A project team worked with clinical experts to develop a list of activities that facility leads may be asked to perform and interviewed leads to find out whether they felt prepared to perform these activities. Most participants reported that they felt prepared to perform the activities and identified training and resource needs that could assist them. These findings have provided valuable guidance to the Partnership in developing resources to support facility leads in performing their role.

Key Report Findings

Figure E shows the percentage of OBSP screening mammograms that were identified as abnormal by radiologists in 2013 and 2014. The national target for this indicator is less than five percent for rescreens. Ten regions had an improved (lower) rate in 2014 compared to 2013. At a facility level, of the 129 facilities that had greater than 1,000 rescreens in both years,[4] 26 (20%) met the target in both 2013 and 2014 (data not shown). It is important to note that having abnormal calls higher than the target is not an Ontario-specific phenomenon; abnormal calls have been increasing in all Canadian jurisdictions and frequently exceed the target;[5] the Partnership will work with stakeholders to address this issue in the future. This important quality indicator should be considered in the context of the two other indicators shown here: positive predictive value and invasive cancer detection rate.

Figure E: Abnormal calls for OBSP facilities with greater than 1,000 rescreens: regional summary



4 Data are less reliable for volumes under 1,000.

5 Canadian Partnership Against Cancer. Breast Cancer Screening in Canada: Monitoring and Evaluation of Quality Indicators - Results Report, January 2011 to December 2012. Toronto: Canadian Partnership Against Cancer; 2017.

Figure F shows the positive predictive value, which is the percentage of OBSP screening mammograms with an abnormal result that were diagnosed with breast cancer (ductal carcinoma in situ or invasive breast cancer). The national target for this indicator is equal to or greater than six percent for rescreens. Most regions met the target, and the majority improved in 2014 compared to 2013. At a facility level, of the 129 facilities that had greater than 1,000 rescreens in both years, 75 (58%) met the target in 2013 and 2014 (data not shown). This indicator should be considered alongside the two other indicators shown here: abnormal calls and invasive cancer detection rate.

Figure F: Positive predictive value for OBSP facilities with greater than 1,000 screens: regional summary

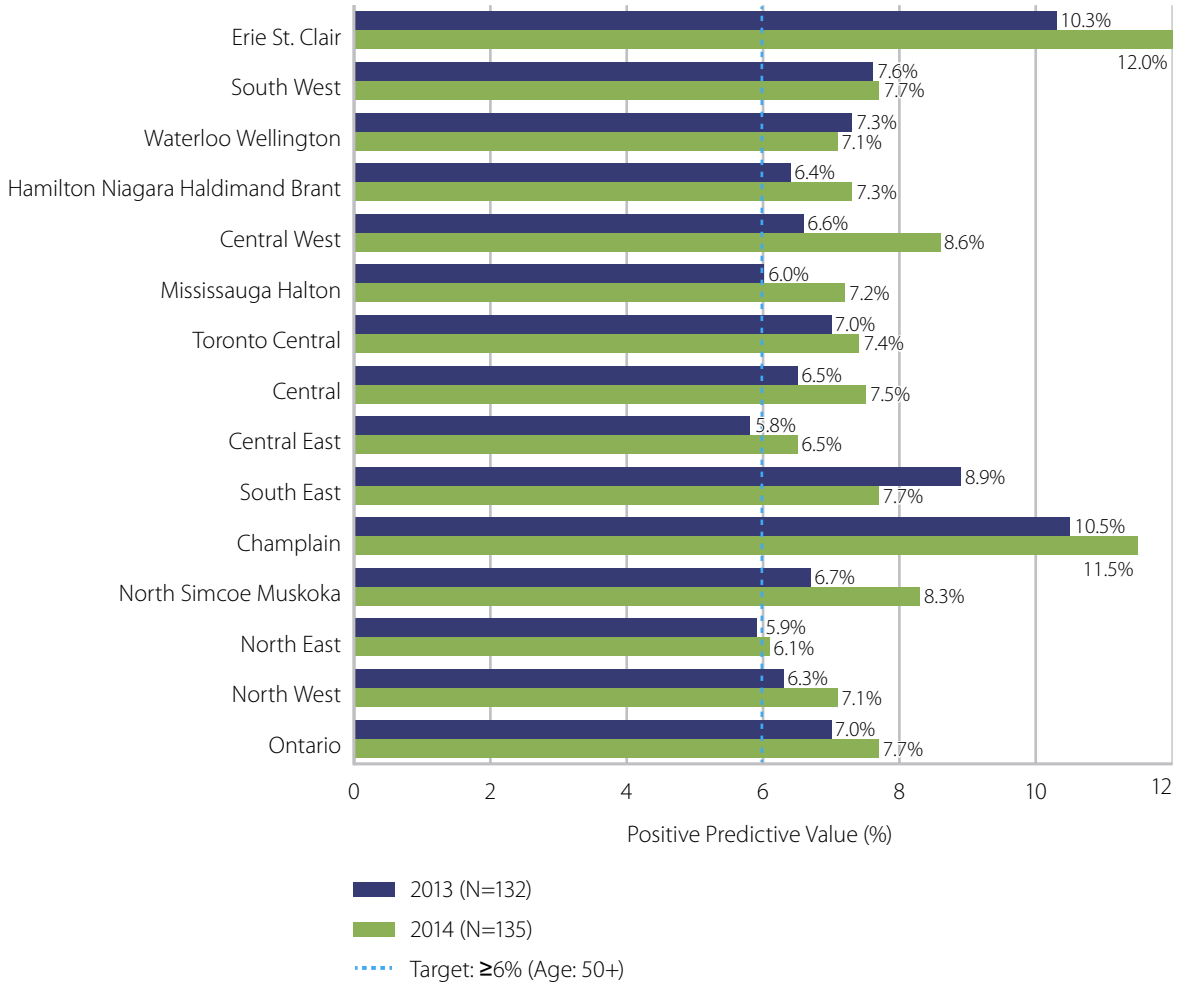
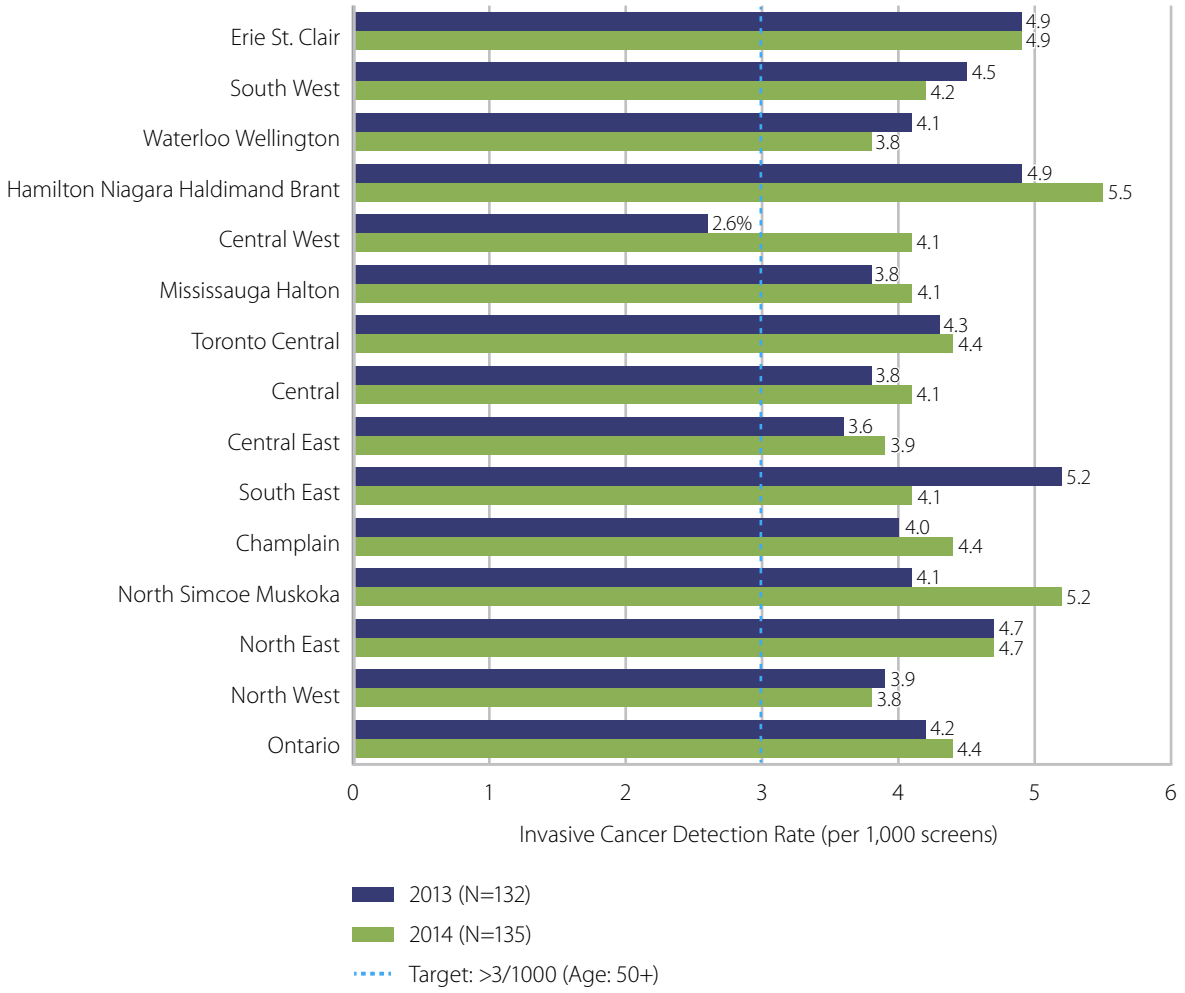


Figure G shows the rate of OBSP screening mammograms with an invasive screen-detected breast cancer per 1,000 mammograms. The national target for this indicator is greater than three per 1,000 rescreens. Most regions met the target, and the majority improved in 2014 compared to 2013. At a facility level, of the 129 facilities that had greater than 1,000 rescreens in both years, 82 (64%) met the target in both 2013 and 2014 (data not shown). This indicator should be looked at in the context of the two other indicators shown here: abnormal calls and positive predictive value.

These figures, taken together, show that the quality of screening mammography in Ontario is good and there are regional variations in outcomes.

Figure G: Invasive cancer detection rate (per 1,000 screens) for OBSP facilities with greater than 1,000 rescreens: regional summary



Pathology

Background

The scope of the Pathology QMP is histopathology (i.e., surgical pathology), which involves the study of tissue samples for diagnostic purposes. In Ontario, diagnostic interpretation of tissue samples is done by anatomical and general pathologists in laboratories. In 2017, histopathology services were provided in 55 facilities: 50 hospitals, four community (private) laboratories and one university-based laboratory.

Progress on Key Priorities

One of the Pathology QMP's core goals is to standardize processes and decrease variability in interpretive pathology practices between laboratories, working closely with existing programs to ensure alignment across initiatives. For example, the Pathology QMP has recommended implementation of 10 prioritized standards that were based on the Standards2Quality Guidelines, developed by the Ontario Medical Association's Section on Laboratory Medicine and the Ontario Association of Pathologists, which detailed the best practice elements of a comprehensive quality management program. In addition, two working groups have been established. One group developed guidance information to assist laboratories in the operationalization of the standards, while the other is working to standardize indicator terminology, definitions and methodology. The Pathology QMP is also participating in an enterprise-wide initiative within Cancer Care Ontario to expand the use of pathology data to include non-cancer data, looking at feasibility, data governance and data quality.

The clinical leadership structure for pathology has been established. Pathology QMP regional leads were newly recruited and also have responsibilities at the facility level, as they are laboratory directors or delegated pathologists who have quality oversight as part of their portfolio.

In 2016, the Pathology QMP released reports at the facility, regional and provincial levels that were sent to all facilities providing surgical pathology in Ontario. These reports were based on self-reported survey data about compliance with the prioritized standards. An evaluation of the reports showed that the majority of respondents found them easy to understand, and many used the reports to contribute to quality improvement plans. Updated reports were released in 2017, and contained the same prioritized standards as the 2016 reports in order to allow comparison over time. The 2017 reports also highlighted self-reported barriers to implementation in facilities that did not have a standard in place. This information was collected in order to help facilities and the Pathology QMP to understand the obstacles facing laboratories in implementing standards.

Preliminary data on challenges related to the uptake of standards and sustainability were also collected, including information on laboratory information systems, decision and administrative support, and workload measurement. The results were not part of the formal 2017 QMP reports, but were summarized in the document *2017 Pathology Quality Management Program Report and Supplementary Data* and were shared with facilities in order to help clinical and administrative leads understand local and regional pressures. They are also being used by the Pathology QMP to learn more about the context in which pathology services are delivered in Ontario.

In 2016, the Pathology QMP developed and released a toolkit of resources to support implementation of the 10 prioritized standards. The toolkit included information taken from Standards2Quality, as well as samples of templates, policies and plans used in Ontario hospital laboratories and community (private) laboratories that have already adopted the standards. The toolkit, which is available on the Partnership's website and LearnQMP, was updated and re-released in June 2017. Other quality initiatives include recommendations about safety aspects of laboratory release of tissue to patients, which were made available to Pathology QMP leads on LearnQMP. Recommendations about opportunities to streamline practices related to tissue handling were also completed.

Key Report Findings

The following figures highlight some of the findings from the 2016 and 2017 reports.

Figure H shows the proportion of Ontario facilities adherent to each of the 10 standards and how this has changed since 2016. There was an increase in self-reported adherence across all 10 standards in 2017.

Figure H: Adherence to prioritized standards, Ontario, 2017

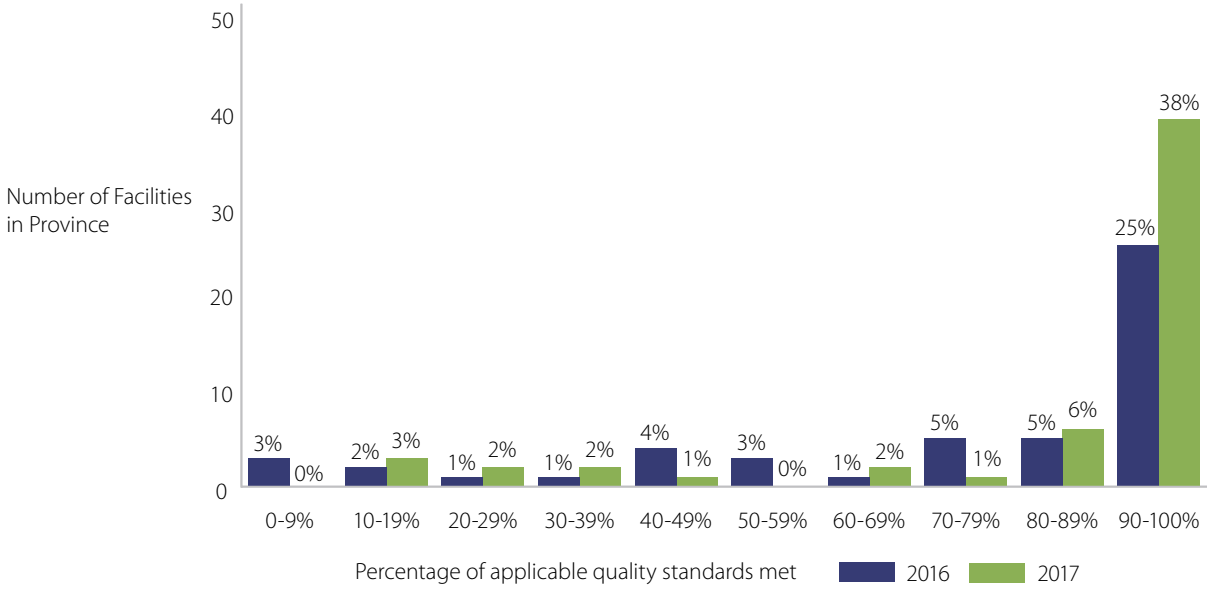
Quality Standard	2017 Adherence to Standards of Facilities Across the Province	Comparison of Adherence: 2016 and 2017
Foundational Elements		
1. Surgical pathology laboratories that have a Pathology Professional Quality Management Committee.	Yes 75%, In Progress 18%, No 7%	2016 64%, 2017 75%
2. Surgical pathology laboratories that have a Pathology Professional Quality Management Plan.	Yes 82%, In Progress 16%, No 2%	2016 58%, 2017 82%
3. Surgical pathology laboratories that have a documented policy for the investigation and/or resolution of report defects/ discrepancies/discordances/errors.	Yes 78%, In Progress 18%, No 4%	2016 72%, 2017 78%
4. Surgical pathology laboratories that have a documented guideline for the classification of report defects/discrepancies/ discordances/errors.	Yes 78%, In Progress 22%, No 0%	2016 70%, 2017 78%
External Review		
5. Surgical pathology laboratories that have a documented policy for handling requests for review of cases by an external source, including the documentation and review of those results.	Yes 78%, In Progress 20%, No 2%	2016 76%, 2017 78%
Intra-operative Consultation		
6. Surgical pathology laboratories that have a documented policy outlining the process and documentation of comparison of intra-operative consultation results with final diagnosis.	Yes 94%, In Progress 6%, No 0%	2016 71%, 2017 94%
7. Surgical pathology laboratories that review data on intra-operative consultation cases with defects/discrepancies/ discordances/errors for the surgical pathology professional group.	Yes 94%, No 6%	2016 80%, 2017 94%
8. Surgical pathology laboratories that review data on deferral rates of intra-operative consultation cases for the surgical pathology professional group.	Yes 81%, No 19%	2016 73%, 2017 81%
Turnaround Times Consultation		
9. Surgical pathology laboratories that have a documented policy which outlines how turnaround times are monitored.	Yes 89%, In Progress 7%, No 4%	2016 78%, 2017 89%
10. Surgical pathology laboratories that review data on turnaround times for the surgical pathology professional group.	Yes 96%, No 4%	2016 92%, 2017 96%

Yes In Progress No 2016 2017

Figure I compares the percentage of overall adherence to the prioritized standards in 2016 and 2017. This figure shows that there has been progress since 2016.

These data show that the majority of pathology laboratories have internal processes in place to ensure high quality and are monitoring data for timeliness and intra-operative consultation discordance and deferral rates.

Figure I: Percentage of prioritized standards met, Ontario, 2016 and 2017



Looking Ahead

This report highlights some of the progress the Partnership has made in implementing QMPs for colonoscopy, mammography and pathology in Ontario. The Partnership would like to acknowledge that this progress would not have been possible without the active engagement of physicians and other health professionals who provide colonoscopy, mammography and pathology services; administrators and executives working in hospitals, community (private) laboratories, university based laboratories, IHFs and OHPs; and Cancer Care Ontario's Regional Cancer Program executives and staff. The Partnership would like to highlight that our progress also reflects, and builds upon, work that is ongoing at the local, regional and provincial levels across the healthcare system to improve performance and quality.

The QMPs are exploring how they can collaborate to move quality forward across health service areas. For example, the Colonoscopy and Pathology QMPs have been developing recommendations around polypectomy clinical history requirements and pathology reporting. The Mammography and Pathology QMPs have begun investigating how to improve breast radiology-pathology correlation through standardized reporting requirements.

Looking forward, the Partnership will continue to release reports for each QMP in order to show where progress is being made and where efforts need to be focused in order to further improve. The Partnership will continue to evaluate and improve reports, and develop tools and supports to assist facility and regionals leads, healthcare professionals and other personnel in facilities, to engage in quality improvement initiatives. Newly developed resources include physician and facility improvement plans and training for regional and facility leads in providing peer feedback. Resources like these will be especially useful as the Partnership moves to include physician-level reporting in all health service areas.

The Partnership is committed to public reporting and working with the Citizens' Advisory Committee and system leaders to develop plans to report publicly. The Citizens' Advisory Committee is actively engaged in identifying what is meaningful to report to the public, and will continue to provide input to the content and design of publicly reported information to ensure it is tailored to users' needs. Ongoing discussions with Health Quality Ontario and the Ministry of Health and Long-Term Care will help ensure an integrated approach to public reporting is taken that allows for the Partnership's publicly reported content to be accessed centrally by the public.

Thank you to everyone who is working with us to improve the consistency of care in colonoscopy, mammography and pathology. We look forward to continuing to work closely with you to achieve consistent, high-quality care in the three health service areas across the province.

This report was developed with the support of Ontario's Ministry of Health and Long-Term Care. The views expressed in this report are those of Cancer Care Ontario, the College of Physicians and Surgeons of Ontario and the Quality Management Partnership and do not necessarily reflect those of the Ministry of Health and Long-Term Care or the Government of Ontario.

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Quality Management Partnership

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Ontario
Cancer Care Ontario

Discipline Committee
Report of Completed Cases – May 2018

This report covers discipline cases completed (i.e., the written decision and reasons on finding and, if applicable, penalty have been released) between February 3, 2018 and May 4, 2018. The decisions are organized according to category, and then listed alphabetically by physician last name.

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Sexual Abuse - 2 cases

1. Dr. J. L. Bingham

Name:	Dr. John Lee Bingham
Practice:	Psychotherapy
Practice Location:	Toronto
Hearing:	Uncontested Facts and Joint Submission on Penalty
Finding/Penalty Decision Date:	January 9, 2018
Written Decision Date:	March 6, 2018

Allegations and Findings

- Sexual abuse of a patient – **proved**
- Disgraceful, dishonourable, or unprofessional conduct – **proved**

Summary

Dr. John Lee Bingham is a family physician who obtained his certificate of registration in Ontario on December 1, 1980. At the material time, he was practising psychotherapy in Toronto.

Patient A

Patient A, a woman in her 30s, saw Dr. Bingham in his office about eight times between July and August of 2016, following the death of her family member earlier in the year. She was having significant problems in her relationship with her partner at the time.

At the first visit, Dr. Bingham asked Patient A if he could give her a hug because she was crying non-stop. Patient A agreed and thought Dr. Bingham was compassionate and seemed professional. Dr. Bingham hugged Patient A, which she described as a non-sexual, platonic hug. Thereafter, Dr. Bingham hugged Patient A after each appointment.

After another visit, which was the last appointment of the day, as Patient A was planning to walk home, Dr. Bingham asked to walk with her. He said he was headed to a store in the same direction Patient A was walking. While walking with Patient A, Dr. Bingham said that he wondered what people would think seeing a pretty young girl like her with him. Patient A found this odd, but thought he was trying to make her feel good about herself. When Patient A and Dr. Bingham got to the store, they hugged as usual, but Dr. Bingham held her longer and closer than before, and then kissed her on the cheek.

Following this, during Patient A's last few appointments, Dr. Bingham asked her to pull her chair close to his and helped her pull the chair over. The chairs were so close their knees were nearly touching.

At the last appointment, while completing paperwork for Patient A's employer, Dr. Bingham patted on Patient A's thigh with his hand while she was wearing shorts and their chairs were moved close together. Dr. Bingham then said he would have to start seeing her every week. When Patient A asked if he had time in his schedule, Dr. Bingham responded that he always had time for her. When Patient A got up to leave, Dr. Bingham pulled her towards him for another hug. He told her he had been thinking about her a lot. He held her more tightly, like a bear hug, so that her body was pressed firmly against his with one of his hands on her lower back tailbone area, just below the waistline. Patient A describes herself as petite. Dr. Bingham is a tall, large man. He began rubbing her back and pressed his face to hers asking if it felt good. He placed Patient A's head on his shoulder. She tried to pull away, but he held onto her arms. Dr. Bingham held Patient A's face close to his, kissed her forehead and cheek, and kept looking at her mouth, which made Patient A feel he wanted to kiss her on the mouth. He said "sometimes two people just click." He said that she was helping him too and that she gave him good feelings. Patient A left the appointment and did not see Dr. Bingham again.

Prior Discipline History

On June 6, 2003, the Discipline Committee found that Dr. Bingham had committed an act of professional misconduct in that he engaged in disgraceful, dishonourable or unprofessional conduct. The conduct was in relation to a 27-year-old psychotherapy patient in 2001. After one of her sessions, Dr. Bingham hugged the patient as she was leaving his office and gave her a kiss on her lips. She did not return for further therapy as a result. Dr. Bingham's certificate of registration was suspended for 6 months, he was ordered to complete the boundaries course and post security by way of letter of credit in the amount of $10,000 to guarantee the payment of any amount the College may pay out in respect of funding for the patient's therapy and counseling.

Between 2001 and 2016, there were no other complaints to the College about Dr. Bingham's behaviour.

Undertaking to Resign

On January 9, 2018, Dr. Bingham entered into an undertaking to the College, by which he has, among other things, resigned his membership with the College and agreed never to apply or re-apply for membership in Ontario or in any other jurisdiction. Had Dr. Bingham not resigned and agreed never to reapply, the College would have been seeking a very significant penalty.

Disposition

In light of the undertaking to resign, the Discipline Committee ordered that:

- Dr. Bingham appear before the panel to be reprimanded.
- Dr. Bingham pay to the College costs in the amount of $5,500 within thirty (30) days

from the date of this Order.

2. Dr. R. A. Kunynetz

Name:	Dr. Rodion Andrew Kunynetz
Practice:	Dermatology
Practice Location:	Aurora
Hearing:	Contested
Finding/Written Decision Date:	March 21, 2017
Penalty/Written Decision Date:	February 20, 2018

Allegations and Findings

- Sexual abuse of a patient – **proved**
- Disgraceful, dishonourable, or unprofessional conduct – **proved**
- Contravened a term, condition or limitation on his certificate of registration - **proved**

Summary

On March 21, 2017, the Discipline Committee found that Dr. Rodion Andrew Kunynetz, committed an act of professional misconduct in that: he engaged in sexual abuse of a patient; 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; and, he contravened a term, condition or limitation on his certificate of registration.

Dr. Kunynetz is a dermatologist.

<u>Sexual Abuse of Patient B by Touching of Breasts</u>

Patient B alleged that during a dermatological examination, Dr. Kunynetz put his hands inside her bra and "fondled" her breasts. He did so after he had examined her legs and had established that she did not have a wheal in response to stroking (a positive Darier's sign), and after she had told him that other physicians had failed to elicit such a finding.

Dr. Kunynetz responded in 2008 after her initial complaint that he merely would have lifted her bra straps to look at the skin underneath. He also said that he might have asked Patient B to lift her breast herself, in order to examine underneath them. He repeated this at the time of his application for judicial review of his interim suspension in 2015. However in testimony at this hearing, he said that he would have stroked each breast, with one hand under her bra, while stabilizing it from beneath with the other hand. His rationale for doing this, he said, was to attempt to elicit Darier's sign.

No justification was provided for the examination of the breasts in urticaria pigmentosa and there was no mention of it in the patient's chart. Moreover the Committee noted that

there was no mention of Darier's sign in the chart, and indeed the first time that this was mentioned by Dr. Kunynetz occurred only after reference had been made to it by a report from an expert in 2015; the expert did not testify in this hearing.
The change in explanation by Dr. Kunynetz, with no clinical notes at the time to support it, provided the Committee with serious doubts about his credibility on this issue. The Committee did not have similar doubts about Patient B's credibility.
The Committee found there is no clinical justification for the touching by Dr. Kunynetz of Patient B's breasts in the manner described by Patient B, which the Committee found did occur. The Committee did not accept as credible Dr. Kunynetz's rationalization for doing so in the circumstances of this case. Therefore, the Committee found that Dr. Kunynetz engaged in sexual abuse in his touching of the breasts of Patient B.

Disgraceful, Dishonourable or Unprofessional Conduct

Removal of clothing of Patients A and D without due warning or consent

Dr. Kunynetz said that he commonly moved or shifted items of clothing such as bra straps to view the skin beneath, or lifted clothing that obscured a portion of the skin that needed to be inspected. He said that he usually gave the patient a reason for this, but he also admitted that his explanations were brief and often occurred during the displacement of clothing. The Committee concluded that the removal of clothing occurred during the process of a clinical examination, and that Dr. Kunynetz was justified in needing to examine the skin underneath the clothing.
The material that had been provided to Dr. Kunynetz by the College investigator emphasized the importance of explaining to a patient ahead of time the nature and reason for any portion of a physical examination. While this may not constitute formal seeking of consent in the way in which this term is usually used, the process of explanation demands that the physician take reasonable steps to ensure that the patient comprehends why something is being done, particularly if the actions are relevant to, or involve, sensitive parts of the body. This was clearly not done before the shifting of clothing performed by Dr. Kunynetz.
The Committee finds that the absence of adequate warning or explanation to Patients A and D by Dr. Kunynetz before moving or removing their clothing, constitutes conduct that would be reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

Physical contact between Dr. Kunynetz's lower abdomen and Patients C and D without warning, apology or excuse

Two of the complainants (Patients C and D) testified that Dr. Kunynetz pressed himself against their legs in such a way that they could feel his penis pressing against them. Of the three similar fact witnesses, two alleged that they felt Dr. Kunynetz's penis pressing against them, and one could feel his testicles pressing against her legs.
The events described by the patients were, in some respects, similar, and in other respects, dissimilar as outlined in the Committee's decision and reasons. There were

inconsistencies in their individual testimonies, both between statements made on examination-in-chief and those made in response to cross-examination, and between statements made earlier to College investigators and those made at the hearing. These inconsistencies related to events or descriptions that would reasonably be less consequential to an observer (such as the lay-out and furnishing of the examination rooms, the precise wording used by them or by Dr. Kunynetz, or the exact timing - to the second - of the contact with Dr. Kunynetz). Similarly, memories of the dates of appointments, or the number of appointments with Dr. Kunynetz, and even at which of three appointments the alleged contact occurred, were variable. What remained consistent even under vigorous cross examination were the details and the certitude with which they expressed their experience of unwanted contact.

Dr. Kunynetz's response to the allegations was two-fold. First, he vehemently denied that he ever had or would deliberately push his genitalia against a female patient, and second, that he could not physically do so, even by accident because of his size, and in particular, the presence of a “pannus” or fat apron, which would be interposed between his genitalia and the patients legs, and thus prevent his penis being felt in the way it was described by the complainants.

In support of this defence, Dr. Kunynetz submitted photographic evidence and underwent two examinations by experts in urology, who provided opinion evidence about the possibility (or impossibility) of the complainants having felt Dr. Kunynetz's penis. The Committee concluded that the impossibility of contact, between the doctor's penis and a patients skin (through clothing), was not established.

After reviewing the totality of the evidence, the Committee found that there had been contact between the patients and that part of Dr. Kunynetz's lower abdomen at the level of his pelvis, and that the patients were distressed by this. The Committee did not find on the evidence that there was intentional touching of Dr. Kunynetz’s genitalia against the body of Patients C and D.

However, the Committee remained concerned that there was contact between a portion of Dr. Kunynetz body, in the area of his large abdominal panniculus, or abdominal fat pad, and this contact was not accompanied by any form of warning, apology or excuse. The Committee was of the view that a reasonable physician would make every attempt to ensure that this did not occur, and that failure to make such attempts or to apologize if it occurred accidentally, or incidentally, represented an unacceptable level of insensitivity on the part of Dr. Kunynetz, without care or concern for the patients.

Therefore, the Committee found that the contact which occurred between Dr. Kunynetz and Patients C and D was conduct that, having regard to all the circumstances, would be reasonably regarded by members as disgraceful, dishonourable or unprofessional.

Contravened a Term, Condition and Limitation

The allegation that Dr. Kunynetz contravened a term, condition or limitation on his certificate of registration arose from Dr. Kunynetz seeing two female patients without the presence of a chaperone, after he had signed an undertaking to see female patients only in the presence of a chaperone. Dr. Kunynetz defence of the breach of the undertaking was that it was an unintentional, non-deliberate lapse occasioned by his focusing on the patients' problems, and also by the failure of the system that he had put in place to ensure such lapses did not occur.

Dr. Kunynetz admitted that he saw and provided advice to two female patients after he had executed an undertaking to only see such patients in the presence of an approved chaperone. While the Committee accepted that this was not a premeditated or deliberate flouting of the College's authority, the Committee found that Dr. Kunynetz's explanation that his staff neglected to place a blank sheet of paper on the door of the examination room (in one instance) was both an inadequate and ingenuous excuse. Dr. Kunynetz's point that he adhered to the undertaking in some 700 patients was given as mitigation; however it can equally be viewed as evidence that Dr. Kunynetz was very aware of the conditions expected by the College. The Committee found that Dr. Kunynetz contravened a term, condition and limitation on his certificate of registration in respect of two breaches of his undertaking to the College to see female patients only in the presence of a chaperone.

Disposition

On February 20, 2018, the Committee ordered and directed that:

- the Registrar revoke Dr. Kunynetz's certificate of registration, effective immediately.
- Dr. Kunynetz reimburse the College for funding provided to patients under the program required under Section 85.7 of the Code, and to post an irrevocable letter of credit or other security acceptable to the College to guarantee payments of such amounts within thirty (30) days of the date this order becomes final, in the amount of $16,060.00.
- Dr. Kunynetz appear before the panel to be reprimanded within thirty (30) days of this Order becoming final.
- Dr. Kunynetz pay to the College costs of the hearing in the amount of $145,460.00, within six (6) months of this Order becoming final.

Appeal

On April, 20, 2017, Dr. Kunynetz appealed the decision of the Discipline Committee to the Superior Court of Justice (Divisional Court).

On March 21, 2018, Dr. Kunynetz appealed the decision on penalty, on costs, and certain motion orders of the Discipline Committee to the Superior Court of Justice (Divisional Court).

Pursuant to s. 71 of the Code, the Discipline Committee's decision remains in effect despite the appeal.

Incompetence - 3 cases

1. Dr. I. K. Shiozaki

Name:	Dr. Ian Kent Shiozaki
Practice:	Family Medicine
Practice Location:	Newboro
Hearing:	Agreed Facts and Joint Submission on Penalty
Finding/Penalty Decision Date:	March 12, 2018
Written Decision Date:	March 21, 2018

Allegations and Findings

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

Summary

Dr. Shiozaki is a general practitioner who, at the relevant time, practiced family medicine in Newboro, Ontario. On October 22, 2015, the College received information from a physician about a mutual elderly patient regarding the dosages of a stimulant prescribed by Dr. Shiozaki. On the basis of this and other information, the College commenced an investigation under section 75(1)(a) of the Health Professions Procedural Code to obtain a broader view of Dr. Shiozaki's general medicine practice, including his prescribing. In February 2016, the College received information from the Ministry of Health and Long-Term Care's Narcotics Monitoring System regarding Dr. Shiozaki's prescribing of controlled drugs, including narcotics, from January 1, 2015 to December 31, 2015 (the "NMS data").

The College retained a specialist in family medicine to provide an opinion on Dr. Shiozaki's general medicine practice, including his prescribing. The family medicine specialist reviewed 25 patient charts, the NMS data and interviewed Dr. Shiozaki on two occasions. In his interview with the family medicine specialist, Dr. Shiozaki described himself as having a special interest in pain management and stated that he received pain consultations from other physicians.

The family medicine specialist identified significant concerns in Dr. Shiozaki's care and treatment of his patients' chronic non-cancer pain, particularly in the areas of a) prescribing of controlled drugs, including narcotics, and b) injecting of opioids, and associated storage and disposal of injectable opioids. The concerns identified by the

specialist included the following:

- Prescribing of controlled drugs, including narcotics:
    - Large numbers of pills/patches were frequently prescribed at a time.
    - Opioids were often titrated rapidly and titrations were frequently done on the basis of a patient's self-escalation.
    - Many opioids were prescribed at unconventional and very off-label dosing intervals.
    - Transdermal opioids were frequently directed to be placed in off-label locations, such as on the location of the pain.
    - Opioids were often blended; many cases involved blending 3 opioids.
        - High doses of opioids were frequently used, even for conditions where opioids were not recommended per the 2010 Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain.
        - Some of the patients on high dose opioid therapy were likely suffering from opioid-induced hyperalgesia.
        - Many patients were on long-term benzodiazepine therapy in addition to high dose opioid therapy (± sleep apnea).
        - Many patients in the charts reviewed exhibited aberrant drug-related behaviour; Dr. Shiozaki consistently continued to prescribe and increase dosages of opioids, and failed to refer patients to other pain or addiction resources, in the face of:
            - repeated patient requests for early releases and renewals (medications "stolen", "lost", "dropped down sink", "going away", etc.);
            - inconsistent urine drug screens (UDS positive for non-prescribed opioids and/or negative for opioids prescribed by Dr. Shiozaki, indicating potential binging or diversion);
            - inadvertent opioid intoxication and overdose;
            - alerts from other professionals (pharmacists and other physicians) regarding patients and the medications prescribed Dr. Shiozaki.
        - Amphetamines were frequently prescribed for "fibro fog, fatigue, energy…"; these patients were often on high-dose opioid therapy and sometimes also using significant amounts of sleep aids.

- Injection of opioids, and associated storage and disposal of injectable opioids:
    - Dr. Shiozaki performed many injections/injection techniques for his patients. Opioids were injected, in the office, into knees, the SI joint, piriformis and even trochanteric areas.
    - In one patient, Dr. Shiozaki injected an opioid (Demerol) into a patient's artificial knee joint which is very unusual and exposed the patient to a risk of infection of the prosthesis.
    - Patients' injectable opioids were stored in Dr. Shiozaki's office in a hollowed out "book". This was not locked. Dr. Shiozaki had previously had a safe in his office for storing opioids; that safe was stolen.
    - Dr. Shiozaki 'shared' patients' injectable opioids between patients when needed.

- Dr. Shiozaki disposed of some opioids in his office (e.g. down the sink).

The family medicine specialist opined that Dr. Shiozaki failed to meet the standard of practice of the profession and that he demonstrated a lack of knowledge, skill and/or judgment in his prescribing of controlled drugs, including narcotics, and, in some cases, his injecting of opioids and associated storage and disposal of injectable opioids, in all 25 patient charts reviewed.

In addition to the concerns identified about Dr. Shiozaki's treatment of pain, the family medicine specialist identified other concerns about Dr. Shiozaki's general medicine practice in 11 of the 25 charts reviewed, including a failure to offer or document age-specific preventive screening and a failure to adequately treat and monitor certain conditions.

Report of College's Pain Medicine Expert

Given the information obtained in the investigation about Dr. Shiozaki's performing injections in his office, the College retained a pain medicine expert to provide an opinion about whether certain injections performed by Dr. Shiozaki were of a nature that they could only be performed in a licensed Out-of-Hospital Premises.

The pain medicine expert reviewed 5 patient charts, and attended at Dr. Shiozaki's office on December 2, 2016, where he toured the clinic, reviewed equipment and interviewed Dr. Shiozaki as to the variety of injections that he performed. Dr. Shiozaki advised the pain medicine expert that he had not performed nerve block injections since the Out-Of-Hospital Premises program was implemented.

In his report, the pain medicine expert took issue with one of the injection procedures conducted by Dr. Shiozaki and concluded that *"Dr. Shiozaki is performing nerve blocks in the form of SI joint injections […] This is a Level 1 nerve block procedure under the OHP guidelines."*

Level 1 nerve block procedures may only be performed in authorized Out-Of-Hospital Premises. Dr. Shiozaki's office was not an authorized Out-Of-Hospital Premises. Dr. Shiozaki applied to the College in 2010 to have his office authorized as an Out-Of-Hospital Premises because he was performing nerve blocks. He elected not to proceed with the application after learning what was required to obtain authorization to operate an Out-Of-Hospital Premises and advised a College investigator at that time that he was no longer performing nerve blocks.

The pain medicine expert identified concerns with Dr. Shiozaki's clinic's preparedness for medical emergencies given that Dr. Shiozaki was performing Level 1 nerve block procedures, and opined that, in the 5 charts that he reviewed, Dr. Shiozaki's procedural notes fell below the standard of practice of the profession and that Dr. Shiozaki demonstrated a lack of knowledge on the safe storage of opioids, specifically injectable Demerol.

Interim Undertaking

By letter dated February 1, 2017, Dr. Shiozaki responded to the reports of the family medicine specialist and the pain medicine expert retained by the College. In that letter, he stated that he had not been aware that SI joint injections were nerve blocks pursuant to the OHP Guidelines and that he had ceased to perform them. He proposed to enter into an Undertaking to cease prescribing Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines and Other Targeted Substances and Monitored Drugs, and to cease injecting opioids. He also provided a list of injections that he proposed to continue to perform.

In support of his proposal, Dr. Shiozaki provided the College with the report an anesthesiologist and pain medicine specialist, who reviewed the same charts as the family medicine specialist and the pain medicine expert. The anesthesiologist and pain medicine specialist's report noted that she "did concur with some of the concerns expressed by the [family medicine specialist and pain medicine expert retained by the College]." She also opined that she had "no concerns" with Dr. Shiozaki's proposal to continue to perform certain types of injections not requiring OHP facilities and that, in her view, he is "competent and capable" to perform them.

Dr. Shiozaki also provided the College with a report dated March 17, 2017 of a family medicine and emergency medicine specialist, who reviewed the 11 patient charts in which the family medicine specialist retained by the College identified other concerns about Dr. Shiozaki's general medicine practice. The family /emergency medicine specialist noted in his report that Dr. Shiozaki has a challenging patient population and, as an isolated rural family physician in a small community, he has limited ancillary resources to assist him with the management of his patients.

On April 3, 2017, following the referral of the allegations in this matter to the Discipline Committee, Dr. Shiozaki voluntarily entered into an Undertaking in lieu of an Order pursuant to s. 37 of the Code (the "Section 37 Undertaking"). The Section 37 Undertaking provides that Dr. Shiozaki shall not prescribe Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines and Other Targeted Substances and Monitored Drugs. In addition, Dr. Shiozaki undertook to cease to provide injections except as expressly provided.

Prior Discipline Committee Findings

On May 31, 2014, the Discipline Committee found that Dr. Shiozaki had committed an act of professional misconduct in that he had engaged in an act or omission relevant to the practice of medicine that, having regard to all of the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional. In particular, Dr. Shiozaki admitted that he had engaged in numerous boundary violations with a patient, including kissing her on the lips and breasts, putting his hand in her pants, and lying on top of her.

The Discipline Committee ordered that Dr. Shiozaki's certificate of registration be suspended for six months, three months of which would be suspended provided that Dr. Shiozaki completed a Boundaries course.

Other Relevant College History

In May 2008, in response to a complaint from a patient of Dr. Shiozaki's regarding Dr. Shiozaki's recommendation of an investment opportunity, the Inquiries, Complaints and Reports Committee of the College (the "ICRC") directed Dr. Shiozaki to attend to be cautioned in person about his conduct and the perception of a conflict of interest in the circumstances.

In April 2012, in response to information from two physicians detailing concerns about Dr. Shiozaki's prescribing of opioids, the ICRC conducted an investigation. The ICRC counselled Dr. Shiozaki to use supportive resources such as the 2010 Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain and to consider other non-medicinal modalities for the treatment of chronic pain.

Cooperation in the matter at hand

Dr. Shiozaki cooperated with the College at all times in its investigation of the matter at hand.

Disposition

The Discipline Committee ordered and directed that:

- the Registrar suspend Dr. Shiozaki's certificate of registration for a period of six (6) months, commencing on March 12, 2018 at 11:59 p.m.
- the Registrar impose the following terms, conditions and limitations on Dr. Shiozaki's certificate of registration:

Restrictions on prescribing and injections

- Dr. Shiozaki shall not issue new prescriptions or renew existing prescriptions for or administer any of the following substances:
    - 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 Part G of the *Food and Drug Regulations* under the *Food and Drugs Act*, S.C., 1985, c. F-27);
    - Benzoiazepines 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 (A summary of the above-named drugs [from Appendix I to the Compendium of Pharmaceuticals and Specialties] is attached hereto as Schedule "A"; and the current regulatory

lists are attached hereto as Schedule "B");
- All other Monitored Drugs (as defined under the Narcotics Safety and Awareness Act, 2010, S.O. 2010, c. 22 as noted in Schedule "C"); and as amended from time to time.

- Dr. Shiozaki shall not perform any injections except as expressly provided below.
- Dr. Shiozaki may perform the following injections with the following substances:
  - Permitted injections:
    - Pre-skin biopsy and other freezing injections such as sutures;
    - Intramuscular Botox injection therapy for treatment of chronic migraine;
    - Trigger point injections;
    - Ligament injections;
    - Tendon sheath injections;
    - Bursa injections (excluding the sacroiliac bursa);
    - Flu shot, tetanus shot, and other general primary care immunization injections.
  - Permitted substances to be injected:
    - Xylocaine (Lidocaine);
    - Durolane/Synvisc (Hyaluronan);
    - Marcaine (Bupivacaine);
    - Botox (Botulism toxin);
    - Kenalog (Triamcinolone);
    - Saline; and
    - Substances related to the injections permitted in sub-paragraph i. 7.
- Dr. Shiozaki 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 at Schedule "D". For further clarity, this sign shall state as follows:

IMPORTANT NOTICE
Dr. Shiozaki will not prescribe or administer any of the following:
- Narcotic Drugs
- Narcotic Preparations
- Controlled Drugs
- Benzodiazepines and Other Targeted Substances
- All other Monitored Drugs

Dr. Shiozaki will not perform any injections except as expressly provided by the Order of the Discipline Committee of the College of Physicians and Surgeons of Ontario dated March 12, 2018.
Further information may be found on the College of Physicians and Surgeons of Ontario website at www.cpso.on.ca

- Dr. Shiozaki shall post a certified translation(s) in any language(s) in which he provide services, of the sign described in paragraph 6(iv) above in all waiting rooms, examination rooms and consulting rooms, in all of his Practice Locations, in a clearly visible and secure location.
- Dr. Shiozaki shall provide the certified translation(s) described in paragraph 6(v) above, to the College within thirty (30) days of this Order.

- Should Dr. Shiozaki elect to provide services in any other language(s), he must notify the College prior to providing any such services.
- Dr. Shiozaki shall provide to the College the certified translation(s) described in paragraph 6(vi) prior to beginning to provide services in the language(s) described in paragraph 6(vii).

Injection observation day in hospital-based pain clinic

- Within three (3) months of resuming practice after the period of suspension of his certificate of registration, Dr. Shiozaki shall spend a day observing injections performed by a physician mentor who is an anesthesiologist and who specializes in pain management (the "Physician Mentor"). The observation shall take place in a hospital-based pain clinic and shall focus on the types on injections that Dr. Shiozaki is permitted to perform.

Supervision and re-assessment of general medicine practice, including injections

- Prior to resuming practice after the period of suspension of his certificate of registration, Dr. Shiozaki shall retain a College-approved clinical supervisor to supervise his general medicine practice including his injections for pain management, who will sign an undertaking in the form attached hereto as Schedule "E" (the "Clinical Supervisor"). For a period of six (6) months, Dr. Shiozaki may practice only under the supervision of the Clinical Supervisor and will abide by all recommendations of his Clinical Supervisor with respect to his practice, including but not limited to practice improvements, practice management, and continuing education. The period of Clinical Supervision will commence on the expiry of the period of suspension, or on the date that the Clinical Supervisor is approved, if one is not approved during the period of suspension;
- If, prior to completion of Clinical Supervision, the Clinical Supervisor is unable or unwilling to continue in that role for any reason, Dr. Shiozaki shall retain a new College-approved Clinical Supervisor who will sign an undertaking in the form attached hereto as Schedule "E". If Dr. Shiozaki fails to retain a Clinical Supervisor on the terms set out above within thirty (30) days of receiving notification that his former Clinical Supervisor is unable or unwilling to continue in that role, he shall cease practicing medicine until such time as he has obtained a Clinical Supervisor acceptable to the College. If Dr. Shiozaki is required to cease practice as a result of this paragraph, this will constitute a term, condition and limitation on his certificate of registration and such term, condition and limitation shall be included on the public register;
- Upon completion of the six (6) month period of Clinical Supervision, as described above, within approximately six (6) months, Dr. Shiozaki shall undergo a re-assessment of his general medicine practice including but not limited to his injections for pain management by a College-appointed Assessor (the "Re-Assessment"). The Re-Assessment may include a review of a selection of Dr. Shiozaki's office charts, direct observation of Dr. Shiozaki's injections for pain management and/or other aspects of his practice, an interview with Dr. Shiozaki and/or any other tools deemed necessary by the College. The Assessor shall report the results of the Re-Assessment to the College;

- Dr. Shiozaki 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. Shiozaki shall consent to the sharing of information between the Physician Mentor, the Clinical Supervisor, the Assessor and the College as any of them deem necessary or desirable in order to fulfill their respective obligations;
- Dr. Shiozaki shall consent to the College making enquiries of the Ontario Health Insurance Program, the Narcotics Monitoring System and/or any person or institution that may have relevant information, in order for the College to monitor his compliance with this Order and shall promptly sign such consents as may be necessary for the College to obtain information from these persons or institutions;
- Dr. Shiozaki shall co-operate with unannounced inspections of his office practice and patient charts by the College for the purpose of monitoring and enforcing his compliance with the terms of this Order; and
- Dr. Shiozaki shall be responsible for any and all costs associated with implementing the terms of this Order.
- Dr. Shiozaki attend before the panel to be reprimanded.
- Dr. Shiozaki pay costs to the College in the amount of $5,500.00 within 30 days of the date of this Order.

2. Dr. C.S. Frank

Name:	Dr. Cathy Sheila Frank
Practice:	Obstetrics and Gynecology
Practice Location:	St. Thomas and/or London ON
Hearing:	Agreed Facts and Joint Submission on Penalty
Finding/Penalty Decision Date:	February 26, 2018
Written Decision Date:	April 30, 2018

Allegations and Findings

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

Summary

Dr. Frank is an obstetrician and gynecologist who received her certificate of registration authorizing independent practice from the College of Physicians and Surgeons of Ontario ("the College") in June 2002. At the relevant time, she practised in St. Thomas and/or London.

Between 2009 and 2012, more than 30 patients filed complaints with the College regarding their treatment by Dr. Frank. Investigations into the patient complaints revealed that Dr. Frank had failed to maintain the standard of practice of the profession

in the care and treatment of patients and demonstrated a lack of knowledge amounting to incompetence in the following respects:

- failing to adequately investigate causes of patients' symptoms prior to deciding on surgical management;
- failing to obtain informed consent before performing surgeries or procedures;
- failing to adequately document informed consent discussions and the manner in which she conducted gynecological surgeries;
- performing surgeries and procedures in a manner inconsistent with the standards of practice of the profession; and
- failing to adequately monitor and assess post-operative patients, including those exhibiting symptoms of complications.

Patient A

Patient A was referred to Dr. Frank for heavy menstrual bleeding in 2003. Dr. Frank offered Patient A an ablation or a laparoscopically assisted vaginal hysterectomy ("LAVH"). Patient A initially chose an ablation but changed her mind to an LAVH. Dr. Frank performed the LAVH.

Prior to proceeding with an LAVH, and in breach of the standard of practice, Dr. Frank failed to complete necessary investigations to diagnose dysfunctional uterine bleeding, such as ordering an ultrasound and blood work. Dr. Frank failed to record any discussion of any options other than ablation and LAVH or any discussion of specific risks of the surgical options in Patient A's medical record, contrary to the standards of practice. Patient A does not recall any such discussion.

Following the surgery, Dr. Frank failed to adequately address Patient A's follow-up care needs, in breach of the standards of practice. She allowed Patient A to be discharged without an examination, despite a hemoglobin reading that had dropped significantly, and a description by the nurse of Patient A as being pale, bruised and diaphoretic. While documenting that this was due to the patient's desire to leave, she did not document that this was against medical advice. Dr. Frank also failed to adequately document the assessments of Patient A upon her re-attendance twice to the hospital. Patient A was readmitted by her family physician on her third attendance and seen by a different gynecologist. Patient A ultimately was found to have internal bleeding with a large pelvic hematoma, bruising of her lower abdomen, and vault cellulitis, which were caused by the LAVH.

Patient B

Patient B saw Dr. Frank in 2007 on referral for cystocele and vaginal vault prolapses from a urologist. Dr. Frank offered a posterior repair and possible Nichol's sling. Dr. Frank's record failed to reflect any discussion of alternative options or of any specific risks for the patient in undergoing the procedures, in breach of the standards of practice.

Dr. Frank attempted the surgical procedures, but was not able to complete all of the intended repairs so she discontinued the procedure. Patient B's prolapse returned and Dr. Frank then referred her to a urogynecologist for ongoing management. The College did not allege that Dr. Frank's performance of the surgery or referral to a urogynecologist after the surgery failed to meet the standard of practice of the profession.

Patient C

Patient C was referred to Dr. Frank for dysmenorrhea. Dr. Frank obtained an ultrasound, which was unremarkable. Patient C was then booked for an LAVH, which Dr. Frank performed. Dr. Frank failed to adequately investigate the possible causes of menorrhagia and dysmenorrhea before booking Patient C for an LAVH. She did not record eliciting a history of pelvic pain, did not check TSH (though Patient C had known hypothyroidism on replacement), did not perform an endometrial biopsy or a pap test, and did not evaluate uterine size and mobility.

Patient C's tolerance for surgical risk from the LAVH was very low because her child was scheduled for surgery four days after her own surgery. Dr. Frank failed to record having discussed with Patient C any specific risks of the LAVH. It was Patient C's recollection that Dr. Frank advised her that she would be well enough to accompany her child to surgery in four days and that the LAVH was a simple operation.

Following the LAVH, Patient C experienced low blood pressure, requiring a fluid bolus, and a significant drop in hemoglobin. There is no evidence in the record that Patient C was assessed by a physician, but she was nonetheless discharged from hospital. Patient C returned to another hospital some days later and was ultimately diagnosed with a hematoma and underwent subsequent surgery. Dr. Frank's failure to monitor for, identify and treat Patient C's complication represents a failure to adequately follow up on her patient post-operatively in breach of the standard of practice.

Patient D

Dr. Frank managed Patient D's pregnancy after 32 weeks' gestation. According to Patient D, when she saw Dr. Frank at 34 weeks' gestation, she reported decreased fetal movement. Dr. Frank recorded that there was fetal movement, but there was no documentation in Dr. Frank's record about kick counting (to measure fetal movement) nor of advising the patient to go to hospital triage to have the baby assessed if there was decreased fetal movement. This lack of documentation breached the standard of practice.

At 35 weeks, Patient D presented to the emergency department and found the fetus was deceased. Patient D was then booked for an induction of labour. Dr. Frank ordered 800 mcg of Misoprostol every four hours, which was an inappropriately high dose for induction of a term 35 week pregnancy and in breach of the standard of practice. Dr.

Frank also failed to obtain Patient D's informed consent to her off-label use of Misoprostol in breach of the standard of practice.

Patient E

Patient E saw Dr. Frank in 2005 for pain associated with ovarian cysts and a family history of ovarian cancer. Dr. Frank conducted a laparoscopic right salpingo-oophorectomy and left ovarian resection.

When Patient E was later reassessed by Dr. Frank post-operatively, Patient E was complaining of pain. An ultrasound was done and revealed a 9cm left adnexal mass. Dr. Frank recommended to Patient E that this mass be removed in its entirety by way of laparotomy. Dr. Frank failed to document any other options for treatment or management offered to the patient and failed to document the specific risks of the laparotomy, in breach of the standards of practice.

Patient F

Patient F was referred to Dr. Frank by her family physician for irregular periods and consideration of an endometrial ablation. Dr. Frank saw Patient F in April 2009 and scheduled her for an endometrial ablation, which she performed in May. Dr. Frank failed to perform the required investigations (for example, blood work and ultrasound) to determine the cause of the irregular periods before proceeding with an endometrial ablation.

Patient G

Patient G saw Dr. Frank in September 2006 for severe abdominal pain. The pain was somewhat, although not completely, cyclical, and thus should have been investigated as potentially chronic pelvic pain via a multidisciplinary approach. An ultrasound was done and was normal. Dr. Frank offered the patient an LAVH. Dr. Frank failed to investigate and propose a cause of Patient G's pain before proceeding with an LAVH, in breach of the standard of practice. Dr. Frank's record failed to reflect having offered Patient G any non-surgical treatments. The LAVH was performed in November 2006, but did not resolve Patient G's pain.

Patient H

Dr. Frank, the on-call physician, attended to Patient H when she was admitted to hospital in labour in 2008. During the second stage of labour, while pushing, a fetal bradycardia occurred. As a result, Dr. Frank performed a forceps delivery with midline episiotomy. Dr. Frank failed to document obtaining consent for either procedure and the patient states that no informed consent discussion took place.

When Dr. Frank repaired the midline episiotomy, she failed to note a fourth degree laceration. Patient H was required to return and undergo a primary repair of the fourth

degree laceration procedure seven days later. Dr. Frank fell below the standard of practice by failing to identify the fourth degree tear at the time of her repair of the episiotomy immediately after delivery.

Patient I

Patient I saw Dr. Frank in 2009 for problems regarding menorrhagia and a prior laparotomy for a ruptured ovarian cyst that had become infected. Dr. Frank failed to complete necessary steps to identify the cause of Patient I's symptoms before scheduling Patient I for an LAVH.

Dr. Frank performed the LAVH. She documented in the operative report that Patient I's right ovary looked abnormal and that she removed it. This was Patient I's only ovary (as her other ovary had been previously removed in another surgery). The removal of Patient I's ovary was not discussed with Patient I before the surgery, nor with any family member during the surgery. Dr. Frank's failure to discuss the removal of the ovary with Patient I meant that Patient I had no opportunity to consent to a procedure that rendered her prematurely menopausal.

Patient I only became aware that her ovary had been removed when she reviewed her medical records several years later. Dr. Frank failed to meet the standard of practice by failing to obtain informed consent for the removal of Patient I's ovary.

Patient J

Patient J saw Dr. Frank in April 2005 regarding an ultrasound that revealed a fibroid in her uterus. She was asymptomatic at that time and did not want any treatment. She saw Dr. Frank again in January 2006 on referral from her family physician as her fibroid was increasing in size.

In her reporting letter to the referring physician, Dr. Frank documented having discussed with Patient J the possibility of complications of an increasing fibroid including the remote possibility of cancer. She only documented discussing two options for treatment of the fibroid: embolization and an LAVH. Dr. Frank failed to document discussion of other non-invasive treatment options. Patient J proceeded with an LAVH due to her misunderstanding of the degree to which cancer was a risk and her lack of understanding of other treatment options.

Patient K

Patient K initially saw Dr. Frank in October 2003 for pain associated with fibroids. Dr. Frank performed a diagnostic laparoscopy in January 2004. Patient K was later re-referred and seen by Dr. Frank in January 2007 for heavy menses and a large uterine fibroid. Dr. Frank's record reflects only having offered Patient K an LAVH to address the fibroid. Dr. Frank's medical record fails to reflect any discussion of non-surgical options or of any specific risks of an LAVH for Patient K, even though she had increased risk

due to the fibroid and two previous caesarean sections, contrary to the standards of practice. Dr. Frank also failed to perform an investigative step necessary to rule out cancer, namely an endometrial biopsy in advance of the LAVH.

Dr. Frank performed the LAVH in April 2007. She failed to adequately document the procedure in her operative note, as it did not clearly describe how the procedure was performed.

Patient L

Patient L was seen by Dr. Frank in March 2006, after having been referred for heavy, irregular bleeding. Dr. Frank failed to conduct required steps, which would have provided more information about Patient L's treatment options, specifically, an endometrial biopsy, before proceeding with an LAVH. Patient L was booked on the first visit for an LAVH. Dr. Frank performed the LAVH. Dr. Frank failed to adequately document the procedure in the operative note, as it does not clearly set out how the procedure was performed, in breach of the standard of practice.

Patient M

Patient M was seen by Dr. Frank in May 2006 for menorrhagia. Dr. Frank failed to take the appropriate investigative step of obtaining an endometrial biopsy before proceeding with an LAVH.

Dr. Frank discussed some other options with Patient M, but booked Patient M for an LAVH on the first visit. Dr. Frank failed to document discussion of risks specific to Patient M. Patient M does not recall having been advised of the risks associated with the procedure. Patient M faced a specific risk of damage to her bladder because of her previous history.

Dr. Frank performed the LAVH. Dr. Frank failed to adequately document the procedure in the operative note, as it does not clearly set out how the procedure was performed, in breach of the standard of practice.

Patient O

Patient O was referred to Dr. Frank for prenatal care and delivery of her fourth child. Following the delivery of her fourth child, Patient O saw Dr. Frank and discussed surgical sterilization. Dr. Frank offered her a tubal ligation, which was then performed. Dr. Frank's record does not reflect any discussion of alternative options or of any specific risks of the procedure, in breach of the standard of practice.

Patient P

Dr. Frank managed Patient P's pregnancy and attended for her delivery. Patient P was admitted for a post-dates induction in May 2006. After Patient P pushed for

approximately one hour, Dr. Frank delivered the baby using forceps. Patient P experienced a third-degree tear of the perineum. Dr. Frank failed to record any discussion with Patient P of the indication for forceps, the risks and benefits of forceps, or the alternatives to forceps use, and Patient P does not recall any such discussion.

Patient Q

Patient Q saw Dr. Frank in October 2005 for heavy, painful periods. Dr. Frank ordered an ultrasound, which was found to be normal. Patient Q was subsequently booked for an LAVH. Dr. Frank failed to take the required step of obtaining an endometrial biopsy preoperatively.

Dr. Frank failed to document discussion of risks specific to Patient Q, in particular the increased risk of bladder injury as a result of Patient Q's prior caesarean sections. Dr. Frank failed to document which medical management options were discussed and the advice given to Patient Q as to each of those options given Patient Q's specific circumstances. It was Patient Q's understanding that Dr. Frank was recommending a hysterectomy for her.

Dr. Frank failed to adequately document the procedure in her operative note, as it did not clearly describe how the procedure was performed.

Patient R

Patient R, in her first pregnancy, was seen by Dr. Frank for prenatal care. She was admitted to hospital in August 2005 for induction of labour. Patient R had a prolonged second stage of labour followed by a failed forceps delivery by Dr. Frank. Dr. Frank then planned for the patient to go for a caesarean section, which she carried out approximately three hours later when an OR became available. In view of Patient R's prolonged labour and the failed forceps delivery, Dr. Frank should have, but did not, order prophylactic antibiotics prior to the caesarean section.

Following surgery, Patient R presented with an abnormal ECG and developed a fever, which continued for five days. Dr. Frank failed to appropriately document and coordinate Patient R's post-operative care and failed to ensure appropriate assessment of the patient. Patient R was found to have an intra-abdominal abscess which was drained by another physician seven days after the caesarian section.

Patient S

Patient S was seen by Dr. Frank in 2008 for heavy menstrual cycles. She was found to have multiple fibroids. She wished to avoid surgery and was given a prescription for an Evra patch. However, she later attended at hospital with abdominal pain, heavy flow and a palpable suprapubic mass. On the same day, she saw Dr. Frank who noted pain and bleeding. Dr. Frank ordered an ultrasound which found a large uterus with multiple fibroids. Dr. Frank booked Patient S for an LAVH. Dr. Frank failed to document the

details of alternative treatment options that were discussed or the specific risks for Patient S, contrary to the standards of practice.

The surgery was completed in December 2008. Dr. Frank's operative note indicated that, following the introduction of the laparoscope, a small bowel puncture due to the trocar placement was identified. Dr. Frank obtained an intra-operative general surgery consultation and, on advice, proceeded to a laparotomy (abdominal approach). Given the size of the uterus and the presence of multiple fibroids, Dr. Frank should have used an abdominal rather than a laparoscopic approach. The manner in which Dr. Frank conducted the surgery therefore breached the standard of practice.

Patient T

Dr. Frank performed an LAVH on Patient T in 2007. During the surgery, Dr. Frank used a laparoscopic LigaSure device for a vaginal approach for cauterization of the uterosacral and cardinal ligaments. The shaft length of the instrument may have increased the risk of injury to the patient which could have been avoided with a different approach or method, such that it amounted to a breach of the standard of practice. Patient T presented to the emergency department a few days following surgery with urinary incontinence, and also presented to Dr. Frank's office. Dr. Frank ultimately facilitated Patient T being seen by further specialists and she was diagnosed with a ureterovaginal fistula, subsequently undergoing reparative surgery.

Patient U

Dr. Frank performed an LAVH on Patient U in 2010. During the surgery, Dr. Frank used a laparoscopic LigaSure device for a vaginal approach to divide the tissues up the broad ligament. The shaft length of the instrument may have increased the risk of injury to the patient which could have been avoided with a different approach or method, such that it amounted to a breach of the standard of practice. Patient U experienced a ureteric vaginal fistula following surgery.

Patient V

Dr. Frank performed an LAVH on Patient V in 2009. During the surgery, Dr. Frank used a laparoscopic LigaSure device for a vaginal approach. The uterosacral and cardinal ligaments were cauterized and cut using the laparoscopic LigaSure device. The shaft length of the instrument may have increased the risk of injury to the patient which could have been avoided with a different approach or method, such that it amounted to a breach of the standard of practice.

Following the surgery, Dr. Frank failed to address in a timely way Patient V's post-operative complications, specifically what was eventually identified as a bowel perforation sustained during the surgery. Dr. Frank should have arranged for a general surgical consultation and a restricted diet earlier in light of Patient V's symptoms of

bloody bowel movements, abdominal distension, severe pain, and a suspicion of bowel perforation.

Patient W

Dr. Frank assumed the prenatal care of Patient W in April 2005. Patient W attended at hospital and was seen by others on three occasions in October 2005. Dr. Frank was then notified of Patient W's re-attendance at hospital, assessed her, and admitted her to hospital with a spontaneous rupture of membranes. An ultrasound showed a fetal heart rate of 133 and decreased amniotic fluid. Dr. Frank prescribed a 50 mcg dose of Misoprostol to augment labour.

There was a non-reassuring difficulty in registering a fetal heart rate. Dr. Frank then performed an emergency caesarean section. The infant was delivered and could not be resuscitated.

The use of Misoprostol for the induction of labour was not appropriate in this case and breached the standard of practice. Misoprostol can cause tetanic uterine contractions. Dr. Frank failed to obtain Patient W's informed consent for an off-label use of Misoprostol.

Immediately after the delivery, Dr. Frank performed a tubal ligation. Patient W did not consent to the tubal ligation. Dr. Frank failed to document any discussion with Patient W about a tubal ligation in her office records nor to document performance of the tubal ligation in her operative note in a timely manner, which breached the standard of practice.

Patient X

Patient X was seen by Dr. Frank in 2005 on referral for menorraghia. Patient X was booked for an LAVH on her first visit. Dr. Frank's medical records do not reflect any discussion of specific alternative options for Patient X, nor of any specific risks of the surgery, in breach of the standards of practice. Dr. Frank failed to conduct or document necessary investigative steps to ascertain the cause of the menorraghia prior to booking Patient X for an LAVH, specifically, Dr. Frank's record does not document any physical examination prior to recommending an LAVH, nor does Patient X recall Dr. Frank having conducted one.

Patient BB

Patient BB saw Dr. Frank in 2003 for menorrhagia, pelvic pain, and stress incontinence. Dr. Frank obtained an ultrasound, which was found to be normal. At a subsequent appointment, Dr. Frank scheduled Patient BB for an LAVH and a tension free transvaginal tape procedure, which she later conducted. Dr. Frank failed to document in Patient BB's medical record any discussion of non-surgical options or of any specific risks related to the procedures.

Patient DD

Patient DD was seen by Dr. Frank in 2003 for menometrorrhagia. An ultrasound showed an ovarian cyst which was noted to be not simple. Dr. Frank booked Patient DD for an endometrial ablation and a diagnostic laparoscopy with possible ovarian cystectomy. Dr. Frank failed to document in Patient DD's medical record any discussion of specific alternative options, or of specific risks related to these procedures. During the surgery, Patient DD's uterus was perforated. The College does not allege that Dr. Frank's performance of the surgery failed to meet the standard of practice of the profession.

Patient EE

Patient EE was referred to Dr. Frank in 2009 for post-menopausal bleeding, hot flashes, and atrophic vaginitis. Dr. Frank ordered an ultrasound and subsequently performed an endometrial biopsy. Dr. Frank then carried out an LAVH with bilateral salpingo-oopherectomy (BSO) in January 2010. Dr. Frank failed to document having discussed the specific risks of the LAVH and BSO along with the risks of not having surgery, such as the risk of progression, spread, and mortality.

The pathology from the LAVH and BSO showed that Patient EE had two types of cancer: a well differentiated endometrioid adenocarcinoma and an adult granulosa cell tumour. Follow-up for these cancers should have included a pelvic exam every three to four months for the first two years and every six months for up to five years. Dr. Frank failed to advise Patient EE of the pathology findings and of the appropriate frequency of follow up required, in breach of the standard of practice, rather advising her to attend for follow up in one year's time.

Patient AAA

Dr. Frank was the physician on-call at the hospital who managed Patient AAA when she was admitted to hospital in labour in 2006. After one hour of pushing, the fetal heart rate tracing showed variable decelerations. Dr. Frank decided to deliver the baby by forceps. Dr. Frank failed to adequately assess and document the station and position of the fetal head before doing this. She then tried using forceps four times. She re-applied the forceps three times (including a change of forceps type). Each time, she noted that the forceps "slipped off." The trial of forceps lasted approximately half an hour. Dr. Frank failed to meet the standard of practice of the profession in her multiple uses of the forceps. Dr. Frank failed to document in the record having received informed consent to proceed with a trial of forceps. Patient AAA does not recall having provided informed consent.

Dr. Frank moved to a caesarean section. However, and in breach of the standard of practice, Dr. Frank failed to appropriately arrange anaesthesia support before starting the trial of forceps, which then resulted in a delay of 48 minutes for anaesthesia to arrive. Dr. Frank failed to adequately document how she performed the caesarean

section. In particular, she failed to properly document the position of the baby at birth. She recorded the delivery as a "breech extraction" in her delivery summary, but did not make any reference to this in her operative note, stating there that it was in a vertex presentation.

Patient AAA and her baby both experienced significant complications following the birth. The baby required resuscitation and transfer to another hospital.

The Facts Regarding Penalty

Prior Decisions

- In 2009, the College's Complaints Committee issued a decision in which it required Dr. Frank to attend to be cautioned. The concerns of the Complaints Committee related to Dr. Frank's management of a twin pregnancy, including inadequate documentation and the failure to order appropriate bloodwork and glucose testing.
- In 2016, the College's Inquiries, Complaints and Reports Committee ("ICRC") issued a decision in which it required Dr. Frank to attend to be cautioned. This decision was disposed of at the same time as some of the complaints at issue in the discipline case. The ICRC's concerns related to Dr. Frank's prenatal care of the patient in 2006 and, specifically, her failure to appropriately manage/investigate the patient's weight gain, hypertension and decreased fetal movement.

Undertakings

- Dr. Frank has been the subject of a number of undertakings with the College as a result of prior complaints, reports, and practice assessments. At the time of the hearing, Dr. Frank's practice was restricted as a result of undertakings entered into in 2011 and 2014, as well as an interim undertaking entered into in 2016 pending the current hearing, in lieu of an interim order.
- On January 19, 2009, Dr. Frank provided an undertaking agreeing to undergo a practice assessment and abide by recommendations of the assessor. She also agreed to complete the College's Medical Record-Keeping course as well as the Society of Obstetricians and Gynaecologists of Canada ("SOGC") ALARM course.
- The 2009 Undertaking arose as a result of concerns regarding Dr. Frank's clinical care arising from two public complaints. As a result of the two public complaints, the College initiated an investigation into Dr. Frank's practice. The 2009 Undertaking was entered into in resolution of the investigation.
- On September 14, 2011, Dr. Frank agreed to an undertaking restricting her ability to practise obstetrical and gynecological surgery. Under the 2011 Undertaking, Dr. Frank was not permitted to practise gynecological or obstetrical surgery, unless as part of a remediation program. She also could not apply for gynecological or obstetrical privileges, and was not permitted to practise as the most responsible physician in respect of any gynecological or obstetrical patients in any hospital. The 2009 Undertaking also remained in effect.

- The 2011 Undertaking arose after St. Thomas-Elgin General Hospital said that it would be conducting an external review into Dr. Frank's practice at the hospital. Dr. Frank subsequently voluntarily resigned her staff appointment at the hospital and this was reported to the College.
- On December 7, 2012, Dr. Frank signed a further undertaking. Under this undertaking, the 2011 Undertaking remained in effect, meaning that the restrictions on Dr. Frank's ability to practise obstetrical and gynecological surgery continued. In addition, under the 2012 Undertaking, Dr. Frank agreed to a two-year period of clinical supervision. She also agreed not to perform ultrasound procedures without further training if the College deemed that her training and certification were not appropriate. She further agreed to complete a program in medical ethics.
- The 2012 Undertaking resulted from recommendations made by assessors under the 2009 Undertaking.
- On October 21, 2014, Dr. Frank executed another undertaking, which replaced the 2009 and 2012 Undertakings. The 2011 Undertaking restricting Dr. Frank's scope of practice to exclude obstetrical and gynecological surgery remained in effect. In addition, under the 2014 Undertaking, Dr. Frank could not conduct ultrasound testing, interpret ultrasound images, or perform ultrasound-guided procedures unless she completed remediation and reassessment. Dr. Frank also agreed to ongoing clinical supervision. The undertaking included an Individualized Education Plan to be completed by Dr. Frank.
- The 2014 Undertaking arose as a result of the recommendations from a clinical supervisor retained under the 2012 Undertaking.
- On April 27, 2016, Dr. Frank provided an undertaking in lieu of an interim order pending the disposition of the discipline case. Under this undertaking, Dr. Frank agreed to practise under a clinical supervisor who would submit reports to the College at least once per quarter. The restrictions on her scope of practice from the 2011 and 2014 Undertakings remained in effect.

Practice Restrictions At the Date of the Hearing

- Dr. Frank had existing practice restrictions at the time of the hearing as a result of her undertakings to the College:
  - under the 2011 Undertaking, Dr. Frank was not permitted to:
    - practise in the area of gynecological or obstetrical surgery unless she as part of a remediation program pre-approved by the College and supervised by a preceptor who was to act as most responsible physician ("MRP") for all patients;
    - apply for gynecological or obstetrical surgery privileges at any hospital , orengage in the practice of medicine as the MRP in respect of any obstetrical or gynecological patients, at any hospital.
  - the terms of the 2014 Undertaking that were not completed remained in effect. Specifically:
    - while Dr. Frank could be the MRP performing ultrasounds on her own patients, she could only do so under the supervision of her clinical supervisor.

  - while Dr. Frank could be the MRP performing ultrasound-guided procedures on her own patients, she could only do so under the supervision of the clinical supervisor, meaning that Dr. Frank's ultrasound-guided procedures could only be performed in the clinical supervisor's clinic and where a reproductive endocrinologist and infertility specialist was to always be available on the premises to intervene if required. Although Dr. Frank was permitted to perform ultrasound-guided procedures in these circumstances, Dr. Frank had ceased performing these procedures.
  - the clinical supervisor was required to select and review a minimum of fifteen charts per month related to imaging, ultrasound-guided procedures and pelvic and pregnancy ultrasounds and meet with Dr. Frank once every month. The clinical supervisor was also required to provide quarterly reports to the College.
- until final disposition of the Discipline Committee proceeding, Dr. Frank had been required to practise under the guidance of a clinical supervisor with respect to all areas of her practice. The clinical supervisor was to review at least fifteen of Dr. Frank's patient charts from all areas of her practice once every month and meet with Dr. Frank once every month. The clinical supervisor was also required to submit written reports to the College at least once a quarter.
- the 2014 Undertaking required reassessment of Dr. Frank's practice following the required remediation. In the process of agreeing to the 2016 Undertaking, Dr. Frank agreed to submit to a reassessment of her practice by an assessor or assessors selected by the College, to take place six months after she had returned to practise following the conclusion of the Discipline Committee proceeding.
- therefore, since 2011, Dr. Frank had been prohibited from performing any obstetrical or gynecological surgeries. Since 2012, Dr. Frank's ability to perform ultrasounds and ultrasound-guided procedures had been restricted. Dr. Frank's practice as of the date of the hearing consisted of reproductive endocrinology and infertility, office gynecology and early obstetrical care.

Monitoring Reports

- The College received reports from Dr. Frank's clinical supervisors under her undertakings and, most recently, under the 2014 and 2016 Undertakings. The recent reports received from Dr. Frank's clinical supervisor were consistently positive. While Dr. Frank's most recent clinical supervisor under the 2014 and 2016 Undertakings raised criticisms in individual cases, the number of criticisms declined over time. He did not raise any significant practice concerns.

Disposition

The Discipline Committee ordered and directed that:

- the Registrar suspend Dr. Frank's certificate of registration for twenty-four (24) months, to commence at 12:01 a.m., February 27, 2018.

- the Registrar impose the following terms, conditions and limitations on Dr. Frank's certificate of registration:

    - Dr. Frank shall practise only in the areas of reproductive endocrinology and infertility, office-based gynecology and early obstetrical care (i.e. before 20 weeks of pregnancy);
    - Upon returning to practice following the suspension of her certificate of registration, Dr. Frank shall comply with any College policy regarding re-entering practice in existence at the time of her resumption of practice. Without restricting the generality of the foregoing, any program pursuant to the College policy regarding re-entering practice shall, at a minimum, require that:
        - Dr. Frank initially perform ultrasound-guided procedures only in a clinic belonging to a clinical supervisor and where a reproductive endocrinologist and infertility specialist is/are always available on the premises to intervene if required; and,
        - Approximately six (6) months following Dr. Frank's return to practice, Dr. Frank undergo a reassessment of her practice (the "Reassessment") by a College-appointed assessor or assessors (the "Assessor(s)"). Dr. Frank shall cooperate fully with the Reassessment, which may include a review of Dr. Frank's patient charts, direct observation, interviews with staff and/or patients, and/or other tools deemed necessary by the College. The results of the Reassessment shall be reported to the College, and, if requested to do so by the College, Dr. Frank shall abide by the recommendations of the Assessor(s). Any of those recommendations of the Assessor(s) which are limitations and/or restrictions on Dr. Frank's practice and/or which the Inquiries, Complaints and Reports Committee identifies as limitations and/or restrictions on her practice shall be included on the public register as terms, conditions, or limitations on her Certificate of Registration for the purposes of section 23 of the Health Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professions Act, 1991,* S.O. 1991, c. 18, as amended;
    - Dr. Frank shall only practise in a group setting which has been approved by the College;
    - Dr. Frank shall consent to sharing of information among the Assessor(s), any of her Clinical Supervisor(s), and the College as any of them deem necessary or desirable in order to fulfill their respective obligations;
    - Dr. Frank 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 and enforce her compliance with the terms of this Order;
    - Dr. Frank shall submit to, and not interfere with, unannounced inspections of her Practice Locations and patient charts by a College representative for the purposes of monitoring her compliance with the terms of this Order;
    - Dr. Frank shall give her irrevocable consent to the College and to her

Assessor(s) to make enquiries of her patients regarding medical services provided by her in order to ensure that she is documenting all information relevant to her practice in an accurate way;
- Dr. Frank shall consent to the College providing any Chief(s) of Staff or a colleague with similar responsibilities at any location where she practises with any information the College has that led to this Order and/or any information arising from the monitoring of her compliance with this Order; and,
- Dr. Frank shall be responsible for any and all costs associated with implementing the terms of this Order.

- Dr. Frank attend before the panel to be reprimanded.
- Dr. Frank to pay to the College costs in the amount of $10,180.00**,** within thirty (30) days of the date of this Order.

3. Dr. C.A. Proulx

Name:	Dr. Christian Andrew Proulx
Practice:	Family Medicine
Practice Location:	St. Catharines
Hearing:	Uncontested Facts and Joint Submission on Penalty
Finding/Penalty Decision Date:	February 6, 2018
Written Decision Date:	April 4, 2018

Allegations and Findings

- Incompetence - **proved**
- Failed to maintain the standard of practise – **proved**
- Disgraceful, dishonourable and unprofessional conduct – **proved**
- Sexual Abuse **– withdrawn**

Summary

Dr. Christian Proulx received his certificate of independent practice from the College of Physicians and Surgeons of Ontario in 2003, and his specialist qualification in family medicine in 2006. Before July 2016, Dr. Proulx practised medicine in St. Catharines, Ontario.

Ms A

Between August 2013 and January 2016, Dr. Proulx prescribed controlled drugs to Ms A, who was his neighbour. Despite beginning to prescribe to her in 2013, Dr. Proulx saw Ms A in a clinical setting only on two occasions, once at the beginning of 2015 and again at the beginning of 2016, and billed OHIP for his care and treatment of Ms A only on those two occasions.

In the beginning of 2016, the College received two reports raising concerns about Dr. Proulx's prescribing to Ms A. The first report was from a physician who had treated Ms

A in the hospital emergency department after she took an impulsive overdose of medication with the intent to end her life. The physician reported that although Ms A's Ontario Drug Benefit profile indicated that Dr. Proulx had been repeatedly prescribing 200 tabs of medication to Ms A every 16 days, she denied taking the medication. The second report was made by Ms A's relative, who advised the College that she was concerned that Dr. Proulx was prescribing 200 tabs of medication to Ms A every two weeks and taking half the medication back from her.

In his initial response to the College, Dr. Proulx stated that:

- he knew Ms A as his neighbour and that one day, when Ms A asked him to be her family doctor, he advised her to come and see him in his family clinic. Ms A explained that she had difficulty with transportation, experienced pain with her ambulation, and that she needed medication as she felt that her pain was largely responsible for her depression;
- when he reiterated that Ms A that she should come to his medical office so he could record her history and symptoms, initiate a proper patient chart and set out her treatment plan, she insisted that she was unable to come to his office and begged him to provide her with a prescription;
- against his better judgment, Dr. Proulx wrote her a prescription for medication accompanied by a discussion about how to take medication and potential effects;
- Ms A returned to his door two weeks later reporting that she felt a lot better and asked to renew her prescription which he did, but insisted that she come to his office for future care;
- Ms A attended at his office in February 2015, at which time she indicated that her problem was depression/anxiety and Dr. Proulx tried her on a short course of the mood stabilizer as he felt she had difficult-to-treat depression, query bipolar disorder;
- in November 2015 Dr. Proulx referred her for a psychiatric support;
- in January 2016, when the reports came to him as her family physician from a couple of hospital attendances, he spoke with Ms A and she agreed to taper off the medication, which he understood she did successfully. He hasn't seen her since and understood that her psychiatrists have been filling her medications for her; and
- Dr. Proulx admitted that he failed to follow a number of College policies regarding medical record-keeping, boundaries and prescription, and in particular, not seeing Ms A in his office. He expressed regret for prescribing medications to Ms A outside of his office and indicated that he takes ownership of his conduct as inappropriate and unprofessional.

When the College requested additional information from Dr. Proulx, including the circumstances which led him to prescribing to Ms A prior to having seen her in his clinic in 2015, he refused to respond to the request.

Dr. Proulx's account of events was untruthful and incomplete. In fact, the following occurred:

- Ms A initially approached Dr. Proulx about obtaining narcotics as a joke, including because she didn't have any money, and/or by asking Dr. Proulx if he could prescribe her "something fun";
- Dr. Proulx agreed to prescribe narcotics to Ms A and devised the specifics of their arrangement;
- Dr. Proulx prescribed narcotics to Ms A about 200 pills at a time, approximately every 16 days, and sometimes more frequently than that. Of the 200 pills Ms A obtained each time, Dr. Proulx would take the first 100 pills, and purchase most or all of the remaining 100 pills from Ms A for between $2.50 and $3.50 per pill. He would typically pay her $3.00 per pill. Sometimes Ms A would keep approximately 20 pills for her own use. All payments by Dr. Proulx to Ms A for the pills were made in cash;
- The transactions were arranged through text messaging. Often, Dr. Proulx would pick Ms A up in his car, drive her to the pharmacy, and write her a prescription in the pharmacy parking lot. Ms A would go into the pharmacy and fill the prescription, paying for it either through her Ontario Drug Benefit coverage, or with cash provided to her by Dr. Proulx;
- Dr. Proulx falsely told Ms A he needed the pills to treat his lymphoma, and that his own doctor wouldn't prescribe them to him. Dr. Proulx does not have lymphoma;
- There were occasions on which Ms A went to the pharmacy without Dr. Proulx after having collected the prescription from Dr. Proulx's mailbox, and then met Dr. Proulx for the exchange;
- Dr. Proulx had a similar arrangement with respect to prescribing and buying narcotics with Ms A's then-boyfriend, Mr. X, whom Ms A introduced to Dr. Proulx. Sometimes the three of them would drive to the pharmacy together. Ms A continued to receive prescriptions from Dr. Proulx after she terminated her relationship with Mr. X;
- Dr. Proulx advised Ms A that their arrangement was a secret, that it was illegal, and that if the College ever discovered it, he would be in a lot of trouble and that Ms A would probably face criminal charges; and
- After the College notified Dr. Proulx of its investigation into his prescribing to Ms A, Dr. Proulx contacted her and told her that he was being investigated, that they would both be in trouble and/or go to jail, and that she specifically would be in trouble. He told her not to speak to the College investigators.

Expert evidence

An expert retained by the College during its investigation had significant concerns with Dr. Proulx's prescriptions for opioids and benzodiazepines. She opined that Dr. Proulx fell below the standard of practice of the profession, that his care displayed a lack of knowledge, skill, or judgment, and that clinical practice, behaviour or conduct was likely to expose his patients to harm or injury:

- Most patients were prescribed opioids without a full assessment of their pain and often when they were quite new to Dr. Proulx's practice. In many cases, Dr. Proulx

initiated opioids after only a few visits when he had not performed a full history or physical examination regarding the pain or tried other non-opioid medications;
- In most cases, Dr. Proulx made no determination regarding patients' potential for addiction or documented discussion regarding functional status, adverse effects, and risks of opioids before prescribing opioids to them;
- In many cases, the opioids were prescribed when Dr. Proulx did not have any results of investigations regarding patients' pain. The actual indication for the opioids was not clear for several of the patients. In some cases, opioid prescriptions were initiated for one diagnosis, then apparently continued for another diagnosis;
- Dr. Proulx typically prescribed very large quantities of opioids, writing prescriptions for 200-300 tablets of short-acting opioids or benzodiazepines or 3-month supplies of chronic opioids, with no documented use of "part-fill" prescriptions which can reduce opioid misuse;
- Many of the patients were prescribed relatively high doses of opioids. In the majority of charts reviewed in which Dr. Proulx prescribed chronic opioids, most patients were prescribed a Morphine Equivalent Dose ("MEQ") greater than 200 mg/day. There was no evidence that Dr. Proulx monitored these patients any more carefully. There was minimal documentation regarding the nature, location or severity of their pain, or their functional status and minimal screening for potential opioid misuse;
- There were further concerns regarding documentation surrounding the opioid prescriptions. Most charts did not include any documentation that patients were advised of the potential adverse effects. There was no documented assessment of the patients' individual risk for addiction, and no documentation as to whether the patient had any past history of addiction prior to prescribing the opioids. There was no use of a formalized addiction risk screening tool or narcotic treatment agreement, and urine drug screens were performed extremely rarely. Only three patients had documented urine drug screens. One urine drug screen yielded an abnormal result, but was not repeated. Several of the patients demonstrated features of inappropriate opioid such as lost medications, early prescription renewals, and requests to escalate the dosage. In the majority of the aspects of care where opioids were prescribed, Dr. Proulx did not demonstrate enough diligence in his documentation and monitoring to determine that they were being used safely; and
- For several patients, the records appeared to indicate that the patients were obtaining excessively large quantities of opioids from Dr. Proulx that were not documented anywhere in their chart notes. There were prescriptions for several thousands of tablets of opioids without any documentation or patient encounters associated with these prescriptions. For two patients to whom he had prescribed opioids, including Ms A's ex-boyfriend, Dr. Proulx had no patient chart whatsoever.

Regarding Ms A's care, the expert opined that:

- Dr. Proulx did not meet the standard of practice of the profession in his care of Ms A, in that:
  - Dr. Proulx provided medical care to Ms A outside of an office setting, without adequate documentation, which falls well below the standard of care with respect

to record-keeping. Any prescription requires documentation of an assessment, diagnosis, and the name and quantity of the medication prescribed. Prescriptions for controlled substances, such as opioids and benzodiazepines, require an even higher level of caution, including knowledge of the patient's clinical status, diagnosis, assessment of risk of misuse, and documentation of informed consent. Dr. Proulx did not document any history regarding the cause of Ms A's pain, any previous investigations, other medications she had taken for the pain, past history of substance abuse, functional status, and he did not document a physical examination prior to prescribing opioids. He also did not document the quantities or dosages of opioids and benzodiazepines that he was prescribing on an ongoing basis for her;

  - Dr. Proulx's care also failed to meet the standard of practice of the profession in terms of the requirements for prescribing. Before prescribing a drug, physicians must have current knowledge of the patient's clinical status. This can only be accomplished through an appropriate clinical assessment of the patient. Dr. Proulx did not appear to have performed a thorough clinical assessment of Ms A prior to prescribing the medications she had requested. He also did not document that he was prescribing Oxycocet and clonazepam regularly to this patient.
- Dr. Proulx's care displayed a severe and ongoing lack of judgment evidenced by his prescriptions of large quantities of a controlled substance to an acquaintance who he had not adequately assessed regarding the indication or safety of the opioids and benzodiazepines. This was not a single lapse in judgment; and
- Dr. Proulx's conduct in this case was likely to expose Ms A to harm or injury, since she was at high risk for opioid misuse or overdose, given her past history of overdose and her current substance use. Ms A had in fact taken an overdose, and Dr. Proulx was not monitoring to ensure that Ms A was using the opioids he prescribed to her safely. Furthermore, the lack of oxycodone on her urine drug screen at the time of the overdose raised questions for the expert as to whether it was being diverted.

<u>Dr. Proulx's Undertaking and Resignation</u>

On July 4, 2016, during the College's investigations, Dr. Proulx resigned his prescribing privileges with respect to narcotic drugs, narcotic preparations, controlled drugs, benzodiazepines and other targeted substances, and all other monitored drugs, and he undertook not issue new prescriptions or renew existing prescriptions for any of those substances.

On July 11, 2016, Dr. Proulx resigned his membership in the College.

On February 21, 2017, in a submission to the Inquiries, Complaints and Reports Committee in respect of its investigations, Dr. Proulx emphasized that he had permanently resigned his membership in the College, and that he has no intention of ever practicing medicine in Ontario, or any other jurisdiction. Dr. Proulx advised that after resigning his membership, he began receiving intensive outpatient addiction

treatment for active alcohol and substance abuse. He advised that his program of recovery is ongoing.

Disposition

The Committee ordered and directed that:

- The Registrar revoke Dr. Proulx's certificate of registration, effective immediately.
- Dr. Proulx appear before the panel to be reprimanded.
- Dr. Proulx pay to the College its costs of this proceeding in the amount of $5,500.00 within thirty (30) days from the date of this Order.

Failed to Maintain the Standard of Practice - 3 cases

1. Dr. A.P.S.Choong

Name:	Dr. Albert Poh Soon Choong
Practice:	Family Medicine
Practice Location:	Toronto
Hearing:	Agreed Facts and Joint Submission on Penalty
Finding/Penalty Decision Date:	February 5, 2018
Written Decision Date:	March 13, 2018

Allegations and Findings

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

Summary

Dr. Choong is a family physician who received his certificate of registration authorizing independent practice from the College of Physicians and Surgeons of Ontario on October 10, 1972. At the relevant time, Dr. Choong practised family medicine in Toronto.

Patient A

Patient A became Dr. Choong's patient about 20 years ago. In June 2016, she attended Dr. Choong with complaints of pain in her rectum due to constipation and as a result of medication she was taking to relieve headache and muscle pain. Given Patient A's presentation, Dr. Choong offered to conduct a digital rectal examination, which the patient accepted.

Patient A was in the examination room alone with Dr. Choong. He did not offer her a chaperone. Dr. Choong directed Patient A to take off her pants and undergarments and

failed to provide the patient with any draping. He then asked Patient A to bend forward and lean over the examining table, raising her rectum towards him. Dr. Choong's positioning did not allow for adequate visual examination and he inadvertently inserted his finger in the patient's vagina in a manner the patient experienced as forceful. Patient A responded quickly stating "oh no not there". Dr. Choong then released his finger and proceeded to insert it in her rectum to perform a digital rectal exam. Following the examination, Dr. Choong recorded in his chart that the left lateral wall of the anus was tender, but there was no induration and no blood. He found no clinical evidence of the abscess. Given Patient A's presentation and finding, Dr. Choong believed she had an anal fissure and prescribed an analgesic cream.

An expert retained by the College concluded that a digital rectal exam was clinically indicated in the circumstances. However, the expert opined that Dr. Choong failed to maintain the standard of practice of the profession in this case, explaining that the standard of practice for a female digital rectal examination is for the patient to be in the lithotomy position (on her back with legs open as for a pelvic examination) or lying on her left side. According to the expert, one would proceed in the lithotomy position, if the patient was being evaluated for possible pelvic complaints and a rectal examination was also required. If only a rectal examination is indicated based on the complaint, the left side lying position is standard. Given that Patient A was complaining specifically of rectal pain and she was constipated, a side lying examination was indicated.

The expert further concluded that Dr. Choong's digital rectal examination technique displayed a lack of judgment. Not only did he not employ the appropriate technique for female patients, he also failed to provide modesty draping, demonstrating a lack of judgment and a failure to maintain the standard of practice. The expert noted that the examination, which was "clumsily performed", may have a lasting negative effect on the patient's experience.

<u>Undertaking to Resign</u>

On January 30, 2018, Dr. Choong entered into an undertaking with the College, wherein he agreed to resign from the College effective immediately and to not apply or re-apply for registration to practise medicine in Ontario or in any other jurisdiction.

Disposition

In light of the undertaking to resign, the Discipline Committee ordered that:

- Dr. Choong attend before the panel to be reprimanded.
- Dr. Choong pay costs to the College in the amount of $5,500.00 within 30 days of the date this Order becomes final.

2. Dr. A.S. Jamal

Name:	Dr. Abida Sophina Jamal
Practice:	Endocrinology
Practice Location:	Toronto

Hearing: Agreed Facts and Joint Submission on Penalty
Finding/Penalty Decision Date: March 6, 2018
Written Decision Date: May 1, 2018

Allegations and Findings

- Failed to maintain the standard of practice – **proved**
- Conduct unbecoming a physician - **proved**
- Disgraceful, dishonourable and unprofessional conduct – **proved**

Summary

Dr. Jamal is a physician who received her certificate of registration authorizing independent practice from the College of Physicians and Surgeons of Ontario (the "College") on June 17, 1991. In 2002, she completed her PhD at the University of Toronto in the field of clinical epidemiology of osteoporosis, with specific interest in the use of nitrate drug treatment.

Between 2007 and 2015, Dr. Jamal held an appointment to the Active Staff at Women's College Hospital ("WCH") as well as an appointment as a Scientist at WCH's Research Institute. She was also appointed as an Associate Professor in the Department of Medicine, University of Toronto. In addition to her research activities, she practiced endocrinology at WCH.

Dr. Jamal resigned from WCH in 2015. Up to the hearing date, she continued to practise endocrinology in the community in an office-based setting in Toronto.

<u>Dr. Jamal's Research in Osteoporosis: three research studies</u>

Dr. Jamal had been involved in the publication of study protocols and research investigations related to the use of nitrate drug treatment in osteoporosis. She conducted three different research studies: the JAMA Study, the Sclerostin Study, and the NABT Study.

The JAMA Study

Dr. Jamal was the Principal Investigator in a study entitled "Effect of Nitroglycerin Ointment on Bone Density and Strength in Postmenopausal Women: A Randomized Trial". This study was published by Dr. Jamal, Dr. Richard Eastell, MD, University of Sheffield and Dr. Stephen Cummings MD, California Pacific Medical Center Research Institute ("CPMCRI"), among others, in the Journal of the American Medical Association ("JAMA") on February 23, 2011.

The JAMA Study was a double blind placebo-controlled randomized control trial designed to determine if nitroglycerin increases lumbar spine bone mineral density and to evaluate changes in bone mineral density. The JAMA Study concluded that among

postmenopausal women, nitroglycerin ointments modestly increased bone mineral density and decreased bone resportion. The Canadian Institute of Health Research ("CIHR") funded the JAMA Study in the amount of $536,796.00. It involved the participation of 400 women in the run-in phase and ultimately enrolled 243 postmenopausal women between the ages of 50 and 80.

As Principal Investigator, Dr. Jamal had full access to all of the data in the study and took responsibility for the integrity of and the accuracy of the data analysis.

The Sclerostin Study

Following the publication of the JAMA Study in 2011, a subgroup of subjects were included in a follow-up study conducted by Dr. Jamal and others. Its purpose was to examine the possible role of sclerostin, a negative regulator of bone turnover, as an underlying mechanism for the effects of nitrates on osteoporosis as had been previously reported in the JAMA study.

A manuscript was prepared and submitted to a journal but was rejected. Dr. Jamal was among the co-authors of this study. It concluded that nitroglycerin substantially increases bone mass in postmenopausal women by decreasing sclerostin production.

The NABT Study

On October 25, 2013, Dr. Cummings, in collaboration with Dr. Jamal and others, submitted a planning grant application to the National Institutes of Health entitled "The NO Fracture Planning Grant". Building on the results of the JAMA Study, Dr. Jamal and her collaborators sought funding for a large scale randomized control trial to test the efficacy and safety of daily nitroglycerin treatment to prevent osteoporotic fractures (the "Fracture Trial"). The results of the JAMA study are quoted in the grant application as part of the rationale for the Fracture Trial. As a preliminary step, Dr. Jamal and others commenced a study to establish the appropriate formulation and dose of nitrate treatment for use in the anticipated Fracture Trial. This study is known as the "Nitrates and Bone Turnover (NABT): trial to select the best nitrate preparation.

The NABT Study was conducted between 2012 and 2014. The study was funded by CIHR in the amount of $263,914, in addition to other sources of funding. The study enrolled 420 women in the run-in phase and ultimately enrolled 210 women aged 50 or older.

Dr. Jamal is identified as the Primary Investigator in the NABT Study Protocol.

<u>Professional Misconduct</u>

On October 9, 2015, WCH concluded an investigation into the three research studies that had been conducted by Dr. Jamal (the JAMA Study, the Sclerostin Study, and the NABT Study). WCH found, and Dr. Jamal admits, that in respect of these studies, and in

respect of the WCH investigation, Dr. Jamal engaged in research misconduct including:

- Dr. Jamal intentionally manipulated study data in each of the JAMA Study, the Sclerostin Study and the NABT Study, with the intention of supporting the underlying study hypothesis in each case;
- Dr. Jamal made wholly unjustified and completely inappropriate allegations against her Research Associate;
- Dr. Jamal systematically altered patient records to match previously altered datasets;
- Dr. Jamal deleted relevant evidence after she had knowledge of the investigation;
- Dr. Jamal failed to maintain and properly archive raw data;
- Dr. Jamal failed to make raw data available to collaborators;
- Dr Jamal intentionally represented falsified and/or fabricated data as raw data;
- Dr. Jamal used falsified results from one study to apply, obtain and use funding for the follow-up Sclerostin and NABT studies.

Concerns Regarding the Integrity of Data Arose in the NABT Study

In July 2014, the collaborators in the NABT Study commenced the process of collecting and analyzing data. Serum and urine samples were analyzed by the University of Sheffield (the institution affiliated with Dr. Eastell) and the data derived from the samples was sent to Toronto for statistical analysis. Dr. Jamal's role was to complete the statistical analysis of the data collected in the NABT Study. While Dr. Jamal was assisted by her Research Associate in data entry tasks, her Research Associate was not trained to analyze data, and it was Dr. Jamal's sole responsibility to analyze data and run the statistical analysis.

On August 18, 2014, Dr. Jamal's Research Associate completed the data entry and provided Dr. Jamal with data files to use in her statistical analysis. Between August 20 and 25, 2014, Dr. Jamal generated a statistical analysis that she shared with her collaborators. As was revealed in the subsequent WCH investigation, unbeknownst to her colleagues and collaborators, Dr. Jamal had manipulated the data and falsified these study results.

On September 13, 2014, Dr. Jamal shared the favourable results of the statistical analysis on the NABT Study to a small group at the American Society for Bone Mineral Research ("ASBMR") Conference in Houston, which included Dr. Jamal's co-collaborators, Drs. Eastell and Dr. Cummings. Dr. Eastell, however, could not understand the results presented by Dr. Jamal, as one aspect was unexpected and not in keeping with the other results from a biological perspective. He asked Dr. Jamal to provide him with the data she relied on so that he could examine it. In response to his request, Dr. Jamal purported to send the data files that had been created by her Research Associate on the premise that this was the data that she relied on to conduct her statistical analysis. In fact, the WCH's investigation revealed that the files Dr. Jamal sent were not what her Research Associate had prepared. Rather, Dr. Jamal sent the files that contained the manipulated data she relied on in her statistical analysis, which she created moments before sending them to Dr. Eastell. Had Dr. Jamal sent Dr.

Eastell the files prepared by her Research Associate, Dr. Eastell would have immediately seen that the data did not support the results Dr. Jamal had circulated to collaborators and presented at the ASBMR meeting.

Ultimately, Dr. Eastell conducted his own statistical analysis, relying on data directly from the source. In his email to Dr. Jamal and Dr. Cummings he indicated that his results did not support the study hypothesis as they showed no difference between treatment groups compared with the placebo controls, a significant departure from Dr. Jamal's results.

The Research Associate, concerned with the discrepancy between Dr. Eastell's results and Dr. Jamal's, requested that Dr. Jamal send her a copy of the data she had sent to Dr. Eastell so she could re-check her data entry. She was concerned she may have made mistakes in her data entry, and that this may have impacted Dr. Jamal's analysis. Dr. Jamal purported to do this, but instead sent her Research Associate the data her Research Associate had prepared so that she would not see that Dr. Jamal had sent Dr. Eastell a different set of data. Had she actually provided her Research Associate with what she had provided to Dr. Eastell, her Research Associate may have detected that Dr. Jamal altered the data. The Research Associate reviewed the data and noted that she had made 16 typographical data-entry errors (in a dataset containing over 1000 reported values). The Research Associate corrected these typographical errors and provided a corrected spreadsheet to Dr. Jamal the same day. These typographical errors would not have generated the statistical analysis originally prepared by Dr. Jamal and shared with her collaborators and colleagues.

Dr. Jamal then purported to "re-enter" the data on her own. She generated a new statistical analysis and sent her results to Dr. Eastell and Dr. Cummings without copying her Research Associate. In her email, she represented that she re-entered the data provided from the source (the University of Sheffield) and confirmed her re-analysis was in line with Dr. Eastell's. She attached a word document with a statistical analysis and pointed to her Research Associate as the source of the discrepancy between her initial analysis and Dr. Eastell's.

Dr. Eastell continued to try to understand the difference between his analysis, which did not support the study hypothesis, and the one originally conducted by Dr. Jamal, which did support the study hypothesis. He examined the data from various sources including the original data derived from the serum and urine samples at the University of Sheffield and the data subsequently provided to him by Dr. Jamal. Subsequently, in his email to Dr. Cummings and Dr. Jamal he indicated that he was worried the changes could have been made deliberately as he could not think of another explanation. Dr. Jamal replied to Dr. Eastell indicating that she agreed with him and sought to deflect blame, advising her collaborators that the spread sheet she sent was based on her Research Associate's data.

On January 14, 2015, following Dr. Eastell's revelation that deliberate changes had been made to the data, Dr. Jamal, Dr. Cummings and Dr. Eastell participated in a

videoconference, focusing on Dr. Jamal's concern that the Research Associate had changed the data and how Dr. Jamal should approach the matter with her Research Associate.

On January 22, 2015, Dr. Jamal sent Dr. Cummings and Dr. Eastell a draft letter she had prepared to send to all those who had participated in the discussion about the NABT Study results at the ASBMR conference, wherein she acknowledged that the previous data that she had shared was incorrect, that the reanalysis demonstrated no relationship between bone turnover markers and nitrates, and that there had been systematic modifications to the data. In her email, Dr. Jamal advised Dr. Cummings and Dr. Eastell that she had spoken with her VP of Research about the concerns regarding the conduct of her Research Associate. This is untrue. Dr. Jamal mentioned nothing to the VP of Research.

After concerns were raised about the NABT data in late 2014 and early 2015, Dr. Cummings and Dr. Eastell discussed the need to confirm the published JAMA results. It seemed unlikely that the JAMA results would differ so significantly from the NABT results. Given that Dr. Cummings, Dr. Jamal and Dr. Eastell had sought funding for a planning grant for a large scale clinical trial (the NIH NO Planning Grant) based on the JAMA results, Dr. Cummings wanted to confirm the JAMA analysis. Accordingly, he requested that Dr. Jamal provide the raw data. On January 20, 2015, Dr. Jamal wrote to Dr. Cummings and Dr. Eastell claiming she had some "bad news" regarding the data sources for the JAMA paper. She advised that none of original/raw data remained available - it had either been lost or destroyed. On January 27, 2015, Dr. Jamal emailed Dr. Cummings advising that she, in fact, did locate some raw data for the JAMA Study. She attempted to discourage any further investigation into the JAMA data.

University of Toronto Inquiry

On February 25, 2015, the Scientific Director at the institution affiliated with Dr. Cummings, lodged a complaint against Dr. Jamal with the Research Oversight and Compliance Department of the University of Toronto, requesting an investigation into whether the data in the NABT Study had been intentionally manipulated and if so, by whom, and whether the raw data for the JAMA Study exists.
The University of Toronto conducted a preliminary inquiry.

Throughout the University of Toronto Inquiry, Dr. Jamal falsely maintained she played no role in the manipulation and fabrication of the study data and continued to deflect blame to her Research Associate seeking to avoid detection. In her submission to the University of Toronto Inquiry, Dr. Jamal purported to include the data sets prepared by her Research Associate. The files she provided to the University of Toronto Inquiry were, in fact, the files Dr. Jamal created shortly before she sent them to Dr. Eastell (and as subsequently determined, reflected the data she had manipulated). Dr. Jamal made this statement to deliberately mislead the Inquiry and to falsely and deliberately implicate her Research Associate. Dr. Jamal asserted falsely during the University of Toronto Inquiry that she was shocked and distraught to learn about the data

manipulation, wished that she had detected the error at an earlier stage, and that she had no intention to deceive anyone. She also falsely asserted that the complaint against her was motivated by Dr. Cummings' "deep personal interest" in ultimately proving nitrates can be used to prevent fractures.

Women's College Hospital ("WCH") Investigation

Following receipt of the University of Toronto Inquiry report, WCH assumed the sole jurisdiction for the investigation. On June 1, 2015, an Investigative Committee (the "IC") was appointed with a mandate to investigate the allegations of research misconduct alleged in the complaint and to expand the investigation if the evidence disclosed new related instances of possible misconduct.

After conducting its extensive investigation, in a report dated October 8, 2015, the IC concluded that she engaged in numerous acts of research misconduct, including that Dr. Jamal fabricated study data in each of the NABT, Scerlostin and JAMA studies to support the study hypothesis. Dr. Jamal acknowledges the extensive steps the IC was required to take to uncover her data falsification. As part of the IC's investigation, a forensic expert was retained to examine various computer hard-drives, email communication, data sets and documents, among other things, passed between researchers and collaborators in the JAMA Study, the Sclerostin Study and the NABT Study.

<u>Dr. Jamal Engaged in Professional Misconduct: NABT Study</u>

Following the extensive investigation of the IC, with respect to the NABT Study, it was determined, and Dr. Jamal admits, that:

- Dr. Jamal manipulated study data in August 2014 with the intention of supporting the underlying hypothesis that nitrates reduced bone loss and prevent osteoporotic fracture;
- Dr. Jamal presented these falsified results to her collaborators and to a small audience at the ASBMR conference;
- Contrary to the repeated assertions made by Dr. Jamal prior to and during the investigation, her Research Associate had no role in the falsification of the study data. These allegations by Dr. Jamal were wholly unjustified and completely inappropriate; and,
- Dr. Jamal engaged in numerous acts to avoid detection and falsely implicate her Research Associate once Dr. Eastell raised concerns that the data had been systematically modified, including ensuring her Research Associate was not copied on various emails, sending falsified data sets to Dr. Eastell and representing those were the data sets prepared by her Research Associate, and misrepresenting to her Research Associate what she had sent Dr. Eastell. Dr. Jamal continued to do the same throughout the University of Toronto Inquiry.

Dr. Jamal Engaged in Professional Misconduct: Sclerostin Study

The IC also closely examined the Sclerostin Study which had been initiated in or around 2011 following the JAMA Study. The hypothesis of the Sclerostin Study was that active treatment subjects receiving nitroglycerin would experience a decrease in serum sclerostin and a corresponding increase in bone mass.

In December 2011, Dr. Jamal provided her collaborators with data in a form ready for statistical analysis, which she purported was the raw data for the Sclersotin Study. However, as revealed by the IC investigation, unbeknownst to her collaborators, the data contained in these files had been manipulated by Dr. Jamal in a systematic fashion to support the study hypothesis.

In early 2012, Dr. Jamal's colleagues noted that Dr. Jamal appeared to have relied on a different set of data than one of their collaborators who had run his own statistical analysis. Dr. Jamal initially identified the correct data, but then, on more than one occasion, specifically directed her colleague to rely on the data she had falsified, claiming it was the correct data. The statistical analysis prepared by her colleague based on the falsified data demonstrated significant reduction of sclerostin in the treatment group. Ultimately, Dr. Jamal's colleagues prepared a manuscript based on this analysis, stating "our results suggest that nitroglycerin treatment substantially increases bone mass in postmenopausal women by decreasing sclerostin production". This conclusion was based on Dr. Jamal's manipulated data. Dr. Jamal reviewed and approved the paper and is identified as an author. The manuscript was submitted for review but was rejected. It was not resubmitted.

With respect to the Sclerostin Study, the IC determined, and Dr. Jamal admits:

- Dr. Jamal manipulated study data with the intention of supporting the underlying hypothesis that active treatment subjects would see a decrease in serum sclerostin; and
- Dr. Jamal directed her colleague to rely on the altered data, representing that it was the accurate data when discrepancies arose in the analysis.

Dr. Jamal Engaged in Professional Misconduct: JAMA Study

Intentional manipulation of Study Data

The JAMA study commenced in November 2005 and was completed in March 2010. It involved obtaining three different measurements from study subjects: Bone Mineral Density ("BMD") involving scans carried out on study subjects; Peripheral quantitative computed tomography ("pQCT") involving scans carried out on study subjects; and BSAP and NTx measured using subjects' serum and urine samples. Dr. Jamal had full access to all of the data in the study and took responsibility for the integrity of the data and the accuracy of the data analysis.

The IC's investigation revealed that Dr. Jamal:

- Systematically altered the BMD data intentionally manipulating it to increase the apparent effectiveness of the treatment, in support of the study hypothesis;
- Systematically altered the pQCT data intentionally manipulating it to increase the apparent effectiveness of the treatment, in support of the study hypothesis; and,
- Systematically altered BSAP and NTx data by reducing the placebo values and increasing the active treatment group data by constant amounts, in support of the study hypothesis.

Dr. Jamal's data manipulation remained undetected until 2015 when concern arose in the NABT Study and her collaborators became frustrated with her failure to deliver the raw data for the JAMA Study, giving rise to the complaint and ultimately the IC's investigation.

Deceiving Colleagues during IC Investigation

When Dr. Cummings and Dr. Eastell discussed the need to confirm the published JAMA results given the NABT results and asked Dr. Jamal to provide the raw data for the JAMA Study, Dr. Jamal sent to Dr. Cummings what she purported was the "raw data" for one of the study measurements. However, the data she provided was data that she had systematically modified. During the IC's investigation, Dr. Jamal continued to falsely maintain that the data she had sent to Dr. Cummings in April 2015 was the actual raw data for the particular measurement.

The IC determined that some of the raw data for the JAMA study had been available to Dr. Jamal such that she could have provided this information to her collaborators as requested. Instead, Dr. Jamal provided altered patient records attempting to pass them off as "raw data" in her possession, and knowingly provided inaccurate data to her collaborators.

Tampering with Patient Records in an Attempt to Avoid Detection

The IC investigation revealed that active treatment subjects' BMD scans had been replaced with scans from other patients, most of whom were not participants in the JAMA Study. Dr. Jamal took BMD scans (patient records) from various patients who had no connection to the study, redacted their names and other information, including scan dates, hand wrote a study subject ID on the patient record, and attempted to pass off the scans as the "raw data" that supported the published study analysis. To do this, Dr. Jamal accessed confidential patient records for an improper purpose, without consent or legal authority to do so, in violation of patient confidentiality and privacy. Dr. Jamal had provided photocopies of these doctored BMD scans to Dr. Cummings under the pretense of providing him the raw data for the JAMA Study.
The IC investigation also revealed that Dr. Jamal manually altered pQCT records (patient records), by superimposing false data onto the actual patient record. The alteration was deliberate and designed to give the appearance that the hard copy pQCT

scans Dr. Jamal was providing to the IC was “raw data” that matched the published JAMA results. Dr. Jamal held out these doctored records to the IC as *bona fide* patient records containing what purported to be the “raw data” that supported the published study analysis.

Dr. Jamal’s actions with original patient records (BMD scans and pQCT records) amount to a misuse and misappropriation of confidential patient information, in violation of patient confidentiality and privacy.

Dr. Jamal’s misconduct during investigation

Dr. Jamal also engaged in additional misconduct during the IC’s investigation by taking steps to make relevant evidence unavailable to the IC:

- When advised that a forensic investigation was going to be conducted on some or all of her computers, she was untruthful regarding the whereabouts of her old computer she used up until January 2014, initially stating she was unaware of its whereabouts and then later acknowledging accessing it. Video footage and witness accounts established that Dr. Jamal removed a computer from the premises during the investigation and it could not be located. In addition Dr. Jamal removed her current computer from her office and brought it to her home. While she falsely claimed she did not alter any data on her current computer, forensic analysis established that she did, in fact, delete relevant files on May 23, 2015, thereby destroying evidence and obstructing the investigation.
- Dr. Jamal entered Canadian Blood Services where raw blood and urine samples from the JAMA Study were stored. She manipulated freezer temperatures, affecting the samples that had been maintained, in order to cover up her misconduct.

Some Consequences of Dr. Jamal’s Misconduct

As early as 2010, Dr. Jamal falsified results leading to the JAMA publication to support a clinical hypothesis, and further studies intended to bolster these findings (Sclerostin and NABT). As part of the JAMA Study, falsified results were communicated to study participants. In some cases, results were copied to the study participant’s family doctor; in other cases, study participants were told to take the results to their family doctor. None of the participants had osteoporosis. The consent forms executed by patients advised that if the study was successful, further research would be required before nitroglycerin treatment would be available for use.

Knowing that she had falsified the JAMA results to support her hypothesis regarding nitroglycerin treatment, Dr. Jamal then continued to collaborate with others, to obtain funding, including from NIH and CIHR, to conduct further research (for example, the Sclersotin Study and NABT Study), including research on human subjects, without any evidentiary foundation.

There are known risks associated with nitrate treatment, including headache, nausea

and postural hypotension. In the JAMA Study, for example, 104 of 157 women who dropped out of the one-week run-in phase reported headaches and nausea. Dr. Jamal placed patients in a subsequent clinical study (the NABT Study), exposed these patients at a minimum to the risk of headaches, and did so with knowledge that there was no basis to support any potential benefit.

Following the IC Investigation, WCH notified each participant in the JAMA Study that they may have in fact received incorrect results. Participants were asked to advise their family physicians, who could in turn consider this information in the ongoing monitoring of the individual's bone health. WCH has stated that "there is no evidence of negative outcomes for any of these research participants."

In December 2015, the Journal of the American Medical Association retracted the JAMA Study.

On May 4, 2016, the President of CIHR declared Dr. Jamal permanently ineligible to hold, participate in, or apply for CIHR funding or funding from the other two federal research agencies (NSERC or SSHRC) or any Tri-Agency programs; and permanently ineligible to participate in Agency review processes. She is also required to reimburse CIHR for the funds spent on the study.

Disposition

The Discipline Committee ordered and directed that:

- the Registrar revoke Dr. Jamal's certificate of registration effective immediately.
- Dr. Jamal appear before the panel to be reprimanded.
- Dr. Jamal pay costs to the College in the amount of $5,500.00 within 30 days of the date of this Order.

3. Dr. K.W-M. Leung

Name:	Dr. Kelvin Wing-Ming Leung
Practice:	Family Medicine
Practice Location:	Toronto
Hearing:	Agreed Facts and Joint Submission on Penalty
Finding/Penalty Decision Date:	December 11, 2017
Written Decision Date:	February 12, 2018

Allegations and Findings

- Failed to maintain the standard of practise – **proved**
- Disgraceful, dishonourable and unprofessional conduct – **proved**
- Incompetence **– withdrawn**

Summary

2014 Mandatory Report

In December 2014, the College received a mandatory report from a family physician expressing concern about Dr. Leung's treatment of hemorrhoids in an 18 yr. old patient who had attended at Dr. Leung's office for a follow up for chlamydia. The patient did not consent to be identified in the report.

Patient A

In December 2014, Patient A presented at Dr. Leung's office with left knee pain. On examining her left hip and lower abdomen, Dr. Leung queried a potential ovarian abnormality. Dr. Leung conducted a vulvar, pelvic and visual peri-anal examination of Patient A, during which he noted an internal hemorrhoid, which he proceeded to incise and cauterize.

In January 2015, following Patient A's complaint, the medical expert retained by the College opined that while the recommended plan to use anti-inflammatories and to participate in physical therapy seemed appropriate, Dr. Leung did not meet the standard of practice of the profession in his care of Patient A including: poor record keeping, examining the patients lower abdomen when not indicated, a pelvic exam when not indicated, a peri-anal exam in an asymptomatic patient, and subsequently recommending and performing a hemorrhoid treatment that was neither indicated nor evidence based. The medical expert concluded that Dr. Leung's treatment of Patient A fell below the standard of practice of the medical profession and that providing this patient with a non-indicated pelvic exam and subsequently a non-indicated hemorrhoid treatment exposed this patient to harm. He further concluded that Dr. Leung`s knowledge and judgment with respect to hemorrhoid treatments and performing non indicated peri-anal and pelvic exams falls well below the standard of practice of the profession.

Dr. Leung retained a medical expert who pointed out that Patient A acknowledged during an interview with the College that nothing seemed out of the ordinary about the pelvic examination and in her mind, it was like a normal vaginal examination.

The Investigation

The College conducted an investigation pursuant to s. 75(1)(a) of the *Health Professions Procedural Code* of Dr. Leung's practice of hemorrhoid treatment. When advised of the Investigation and the potential concerns regarding the appropriateness of his hemorrhoid procedures, Dr. Leung voluntarily stopped performing all hemorrhoid procedures and has not performed any hemorrhoid procedures since that time. He has agreed not to perform any such procedures in the future.

Upon reviewing 10 female patients' charts, the medical expert retained by the College made positive findings including: Dr. Leung appropriately treated one patient and she was comfortable with the care provided for genital warts; a patient's UTI was treated appropriately; a third patient had an appropriate pelvic exam and vaginal swab and education about conservative measures; a fourth patient had an appropriate pelvic exam and Dr. Leung displayed a good knowledge base regarding the differential diagnosis of pelvic pain; regarding a fifth patient, there was no concern regarding Dr. Leung's knowledge, judgment or skill and he is not exposing patients to harm regarding prenatal care; in a sixth patient, plantar wart treatment was well documented and appropriate; a seventh patient was treated appropriately for peri anal warts. The medical expert concluded that Dr. Leung fell below the standard of care expected by the profession in 9 of the 10 charts reviewed; his knowledge and judgement with respect to hemorrhoid treatments fell below the standard of care of the profession; and providing these treatments exposed 9 patients to potential harm. Specific concerns included:

- Dr. Leung performing intimate exams (rectal, peri-anal) without clear indication and consent.
- Multiple rectal area exams and hemorrhoid treatments did not have clear explicit indications.
- Lack of informed consent to perform intimate exams and hemorrhoid treatments
- Dr. Leung's record keeping in all ten charts fell below the standard expected.

Upon reviewing 10 male patients' charts, the medical expert made positive findings including:

Dr. Leung appropriately recommended conservative measures for one patient's anal complaint; regarding treatment of hemorrhoid concerns in four patients, Dr. Leung met the standard of practice of the profession, did not display a lack of knowledge, lack of skill, nor a lack of judgment and did not expose patients to harm. However, the expert opined that Dr. Leung's record-keeping fell below the standard of practice of the profession in all 10 cases. Dr. Leung met the standard of practice in his care of 4 out of 10 patients. In 5 of 10 patient charts reviewed, Dr. Leung displayed a lack of knowledge and judgment with respect to the hemorrhoid treatment. He was over treating hemorrhoids without a period of conservative measures; the treatment protocol was not evidence-based and is not the standard of practice. Dr. Leung exposed 5 out of 10 patients to potential harm in performing a procedure on the perineum that was not indicated.

The medical expert retained by Dr. Leung indicated that genital urinary (GU) examinations were performed on 5 of the female patients for legitimate reasons.

2017 Interim Order of the ICRC

On January 18, 2017, allegations of Dr. Leung's professional misconduct were referred to the Discipline Committee. On February 10, 2017, the Inquiries, Complaints and

Reports Committee (ICRC) made an interim order which included, among other things, the following requirements:

- Dr. Leung is not to perform hemorrhoid procedures;
- Dr. Leung is to post a sign in his office indicating that Dr. Leung must not perform hemorrhoid procedures;
- Dr. Leung is not to engage in any professional encounters except in the presence of a Practice Monitor;
- Dr. Leung is to post a sign in his office indicating that Dr. Leung must not have any professional encounters with any patients unless a practice monitor is present and that Dr. Leung must not be alone with any patients in any examination or consultation room;
- Dr. Leung is to notify patients of the details of the restriction to practice unless a Practice Monitor is present;
- Dr. Leung is to maintain a log of all intimate examinations conducted and the indication for the examination and ensure his Practice Monitor verifies the accuracy;
- Dr. Leung is to practice under the guidance of a clinical supervisor; and
- Dr. Leung is to consent and submit to monitoring by the College.

Dr. Leung billed for all of the services at issue.

Compliance and Monitoring

On March 1, 2017, Compliance Monitoring and Supervision conducted an unannounced compliance visit to Dr. Leung's office. It was observed that the Practice Monitor did not have her own username for the electronic medical records (EMR) system and was signing off patient encounter notes under Dr. Leung's username. Once Dr. Leung was informed that he must provide the Practice Monitor with her own password that is unknown to other clinic users, he contacted the EMR vendor to make arrangements. On March 8, 2017, the Practice Monitor informed the College that Dr. Leung had provided her with her own a username. Dr. Leung provided the Practice Monitor with her own password by March 23, 2017.

On March 29, 2017, the College received a document from the Practice Monitor that Dr. Leung had given the Practice Monitor, authored by Dr. Leung, in which Dr. Leung expressed his feelings with respect to the College process.

On May 2, 2017, an additional allegation was referred to the Discipline Committee that Dr. Leung engaged in disgraceful, dishonourable or unprofessional conduct in his conduct in implementing the s.37 Order, including in his dealings with his practice monitor and patients.

The following facts were presented during the penalty portion of the hearing:
Dr. Leung has not had any prior allegations referred to the Discipline Committee or findings made against him.

Dr. Leung has had a Practice Monitor present for every patient encounter since February 10, 2017.

Since the Interim Order has been in place, Dr. Leung has had to arrange for 5 different Practice Monitors acceptable to the College. He has had up to four Practice Monitors at one time in order to have adequate coverage but currently only has two Practice Monitors because of Practice Monitors leaving for other positions.
Dr. Leung has paid all of the costs associated with the practice monitoring. To date, the costs of practice monitoring are approximately $29,500.

Disposition

The Discipline Committee ordered and directed that:

- the Registrar suspend Dr. Leung's Certificate of Registration for a two month period commencing December 18, 2017.
- the Registrar impose the following terms, conditions and limitations on Dr. Leung's Certificate of Registration:
  Practice Restriction
  - Dr. Leung shall not perform hemorrhoid procedures.

  Posting a Sign (Practice Restriction)
  - Dr. Leung shall post a sign in the waiting room(s) of all his Practice Locations, in a clearly visible and secure location, in the form set out at Appendix "A." For further clarity, this sign shall state as follows: "Dr. Leung must not perform hemorrhoid procedures. Further information may be found on the College of Physicians and Surgeons of Ontario website at www.cpso.on.ca".
  - Dr. Leung shall post a certified translation(s) in any language(s) in which he provides services, of the sign described above in the waiting room(s) of all his Practice Locations, in a clearly visible and secure location, in the form set out at Appendix "A."
  - Dr. Leung shall provide the certified translation(s) to the College within thirty (30) days of the date of this Order.
  - If Dr. Leung elects, after the date of this Order, to provide services in any other language(s), he will notify the College prior to providing any such services.
  - Dr. Leung shall provide to the College the certified translation(s) prior to beginning to provide services in the language(s) described in (v) above.
    Practice Monitor and Patient Log
  - Dr. Leung shall not engage in any professional encounters of any kind (the "Patient Encounter") with patients, unless the Patient Encounter takes place in the continuous presence of 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. Leung shall ensure that the Practice Monitor shall:
    - Provide reports (as described in the Practice Monitor's undertaking) to

the College on a monthly basis;
- Remain present at all times during all Patient Encounters, even if another person is accompanying the patient, and carefully observing all of Dr. Leung's Patient Encounters including, but not limited to, physical examinations. It is Dr. Leung's obligation to ensure that the Practice Monitor's view of his examinations is unobstructed at all times;
- Refrain from performing other functions, except those required in the Practice Monitor's undertaking attached as Appendix "B", while observing all Patient Encounters;
- Maintain a log of all Patient Encounters in the form attached as Appendix "C" (the "Log");
- Initial all corresponding entries in the records of patients noted in the Log; and
- Submit the original Log to the College on a monthly basis.

- Dr. Leung shall maintain a copy of the Log at all times, and shall make it available to the College upon request.

Posting a Sign (Practice Monitor)

- Dr. Leung shall post a sign in his waiting room(s) and each of his examination and/or consulting rooms, in all of his Practice Locations, in a clearly visible and secure location, in the form attached hereto as Appendix "D" that states: "Dr. Kelvin Wing-Ming Leung must not have any professional encounters with any patients unless under the continuous observation of a practice monitor acceptable to the College of Physicians and Surgeons of Ontario. Further information may be found on the College website at www.cpso.on.ca."
- Dr. Leung shall post a certified translation(s) in any language(s) in which he provides services, of the sign described in (xi) above, in his waiting room(s) and each of his examination and/or consulting rooms, in all of his Practice Locations, in a clearly visible and secure location.
- Dr. Leung shall provide the certified translation(s) described in (xii) above to the College within 30 days of the date of this Order.

Notifying Patients

- Dr. Leung is to directly notify each patient scheduled for an appointment with him, prior to the appointment, and at least within seven (7) days after the appointment is booked, of the details of the restriction described in section b(i) above or section d(ii) below.

Clinical Supervision: Indication for Intimate Examinations

Intimate Examination Log

- Dr. Leung shall maintain an up-to-date daily log listing every patient seen by him in his family practice, including the patient's name, date of birth, OHIP number, date of appointment or visit, reason for visit, any intimate examination(s) conducted and the indication for the examination in the form attached as Appendix "E" (the "Intimate Examination Log").

- Dr. Leung shall ensure that his Practice Monitor verifies the accuracy of each entry and initials the Intimate Examination Log after every patient encounter**.**

Supervision

- For a period of six months from the date of resumption of practice following suspension, Dr. Leung shall practise under the guidance of a clinical supervisor(s) acceptable to the College in respect of the indication for intimate examinations in his family medicine practice (the "Clinical Supervisor(s)"), at his own expense.
- Dr. Leung shall meet with the Clinical Supervisor(s) once every two weeks, which shall consist of the Clinical Supervisor reviewing Dr. Leung's Intimate Examination Log, with reports to be provided to the College at least monthly by the Clinical Supervisor(s). The Clinical Supervisor shall examine the relevant patient charts if and when there is concern about the indication of any intimate examination conducted.
- Dr. Leung shall provide his Clinical Supervisor(s) with full access to his OHIP billings, his appointment scheduling book/program, and the Intimate Examination Log. He shall maintain the original Intimate Examination Log and shall send a copy to the College at the end of every calendar month.
- Dr. Leung shall ensure that the undertaking of the Clinical Supervisor(s) attached at Appendix "F" to this Order is delivered to the College within ten (10) days of the date of this Order. If Dr. Leung has not delivered the Clinical Supervisor(s)' undertaking to the College by that date, Dr. Leung shall cease to practise family medicine until delivery of the undertaking, and the fact that he has done so will constitute a term, condition or limitation on his certificate of registration.
- Dr. Leung shall fully cooperate with the clinical supervision of his family medicine practice, and shall abide by any recommendations of his Clinical Supervisor(s).
- If a Clinical Supervisor(s) who has given an undertaking in Appendix "F" to this Order is unable or unwilling to continue to fulfil its terms, Dr. Leung shall, within ten (10) 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. Leung is unable to obtain a Clinical Supervisor in accordance with this Order, he shall cease practising family medicine immediately until such time as he has done so, and the fact that he has done so will constitute a term, condition or limitation on his certificate of registration until that time.

Reassessments

<u>Six Month Reassessment</u>

- At six (6) months following from the date of resumption of practice following suspension, Dr. Leung shall submit to an assessment of his practice by an assessor or assessors selected by the College (the

"Assessment"). The Assessment may include chart reviews, direct observation of Dr. Leung's care, interviews with colleagues and co-workers, feedback from patients and any other tools deemed necessary by the College. Dr. Leung shall abide by all recommendations made by the assessor(s), and the results of the Assessment will be reported to the College and may form the basis of further action by the College;

- In the event the reassessment is positive, the practice restriction set out at b(vii) above can be varied to: Dr. Leung shall not engage in any breast, pelvic, genital, urinary, perineal, perianal and rectal examinations of patients, unless the examination takes place in the continuous presence of and under the continuous observation of a monitor who is a regulated health professional acceptable to the College (the "Practice Monitor").
- If and when the role of the practice monitor is reduced, Dr. Leung shall post a sign in his waiting room(s) and each of his examination and/or consulting rooms, in all of his Practice Locations, in a clearly visible and secure location, in the form attached hereto as Appendix "G" that states: "Dr. Kelvin Wing-Ming Leung must not conduct breast, genital, urinary, or rectal examinations except under the continuous observation of a practice monitor acceptable to the College of Physicians and Surgeons of Ontario. Further information may be found on the College website at www.cpso.on.ca."
- The Undertaking of the Practice Monitor is attached at Appendix "H" to this Order.

<u>Eighteen Month Reassessment</u>

- At eighteen (18) months following from the date of resumption of practice following suspension, Dr. Leung shall submit to a further assessment of his practice by an assessor or assessors selected by the College (the "Assessment"). The Assessment may include chart reviews, direct observation of Dr. Leung's care, interviews with colleagues and co-workers, feedback from patients and any other tools deemed necessary by the College. Dr. Leung shall abide by all recommendations made by the assessor(s), and the results of the Assessment will be reported to the College and may form the basis of further action by the College;
- In the event the reassessment is positive, Dr. Leung will no longer be required to conduct breast, pelvic, genital, urinary, perineal, perianal and rectal examinations in the presence of a practice monitor.

Education

- Dr. Leung will successfully complete, within six months of the date of this Order, a one on one educational session to address the sensitivity of patients with regards to intimate examinations.
- Dr. Leung will successfully complete instruction in medical record keeping within six months of the date of this Order.

Costs

- Dr. Leung shall be responsible for any and all costs associated with implementing the terms of this Order

Monitoring

- Dr. Leung shall inform the College of each and every location that he practices or has privileges including, but not limited to, hospital(s), clinic(s) and office(s), in any jurisdiction (collectively the "Practice Location(s)"), within five (5) days of this Order. Going forward, he shall inform the College of any and all new Practice Locations within five (5) days of commencing practice at that location.
- Dr. Leung shall consent to the College to make appropriate enquiries of the Ontario Health Insurance Plan and/or any person or institution who may have relevant information in order for the College to monitor Dr. Leung's compliance with the terms of this Order and shall promptly sign such consents as may be necessary for the College to obtain information from these persons or institutions;
- Dr. Leung shall submit to, and not interfere with, unannounced inspections of his Practice Locations and to inspections of patient charts by the College and to any other activity the College deems necessary in order to monitor Dr. Leung's compliance with the terms of this Order;
- Dr. Leung shall consent to the College providing any and all information to the Practice Monitor and Clinical Supervisor that the College deems necessary or desirable in order to assist the Practice Monitor and Clinical Supervisor in fulfilling their Undertakings and in order to monitor Dr. Leung's compliance with the terms of this Order;
- Dr. Leung shall consent to all Practice Monitors and Clinical Supervisor to disclose to the College, and to one another, any information relevant to this Order, relevant to the terms of the Practice Monitor's or Clinical Supervisor's Undertaking and/or relevant for the purposes of monitoring Dr. Leung's compliance with this Order; and
- Dr. Leung shall consent to the College providing the Order to any Chief(s) of Staff, or a colleague with similar responsibilities, at any Practice Location where he practices or has privileges ("Chief(s) of Staff"), and to provide said 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. Leung appear before the panel to be reprimanded.
- Dr. Leung pay costs to the College in the amount of $5,500.00 within thirty (30) days of the date of this Order.

Conduct Unbecoming a Physician – 1 case

1. Dr. L.C. Wright

Name:	Dr. Leslie Curtis Wright
Practice:	Psychiatry
Practice Location:	Toronto
Hearing:	Statement of Facts and Joint Submission on Penalty

Finding/Penalty Decision Date: February 21, 2018
Written Decision Date: April 23, 2018

Allegations and Findings

- Conduct Unbecoming a physician – **proved**
- Disgraceful, dishonourable, or unprofessional conduct – **withdrawn**

Summary

Dr. Wright is a psychiatrist who practises in Toronto. He obtained his medical degree in 1993, completed his specialty training in psychiatry in 1998, and obtained his Certificate of Independent Practice in Ontario on June 30, 1998.

In about 2012, Dr. Wright became particularly active on social media sites, including Facebook groups touching on various social and political issues, including feminist issues. When posting messages in the online chat groups, Dr. Wright identified himself as a psychiatrist who is single and practising in the city of Toronto.

Beginning in 2012, Dr. Wright began to, by various online messaging routes, systematically approach and befriend women who were also followers of the Facebook groups in which Dr. Wright participated, or who were friends of the followers he befriended. All of the women resided in the United States. After establishing a connection, Dr. Wright would immediately send numerous messages to the women. The original messages were about shared issues from the Facebook groups (generally "progressive" feminist issues). In the messages, Dr. Wright referred to his status as a psychiatrist in Ontario and discussed therapeutic techniques and mental health issues in a general manner. Dr. Wright then rapidly sexualized the conversations, engaging in online sexual relationships in a lewd manner. This included sending the women naked pictures of himself, including his genitalia, and encouraging them to send him naked pictures of themselves, including their genitalia. He engaged in repeated, explicit and graphic intimate and online sexual behaviour with multiple women at the same time. When one of the women got upset with him about his continued sexualization of their discussions, he replied "*No one is responsible for another's feelings. Cardinal rule in my line of work*." On occasion, Dr. Wright would provide medical comments directly connected to the women's own health issues such as post-surgical pain, fibromyalgia, chronic pain and the use of narcotics.

The women with whom Dr. Wright established these relationships on the internet learned that he had engaged in the same behaviour with multiple women at the same time. The women requested that Dr. Wright cease contacting them, but he did not immediately do so. The women were not patients of Dr. Wright.

The College has a guideline on social media use by its members. It recommends, among other things, that physicians:

> "Protect their own reputation, the reputation of the profession, and the public trust by not posting content that could be viewed as unprofessional. Be mindful of their Internet presence, and be proactive in removing content posted by themselves or others which may be viewed as unprofessional."

Disposition

The Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Wright's Certificate of Registration for a one month period, commencing February 22, 2018.
- The Registrar impose the following as a term, condition and limitation on Dr. Wright's certificate of registration:
  - Dr. Wright 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, by August 31, 2018. Dr. Wright will agree to abide by any recommendations of the PROBE program and provide proof of completion to the College.
- Dr. Wright appear before the panel to be reprimanded.
- Dr. Wright pay costs to the College in the amount of $5,500.00 within thirty (30) days of the date of this Order.

Disgraceful, Dishonourable, or Unprofessional Conduct - 7 cases

1. Dr. M.A.H. Al Abdulmohsin

Name:	Dr. Mohammed Abdullah H. Al Abdulmohsin
Practice:	Thoracic Surgery
Practice Location:	Hamilton
Hearing:	Allegations Contested Joint Submission on Penalty
Finding/Written Decision Date:	October 11, 2017
Penalty Decision Date:	December 18, 2017
Penalty Written Decision Date:	February 15, 2018

Allegations and Findings

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

Summary

Dr. Al Abdulmohsin is a general surgeon, who participated in a PGY 7 residency in thoracic surgery at McMaster University, funded by the Saudi Bureau. Dr. Al Abdulmohsin is a graduate of the Arabian Gulf University in Bahrain. In 2012, he was granted an Independent Practice Certificate by the College.

OHIP Billings

In June 2014, the College received a mandatory report by McMaster University indicating that Dr. Al Abdulmohsin was suspended due to inappropriate OHIP Billing. The College was notified that Dr. Al Abdulmohsin billed OHIP for services he provided during his thoracic surgery residency, despite this not being permitted under the agreement between the Saudi Bureau and Revenue Canada.

Prior to this, Dr. Al Abdulmohsin approached the Division Head and the Program Director at McMaster University to ask whether he could submit OHIP billings to help supplement his income. He was advised that he was not permitted to do so, as this would be considered double billing, given that he was being paid by the Saudi Bureau for his training. It was explained to Dr. Al Abdulmohsin that he was being paid a salary to learn through his program, and as a result, he could not bill for procedures that he observed during his learning period.

In April 2014, the thoracic surgeons at Hamilton Healthcare and McMaster University discovered that despite being told he was not permitted to do so, Dr. Al Abdulmohsin, submitted clinical billings to OHIP for the purposes of personal payment. Dr. Al Abdulmohsin was placed on paid leave from the program for two months.

In May 2014, Dr. Al Abdulmohsin submitted a letter to the Assistant Dean at the University asserting that there was a misunderstanding as to what was communicated to him by the Division Head and the Program Director regarding his request to bill. Dr. Al Abdulmohsin stated in the letter that other than concerns raised by the post graduate office regarding income tax issues, no other concerns were expressed to him in response to his request to bill and there were no concerns regarding general propriety of his billing. Given that Dr. Al Adulmohsin was advised by the Division Head and the Program Director that he was not permitted to bill OHIP, the information he provided in his letter to the Assistant Dean in May 2014 was inaccurate.

In May 2014, Dr. Al Abdulmohsin voluntarily proposed that he be re-admitted to the thoracic surgery residency program conditional upon his repayment of the full amount billed to OHIP, completing McMaster University professionalism training sessions at his own cost, and issuing an apology to the staff and the program. Dr. Al Abdulmohsin completed these terms and was re-admitted to the thoracic surgery residency program in June, 2014.

The Committee found that Dr. Al Abdulmohsin engaged in conduct which would reasonably be regarded by members as disgraceful, dishonourable or unprofessional by inappropriately submitting OHIP clinical billings for payment for services he provided during his residency education program for personal gain, despite this not being permitted under the agreement between the Saudi Bureau and Revenue Canada and against the express advice of his Divisional Chief and Program Director.

Dealings with Nursing Staff at the Hospital

As part of the mandatory report by McMaster University in June 2014, the College was also notified about complaints from two nurses at the Hospital where Dr. Al Abdulmohsin completed his residency. The two nurses complained that Dr. Al Abdulmohsin's behaviour made them feel uncomfortable. The complaints were addressed by the Hospital in 2012 and the behaviour was not repeated.

The first nurse was a young, recent graduate, who was working at the Hospital in 2012. She testified that when she first met Dr. Al Abdulmohsin, he was very friendly. Over a few months he became more physical. He would lean forward slightly and begin conversing to the point where she would move away. That evolved within the first year or two to his placing his hands on the small of her back, close to the line of her scrub pants, while he was speaking with her. She estimated this happened at least 20 times. She described Dr. Al Abdulmohsin's placing of his hand at the small of nurses' backs to be a frequent occurrence on the Unit, especially with newer younger staff. This behavior progressed to an event that caused her particular discomfort. She testified that one day, she was charting at the nursing station. Approximately nine or ten nursing colleagues were present in the same area. She asked Dr. Al Abdulmohsin a question; he approached her from behind and as he was speaking to her, he started to massage her shoulders, which she found uncomfortable. She responded by raising her shoulders to her ears and pushing the chair away and she told Dr. Al Abdulmohsin to stop. She told him that it made her very uncomfortable, and she asked him not to do it again. She testified that Dr. Al Abdulmohsin appeared embarrassed when she confronted him; he finished replying to her questions and then left the work space. After making a complaint via her charge nurse, she did not experience any further unwanted behaviour from him. She developed personal strategies by placing physical barriers to prevent further conversations in close proximity to him, and he did not advance further than that. As far as she was concerned, the issue had been resolved.

The second nurse was a young nurse working at the Hospital in 2012. She testified that she witnessed Dr. Al Abdulmohsin's behaviour of frequently massaging the shoulders of nurses and other staff, and she discussed the behaviour with fellow nursing staff. She testified that several times, she personally experienced Dr. Al Abdulmohsin rubbing or massaging her lower mid back. She also recalled one particular incident of Dr. Al Abdulmohsin caressing the upper part of her wrist with a circular gesture. She testified that she told Dr. Al Abdulmohsin at times to stop. Dr. Al Abdulmohsin's conduct caused her to complain to her charge nurse.

The second nurse also testified that after she got engaged to be married, she was upset and hurt by an unsolicited comment from Dr. Al Abdulmohsin. He asked her why she would want to stay with someone for the rest of her life. She said that he didn't express it as a joke, that he was very serious.

Four other nurses and the Division Head testified in relation to Dr. Al Abdulmohsin's behaviour. One nurse indicated that she witnessed Dr. Al Abdulmohsin's behaviour of approaching the nursing staff from behind and rubbing their shoulders, but stated that she did not experience such behaviour toward herself. The other three nurses testified that they observed Dr. Al Abdulmohsin's tactile behaviour. All three nurses testified that they were not disturbed by it. One nurse indicated that being tactile was part of his personality. Another nurse, who worked with him for several years, considered his behaviour appropriate in the workplace. The Division Head testified that when confronted with these complaints, Dr. Al Abdulmohsin was surprised, apologetic and embarrassed and responded that he would change his behaviour to accommodate the requests of the nurses. No further complaints regarding this type of Dr. Al Abdulmohsin's behaviour were received.

The Committee found that Dr. Al Abdulmohsin engaged in conduct which would reasonably be regarded by members as unprofessional by touching two nurses in an intimate an intrusive manner.

The Committee found that Dr. Al Abdulmohsin repeatedly touched the two nurses on the small of their backs, close to the line of their scrub pants, massaged the one nurse's shoulders on one occasion, and caressed the other nurse's wrist on one occasion. Massaging professional colleagues, touching them at their waistline, and caressing their wrists are intrusive acts and are of an intimate nature. These actions cross acceptable boundaries, and they constitute unprofessional conduct.

Boundaries in a physician's workplace are important so as to provide an atmosphere of safety and respect for all health professionals working there. The intrusion by a member of the health care team into the physical space of another could precipitate many reactions, including fear and discomfort, and can have negative consequences for the overall collegiality of the workplace environment. In this case, Dr. Al Abdulmohsin's touching caused discomfort to two nurses to the extent that they complained; one of the nurses even took steps to avoid him touching her in the future.

It does not matter that only two individual nurses out of a larger group complained, or that other nurses found Dr. Al Abdulmohsin's tactile behaviour toward them to be acceptable. This does not change the fact that he crossed acceptable boundaries in his conduct toward the two nurses.

The fact that his inappropriate physical behaviour toward nurses stopped after it was brought to Dr. Al Abdulmohsin's attention does not detract from the finding that his conduct was unprofessional. A single event can constitute professional misconduct, and in this case there was more than one instance of unprofessional behaviour. Considering

the context, and the at least seven years of experience that Dr. Al Abdulmohsin had as a surgical resident, he should have known better and should have been more sensitive to the effect of his actions.

The evidence indicated that Dr. Al Abdulmohsin was surprised, apologetic and embarrassed when he was told that his behaviour had caused harm and discomfort to his nursing colleagues. Furthermore, as soon as the concern about his behaviour was brought to his attention, he stopped the behaviour and did not repeat it. Generally, conduct that is disgraceful or dishonourable carries an element of moral failure, whereas unprofessional conduct does not require dishonest or immoral elements. Therefore, while finding Dr. Al Abdulmohsin's conduct is unprofessional, the Committee was not satisfied that it was disgraceful or dishonourable.

The Committee found that that the allegation, of disgraceful, dishonourable or unprofessional conduct, was not proven in relation to Dr. Al Abdulmohsin's comment to the second nurse regarding staying with her husband. The Committee found that while the comment was inappropriate and was a further indication of Dr. Al Abdulmohsin's limited awareness of the effects of his actions on colleagues, it did not raise to the level of professional misconduct, because it was most likely made in a tactless, impulsive manner. It was inappropriate, but it was not disgraceful, dishonourable or unprofessional conduct.

Disposition

The Discipline Committee ordered and directed that:

- the Registrar suspend Dr. Al Abdulmohsin's certificate of registration for three (3) months commencing December 18, 2017.
- the Registrar impose a term, condition, and limitation on Dr. Al Abdulmohsin's certification of registration that at his own expense, Dr. Al Abdulmohsin shall participate in and successfully complete all aspects of the following programs, at the earliest opportunity:
  - Individualized instruction in professionalism/ethics satisfactory to the College, with an instructor selected by the College; and
  - Understanding Boundaries in Managing the Risks Inherent in the Doctor- Patient Relationship.
- Dr. Al Abdulmohsin appear before the panel to be reprimanded.
- Dr. Al Abdulmohsin pay to the College its costs of this proceeding in the amount of $16,500.00 within thirty (30) days from the date of this Order.

2. Dr. M. Bélanger

Name:	Dr. Mathieu Bélanger
Practice:	Pain Management
Practice Location:	Ottawa
Hearing:	Agreed Facts and Joint Submission Penalty

Finding/Penalty Decision Date: February 15, 2018
Written Decision Date: April 16, 2018

Allegations and Findings

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

Summary

Dr. Bélanger is a family physician who practises in the area of interventional pain management. Dr. Bélanger currently works at, and owns, the Inovo Medical clinic in Ottawa, a clinic that provides interventional pain management procedures. Dr. Bélanger was the Medical Director of Inovo. Following referral of this matter to discipline and at the request of the College, Dr. Bélanger appointed an acting Medical Director, effective August 22, 2017.

Nerve blocks, which are categorized as Level 2 Interventional Pain Management procedures, are only authorized to be performed in an Out-of-Hospital premises ("OHP") that is approved by the College. Between October 15 and January 2016, Dr. Bélanger provided interventional pain treatments to patients, including Level 2 nerve blocks, while working in a clinic that was not an approved OHP.

Dr. Bélanger was aware of the requirement that Level 2 procedures can only be performed in an OHP that has been approved and that responsibility for notifying the College's OHP program is on the physician. He was aware that the clinic where he was performing Level 2 procedures was not an approved OHP, had never been inspected under the Out of Hospital Premises Inspection Program, did not meet program requirements and that he was not authorized to provide Level 2 procedures in that location.

There is no evidence that Dr. Bélanger's performance of any of these procedures caused any harm to any patients.

As part of the College investigation, information was obtained from the Ontario Health Insurance Plan ("OHIP"). The information from OHIP confirms that Dr. Bélanger submitted claims to OHIP between October 21, 2015 and January 13, 2016, for Level 2 procedures, particularly nerve blocks, that were performed by Dr. Bélanger at the clinic that was not an approved OHP. The OHIP information indicates that between October 21, 2015 and January 13, 2016, Dr. Bèlanger billed approximately $103,428.00 for performing Level 2 procedures in the clinic that was not an approved OHP, that are only authorized to be performed in an OHP.

Disposition

The Discipline Committee ordered that:

- The Registrar suspend Dr. Bélanger's Certificate of Registration for a five (5) month period, effective February 17th, 2018 at 12:01 a.m.
- The Registrar to impose the following terms, conditions and limitations on Dr. Bélanger's Certificate of Registration:
  - Dr. Bélanger will successfully complete the PROBE course in ethics and professionalism, at his own expense, within (twelve) 12 months of the date of this Order, or any alternate course in ethics and professionalism approved by the College. Dr. Bélanger will agree to abide by any recommendations of the PROBE program and provide proof of completion to the College;
  - Approval of the College's Out of Hospital Premises program is required before Dr. Bélanger resumes the Medical Director role in an Out of Hospital Premises.
- Dr. Bélanger to appear before the panel to be reprimanded.
- Dr. Bélanger to pay to the College its costs of this proceeding in the amount of $5,500 within ninety (90) days from the date of this Order.

3. Dr. J. L. Dimock

Name:	Dr. John Leslie Dimock
Practice:	Psychiatry
Practice Location:	Ottawa; Virginia, USA
Hearing:	Agreed Facts and Joint Submission on Penalty
Finding/Penalty Decision Date:	January 10, 2018
Written Decision Date:	March 9, 2018

Allegations and Findings

- Disgraceful, dishonourable, or unprofessional conduct – **proved**
- Conduct unbecoming a physician **- withdrawn**

Summary

Dr. John Dimock is a psychiatrist practising in Ottawa, Ontario and Virginia, USA. He received his certificate of registration authorizing independent practice in Ontario in 1980.

Patient A

On June 26, 2014, Patient A complained to the College regarding his two appointments with Dr. Dimock in May 2013, and a report Dr. Dimock had written about Patient A to Patient A's family doctor in June 2013. Patient A complained that Dr. Dimock failed to conduct an adequate psychiatric assessment and care, failed to provide an adequate report, behaved unprofessionally, was rude and arrogant, and made inappropriate comments, including about his secretary and about Jewish and Palestinian people, talked about his personal matters for a good portion of the appointment, and used the word "apparently" seven times in his written report, including referring to Patient A as

"apparently Canadian", which indicated a form of racism, discrimination or bias towards Patient A.

After having been notified of Patient A's complaint, Dr. Dimock telephoned the College investigator stating that Patient A complained because he recorded in Patient A's notes that Patient A threatened to kill a certain person, which made Patient A unable to return to work or caused problems with his place of employment. Dr. Dimock stated that if the College proceeded with the complaint, he would make a civil rights complaint. He indicated that although this was not a threat, he believed that proceeding with the complaint was just another example of College harassment.

In response to Patient A's complaint, Dr. Dimock denied that he made the inappropriate comments alleged by Patient A, he denied that he exhibited racism, discrimination or bias towards Patient A. He stated the allegations were extremely distressing to him as during the two appointments with Patient A, he was professional, respectful and provided proper medical care, free from any racism, discrimination or bias at all times during his two appointments with Patient A. He denied that he made any comments or references with respect to the Jewish people.

On October 5, 2015, the Inquiries, Complaints, and Reports Committee ("ICRC") of the College considered and disposed of Patient A's complaint. The ICRC noted that:

- there was similarity between Patient A's concerns and concerns raised in previous complaints regarding Dr. Dimock's care and professionalism, upon which the College had previously taken action.
- Dr. Dimock's inference that the College was harassing him shows that Dr. Dimock has little insight into why he has had so many encounters with the College.
- Dr. Dimock could reflect on ways to avoid the College's attention by respecting patients, being courteous and professional, behaving with decorum, and reviewing his own attitudes and personal style to gain insight into what is causing patients to complain.
- Dr. Dimock would benefit from education to ensure improvement in his practice with respect to: assessment of patients, documentation, and preparation of consultation reports that meet the standard of practice of psychiatrists in Ontario; understanding of general principles in effective communication, and the specific issues that led to the current complaint; communication with patients and others that is respectful and professional; ensuring appropriate consent before releasing documentation to third parties; and understanding acceptable professional behaviour by a physician in Ontario.

The ICRC ordered that:

- Dr. Dimock complete a Specified Continuing Education and Remediation Program ("SCERP"), consisting of a period of clinical supervision focusing on both medical care and communication, including general principles in effective communication and the specific issues that led to the complaint in this matter as well as communication with

patients and others that is respectful and professional.
- Dr. Dimock complete one-on-one instruction in professionalism and communication.
- Dr. Dimock be reassessed.

In January 2016, Dr. Dimock requested a review of the ICRC's decision by Health Professions Appeal and Review Board ("HPARB"). During HPARB's pre-review case teleconference on August 17, 2016, Dr. Dimock stated that he was in Virginia due to concerns for his safety because of Patient A, that the information about Patient A had come to his attention about which the College, Homeland Security, and the RCMP should be concerned, and suggested that Patient A was a terrorist.

On October 5, 2016, during the HPARB review hearing, which is open to the public, Dr. Dimock stated:

- Patient A worked for the terrorist organization ISIS, and that the matter should be referred to the RCMP and Homeland Security;
- His concerns about Patient A were "doubled", because Dr. Dimock had previously worked for the Canadian Armed Forces;
- Patient A had been arrested in another country for the abduction of his own children;
- Patient A was committing insurance fraud, because he was benefiting from insurance in Ontario, but was living in another country with his child whom he had abducted;
- Patient A had accused Dr. Dimock of being a "Palestinian hater";
- Patient A was a sociopath, and his actions were those of a sociopath;
- Even though Patient A was a dangerous psychopath and should be locked up, he had "toned down" his assessment of Patient A so that Patient A could prove how sick he was and qualify for insurance in Ontario; and
- He had previously "diagnosed" the former pediatric forensic pathologist Charles Smith as "incompetent" while doing research on Dr. Smith, and that the College was biased against Dr. Dimock because it had failed to act in a timely manner on this information.

Dr. Dimock's assertions to the HPARB were false and unfounded.

Dr. Dimock later indicated that he was angry during the HPARB proceedings, that HPARB proceedings were completely unfamiliar to him and he found it difficult and frustrating, that he was not represented by counsel, and that because at the hearing the three panel members were francophone, he was concerned about a language barrier and was worried he was not being heard. He indicated that he was not at his best during the HPARB proceedings, and that he wanted to assure the College that this is not representative of the manner in which he communicates with colleagues and patients.

Patient B

Patient B saw Dr. Dimock in July, 2016 for an Independent Medical Examination ("IME") at the request of her insurance company and signed the "Claimant/Employee Authorization Form" in advance of the IME. Dr. Dimock's IME report contained all the

details Patient B related to him during their session, as well as his conclusion that "there are no restrictions to immediately beginning a slow reintroduction to Patient B's old workplace". On November 4, 2016, Patient B complained to the College that Dr. Dimock had promised that the detailed information she told him during the course of the IME would remain confidential as between the two of them, and that Dr. Dimock would only tell the insurance company what his conclusion or diagnosis was.

In September 2016, before complaining to the College, Patient B addressed her concern directly with Dr. Dimock in a series of emails. Following their email exchange Dr. Dimock sent Patient a request via the social media site LinkedIn to join her LinkedIn network, which confused and scared Patient B.

The expert retained by the College to provide an independent opinion with respect to the IME Dr. Dimock performed of Patient B, including whether his care displayed a lack of judgment, concluded that the only concern was a lack of judgment Dr. Dimock showed in his responses to Patient B's emails. The expert noted that while, at first, Dr. Dimock's responses were reasonable and measured, they eventually became antagonistic and peevish. The expert found the LinkedIn request extremely puzzling and somewhat concerning as Dr. Dimock did not provide an explanation.

Behaviour towards Professional Colleagues

In 2014, Dr. Dimock was practising psychiatry in a shared office setting with Colleague X and Colleague Y, both of whom are regulated professionals.

In November, 2014, Colleague X telephoned the College about matters Colleague Y had discussed about Dr. Dimock's behaviour. As a result of Colleague X's call to the College, Dr. Dimock's was required to undergo a psychiatric assessment to assess his fitness to practice, which concluded that he was not suffering from a mental condition that would expose or was likely to expose patients to risk of harm.

In December 2014, Dr. Dimock telephoned the College, demanding to know the identity of the "spreader of vicious allegations against him", which he claimed were "clearly aimed at discrediting him and to close down his very successful psychiatry practice", because they were "jealous" of him as he was "the best psychiatrist probably in the province of Ontario".

Following this Dr. Dimock exhibited inappropriate behaviour toward Colleague X and Colleague Y, including:

- left two messages for Colleague X's work voicemail, stating that Colleague X should not have expressed concerns about his behaviour to the College, that the information related to his behaviour was confidential, that he will report Colleague X's professional regulator for having done so, accused Colleague X and Colleague Y for plotting together to discredit him, report him, and planning to steal his practice, share his patients between the two of them, and used insulting language;

- Banged forcefully and repeatedly on Colleague Y's office door, yelled at Colleague Y and called Colleague Y profane names in the presence of Colleague Y's patients.
- Shouted over the phone and spoke to his lawyer with the door to his office wide open so he could be overheard by Colleague X, Colleague Y and their patients; slammed doors in the office.
- left Colleague Y a note, accusing Colleague Y and Colleague X of conspiring against him, threatening civil and criminal action, stating that he was off to the police station and calling Colleague Y profane names.
- emailed Colleague Y a complaint letter he threatened to make against Colleague X to the College of Psychologists of Ontario, alleging among other things that Colleague X had conspired with Colleague Y to make a false allegation to the College with respect to his fitness to practice in an effort to discredit him, to have him removed from practice, and to steal his patients.
- left a series of threatening and accusatory voice messages on Colleague Y's office voicemail, accusing Colleague Y of being responsible for a complaint about him, calling Colleague Y profane names, stating that he wants Colleague Y and Colleague X out of the clinic, threatening to complain about Colleague Y and Colleague X to their respective regulatory bodies, demanding compensation for the patients that he had referred to Colleague X over the years, accusing Colleague Y in threatening him, accusing Colleague Y of hindering his ability to respond to allegations from the College, accusing Colleague Y and Colleague X for stealing his keys to the clinic, which he later found on the floor of his car, and threatening civil and criminal action.

Prior Dispositions by the Complaints Committee

In September 1998, following Dr. Dimock's report of an independent psychiatric examination of an alleged pedophile, which included the statement "[w]ith such low levels of sexual biological drive one wonders if the aggressor may not have been the alleged victim in this case!" It was presented in court and viewed as "appalling" by the victim, the Assistant Crown Attorney, the Judge and the press, Dr. Dimock was required to attend before the Complaints Committee to be cautioned to discuss the importance of being extremely cautious in sharing what may be unsubstantiated, insupportable, or unreasonable opinions in his consultations, particularly in situations where those opinions concern legal or criminal matters and may be used in a public forum. The Committee viewed the opinion Dr. Dimock expressed in his report unreasonable and inflammatory.

In February 2004, the Complaints Committee required Dr. Dimock to attend at the College to be cautioned about his communications with respect to two separate patient complaints and about his communication approach. Noting that in response to complaints about him, Dr. Dimock essentially blamed the complainants, suggesting, in each case, that the complainant misunderstood and had "transference issues", which prompted them to react negatively towards him, the Complaints Committee found that Dr. Dimock has not considered the possibility that something in his own manner or behaviour may lead patients to form the impression that he is rude or dismissive.

Disposition

The Discipline Committee ordered that:

- the Registrar suspend Dr. Dimock's certificate of registration for a period of four (4) months commencing on January 10, 2018.
- the Registrar impose the following terms, conditions and limitations on Dr. Dimock's Certificate of Registration:
  - Dr. Dimock will successfully complete, within six months of the date of this Order, a course in ethics and boundaries acceptable to the College (such as the PROBE course);
  - Dr. Dimock will successfully complete, within six months of the date of this Order, counselling in anger management or communication in difficult settings acceptable to the College; and
  - Dr. Dimock shall be responsible for any and all costs associated with implementing the terms of this Order.
- Dr. Dimock appear before the panel to be reprimanded.
- Dr. Dimock pay costs to the College in the amount of $5,500 within thirty (30) days from the date of this Order.

4. Dr. M. Kaminski

Name:	Dr. Michael Kaminski
Practice:	Family Medicine
Practice Location:	Toronto
Hearing:	Uncontested Facts and Penalty Not Opposed
Finding/Penalty Decision Date:	March 15, 2018
Written Decision Date:	March 21, 2018

Allegations and Findings

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

Summary

Dr. Michael Kaminski is a family medicine physician who practised in Toronto.

<u>Cease to Practice Undertaking</u>

On June 10 of 2015, Dr. Kaminski executed a Cease to Practice undertaking ("the June 2015 Undertaking"), by which he voluntarily agreed to cease practising medicine in any jurisdiction until particular conditions had been met including:

- Providing a minimum of forty-five days' notice to the College of his intent to return to the practice of medicine;
- Providing the College with proof that he is participating in a program of continuing

professional development that meets the requirements for continuing professional development of the College of Family Physicians of Canada, and
- Approval by the College of Dr. Kaminski's return to the practice of medicine.

Pursuant to the June 2015 Undertaking, Dr. Kaminski also undertook to forward a request to the General Manager of the Ontario Health Insurance Plan ("OHIP') that his billing number be deactivated for services rendered after the date on which he would cease to practise. He further undertook to abide by the College's Policy on Practice Management Considerations for Physicians Who Cease to Practice, Take an Extended Leave of Absence or Close Their Practice Due to Relocation.
Dr. Kaminski consented to certain terms of the June 2015 Undertaking being deemed to be specified terms, conditions and limitations imposed upon his certificate of registration. Specifically the following became a term, condition and limitation upon his certificate: "Dr Michael Kaminski has voluntarily ceased to practice medicine in all jurisdictions effective May 30, 2015."

Investigation

In May of 2016, a Senior Investigative Analyst in Risk Management with Manulife Financial emailed the College expressing concern that Dr. Kaminski was practising medicine, contrary to the restriction on his certificate. The Analyst identified that Dr. Kaminski was practising at a clinic called "Skin Med Clinic". Enclosed with her email was a copy of a prescription signed by Dr. Kaminski dated March 31, 2016, for compression stockings, thigh high and knee high with instructions to wear for daily activities for varicose veins.
A further complaint about Dr. Kaminski, from a pharmacist, was received in May of 2016. The pharmacist complained that Dr. Kaminski was writing prescriptions even though he is restricted from practicing medicine.
In July of 2016, Dr. Kaminski spoke with a College investigator. Dr. Kaminski indicated that he was not aware that he could not practice and apologized.
In response to a summons, Manulife Financial provided claim documents related to Dr. Kaminski including a summary document together with prescriptions and consultation notes for 19 patients written by Dr. Kaminski during the time he was restricted from practising. The prescriptions range from May 30, 2015 to April 7, 2016.

Failure to Renew
Dr. Kaminski's certificate of registration expired in August of 2016 as a result of a failure to renew.

Disposition

The Discipline Committee ordered and directed on the matter of penalty and costs that:

- The Registrar revoke Dr. Kaminski's certificate of registration effective immediately.

- Dr. Kaminski, within six (6) months, pay a fine to the Minister of Finance in the amount of $5,500.00, and Dr. Kaminski to provide proof of this payment to the Registrar of the College.
- Dr. Kaminski appear before the panel to be reprimanded.
- Dr. Kaminski pay costs to the College in the amount of $5,500 within 30 days of the date of this Order.

5. Dr. A. Kesarwani

Name:	Dr. Atul Kesarwani
Practice:	Plastic Surgery
Practice Location:	Toronto
Hearing:	Agreed Facts and Joint Submission Penalty
Finding/Penalty Decision Date:	January 5, 2018
Written Decision Date:	March 2, 2018

Allegations and Findings

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

Summary

Dr. Kesarwani is a physician practising medicine in the area of plastic surgery in an Out-of-Hospital Premises (OHP) and in a public hospital in Toronto. He received his specialist qualification in plastic surgery in 1987. Dr. Kesarwani was certified as a specialist by the Royal College of Surgeons of Canada in 1988.

Dr. Kesarwani has been the Medical Director of an OHP, Cosmedical Rejuvenation Clinic ("Cosmedical") since it began operating in Toronto in 2006. Cosmedical provides facial plastic and cosmetic procedures, as well as other cosmetic surgeries.

<u>Out-of-Hospital Premises Inspection Program (OHPIP)</u>

The OHPIP is a College program which is overseen by the College's Premises Inspection Committee (PIC) and by Program Staff. OHPIP applies to all settings or premises outside a hospital that perform procedures involving the use of anesthesia or sedation.

Pursuant to statutory requirements in April 2010, all CPSO members performing or assisting in procedures in OHPs were required to notify the College. All premises where a member performs or may perform a procedure on a patient are subject to an inspection by the College once every five years after its initial inspection or more often, if, in the opinion of the College, it is necessary and advisable to do so. New premises or relocating premises continue inspected within 180 days of notification.

The Medical Director of an OHP is responsible for providing notification to the College of plans to operate a new OHP or plans to move an existing OHP. The OHPIP relies on self-reporting from Medical Directors and physicians as the only mechanism for initiating inspection-assessment process is notification by a member to the College. PIC must approve the premises following the inspection before any patient procedures can be performed.

Disgraceful, Dishonourable or Unprofessional Conduct

On July 6, 2016, when contacted by the Program Staff of the OHPIP for the purpose of an inspection-assessment visit scheduled as part of the five-year cycle, Dr. Kesarwani confirmed the existing practice address and told Program Staff that he was planning a move in the future. Dr. Kesarwani was advised that any new location must be inspected and assessed, and receive approval from PIC prior to performing any OHP procedures.

On August 5, 2016, Program Staff received Cosmedical's Pre-visit Questionnaire and Policy and Procedures Manual for the upcoming five-year inspection-assessment indicating the address which was different from the practice address on file with the OHP program. On August 15, 2016, in response to telephone inquiries from Program Staff, Cosmedical contacted the College and confirmed that the OHP had recently relocated to the new location and had stopped performing OHP procedures at the previous location on August 15, 2016.

On August 18, 2016, a Nurse Assessment Coordinator conducted the unannounced inspection directed by PIC. Dr. Kesarwani informed the Nurse Assessment Coordinator that he had moved Cosmedical to its new location at the end of March 2016 and indicated that since the move, he had only been performing non-OHP Botox injections at the new location. However, when asked for his controlled substances records and surgical logs, Dr. Kersaarwani acknowledged and the review of the surgical logs confirmed that he had been providing OHP procedures at the new location since the move.

On August 24, 2016, PIC considered the Unannounced Assessment Report and the premises received a "Fail." Cosmedical was not permitted to provide OHP procedures until the outstanding deficiencies were addressed and a site inspection was conducted. The following outstanding conditions were set out by PIC:

- The medical director must notify College staff in writing of the new name and address of this premise.
- The Committee requires a copy of current CNO status documentation for all nursing staff. The BLS/ACLS courses must include both a hands-on and theory component.
- The Committee requires staff member's s current certificate for training in reprocessing and sterilization, valid within the past 5 years. The Committee also requires evidence that a staff member has had manufacturer training for the use of the autoclave.

In addition, on August 24, 2016, PIC referred the file to the College's Investigation and Resolutions Department for further investigation. When College investigators conducted an unannounced inspection at Cosmedical on October 6, 2016, they were advised by the staff that Cosmedical was not operational and no procedures had been performed since August 24, 2016.

On October 17, 2016, the OHP program conducted further inspection-assessment of the new location, during which the Nurse Assessment Coordinator noted deficiencies.

On December 7, 2016, PIC considered the deficiencies reported by the Nurse Assessment Coordinator and the premises again received a "Fail". Cosmedical was not permitted to provide OHP procedures until the following outstanding conditions were met:

- A Registered Practical Nurse has a restricted registration and in accordance with the College of Nurses of Ontario (CNO) Standards, she may not circulate independently, but she may function as a scrub nurse. An RPN may not function in a circulating capacity without an RN as a resource, circulating alongside. The Committee requires a written understanding of these restrictions and a revised outline the RPN's duties and responsibilities at the premises.
- The Committee understands that the premise has an elevator that has a back- up power source in the event of a power failure. However, the Committee requires an evacuation policy that covers all types of emergencies, including fire. In the event that the elevators cannot be accessed, the Committee requires a policy outlining the emergency measures for transporting patients down stairs.
- The Committee requires the centrifuge to be inspected by a biomedical technician and the resulting report is to be provided to the Committee.
- The Committee requires the newly purchased Zoll defibrillator to be inspected by a biomedical technician and the resulting report is to be provided to the Committee. Evidence should be provided that this defibrillator is certified by the CSA or licensed for use in Canada.
- The premises must have a sterilizer that is certified by CSA or licensed for use in Canada and it should hold an active licence. The Committee understands that the premise will be purchasing a new sterilizer that will meet these requirements and should provide the evidence of purchase and valid licensing to the Committee. If the sterilizer is not brand new and/or has been refurbished, it must be inspected by a biomedical technician and the resulting report should be provided to the Committee.

On January 26, 2017, following receipt of information and documentation from Dr. Kesarwani, Cosmedical received a "Pass with Conditions" from PIC that allowed the clinic to resume OHP procedures.

Disposition

The Discipline Committee ordered that:

- the Registrar suspend Dr. Kesarwani's Certificate of Registration for a three (3) month period, effective January 6, 2018 at 12:01 a.m.
- the Registrar impose the following terms, conditions and limitations on Dr. Kesarwani's Certificate of Registration:
    - Dr. Kesarwani will successfully complete the PROBE course in ethics and professionalism, at his own expense, within 6 months of the date of this Order, or any alternate course in ethics and professionalism approved by the College. Dr. Kesarwani will agree to abide by any recommendations of the PROBE program and provide proof of completion to the College;
    - Approval of the College's Out of Hospital Premises program is required before Dr. Kesarwani resumes the Medical Director role in an Out of Hospital Premises.
- Dr. Kesarwani appear before the panel to be reprimanded.
- Dr. Kesarwani pay to the College its costs of this proceeding in the amount of $5,500 within thirty (30) days from the date of this Order.

6. Dr. A.F.Z. Mourcos

Name:	Dr. Ashraf Fekry Zaki Mourcos
Practice:	Family Medicine
Practice Location:	Kitchener
Hearing:	Uncontested Facts and Joint Submission on Penalty
Finding/Penalty Decision Date	January 15, 2018
Written Decision Date:	March 13, 2018

Allegations and Findings

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

Summary

Dr. Mourcos is a family physician who received his certificate of registration authorizing independent practice in Ontario in 2001. At the relevant time, Dr. Mourcos practised family medicine in his clinic in Kitchener.

<u>Disgraceful Dishonourable or Unprofessional Conduct regarding Ms A</u>

In or around March 2013, Ms A commenced employment for Dr. Mourcos as medical receptionist. She was in her early thirties at the time. She is married. Her job involved answering telephones, filing, booking appointments, collecting urine samples and taking patients to examination rooms.

In June 2013, after the last patient for the day had left, Ms A and Dr. Mourcos were alone in the office and engaged in conversation. It had been a very busy day, with several patient appointments, and Ms A commented that it had been a rough day. Dr. Mourcos responded that she looked tense. She said "Yeah" and was rubbing her neck

and shoulders due to upper back pain. Dr. Mourcos offered to give her a massage. He had offered massages on earlier occasions, and had massaged the back of her neck while she sat at her desk working. On those occasions, Ms A agreed to the massage and when she asked Dr. Mourcos to stop, he stopped. On that day, Ms A declined Dr. Mourcos' offer and told him she did not need a massage. When Dr. Mourcos persisted, telling her that this would be a good practice for him as he was taking classes in massage therapy, Ms A gave in and agreed to the massage.

After rubbing her shoulders while standing behind her at her desk for about a minute, Dr. Morcous told Ms A he could not massage her in the reception area and asked her to go into an examination room. When Ms A went into the examination room and sat on a stool, Dr. Mourcos went into his office briefly and, unbeknownst to Ms A at the time, locked the main entrance to the office. Dr. Mourcos then entered the examination room and told Ms A that he could give her a better massage if she lay down on the examination table. Ms A lay on the examination table face down and Dr. Mourcos commenced massaging her back over top of her shirt. She was wearing scrubs at the time. Dr. Mourcos then inserted his hands underneath her shirt. Ms A did not object to this touching as she felt it was like a regular massage. Dr. Mourcos began touching her lower back and moving his hands down her back towards the waistband of her pants. Ms A felt Dr. Mourcos slip his hand underneath the waistband of her pants and move his hand towards her right hip. He asked if he could massage under her pants and she said "no". Dr. Mourcos then moved his hand upwards and continued to massage Ms A's back under her shirt for about a minute. He then moved his hands towards Ms A's mid-back and unclasped her bra, while Ms A did not realize it. Without warning or consent, Dr. Mourcos moved his right hand toward her right breast, placing his fingers on the side and upper part of her right breast for a couple of seconds. Ms A sat up quickly, and ended the massage. At that point, Ms A realized that her bra was undone. She struggled to do it up. Dr. Mourcos stood at the doorway, and told her everything was "okay". When Dr. Mourcos asked if he could help her with her bra, Ms. A was in shock and did not respond. Dr. Mourcos inserted his hands under her shirt, and helped her do up her bra. As she moved towards the door to leave the exam room, Dr. Mourcos stood at the doorway and repeated "it's okay". He asked Ms A to kiss him. Ms A said no. He leaned in to kiss her, but Ms A turned her head and he ended up kissing her on the cheek. He stepped back from the door so she could leave.

Ms A left the examining room and returned to her desk in the reception area. Shortly thereafter, Dr. Mourcos engaged her in conversation in the reception area asking her about her marriage and whether she had engaged in sexual relations with other people. The conversation ended when the phone rang and Ms A attended to the call. At that time, Dr. Mourcos returned to his office. He then unlocked the main door to the office. Ms A finished her duties for the day and left the office. She was upset about what had occurred. She told her mother what happened and then contacted police that evening. She did not return to work.

Disposition

The Discipline Committee ordered that:

- the Registrar suspend Dr. Mourcos' certificate of registration for a period of six (6) months, to commence immediately.
- the Registrar impose the following terms, conditions and limitations on Dr. Mourcos' certificate of registration:
  - Dr. Mourcos shall be subject to workplace monitoring in all practice locations by a regulated health professional, approved by the College, who executes an undertaking with the College in the form attached as Appendix "A" (Office Practice) or "B" (Other Practice Locations) (the "Practice Monitor"). Monitoring shall continue for a minimum period of two years in each of Dr. Mourcos' practice locations and shall continue, in the College's sole discretion, if reports are unsatisfactory;
  - The Practice Monitor(s) shall be required to, among other things:
    - provide written reports to the College on a quarterly basis. Such reports are to include information regarding Dr. Mourcos' conduct, behavior, and professionalism including information provided to the Practice Monitor by nurses, medical staff and/or any other staff working directly or indirectly with Dr. Mourcos; and
    - provide immediate reporting to the College if the Practice Monitor has any concerns about Dr. Mourcos' conduct, behavior or professionalism, concerns that people or patients in the workplace may be at risk of harm, or concerns that Dr. Mourcos is not in compliance with the panel's Order;
  - Dr. Mourcos shall provide an executed Appendix "A" and "B" from a College approved Practice Monitor no later than thirty (30) days before he resumes practice following his suspension. If the person who has given an undertaking in the form of Appendix "A" or "B" is unable or unwilling to continue to fulfill its terms, or the College determines the Practice Monitor is no longer acceptable, Dr. Mourcos 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. Mourcos is unable to obtain a Practice Monitor on the terms set out in this Order, he shall cease practising medicine until such time as he has obtained a Practice Monitor acceptable to the College on the terms set out above;
  - Dr. Mourcos shall provide written notice to the College at least thirty (30) days before seeking privileges, employment or any other position, at any hospital, independent health facility, out-of-hospital premise, facility, or any other location. Dr. Mourcos shall inform the College within ten (10) days of the date he receives notice that he has been granted such privileges, employment or position. Dr. Mourcos shall ensure that he has obtained an undertaking in the form of Appendix "B" from a College-approved regulated health professional who works at that location and shall provide same to the College before commencing work at such location;
  - Dr. Mourcos shall ensure that all individuals who work in his office, whether

employed by him or not, review this Order and the Statement of Uncontested Facts by no later than January 30, 2018 and review the Decision and Reasons of the Discipline Committee within 15 days of its release.
  - Dr. Mourcos shall ensure that any new individual hired to work in his office shall review this Order, the Statement of Uncontested Facts and the Decision and Reasons of the Discipline Committee prior to commencing work at Dr. Mourcos' office.
  - Dr. Mourcos shall be responsible for any and all costs associated with implementing the terms of this Order.
- Dr. Mourcos attend before the panel to be reprimanded.
- Dr. Mourcos pay the College costs in the amount of $5,500 within thirty (30) days from the date of this Order.

7. Dr. M.K. Raja

Name:	Dr. Mohan Krishnan Raja
Practice:	Family Medicine; Methadone
Practice Location:	St. Catharines
Hearing:	Allegations Contested Joint Submission on Penalty
Finding/Written Decision Date	November 27, 2017
Penalty Decision Date:	April 20, 2018
Penalty Written Decision Date:	May 1, 2018

Allegations and Findings

- Disgraceful, dishonourable, or unprofessional conduct – **proved**
- Sexual abuse – **not proved**

Summary

The allegations arose from the conduct of Dr. Raja during a number of clinical appointments when Patient A saw Dr. Raja for methadone treatment. The Committee found that in at least two examinations of Patient A, Dr. Raja had her raise her shirt above her bra, lifted the left side of her bra, and exposed her left breast. He then listened to her heart sounds in four areas, which included touching the periphery of her left breast with his stethoscope and pushing aside her breast for optimal skin contact. There was no evidence that Dr. Raja made any comments of a sexual nature.

The Committee found that while he did raise Patient A's bra, there was no evidence that Dr. Raja touched her breast in a sexual manner. The Committee noted that there was no fondling, massaging of the breast, squeezing, or touching of the nipple. The Committee accepted that listening to the heart sounds in the four areas described by Dr. Raja was an acceptable focused cardiac examination. Examination of the heart in this manner with a stethoscope would involve placing the stethoscope close to the breast or at the periphery of the breast. In some cases, the breast would need to be pushed

aside for optimal contact between the stethoscope and skin. The Committee found there was no sexual character to the examination as performed in this fashion. While Dr. Raja may have touched her breast while carrying out the examination of her heart, such touching of the breast in this context did not constitute a violation of sexual integrity. Dr. Raja's approach appeared to have a mechanical quality, but was not of a sexual character.

In making a finding of disgraceful, dishonourable and unprofessional conduct, the Committee considered that:

- Dr. Raja failed to respect the privacy owed to his patient;
- The unanticipated exposure of her breast on its own constituted a significant boundary violation;
- Dr. Raja was inconsiderate when he exposed Patient A's breast;
- Dr. Raja did not understand or disregarded how his actions would make Patient A feel;
- Dr. Raja's explanation to Patient A of why he needed to repeatedly listen to her heart sounds was unclear or nonexistent; and
- Patient A was a particularly vulnerable patient, which makes a lack of respect for her dignity and privacy more egregious.

In failing to respect his patient's privacy by not offering appropriate draping and by unnecessarily exposing her left breast during examinations, the Committee held that Dr. Raja left his patient feeling uncomfortable and scared. She needed to understand why he was examining her. His explanations were superficial and left her wondering about his true motive. In his manner of examination, he had little regard as to Patient A's sensitivity or the embarrassment she might experience.
On June 3-4 2016, Dr. Raja attended a one-and-a-half day course on *Understanding Boundaries and Managing the Risks Inherent in the Doctor-Patient Relationship* through the Western University's Schulich School of Medicine and Dentistry.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Raja's certificate of registration for a period of two (2) months, to commence at 12:01 a.m. on May 18, 2018.
- Dr. Raja appear before the panel to be reprimanded.
- Dr. Raja pay to the College its costs of this proceeding in the amount of $22,000.00 within thirty (30) days from the date of this Order.

APPENDICES TO THE PROCEEDINGS OF THE

MEETING OF COUNCIL

OF

THE COLLEGE OF PHYSICIANS AND SURGEONS OF

ONTARIO

MAY 24 AND 25, 2018

Appendix A

Interim Registrar's Report

Council

May 24/25, 2018

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

QUALITY PROFESSIONALS • HEALTHY SYSTEM • PUBLIC TRUST

Overview

- Corporate Report – Q1 Highlights
- Dashboard – Q1 Highlights
- Risk Management Report
- College Updates

2018 Corporate Report
Q1 Highlights

Highlights

- Transparency
  - Access and usability
  - Revisit “what” as a result of Star articles
- Multiple issues on hold pending election
  - CHF, opioids, Bill 87 regulations
- I&R process work to address risk and timelines
  - Includes triage cases based on risk; use of independent opinions; discipline decision drafting
  - end of year report
- Bill 87 implementation significant work
  - 3 regulations; new sections proclaimed (eg. Patient relations)
- Staffing in I&R; Legal - Multiple strategies to ensure full staff complement
- Assessment model - use of risk & support factors under review by QAC

2018 Dashboard
Q1 Highlights

Overview – 11 targets

8	On track
1	Approaching target (policy reviews)
2	Require attention

Require Attention

Every physician assessed every 10 years (EDEX)	2475 assessments/year	269 assessments completed = 43% of quarterly target Note: this target is usually red at the beginning of the year.

Increase input in policy	130 responses/ policy	88 average responses on 2 policies. Note: Policy response depends on the policy.

Investigations Target

Current: Focus on completion

Reduce time for completion of high risk investigations	90% of high risk investigations completed in 243 days. *(existing indicator)*		January 1st – March 31st , 2018: 90% of high risk investigations were completed in an average of 208 days, (48 investigations involving 40 unique physicians).

Investigations Target

NEW: Focus on mitigation of risk

Reduce time to mitigate risk for high risk investigations	**New** **90% of high risk investigations had risk mitigated in an average of 150 days.**		**New** 90% of high risk investigations had risk mitigated in an average of 170 days (48 investigations involving 40 unique physicians).

Risk Management Report

Q1 Risk Report

Issue	Risk Level
Physician Assistant Regulation	MEDIUM
Physician Incorporation	LOW
Sexual Abuse	MEDIUM
Wettlaufer Inquiry	LOW
Public Member Payment	LOW
Transparency	HIGH

Registrar’s Update

Media Update

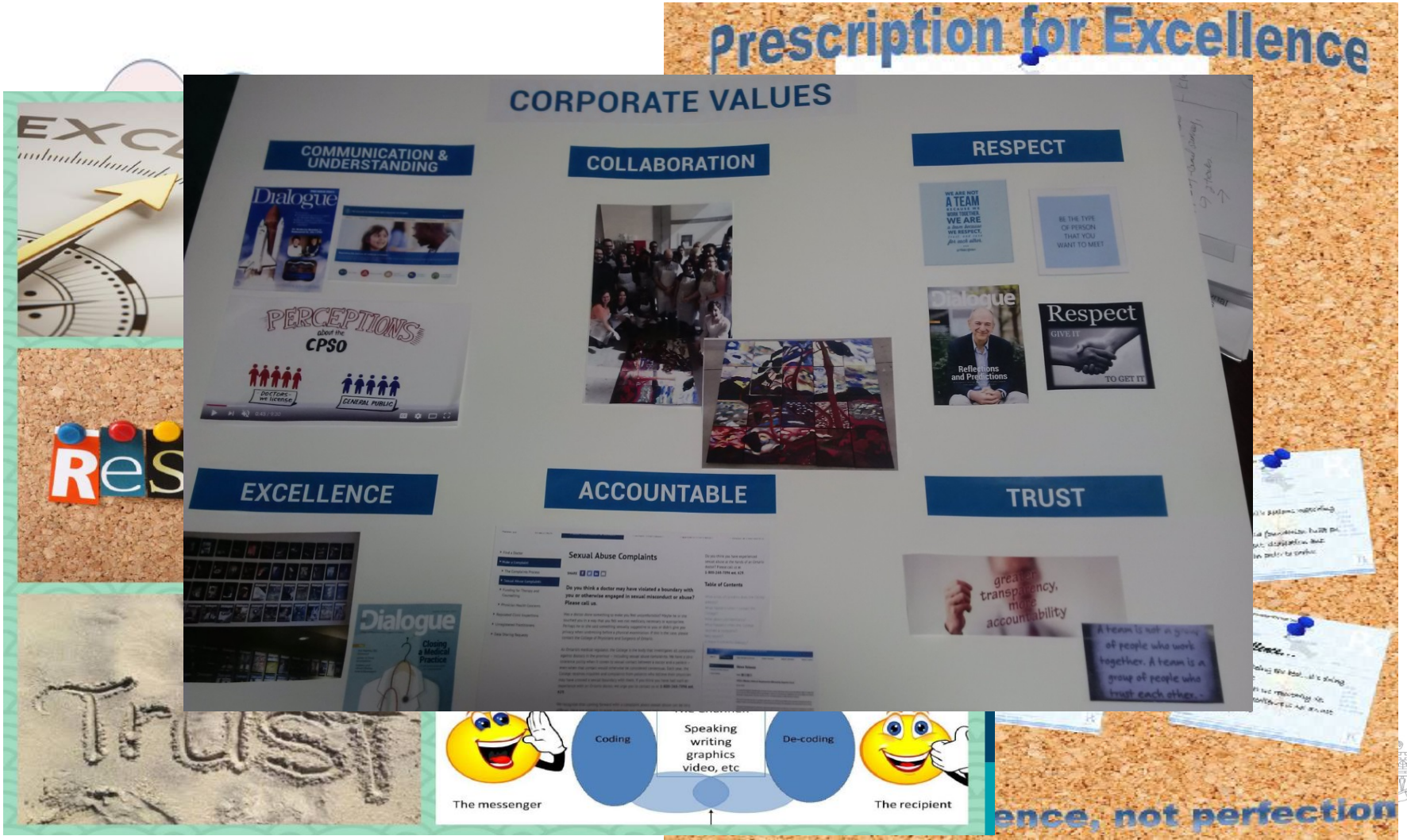
- April 30 – May 4
- Cooperation with reporters
- Internal review of our systems
- Washington Commission follow-up
- Other Canadian regulators – what opportunities?

Canadian Regulators & FMRAC

- Governance and regulatory oversight
  - Most College's west of ON
  - Oversight units in Ministries
  - Supervisors – Dental College BC
  - Alberta Minister's response to the Star
  - Board composition
- AGM June (1st meeting of Registrars and Presidents)

Around the College

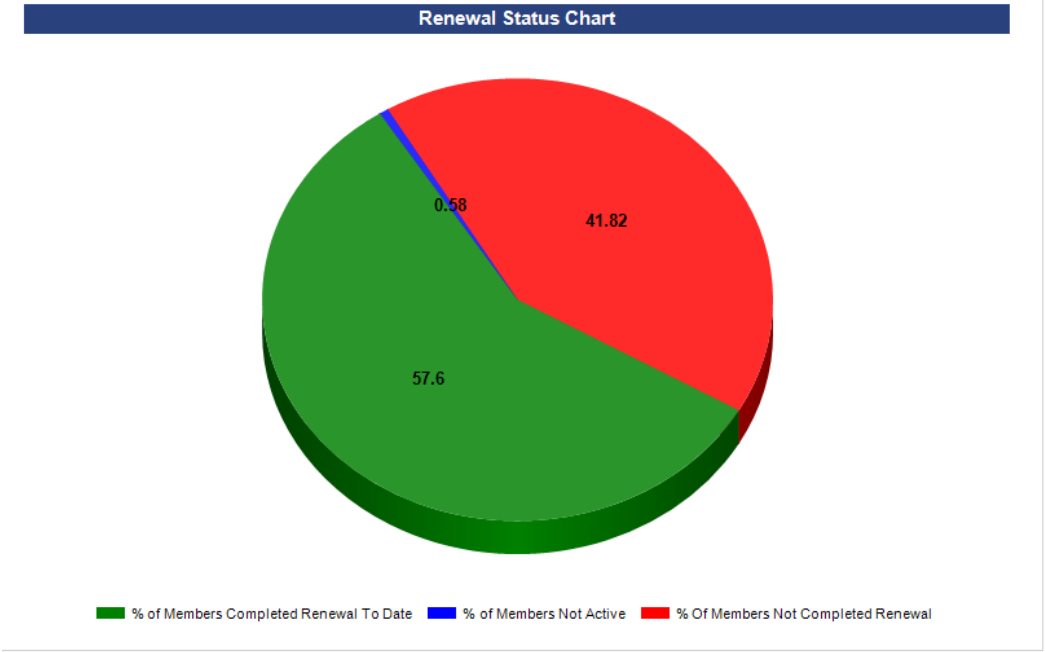
- Leadership development
  - Development of Key Performance Indicators for regulatory functions
  - Staff involvement in developing values and what they mean day-to-day


Prescription for Excellence
CORPORATE VALUES
COMMUNICATION & UNDERSTANDING
COLLABORATION
RESPECT
Dialogue
PERCEPTIONS about the CPSO
DOCTORS
GENERAL PUBLIC
WE ARE NOT A TEAM BECAUSE WE WORK TOGETHER. WE ARE A team BECAUSE WE RESPECT, for each other.
BE THE TYPE OF PERSON THAT YOU WANT TO MEET
Dialogue
Reflections and Predictions
Respect
GIVE IT
TO GET IT
EXCELLENCE
ACCOUNTABLE
TRUST
Sexual Abuse Complaints
Dialogue
Closing a Medical Practice
greater transparency, more accountability
A team is not a group of people who work together. A team is a group of people who trust each other.
Coding
Speaking writing graphics video, etc
De-coding
The messenger
The recipient
ence, not perfection

Annual Renewal Statistical Report - 2018

As Of	Renewal Day	Members Billed	Members Completed Renewal To Date **	Members No Longer Active	Members Not Completed Renewal	Average Number of Renewals Completed Daily
May 17, 2018	32	35633	20525	205	14903	641

** Members Completed Renewal = Member has successfully completed Online Survey and payment has been received by the College.



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Around the College

Investigations & Resolutions

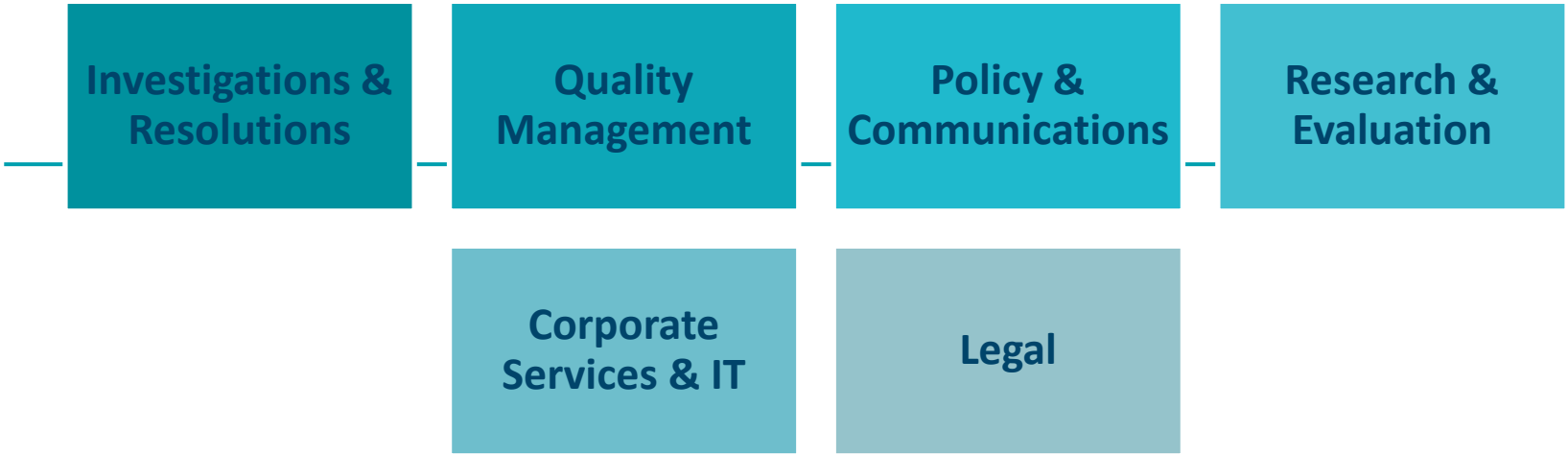
Quality Management

Policy & Communications

Research & Evaluation

Corporate Services & IT

Legal



- Volume, timelines, outcomes
  - Eg. Discipline Committee decision release
  - Eg. Assessments, applications, CPCs
- Volume of recruitments and HR indicators
- Infrastructure support including IT, Finance, Facilities, Research/Data
- Social media, targeted newsletters (eg. students)
- Legal's review of their processes and use of technology (eg. disclosure)

Questions?

Appendix B

CPSO Governance Review

Council

May 24, 2018

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

QUALITY PROFESSIONALS • HEALTHY SYSTEM • PUBLIC TRUST

Today's discussion…

1	2	3	4	5
Approach, Goals, Objectives	**External Environment**	**Overview of Jurisdictional and Literature Reviews**	**Working Group Discussion**	**Discussion and Next steps**

Questions for consideration

Day 1: After review of materials

1. What are the strengths and weaknesses of the current

2

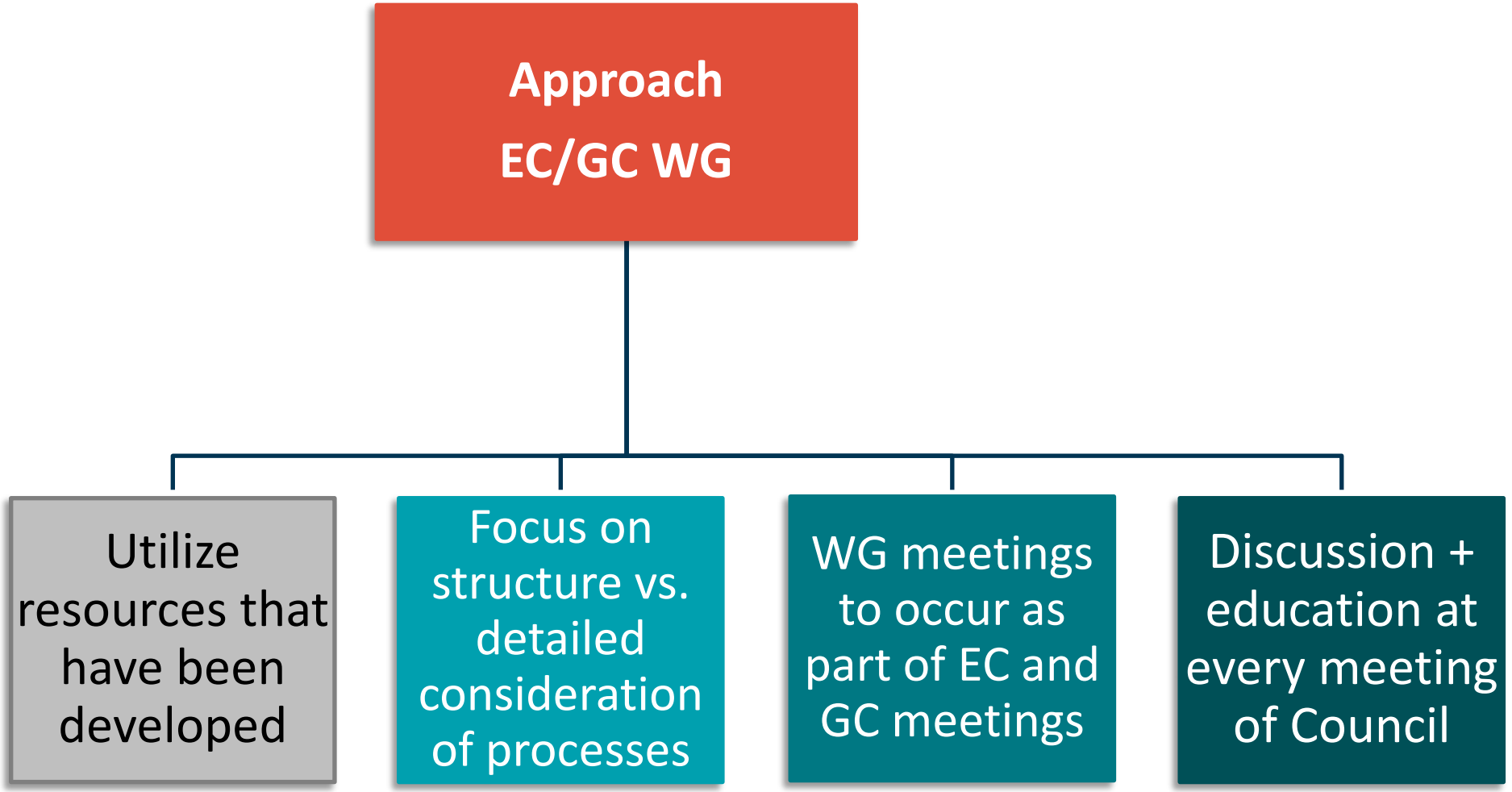
Day 2: Small group discussions

1. What are the characteristics of a high functioning modern board?
2. What are the key elements of the existing structure and approach that you believe should be retained?
3. What changes to the College's governance structure would improve the College's effectiveness?

1

Approach, Goals, Objectives of Governance Review

CPSO Governance Review: Approach



Goal

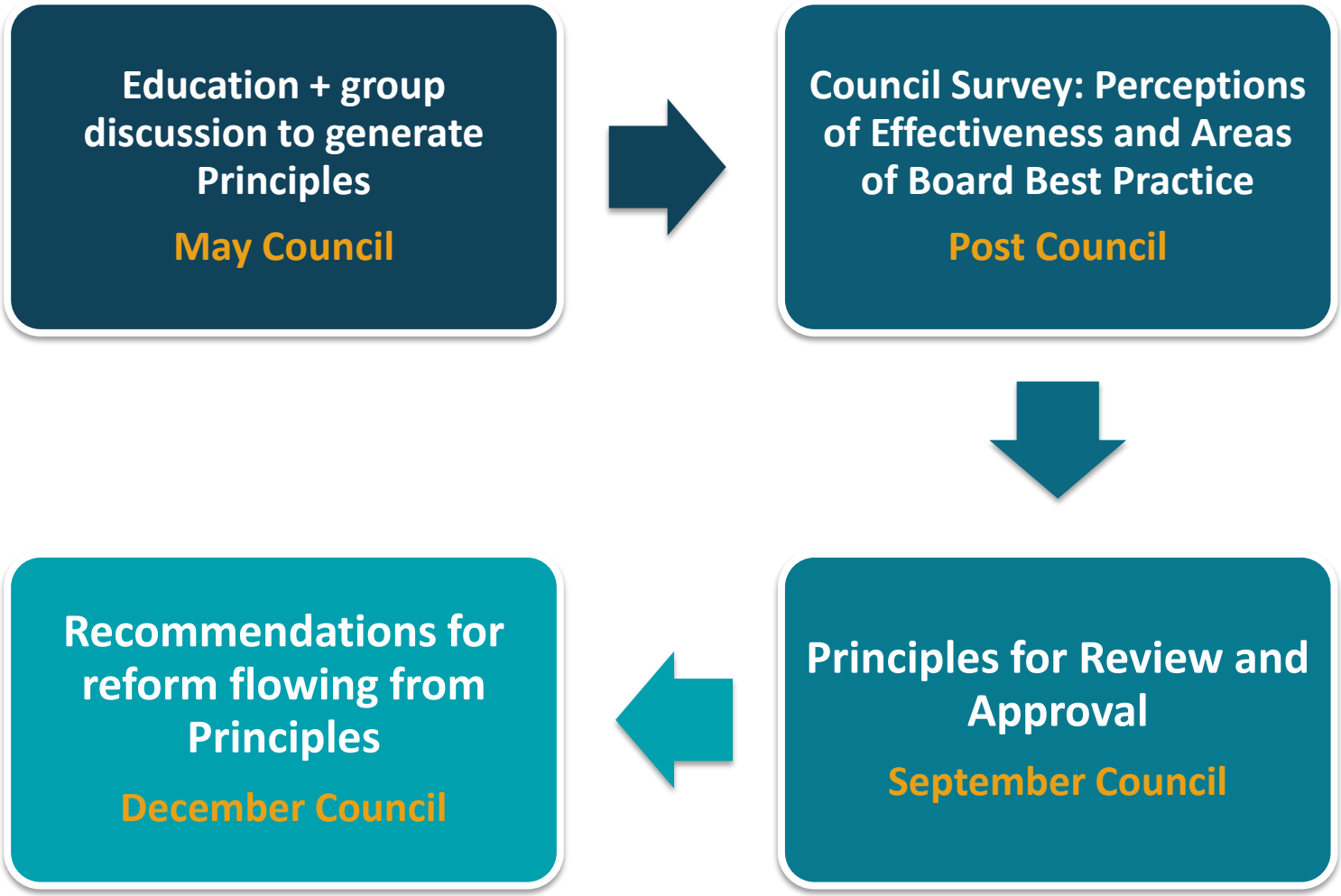
Identify governance principles and best practice structural changes to update and strengthen the integrity of the regulatory system and mandate to ensure public protection.

Objectives

1. **Education:**
   - Governance structures of similar organizations
   - Governance best practises
   - External environment
   - Regulatory oversight mechanisms
2. **Position organization** to influence and respond to external environment
3. **Adopt principles** re. a high performing board
4. **Identify recommendations** where indicated

Work Plan & Timeline

To be completed by 2018



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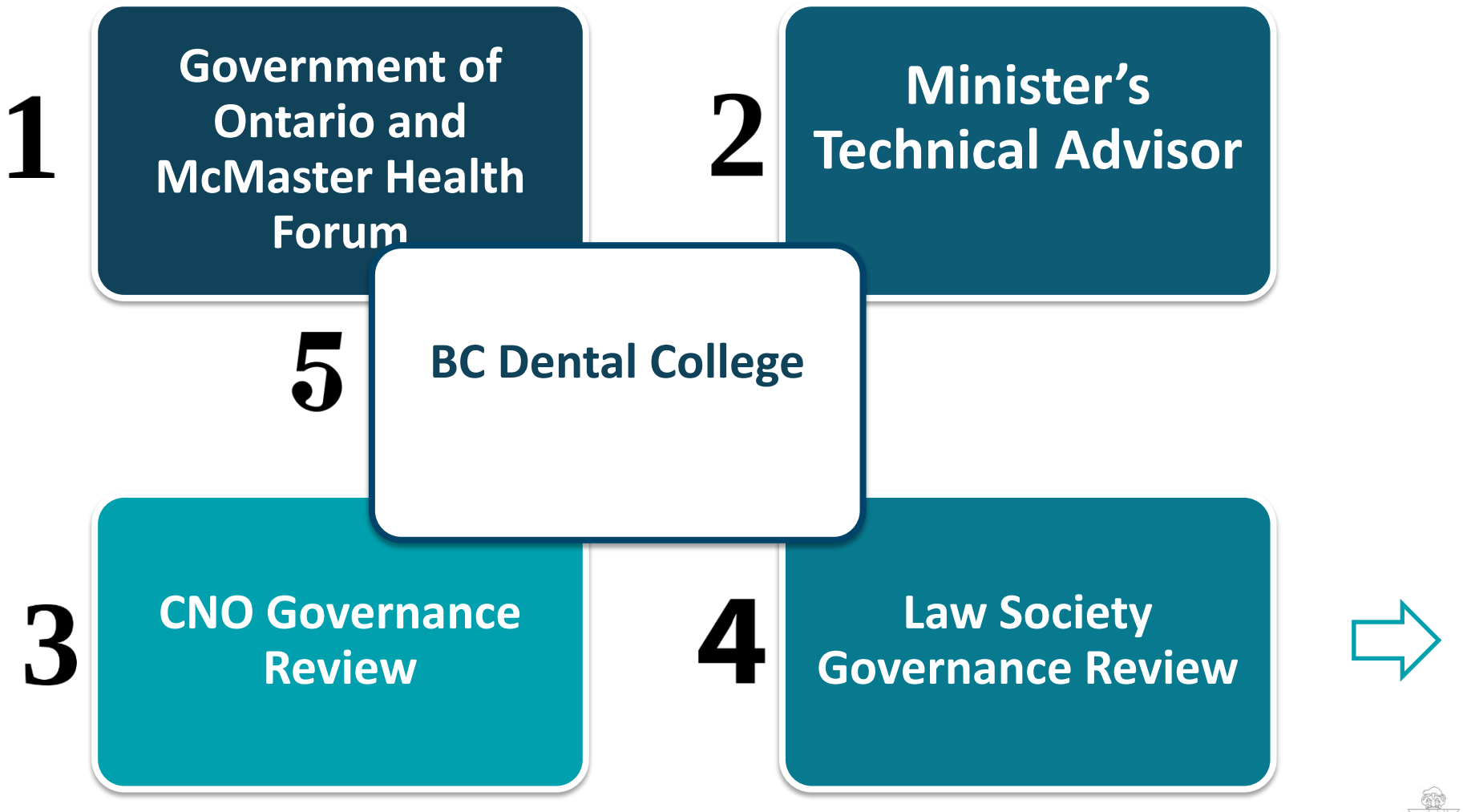
External Environment

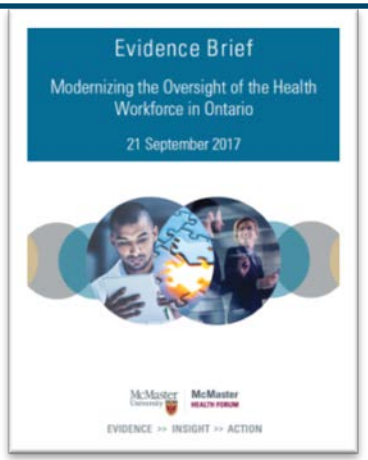
External Environment



External Environment: Ontario Government

- ***RHPA*** **is 25 Years old**
- **Liberal Government committed to medical workforce modernization**
- **Bill 87: Protecting Patients Act, 2017 introduced comprehensive changes to the *RHPA***

The Minister is given the power to make regulations respecting College committees and panels.



External Environment: McMaster Health Forum

Evidence Brief:

1) Oversight mechanisms have not kept pace with changing health system
2) Current oversight framework is focused on regulating individual categories of health workers, and captures some but not all health workers
3) Oversight framework has a different focus than framework used in education and training of health workers
4) Financing and funding of oversight bodies - not designed to optimize public-protection efforts
5) Difficult to find information on how the health workforce and its oversight bodies are performing
6) Citizens are not consistently engaged in meaningful ways in oversight activities

External Environment: McMaster Health Forum

Citizens Panels

Challenges that warrant modernization:

1) Oversight bodies have not adapted to changes in the delivery of care;
2) Many bodies responsible for oversight makes navigating system challenging and inefficient;
3) Oversight framework doesn't put enough emphasis on soft skills;
4) Oversight bodies not set up in a way that prioritizes interests of patients;
5) Finding information about health workers and their oversight bodies is difficult and there are limited opportunities for patients to contribute to oversight efforts; and
6) Risk of harm needs to be identified and addressed across a patient's entire care pathway.

External Environment: McMaster Health Forum

Stakeholder Dialogue:

General agreement about factors, focus on four:

1) The existing oversight framework is no longer fit for purpose
2) The media frequently draws attention to issues that may not warrant it
3) Politicians typically react to every issue regardless of its importance to the system as a whole
4) Some professional associations are not advancing their members' understanding of the importance of protecting the public

External Environment: Technical Advisor

- Appointed by Minister in mid-2017 following the Minister's sexual abuse task force report
- **Mandate:** providing advice on issues that flow from the regulations relating to Bill 87.
- **Also:** Consideration of best practices in ON and other jurisdictions in college governance and college committee membership
- **And:** Review and analysis of the Sexual Abuse Task Force recommendations.

External Environment: CNO

CNO –comprehensive governance review: Commitment to reforms by 2020

- Smaller board
- Competency-based appointments
- Equal representation between public and professional members
- No overlap in membership between board and statutory committees

External Environment: Law Society

Governance Task Force

Began review September 2016:

- **practical process issues** that should be addressed in the shorter term;
- **governance structure issues:** how committees are constituted and do their work, election reforms, etc.,
- **make recommendations** to improve governance through greater transparency, inclusiveness, effectiveness, efficiency and cost effectiveness

Changes to occur by 2023

Jurisdictional Review:

- **33 self-regulated organizations**
- Canada, UK, AU, and NZ
- Lawyers, accountants, engineers, teachers, doctors, nurses and dentists:
  - ✓ Board Function and Size
  - ✓ How Directors are Selected
  - ✓ Director Terms
  - ✓ Director Term Limits
  - ✓ Committee Structure
  - ✓ How Board Officers are Selected
  - ✓ Adjudication

And…outside of Ontario

"Board appointments help dental college put public first"

CDSBC College of Dental Surgeons of British Columbia

Int'l Expert: Harry Cayton

CPSO's Preliminary Work

Date	Governance Work
Feb 2016	• **Presentation, Deputy Minister of Health, Bob Bell** *Overview of regulatory models/jurisdiction summary* • **Presentation, Robert Lapper Law Society** *Regulatory Models and an Overview of the Law Society*
Feb 2017	• Recommended greater independence of Discipline Committee (Bill 87 submissions) • Recommended changes to prevent overlap in membership between Council and discipline
Sep 2017	• **Presentation, Anne Coghlan, CNO** *Governance Vision 2020* • Endorsed election of a public president
Feb 2018	• Supported Governance Review

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Overview of Jurisdictional and Literature Reviews

Other Jurisdictions

Quebec	UK	Australia
New Zealand	**Law Society**	**+++**

Governance

	CPSO	ON (Lawyers)	NZ	QC	Aus.	UK
# Members	up to 34	95	12	28	19	12
Prof/lay	19/15	>40/8	8/4	24/4	13/6	6/6
Elected	16	Elected & Appt'd	4 docs	20	Appt'd	Appt'd
Appointed	3 docs; + public		4 docs; 4 lay	8		
Represent-ation	Regional + Medical Faculty	Regional + Profession		Regional + Faculty	Specialties Legal profession Multi-cultural appointee	Regional

Discipline Body

	CPSO	ON (Lawyers)	NZ	QC	Aus.	UK
Members	42	92	3	59	n/a	280
Compos-ition	2 lay members, 1 prof'l member of Council on every panel	Chair* (not bencher) Vice-chair – elected 90 people (prof and lay)	1 Chair* 2 Deputy chairs*	Chair* Sub chairs* – 7 Doctors – 51 Cannot be on board	Judges, laypeople and docs Cannot be on board	Doctors and laypeople (fewer doctors) Cannot be on board, take part in investigative process
Selection	By Council	By benchers	By Minister of Health	Chairs by gov't Others by board	Judges by Discipline Tribunal; Docs and laypeople by board	By Medical Practitioner Tribunal Service (MPTS)

Discipline Body – con't

	CPSO	ON (Lawyers)	NZ	QC	Aus.	UK
Panel	2 must be public (appointed) 1 must be physician member of Council	Can be majority benchers & majority lawyers	Legal chair 3 docs (not board members) 1 lay	Legal chair 2 Docs (not board members)	Judge chair 2 Docs 1 Lay	ILC or Legal chair Majority non-docs if legal chair

Oversight Body

	CPSO	ON (Lawyers)	NZ	QC	Aus.	UK
Name	Fragmented: • Minister of Health and Long-Term Care • HPARB • HPRAC • Fairness Com. • Divisional Court	Advisory Council	N/A	Office des Professions + 2 other oversight bodies Extensive reporting to office required: - Complaints - Outcomes, incl. resolutions and no action - Timelines - Discipline hearing: # of days - registrations	Advisory Council	Privy Council Professional Standards Authority Reviews all Discipline decisions and has independent power to have them reviewed by a court

Other Jurisdictions – Observations

Summary:

- A move to smaller boards
- A move to separate or more independence between board and adjudicative functions;
- A variety of oversight models – the UK's PSA seen as the gold standard by many;
- A move away from "electing" board members from amongst membership.
- Geographic representation is common in Canadian organizations.
- In other jurisdictions, directors are elected to represent fields within the practice or other non-geographic constituencies within the profession (common among Australian organizations).

Discussion:

What elements of other governance models do you find most appealing?

Literature: Sources

3 main source documents:

1. CNO's *Governance Literature Review*
2. UK's Council for Healthcare Regulatory Excellence's report, *Board size and effectiveness advice to the Department of Health*
3. CNO's *Trends in Regulatory Governance*

A. Effective Boards and Best Practices

- Board functions and roles
- Optimal board size for board effectiveness
- Behaviour and board size
- Board composition: Diversity and Performance

B. Trends in Regulatory Governance

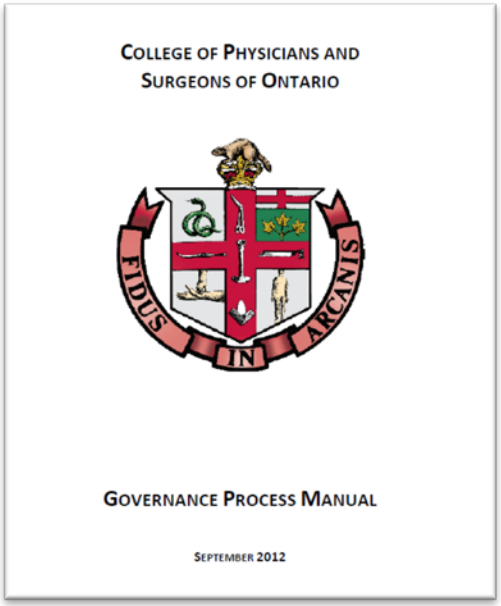
- Elections and Appointments
- Recruitment and Board Competencies
- Committee Roles/Oversight

Literature: Functions and Roles

Board functions and roles

1. Strategic leadership and strategic decision making
2. Stewardship, including holding the executive to account
3. External relations and accountability
4. Board maintenance

*Applicable to wide range of sectors



Roles align with role of Council set out in the CPSO's *Governance Process Manual*

Literature: Board Size

Optimal Board Size for Board Effectiveness:

Smaller boards are considered a best practice for board effectiveness

Recommendations: Generally 8-12 members; not over 15

Larger Boards

- More difficult for team members to contribute knowledge, skills and experience to their full potential
- Social loafing phenomenon or "free riding"
- Small number of individuals often dominate
- Greater resources to support and administer

Smaller Boards:

- ✓ **Teamwork:** Efficient communication, greater efforts by all team members and better utilization of team members' potential
- ✓ **Participation:** Create an environment with active participation in meetings
- ✓ **Communication and Decision Making:** Communicate more effectively and reach decisions more quickly
- ✓ **Flexibility:** Organic and flexible structure

Literature: Diversity

Diversity: Expands views on issues, options and solutions

Broad term

Can have different meanings depending on context

Literature: Elections and Appointments

Elections

1. Confusion for Membership and Public
2. Potential Conflicts
3. Perceived Conflicts

Appointment suggested to dispel perception that councils are overly sympathetic to those they regulate

Literature: Recruitment and Board Competencies

- ✓ As a whole, should have attributes to perform duties and functions of board
- ✓ Consider existing skills/expertise and fill gaps
- ✓ Appointments based on competencies ensures board is comprised of a diverse group with a wide range of expertise and different perspectives.

The right people in place to fulfill the mandate

Literature: Competencies

Characteristics

- ✓ Well-Informed, strategic and energized
- ✓ Engaged (attending meetings regularly and coming prepared to ask questions and consider issues)

Skills

- ✓ Governance and organizational effectiveness
- ✓ Policy development
- ✓ Regulation and the public interest
- ✓ Specific fields: Communications, Finance, HR, Law, etc.

Training alone is not sufficient to ensure the necessary competencies.

Literature: Committee Roles/Oversight

- The role of committees is to serve the Board - not vice versa;
- Adopting an entirely independent adjudication process promotes wider confidence and clarity of roles;
- Separation of the adjudication process allows Council to focus on the elements of good governance:
  - ✓ strategic direction;
  - ✓ holding the executive to account; and
  - ✓ proper use of resources

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Governance Review Working Group: Preliminary Discussion

Working Group Discussion

Change is coming. Not sure when or what type.

Does not mean Council is not doing a good job.

Council should be smaller.

Should have equal representation of public and physician members.

Council and Committees should be separated (particularly DC)

Working Group Discussion

Comments about Jurisdictional Research and Lit Review

- Evidence for best practice is more anecdotal than scientific.
- Competency-based board is desirable, however not clear what competencies are being considered and who gets to decide.
- Physician perspective must be present on Council
- Important to avoid a council made up of professional/career board members, who are disconnected from the public and the profession.
- Physicians must believe in the legitimacy of the board and committee structure.
- Can be challenging to get both diversity and competency, particularly if the board is smaller

Working Group Discussion

Most important qualities of council:

a. Including physicians ‘at the coalface’ (a diverse group of physicians)

b. Geographical diversity

c. Diversity of perspective/opinion

d. Diversity of age and career stage (would require changes to the way council operates – i.e., evening meetings)

- Election and public appointments have pros and cons.
- More clarity around board diversity, competencies is required
- Equal compensation for public members of Council was identified.
- Useful to separate the discussion about the ideal structure and composition of council from the mechanism used to select the members.
- A smaller Council could mean the elimination of the Executive Committee.

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Discussion & Next Steps

Discussion for Council:

1) What are the strengths and weaknesses of the current governance structure?

2) What elements of other governance models do you find most appealing?

NEXT STEPS:

Tomorrow at Council: focused small group discussion

1. What are the characteristics of a high functioning modern board?
2. What are the key elements of the existing structure and approach that you believe should be retained?
3. What changes to the College's governance structure would improve the College's effectiveness?

Appendix C

Bill 87: CPSO Psychotherapy Regulation Proposal

Vicki White

Co-Director, Legal Office

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

QUALITY PROFESSIONALS • HEALTHY SYSTEM • PUBLIC TRUST

Bill 87

Royal Assent May 2017

- Provincial government's response to Sexual Abuse Task Force, Goudge Review

- CPSO engaged throughout development process
  - submissions March and April 2017

Key provisions

Statutory Committees & Governance

Sexual Abuse, Sexual Misconduct

Definit

Orders

Provisions came into force at different times

- May 2017
- May 2018
- Awaiting regulation development

Third Party Records

Transparency

Patient Relations Program

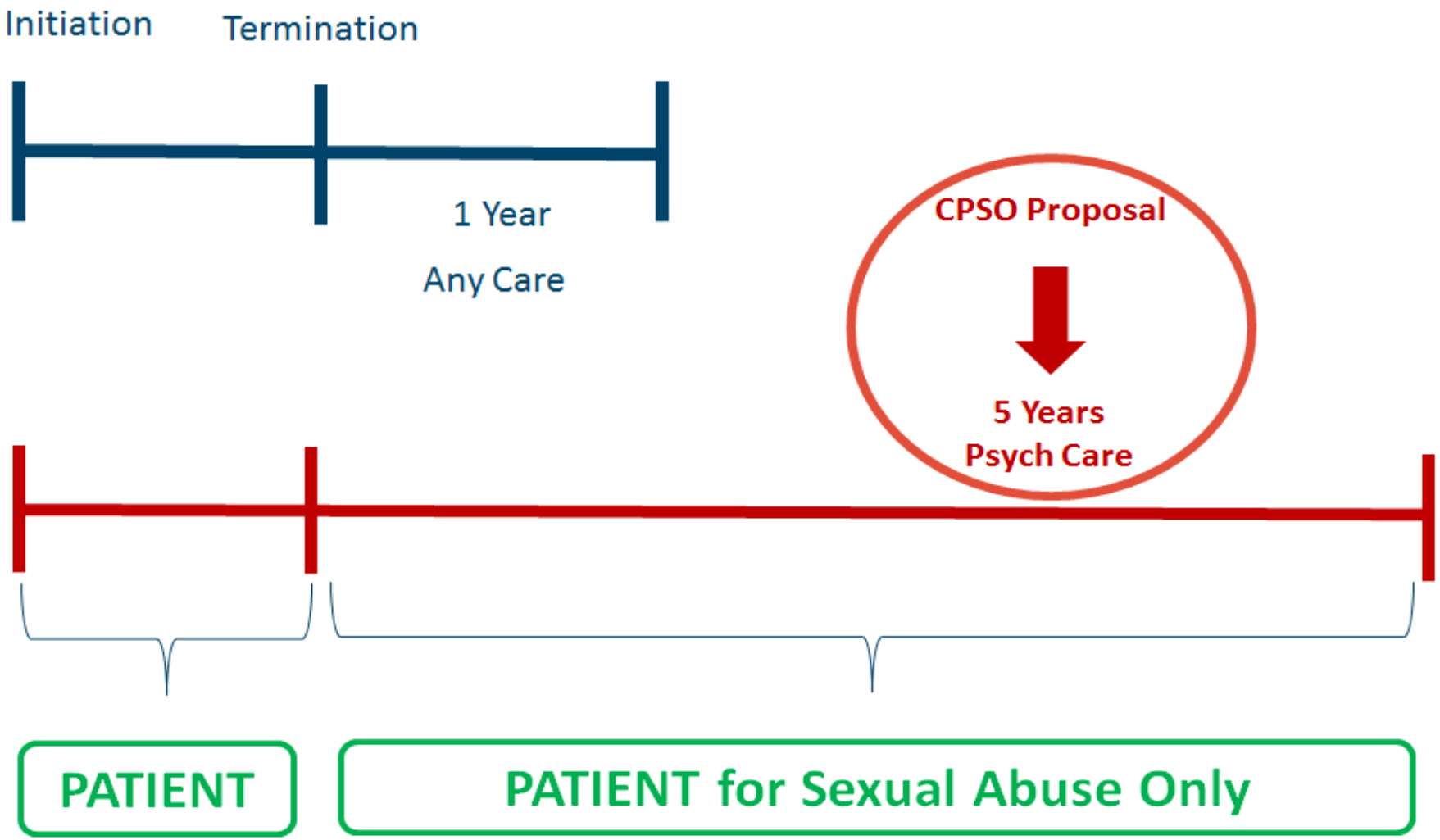
Definition of Patient – Before Bill 87

- **Q: Who is a patient? For how long?**
- ***A: Examine all the circumstances***
  - ***Nature of treatment***
    - *Family doctor vs. radiologist*
  - ***Intensity of treatment***
    - *Ongoing vs. isolated*
    - *Psychotherapy vs. minor / incidental care*
  - ***Duration of treating relationship***
  - ***Evidence of termination***
    - *New physician*

Definition of Patient – After Bill 87

CPSO proposal – extend doctor-patient relationship to 5 years after termination for psychotherapy

DURATION OF DR-PATIENT RELATIONSHIP FOR SEXUAL ABUSE



College Regulation

Psychotherapeutic relationships

- Physician-patient relationship extended for FIVE YEARS following termination
- Sexual contact prohibited during FIVE YEAR period; subject to mandatory revocation
- Discipline Committee retains discretion to order revocation for relationships after FIVE YEARS

Why Psychotherapy?

- Unique treating relationship, unique power imbalance
- Particular vulnerabilities of patients

Reflected in

Maintaining Appropriate Boundaries and Preventing Sexual Abuse policy

2015 Discipline Committee decision: Dr. Peter John Brown

Why Five Years?

- Protects patients: significant time to enable power imbalance to resolve
- Reflects the fact that psychotherapeutic relationships may differ: how much psychotherapy is provided, the nature/intensity of therapy
- Ensures the legislative provision is fair and defensible

Proposed Regulation

"Where the treatment provided by the member to the individual involves psychotherapy that is more than minor or insubstantial, an individual will be deemed to be a member's patient for five years after the date on which the individual ceased to be the member's patient."

Process & Government

All gov't activity has stopped until post-election

Proposed Next Steps:

- Align CPSO consultation with Ministry processes
- Consult on proposed regulation post-election
- Bring back to Council for final approval after 60-day circulation to membership
- gov't approval req'd

Decisions for Council

1. Does Council approve the draft regulation?

2. Does Council agree that consultation on the regulation can be delayed to communicate/ coordinate with the government, post-election?

Appendix D

Financial statements of

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 31, 2017

TINKHAM LLP | CHARTERED PROFESSIONAL ACCOUNTANTS

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INDEPENDENT AUDITOR'S REPORT

To the Members of
The College of Physicians and Surgeons of Ontario

We have audited the accompanying financial statements of The College of Physicians and Surgeons of Ontario, which comprise the statement of financial position as at December 31, 2017 and the statements of operations and changes in net assets, and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian accounting standards for not-for-profit organizations, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of The College of Physicians and Surgeons of Ontario as at December 31, 2017 and the results of its operations and its cash flows for the year then ended in accordance with Canadian accounting standards for not-for-profit organizations.

TORONTO, Ontario
May 24, 2018

Licensed Public Accountants

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Statement of Financial Position

As at December 31	2017	2016
Assets		
Current		
Cash (note 2a)	**$ 30,587,647**	$ 27,333,907
Accounts receivable (note 3)	**435,235**	933,950
Prepaids	**777,460**	436,647
	31,800,342	28,704,504
Investments (note 4)	**50,886,488**	50,543,913
Capital assets (note 5)	**10,131,121**	10,737,540
	$ 92,817,951	$ 89,985,957
Liabilities		
Current		
Accounts payable and accrued liabilities	**$ 6,173,307**	$ 6,528,693
Administered programme (note 7)	**58,589**	64,497
Current portion of obligations under capital leases (note 9)	**422,981**	386,815
	6,654,877	6,980,005
Deferred revenue (note 6)	**28,933,972**	27,528,513
	35,588,849	34,508,518
Accrued pension cost (note 8)	**5,687,665**	5,472,074
Obligations under capital leases (note 9)	**537,087**	491,199
	41,813,601	40,471,791
Net assets (note 10)		
Invested in capital assets	**9,171,053**	9,859,526
Building fund	**41,833,297**	39,654,640
Unrestricted	**617,362**	312,159
Pension remeasurements (note 8)	**(617,362)**	(312,159)
	51,004,350	49,514,166
	$ 92,817,951	$ 89,985,957

Commitments and contingencies (notes 11 and 12, respectively)

Approved on behalf of the Council

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See accompanying notes to the financial statements.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Statement of Operations and Changes in Net Assets

Year ended December 31	**2017**	2016
Revenue		
Membership fees		
General and educational (note 6)	**$ 58,374,991**	$ 56,719,244
Penalty fee	**256,662**	348,906
	58,631,653	57,068,150
Application fees	**7,657,450**	5,483,734
OHPIP annual and assessment fees (note 6)	**1,460,514**	1,215,732
IHF annual and assessment fees (note 6)	**1,053,893**	1,078,327
OHPIP, IHF application fees and penalties	**64,469**	71,685
Cost recoveries and other income	**1,775,172**	1,920,583
Investment income	**1,165,492**	1,015,005
	71,808,643	67,853,216
Expenses		
Committee costs (schedule I)	**15,581,175**	15,288,667
Staffing costs (schedule II)	**43,891,826**	43,485,099
Department costs (schedule III)	**7,159,261**	7,020,345
Depreciation of capital assets	**1,236,585**	1,270,931
Occupancy (schedule IV)	**2,144,409**	1,670,702
	70,013,256	68,735,744
Excess (deficiency) of revenue over expenses for the year	**1,795,387**	(882,528)
Net assets, beginning of year	**49,514,166**	50,511,205
Actuarial remeasurement for pension (note 8)	**(305,203)**	(114,511)
Net assets, end of year	**$ 51,004,350**	$ 49,514,166

See accompanying notes to the financial statements.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Statement of Cash Flows

Year ended December 31	2017	2016
Cash flows from operating activities:		
Excess (deficiency) of revenue over expenses for the year	**$ 1,795,387**	$ (882,528)
Depreciation of capital assets	**1,236,585**	1,270,931
	3,031,972	388,403
Net change in non-cash working capital items:		
Accounts receivable	**498,715**	77,458
Prepaids	**(340,813)**	(32,802)
Accrued interest receivable	**(342,575)**	(458,784)
Accounts payable and accrued liabilities	**(355,386)**	611,360
Due to Ministry of Health and Long Term Care	**-**	(1,288,849)
Administered programme	**(5,908)**	(88,481)
Deferred revenue	**1,405,460**	1,026,948
Pension cost	**(89,612)**	(87,465)
Cash provided by operating activities	**3,801,853**	147,788
Cash flows used by investing activities:		
Purchase of capital assets	**(57,501)**	(463,880)
Cash flows used by financing activities:		
Payment of capital lease obligations	**(490,612)**	(447,451)
Net increase (decrease) in cash	**3,253,740**	(763,543)
Cash, beginning of year	**27,333,907**	28,097,450
Cash, end of year	**$ 30,587,647**	$ 27,333,907

See accompanying notes to the financial statements.

1 Organization

The College of Physicians and Surgeons of Ontario ("the College") was incorporated without share capital as a not-for-profit organization under the laws of Ontario for the purpose of regulating the practice of medicine to protect and serve the public interest. Its authority under provincial law is set out in the Regulated Health Professions Act (RHPA), the Health Professions Procedural Code under RHPA and the Medicine Act.

The College is exempt from income taxes provided certain criteria are met.

2 Significant accounting policies

These financial statements have been prepared by management in accordance with Canadian accounting standards for not-for-profit organizations.

a) Cash

Cash includes cash deposits held in an interest bearing account at a major financial institution.

b) Investments

Guaranteed investment certificates are valued at amortized cost.

c) Capital assets

The cost of a capital asset includes its purchase price and any directly attributable cost of preparing the asset for its intended use.

A capital asset is tested for impairment whenever events or changes in circumstances indicate that its carrying amount may not be recoverable. An impairment loss is recognized in the statement of operations when the carrying amount of the asset exceeds the sum of the undiscounted cash flows resulting from its use and eventual disposition. The impairment loss is measured as the amount by which the carrying amount of the capital asset exceeds its fair value. An impairment loss is not reversed if the fair value of the capital asset subsequently increases. As at December 31, 2017, no such impairment exists.

Amortization is provided for on a straight-line basis over their estimated lives as follows:

Building	10 - 25 years	Computer and other equipment	3 - 5 years
Leasehold improvements	5 years	Computer equipment under capital lease	3 - 4 years
Furniture and fixtures	10 years		

d) Pension plans

The College recognizes its defined benefit obligations as the employees render services giving them right to earn the pension benefit. The defined benefit obligation at the statement of financial position date is determined using the most recent actuarial valuation report prepared for funding purposes. The measurement date of the plan assets and the defined benefit obligation is the College's statement of financial position date.

In its year-end statement of financial position, the College recognizes the defined benefit obligation, less the fair value of plan assets, adjusted for any valuation allowance in the case of a net defined benefit asset. The plan cost for the year is recognized in the excess of revenues over expenses for the year. Past service costs resulting from changes in the plan are recognized immediately in the excess of revenue over expenses for the year at the date of the changes.

Remeasurements and other items comprise the aggregate of the following: the difference between the actual return on plan assets and the return calculated using the discount rate; actuarial gains and losses; the effect of any valuation allowance in the case of a net defined pension asset; past service costs; and gains and losses arising from settlements or curtailments. Remeasurements are recognized as a direct charge (credit) to net assets.

2 Significant accounting policies continued

e) Revenue recognition

i) Members' fees and application fees

These fees are set annually by Council and are recognized as revenue proportionately over the fiscal year to which they relate. Fees received in advance are recorded as deferred revenue.

ii) Independent Health Facility (IHF) and Out of Hospital Premises Inspection Program (OHPIP) fees

IHF and OHPIP annual and assessment fees are recognized at the same rate as the related costs are expensed.

iii) Investment income

Investment income is comprised of interest from cash and cash equivalents, and guaranteed investment certificates. Interest and dividends are recognized when earned.

f) Financial instruments

i) Measurement

The College initially measures its financial assets and financial liabilities at fair value, adjusted by, in the case of a financial instrument that will not be measured subsequently at fair value, the amount of transaction costs directly attributable to the instrument.

The College subsequently measures its financial assets and liabilities at amortized cost. Transaction costs are recognized in income in the period incurred.

ii) Impairment

At the end of each reporting period, the College assesses whether there are any indications that a financial asset measured at amortized cost may be impaired. When there is an indication of impairment, the College determines whether a significant adverse change has occurred during the period in the expected timing or amount of future cash flows from the financial asset.

g) Management estimates

In preparing the College's financial statements, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and reported amounts of revenue and expenses during the period. Actual results may differ from these estimates, the impact of which would be recorded in future periods. Estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognized in the year in which the estimates are revised and in any future years affected.

h) Net assets invested in capital assets

Net assets invested in capital assets comprises the net book value of the capital assets less the related obligations under capital leases.

3 Cancer Care Ontario Quality Management Partnership

The College and Cancer Care Ontario (CCO), are jointly developing a provincial quality management program in three areas: mammography, colonoscopy and pathology. The program is fully funded by CCO. The program's expenses totaling $640,362 (2016 - $698,360) are excluded from the College's financial statements.

As at December 31, 2017, the College's account receivable arising from reimbursement of expenses incurred on behalf of CCO are $116,971 (2016 - $539,221). CCO has the right to audit the expenses charged to the program and adjustments, if any, to the accounts will be accounted for in the year of settlement.

4 Investments

As at December 31	**2017**	2016
Guaranteed Investment Certificates (GIC)		
Manulife Bank, 1.70%, due November 14, 2017	**$ -**	$ 10,000,000
Manulife Bank, 1.95%, due November 13, 2018	**10,000,000**	10,000,000
Manulife Bank, 2.20%, due November 16, 2020	**10,000,000**	-
CIBC, guaranteed growth, minimum 0.50% annual return, due November 13, 2019	**10,000,000**	10,000,000
CIBC, guaranteed growth, minimum 0.60% annual return, due November 13, 2020	**10,000,000**	10,000,000
National Bank, 2.01%, due November 22, 2022	**10,000,000**	10,000,000
Accrued interest	**886,488**	543,913
	$ 50,886,488	$ 50,543,913

The GIC investments are measured at amortized cost. Interest on the guaranteed growth investments held at CIBC will be determined at maturity based on the percentage change in price of an equally weighted portfolio of five Canadian bank's shares. Interest has been accrued at the minimum guaranteed rates.

5 Capital assets

As at December 31	**2017**		2016	
	Cost	**Accumulated Amortization**	Cost	Accumulated Amortization
Land	**$ 2,142,903**	**$ -**	$ 2,142,903	$ -
Building and building improvements	**20,779,959**	**14,637,816**	20,735,933	14,134,456
Furniture and fixtures	**4,380,871**	**3,540,453**	4,357,209	3,384,491
Computer and other equipment	**1,268,078**	**1,262,123**	1,266,212	1,236,255
Computer equipment under capital lease	**2,200,964**	**1,240,896**	1,804,569	932,986
Leasehold improvements	**396,339**	**356,705**	396,339	277,437
	$ 31,169,114	**$ 21,037,993**	$ 30,703,165	$ 19,965,625
Net book value		**$ 10,131,121**		$ 10,737,540

6 Deferred revenue

Deferred revenue consists of membership fees received in advance for the next year as well as unearned fees related to the Independent Health Facility program (IHF) and Out of Hospital Premises Inspection Program (OHPIP). The change in the deferred revenue accounts for the year is as follows:

	Membership Fees	IHF	OHPIP	2017 Total	2016 Total
Balance, beginning of year	**$ 24,282,912**	**$ 1,949,351**	**$ 1,296,250**	**$ 27,528,513**	$ 26,501,566
Amounts billed during the year	**59,677,262**	**1,433,136**	**1,184,459**	**62,294,857**	58,095,097
Less: Recognized as revenue	**(58,374,991)**	**(1,053,893)**	**(1,460,514)**	**(60,889,398)**	(57,068,150)
Balance, end of year	**$ 25,585,183**	**$ 2,328,594**	**$ 1,020,195**	**$ 28,933,972**	$ 27,528,513

The IHF and OHPIP Programs are budgeted and billed on a cost recovery basis.

7 Administered programme

The College administers the Methadone programme on behalf of the Ministry of Health and Long Term Care (MOHLTC). The revenues and expenses incurred for the programme are not included in the statement of operations of the College as they are the responsibility of the MOHLTC.

	2017	2016
Balance, opening	**$ 64,497**	$ 152,978
MOHLTC	**513,744**	322,158
Expenditures	**(519,652)**	(410,639)
Balance, closing	**$ 58,589**	$ 64,497

8 Pension Plans

i) Plan description

The College maintains a defined contribution pension plan for the benefit of its employees. The College also sponsors a supplementary defined contribution retirement plan for employees of the College in order to supplement the pension benefits payable to employees which are subject to the maximum contribution limitations under the Canadian Income Tax Act.

In addition, the College maintains a closed (1998) defined benefit pension plan for certain designated former employees. The retirement benefits of these designated employees are provided firstly through a funded plan and secondly through an unfunded supplementary plan.

ii) Reconciliation of funded status of the defined benefit pension plan to the amount recorded in the statement of financial position

Defined Benefit Plan	Funded Plan	Unfunded Plan	2017 Total	2016 Total
Plan assets at fair value	**$ 2,742,860**	**$ -**	**$ 2,742,860**	$ 2,929,387
Accrued pension obligations	**(3,980,411)**	**(4,450,114)**	**(8,430,525)**	(8,401,461)
Funded status - deficit	**$ (1,237,551)**	**$ (4,450,114)**	**$ (5,687,665)**	$ (5,472,074)

8 Pension plans continued

iii) Plan assets

Defined Benefit Plan	**Funded Plan**	**Unfunded Plan**	**2017 Total**	2016 Total
Fair value, beginning of year	**$ 2,929,387**	**$ -**	**$ 2,929,387**	$ 3,243,210
Interest income	**107,216**	**-**	**107,216**	121,620
Return on plan assets (excluding interest)	**48,797**	**-**	**48,797**	(113,692)
Employer contributions	**-**	**289,889**	**289,889**	291,654
Benefits paid	**(342,540)**	**(289,889)**	**(632,429)**	(613,405)
Fair value, end of year	**$ 2,742,860**	**$ -**	**$ 2,742,860**	$ 2,929,387

iv) Accrued pension obligations

Defined Benefit Plan	**Funded Plan**	**Unfunded Plan**	**2017 Total**	2016 Total
Balance, beginning of year	**$ 3,987,128**	**$ 4,414,333**	**$ 8,401,461**	$ 8,688,238
Interest cost on accrued pension obligations	**145,928**	**161,565**	**307,493**	325,809
Benefits paid	**(342,540)**	**(289,889)**	**(632,429)**	(613,405)
Actuarial (gains) losses	**189,895**	**164,105**	**354,000**	819
	$ 3,980,411	**$ 4,450,114**	**$ 8,430,525**	$ 8,401,461

The most recent actuarial valuation of the pension plan for funding and accounting purposes was made effective December 31, 2015. In accordance with that valuation, no payments have been made or are required under the funded plan. The next required actuarial valuation for funding purposes must be as of a date no later than December 31, 2018.

v) The net expense for the College's pension plans is as follows:

	2017	2016
Funded defined benefit plan	**$ 38,712**	$ 34,008
Unfunded supplementary defined benefit plan	**161,565**	170,181
Defined contribution plan	**2,849,219**	2,765,209
Supplementary defined contribution plan	**229,047**	193,179
	$ 3,278,543	$ 3,162,577

vi) The elements of the defined benefit pension expense recognized in the year are as follows:

Defined Benefit Plan	**Funded Plan**	**Unfunded Plan**	**2017 Total**	2016 Total
Interest cost on accrued pension obligations	**$ 145,928**	**$ 161,565**	**$ 307,493**	$ 325,809
Interest income on pension assets	**(107,216)**	**-**	**(107,216)**	(121,620)
Pension expense (recovery) recognized	**$ 38,712**	**$ 161,565**	**$ 200,277**	$ 204,189

8 Pension plans continued

vii) Remeasurements and other items recognized as a direct charge (credit) to net assets are as follows:

Defined Benefit Plan	**Funded Plan**	**Unfunded Plan**	**2017 Total**	2016 Total
Actuarial (gain) losses	**$ 189,895**	**$ 164,105**	**$ 354,000**	$ 819
Return on plan assets (excluding interest)	**(48,797)**	**-**	**(48,797)**	113,692
Charge (credit) to net assets	**$ 141,098**	**$ 164,105**	**$ 305,203**	$ 114,511

viii) Actuarial assumptions

The significant actuarial assumptions adopted in measuring the accrued pension obligations as at December 31 are as follows:

	2017	2016
Discount rate	**3.30 %**	3.66 %
Rate of compensation increase	**N/A**	N/A

9 Obligations under capital leases

The College has entered into several capital leases for computer equipment. The following is a schedule of the future minimum lease payments of the obligations under these leases expiring on various dates to April 2021:

2018	$ 422,981
2019	341,077
2020	160,013
2021	35,997
	960,068
Less: current portion	422,981
	$ 537,087

10 Net assets

2017	**Invested in Capital Assets**	**Building Fund**	**Unrestricted**	**Pension Re-measurement**	**Total**
Balance, January 1	**$ 9,859,526**	**$ 39,654,640**	**$ 312,159**	**$ (312,159)**	**$ 49,514,166**
Excess (deficiency) of revenue over expenses for the year	**(688,473)**	**-**	**2,483,860**	**-**	**1,795,387**
Actuarial remeasurement for pensions	**-**	**-**	**-**	**(305,203)**	**(305,203)**
Transfers	**-**	**2,178,657**	**(2,178,657)**	**-**	**-**
Balance, December 31	**$ 9,171,053**	**$ 41,833,297**	**$ 617,362**	**$ (617,362)**	**$ 51,004,350**

2016	Invested in Capital Assets	Building Fund	Unrestricted Net Assets	Pension Re-measurement	Total
Balance, January 1	$ 10,219,127	$ 40,292,078	$ 197,648	$ (197,648)	$ 50,511,205
Excess of revenue over expenses for the year	(359,601)	-	(522,927)	-	(882,528)
Actuarial remeasurement for pensions	-	-	-	(114,511)	(114,511)
Transfers	-	(637,438)	637,438	-	-
Balance, December 31	$ 9,859,526	$ 39,654,640	$ 312,159	$ (312,159)	$ 49,514,166

The College has transferred $2,178,657 to the building fund from unrestricted net assets (2016 - $637,438 transferred from the building fund to unrestricted net assets).

Net assets invested in capital assets is calculated as follows:

As at December 31	**2017**	2016
Net book value of capital assets	**$ 10,131,121**	$ 10,737,540
Less: obligations under capital leases	**(960,068)**	(878,014)
	$ 9,171,053	$ 9,859,526

11 Commitments

The College has a lease for additional office space which extends to December 31, 2021 with two options to renew for additional five year terms subsequent. Minimum payments for base rent and estimated maintenance, taxes and insurance in aggregate and for each of the next four years are estimated as follows:

2018	$ 691,587
2019	716,394
2020	724,475
2021	732,717
Total	$ 2,865,173

12 Contingencies

The College has been named as a defendant in lawsuits with respect to certain of its members or former members. The College denies any liability with respect to these actions and no amounts have been accrued in the financial statements. Should the College be unsuccessful in defending these claims, it is not anticipated that they will exceed the limits of the College's liability insurance coverage.

The College acknowledges that it has an obligation to provide funding to patients who are approved by the Patient Relations Committee.

13 Financial instruments

General objectives, policies and processes

Council has overall responsibility for the determination of the College's risk management objectives and policies.

Credit risk

Credit risk is the risk that one party to a financial instrument will cause a financial loss for the other party by failing to discharge an obligation. The College is exposed to credit risk through its cash, accounts receivable and investments.

Accounts receivable are generally unsecured. This risk is mitigated by the College's requirement for members to pay their fees in order to renew their annual license to practice medicine. The College also has collection policies in place.

Credit risk associated with cash and investments is mitigated by ensuring that these assets are invested in financial obligations of major financial institutions.

Liquidity risk

Liquidity risk is the risk that the College will not be able to meet a demand for cash or fund its obligations as they come due. The College meets its liquidity requirements and mitigates this risk by monitoring cash activities and expected outflows and holding assets that can be readily converted into cash, so as to meet all cash outflow obligations as they fall due.

Market risk

Market risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices. Market risk is comprised of currency risk, interest rate risk and equity risk.

i) Currency risk

Currency risk reflects the risk that the College's earnings will vary due to the fluctuations in foreign currency exchange rates. The College is not exposed to foreign exchange risk.

ii) Interest rate risk

Interest rate risk refers to the risk that the fair value of financial instruments or future cash flows associated with the instruments will fluctuate due to changes in market interest rates. The exposure of the College to interest rate risk arises from its interest bearing investments and cash. The primary objective of the College with respect to its fixed income investments ensures the security of principal amounts invested, provides for a high degree of liquidity, and achieves a satisfactory investment return giving consideration to risk. The College has mitigated exposure to interest rate risk.

iii) Equity risk

Equity risk is the uncertainty associated with the valuation of assets arising from changes in equity markets. The College is not exposed to this risk.

Changes in risk

There have been no significant changes in risk exposures from the prior year.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
Schedule I
Committee Costs

Year ended December 31	2017	2016
Attendance	**$ 3,683,250**	$ 4,011,557
Preparation time	**3,164,413**	3,031,900
Decision writing	**901,074**	978,582
Expert opinions	**1,838,289**	1,481,904
Assessors	**330,793**	342,309
Travel time	**1,616,670**	1,718,558
HST on per diems	**650,946**	601,856
Legal costs	**1,956,780**	1,498,452
Audit fees	**44,526**	38,092
Sustenance	**236,991**	316,577
Meals and accommodations	**366,523**	390,895
Travel expenses	**750,491**	847,685
Witness expenses	**40,429**	30,300
	$ 15,581,175	$ 15,288,667

Schedule II
Staffing Costs

Year ended December 31	2017	2016
Salaries	**$ 34,895,857**	$ 34,489,020
Employee benefits	**4,486,376**	4,571,881
Pension (note 8)	**3,278,543**	3,162,577
Training, conferences and employee engagement	**691,195**	670,103
Personnel, placement and pension consultants	**539,855**	591,518
	$ 43,891,826	$ 43,485,099

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
Schedule III
Department Costs

Year ended December 31	2017	2016
Consultant fees	**$ 1,292,550**	$ 1,069,231
Credit card service charges	**1,335,698**	1,253,249
IT Projects - external partners	**399,337**	424,475
Software	**367,590**	265,693
Equipment leasing	**10,796**	110,894
Equipment maintenance	**55,711**	39,937
Miscellaneous	**417,439**	393,576
Photocopying	**352,211**	357,756
Printing	**22,828**	37,341
Postage	**280,095**	294,698
Members dialogue	**339,522**	380,297
Courier	**68,669**	118,228
Telephone	**325,511**	315,305
Office supplies	**315,636**	340,251
Reporting and transcripts	**453,629**	353,184
Professional fees - staff	**91,324**	82,039
FMRAC Membership fee	**490,620**	471,000
Publications and subscriptions	**193,784**	191,780
Travel	**252,311**	447,411
Grants	**94,000**	74,000
	$ 7,159,261	$ 7,020,345

Schedule IV
Occupancy

Year ended December 31	2017	2016
Building maintenance and repairs	**$ 681,026**	$ 465,192
Insurance	**500,276**	496,566
Realty taxes	**87,457**	78,236
Utilities	**248,325**	246,055
Rent	**627,325**	384,653
	$ 2,144,409	$ 1,670,702

Continuity of Care

Drafts for Consultation

Dr. Brenda Copps

Working Group Chair

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

QUALITY PROFESSIONALS • HEALTHY SYSTEM • PUBLIC TRUST

Presentation Overview

- Background and Project Genesis
- Consultation Activities
- Drafts for Consultation

Background

- We've been down this road before…
  - Previous policy development work
    - *Duty of Care (2000), Continuity of Care (2002), Continuity of Care After Hours and During Other Absences (2004)*
  - Council did not approve this work

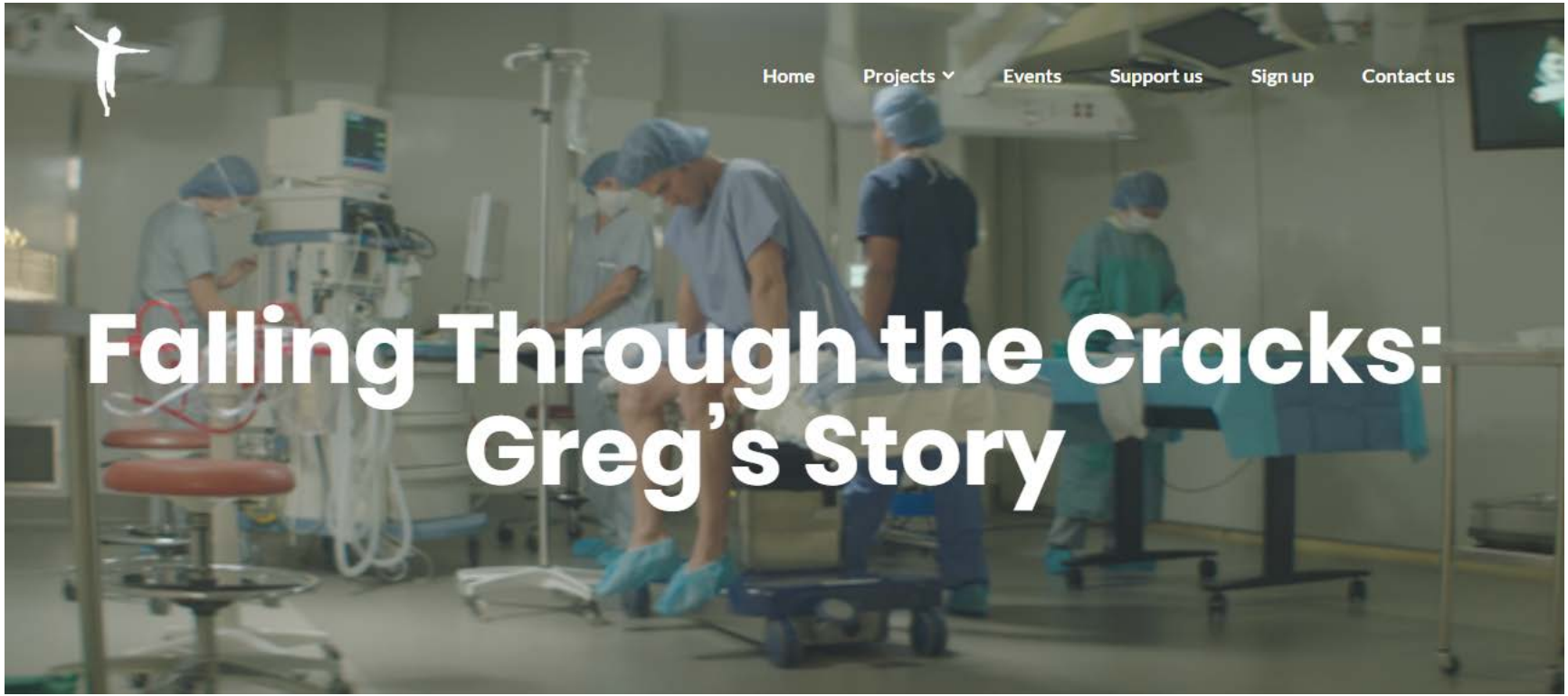
New Developments

- Issues at the College include:
  - Physician availability to patients and other health-care providers
  - Walk-in clinic care

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- Increased attention on continuity of care
  - Commonwealth Fund & Health Quality Ontario reporting
  - Greg Price & Health Quality Council of Alberta

Falling Through the Cracks



Our Starting Point

2014

Continuity of Care Planning and Proposal

A. Project Scope

- Policy analysis, research, and consultation relating to the development of a new *Continuity of Care* policy will begin in 2016 under the direction of a Working Group.
- The current *Test Results Management* policy will also be reviewed, as this policy addresses issues relating to continuity of care. The same Working Group will oversee this review.
- To minimize confusion and focus the policy development process, a working definition of "continuity of care" will be proposed at the outset:
  - Continuity of care: the degree to which a series of discrete healthcare events is experienced as coherent and connected and consistent with the patient's medical needs and personal context. (HQCA, *Continuity of Patient Care Study*)

2016

Project Scope

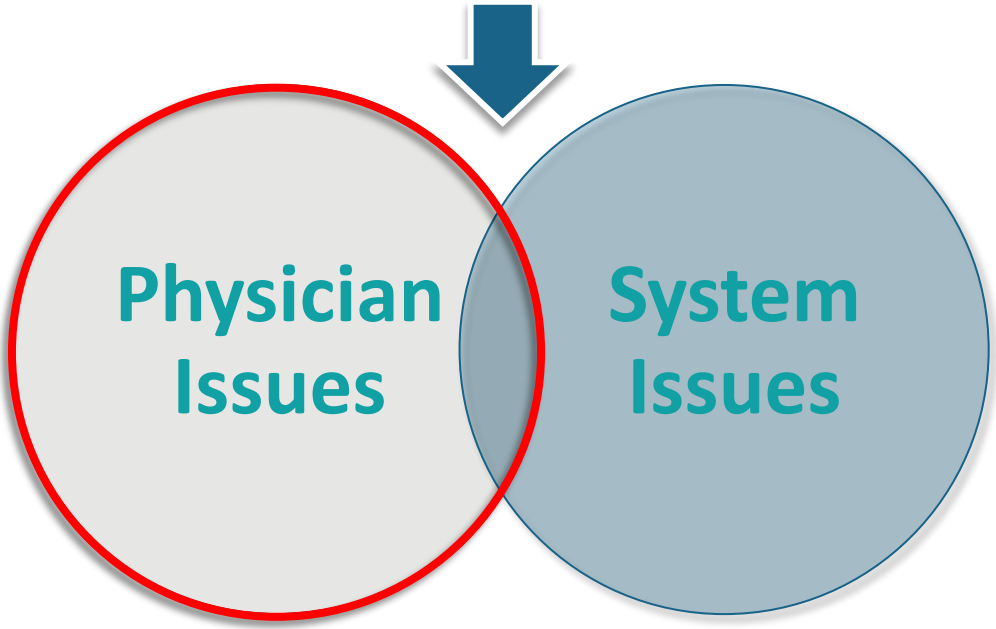
Mandate

- ✓ To develop NEW policy content relating to *Continuity of Care*;
- ✓ To REVISE the current *Test Results Management* policy

***Focus:** patient experience, patient safety, and the public interest.*

Project Scope

Continuity of Care



- Integrated EMR/EHR with enhanced functionality
- Wait times for consultations
- Support from labs
- Hospital discharge processes
- Resources for after-hours care

'White Paper'

Recommendations for Systems Issues

How We Compare

College of Physicians & Surgeons of Alberta

THE COLLEGE OF PHYSICIANS & SURGEONS OF PRINCE EDWARD ISLAND

YUKON MEDICAL COUNCIL

COLLEGE OF PHYSICIANS & SURGEONS OF NOVA SCOTIA

COLLEGE OF PHYSICIANS & SURGEONS INCORPORATED 1886 VIRTUTE ET VERITATE BRITISH COLUMBIA

Many Colleges already have positions on various continuity of care issues.

Policy Development Process

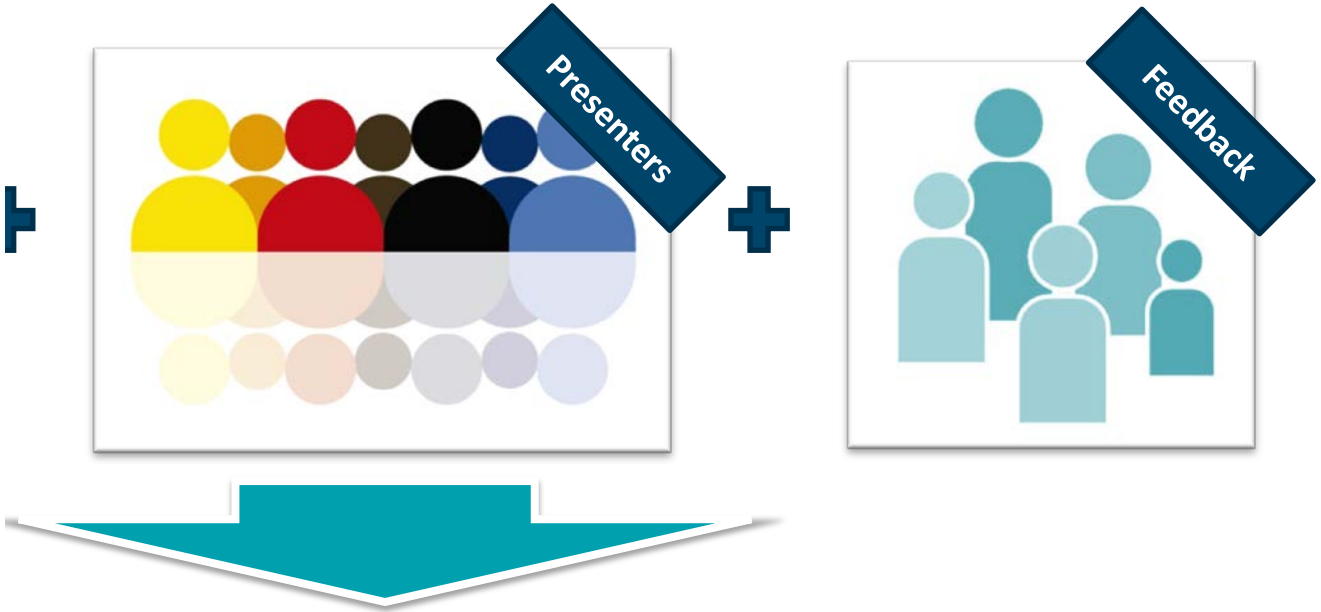
Policy Development Process

- 150+ articles, reports, position papers etc. and still ongoing
- In-depth jurisdictional review
- ICRC decisions and data

Policy Development Process

- Two external consultations
- Staff feedback (e.g., PPAS and Investigations)
- ICRC, QAC, and Council feedback
- Chiefs' and Presidents' Day
- Public Opinion Polling

Policy Development Process



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"Suite" of policies

Continuity of Care

'Umbrella' policy
Contains principles and core policy expectations

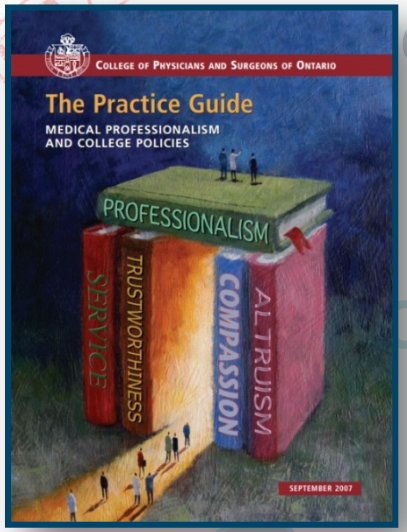
Availability & Coverage

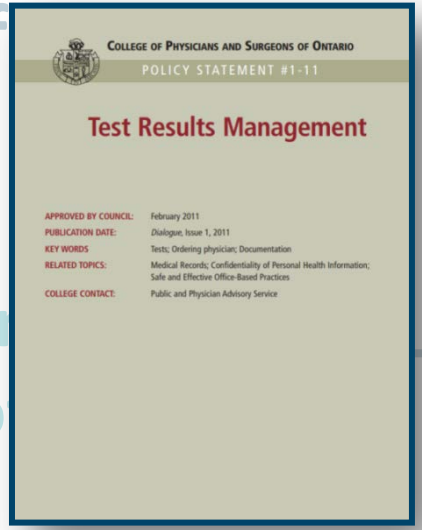
Managing Tests

Transitions in Care

Walk-in Clinics

Companion policies
Address specific practice issues

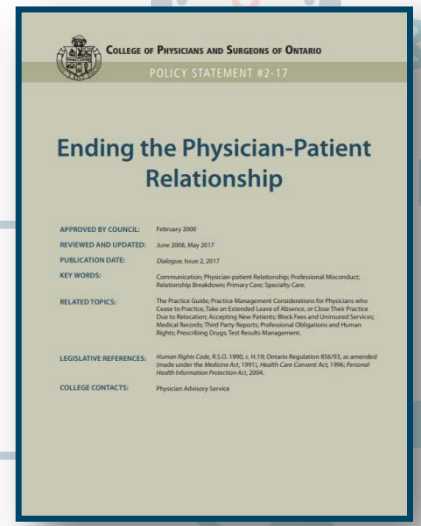



College of Physicians and Surgeons of Ontario

POLICY STATEMENT #1-11

Test Results Management

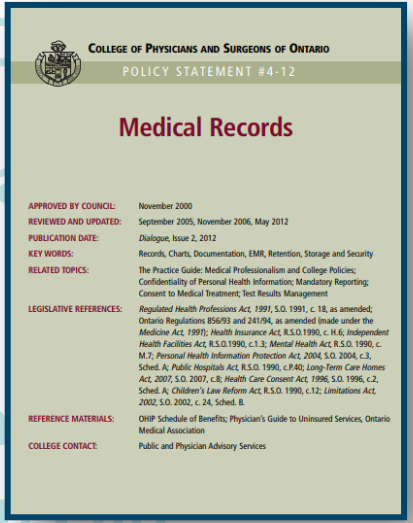
APPROVED BY COUNCIL:	February 2011
PUBLICATION DATE:	*Dialogue*, Issue 1, 2011
KEY WORDS	Tests; Ordering physician; Documentation
RELATED TOPICS:	Medical Records; Confidentiality of Personal Health Information; Safe and Effective Office-Based Practices
COLLEGE CONTACT:	Public and Physician Advisory Service


College of Physicians and Surgeons of Ontario

POLICY STATEMENT #2-17

Ending the Physician-Patient Relationship

APPROVED BY COUNCIL:	February 2000
REVIEWED AND UPDATED:	June 2008, May 2017
PUBLICATION DATE:	*Dialogue*, Issue 2, 2017
KEY WORDS:	Communication; Physician-patient Relationship; Professional Misconduct; Relationship Breakdown; Primary Care; Specialty Care.
RELATED TOPICS:	The Practice Guide; Practice Management Considerations for Physicians who Cease to Practice, Take an Extended Leave of Absence, or Close Their Practice Due to Relocation; Accepting New Patients; Block Fees and Uninsured Services; Medical Records; Third Party Reports; Professional Obligations and Human Rights; Prescribing Drugs; Test Results Management.
LEGISLATIVE REFERENCES:	*Human Rights Code*, R.S.O. 1990, c. H.19; Ontario Regulation 856/93, as amended (made under the *Medicine Act*, 1991), *Health Care Consent Act*, 1996; *Personal Health Information Protection Act*, 2004.
COLLEGE CONTACTS:	Physician Advisory Service


College of Physicians and Surgeons of Ontario

POLICY STATEMENT #4-12

Medical Records

APPROVED BY COUNCIL:	November 2000
REVIEWED AND UPDATED:	September 2005, November 2006, May 2012
PUBLICATION DATE:	*Dialogue*, Issue 2, 2012
KEY WORDS:	Records, Charts, Documentation, EMR, Retention, Storage and Security
RELATED TOPICS:	The Practice Guide: Medical Professionalism and College Policies; Confidentiality of Personal Health Information; Mandatory Reporting; Consent to Medical Treatment; Test Results Management
LEGISLATIVE REFERENCES:	*Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended; Ontario Regulations 856/93 and 241/94, as amended (made under the *Medicine Act, 1991*); *Health Insurance Act*, R.S.O.1990, c. H.6; *Independent Health Facilities Act*, R.S.O.1990, c.1.3; *Mental Health Act*, R.S.O. 1990, c. M.7; *Personal Health Information Protection Act, 2004*, S.O. 2004, c.3, Sched. A; *Public Hospitals Act*, R.S.O. 1990, c.P.40; *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8; *Health Care Consent Act, 1996*, S.O. 1996, c.2, Sched. A; *Children's Law Reform Act*, R.S.O. 1990, c.12; *Limitations Act, 2002*, S.O. 2002, c. 24, Sched. B.
REFERENCE MATERIALS:	OHIP Schedule of Benefits; Physician's Guide to Uninsured Services, Ontario Medical Association
COLLEGE CONTACT:	Public and Physician Advisory Services

'Umbrella' policy

Contains principles and
policy expectations

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Standard of Practice

Availability

Walk-in Clinics

Companion policies

Address specific practice issues

Decisions for Council

1) Asking for your feedback on the draft policies.

2) Asking for your recommendation that the draft policies be released for external consultation.

Consultation Process

- ✓ **Extended Consultation**
- ✓ **Stakeholder Summit**
- ✓ **Tweet Chat**
- ✓ **And more…**

Direct email campaigns

Adding it to the Policy section of the CPSO website

Promo
soc

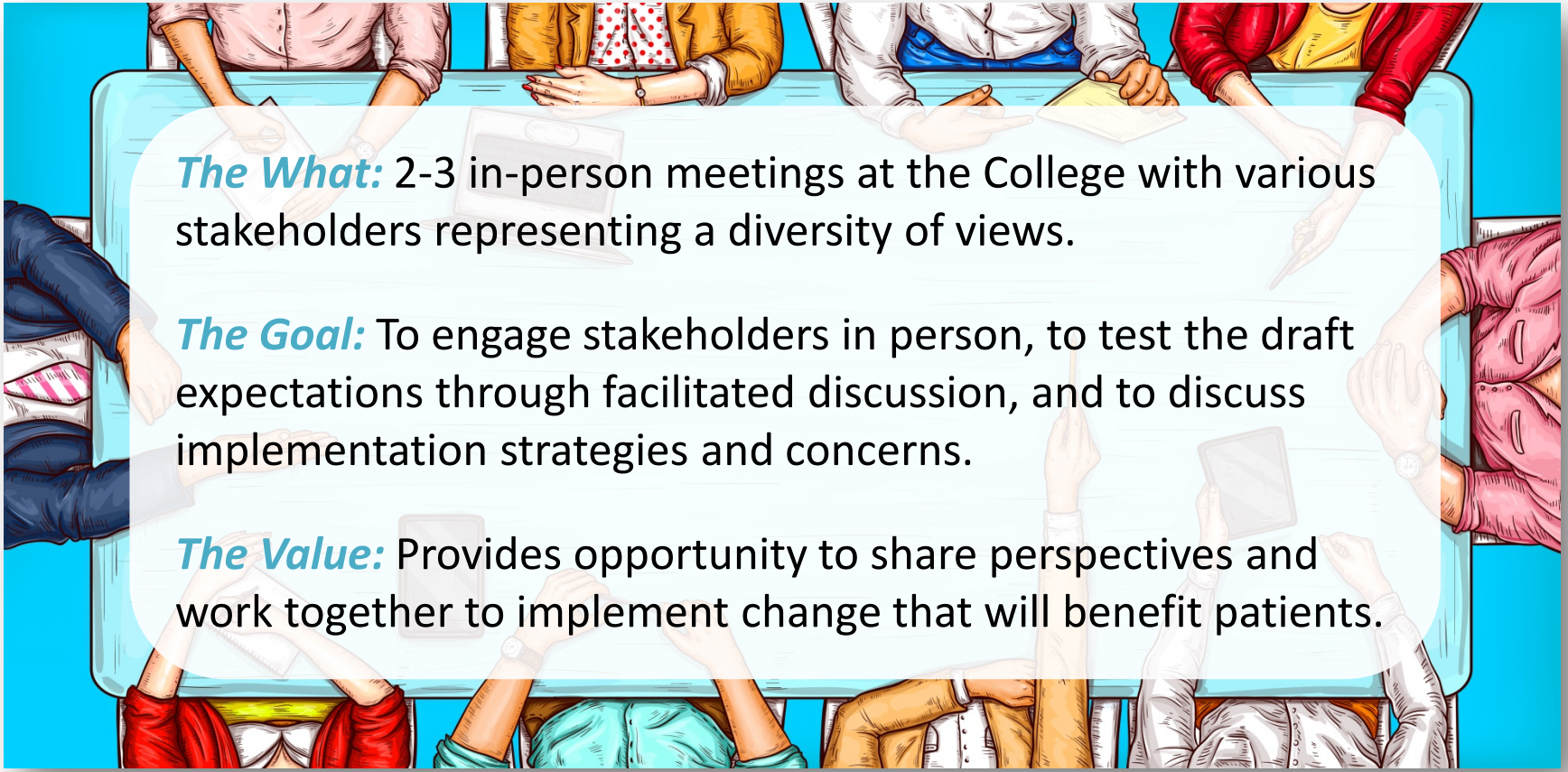
Publishing a notice in *Patient Compass*, *Council Update* and other College newsletters

Publishing a notice about it in our membership magazine, *Dialogue*

External Consultation

- *Extended Consultation Period:* 4 (or 6) months, rather than 60 days
- *Extensive Promotion:* Council Update, Consultation Newsletter, College Newsletters, Social Media (incl. paid advertising)
- *Communication Tools: "Primers"* capturing research, feedback, and key policy positions and rationale.

Stakeholder Summit



The What: 2-3 in-person meetings at the College with various stakeholders representing a diversity of views.

The Goal: To engage stakeholders in person, to test the draft expectations through facilitated discussion, and to discuss implementation strategies and concerns.

The Value: Provides opportunity to share perspectives and work together to implement change that will benefit patients.

Tweet Chat

@cpso_ca **#cpso_chat**

- Online and real-time discussions via ***Twitter*** on the ‘suite’ of draft policies
- Any Twitter user can participate, but key social media influencers will be invited
- College can pose direct questions and respond as necessary
- Drive participants to the consultation page

And more….

- Citizen Advisory Group
- Articles & Newsletters
- Communications & media strategy
- Additional strategies as needed

Ontario Medical Association

OMA
ONTARIO MEDICAL ASSOCIATION

Letter addressed to Interim Registrar and circulated to all Council Members

Requests

- Begin consultation in Fall 2018
- Extend consultation to 6 months
- Step-wise consultation
  - Beginning with only the draft ‘umbrella’ policy

Ontario Medical Association

OMA
ONTARIO MEDICAL ASSOCIATION

Letter addressed to Interim Registrar and circulated to all Council Members

Working Group Recommendation:

- *Delaying the consultation*
- *Consulting in a step-wise fashion*

- *6 month consultation*

Ontario Medical Association

OMA
ONTARIO MEDICAL ASSOCIATION

Letter addressed to Interim Registrar and circulated to all Council Members

Requests

- Begin consultation in Fall 2018
- Extend consultation to 6 months
- Step-wise consultation
  - Beginning with only the draft ‘umbrella’ policy

DRAFT

"Suite" of policies

Continuity of Care

'Umbrella' policy
Contains principles and core policy expectations

Availability & Coverage

Managing Tests

Transitions in Care

Walk-in Clinics

Companion policies
Address specific practice issues

Appendix E

Continuity of Care
Umbrella Policy
Draft for Consultation

Ms. Joan Powell

Working Group Member

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

QUALITY PROFESSIONALS • HEALTHY SYSTEM • PUBLIC TRUST

DRAFT

"Suite" of policies

Continuity of Care

'Umbrella' policy
Contains principles and core policy expectations

- **Availability & Coverage**
- **Managing Tests**
- **Transitions in Care**
- **Walk-in Clinics**

Companion policies
Address specific practice issues

DRAFT

‘Umbrella Policy’

- *Purpose:* To set out principles and expectations that apply broadly and underpin the suite of policies

- *Principles:* Anchored to the College’s *Practice Guide*, the principles of the suite focus on:
  - Patients’ best interests, communication and collaboration, public trust, physician competence, and participation in medical regulation

DRAFT

‘Umbrella Policy’

Physicians

Patient Engagement

Technology

DRAFT

‘Umbrella Policy’ - Key Expectations

Physicians

- Recognize that patient interactions are not discrete events
  - They require oversight & management over time.
- Collaborate and communicate with other health-care providers
  - Discharging this responsibility will be context dependent
- As a *health advocate*, physicians are advised to participate in opportunities to improve continuity of care within the health system

DRAFT

‘Umbrella Policy’ - Key Expectations

Patient Engagement

- Identifies the important role that patients play in facilitating continuity of care
  - Patient actions contribute to or help prevent breakdowns in continuity of care
- Physicians are advised to facilitate and support patient engagement
  - Using professional judgment
  - Helping them to understand their role
  - Complements physician efforts

DRAFT

‘Umbrella Policy’ - Key Expectations

Technology

- Technology can be a valuable tool
  - EMR, connectingOntario, Hospital Report Manager, e-consult, etc.
- Physicians are advised to capitalize on advances in technology that facilitate continuity of care
  - Obligations exist whether technology exists or whether existing technology is adopted

Decisions for Council

1) Does Council have any feedback on the draft ***Continuity of Care*** policy?

2) Does Council recommend that the draft ***Continuity of Care*** policy be released for external consultation?

Appendix F

Continuity of Care:
Availability and Coverage

Draft for Consultation

Dr. Brenda Copps

Working Group Chair

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

QUALITY PROFESSIONALS • HEALTHY SYSTEM • PUBLIC TRUST

DRAFT

"Suite" of policies

Continuity of Care

'Umbrella' policy
Contains principles and core policy expectations

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Companion policies
Address specific practice issues

DRAFT

Availability and Coverage

- *Purpose:* Set out expectations regarding physician availability, after-hours coverage, and coverage for temporary absences.

What we are <u>not</u> doing:

Requiring individual physicians to provide on-demand and 24-7 access to care.

What we are doing:

Improving availability and requiring physicians to have plans in place when they are unavailable.

DRAFT

Availability and Coverage - Key Expectations

Availability and Responsiveness:

- Office phone and voicemail
  - Phone is answered or voicemails can be left during operating hours
  - Voicemails can be left after operating hours
  - Messages reviewed in timely manner
  - Accurate outgoing message

"Good communication and collaboration are fundamental components of high quality care, but are not possible if patients and health-care providers are unable to contact physicians."

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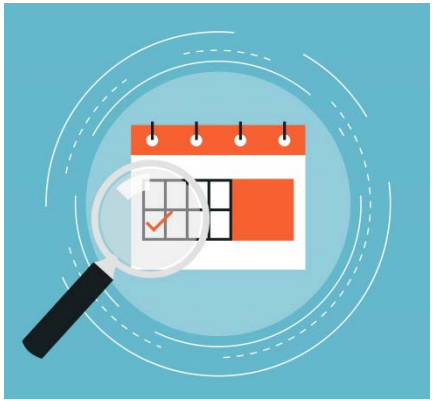
Availability and Coverage - Key Expectations

Availability and Responsiveness:



"Treating patients as part of a sustained physician-patient relationship facilitates continuity of care, which improves patient health outcomes."

- Practice structures must allow for appropriate triaging of patients with time-sensitive or urgent issues
  - Same-day scheduling systems and/or coordinating with other physicians may help achieve this.

DRAFT

Availability and Coverage

Coverage:

How have other jurisdictions addressed after-hours patient care?

College of Physicians & Surgeons of Alberta

"Physicians must directly provide or arrange for continuous after-hours care to be provided."

HQCA
Health Quality Council of Alberta

The CPSA should proactively monitor compliance with this requirement.

DRAFT

Availability and Coverage

Coverage:

How have other jurisdictions addressed after-hours patient care?

College of Physicians & Surgeons of Alberta

"Physicians must directly provide or arrange for continuous after-hours care to be provided."

"We sought to strike a different balance."

Realities of Practice **Public Interest**

DRAFT

Availability and Coverage - Key Expectations

Coverage:

- Physi… …hysician-pa… …plan for…
  - …rgency
  - …y,
  - re…

- Not the same position as other medical regulatory Colleges
- Important role for the professional judgment of physicians
- Not uncommon among other health-care providers or other customer service professions

DRAFT

Availability and Coverage - Key Expectations

Coverage:

Test Results

"All physicians who order tests must ensure that critical test results can be received and responded to 24 hours a day, 7 days a week."

- Refinement of ***existing*** policy expectations
  - The Ontario Association of Medical Laboratories provided feedback that laboratories often have difficulty communicating critical test results even when coverage information is provided.

DRAFT

Availability and Coverage - Key Expectations

Coverage:

Temporary absences from practice

- Vacation, leaves of absence, illness

- When providing care within a sustained physician-patient relationship, must make coverage arrangements for patient care
  - The nature of the arrangement will vary, much like the after-hours plan
  - Physicians will need to use their professional judgment
- Must make coverage arrangements for test results
  - To receive, review, and follow-up on care.

Decisions for Council

1) Does Council have any feedback on the draft ***Availability and Coverage*** policy?

2) Does Council recommend that the draft ***Availability and Coverage*** policy be released for external consultation?

Appendix G

Continuity of Care:
Managing Tests

Draft for Consultation

Dr. David Rouselle

Working Group Member

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

QUALITY PROFESSIONALS • HEALTHY SYSTEM • PUBLIC TRUST

DRAFT

"Suite" of policies

Continuity of Care

'Umbrella' policy
Contains principles and core policy expectations

Availability & Coverage

Managing Tests

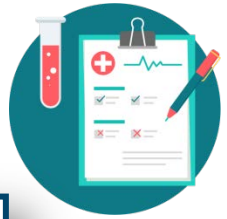
Transitions in Care

Walk-in Clinics

Companion policies
Address specific practice issues

DRAFT

Managing Tests



College of Physicians and Surgeons of Ontario

POLICY STATEMENT #1-11

Test Results Management

APPROVED BY COUNCIL: February

PUBLICATION DATE: *Dialogue,*

KEY WORDS: Tests; Ord

RELATED TOPICS: Medical R… Safe and …

COLLEGE CONTACT: Public and…

Continuity of Care: Managing Tests

Executive Summary:

This policy sets out the College's expectations for physicians regarding the management of all types of tests. Key topics and expectations include:

- *Test Result Management System:* Physicians must have an effective test results management system so that appropriate follow-up on test results occurs.
- *Tracking Tests:* Physicians must track test results for high-risk patients and must use their …on-high-risk …inically significant …ust use their …lts. …ws is good news' …orm patients that … critical or clinically …s set out in the … …an provide

Purpose

This policy sets out the College's expectations for physicians regarding the management of all types of tests.

Definitions

Test Result: Includes results for tests performed at laboratories, diagnostic facilities (including imaging facilities), and in physicians' offices, and also includes pathology results.

Core expectations have been retained with some refinements.

Managing Tests

Test Results Management → 

Managing Tests

- *Purpose:* Set out expectations regarding the ordering and management of *all types of tests*.

DRAFT

Managing Tests - Key Expectations

- *Ordering of Tests:*
  - Use clinical judgment in determining whether to order a test
  - Provide contextual information on the requisition form
  - Copy the patient's primary care provider

DRAFT

Managing Tests - Key Expectations

- *Tracking Tests:*

Confirming that the patient has done the test and that a result has been sent.

- Retained requirement to track tests for high risk patients
- Physicians must use their professional judgment in other cases
  - *Consider:* patient's health status, nature of the test, patient anxiety, significance of potential result

"Revised in order to minimize breakdowns in the process."

Managing Tests - Key Expectations

- *Communicating Results:* Use professional judgment to determine how to communicate test results (e.g., in person, over the phone, using staff, etc.).

- *'No News is Good News':*
  - Physicians may use this strategy provided that:
    - Physicians are confident in their test results management system
    - Physicians consider whether it is appropriate in the circumstances
    - Patients are informed when this strategy is used and be given the option to call physician's office for results.

Managing Tests - Key Expectations

- *Patient Portals:* Physicians are advised to inform patients of availability of patient portals.
  - Use of patient portals does not discharge responsibility.

- *Receiving Test Results in Error:* Clarifies expectations set out in current policy.
  - Aligns with guidance from CMPA.

Managing Tests - Key Expectations

- *Patient Engagement:*
  - Guidance on how to involve patients
    - Encouraging patients to discuss test results, to ask questions, and to follow-up if they still feel unwell.
    - Informing patients about significance of the ordered test, importance of getting test done, doing so in a timely manner, complying with requisition instructions.

Decisions for Council

1) Does Council have any feedback on the draft ***Managing Tests*** policy?

2) Does Council recommend that the draft ***Managing Tests*** policy be released for external consultation?

Appendix H

Continuity of Care:
Transitions in Care

Draft for Consultation

Dr. Peeter Poldre

Working Group Member

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

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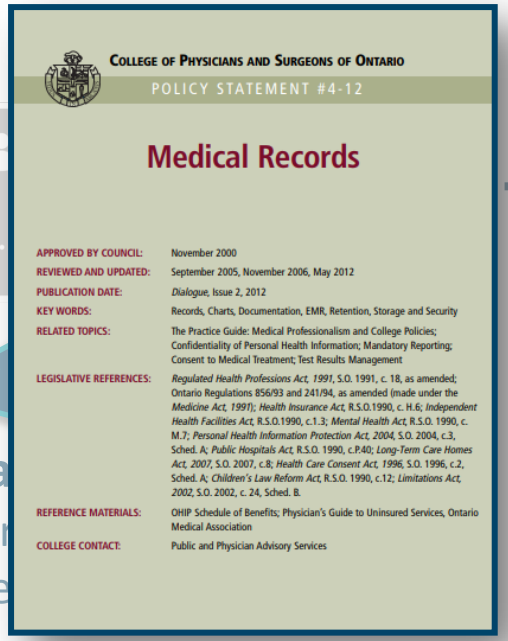
DRAFT

"Suite" of policies



COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

POLICY STATEMENT #4-12

Medical Records

APPROVED BY COUNCIL:	November 2000
REVIEWED AND UPDATED:	September 2005, November 2006, May 2012
PUBLICATION DATE:	*Dialogue*, Issue 2, 2012
KEY WORDS:	Records, Charts, Documentation, EMR, Retention, Storage and Security
RELATED TOPICS:	The Practice Guide: Medical Professionalism and College Policies; Confidentiality of Personal Health Information; Mandatory Reporting; Consent to Medical Treatment; Test Results Management
LEGISLATIVE REFERENCES:	*Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended; Ontario Regulations 856/93 and 241/94, as amended (made under the *Medicine Act, 1991*); *Health Insurance Act*, R.S.O.1990, c. H.6; *Independent Health Facilities Act*, R.S.O.1990, c.1.3; *Mental Health Act*, R.S.O. 1990, c. M.7; *Personal Health Information Protection Act, 2004*, S.O. 2004, c.3, Sched. A; *Public Hospitals Act*, R.S.O. 1990, c.P.40; *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8; *Health Care Consent Act, 1996*, S.O. 1996, c.2, Sched. A; *Children's Law Reform Act*, R.S.O. 1990, c.12; *Limitations Act, 2002*, S.O. 2002, c. 24, Sched. B.
REFERENCE MATERIALS:	OHIP Schedule of Benefits; Physician's Guide to Uninsured Services, Ontario Medical Association
COLLEGE CONTACT:	Public and Physician Advisory Services

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Availability & Coverage

Managing Tests

Transitions in Care

Walk-in Clinics

Companion policies

Address specific practice issues

DRAFT

Transitions in Care - Key Expectations

- *Purpose:* Set out expectations for when patient care or an element of patient care is transferred between physicians, or between physicians and other health-care providers.
  - *Focus:* Helping patients understand who is involved in their care, patients handovers within institutions, hospital discharges, and the consultation process.

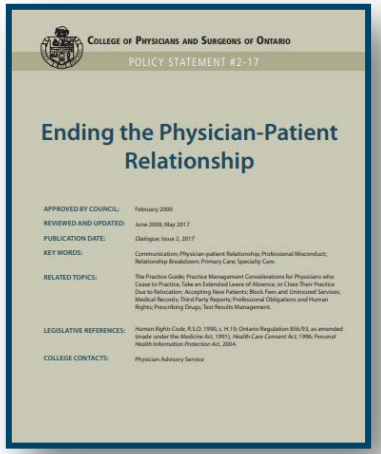
DRAFT

Transitions in Care - Key Expectations

Keeping patients informed:

Expectations to help patients…

- Know who their MRP is; and
- Understand the roles and responsibilities of referring and consulting physicians.



College of Physicians and Surgeons of Ontario

POLICY STATEMENT #2-17

Ending the Physician-Patient Relationship

APPROVED BY COUNCIL: February 2000

REVIEWED AND UPDATED: June 2008, May 2017

PUBLICATION DATE: *Dialogue*, Issue 2, 2017

KEY WORDS: Communication; Physician-patient Relationship; Professional Misconduct; Relationship Breakdown; Primary Care; Specialty Care.

RELATED TOPICS: The Practice Guide: Practice Management Considerations for Physicians who Cease to Practice, Take an Extended Leave of Absence, or Close Their Practice Due to Relocation; Accepting New Patients; Block Fees and Uninsured Services; Medical Records; Third Party Reports; Professional Obligations and Human Rights; Prescribing Drugs; Test Results Management.

LEGISLATIVE REFERENCES: *Human Rights Code*, R.S.O. 1990, c. H.19; Ontario Regulation 856/93, as amended [made under the *Medicine Act*, 1991], *Health Care Consent Act*, 1996; *Personal Health Information Protection Act*, 2004.

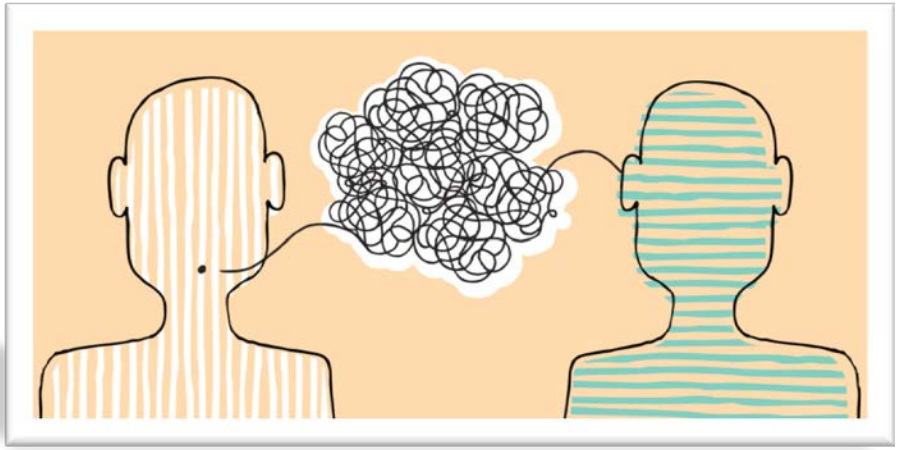
COLLEGE CONTACTS: Physician Advisory Service

DRAFT

Transitions in Care - Key Expectations

Handovers of Care:

Advice regarding best practices



Information exchange:

- Standardized or structured tools
- Real-time and personal (e.g., not leaving notes)

DRAFT

Transitions in Care - Key Expectations

Hospital Discharges:

- Physicians must ensure that they or a member of the health-care team have a discussion with the patient prior to discharge
  - Signs and symptoms that need monitoring, where to go if complications arise, etc.
- Physicians must take reasonable steps to facilitate involving family and/or caregivers in the discharge discussion
- Support discharges with written materials where appropriate
  - Use professional judgment to determine when and what to provide

DRAFT

Transitions in Care - Key Expectations

Hospital Discharges:

- *Complete* discharge summaries in a timely manner
- If a delay in *distribution* is anticipated, physicians must send a brief note
- *Direct* that discharge summaries be distributed to the primary care provider and take steps to identify others who would benefit and direct that it be sent to them as well

DRAFT

Transitions in Care - Key Expectations

Consultation Process: Minimizing delays & breakdowns

- Referring Physicians: Take reasonable steps to confirm the referral is ‘in scope’ and be mindful of whether consultant is accepting patients
- Consultant Physicians: Acknowledge the referral in a timely manner, no later than 30 days.
  - Adapted from other medical regulatory Colleges

DRAFT

Transitions in Care - Key Expectations

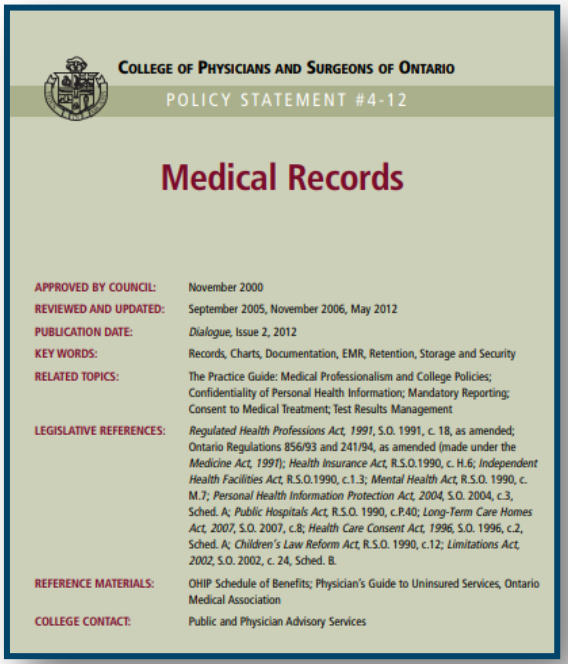
Consultation Process: Communicating with patients

- Referring physicians must communicate appointment information, unless the consultant physician indicates that they have or intend to.
- Consultant physicians must communicate any instructions or information that is needed in advance of the appointment, unless the referring physician agrees to do so.

DRAFT

Transitions in Care - Key Expectations

Consultation Process: Referral Requests and Consultation Reports



College of Physicians and Surgeons of Ontario

POLICY STATEMENT #4-12

Medical Records

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REFERENCE MATERIALS:	OHIP Schedule of Benefits; Physician's Guide to Uninsured Services, Ontario Medical Association
COLLEGE CONTACT:	Public and Physician Advisory Services

- Refined existing policy expectations regarding content of referral requests and consultation reports.

Transitions in Care - Key Expectations

Consultation Process: Consultation Reports

- Must distribute in a timely manner, but no later than 30 days
  - Send to the primary care provider and/or referring provider
  - Take steps to identify others who would benefit as well and send it to them as well

Decisions for Council

1) Does Council have any feedback on the draft ***Transitions in Care*** policy?

2) Does Council recommend that the draft ***Transitions in Care*** policy be released for external consultation?

Appendix I

Continuity of Care:
Walk-in Clinics

Draft for Consultation

Dr. Barbara Lent

Working Group Member

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

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DRAFT

"Suite" of policies

Continuity of Care

'Umbrella' policy
Contains principles and core policy expectations

Availability & Coverage

Managing Tests

Transitions in Care

Walk-in Clinics

Companion policies
Address specific practice issues

DRAFT

Walk-In Clinics

- *Purpose:* Set out expectations of physicians practising in walk-in clinics.

- Focus on those elements of walk-in clinic care most closely related to continuity of care.
- Does not address episodic care more broadly.

DRAFT

Walk-In Clinics - Key Expectations

Standard of Practice:

Applies equally in a walk-in clinic setting.

- Conducting appropriate assessments, ordering indicated tests and investigations, and addressing presenting concerns
- Physicians who order tests are responsible for follow-up

  - Only rely on others to provide follow-up when they have agreed to do so.

DRAFT

Walk-In Clinics - Key Expectations

Coordinating with Primary Care:

- Physicians must provide a record of the encounter to the patient's primary care provider.
  - Take reasonable steps to identify others who would benefit as well, and send the record to them.

DRAFT

Walk-In Clinics

Unattached Patients:

How have other jurisdictions addressed this issue?

Patients without a family physician who attend the same walk-in clinic are assumed to be receiving longitudinal primary care from that clinic.

Inform the patient that care will not be provided beyond addressing the patient's presenting concern(s) or identified medical condition(s).

College of Physicians & Surgeons of Alberta

DRAFT

Walk-In Clinics

Unattached Patients:

How have other jurisdictions addressed this issue?

"We sought to strike a balance between these positions."

Helping Vulnerable Patients

Role in the System

College of Physicians & Surgeons of British Columbia

College of Physicians & Surgeons of Alberta

DRAFT

Walk-In Clinics - Key Expectations

Unattached Patients:

- Physicians are *advised* to offer comprehensive primary care to unattached patients.
  - Where their scope of practice permits
  - In coordination with other physicians in the practice
    - For example, to share responsibility and offer comprehensive care throughout clinic operating hours

DRAFT

Walk-In Clinics - Key Expectations

Unattached Patients:

- Whether or not comprehensive primary care is offered, may still offer to provide elements of care related to chronic disease management.
  - For example, monitoring hypertension
  - To help maintain access to care

Decisions for Council

1) Does Council have any feedback on the draft ***Walk-in Clinics*** policy?

2) Does Council recommend that the draft ***Walk-in Clinics*** policy be released for external consultation?

Thank You!

Continuity of Care

Executive Summary

In order to set out expectations pertaining to continuity of care, the College has developed a 'suite' of policies. The suite is comprised of this foundational policy, referred to as the umbrella policy, as well as a number of companion policies that set out expectations regarding: Availability and Coverage; Managing Tests; Transitions in Care; and Walk-in Clinics.

This umbrella policy sets out general expectations relating to the important role that physicians, patient engagement, and the use of technology play in facilitating continuity of care. Key topics and expectations include:

- *Physicians:* As active participants in the oversight and management of patient care across interactions with the health-care system, physicians must collaborate and communicate effectively with other health-care providers. Discharging these obligations is context dependent and requires, in part, complying with expectations in the companion policies.
- *Patient Engagement:* Physicians are advised to facilitate and support patient engagement as part of facilitating continuity of care.
- *Technology:* Physicians are strongly advised to capitalize on advances in technology that can facilitate continuity of care.

Introduction

Continuity of care is an essential component of patient-centred care and is critical to patient safety. While continuity of care can be understood in a number of ways, central themes include the importance of connected and coordinated patient interactions within the health-care system and the need for information to be exchanged in a manner that allows for patient care decisions to be informed by prior interactions within the health-care system. Test results that are delayed or missed, limited physician availability and accessibility, receiving care in an uncoordinated manner, and transitions in care all create the potential for breakdowns in continuity of care that may negatively impact patient health outcomes and the quality of care provided.

The College recognizes that health system level factors that are beyond the control or influence of individual physicians may often influence whether or not continuity of care can be achieved. However, many continuity of care issues are within the control or influence of physicians. The College has focused on setting out policy expectations related to those elements of continuity of care where physicians have a role to play. The College's recommendations regarding broader

systems issues that can be a barrier to or facilitator of continuity of care will be set out in a separate 'white paper' at a later date.[1]

Purpose and Organization

In order to set out expectations pertaining to continuity of care, the College has developed a 'suite' of policies. The suite is comprised of this foundational policy, referred to as the umbrella policy, as well as a number of companion policies that set out expectations regarding specific elements of practice. The purpose and scope of each of these policies is as follows:

Continuity of Care: This umbrella policy sets out the principles of professionalism that underpin the suite of policies, as well as general expectations relating to the important role that physicians, patient engagement, and the use of technology play in facilitating continuity of care.

Availability and Coverage: This policy sets out the College's expectations of physicians regarding physician availability, after-hours coverage, and coverage during temporary absences from practice. Unless otherwise specified, this policy applies to all physicians regardless of practice area or specialty.

Managing Tests: This policy sets out the College's expectations for physicians regarding the management of all types of tests.

Transitions in Care: This policy sets out the College's expectations of physicians where patient care or an element of patient care is transferred between physicians, or between physicians and other health-care providers. This includes expectations in relation to keeping patients informed about who is responsible for their care, patient handovers within a hospital or health-care institution, discharges from hospital, and the referral and consultation process.

Walk-in Clinics: This policy sets out the College's expectations of physicians practising in walk-in clinics. This policy does not address all aspects of practising in a walk-in clinic setting; rather it focuses on those elements that most closely relate to continuity of care. This policy also does not address the provision of episodic care in other practice environments or settings.

Principles

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

1. Acting in the best interests of their patients;

[1] The white paper is under development and will be released at a later date. When it is released, it will be made available on the College's website alongside this suite of policies.

2. Communicating and collaborating effectively with patients, other physicians, and other health-care providers in order to facilitate continuity of care and minimize risks to patient safety;
3. Maintaining public trust in the profession by ensuring patients are not abandoned and by enabling access to coordinated care;
4. Demonstrating professional competence, which includes meeting the standard of practice of the profession and acting in accordance with all relevant legal and professional obligations to provide high quality patient care; and
5. Participating in medical regulation by complying with the expectations set out in this suite of policies.

Policy

Physicians, patients, and technology all play a key role in facilitating continuity of care. This umbrella policy sets out general expectations relating to these important roles.

Physicians

Physicians hold a prominent and important role in the health-care system and in turn are key facilitators of continuity of care. Central to this role is the need for physicians to recognize that patient interactions with the health-care system are best viewed not as discrete events, but rather as a set of interactions that require oversight and management.

As active participants in this oversight and management, physicians must collaborate with other health-care providers and enable effective communication and information sharing with others. How physicians can discharge these responsibilities will be context dependent and will require, in part, that physicians comply with the specific expectations set out in the companion policies.

Additionally, as health advocates, physicians are advised to use their expertise and influence to help advance the health and well-being of their patients, their communities, and the broader populations they serve.[2] Physicians can do this, in part, by responding to and participating in opportunities to improve continuity of care in both the local and broader health systems within which they work.

Patient Engagement

Patients also have an important and growing role to play in facilitating continuity of care, as actions they take may contribute to or help prevent breakdowns in continuity of care. While patient engagement can supplement and support physicians' efforts to facilitate continuity of

[2] As set out by the CanMEDS framework, physicians have a role to play in improving patient care by being a health advocate.

care and is an important element of patient-centred care, patient engagement is not meant to absolve physicians of their responsibilities in this regard.

Physicians are advised to facilitate and support patient engagement, doing so in a professional manner that is sensitive to the knowledge, needs, and desires of their patients. Physicians can do this by, for example, helping patients understand their role in their health care, as well as how their actions or inaction can facilitate or disrupt continuity of care. Physicians are also advised to direct patients to the companion Patient Engagement document that the College has developed in order to assist patients in understanding how they can facilitate continuity of care.[3]

More specific expectations regarding patient engagement have been articulated, where relevant, in the companion policies.

Technology

While the use of technology is not required to achieve continuity of care, a growing number of technological advances may assist in doing so. For example, there are technological solutions that can assist with test results management, facilitating access and/or coverage, facilitating information exchange between health-care providers, and improving transitions in care, especially as it pertains to handovers within health-care institutions, hospital discharges, and the referral and consultation process.

Physicians are strongly advised to capitalize on advances in technology that can facilitate continuity of care.[4] However, physicians' responsibilities to facilitate continuity of care continue to exist whether or not there are technological solutions that can assist in this regard and whether or not those solutions are adopted.

[3] This document will be developed at a later date and made available on the College's website alongside this suite of policies.

[4] See also the College's statement on eHealth: http://www.cpso.on.ca/Policies-Publications/Positions-Initiatives/eHealth

Continuity of Care: Availability and Coverage

Executive Summary

This policy sets out the College's expectations of physicians regarding physician availability, after-hours coverage, and coverage during temporary absences from practice. Key topics and expectations include:

- *Being Available by Telephone*: Physicians must have an office telephone that is answered and/or a voicemail that allows messages to be left during operating hours and a voicemail that allows messages to be left outside of operating hours.
- *Facilitating Access to Appointments:* Physicians must structure their practice in a manner that allows for appropriate triaging of patients with time-sensitive or urgent issues.
- *Being Available and Responding to Other Health-Care Providers:* Physicians must respond in a timely and professional manner when contacted by physicians or other health-care providers who want to communicate or request information pertaining to a patient.
- *Coordinating After-Hours Coverage for Patients:* Physicians providing care as part of a sustained physician-patient relationship must have a plan in place to coordinate care for patients outside of regular operating hours. The nature of the plan will depend on a variety of factors.
- *Coordinating After-Hours Coverage for Test Results:* Physicians who order tests must ensure that critical test results can be received and responded to 24 hours a day, 7 days a week.
- *Coordinating Coverage for Temporary Absences from Practice:* During temporary absences from practice physicians providing care as part of a sustained physician-patient relationship must make coverage arrangements for patient care, the nature of which will depend on a variety of factors, and all physicians must make coverage arrangements for test results.

Purpose and Scope

This policy sets out the College's expectations of physicians regarding physician availability, after-hours coverage, and coverage during temporary absences from practice. Unless otherwise specified, this policy applies to all physicians regardless of practice area or specialty.

Policy

Continuity of care does not require individual physicians to personally provide on-demand and continuous access to care. Doing so would negatively impact the quality of care being provided

and compromise physician health.[1] Rather, continuity of care means being available and responsive to patients and health-care providers and making plans or coverage arrangements when physicians are unavailable.

Availability and Responsiveness

Physician availability to patients and other health-care providers is an essential element of continuity of care. Breakdowns in care that can negatively impact patient health outcomes may occur, for example, when patients or health-care providers are unable to contact physicians, when patients are unable to get appointments for time-sensitive or urgent issues, or when there are delays in responding to health-care providers trying to communicate or request information pertaining to a patient. Physicians have a responsibility to be available and responsive to both patients and other health-care providers.

Being Available by Telephone

Good communication and collaboration are fundamental components of high quality care, but are not possible if patients and health-care providers are unable to contact physicians.

To facilitate good communication and collaboration, physicians must have an office telephone that is answered and/or a voicemail that allows messages to be left during operating hours and a voicemail that allows messages to be left outside of operating hours. Physicians must ensure that voicemail messages are reviewed and responded to in a timely manner. What is timely will depend on a variety of factors including, but not limited to, the impact to patient safety that may be caused by a delay in responding and when the message was left (e.g., after-hours, weekend, holiday, etc.).[2] Physicians must also ensure that the voicemail outgoing message is up to date and accurate, indicating, for example, practice office hours, any closures, and any relevant coverage information.

Physicians who also use electronic means of secure communication[3] to communicate with patients and/or other health-care providers must ensure that messages they receive through these means are reviewed and responded to in a timely manner.

[1] Physician wellness is a critical component of the professional practice of medicine (see the Practice Guide). Evidence also suggests that when physicians are unwell, the performance of the health-care system suffers (see, for example, Ruzycki, S.M. & Lemaire, J.B. (2018) "Physician burnout" *CMAJ,* 190:E53 & Wallace, J.E., Lemaire, J.B., & Ghali, W.A. (2009) "Physician wellness: a missing quality indicator" *Lancet*, 374: 1714–21).

[2] See also the section of this policy titled "Being Available and Responding to Other Health-Care Providers".

[3] This may include, for example, e-mail or a messaging portal. Physicians are reminded that electronic means of communication must comply with privacy legislation, including, the *Personal Health Information Protection Act, 2004* S.O. 2004, c. 3 Sched. A. (hereinafter, *PHIPA*).

Facilitating Access to Appointments

Treating patients as part of a sustained physician-patient relationship facilitates continuity of care, which improves patient health outcomes. It is ideal for patients to see physicians with whom they have a sustained physician-patient relationship for care that is within their physician's scope of practice, rather than relying on walk-in clinics or emergency rooms.

In order to facilitate timely access to care and continuity of care, physicians must structure their practice in a manner that allows for appropriate triaging of patients with time-sensitive or urgent issues. This may include implementing a same-day scheduling system[4] or utilizing other physicians or health-care staff within or outside their practice.

Being Available and Responding to Other Health-Care Providers

Good communication and timely access between physicians and between physicians and other health-care providers is essential to ensuring patient safety and can help promote a connected and coordinated patient experience.

Physicians must respond in a timely and professional manner when contacted by physicians or other health-care providers who want to communicate or request information pertaining to a patient.[5] How quickly physicians must respond will depend on the degree to which the information may impact patient safety, including exposure to any adverse clinical outcomes. With respect to test results, this means physicians must be responsive in a timely manner, urgently if necessary, to health-care providers communicating critical and/or clinically significant results.[6] Similarly, physicians must respond in a timely manner, urgently if necessary, to pharmacists or other health-care providers seeking to verify a prescription or requesting information about the drug prescribed.[7]

To facilitate access and to enable communication with other health-care providers, physicians must include their professional contact information when ordering a test, writing a

[4] For example: advance access, open access, or easy access scheduling systems. See, for example, Health Quality Ontario's Quality Compass Regarding Timely Access and The College of Family Physicians of Canada's Timely Access to Appointments in Family Practice for more information.

[5] Under *PHIPA*, physicians can assume they have patient consent to share personal health information with those in the patient's circle of care unless the patient has expressly withdrawn their consent to do so.

[6] Additional expectations pertaining to coverage for test results are set out in the next section of this policy. See as well the Managing Tests policy for more information on ordering and managing tests.

[7] In accordance with the Prescribing Drugs policy.

prescription, or making a referral.[8] Physicians must also provide their relevant coverage contact information directly to other health-care providers where it is appropriate to do so.[9]

Coverage

Continuity of care does not require individual physicians to be personally and continuously available to patients and other health-care providers involved in their patients' care. It does, however, require that physicians establish coverage arrangements to facilitate access to coordinated care for patients and to enable effective and timely information exchange with other health-care providers when they are unavailable.

Coordinating After-Hours Coverage for Patients

Primary care physicians and specialists providing care as part of a sustained physician-patient relationship where care is actively managed over multiple encounters must have a plan in place to coordinate care for their patients outside of regular operating hours. This is often referred to as after-hours. The nature of the plan will depend on the time of day and type of day (i.e., weekday, weekend, and holiday), the needs of their patients, as well as on the health-care provider and/or health system resources in the community. Physicians must use their professional judgment to determine how best to structure their plan and must act in good faith, making a reasonable attempt to minimize uncoordinated access to care and the inappropriate utilization of emergency rooms or walk-in clinics.

Coordinating After-Hours Coverage for Test Results

All physicians who order tests[10] must ensure that critical test results[11] can be received and responded to 24 hours a day, 7 days a week. Unless physicians choose to be available themselves this will necessitate making coverage arrangements for those times when they are unavailable (e.g., participating in an after-hours call group, telephone triage, or making specific on-call arrangements with other physicians or practices).

Coordinating Coverage for Temporary Absences

Primary care physicians and specialists providing care as part of a sustained physician-patient relationship where care is actively managed over multiple encounters have a responsibility to

[8] See also the Managing Tests, Prescribing Drugs, and Transitions in Care policies for more information on ordering tests, writing prescriptions, or making referrals.

[9] Most notably, laboratories keep physician coverage information on file, but there may be other instances where it is appropriate for physicians to provide their coverage information as well.

[10] As per the Managing Tests policy, this includes tests performed at laboratories, diagnostic facilities (including imaging facilities), and in physicians' offices and also includes pathology results.

[11] The Managing Tests policy defines critical test results as results of such a serious nature that immediate patient management decisions may be required

coordinate care for their patients during temporary absences from practice.[12] This includes, vacations and leaves of absence (e.g., parental leave, educational leave, suspension of a physician's certificate of registration), but also includes unplanned absences due to, for example, illness or family emergency.

To discharge this responsibility, physicians must arrange for another health-care provider(s) to provide patient care during temporary absences from practice. The specific nature of the coverage arrangement will depend on the length of the absence, whether the absence is planned or not, the needs of the physician's patients (including the need for follow-up care during the absence), and the health-care provider and/or health system resources in the community. Physicians are also advised to proactively plan for how to manage unplanned temporary absences from practice.

All physicians who order tests must make specific coverage arrangements with another health-care provider(s) to provide coverage during temporary absences to ensure that all test results are received, reviewed, and followed up appropriately.

To facilitate information exchange with other health-care providers all physicians who are temporarily absent from practice must have a plan or coverage arrangement that allows other health-care providers to communicate or request information pertaining to patients under their care.[13]

Notifying Patients

Physicians must inform patients about the after-hours plan they have put in place.

Physicians must also inform patients of any coverage arrangements that have been made for a temporary absence from practice. Physicians must use their professional judgement to determine if advance notice of a temporary absence from practice and the coverage arrangements that have been made is warranted. In making this determination, physicians must consider a variety of factors including, but not necessarily limited to, the needs of their patients, the nature of the coverage arrangement, and the length of the temporary absence.

Sharing Patient Information

Coordinated care is best delivered when those providing coverage are informed about or have access to patient health information. Physicians are advised to grant access to patient health

[12] Expectations relating to physicians who are not returning to practice as set out in the Closing a Medical Practice policy (which is currently under review).

[13] Under the *PHIPA*, physicians can assume they have patient consent to share personal health information with those in the patient's circle of care unless the patient has expressly withdrawn their consent to do so.

information to those providing coverage where the nature of the coverage arrangement is such that it is possible to do so.[14]

Patient Engagement

Physicians are advised to engage and support patients by encouraging them to develop a list of important information pertaining to their health status or needs (e.g., medication list, diagnosis, treatment plan, expected complications, etc.), which they can bring with them when seeking care when their physicians are unavailable.

[14] See footnote 13. Additionally, physicians providing coverage are reminded to only access patient personal health information as needed and within the context of providing care. For more information about physicians obligations in regards to privacy, see the Confidentiality of Personal Health Information policy and *PHIPA*.

Continuity of Care: Managing Tests

Executive Summary:

This policy sets out the College's expectations for physicians regarding the management of all types of tests. Key topics and expectations include:

- *Test Result Management System:* Physicians must have an effective test results management system so that appropriate follow-up on test results occurs.
- *Tracking Tests:* Physicians must track test results for high-risk patients and must use their professional judgment to determine whether to track a test result for non-high-risk patients.
- *Communication of Test Results*: Physicians must always communicate clinically significant test results to patients and must do so in a timely fashion. Physicians must use their professional judgment to determine how best to communicate test results.
- *'No News is Good News' Strategies:* Physicians who want to use a 'no news is good news' strategy must follow the expectations set out in the policy and must inform patients that they can contact the physician's office for the test result.
- *Receiving Tests Results in Error or Incidentally*: Physicians who receive a critical or clinically significant test result in error or incidentally must contact the individuals set out in the policy.
- *Patient Engagement:* The policy sets out two ways in which physicians can provide opportunities for patient engagement.

Purpose

This policy sets out the College's expectations for physicians regarding the management of all types of tests.

Definitions

Test Result: Includes results for tests performed at laboratories, diagnostic facilities (including imaging facilities), and in physicians' offices, and also includes pathology results.

Critical Test Result: Results of such a serious nature that immediate patient management decisions may be required.[1]

Clinically Significant Test Result: A test result determined by a physician to be one which requires follow-up in a timely fashion, urgently if necessary. Physicians determine the clinical significance of a test result using their clinical judgment and knowledge of the patient's symptoms, previous test results, and/or diagnosis.

Follow-up: Communication of the test result to the patient in an appropriate manner and taking appropriate clinical action in response to the test result.

High-risk patients: Patients who present with serious clinical symptoms, who have been diagnosed with a life-threatening illness, or who have been identified as high-risk by their physicians.

Policy

Managing tests effectively is an essential part of continuity of care. It includes having a robust test management system, ordering and tracking of tests, following up with patients once test results are known, communicating and collaborating with other health-care providers, and providing opportunities for patients to engage in the test results management process.

Test Results Management System

Physicians must have an effective test results management system so that appropriate follow-up on test results can occur in all of their work environments. In order for a test results management system to be effective, the system (whether it is electronic or paper-based) must at a minimum enable physicians to:

- Record all tests they order;
- Record all test results received;
- Record that all test results received by physicians have been reviewed;
- Identify high-risk patients and critical and/or clinically significant test results;
- Record that a patient has been informed of any clinically significant test results and the details of the follow-up taken by the physician.

If physicians are not responsible for choosing the test results management system, they must be satisfied that the system in place has the capabilities listed above.

[1] A FAQ will be developed once the policy is finalized setting out information about existing guidelines (e.g., Canadian Association of Radiologists, Ontario Association of Medical Laboratories) regarding reporting test results and findings as well as clinical practice guidelines related to reporting for Independent Health Facilities.

Ordering and Tracking Tests

Ordering

Physicians must use their clinical judgment in determining whether to order a test for a patient. When ordering a test, providing contextual patient information to laboratories and/or diagnostic facilities is important, as sometimes test results that fall within the normal range may actually be abnormal for a particular patient. Therefore, when ordering a test, physicians are advised to provide sufficient relevant patient health information on the test requisition form that will help with interpreting the test result.[2]

In addition, where ordering physicians are not the patient's primary care provider[3], they must copy a patient's primary care provider on the requisition form.[4]

Tracking

Tracking test results involves verifying that the patient has taken the test and ensuring that the laboratory and/or diagnostic facility has sent the test result to the physician.

Physicians must track test results for high-risk patients to ensure that their test results are not lost or missed. For example, if physicians do not receive a test result for a high-risk patient, they must follow-up with the patient to verify that the patient has had the test and/or follow-up with the laboratory and/or diagnostic facility to verify that the laboratory and/or diagnostic facility has the test result. For patients that are not high-risk, physicians must use their professional judgment to determine whether to track a test result. In making this determination, physicians must consider the following factors:

- The nature of the test that was ordered;
- The patient's current health status;
- If the patient appears anxious or has expressed anxiety about the test; and
- The significance of the potential result.

Physicians must either personally track test results or assign[5] this task to others.

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[2] Under the *Personal Health Information Protection Act, 2004* S.O. 2004, c. 3, Sched. A (PHIPA), physicians can assume they have patient consent to share relevant information with the laboratory and/or diagnostic facility unless the patient has expressly withdrawn their consent.

[3] This includes subspecialists where a patient has been referred to by a specialist.

[4] Under PHIPA, physicians can assume they have consent to share relevant information with the patient's primary care provider unless the patient has expressly withdrawn their consent.

[5] One of the controlled acts under the RHPA is "communicating a diagnosis". Specifically, the wording in the RHPA states: "Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the

Follow-up

Once physicians receive a patient's test results, they must ensure that appropriate follow-up occurs. Follow-up includes communicating test results to patients[6] and taking clinically appropriate action in response to the test results.

Physicians must either personally follow-up on test results or assign or delegate this task to others[7].

In certain health-care environments, the physician who orders a test may not be the same physician who receives the test result (e.g., in an emergency room or a walk-in clinic). In these situations, the ordering physician must either delegate or assign[8] the task of follow-up to others or ensure that there is another person that is responsible for coordinating the follow-up or that there is a system in place to do so.

Communication of Test Results

When in receipt of a clinically significant test result, physicians must always communicate the test result to their patient and must do so in a timely fashion. The timeliness of the communication will depend on the degree to which the information may impact patient safety, including exposure to adverse clinical outcomes. For test results that are not clinically significant, physicians must use their professional judgment as to if and when to communicate the test result.

Physicians must also use their professional judgment to determine how to best communicate a test result, for example, over the phone, or at the next appointment. In determining how to best communicate a test result, there are a number of factors that physicians must consider, including but not limited to:

- The nature of the test;
- The significance of the test result;
- The complexity and implications of the result;
- The nature of the physician-patient relationship;

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individual or his or her personal representative will rely on the diagnosis". If the task includes performance of this controlled act, then the physician must delegate it to another person. When delegating a controlled act, physicians must comply with the College of Physicians and Surgeons of Ontario's Delegation of Controlled Acts policy. If the task does not include a controlled act, the physician would be assigning the task to the other person.

[6] Test results do not need to be communicated to patients if the test result is not clinically significant and the physician has used their professional judgment to determine that the test result need not be communicated or the physician is utilizing a 'no news is good news' strategy and is following the provisions set out in this policy in regard to 'no news is good news' strategies.

[7] Please see footnote 5.

[8] Please see footnote 5.

- Patient preferences/needs; and
- Whether the patient appears anxious or has expressed anxiety about the test.

Physicians must ensure that the communication of test results adheres to their legal[9] and professional obligations[10] to maintain patient confidentiality and privacy.

Physicians do not necessarily have to personally communicate test results to their patients. Physicians must use their professional judgment to determine the circumstances where it makes sense for other health-care providers and/or non-medical staff to do so. Factors physicians must consider in making this determination include, but are not limited to:

- The nature of the test;
- Whether the patient appears anxious or has expressed anxiety about the test;
- The significance or implications of the test result; and
- Whether communicating the test result would mean communicating a diagnosis.[11]

If physicians rely on others to communicate test results, they must have a mechanism in place whereby physicians are able to respond to any follow-up questions that the patient may have.

'No News is Good News' Strategies

Physicians who want to use a 'no news is good news' strategy for test results management must be confident that the test result management system in place is sufficiently robust to ensure that no test results will be missed and that no news really means good news. That is, the absence of a call back to the patient means that the test result was received, reviewed and a determination was made that no follow-up was required.

Even with a robust test results management system, a 'no news is good news' strategy may not always be appropriate. Physicians must use their professional judgment to determine when a 'no news is good news' strategy is appropriate. Physicians must consider the following factors in making this determination:

- The nature of the test that was ordered;
- The patient's current health status;

[9] PHIPA sets out requirements with respect to collecting, using and disclosing a patient's personal health information.

[10] See the CPSO Medical Records and the Confidentiality of Personal Health Information policies for more information. The *Confidentiality of Personal Health Information* policy states that "the College advises physicians that messages left for patients on a voice mail that is not private or with a third party should not contain any personal health information of the patient, such as details about the patient's medical condition, test results or other personal matters".

[11] Please see Footnote 5.

- If the patient appears anxious or has expressed anxiety about the test; and
- The significance or implications of the potential result.

Physicians must inform patients as to whether they are using a 'no news is good news' strategy and must tell patients that they have the option to personally contact the physician's office for the test result.

Contact Information

To ensure that test results can be communicated to patients and that follow-up appointments can be booked, physicians are advised to do the following:

- confirm, or have their staff confirm, patient contact information at each appointment;
- confirm, or have their staff confirm, whether patients are comfortable with voice mail messages being left on their phones especially if the voicemail can be accessed by other people[12]; and
- note the patient's emergency contact information in the patient record.

If physicians attempt to contact a patient to carry out the required follow-up but have been unable to reach the patient, they must document in the patient's record all attempts that were made to either communicate the test result to the patient and/or to book a follow-up appointment to discuss a test result.

Patient Portals

Patient portals, where patients can access their test results electronically, are becoming increasingly common. As part of actively involving patients in their own care, physicians are advised to inform patients of the availability of patient portals.

Informing patients about getting their test results through a patient portal does not discharge physicians' obligations to communicate test results as set out in this section.

Clinically Appropriate Action Following Receipt of Test Results

When physicians receive a critical and/or clinically significant test result for a test that they have ordered, they must take clinically appropriate action. What may be considered a clinically appropriate action is case specific and will be based on a physician's clinical judgment.[13] The

[12] Please see Footnote 10.

[13] Some examples of clinically appropriate actions include having the patient take another test or making a referral to a specialist.

timeliness of these actions will depend on the significance of the test result. Physicians can take clinically appropriate actions personally or they can assign or delegate this task to others.[14]

Receiving Test Results in Error or Incidentally

If physicians receive a critical or clinically significant test result in error (i.e., they have not ordered the test and have received the result in error because they have the same or a similar name as the ordering physician or the same address as the ordering physician), they must inform the ordering health-care provider, the patient's primary care provider, or the patient of the test result. Physicians or those acting on their behalf must also inform the laboratory or diagnostic facility of the error.

Additionally, physicians who become aware, even incidentally (e.g., physicians who are cc'd on a report), of a critical or clinically significant test result where they have reason to believe that the ordering health-care provider did not or will not get the test result, must make reasonable efforts to inform the ordering health-care provider or the patient of the test result. The physician must also make reasonable efforts to contact the laboratory and/or diagnostic facility that sent the test result.

Communication and Collaboration with other Health-Care Providers

Physicians must use their professional judgment to determine if it is necessary to share a patient's test result with other relevant health-care providers whose ongoing care of the patient would benefit from that knowledge.[15] In situations where patient safety may be impacted, it may be necessary for physicians to contact the patient's other health-care providers in a more urgent manner than usual (e.g., when in receipt of a critical and/or clinically significant test result that may impact the care provided to the patient by the patient's other health-care providers). The timeliness of the communication will depend on the degree to which the information may impact patient safety, including exposure to adverse clinical outcomes.

In addition, physicians whose role is to interpret and report test results (e.g., a radiologist) can help to prevent failures in follow-up by contacting the health-provider who ordered the test when a potentially clinically significant test result is discovered to ensure that this information is communicated quickly and that it does not go astray. [16]

[14] Please see Footnote 5.

[15] Under PHIPA, physicians can assume they have consent to share relevant test results with those in the patient's circle of care unless consent to do so has been expressly withdrawn by the patient.

[16] For example, a physician interpreting a prenatal ultrasound where there is a risk to the fetus would phone the referring health-care provider in addition to generating a written report.

Patient Engagement

Involving patients in their own care is important in ensuring continuity of care. Physicians can provide opportunities for patient engagement in two ways. Physicians must inform patients of the significance of the test, the importance of getting the test done (in a timely manner, as appropriate), and the importance of complying with requisition form instructions. This is especially important when dealing with high-risk patients. While doing this, physicians are advised to consider and address language and/or communication issues that may impede a patient's ability to comprehend the information provided by the physician.[17]

The College also advises physicians to encourage patients to discuss test results with the physician, to feel free to ask questions about the test results, and to follow up with the physician after receiving a test result if they continue to feel unwell, regardless of the test result.

Availability and Coverage

For expectations regarding availability and coverage with respect to test results, please see the Continuity of Care: Availability and Coverage policy.

[17] Physicians may want to consider using the following resources or tools to help overcome any language and/or communication issues:

- Family members or third party interpreters.
- Speech language pathologists.
- Occupational therapists.
- Communication techniques.
    - o Writing
    - o Typing
    - o Non-verbal communication

Also, please see the Consent to Treatment policy and Frequently Asked Questions document for guidance on addressing language and/or communication barriers.

Continuity of Care: Transitions in Care

Executive Summary

This policy sets out the College's expectations of physicians when patient care or an element of patient care is transferred between physicians, or between physicians and other health-care providers. Key topics and expectations include:

- *Keeping Patients Informed*: Within hospitals and health-care institutions physicians must coordinate with others to keep patients informed about who is their most responsible provider. When referrals are made, both referring and consultant physicians must inform patients about the nature of their role and keep patients updated if their role changes.
- *Managing Handovers in Hospitals and Health-Care Institutions:* Physicians are advised to approach patient handovers in a systematic manner and to set time aside to allow for a real-time and personal exchange of information between health-care providers.
- *Completing and Distributing Discharge Summaries:* The most responsible physician must complete a discharge summary for all in-patients in a timely manner. If a delay in distribution is anticipated, the most responsible physician must provide a brief summary directly to those health-care providers responsible for follow-up care.
- *Making and Acknowledging a Referral:* Referring physicians must make a referral in writing and consultant physicians must acknowledge a referral request in a timely manner, urgently if necessary, but no later than 14 days from the date of receipt.
- *Distributing Consultation Reports:* Consultation reports must be distributed in a timely manner, but no later than 30 days, following an assessment of the patient or when there are new findings or changes in the management plan.

Purpose and Scope

This policy sets out the College's expectations of physicians when patient care or an element of patient care is transferred between physicians, or between physicians and other health-care providers. This includes expectations in relation to keeping patients informed about who is responsible for their care, patient handovers within a hospital or health-care institution, discharges from hospital, and the referral and consultation process.

Policy

When responsibility for patient care or an element of patient care is transferred between physicians, or between physicians and other health-care providers, breakdowns in continuity of care may occur that can negatively impact patient health outcomes and the quality of care provided. Physicians have a role to play in facilitating continuity of care during transitions by

helping to keep patients informed about who is responsible for their care, facilitating the timely exchange of information between health-care providers, and coordinating transitions by collaborating with both patients and other health-care providers.

Keeping Patients Informed

Patients are often provided care by a number of health-care providers and keeping patients informed about who is responsible for their care or an element of their care is an important component of quality care. How physicians support patients in this regard will depend on their practice setting and their role in managing patient care.

Hospitals and Health-care Institutions

In a hospital or health-care institution, patient care is often provided by a team of health-care providers, and who the most responsible provider[1] is may regularly change. In these instances it can be difficult for patients to know who is responsible for their care. Physicians must coordinate with other health-care providers to keep patients informed about who is their most responsible provider.

Referring and Consultant Physicians

Referring physicians must clearly communicate to patients what their anticipated role will be in managing care during the referral process. This includes how patient care and follow-up may be managed and by whom.

Consultant physicians[2] must also discuss with patients the nature of their role in providing care to patients. This includes explaining which elements of care they are responsible for, and the anticipated duration of care. When it is possible to do so, consultant physicians must also clearly communicate when their relationship has reached its natural conclusion or when it is anticipated that it will reach its natural conclusion to help patients understand when the treating relationship ends.[3]

If there are any changes in these responsibilities, both referring and consultant physicians must keep patients informed about their changing role.

[1] Recognizing that the scopes of practice of other health-care providers are evolving and that other health-care providers may have overall responsibility for managing patient care, this section of the policy has adopted the term "most responsible provider" as opposed to "most responsible physician" (see the Canadian Medical Protective Association's "The most responsible physician: a key link in the coordination of care" for more information).
[2] This policy uses the term "consultant physician" in order to capture any physician, including primary care physicians, who accept referrals.
[3] See also the Ending the Physician-Patient Relationship policy.

Managing Handovers in Hospitals and Health-Care Institutions

Effective patient handovers equip those assuming responsibility for patient care with the information they need to appropriately manage that care. In order for this to occur, there needs to be a timely exchange of information, where the information exchanged is accurate, complete, and unambiguous, and where the health-care provider assuming responsibility has understood the information that has been exchanged.[4] Physicians have an essential role to play in ensuring that patient handovers are effective.

Physicians handing over patient care to another health-care provider are strongly advised, wherever possible, to have a real-time and personal exchange of information that includes an opportunity for a discussion to occur and for questions to be asked.[5] Physicians are also advised to approach patient handovers in a systematic manner and to set time aside for the information exchange process. This may mean, for example, utilizing standardized or structured communication approaches or tools[6] that help focus information sharing practices.

Discharging patients from hospital

Transitions from hospital to the community present a number of challenges for both patients and health-care providers providing care in the community, and breakdowns in continuity of care may occur. While other health-care providers may play a role in the discharge process and the coordination of supports in the community, this policy will focus on the role physicians play in preparing patients for discharge from hospital,[7] as well as their role in completing and distributing discharge summaries.

Preparing Patients for Discharge

Prior to discharging a patient from hospital, physicians must ensure that they or a member of the health-care team has a discussion with the patient and/or substitute decision-maker about:[8]

[4] The Canadian Medical Protective Association provides advice on managing handovers as well (see their "Improving patient handovers").

[5] This may occur via an in-person exchange, but may also be achieved through a telephone call, video conferencing or other e-communication technology so long as doing so complies with physicians' legal and professional obligations to protect the privacy and confidentiality of the patient's personal health information (see the Confidentiality of Personal Health Information policy and *PHIPA*).

[6] A number of tools have been developed to standardize and systematize patient handovers. This includes, for example, SBAR, I-PASS, or I START-END. The College does not endorse any specific approach or tool, recognizing that a variety of methods can facilitate the same successful information exchange.

[7] This policy addresses only those issues that arise in relation to a discharge from hospital. Information on discharging of patients from, for example, an Out of Hospital Premise or Independent Health Facility (or what will soon be called Community Health Facilities) can be found the College's website.

[8] See also the Canadian Medical Protective Association's "Discharging patients following day surgery".

- Post treatment or hospitalization risks or complications;
- Signs and symptoms that need monitoring and when action is required;
- Whom to contact and where to go if complications arise;
- Instructions and recommendations to the patient and/or substitute decision-maker with respect to managing post-discharge care, including medications (e.g., frequency, dosage, duration); and
- Information about any follow-up appointments or outpatient investigations that have been or are being scheduled, or that the patient is responsible for arranging and a timeline for doing so.

Involving the patient's family and/or caregivers[9] in discharge discussions may benefit both the patient and those involved in managing the patient's post-discharge care. Physicians must take reasonable steps to facilitate the involvement of these individuals in the discharge discussion when patients or substitute decision-makers indicate that they would like them involved and provide consent to disclose personal health information.[10]

There may be instances where the patient and/or substitute decision-maker would benefit from having elements of the discharge discussion captured in writing in order to support their ability to recall and act on that information once discharged. Physicians must use their professional judgment to determine both whether this discussion should be accompanied by written reference materials and the specific nature of those materials. Factors that physicians must consider when making these determinations include, but are not limited to: the health status and needs of the patient; any post treatment risks or complications; the need to monitor signs or symptoms; whether follow-up care is required; any language and/or communication issues that may impact comprehension;[11] and whether the recipient of the information is experiencing stress or anxiety which may impair their ability to recall and act on the information shared.

Completing Discharge Summaries

The most responsible physician must complete a discharge summary for all in-patients. In order to facilitate continuity of care, physicians must complete the discharge summary in a timely

[9] Caregivers may be formal or informal, and may include, for example, family and/or others close to the patient.
[10] For more information on physicians obligations relating to the disclosure of personal health information, see the Confidentiality of Personal Health Information policy and *PHIPA*.
[11] See the Consent to Treatment policy and Frequently Asked Questions document for guidance on addressing language and/or communication barriers.

manner. What is timely will depend on the patient's condition and the urgency associated with their follow-up care needs.[12]

The purpose of the discharge summary is to equip those health-care providers responsible for post-discharge care with the information they need to understand the admission, the care provided, and the patient's health-care condition and needs. The discharge summary must be signed and dated by the most responsible physician and must include:

- Identifying information, including the most responsible physician's name, the author's name and status if different than the most responsible physician, the patient's name and health record number, and the admission and discharge dates;
- The reason(s) for the admission and the patient's discharge diagnosis;
- A brief summary of how each active medical problem was managed, including any major investigations, treatments, and outcomes;
- Details regarding any discharge medications (e.g., frequency, dosage, durations), any changes to ongoing medication, and the reasons for giving or altering medications; and
- Follow-up care needs and recommendations, as well as a list of scheduled appointments, any further outpatient investigations, and any outstanding test or investigation results or consultant reports.

Physicians must avoid using terminology, acronyms, or abbreviations in the discharge summary that are known to have more than one meaning in a clinical setting or that might cause confusion among those health-care providers receiving the discharge summary.[13]

Distributing Discharge Summaries

The timely distribution of a discharge summary is an essential element of continuity of care and delays in distribution may expose patients to adverse clinical outcomes. If a delay in distribution of the discharge summary is anticipated, the most responsible physician must provide a brief summary of the admission and discharge directly to those health-care providers responsible for follow-up care in a timely manner to ensure they have the information they need to provide post-discharge care. Additionally, when the required follow-up care is time-sensitive or the patient's health condition requires close monitoring, the most responsible physician must also consider whether direct communication with the health-care provider assuming responsibility is warranted.

[12] Physicians are reminded that they must complete the discharge summary within 48 hours of discharge in order to bill the Ontario Health Insurance Plan for a patient visit on the day of discharge.
[13] This is consistent and builds upon the general requirements set out in the Medical Records policy.

The most responsible physician must direct that the discharge summary be sent to the patient's primary care provider.[14] The most responsible physician must also take reasonable steps to identify other relevant health-care providers whose ongoing care of the patient would benefit from knowledge of the hospitalization and direct that the discharge summary be sent to them as well.[15]

Referring Patients and Consulting on Patient Care

Breakdowns in care may occur during the referral and consultation process when there are unnecessary delays in receiving the care the patient needs or where there is a breakdown in the information exchange and communication between health-care providers. As such, physicians have a role to play in coordinating these transitions to facilitate continuity of care.

Planning for a Referral

In order to minimize unnecessary delays that may compromise patient safety, referring physicians must take reasonable steps to confirm that the patient's condition(s) is (are) within the scope of practice of the consultant physician to whom they intend to refer the patient. This may involve, for example, being mindful of sub-specialties and/or areas of focus to which physicians may choose to limit their practice. Physicians are also advised to be mindful of whether the consultant physician is accepting patients and whether the consultant physician's practice is accessible to the patient (e.g., location, physical accessibility, etc.).

Making a Referral

Referrals[16] must be made in writing[17] and signed by the referring physician. If urgent, a verbal request may be appropriate, but must be followed by a written request. If the referring and consultant physician have access to a common medical record, the written request may be made and contained in that medical record. Otherwise, both the referring and consultant physicians must keep a copy of the written request in their respective medical records.

[14] Under *PHIPA*, physicians can assume they have patient consent to share personal health information with those in the patient's circle of care unless the patient has expressly withdrawn their consent to do so.
[15] See Footnote 14.
[16] The expectations set out in this policy apply broadly to all referrals with the exception of effective referrals that are made when physicians choose to limit the services they provide for reasons of conscience or religion. Specific expectations for effective referrals are set out in the Professional Obligations and Human Rights and Medical Assistance in Dying policies.
[17] A referral may be made electronically or in paper form.

All referrals must include:

- Identifying information, including the name and contact information of the referring physician, primary care provider (if different than the referring physician), consultant physician, and patient;
- Reason(s) for the consultation, as well as any information the referring physician is seeking and/or questions they would like answered;
- Where relevant, the referring physician's sense of the urgency of the consultation; and
- Summary of relevant medical history, including current medications and copies or summaries of all relevant test and procedure results.

Where referring and consultant physicians have access to a common medical record, a brief summary of the relevant medical history may be appropriate provided that the referring physician clearly indicates which elements of the common medical record (e.g., medications, test results, etc.) must be reviewed.

Tracking a Referral

Referring physicians must have a mechanism in place to track that the referral has been received and that an acknowledgment of the referral will be provided. The urgency of the referral will determine the degree to which the referring physician must monitor the referral request. Referring physicians are also advised to engage patients in this process by, for example, informing patients that they may follow-up with the referring physician if they have not heard anything within a specific time frame.

Being Available to Consultant Physicians

When making a referral, physicians must also comply with relevant expectations set out in the Availability and Coverage policy. For example, referring physicians must respond in a timely and professional manner when contacted by a consultant physician who wants to communicate or request information pertaining to the patient (e.g., to clarify a referral request, urgently communicate findings). Additionally, when making a referral for the purposes of a test, referring physicians must ensure that critical test results can be received and responded to 24 hours a day, 7 days a week.

Acknowledging a Referral

Physicians who are asked to consult on a patient's care must acknowledge the referral in a timely manner, urgently if necessary, but no later than 14 days from the date of receipt. How quickly consultant physicians must acknowledge the request will depend on the patient's condition and their need for a consultation, including whether a delay in acknowledgement

may expose the patient to any adverse clinical outcomes. When acknowledging the referral, consultant physicians must indicate whether or not they are able to accept the referral.

If consultant physicians are able to accept the referral, they must provide an estimated or actual appointment date and time to the referring health-care provider. They must also indicate whether they have communicated an appointment date and time with the patient directly or intend to do so.

If consultant physicians are not able to accept the referral, they must communicate their reasons for declining the referral to the referring health-care provider.[18] Where a consultation is urgently needed, consultant physicians must provide suggestions to the referring health-care provider of alternative health-care provider(s) who may be able to accept the referral, and are advised to do so for non-urgent referrals as well.

Communicating with Patients

Referring physicians must communicate the estimated or actual appointment date and time to the patient unless the consultant physician has indicated that they have already done so or intend to do so.

Consultant physicians must communicate any instructions or information[19] to patients that they will need in advance of the appointment, unless the referring physician has agreed to assume this responsibility. Consultant physicians must also communicate any changes in the appointment date and time with the patient directly and must allow patients to make changes to the appointment date and time directly with them.

Preparing Consultation Reports

Following an assessment of the patient (which may take place over more than one visit), consultant physicians must prepare a consultation report.[20] The purpose of the consultation report is to ensure that those involved in the patient's care have the information they need to understand the patient's health status and needs and to facilitate the coordination of care among those involved. The consultation report must include:

[18] For example, because the consultant physician is not currently accepting referrals or because the referral is outside the consultant physician's clinical competence or scope of practice. See also the Accepting New Patients policy.

[19] For example, any preparation the patient must make in advance of the appointment (e.g., fasting, drinking water, etc.), directions to the physician's practice, how to cancel appointments and fees for missed appointments, etc.

[20] For information regarding what consultants must document in their own medical record, please see the Medical Records policy. This policy addresses only the content of the report that will be distributed to others involved in the patient's care.

- Identifying information, including the name and contact information of the consulting physician, referring health-care provider, primary care provider (if different than the referring health-care provider), and patient;
- The date(s) of the consultation;
- The purpose of the referral as understood by the consultant physician;
- A summary of the information considered, including the patient's medical history and relevant family or social history, a review of systems, examinations and physical findings, tests or investigations undertaken, their purpose and their results, and any other pertinent patient data;
- A summary of conclusions reached, including any diagnostic conclusions or differential diagnoses;
- Treatments or interventions initiated or recommended and their rationale, including any medications prescribed or changes to ongoing medications;
- Outstanding investigations and additional referrals and their purpose;
- Advice given to the patient, including risks that were disclosed regarding initiated or recommended treatment and information regarding follow-up care needs; and
- Recommendations regarding follow-up by the referring health-care provider and whether ongoing care by the consultant physician is required.

When consultant physicians are involved in the provision of ongoing care, they must also prepare follow-up consultation reports when there are new findings or changes are made to the management plan. The purpose of follow-up reports is to ensure that those involved in the patient's care have the information they need to understand the patient's ongoing health status and needs, and to facilitate the coordination of care among those involved. Follow-up consultation reports must include a summary of:

- The original problem and any response to treatment;
- Any subsequent physical examinations related to the system(s) or problem(s) and their results;
- Any laboratory or investigation results, consultation reports, and any other pertinent data received since the previous visit related to the system(s) or problem(s); and
- Conclusions, recommendations, and follow-up plan(s).

Distributing Consultation Reports

Consultant physicians must distribute the consultation report and any subsequent follow-up reports in a timely manner, urgently if necessary, but no later than 30 days after an assessment or after a new finding or change in the patient's management plan. What is timely will depend on the nature of the patient's condition and any risk to the patient if there is a delay in sharing

the report, including exposure to any adverse clinical outcomes. If urgent, a verbal report may be appropriate, but must be followed by a written consultation report.

Consultant physicians must send consultation reports to the referring health-care provider and the patient's primary care provider, if different.[21] Consultant physicians must also take reasonable steps to identify other relevant health-care providers whose ongoing care of the patient would benefit from awareness of the consultation and share consultation reports with them as well.[22]

A copy of the consultation report must be retained in both the referring and consultant physician's medical record for the patient. Where the referring and consultant physician have access to a common medical record, the consultation report may be contained in that medical record.

Using Technology

Making a referral or preparing and distributing consultation reports may be facilitated by technological solutions that, for example, automatically produce required content or transcribe notes. Physicians are responsible to ensure the accuracy of their referral requests or consultation reports. If a referral or consultation report is produced and distributed automatically and prior to physician review, physicians must review it as soon as possible after it is sent to ensure it is accurate. If there are any errors, physicians must follow-up in a timely manner with those to whom the referral or consultation report has been sent.

[21] Under *PHIPA*, physicians can assume they have patient consent to share personal health information with those in the patient's circle of care unless the patient has expressly withdrawn their consent to do so.
[22] See Footnote 21.

Continuity of Care: Walk-in Clinics

Executive Summary

This policy sets out the College's expectations of physicians practising in walk-in clinics, focusing on those elements that most closely relate to continuity of care. Key topics and expectations include:

- *Meeting the Standard of Practice of the Profession:* Physicians practising in a walk-in clinic must meet the standard of practice of the profession, which applies regardless of whether care is being provided in a sustained or episodic manner.
- *Providing Follow-Up Care:* Physicians practising in a walk-in clinic must provide or arrange for the provision of appropriate follow-up care when ordering a test or making a referral. Additional expectations set out in the Managing Tests policy also apply.
- *Being Available and Coordinating Coverage:* Physicians practising in a walk-in clinic must ensure that critical test results can be received and responded to 24 hours a day, 7 days a week. Additional expectations set out in the Availability and Coverage policy also apply.
- *Coordinating with Other Health-Care Providers:* Physicians practising in a walk-in clinic must provide the patient's primary care provider, if there is one, with a record of the encounter and take reasonable steps to identify other health-care providers who would benefit from knowledge of the encounter and provide a record of the encounter to them as well.
- *Providing Comprehensive Primary Care:* Physicians practising in a walk-in clinic are advised to offer, where their scope of practice permits, comprehensive primary care to patients without a primary care provider who visit the same clinic for all their primary care needs.

Purpose and Scope

This policy sets out the College's expectations of physicians practising in walk-in clinics. This policy does not address all aspects of practising in a walk-in clinic setting; rather it focuses on those elements that most closely relate to continuity of care. This policy also does not address the provision of episodic care in other practice environments or settings.

Definitions

Walk-in Clinic: Medical practices that provide care to patients where there may be no existing association with the practice, where there may be no requirement to book appointments, and where the care provided is generally, although not always, episodic in nature. This includes urgent care centres, but does not include hospital-based emergency rooms.

Policy

Physicians practising in walk-in clinics contribute to the health-care system by, for example, providing an alternative to crowding emergency departments with patients who are better treated in the community but either cannot access their primary care provider or do not have a primary care provider. The nature of walk-in clinic care may, however, lead to breakdowns in continuity of care that can negatively impact patient health outcomes. Physicians practising in walk-in clinics have a responsibility to ensure that patients are being provided with quality care that facilitates continuity of care.

Supporting Patients

Patients may not always be aware that there are limits to the types of care that can be provided in an episodic manner and may not know that receiving care as part of a sustained physician-patient relationship facilitates continuity of care. Recognizing that there are a variety of reasons why patients visit walk-in clinics, physicians practising in a walk-in clinic must use their professional judgement to determine whether it would be appropriate to sensitively:

- Remind patients that there are differences between episodic care and care that is provided as part of a sustained physician-patient relationship;
- Remind patients who have a primary care provider about the benefits of seeing their primary care provider for care within their scope of practice; and/or
- Remind patients without a primary care provider of the benefits of having one and encouraging them to seek one out.

If asked for assistance in finding a primary care provider, physicians practising in a walk-in clinic must be as helpful as possible in supporting the patient.[1]

Facilitating Continuity of Care

Physicians practising in a walk-in clinic can facilitate continuity of care by: providing care in accordance with the standard of practice of the profession; providing appropriate follow-up care; being available and making coverage arrangements in certain instances; and by keeping other health-care providers involved in a patient's care informed about the care provided.

[1] The help that a physician is able to provide will ultimately be case-specific but could include referring patients to an organization that may be able to assist them in finding a health care provider or to a colleague who may be accepting new patients. Patients may also benefit from calling the College's Physician and Public Advisory Service (1-800-268-7096, Ext. 603) which can provide general tips and advice to those seeking a new provider. See also the Ending the Physician Patient Relationship policy.

Meeting the Standard of Practice of the Profession

Physicians practising in a walk-in clinic must meet the standard of practice of the profession, which applies regardless of whether care is being provided in a sustained or episodic manner. This means, for example, conducting any assessments, tests, or investigations that are required in order to treat the presenting concern(s) or identified medical condition(s) and providing any follow-up care that may be required in accordance with the standard of practice of the profession.

If physicians practising in a walk-in clinic limit the care or services offered due to the episodic nature of walk-in clinic care, they must communicate these limitations to patients in a clear and straightforward manner. In these instances, physicians must also communicate appropriate next steps, considering factors such as the urgency of the patient's needs and whether other health-care providers are involved in the patient's care. Any decision to limit the care or services being provided due to the episodic nature of walk-in clinic care must be made in good faith.

Providing Follow-up Care

Physicians ordering tests within a walk-in clinic environment must comply with the expectations set out in the Managing Tests policy. This includes, but is not limited to, having a system in place to ensure that appropriate follow-up occurs for all tests that they order and ensuring that clinically appropriate actions are taken in response to results.[2] Similarly, physicians practising in a walk-in clinic who make referrals must provide or arrange for the provision of necessary follow-up care, including reviewing consultation reports.[3]

It is not appropriate to rely on the patient's primary care provider or another health-care provider involved in the patient's care to provide or coordinate appropriate follow-up for tests or referrals unless they have explicitly agreed to assume this responsibility.

Being Available and Coordinating Coverage

Physicians practising in a walk-in clinic must comply with relevant expectations set out in the Availability and Coverage policy. For example, physicians practising in a walk-in clinic must:

[2] See the Managing Tests policy for more information.
[3] See the Transitions in Care policy for more information about the referral and consultation process.

- Respond in a timely and professional manner when contacted by physicians or other health-care providers who want to communicate or request information pertaining to a patient.[4]
- Ensure that critical test results can be received and responded to 24 hours a day, 7 days a week. This will necessitate making coverage arrangements for those times where physicians are unavailable.

Coordinating with Other Health-Care Providers

Physicians practising in a walk-in clinic must provide the patient's primary care provider, if there is one, with a record of the encounter.[5] This may include, for example, a record of any tests ordered, diagnoses reached, any treatment and advice provided, any referrals that were made, and any follow-up care that was arranged or advised. Physicians practising in a walk-in clinic must also take reasonable steps to identify other relevant health-care providers whose ongoing care of the patient would benefit from knowledge of the encounter and provide them with a record of the encounter as well.[6] Physicians are advised to consider whether it would be appropriate to inform patients that a record of the encounter will be shared with others prior to doing so.

Providing Comprehensive Primary Care

Walk-in clinics are not intended to be a substitute or replacement to a sustained relationship between a primary care provider and a patient. Rather, walk-in clinic care is intended to be episodic where neither the patient nor the physician have an expectation of a sustained relationship beyond any follow-up care that is necessary to address the presenting concern(s) or identified medical condition(s).

Some patients may, however, experience difficulty finding a primary care provider and may regularly attend the same walk-in clinic for all their primary care needs. In these instances, physicians practising in a walk-in clinic are advised to offer, where their scope of practice permits and in coordination with other physicians in the practice, comprehensive primary care to the patient as an interim measure.

Additional expectations set out in this suite of policies and other College policies will apply to physicians who provide comprehensive primary care as an interim measure.[7] With respect to

[4] Under *PHIPA*, physicians can assume they have patient consent to share personal health information with those in the patient's circle of care unless the patient has expressly withdrawn their consent to do so.
[5] See footnote 4
[6] See Footnote 4.
[7] For example, Medical Records, Ending the Physician-Patient Relationship, and Closing a Medical Practice (which is currently under review).

continuity of care and in accordance with the Availability and Coverage policy, when offering comprehensive primary care as an interim measure physicians practising in a walk-in clinic must have a plan in place to coordinate patient care outside regular operating hours (i.e., after-hours). Similarly, in these instances physicians must make or ensure arrangements are made with another health-care provider(s) to provide patient care during temporary absences from practice.[8] In both cases the specific nature of the plan or coverage arrangement will depend on a variety of factors, as set out in the Availability and Coverage policy.

Physicians practising in a walk-in clinic who do not offer comprehensive primary care as an interim measure may still offer to provide elements of care related to the management or monitoring of chronic diseases.[9]

[8] Periods of time where physicians are absent from their practice. This includes vacations and leaves of absence (e.g., parental leave, educational leave, suspension of a physician's certificate of registration), but also includes unplanned absences due to, for example, illness or family emergency.

[9] Physicians practising in a walk-in clinic may not be able to offer comprehensive primary care, but may be able to help patients without a primary care provider manage, for example, their hypertension over an extended period of time.

Outcomes of NMS-initiated investigations as of May 23, 2018 Appendix J	# Cases
No action	22
Advice	5
Remedial self-study	2
Mandated remediation	*38
Mandated remediation and a caution	8
Prescribing restrictions	2
Prescribing restrictions and a caution	1
No longer in practice	*4
Referral to the Discipline Committee (with prescribing restrictions pending hearing)	1
Revoked by Discipline Committee	*1
Total	84