CPSO

Meeting of Council

Annual Financial Meeting

June 17 & 18, 2021

NOTICE

OF

MEETING OF COUNCIL

A virtual meeting of the Council of the College of Physicians and Surgeons of Ontario (CPSO) will take place on June 17 & 18, 2021. This meeting is the annual financial meeting of Council. Due to the current pandemic situation, an in-person meeting at a physical location will not be held.

The meeting will be conducted by remote communication and streamed live. Members of the public who wish to observe the meeting can register on CPSO's website using the online registration. Instructions for accessing the meeting will be sent to those who have registered.

The meeting will convene at 9:00 am.

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

June 1, 2021

Council Meeting Agenda
Annual Financial Meeting
June 17-18, 2021

CPSO

THURSDAY, JUNE 17, 2021

Item	Time	Topic and Objective(s)	Purpose	Page No.
*	**8:30 am**	**INFORMAL NETWORKING**		
1	**9:00 am** (15 mins)	**Call to Order and Welcoming Remarks** (J. Plante) • Participate in roll call and declare any conflicts of interest	Discussion	**N/A**
2	**9:15 am** (5 mins)	**Consent Agenda** (J. Plante) **2.1 Approve Council meeting agenda** **2.2 Approve minutes from Council meeting held March 4, 2021 and March 5, 2021**	Approval (with motion)	1-10
3	**9:20 am** (10 mins)	**Items for information:** 3.1 Executive Committee Report 3.2 Discipline Committee Cases 3.3 Government Relations Report 3.4 Finance and Audit Committee Report 3.5 Policy Report 3.6 Medical Learners Report 3.7 Update on Council Action Items	Information	 11-28 29-34 35-38 39 40-50 51-55 56-58
4	**9:30 am** (50 mins)	**CEO/Registrar's Report** (N. Whitmore) • Update on Physician Assistant Regulation (Briefing Note Included)	Discussion	**N/A** 59-66
5	**10:20 am** (15 mins)	**President's Report** (J. Plante)	Discussion	**N/A**
*	**10:35 am** (20 mins)	**NUTRITION BREAK**		
6	**10:55 am** (15 mins)	**COUNCIL AWARD PRESENTATION** (J. Fisk) Celebrate the achievements of Dr. Sharon Kular Bal, Cambridge		67-68
7	**11:10 am** (20 mins)	**Member Topics** (J. Plante) • National Locum Licensure	Discussion	**Additional Item I-IV**

Item	Time	Topic and Objective(s)	Purpose	Page No.
8	**11:30 am** (15 mins)	**Interprofessional Collaboration** (R. Bernstein) • Consider a proposal to rescind three statements related to interprofessional collaboration and adopt one broader statement that supports interprofessional collaboration with all health care professionals.	Decision (with motion)	69-74
9	**11:45 am** (25 mins)	**Ontario Physicians and Surgeons Discipline Tribunal (OPSDT) Logo** (D. Wright, F. Hill-Hinrichs) • Approval of a logo for the OPSDT	Decision (with motion)	75-78
*	**12:10 pm** (60 mins)	**LUNCH**		
10	**1:10 pm**	**Motion to Go in Camera** (J. Plante)	Decision (with motion)	
*	**1:10 pm** (20 mins)	**In-Camera**		
11	**1:30 pm** (60 mins)	**Proposal for Legislative Change – Governance Modernization and Red-Tape Reduction** (M. Barna, L. Brownstone) • Consider previously approved legislative changes and suggested proposals to strengthen these recommendations.	Decision (with motion)	79-88
*	**2:30 pm** (15 mins)	**NUTRITION BREAK**		
12	**2:45 pm** (20 mins)	**Female Genital Cutting / Mutilation (FGC/M)** (C. Brown, R. Bernstein) • Consider rescinding the FGC/M policy or rescinding and replacing the policy with a statement.	Decision (with motion)	89-95
13	**3:05 pm** (20 mins)	**Academic Registration Policy** (S. Tulipano) • Consider the proposal to approve the recommended revisions to the existing Council policy on Academic Registration.	Decision (with motion)	96-104
14	**3:25 pm**	**Adjournment Day 1** (J. Plante)	N/A	**N/A**

FRIDAY, JUNE 18, 2021

Item	Time	Topic and Objective(s)	Purpose	Page No.
*	**8:30 am**	**INFORMAL NETWORKING**		
15	**9:00 am** (10 mins)	**Call to Order** (J. Plante) • Participate in roll call and declare any conflicts of interest	Discussion	**N/A**
16	**9:10 am** (25 mins)	**Professional Responsibilities in Medical Education – Revised Draft Policy for Final Approval** (K. Saperson, L. Kirshin) • Consider approving the revised draft Professional Responsibilities in Medical Education policy as a policy of the College.	Decision (with motion)	105-125
17	**9:35 am** (25 mins)	**Governance Committee Report** (B. Copps) 17.1 Committee Education Sessions Update 17.2 Recruitment: Updated Timing – September Appointments 17.3 Executive Committee Elections Update 17.4 Update on Council Elections 17.5 Committee Appointments (Decision) 17.6 Requests for Exceptional Circumstances (Decision)	Decisions (with motions)	126-128 Item 17.5 to follow under separate cover 129-138
18	**10:00 am** (30 mins)	**Finance and Audit Committee** (T. Bertoia, D. Anderson) 18.1 Audited Financial Statements for the 2020 Year		139-157
		18.2 Approval of the Audited Financial Statements for the fiscal year ended December 31, 2020	Decision (with motion)	158
		18.3 Appointment of the Auditor for 2021 fiscal year	Decision (with motion)	159
		18.4 Establishment of an internally restricted Intangible Asset Fund and Asset Transfer	Decision (with motion)	160
		18.5 Remuneration for Physician Council and Committee Members	For Information	161
*	**10:30 am** (15 mins)	**NUTRITION BREAK**		
19	**10:45 am** (25 mins)	**Third Party Medical Reports – Revised Draft Policy for Final Approval** (T. Everson, M. Cabrero Gauley) • Consider approving the revised draft Third Party Medical Reports policy as a policy of the College.	Decision (with motion)	162-190
20	**11:10 am** (20 mins)	**Psychotherapy Regulation** (L. Kirshin) • Consider not proceeding with a proposed psychotherapy regulation.	Decision (with motion)	191-195

Item	Time	Topic and Objective(s)	Purpose	Page No.
21	**11:30 am** (25 mins)	**Social Media – Draft Policy for Consultation** (J. van Vlymen, A. Wong) • Consider approving the draft Social Media policy for external consultation.	Decision (with motion)	196-212
22	**11:55 am** (10 mins)	**Registration Policies Redesign** (S. Tulipano) • Consider approving the housekeeping revisions to the Registration Policies as highlighted in the briefing note.	Decision (with motion)	213-224
23	**12:05 pm** (5 mins)	**Adjournment Day 2** (J. Plante) • Reminder that the next meeting is scheduled on September 13-14, 2021	N/A	**N/A**
*	**12:10 pm**	**Meeting Reflection Session** (J. Plante) • Share observations about the effectiveness of the meeting and engagement of Council members	Discussion	**N/A**

Council Motion

Motion Title	Council Meeting Consent Agenda
Date of Meeting	June 17, 2021

It is moved by_____, and seconded by_____, that:

The Council approves the items outlined in the consent agenda, which include in their entirety:

- The Council meeting agenda for June 17 & 18, 2021
- The minutes from the meeting of Council held March 4 & 5, 2021

DRAFT PROCEEDINGS OF THE MEETING OF COUNCIL
March 4 and 5, 2021

March 4, 2021

Attendees

Dr. Andrew Turner
Dr. Anne Walsh
Dr. Camille Lemieux
Ms. Catherine Kerr
Dr. Deborah Robertson
Mr. Fred Sherman
Dr. Glen Bandiera
Dr. Ian Preyra
Dr. Janet Van Vlymen
Dr. Jerry Rosenblum
Ms. Joan Fisk
Dr. John Rapin
Mr. Jose Cordeiro
Dr. Judith Plante (President)
Dr. Kashif Pirzada
Ms. Linda Robbins
Ms. Lydia Miljan
Dr. Michael Franklyn
Mr. Murthy Ghandikota
Dr. Patrick Safieh
Dr. Paul Hendry
Mr. Paul Malette
Mr. Peter Pielsticker
Mr. Pierre Giroux
Mr. Rob Payne
Dr. Robert Gratton
Dr. Roy Kirkpatrick
Dr. Sarah Reid
Mr. Shahid Chaudhry
Ms. Shannon Weber

Non-Voting Academic Representatives on Council Present:

Dr. Mary Bell
Dr. Terri Paul
Dr. Karen Saperson

Regrets:
Dr. Deborah Hellyer

1. Call to Order and Welcoming Remarks

Dr. J. Plante, President of Council and Chair, called the meeting to order at 9:00am. J. Plante welcomed members of Council and guests to the virtual Council meeting.

J. Plante acknowledged the efforts that Ontario's physicians have made in collaboration with system stakeholders to provide patients with care during the COVID-19 pandemic. She noted the importance of diversity in the College's governance processes and reported that in January of this year, Dr. Saroo Sharda, Medical Advisor, was appointed as the Diversity, Equity and Inclusion Lead.

S. Sharda gave a land acknowledgement as a demonstration of recognition and respect for Indigenous peoples. S. Sharda highlighted the continued impact of colonialism on health outcomes for Indigenous peoples.

J. Plante reminded attendees of the College's mission and vision.

2. Consent Agenda

Dr. D. Robertson requested to remove the Revised Operational Policies from the Consent Agenda motion. This item was moved for discussion on March 5.

It is moved by J. Fisk, and seconded by I. Preyra, that:

The Council approves the items outlined in the consent agenda, which include in their entirety:

- The Council meeting agenda for March 4 & 5, 2021
- The minutes from Council held December 3-4, 2020
- The minutes of a Special Meeting of Council held February 9, 2021

Items for information:

- Executive Committee Report
- Discipline Committee Report
- Government Relations Report
- Finance Report
- Policy Report
- Medical Learners Report

CARRIED

3. Status Update on Council Meeting Decisions

J. Plante provided an update on the implementation status of decisions from the last Council meeting.

4. CEO/Registrar's Report

Dr. Nancy Whitmore, CEO/Registrar, presented her report and shared updates on the CPSO's Quality Improvement program, redesigned policies and new policies, engagement activities with the public and profession, and system collaboration. She highlighted several improvement updates, including around technology enhancements, investigations and resolutions, and Discipline hearings. She also talked about CPSO's Diversity, Equity, and Inclusion Strategy, and discussed other issues related to the CPSO's strategic priorities.

5. President's Report

Dr. J. Plante presented her report to Council and discussed outreach activities, including with the Ontario Medical Association and the Ontario Medical Students Association, and upcoming meetings with government. J. Plante also discussed CPSO's work around providing continuing guidance to physicians providing care during the pandemic.

6. In Camera

It is moved by J. Rosenblum, and seconded by L. Miljan, that:

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

CARRIED

Council entered into an in-camera session at 11:00 am. and returned to open session at 11:30 am.

7. Council Award Presentation

Dr. Mary Bell, Council Member, presented the Council Award to Dr. Mihaela Nicula of Toronto for her work in the advancement of geriatric services.

8. Medical Council of Canada Qualifying Examination Part II

J. Plante and K. Pirzada declared conflicts and recused themselves for this item.

Samantha Tulipano, Director of Registration and Membership Services, introduced the proposed policy around MCCQE Part II. The proposed policy provides that the Registration Committee may direct the Registrar to issue a certificate of registration authorizing independent practice to applicants who are lacking MCCQE Part II where specific requirements are met. This would be a temporary exemption to address the backlog created by the pandemic.

It is moved by M. Franklyn, and seconded by S. Reid, that:

The Council approves the policy “Requirement for Successful Completion of Part 2 of the MCCQE – Pandemic Exemption”, (a copy of which forms Appendix “A” to the minutes of this meeting).

CARRIED

9. In Camera

It is moved by L. Miljan, and seconded by I. Preyra, that:

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

CARRIED

Council entered into an in-camera session at 12:55 pm and returned to open session at 1:45 pm.

10. Discipline Committee Enhancements

David Wright, Tribunal Director and Chair of the Discipline Committee and Hearings Office, introduced two proposed Discipline Committee enhancements. First, that four to five experienced adjudicators be recruited through a competitive process to the Discipline Committee, to replace the use of Independent Legal Counsel. Second, that the name of the Discipline Committee be changed to the Ontario Physicians and Surgeons Discipline Tribunal (OPSDT) in English and Tribunal de discipline des médecins et chirurgiens de l’Ontario (TDMCO) in French, to signal the independence of the tribunal from the College and make the purpose of the tribunal clear to the public and profession.

It is moved by R. Kirkpatrick, and seconded by P. Malette, that:

1) The Council of the College of Physicians and Surgeons approves the recruitment of four to five experienced adjudicators to be put forward to Council for appointment to the Discipline Committee.
2) The Council of the College of Physicians and Surgeons of Ontario makes the following bylaw No. 141, to take effect on a date to be determined by the Executive Committee:

By-law No. 141

(1) The General By-law is amended by adding the following:

Discipline Committee

40b. The Discipline Committee shall be known as the Ontario Physicians and Surgeons Discipline Tribunal (OPSDT) in English and Tribunal de discipline des médecins et chirurgiens de l’Ontario (TDMCO) in French, and each reference to the Ontario Physicians and Surgeons Discipline Tribunal or the Tribunal de discipline des Médecins et chirurgiens de l’Ontario, whether orally or in writing, shall be deemed to be a

reference to the Discipline Committee of CPSO as specified in the Health Professions Procedural Code, Schedule 2 to the *Regulated Health Professions Act, 1991.*

CARRIED

11. Member Topics

Shannon Weber, Council Member, introduced the topic for discussion relating to the role of the Executive Committee and its functioning from a governance perspective. Ms. Weber raised a concern that, given the Executive Committee composition and quorum rules, a decision could be made on behalf of Council by four people, which could include no public members. A discussion ensued, including an explanation about the governing legislation and its grant of powers to the Executive Committee, and Executive Committee's regular reports to Council.

12. Alternative Pathways to Registration

S. Tulipano, Director, Registration and Membership Services reviewed the revised draft *Alternative Pathways to Registration* policy for approval by Council.

It is moved by C. Lemieux, and seconded by S. Chaudhry, that:

The Council approves the revised policy *"Alternative Pathways to Registration"*, (a copy of which forms Appendix "B" & "C" to the minutes of this meeting).

CARRIED

13. Delegation of Controlled Acts

Dr. Sarah Reid, member of the Policy Review Working Group, presented on the revised policy *Delegation of Controlled Acts* for approval by Council.

It is moved by P. Pielsticker, and seconded by D. Robertson, that:

The Council approves the revised policy "Delegation of Controlled Acts", (a copy of which forms Appendix "D" to the minutes of this meeting).

CARRIED

14. Adjournment Day 1

J. Plante adjourned day 1 of the meeting at 3:45 pm.

March 5, 2021

Attendees

Dr. Andrew Turner
Dr. Anne Walsh
Dr. Camille Lemieux
Ms. Catherine Kerr
Dr. Deborah Robertson
Mr. Fred Sherman
Dr. Glen Bandiera
Dr. Ian Preyra
Dr. Janet Van Vlymen
Dr. Jerry Rosenblum
Ms. Joan Fisk
Dr. John Rapin
Mr. Jose Cordeiro
Dr. Judith Plante (President)
Dr. Kashif Pirzada
Ms. Linda Robbins
Ms. Lydia Miljan
Dr. Michael Franklyn
Mr. Murthy Ghandikota
Dr. Patrick Safieh
Dr. Paul Hendry
Mr. Paul Malette
Mr. Peter Pielsticker
Mr. Pierre Giroux
Mr. Rob Payne
Dr. Robert Gratton
Dr. Roy Kirkpatrick
Dr. Sarah Reid
Mr. Shahid Chaudhry
Ms. Shannon Weber

Non-Voting Academic Representatives on Council Present:

Dr. Mary Bell
Dr. Terri Paul
Dr. Karen Saperson

Regrets:
Dr. Deborah Hellyer

15. Call to Order

J. Plante called the meeting to order at 9:00 am.

16. Council Profile

Dr. B. Copps, Chair of the Governance Committee and Past President of Council, presented on the proposed Council Profile for approval by Council. CPSO staff have further refined the Diversity and Skills Matrix that was developed last summer into the Council Profile. The Council Profile was developed to meet the requirement of the Ministry of Health's College Performance Measurement Framework for health regulatory colleges to have a pre-defined set of skills and competencies for Council members.

It is moved by P. Safieh, and seconded by R. Payne, that:

The Council approves the adoption of the Council Profile (a copy of which forms Appendix "E" to the minutes of this meeting).

CARRIED

17. Guest Presentation: Anti-Indigenous Racism

Dr. S. Sharma, Diversity, Equity, and Inclusion Lead, introduced the featured guest speaker, Dr. Lisa Richardson. Dr. Lisa Richardson is a mixed blood Anishinaabe (Shebahononing/Killarney) physician and clinician-educator. She practices General Internal Medicine at the University Health Network in Toronto. She is the Strategic Advisor in Indigenous Health for the University of Toronto's Temerty Faculty of Medicine and for Women's College Hospital where she founded the Centre for Wise Practices in Indigenous Health. She is an Associate Professor and Vice-Chair of Culture and Inclusion in the Department of Medicine. Dr. Richardson is a strong advocate for Indigenous health equity and Indigenous health education at the local, provincial and national level.

L. Richardson presented on *Wise Practices for Reconciliation in Health Care* to the Council, discussing foundational concepts about anti-Indigenous racism, cultural safety and humility.

18. College Performance Measurement Framework

Dr. B. Copps, Chair of the Governance Committee, introduced the topic of the College Performance Measurement Framework report. Laurie Cabanas, Director of Governance and Susan Klejman, Director of Information Management and Business Analytics provided an overview of the draft report for approval by Council.

It is moved by R. Payne, and seconded by R. Gratton, that:

The Council approves the College Performance Management Framework Report (a copy of which forms Appendix "F" to the minutes of this meeting) for submission to the Ministry of Health by March 31, 2021.

CARRIED

19. Methadone Maintenance Treatment

Craig Roxborough, Director, Policy presented to Council the proposal to rescind the *Methadone Maintenance Treatment for Opioid Dependence* policy and *Maintenance Treatment Program Standards and Guidelines*.

It is moved by R. Payne, and seconded by J. Fisk, that:

The Council rescind the College's:

a) *Methadone Maintenance Treatment for Opioid Dependence* policy (a copy of which forms Appendix "G" to the minutes of this meeting); and
b) *Methadone Maintenance Treatment Program Standards and Guidelines* (a copy of which forms Appendix "H" to the minutes of this meeting).

CARRIED

20. Governance Committee Report

20.1 Governance Committee Vacancy

Laura Rinke-Vanderwoude, Junior Governance Analyst, reviewed the proposal to move to an appointment process for vacancies on the Governance Committee, moving forward.

Council wanted more discussion on this item as it relates to future Governance Committee positions and so deferred the motion to the June 2021 meeting.

Council did agree that for the current public member vacancy, the Executive Committee could make the appointment.

20.2 Committee Appointments

B. Copps informed Council that Fred Sherman, Council Member, was appointed by the Executive Committee to Quality Assurance Committee for a one-year term.

20.3 Quality Assurance Committee Renewal/Appointments

J. van Vlymen, Chair of QAC, informed Council of the review conducted of the Quality Assurance Committee membership composition and the recommended appointments to the Quality Assurance Committee Membership for approval by Council.

It is moved by S. Chaudhry, and seconded by P. Hendry, that:

The Council appoints the following committee members to the Quality Assurance Committee from April 1, 2021 to December 10, 2021:

Dr. Steven Bodley
Dr. Jacques Dostaler
Dr. Ken Lee
Dr. Camille Lemieux
Dr. Michael Franklyn
Mr. Paul Malette
Mr. Peter Pielsticker
Dr. Patrick Safieh
Dr. Ashraf Sefin
Dr. Robert Smith
Dr. Tina Tao

CARRIED

21. In Camera

It is moved by D. Robertson, and seconded by S. Weber, that:

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

CARRIED

Council entered into an in-camera session at 2:50 pm and returned to open session at 3:25 pm.

22. Adjournment Day 2

J. Plante adjourned day 2 of the meeting at 3:32 pm.

Appendix A

REQUIREMENT FOR SUCCESSFUL COMPLETION OF PART 2 OF THE MCCQE – PANDEMIC EXEMPTION

The standards and qualifications for the issuance of a certificate of registration authorizing independent practice, set out in Section 3 of Ontario Regulation 865/93, stipulate that the applicant must have:

1. A degree in medicine.
2. Successfully completed Part 1 and Part 2 of the Medical Council of Canada Qualifying Examination.
3. Completed a clerkship at an accredited medical school in Canada; or one year of postgraduate medical education at an accredited medical school in Canada; or one year of active medical practice in Canada.
4. Certification by examination by the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College of Family Physicians of Canada (CFPC); and

Part 2 of the Medical Council of Canada Qualifying Examination (known as "MCCQE2") is a clinical examination administered by the Medical Council of Canada which is challenged in locations across Canada, typically after completion of 12 months of postgraduate training.

The MCCQE2 is important as a reliable, independent and objective method of assessment of an applicant's broad-based medical knowledge, skills, judgment and professional attitude.

Due to the pandemic, MCCQE2 examinations scheduled for May 2020 and October 2020 were postponed indefinitely. Applicants in Ontario who otherwise qualified for Independent Practice Certificates but were lacking MCCQE2 were issued restricted certificates permitting practice under supervision in accordance with the Restricted Certificates of Registration for Exam Eligible Candidates.

The MCCQE2 examination scheduled for February 2021 has been cancelled. At this time, it is not clear when the MCCQE2 exam will be made available to eligible candidates.

This Policy provides an exception to the licensure requirement for the MCCQE2 for applicants whose pathway to independent licensure in Ontario has stalled due to the pandemic-related postponements of the examination in circumstances set out below.

MCCQE2 Pandemic Exemption

The Registration Committee may direct the Registrar to issue a certificate of registration authorizing **independent practice** to applicants who are lacking MCCQE2 where:

i) The applicant demonstrates that they were eligible to challenge the MCCQE2 at the May 2020, October 2020, and/or February 2021 sittings*;

ii) The applicant is presently registered in Ontario or was registered in Ontario at the time that they were eligible to challenge the MCCQE2 at the May 2020, October 2020, and/or February 2021 sittings;

iii) The applicant was within 24 months from the completion of their postgraduate training at the time that they were eligible to challenge the MCCQE2 at the May 2020, October 2020, and/or February 2021 sittings;

iv) The applicant otherwise meets the prescribed requirements for an Independent Practice Certificate of Registration and,

v) The applicant satisfies the non-exemptible requirements set out in Section 2(1) of Ontario Regulation 865/93.

*** Note**: The Policy may be extended to apply to other future scheduled sittings of the MCCQE2 as may be required during the pandemic.

****Note**: Applicants with prior exam failures may be directed to the Registrar for review by the Registration Committee under Section 2(1) of Ontario Regulation 865/93.

Appendix B

PATHWAY 1 – CANADIAN MEDICAL DEGREE AND POSTGRADUATE TRAINING WITHOUT RCPSC OR CFPC CERTIFICATION

Approved by Council: September 2008; February 2010

In an effort to improve access and reduce barriers for qualified physicians, the College's Council approved groundbreaking policy in September 2008 that established four new registration pathways. The four approved pathways came into effect on December 1, 2008. Subsequently, Pathways 1, 2 and 3 were amended in February 2010 to comply with the CFTA and the FMRAC National Standard. These new registration requirements vary depending on the source of the applicant's medical degree, where the applicant is currently practising and where the applicant received postgraduate training.

The Pathways are applicable to the following groups of physicians:

1. Physicians with a Canadian medical degree and postgraduate training without RCPSC or CFPC certification. See details below.
2. International medical graduates (IMGs) with Canadian postgraduate training without RCPSC or CFPC certification. See Pathway 2.
3. Physicians with a U.S. or Canadian medical degree or Doctor of Osteopathy degree with U.S. postgraduate training and certification. See Pathway 3.
4. IMGs with US postgraduate training and certification. See Pathway 4.

Preamble

The College's registration regulation sets out the requirements which must be met in order for an applicant to be issued a certificate of registration.

If an applicant does not meet the requirements set out in the regulation it may still be possible for an applicant to qualify pursuant to one of the exemption policies.

Please note that if you currently hold a certificate of registration in any Canadian jurisdiction except Nunavut you may be eligible for registration in Ontario under new provisions of the *Health Professions Procedural Code*. See Legislation and By-Laws for more detail.

All applicants must be able to demonstrate that their past and present conduct indicates that they are mentally competent to practise medicine; will practise with decency, integrity and honesty and in accordance with the law; have sufficient knowledge, skill and judgment to engage in the kind of practice authorized by the certificate and can communicate effectively; and will display an appropriately professional attitude.

In addition to the registration regulation and policies, all applicants will also be subject to other CPSO policies and regulations which apply to current registrants. In particular, the Changing Scope of Practice and Re-entering Practice policies, and the regulation pertaining to the use of specialist titles may have relevance for new applicants. All applicants will also be subject to the College's expectations with respect to continuing professional development.

All registrants qualified under this policy will undergo an assessment after completing a minimum of one year of practice in Ontario. Assessments ensure that physicians are practising competently and safely. All physicians in Ontario undergo assessments and it is part of the College's vision of quality professionals that all physicians will be assessed every 10 years.

Pathway 1: Canadian Medical Degree and Postgraduate Training without RCPSC or CFPC Certification

Appendix B

The Registration Committee may direct the Registrar to issue a certificate of registration to an applicant who has a medical degree from a medical school in Canada accredited by the Council on Accreditation of Canadian Medical Schools, if the applicant has:

1. successfully completed:
    1. a Canadian residency program; or
    2. acceptable pre-1993 training;
2. successfully completed:
    1. the Medical Council of Canada Qualifying Examinations; or
    2. an acceptable qualifying examination; and
3. practised for five or more continuous years in Canada or the United States (US), while holding an independent or full license or certificate of registration without restrictions but does not currently hold a certificate in a Canadian jurisdiction. [1]

The following conditions will be placed on the certificate of registration:

1. The physician must practice with a mentor and/or supervisor until he or she has successfully completed an assessment.
2. The physician must undergo an assessment after completing a minimum of one year of practice in Ontario. The certificate of registration automatically expires 18 months from the date of issuance, but may be renewed by the Registration Committee, with or without additional or other terms, conditions and limitations.

How Barriers are Reduced

This policy adds another pathway to licensure for applicants who are not certified by the RCPSC or CFPC and do not currently hold a certificate in a Canadian jurisdiction. (See footnote [1]). Under this policy, eligible candidates now have a route to a certificate of registration to practice medicine independently limited to their scope of practice, subject to an initial one-year period of practice under supervision (or a mentor) and successful completion of an assessment after the first year of practice. Unsuccessful completion of an assessment would result in expiry of the certificate of registration unless it is renewed by the Registration Committee, with or without additional or other terms, conditions and limitations.

Endnote

[1] If you currently hold a certificate of registration in any Canadian jurisdiction except Nunavut you may be eligible for registration in Ontario under the CFTA. To find out more, please see Registration Requirements for out-of-province licence holders.

Related Information

Guidelines for College-Directed Supervision

The CPSO provides guidance for physicians required to take part in supervised practice by our policies or committees.

Appendix B

PATHWAY 2 – IMG WITH CANADIAN POSTGRADUATE TRAINING WITHOUT RCPSC OR CFPC CERTIFICATION

Approved by Council: September 2008; February 2010

In an effort to improve access and reduce barriers for qualified physicians, the College's Council approved groundbreaking policy in September 2008 that established four new registration pathways. The four approved pathways came into effect on December 1, 2008. Subsequently, Pathways 1, 2 and 3 were amended in February 2010 to comply with the AIT and the FMRAC National Standard. These new registration requirements vary depending on the source of the applicant's medical degree, where the applicant is currently practising and where the applicant received postgraduate training.

The Pathways are applicable to the following groups of physicians:

1. Physicians with a Canadian medical degree and postgraduate training without RCPSC or CFPC certification. See Pathway 1.
2. International medical graduates (IMGs) with Canadian postgraduate training without RCPSC or CFPC certification. See details below.
3. Physicians with a U.S. or Canadian medical degree or Doctor of Osteopathy degree with U.S. postgraduate training and certification. See Pathway 3.
4. IMGs with US postgraduate training and certification. See Pathway 4.

Preamble

The College's registration regulation sets out the requirements which must be met in order for an applicant to be issued a certificate of registration.

If an applicant does not meet the requirements set out in the regulation it may still be possible for an applicant to qualify pursuant to one of the exemption policies.

Please note that if you currently hold a certificate of registration in any Canadian jurisdiction except Nunavut you may be eligible for registration in Ontario under new provisions of the *Health Professions Procedural Code*. See Legislation and By-Laws for more detail.

All applicants must be able to demonstrate that their past and present conduct indicates that they are mentally competent to practise medicine; will practise with decency, integrity and honesty and in accordance with the law; have sufficient knowledge, skill and judgment to engage in the kind of practice authorized by the certificate and can communicate effectively; and will display an appropriately professional attitude.

In addition to the registration regulation and policies, all applicants will also be subject to other CPSO policies and regulations which apply to current registrants. In particular, the Changing Scope of Practice and Re-entering Practice policies, and the regulation pertaining to the use of specialist titles may have relevance for new applicants. All applicants will also be subject to the College's expectations with respect to continuing professional development.

All registrants qualified under this policy will undergo an assessment after completing a minimum of one year of practice in Ontario. Assessments ensure that physicians are practising competently and safely. All physicians in Ontario undergo assessments and it is part of the College's vision of quality professionals that all physicians will be assessed every 10 years.

Pathway 2: IMG with Canadian Postgraduate Training without RCPSC or CFPC Certification

Appendix B

The Registration Committee may direct the Registrar to issue a certificate of registration to an applicant who is an IMG, if the applicant has:

1. successfully completed:
    1. a Canadian residency program; or
    2. acceptable pre-1993 training;
2. successfully completed:
    1. the Medical Council of Canada Qualifying Examinations; or
    2. an acceptable qualifying examination; and
3. practised for five or more continuous years in Canada while holding an independent or full license or certificate of registration without restrictions but do not currently hold a certificate in a Canadian jurisdiction.[1]

The following conditions will be placed on the certificate of registration:

1. The physician must practice with a mentor and/or supervisor until he or she has successfully completed an assessment.
2. The physician must undergo an assessment after completing a minimum of one year of practice in Ontario. The certificate of registration automatically expires 18 months from the date of issuance, but may be renewed by the Registration Committee, with or without additional or other terms, conditions and limitations.

How Barriers are Reduced

This policy adds another pathway to licensure for applicants who are not certified by the RCPSC or CFPC and do not currently hold a certificate in a Canadian jurisdiction. (See endnote 1). Under this policy, eligible candidates now have a route to a certificate of registration to practice medicine independently limited to their scope of practice, subject to an initial one-year period of practice under supervision (or a mentor) and successful completion of an assessment after the first year of practice. Unsuccessful completion of an assessment would result in expiry of the certificate of registration unless it is renewed by the Registration Committee, with or without additional or other terms, conditions and limitations.

Endnote

Related Information

Guidelines for College-Directed Supervision

The CPSO provides guidance for physicians required to take part in supervised practice by our policies or committees.

Appendix B

PATHWAY 3 – U.S. OR CANADIAN MEDICAL DEGREE OR DOCTOR OF OSTEOPATHY WITH U.S. POSTGRADUATE TRAINING

Approved by Council: September 2008; February 2010

In an effort to improve access and reduce barriers for qualified physicians, the College's Council approved groundbreaking policy in September 2008 that established four new registration pathways. The four approved pathways came into effect on December 1, 2008. Subsequently, Pathways 1, 2 and 3 were amended in February 2010 to comply with the AIT and the FMRAC National Standard. These new registration requirements vary depending on the source of the applicant's medical degree, where the applicant is currently practising and where the applicant received postgraduate training.

The Pathways are applicable to the following groups of physicians:

1. Physicians with a Canadian medical degree and postgraduate training without RCPSC or CFPC certification. See Pathway 1.
2. International medical graduates (IMGs) with Canadian postgraduate training without RCPSC or CFPC certification. See Pathway 2.
3. Physicians with a U.S. or Canadian medical degree or Doctor of Osteopathy degree with U.S. postgraduate training and certification. See details below.
4. IMGs with US postgraduate training and certification. See Pathway 4.

Preamble

The College's registration regulation sets out the requirements which must be met in order for an applicant to be issued a certificate of registration.

If an applicant does not meet the requirements set out in the regulation it may still be possible for an applicant to qualify pursuant to one of the exemption policies.

Please note that if you currently hold a certificate of registration in any Canadian jurisdiction except Nunavut you may be eligible for registration in Ontario under new provisions of the *Health Professions Procedural Code*. See Legislation and By-Laws for more detail.

All applicants must be able to demonstrate that their past and present conduct indicates that they are mentally competent to practise medicine; will practise with decency, integrity and honesty and in accordance with the law; have sufficient knowledge, skill and judgment to engage in the kind of practice authorized by the certificate and can communicate effectively; and will display an appropriately professional attitude.

In addition to the registration regulation and policies, all applicants will also be subject to other CPSO policies and regulations which apply to current registrants. In particular, the Changing Scope of Practice and Re-entering Practice policies, and the regulation pertaining to the use of specialist titles may have relevance for new applicants. All applicants will also be subject to the College's expectations with respect to continuing professional development.

All registrants qualified under this policy will undergo an assessment after completing a minimum of one year of practice in Ontario. Assessments ensure that physicians are practising competently and safely. All physicians in Ontario undergo assessments and it is part of the College's vision of quality professionals that all physicians will be assessed every 10 years.

Pathway 3: US or Canadian Medical Degree or "Doctor of Osteopathy" Degree with US Postgraduate Training and Certification

Appendix B

The Registration Committee may direct the Registrar to issue a certificate of registration to an applicant who has a medical degree from a medical school in the US which is accredited by the Liaison Committee of Medical Education, or a medical degree from a medical school in Canada accredited by the Council on Accreditation of Canadian Medical Schools or a "doctor of osteopathy" degree granted by an osteopathic medical school in the US that was, at the time the degree was granted, accredited by the American Osteopathic Association, if the applicant has:

1. successfully completed a residency program accredited by the Accreditation Council for Graduate Medical Education;
2. been certified by a US Specialty Board;
3. successfully completed the US Medical Licensing Examination or successfully completed an acceptable qualifying examination; and
4. an independent or full license or certificate of registration to practise without restrictions in the US.

The following conditions will be placed on the certificate of registration:

1. The physician must practice with a mentor and/or supervisor until he or she has successfully completed an assessment.
2. The physician must undergo an assessment after completing a minimum of one year of practice in Ontario. The certificate of registration automatically expires 18 months from the date of issuance, but may be renewed by the Registration Committee, with or without additional or other terms, conditions and limitations.

How Barriers are Reduced

This policy adds another pathway to licensure for applicants who are not certified by the RCPSC or CFPC. Under this policy, eligible candidates now have a route to a certificate of registration to practice medicine independently limited to their scope of practice, subject to an initial one-year period of practice under supervision (or a mentor) and successful completion of an assessment after the first year of practice. Unsuccessful completion of an assessment would result in expiry of the certificate of registration unless it is renewed by the Registration Committee, with or without additional or other terms, conditions and limitations.

Unlike the College's policy for ACGME-trained specialists,[1] this pathway does not require that the ACGME residency be comparable in content and duration to a Canadian training program in the same discipline.

Endnote

[1] The policy for ACGME-trained specialists was rescinded by CPSO Council in November 2008 because applicants now have access to licensure under Pathway 3

Related Information

Guidelines for College-Directed Supervision

The CPSO provides guidance for physicians required to take part in supervised practice by our policies or committees.

Registration Committee FAQ

Common questions and answers relating to the Registration Committee process.

Appendix B

PATHWAY 4 – IMG WITH US POSTGRADUATE TRAINING AND CERTIFICATION

In an effort to improve access and reduce barriers for qualified physicians, the College's Council approved groundbreaking policy in September 2008 that established four new registration pathways.

Approved by Council: September 2008

In an effort to improve access and reduce barriers for qualified physicians, the College's Council approved groundbreaking policy in September 2008 that established four new registration pathways. The four approved pathways came into effect on December 1, 2008. Subsequently, Pathways 1, 2 and 3 were amended in February 2010 to comply with the AIT and the FMRAC National Standard. These new registration requirements vary depending on the source of the applicant's medical degree, where the applicant is currently practising and where the applicant received postgraduate training.

The Pathways are applicable to the following groups of physicians:

- Physicians with a Canadian medical degree and postgraduate training without RCPSC or CFPC certification. See Pathway 1.
- International medical graduates (IMGs) with Canadian postgraduate training without RCPSC or CFPC certification. See Pathway 2.
- Physicians with a US or Canadian medical degree or "Doctor of Osteopathy" Degree with US postgraduate training and certification. See Pathway 3.
- IMGs with US postgraduate training and certification. See details below.

Preamble

The College's registration regulation sets out the requirements which must be met in order for an applicant to be issued a certificate of registration.

If an applicant does not meet the requirements set out in the regulation it may still be possible for an applicant to qualify pursuant to one of the exemption policies.

Please note that if you currently hold a certificate of registration in any Canadian jurisdiction except Nunavut you may be eligible for registration in Ontario under new provisions of the *Health Professions Procedural Code*. See Legislation and By-Laws for more detail.

All applicants must be able to demonstrate that their past and present conduct indicates that they are mentally competent to practise medicine; will practise with decency, integrity and honesty and in accordance with the law; have sufficient knowledge, skill and judgment to engage in the kind of practice authorized by the certificate and can communicate effectively; and will display an appropriately professional attitude.

In addition to the registration regulation and policies, all applicants will also be subject to other CPSO policies and regulations which apply to current registrants. In particular, the Changing Scope of Practice and Re-entering Practice policies, and the regulation pertaining to the use of specialist titles may have relevance for new applicants. All applicants will also be subject to the College's expectations with respect to continuing professional development.

All registrants qualified under this policy will undergo an assessment after completing a minimum of one year of practice in Ontario. Assessments ensure that physicians are practising competently and safely. All physicians in Ontario undergo assessments and it is part of the College's vision of quality professionals that all physicians will be assessed every 10 years.

Pathway 4: IMG with US Postgraduate Training and Certification

Appendix B

The Registration Committee may direct the Registrar to issue a certificate of registration to an applicant who is an IMG, if the applicant has:

1. successfully completed a residency program accredited by the Accreditation Council for Graduate Medical Education;
2. been certified by a US Specialty Board;
3. successfully completed the US Medical Licensing Examination or successfully completed an acceptable qualifying examination; and
4. an independent or full license or certificate to practise without restrictions in the US or is eligible to apply for an independent or full license or certificate of registration to practise without restrictions in the US.

The following conditions will be placed on the certificate of registration:

1. The physician must practice with a mentor and/or supervisor until he or she has successfully completed an assessment.
2. The physician must undergo an assessment after completing a minimum of one year of practice in Ontario. The certificate of registration automatically expires 18 months from the date of issuance, but may be renewed by the Registration Committee, with or without additional or other terms, conditions and limitations.

How Barriers are Reduced

This policy adds another pathway to licensure for applicants who are not certified by the RCPSC or CFPC. Under this policy, eligible candidates now have a route to a certificate of registration to practice medicine independently limited to their scope of practice, subject to an initial one-year period of practice under supervision (or a mentor) and successful completion of an assessment after the first year of practice. Unsuccessful completion of an assessment would result in expiry of the certificate of registration unless it is renewed by the Registration Committee, with or without additional or other terms, conditions and limitations.

Unlike the College's policy for ACGME-trained specialists,[1] this pathway does not require that the ACGME residency be comparable in content and duration to a Canadian training program in the same discipline.

Endnote

1. The policy for ACGME-trained specialists was rescinded by CPSO Council in November 2008 because applicants now have access to licensure under Pathway 3 and Pathway 4.

Related Information

Guidelines for College-Directed Supervision

The CPSO provides guidance for physicians required to take part in supervised practice by our policies or committees.

Registration Committee FAQ

Common questions and answers relating to the Registration Committee process.

Appendix C

1. Alternative Pathways to Registration

We are committed to improving access for qualified doctors looking to practice medicine in Ontario.

The CPSO offers two alternative pathways for physicians looking to gain licensure in the province of Ontario but who are applying outside of our regular registration requirements.

If you gain licensure under one of these pathways, you will undergo an assessment after completing a minimum of one year of supervised practice in Ontario. Upon satisfactory completion of the assessment, you will be issued a certificate of registration to practice independently in the area that was assessed. Your initial certificate automatically expires 18 months from the date of issuance, but the Registration Committee may renew it with or without terms, conditions and limitations.

Pathway A

We may issue you a certificate if you have:

- One of the following degrees:
  - an acceptable medical degree as defined in Ontario Regulation 865/93 under the *Medicine Act, 1991*; **or**
  - a "doctor of osteopathy" degree granted by an osteopathic medical school in the US that was accredited by the American Osteopathic Association at the time it granted you your degree;
- successfully completed a residency program accredited by the ACGME;
- been certified by a US Specialty Board;
- successfully completed the US Medical Licensing Examination or successfully completed an acceptable qualifying exam; and
- an independent or full licence to practise without restrictions in the US or are eligible to apply for such a licence.

How we've reduced barriers

This adds another pathway to licensure if you are not certified by the RCPSC or CFPC. Under this policy, you now have a route to a certificate of registration to practice medicine independently, limited to your scope of practice.

Unlike our previous policy for ACGME-trained specialists, this pathway does not require that the ACGME residency be comparable in content and duration to a Canadian training program in the same discipline.

Appendix C

Pathway B

The CPSO may issue you a certificate if you have a medical degree from a medical school in Canada accredited by the Council on Accreditation of Canadian Medical Schools, or an acceptable international medical degree. To qualify, you must have:

- successfully completed a Canadian residency program or acceptable pre-1993 training;
- successfully completed the Medical Council of Canada Qualifying Examinations or an acceptable qualifying exam;
- practised for five or more continuous years in Canada or the United States (US) while holding an independent or full license or certificate of registration without restrictions but does not currently hold a certificate in a Canadian jurisdiction.

How we've reduced barriers

This adds another pathway if you are not certified by the RCPSC or CFPC and do not currently hold a certificate in a Canadian jurisdiction. You now have a route to practice medicine independently, limited to your scope of practice.

Appendix D

Delegation of Controlled Acts

Policies of the College of Physicians and Surgeons of Ontario (the "College") set out expectations for the professional conduct of physicians practising in Ontario. Together with the *Practice Guide* and relevant legislation and case law, they will be used by the College and its Committees when considering physician practice or conduct.

Within policies, the terms 'must' and 'advised' are used to articulate the College's expectations. When 'advised' is used, it indicates that physicians can use reasonable discretion when applying this expectation to practice.

Definitions

Controlled Acts[1]: Controlled acts are specified in the *Regulated Health Professions Act, 1991 (RHPA)* as acts which may only be performed by authorized regulated health professionals.[2]

Delegation: Delegation is a mechanism that allows a regulated health professional (e.g., a physician) who is authorized to perform a controlled act to temporarily grant that authority to another person (whether regulated or unregulated) who is not legally authorized to perform the act independently.

For the purposes of this policy, delegation does **not** include:

- Assignments of tasks that do not involve controlled acts (e.g., taking a patient's history, obtaining informed consent, administering a test that does not involve a controlled act, taking vitals, etc.); or
- Orders that authorize the initiation of a controlled act that is within the scope of practice of another health care professional (e.g., nurses are legally authorized to "administer a substance by injection" when the procedure has been ordered by a specified regulated health professional (e.g. a physician). Therefore, a nurse would require an order to perform this procedure, but this would not be considered delegation).[3]

[1] See Appendix A for a list of controlled acts defined under subsection 27 (2) of the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18 *(RHPA)*.
[2] Although the *RHPA* prohibits performance of controlled acts by those not specifically authorized to perform them, it permits performing controlled acts if the person performing the act is doing so to render first aid or temporary assistance in an emergency, or if they are fulfilling the requirements to become a member of a health profession and the act is within the scope of practice of the profession and is performed under the supervision or direction of a member of the profession (*RHPA*, s. 29(1)(a,b)).
[3] For additional information about what is not considered "delegation" as defined in the policy, see the *Advice to the Profession: Delegation of Controlled Acts* document.

Direct Order: Direct orders are written or verbal instructions from a physician to another health care provider or a group of health care providers to carry out a specific treatment, procedure, or intervention for a specific patient, at a specific time. Direct orders provide the authority to carry out the treatments, procedures, or other interventions that have been directed by the physician and generally take place after a physician-patient relationship has been established.

Medical Directive[4]**:** Medical directives are written orders by physician(s) to other health care provider(s) that pertain to any patient who meets the criteria set out in the medical directive. When a medical directive calls for acts that need to be delegated, it provides the authority to carry out the treatments, procedures, or other interventions that are specified in the directive, provided that certain conditions and circumstances exist.

Policy

Delegation is intended to provide physicians with the ability to extend their capacity to serve patients by temporarily authorizing an individual to act on their behalf. Delegation is intended to be a physician extender, not a physician replacement. Physicians remain accountable and responsible for the patient care provided through delegation.

When to Delegate

In the patient's best interest

1. Physicians **must** only delegate controlled acts when doing so is in the best interest of the patient. This includes only delegating when the act can be performed safely, effectively, and ethically. Therefore, physicians **must** only delegate when:

    a. the patient's health and/or safety will not be put at risk;
    b. the patient's quality of care will not be compromised by the delegation; and
    c. delegating serves at least one of the following purposes:
        i. promotes patient safety,
        ii. facilitates access to care where there is a need,
        iii. results in more timely or efficient delivery of health care, or
        iv. contributes to optimal use of health-care resources.

When not to delegate

2. Physicians **must not** delegate where the primary reasons for delegating are monetary or physician convenience.

[4] For examples of prototype medical directives, please consult the Emergency Department Medical Directives Implementation Kit which has been developed jointly by the Ontario Hospital Association (OHA), the Ontario Medical Association, and the Ministry of Health and is available on the OHA website.

3. Physicians **must not** delegate the performance of a controlled act to:

    a. a health professional whose certificate of registration is revoked or suspended at the time of the delegation[5]; or
    b. unregistered practitioners[6] (i.e., individuals who have claimed to be or have posed as a physician).

4. Physicians **must not** delegate the controlled act of psychotherapy.[7]

What to Delegate

5. Physicians **must** only delegate the performance of controlled acts that they can personally perform competently (i.e., acts within their scope of practice).[8]

How to Delegate

Use of direct orders and medical directives

6. Physicians **must** delegate either through the use of a direct order or a medical directive that is clear, complete, appropriate, and includes sufficient detail to facilitate safe and appropriate implementation (see the *Documentation* section of this policy for more information).

In the context of a physician−patient relationship

7. Physicians **must** only delegate in the context of an existing or anticipated physician-patient relationship, unless a patient's best interest dictates otherwise (e.g., public health or public safety measures).[9]

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[5] For additional information about determining the status of a health professional's certificate of registration, see the *Advice to the Profession: Delegation of Controlled Acts document*.
[6] For a list of individuals identified by the CPSO see the CPSO's website.
[7] This does not prohibit health care professionals who are authorized to perform the controlled act of psychotherapy from doing so, including nurses of all classes, psychologists, occupational therapists, social workers, and registered psychotherapists.
[8] O. Reg. 865/93, *Registration*, enacted under the *Medicine Act, 1991*, S.O. 1991, c.30, s. 2(5) requires physicians to only practise in the areas of medicine in which they are trained and experienced. For more information see the College's *Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice* policy and the *Delegation of Controlled Acts*: *Advice to the Profession* document.
[9] Generally, a patient's best interests will be served by delegation that occurs in the context of an existing or anticipated physician-patient relationship. However, in some instances a patient's best interests might be served by receiving care in the absence of a traditional physician-patient relationship. For example, in instances where access would otherwise be compromised to the point of risking patient safety, or where patient or public safety might be otherwise compromised. Examples of appropriate circumstances in which delegation may occur in the absence of a traditional physician-patient relationship include, but are not limited to:

8. Physicians **must** perform a clinical assessment prior to delegating or as soon as possible afterward, unless a patient's best interest dictates otherwise.

9. Where, in the context of a physician-patient relationship, delegation is occurring on an ongoing basis, physicians **must:**

    a. ensure that patients are informed of who the delegating physician is and that they can make a request to see the physician if they wish to; and
    b. periodically re-assess[10] the patient to ensure that delegation continues to be in the patient's best interest (e.g., when there is a change in the patient's clinical status or treatment options).

Ensure consent to treatment is obtained

10. Physicians **must** ensure informed consent is obtained and documented, in accordance with the *Health Care Consent Act, 1996* and the College's *Consent to Treatment* policy, for any treatments that are delegated.[11]

    a. In circumstances where the delegation takes place pursuant to a medical directive, physicians **must** ensure the medical directive includes obtaining the appropriate patient consent.[12]

- the provision of care by paramedics under the direct control of base hospital physicians or within community paramedicine programs;
- the provision of primary care in remote and isolated regions of the province by registered nurses acting in expanded roles;
- the provision of public health programs, such as vaccinations;
- post-exposure prophylaxis following potential exposure to a blood borne pathogen or the provision of the hepatitis B vaccine in the context of occupational health medicine;
- hospital emergency departments for routine protocols; and
- lay person first responders performing controlled acts for the purposes of first aid in an emergency.

[10] In some circumstances, an assessment might take the form of a chart review or consultation with the delegate rather than an in-person assessment.

[11] Please see the *Health Care Consent Act, 1996* and the College's *Consent to Treatment* policy for more information.

[12] Obtaining informed consent includes providing the patient with information about the individual who will be providing the treatment and their role and/or credentials. Obtaining informed consent also includes the provision of information and the ability to answer questions about the material risks and benefits of the procedure, treatment or intervention proposed. If the individual who will be enacting the medical directive is unable to provide the information that a reasonable person would want to know in the circumstances, the implementation of the medical directive is inappropriate.

Quality Assurance

Identifying and mitigating risks

11. Prior to delegating, physicians **must** identify significant or common risks associated with the delegation and mitigate them such that patient safety is at no greater risk than had the act not been delegated.

    a. Physicians **must** only delegate controlled acts if the necessary resources and environmental supports are in place to ensure safe and effective delegation.

Evaluating delegates and establishing competence

12. Physicians **must** be satisfied that individuals to whom they delegate have the knowledge, skill, and judgment to perform the delegated acts competently and safely. Prior to delegating physicians **must**:

    a. review the individual's training and credentials, unless the physician is not involved in the hiring process and it is reasonable to assume that the hiring institution has ensured that its employees have the requisite knowledge, skill, and judgment[13]; and
    b. observe the individual performing the act, where necessary (e.g., where the risk is such that observation is necessary to ensure patient safety).

Ensuring delegates can accept the delegation

13. Physicians **must** only delegate to individuals who are able to accept the delegation.[14] In particular, physicians **must not:**

    a. delegate to an individual if they become aware the individual is not permitted to accept the delegation; or
    b. compel an individual to perform a controlled act they have declined to perform.

[13] In some cases, the physician may not personally know the individual to whom they are delegating. For example, medical directors at base hospitals delegating to paramedics or in hospital settings, where the hospital employs the delegates (nurses, respiratory therapists, etc.) and the medical staff is not involved in the hiring process. For additional guidance about ensuring competence when a physician has not personally employed a delegate, see the *Advice to the Profession: Delegation of Controlled Acts* document.

[14] In addition to the limitations set out in the *RHPA*, some regulatory colleges in Ontario place limits on the types of acts that their members may be authorized to carry out through delegation. The delegate is responsible for informing the delegating physician of any regulations, policies, and/or guidelines of their regulatory body that would prevent them from accepting the delegation.

Supervision and support of delegates

14. Physicians **must** provide a level of supervision and support that is proportionate to the risk associated with the delegation and that is reflective of the following factors:

    a. the specific act being delegated;
    b. the patient's specific circumstances (e.g., health status, specific health-care needs);
    c. the setting where the act will be performed and the available resources and environmental supports in place; and
    d. the education, training and experience of the delegate.

15. If on the basis of the risk assessment onsite supervision is not necessary, physicians **must** be available to provide appropriate consultation and assistance (e.g., in person, if necessary, or by telephone).

16. Physicians **must** be satisfied that the individuals to whom they are delegating:

    a. understand the extent of their responsibilities; and
    b. know when and who to ask for assistance, if necessary.

17. Physicians **must** ensure that the individuals to whom they are delegating accurately identify themselves and their role in providing care to patients and that patients with questions about the delegate's role are provided with an explanation.

Managing adverse events

18. Physicians **must**:

    a. have protocols in place to appropriately manage any adverse events that occur;
    b. be available to provide assistance in managing any adverse events, if necessary;
    c. be satisfied that the delegate is capable of managing any adverse events themselves, if necessary; and
    d. have a communication plan in place to keep informed of any adverse events that take place and any actions taken by the delegate to manage them.

Ongoing monitoring and evaluation

19. Where acts are routinely delegated, physicians **must** have a reliable and ongoing monitoring and evaluation system for both the delegate(s) and the delegation process itself.

20. As part of this system, physicians **must**:

    a. confirm currency of the delegate's knowledge and skills; and
    b. evaluate the delegation process to ensure it is safe and effective; and
    c. review patient medical records to ensure the care provided through delegation is appropriate and meets the standard of practice.
        i. What is necessary will depend on the specific acts being delegated and the other quality assurance processes in place to ensure safe and effective delegation.

Documentation

Medical Directives

21. Physicians **must** ensure the following information is included in the medical directive[15]:

    a. The name and a description of the procedure, treatment, or intervention being ordered;
    b. An itemized and detailed list of the specific clinical conditions that the patient must meet before the directive can be implemented;
    c. An itemized and detailed list of any situational circumstances that must exist before the directive can be implemented;
    d. A comprehensive list of contraindications to implementation of the directive;
    e. Identification of the individuals authorized to implement the directive;[16]
    f. A description of the procedure, treatment, or intervention itself that provides sufficient detail to ensure that the individual implementing the directive can do so safely and appropriately;[17]
    g. The name and signature of the physician(s) authorizing and responsible for the directive and the date it becomes effective; and
    h. A list of the administrative approvals that were provided to the directive, including the dates and each committee (if any).

[15] A comprehensive guide and toolkit was developed by a working group of the Health Profession Regulators of Ontario (HPRO) in 2006 and is posted on their website.
[16] The individuals need not be named but may be described by qualification or position in the workplace.
[17] The directive may call for the delegate to follow a protocol that describes the steps to be taken in delivering treatment if one has been developed by the physician or the institution.

22. Each physician responsible for the care of a patient who may receive the proposed treatment, procedure, or intervention **must** review and sign the medical directive each time it is updated.[18]

Medical Records

23. Physicians **must** ensure that:

    a. the care provided through delegation is documented in accordance with the College's *Medical Records Documentation* policy, including that each entry in the medical record is identifiable and clearly conveys who made the entry and performed the act;
    b. it is clear who the authorizing physician(s) are (e.g., the name(s) of the authorizing physician(s) are captured in the medical record); and
    c. verbal direct orders are documented in the patient's medical record by the recipient of the direct order and are reviewed or confirmed at the earliest opportunity by the delegating physician.[19]

[18] It is acceptable for physicians working at institutions with multiple directives to receive copies of each directive and sign one statement indicating that they have read and agreed with all the medical directives referred to therein. This can be done as part of the annual physician reappointment process.
[19] Physicians practising in hospitals may be subject to additional requirements under the *Public Hospitals Act, 1990*.

Appendix D

Controlled Acts under the *RHPA*

1. 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 individual or his or her personal representative will rely on the diagnosis.
2. Performing a procedure on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, or in or below the surfaces of the teeth, including the scaling of teeth.
3. Setting or casting a fracture of a bone or a dislocation of a joint.
4. Moving the joints of the spine beyond the individual's usual physiological range of motion using a fast, low amplitude thrust.
5. Administering a substance by injection or inhalation.
6. Putting an instrument, hand or finger,
    i. beyond the external ear canal,
    ii. beyond the point in the nasal passages where they normally narrow,
    iii. beyond the larynx,
    iv. beyond the opening of the urethra,
    v. beyond the labia majora,
    vi. beyond the anal verge, or
    vii. into an artificial opening in the body.
7. Applying or ordering the application of a form of energy prescribed by the regulations under the *RHPA*.
8. Prescribing, dispensing, selling or compounding a drug as defined in the *Drug and Pharmacies Regulation Act*, or supervising the part of a pharmacy where such drugs are kept.
9. Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses other than simple magnifiers.
10. Prescribing a hearing aid for a hearing impaired person.
11. Fitting or dispensing a dental prosthesis, orthodontic or periodontal appliance or device used inside the mouth to prevent the teeth from abnormal functioning.[20]
12. Managing labour or conducting the delivery of a baby.
13. Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response.
14. Treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning.

[20] This is the only controlled act that physicians are not authorized to perform.

Council Profile

The Council Profile outlines the diversity attributes, technical skills, and behavioural competencies that should be represented in Council to effectively set strategic direction, develop policies, and provide oversight of CPSO's performance. The Council Profile will also provide a basis for assessing where there may be gaps in the diversity attributes, skills, and behaviour of current Council members and inform CPSO's outreach efforts for Council elections, and the learning/training needs of current members.

While individual Council members are not expected to possess all the technical skills and diversity attributes outlined in the Profile, Council can assess the current competence and diversity of its collective members and, through training and recruitment, work towards an appropriate composition of Council based on these requirements.

Diversity Attributes	Technical Skills	Behavioural Competencies
• Race/Ethnicity • Indigenous • Gender • LGBTQ2S+ • Age • Disability • Practice Setting • Practice Specialty	• Financial Literacy • Governance • Knowledge of Anti-racism and Anti-oppression • Legal and Fiduciary Knowledge • Technological Proficiency • French • Health Systems Knowledge • Human Resources • Leadership • Policy Development	• Continuous Learning • Creativity • Effective Communication • Planning & Initiative • Relationship Building • Results Oriented • Stakeholder Focused • Strategic Thinking • Teamwork

Appendix E: Council Profile

Descriptions of Technical Skills and Behavioural Competencies

Technical Skills	
Financial Literacy	Ability to understand conceptually the financial position of CPSO as presented in its financial statements and generally accepted accounting principles; can read, interpret, and ask questions about financial statements.
Governance	Demonstrated experience of governance principles and practices.
Knowledge of Anti-racism and Anti-oppression	Awareness of the impacts of racism and oppression on the individual, institutional, and societal levels. Builds awareness to create more just, equitable, and inclusive environments.
Legal and Fiduciary Knowledge	Understanding of one's legal and fiduciary duties and responsibilities including loyalty, good faith, trust, preparedness, participation.
Technological Proficiency	Ability to use software and digital platforms that CPSO uses to conduct its business.
French	Demonstrated capacity to comprehend and articulate complex materials in both spoken and written format.
Health System Knowledge	Understanding of the health care system in Ontario and Canada and the roles and responsibilities of health sector actors, including the different levels of government and other health organizations. A familiarity with historical and current trends in improvements to health services delivery, access to care and health outcomes.
Human Resources	Demonstrated experience in planning human resource strategies.
Leadership	Demonstrated experience in leadership positions.
Policy Development	Knowledge and understanding of the purpose of policy at CPSO and engagement in the policy development process.

Appendix E: Council Profile

Behavioural Competencies	
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.
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

Appendix F

CPSO

Serving the people of Ontario through effective regulation of medical doctors

College Performance Measurement Framework (CPMF) Reporting Tool

March 31, 2021

Appendix F

INTRODUCTION

THE COLLEGE PERFORMANCE MEASUREMENT FRAMEWORK (CPMF)

A CPMF has been developed by the Ontario Ministry of Health in close collaboration with Ontario's health regulatory Colleges (Colleges), subject matter experts and the public with the aim of answering the question "how well are Colleges executing their mandate which is to act in the public interest?". This information will:

1. strengthen accountability and oversight of Ontario's health regulatory Colleges; and
2. help Colleges improve their performance.

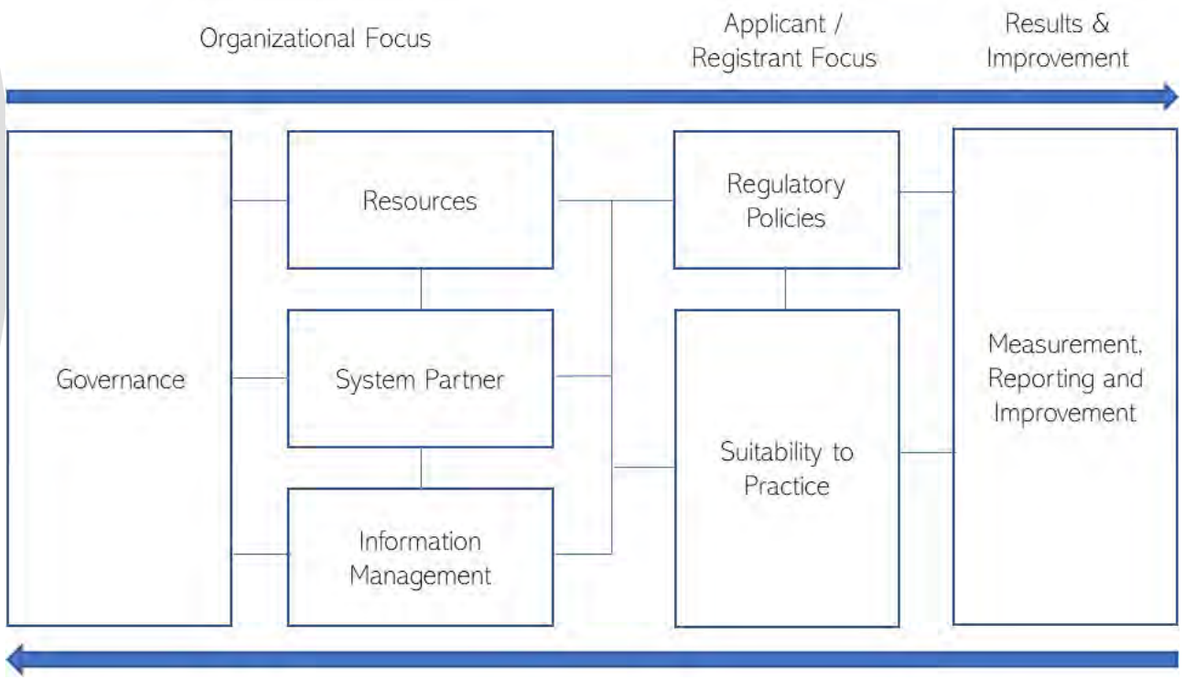
a) Components of the CPMF:

1	**Measurement domains**	→	Critical attributes of an excellent health regulator in Ontario that should be measured for the purpose of the CPMF.
2	**Standards**	→	Best practices of regulatory excellence a College is expected to achieve and against which a College will be measured.
3	**Measures**	→	Further specifications of the standard that will guide the evidence a College should provide and the assessment of a College in achieving the standard.
4	**Evidence**	→	Decisions, activities, processes, or the quantifiable results that are being used to demonstrate and assess a College's achievement of a standard.
5	**Context measures**	→	Statistical data Colleges report that will provide helpful context about a College's performance related to a standard.
6	**Planned improvement actions**	→	Initiatives a College commits to implement over the next reporting period to improve its performance on one or more standards, where appropriate.

b) Measurement domains:

The proposed CPMF has seven measurement domains. These domains were identified as the most critical attributes that contribute to a College effectively serving and protecting the public interest (Figure 1). The measurement domains relate to Ontario's health regulatory Colleges' key statutory functions and key organizational aspects, identified through discussions with the Colleges and experts, that enable a College to carry out its functions well.

Figure 1: CPMF Model for measuring regulatory excellence



The seven domains are interdependent and together lead to the outcomes that a College is expected to achieve as an excellent regulator. Table 1 describes what is being measured by each domain.

Table 1: Overview of what the Framework is measuring

	Domain	Areas of focus
1	**Governance**	• The efforts a College undertakes to ensure that Council and Statutory Committees have the required knowledge and skills to warrant good governance. • Integrity in Council decision making. • The efforts a College undertakes in disclosing decisions made or is planning to make and actions taken, that are communicated in ways that are accessible to, timely and useful for relevant audiences.
2	**Resources**	• The College's ability to have the financial and human resources to meet its statutory objects and regulatory mandate, now and in the future.
3	**System Partner**	• The extent to which a College is working with other Colleges and system partners, where appropriate, to help execute its mandate in a more effective, efficient and/or coordinated manner and to ensure it is responsive to changing public expectation.
4	**Information Management**	• The efforts a College undertakes to ensure that the confidential information it deals with is retained securely and used appropriately in the course of administering its regulatory activities and legislative duties and objects.
5	**Regulatory Policies**	• The College's policies, standards of practice, and practice guidelines are based on the best available evidence, reflect current best practices, are aligned with changing publications and where appropriate aligned with other Colleges.
6	**Suitability to Practice**	• The efforts a College undertakes to ensure that only those individuals who are qualified, skilled and competent are registered, and only those registrants who remain competent, safe and ethical continue to practice the profession.
7	**Measurement, Reporting and Improvement**	• The College continuously assesses risks, and measures, evaluates, and improves its performance. • The College is transparent about its performance and improvement activities.

c) Standards, Measures, Evidence, and Improvement:

The CPMF is primarily organized around five components: **domains**, **standards**, **measures**, **evidence** and **improvement**, as noted on page 3. The following example demonstrates the type of information provided under each component and how the information is presented within the Reporting Tool.

Appendix F

Example:

Domain 1: Governance			
Standard →	**Measure** →	**Evidence** →	**Improvement**
1. Council and Statutory Committee members have the knowledge, skills, and commitment needed to effectively execute their fiduciary role and responsibilities pertaining to the mandate of the College.	1. Where possible, Council and Statutory Committee members demonstrate that they have the knowledge, skills, and commitment prior to becoming a member of Council or a Statutory Committee.	a. Professional members are eligible to stand for election to Council only after: i. Meeting pre-defined competency / suitability criteria, and ii. attending an orientation training about the College's mandate and expectations pertaining to the member's role and responsibilities.	• The College is planning a project to develop required competencies for Council and Committees and will develop screening criteria. By-laws will be updated to reflect the screening criteria as a component of the election process to determine professional registrant eligibility to run for a Council position.
		b. Statutory Committee candidates have: i. met pre-defined competency / suitability criteria, and ii. attended an orientation training about the mandate of the Committee and expectations pertaining to a member's role and responsibilities.	• The College is planning a project to develop required competencies for Council and Committees and will develop screening criteria.
		c. Prior to attending their first meeting, public appointments to Council undertake a rigorous orientation training course about the College's mandate and expectations pertaining to the appointee's role and responsibilities.	Nil
	2. Council and Statutory Committees regularly assess their effectiveness and address identified opportunities for improvement through ongoing education.	a. Council has developed and implemented a framework to regularly evaluate the effectiveness of: i. Council meetings; ii. Council	Nil
		b. The framework includes a third-party assessment of Council effectiveness at minimum every three years.	Nil

THE CPMF REPORTING TOOL

For the first time in Ontario, the CPMF Reporting Tool (along with the companion Technical Specifications for Quantitative CPMF Measures document) will provide comprehensive and consistent information to the public, the Ministry of Health ('ministry') and other stakeholders by each of Ontario's health regulatory Colleges (Colleges). In providing this information each College will:

1. meet with the ministry to discuss the system partner domain;
2. complete the self-assessment;
3. post the Council approved completed CPMF Report on its website; and
4. submit the CPMF Report to the ministry.

The ministry will not assess whether a College meets or does not meet the Standards. The purpose of the first iteration of the CPMF is to provide the public, the ministry and other stakeholders with baseline information respecting a College's activities and processes regarding best practices of regulatory excellence and, where relevant, the College's performance improvement commitments. Furthermore, the reported results will help to lay a foundation upon which expectations and benchmarks for regulatory excellence can be refined and improved. Finally, the results of the first iteration may stimulate discussions about regulatory excellence and performance improvement among Council members and senior staff within a College, as well as between Colleges, the public, the ministry, registrants and other stakeholders.

The information reported through the completed CPMF Reporting Tools will be used by the ministry to strengthen its oversight role of Ontario's 26 health regulatory Colleges and may help to identify areas of concern that warrant closer attention and potential follow-up.

Furthermore, the ministry will develop a Summary Report highlighting key findings regarding the best practices Colleges already have in place, areas for improvement and the various commitments Colleges have made to improve their performance in serving and protecting the public. The focus of the Summary Report will be on the performance of the regulatory system (as opposed to the performance of each individual College), what initiatives health regulatory Colleges are undertaking to improve regulatory excellence and areas where opportunities exist for colleges to learn from each other. The ministry's Summary Report will be posted publicly.

As this will be the first time that Colleges will report on their performance against the proposed CPMF standards, it is recognized that the initial results will require comprehensive responses to obtain the required baseline information. It is envisioned that subsequent reporting iterations will be less intensive and ask Colleges only to report on:

- Improvements a College committed to undertake in the previous CPMF Report;
- Changes in comparison to baseline reporting; and
- Changes resulting from refined standards, measures and evidence.[1]

[1] Informed by the results from the first reporting iteration, the standards, measures and evidence will be evaluated and where appropriate further refined before the next reporting iteration.

Completing the CPMF Reporting Tool

Colleges will be asked to provide information in the right-hand column of each table indicating the degree to which they fulfill the "required Evidence" set out in column two.

Furthermore,

- where a College fulfills the "required evidence" it will have to:
  - provide link(s) to relevant background materials, policies and processes ***OR*** provide a concise overview of this information.
- where a College responds that it "partially" meets required evidence, the following information is required:
  - clarification of which component of the evidence the College meets and the component that the College does not meet;
  - for the component the College meets, provide link(s) to relevant background material, policies and processes ***OR*** provide a concise overview of this information; and
  - for the component the College does not meet, whether it is currently engaged in, or planning to implement the missing component over the next reporting period.
- where a College does not fulfill the required evidence, it will have to:
  - indicate whether it is currently engaged in or planning to implement the standard over the next reporting period.

Furthermore, there may be instances where a College responds that it meets required evidence but, in the spirit of continuous improvement, plans to improve its activities or processes related to the respective Measure. A College is encouraged to highlight these planned improvement activities.

While the CPMF Reporting Tool seeks to clarify the information requested, it is not intended to direct College activities and processes or restrict the manner in which a College fulfills its fiduciary duties. Where a term or concept is not explicitly defined in the proposed CPMF Reporting Tool the ministry relies on individual Colleges, as subject matter experts, to determine how a term should be appropriately interpreted given the uniqueness of the profession each College oversees.

The areas outlined in red in the example below are what Colleges will be asked to complete.

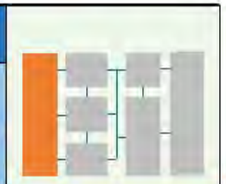
Appendix F

Example:

DOMAIN 1: GOVERNANCE

Standard 1

Council and statutory committee members have the knowledge, skills, and commitment needed to effectively execute their fiduciary role and responsibilities pertaining to the mandate of the College.



Measure	Required evidence	College response
1. Where possible, Council and Statutory Committee members demonstrate that they have the knowledge, skills, and commitment prior to becoming a member of Council or a Statutory Committee.	a. Professional members are eligible to stand for election to Council only after: i. Meeting pre-defined competency / suitability criteria, and ii. attending an orientation training about the College's mandate and expectations pertaining to the member's role and responsibilities.	The College fulfills this requirement: Yes ☐ Partially ☐ No ☐ • The competency/suitability criteria are public: Yes ☐ No ☐ *If yes, please insert link to where they can be found, if not please list criteria:* • Duration of orientation training: • Format of orientation training (e.g. in-person, online, with facilitator, testing knowledge at the end): • Insert a link to website if training topics are public ***OR*** list orientation training topics: *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐* *Additional comments for clarification (optional):*

PART 1: MEASUREMENT DOMAINS

The following tables outline the information that Colleges are being asked to report on for each of the Standards. Colleges are asked to provide **evidence** of decisions, activities, processes, and verifiable results that demonstrate the achievement of relevant standards and encourages Colleges to not only to identify whether they are working on, or are planning to implement, the missing component if the response is "No", but also to provide information on improvement plans or improvement activities underway if the response is "Yes" or "Partially".

DOMAIN 1: GOVERNANCE		
Standard 1 **Council and statutory committee members have the knowledge, skills, and commitment needed to effectively execute their fiduciary role and responsibilities pertaining to the mandate of the College.**		
Measure	**Required evidence**	**College response**
1.1 Where possible, Council and Statutory Committee members demonstrate that they have the knowledge, skills, and commitment prior to becoming a member of Council or a Statutory Committee.	a. Professional members are eligible to stand for election to Council only after: i. meeting pre-defined competency / suitability criteria, and ii. attending an orientation training about the College's mandate and expectations pertaining to the member's role and responsibilities.	The College fulfills this requirement: **Yes (pending Council approval of the Council Profile).** **i. meeting pre-defined competency/suitability criteria** **Section to be completed following the March Council meeting to reflect Council's decision regarding the Council Profile.** **ii. attending an orientation training about the College's mandate and expectations pertaining to the member's role and responsibilities** **CPSO is meeting this requirement. In December 2020, CPSO changed its elections process to incorporate a mandatory orientation session - professional members are eligible to stand for election to Council after they have attended an orientation training about CPSO's mandate and expectations for Council members.**

		• The competency/suitability criteria are public: **If approved, link to the Council Profile will be included here.** • Duration of orientation training: **The live orientation training is approximately 1.5 hours in duration. In addition, prospective candidates are expected to review key materials that provide information about CPSO (i.e. Strategic Plan, Annual Report, eDialogue, By-Laws, previous Council meeting package)** • Format of orientation training (e.g. in-person, online, with facilitator, testing knowledge at the end): **The format is a combination of pre-reading materials and a virtual, real-time session that includes some testing elements.** • Insert a link to website if training topics are public ***OR*** list orientation training topics: **The list of training topics include: The Role of the College, By-Laws, Legislation and Regulation, Fiduciary Duty and Protecting the Public, Confidentiality and Communications, A Day at Council, A Day at Committee, Council Election Process, Remuneration, Anti-Indigenous Racism in Healthcare, Anti-Black Racism in Healthcare, Discrimination Against LGBTQ2S Patients, Implicit Bias in healthcare. Within each of these categories, are various topics which include references to our policies, guidelines and expectations.**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		Currently the legislation requires that professional members are elected to Council so there is limited control within CPSO to truly ensure that all professional members possess the required skills, knowledge and commitment to be an effective member on Council. CPSO recognizes that a competency-based process for selecting Council members is a leading governance practice and encourages the Ministry to better enable health regulatory colleges to *select* rather than elect. **While this expectation applies to professional members, public members are appointed to Council based on the Minister's prerogative. It is critical that public members also possess the required skills and knowledge to be effective in their role as governors. Moreover, it is extremely challenging for public members to gain the required skills and knowledge within a one-year appointment.** **There is an opportunity to improve the transparency of the public appointment process. The Ministry is encouraged to consider applying a competency-based framework consistent with what is expected of professional members and one that considers diversity of public members.**
	b. Statutory Committee candidates have:	The College fulfills this requirement: **Yes** **<u>i. met pre-defined competency/suitability criteria</u>**

	i. met pre-defined competency / suitability criteria, and ii. attended an orientation training about the mandate of the Committee and expectations pertaining to a member's role and responsibilities.	**The Governance Committee recruits non-Council Committee members using competencies and suitability criteria that are required by the particular Committee. Applicants provide a cover letter and resume outlining the skills and experience they will contribute to the Committee. Interviews are conducted with strong candidates to better assess their fit and identify whether they have any potential conflicts of interest.** **When appointing Council members to Statutory Committees, the Governance Committee considers the skills, experience and commitment of Council members and makes Committee appointments based on the skills and experience required for the Statutory Committee.** **In alignment with the Council Profile, CPSO is in the process of developing skills, competencies and diversity attributes for each Statutory Committee to better inform the recruitment and appointment process.** **ii. attended an orientation training about the mandate of the Committee and expectations pertaining to a member's role and responsibilities** **Currently all new Statutory Committee candidates attend an orientation training about the mandate of the College, the Committee and expectations pertaining to a Committee member's roles and responsibilities.** • The competency / suitability criteria are public: **Yes. Click here to view the behavioural competencies that are expected of all Committee members (p. 15). When CPSO posts vacancies for its Committees, the skills and qualifications are posted publicly on our website (currently we are not recruiting). All non-Council members that are being recruited for committees must submit a cover letter and resume outlining what skills they possess as they relate to the Committee to which they are applying. Behavioural interviews are conducted with each non-Council candidate to assess suitability and decisions are made based on the candidate who best matches the skills and qualifications posted with the vacancy.** *If yes, please insert link to where they can be found, if not please list criteria:* • Duration of each Statutory Committee orientation training: **The duration of the training varies depending on the committee, anywhere from 1-2 hours to 1 full day depending on the Committee.** • Format of each orientation training (e.g. in-person, online, with facilitator, testing knowledge at the end): **In light of the pandemic, the format of all orientation training is virtual and involves live presenters as well as reference materials to review following the orientation training**

		• Insert link to website if training topics are public ***OR*** list orientation training topics for Statutory Committee: **The orientation training topics for all Statutory Committees include an overview to CPSO Governance. In addition, the Committee specific orientation topics are listed below.** **Discipline Committee and Fitness to Practice Committee:** **Legislative Context, Referrals, Pre-Hearing Processes, Hearing Process, Roles of Participants, Burden of Proof and Evidence. For more details see: https://cpsoonca-my.sharepoint.com/:p:/g/personal/hearings2_cpso_on_ca/EVCQsG1A89FOjZvOIg7-WGwB4h19YF02khfy0-SMAJ2vFg?e=iU8gVQ** **Executive Committee** **Strategic Plan and Key Performance Indicators, CPSO Leadership Team, Legislative and Regulatory Framework, Government Relations Initiatives, Governance Modernization** **Inquiries Complaints and Reports Committee** **Welcome and Introduction to ICRC outlining basic responsibilities of ICRC and introducing the Investigations and Resolutions area, Meeting Logistics, the Pre/Post/During ICRC Panel overview, Administrative Law Part I, Role of the RHPA, Role of ICRC and their focus of analysis in Decision Making, Administrative Law Part II, Deliberative Privilege, Legal Counsel Advice, Basic framework re sexual abuse and ICRC relationship with the Discipline Committee** **Patient Relations Committee:** **Terms of Reference, Funding for Therapy and Counselling, Benchmarks, Privacy/Confidentiality, Webmail, Legal Opinions, Decision Components, Application Package, Legislation, Annual Report** **Quality Assurance Committee:** **QAC Primer and Competency Framework, Policy Minutes, QAC Regulations, QAC Meeting resource material, Remuneration, Sample Peer Report, Orientation to CPSO Technology, Privacy and Confidentiality** **Registration Committee:** **CPSO registration policies https://www.cpso.on.ca/Physicians/Registration/Registration-Policies, CPSO Practice Guide: https://www.cpso.on.ca/admin/CPSO/media/Documents/physician/polices-and-**

		guidance/practice-guide/practice-guide.pdf, CPSO Best Practices – Privacy & Confidentiality http://intra.cpso.on.ca/Employee-Resources-Benefits/Compliance/Confidentiality/Best-Practices-Privacy-Confidentiality, CPD site is an internal site with resources assisting Committee and staff when making education-related decisions: http://cpd.cpso.on.ca/
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		CPSO is currently improving its current Committee recruitment process and is developing Committee Profiles for each of its Statutory and Standing Committees. The Committee Profiles will include not only skills and behavioural competencies but also diversity attributes that are most valuable for the Committee. To ensure that Committee members have some foundational diversity, equity and inclusion training, the following topics have been included as part of the training for Statutory Committees: Anti-Indigenous Racism in Healthcare, Anti-Black Racism in Healthcare, Discrimination Against LGBTQ2S Patients, Implicit Bias in healthcare.
	c. Prior to attending their first meeting, public appointments to Council undertake an orientation training course about the College's mandate and expectations pertaining to the appointee's role and responsibilities.	The College fulfills this requirement: **Yes.**
		• Duration of orientation training: **Public members are asked to complete 4 hours of orientation training in total.** • Format of orientation training (e.g. in-person, online, with facilitator, testing knowledge at the end): **The format of the orientation training is online and includes an on demand, interactive course (provided by the Council on Licensure and Enforcement), as well as a live session with the Director of Governance.** • Insert link to website if training topics are public ***OR*** list orientation training topics: **The on demand orientation topics can be found here. The list of training topics covered in the live session include: The Role of the College, By-Laws, Legislation and Regulation, Fiduciary Duty and Protecting the Public, Confidentiality and Communications, A Day at Council, A Day at Committee, Remuneration. Within each of these categories, are various topics which include references to our policies, guidelines and expectations.**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ

		Public appointments are made at various times throughout the year, sometimes with little notice to CPSO. At times, it can be very challenging for these orientations to take place in advance of a public member's first meeting, particularly if they have been appointed very close to a Council meeting. There have been instances where the public member doesn't know that they have been appointed by the Minister and are learning of the decision some time after. **Where possible, the Minister's Office is encouraged to provide sufficient notice to CPSO regarding appointment and reappointment decisions to promote stability and effective functioning of Council and its Committees.**
1.2 Council regularly assesses its effectiveness and addresses identified opportunities for improvement through ongoing education.	a. Council has developed and implemented a framework to regularly evaluate the effectiveness of: i. Council meetings; ii. Council	The College fulfills this requirement: **Yes. Council evaluates every meeting to identify strengths, opportunities for improvement and educational topics for Council members. The results are shared with Council members at the next meeting. Council also conducts an annual assessment using a third party to evaluate its effectiveness and benchmark with other not-for-profit health care boards.**
		• Year when Framework was developed ***OR*** last updated: **The framework was last updated in 2020.** • Insert a link to Framework ***OR*** link to Council meeting materials where (updated) Framework is found and was approved: **Information about CPSO Council's annual assessment can be found here. The Council meeting evaluation results are not publicly available.** • Evaluation and assessment results are discussed at public Council meeting: **The evaluation and assessment results are discussed at Council meetings in camera.**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (optional)
	b. The framework includes a third-party assessment of Council effectiveness at a minimum every three years.	The College fulfills this requirement: **Yes.**
		• A third party has been engaged by the College for evaluation of Council effectiveness: **Yes.** • Year of last third-party evaluation: **CPSO last engaged a third-party to provide advice regarding Council effectiveness in 2020.**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐

		CPSO's framework for assessing the effectiveness of Council includes a board assessment tool developed by the Ontario Hospital Association. The tool enables Council to compare its performance from year to year and also benchmarks CPSO with other not-for-profit boards. Council also engages external governance experts from time to time to assess Council's effectiveness related to specific areas of its functions.
	c. Ongoing training provided to Council has been informed by: i. the outcome of relevant evaluation(s), and/or ii. the needs identified by Council members.	The College fulfills this requirement: **Yes. Council members receive an online meeting evaluation after each meeting to identify strengths and opportunities for improvement and potential educational topics of interest.** **Ongoing training provided to Council has been informed by:** **i. the outcome of relevant evaluation(s)** **The feedback received through the meeting evaluations informs improvement initiatives and future educational offerings. At the end of each Council meeting, there is also a reflection session which provides a forum for Council members to share observations about the meeting and comment on how effective the Council was in achieving the objectives of the meeting.** **ii. the needs identified by Council members** **Last year, Council members specifically requested more information and education about diversity, equity and inclusion. Based on this feedback, we invited Dr. Javeed Sukhera, to share his expertise and engage Council in a discussion about diversity, equity and inclusion in the health regulatory space. It was very well-received and additional sessions have been planned to build the knowledge and skills gained from the initial session.** *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐* **Ongoing training is also informed by emerging trends as well as government priorities that may be impacting physicians. For example, Council and Committee members will be participating in various education sessions this year related to implicit bias and anti-Indigenous racism.**

Standard 2 **Council decisions are made in the public interest.**		
Measure	**Required evidence**	**College response**
2.1 All decisions related to a Council's strategic objectives, regulatory processes, and activities are impartial, evidence-informed, and advance the public interest.	a. The College Council has a Code of Conduct and 'Conflict of Interest' policy that is accessible to the public.	The College fulfills this requirement: **Yes. The Code of Conduct and Conflict of Interest Policies are accessible to the public.**
		• Year when Council Code of Conduct and 'Conflict of Interest' Policy was implemented ***OR*** last evaluated/updated: **The Council Code of Conduct and Conflict of Interest Policy was last updated in 2014.** • Insert a link to Council Code of Conduct and 'Conflict or Interest' Policy ***OR*** Council meeting materials where the policy is found and was discussed and approved: **Click here to access the Code of Conduct policy (p. 59) Click here to access the Conflict of Interest policy (p. 63)**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		CPSO is currently reviewing its website to identify ways to make information more accessible to the public.
	b. The College enforces cooling off periods[2].	The College fulfills this requirement: **Yes.**

[2] Cooling off period refers to the time required before an individual can be elected to Council where an individual holds a position that could create an actual or perceived conflict of interest with respect to his or her role and responsibility at the college.

		• Cooling off period is enforced through: **By-Law** • Competency/Suitability criteria **Eligibility Criteria** • The year that the cooling off period policy was developed ***OR*** last evaluated/updated: **The cooling off period was included in the General By-Law in 2020** • How does the college define the cooling off period? **CPSO defines cooling off periods in the manner below. Click here to access the by-laws that describe the cooling off periods.** o **the member does not hold, and has not held within one year before the date of the election, a position which would cause the member, if elected as a councillor, to have a conflict of interest by virtue of having competing fiduciary obligations to both the College and another organization;** o **the member is not, and has not been within five years before the date of the election, an employee of the College (whether on contract or permanent, and whether on a full-time or part-time basis)**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		Additional comments for clarification (optional)
	c. The College has a conflict of interest questionnaire that all Council members must complete annually. Additionally:	The College fulfills this requirement: **Yes. On an annual basis, Council members sign a Declaration of Adherence which is a compilation of expectations and policies that they are required to comply with during their term. The Declaration of Adherence includes the conflict of interest policy which has definitions of what would constitute a conflict of interest.**

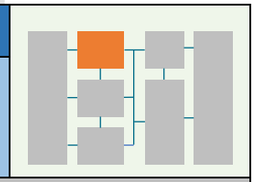
	i. the completed questionnaires are included as an appendix to each Council meeting package; ii. questionnaires include definitions of conflict of interest; iii. questionnaires include questions based on areas of risk for conflict of interest identified by Council that are specific to the profession and/or College; and iv. at the beginning of each Council meeting, members must declare any updates to their responses and any conflict of interest specific to the meeting agenda.	• The year when conflict of interest the questionnaire was updated: **2014** • Member(s) update his or her questionnaire at each Council meeting based on Council agenda items: **Council has a practice of asking members to verbally declare any conflicts of interest at the beginning of each Council meeting. The recording secretary documents any conflicts declared and the Chair and staff ensure that those Council members who have declared a conflict are not present for the agenda items with which they have a conflict. Those who have declared a conflict leave the meeting at the start of the agenda item and are notified to return once the item is over. Click here to see where conflicts are declared during Council meetings.**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		Additional comments for clarification (optional)
	d. Meeting materials for Council enable the public to clearly identify the public interest rationale (See Appendix A) and the evidence supporting a decision related to the College's strategic direction or regulatory processes and actions (e.g. the minutes include a link to a publicly available briefing note).	The College fulfills this requirement: **Yes**
		• Describe how the College makes public interest rationale for Council decisions accessible for the public: **Over the past year, CPSO has refreshed its briefing note templates for Council to include a field regarding public interest rationale. The briefing note also links the agenda item to CPSO's Strategic Plan. Click here for an example of how CPSO references a public interest rationale and its Strategic Plan. This practice is used for all decision items on a Council meeting agenda.** **Council minutes also include any relevant appendices (i.e. briefing notes or other relevant materials) that are used to support a decision related to the strategic direction or regulatory processes and actions.**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		Other examples of referencing public interest can be found in our policies. **Click here to see examples from September 2020 (p. 113, 115-116)** **Click here to see examples from March 2020 (p. 96-97, p. 158-160)**

Standard 3 **The College acts to foster public trust through transparency about decisions made and actions taken.**		
Measure	**Required evidence**	**College response**
3.1 Council decisions are transparent.	a. Council minutes (once approved) are clearly posted on the College's website. Attached to the minutes is a status update on implementation of Council decisions to date (e.g. indicate whether decisions have been implemented, and if not, the status of the implementation).	The College fulfills this requirement: **Yes** **Click here to access where Council minutes are posted once they are approved CPSO Council recently introduced a Status Update on Council Decisions, which accompanies the Council meeting minutes (i.e. beginning with the March 4-5, 2021 meeting). This provides an update regarding the implementation of Council's decisions from the previous meeting.** *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐* *Additional comments for clarification (optional)*
	b. The following information about Executive Committee meetings is clearly posted on the College's website (alternatively the College can post the approved minutes if it includes the following information). i. the meeting date; ii. the rationale for the meeting; iii. a report on discussions and decisions when Executive Committee acts as Council or discusses/deliberates on matters or materials that will be brought forward to or affect Council; and iv. if decisions will be ratified by Council.	The College fulfills this requirement: **Yes.** **Click here to see the Terms of Reference for the Executive Committee as well as the meetings that have been scheduled for the year. From time to time there may be ad hoc meetings to address time sensitive matters, for example timely Committee appointments to Statutory Committees so that they can carry out their work effectively. As outlined in our General By-Law, section 29(4), decisions that will be ratified by Council are generally required to be discussed with the Executive Committee first:** • **The council shall, and may only, consider, (a) at a special meeting, the matter for decision at the meeting contained in the requisition deposited with the registrar; (b) at a regular meeting, a motion made and seconded in writing, (i) on behalf of the executive committee; (ii) in a report by a committee which has received prior review by the executive committee; (iii) of which a notice of motion was given by a councillor at the preceding council meeting; or 17 (iv) which the councillors agree to consider by a two-thirds vote of those in attendance; and (c) at any meeting, routine and procedural motions in accordance with the rules of order.** **Thus, when matters such as policy reviews come to Council, they have been reviewed first by the Executive Committee. In situations where the Executive Committee has acted on behalf of Council, those decisions are communicated to Council members by email after the Executive Committee meeting. The Executive**

		Committee's decisions are made available again to Council and to the public in the Executive Report that is included in subsequent Council meeting materials. Click here to see an example of the Executive Committee Report (p. 21)
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		Additional comments for clarification (optional)
	c. Colleges that have a strategic plan and/or strategic objectives post them clearly on the College's website (where a College does not have a strategic plan, the activities or programs it plans to undertake).	The College fulfills this requirement: **Yes**
		Click here to access the Strategic Plan **The Registrar/CEO regularly provides updates on how CPSO is progressing against the strategic plan and the Key Performance Indicators. Beginning in 2021, the Council meeting materials were enhanced to clearly indicate which element of the strategic plan applied to a given agenda item. This enables management to think critically about each item that is brought to Council for discussion or decision; it also serves as a reminder to Council how each agenda item is contributing to CPSO's strategic priorities. Click here to see an example of how agenda items are linked to the Strategic Plan**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		Additional comments for clarification (optional)
3.2 Information provided by the College is accessible and timely.	a. Notice of Council meeting and relevant materials are posted at least one week in advance.	The College fulfills this requirement: **Yes Click here to see an example of a Notice of Meeting (posted 2.5 weeks in advance). In addition to posting the Notice of Meeting and Council meeting materials on CPSO's website at least one week in advance of the meeting, efforts are made to promote Council meetings to physicians and members of the public, using various social media channels.**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		Additional comments for clarification (optional)

	b. Notice of Discipline Hearings are posted at least one week in advance and materials are posted (e.g. allegations referred)	The College fulfills this requirement: **Yes. Notice of discipline hearings is posted approximately one month in advance at https://www.cpso.on.ca/News/Discipline-Hearings. The allegations referred, contained in the Notice of Hearing, are posted in the subject physician's profile, which can be searched at https://doctors.cpso.on.ca/.** *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ* *Additional comments for clarification (optional)*

DOMAIN 2: RESOURCES



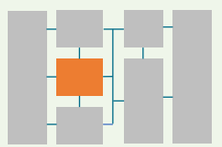
Standard 4

The College is a responsible steward of its (financial and human) resources.

Measure	Required evidence	College response
4.1 The College demonstrates responsible stewardship of its financial and human resources in achieving its statutory objectives and regulatory mandate.	a. The College's strategic plan (or, where a College does not have a strategic plan, the activities or programs it plans to undertake) has been costed and resources have been allocated accordingly. Further clarification: A College's strategic plan and budget should be designed to complement and support each other. To that end, budget allocation should depend on the activities or programs a College undertakes or identifies to achieve its goals. To do this, a College should have estimated the costs of	The College fulfills this requirement: **Yes** **Click here to access the 2021 annual budget approved by Council (p. 113) Budget allocations are made based on the projected work for the year in every area of the organization which is tied to the strategic plan.** *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ*

	each activity or program and the budget should be allocated accordingly.	*Additional comments for clarification (optional)*
	b. The College: i. has a "financial reserve policy" that sets out the level of reserves the College needs to build and maintain in order to meet its legislative requirements in case there are unexpected expenses and/or a reduction in revenue and furthermore, sets out the criteria for using the reserves; ii. possesses the level of reserve set out in its "financial reserve policy".	The College fulfills this requirement: **Yes. The Finance and Audit Committee regularly reviews the Reserve Fund Policy to ensure it is appropriate and makes recommendations to Council.**
		If applicable: **CPSO Council reviewed its Reserve Fund Policy in September 2020. Click here to view the policy (p. 43).** Has the financial reserve policy been validated by a financial auditor? **CPSO's Reserve Fund Policy was reviewed by a financial auditor.**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		Additional comments for clarification (optional)
	c. Council is accountable for the success and sustainability of the organization it governs. This includes ensuring that the organization has the workforce it needs to be successful now and, in the future (e.g. processes and procedures for succession planning, as well as current staffing levels to support College operations).	The College fulfills this requirement: **Yes.**
		Click here to access the annual budget approved by Council which incorporates the Human Resources Plan (p. 113). **During the budget process all, new FTEs are brought forward for approval with a business plan as part of the budget cycle. Due to ongoing process efficiencies and leveraging strategic enterprise solutions, no new human capital was requested in 2020/2021. Leadership leverages the annual performance review to discuss succession planning with managers, and senior leadership. Discussions are recorded in Ultipro (HR management system).**

		CPSO enhanced the succession planning within its Statutory and Standing Committees in 2020. Each Committee now has a Chair/Vice-Chair model which promotes stability and succession planning to ensure effective functioning of the Committee. In addition, a Mentoring Program was launched in the past year for all Committees to support the onboarding process as well as promote effective knowledge transfer between newer and seasoned Committee members.
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (optional)

DOMAIN 3: SYSTEM PARTNER	
Standard 5 **The College actively engages with other health regulatory Colleges and system partners to align oversight of the practice of the profession and support execution of its mandate.**	
Standard 6 **The College maintains cooperative and collaborative relationships to ensure it is responsive to changing public expectations.**	
Standard 7 **The College responds in a timely and effective manner to changing public expectations.**	

	College response
Measure / Required evidence: N/A	***Colleges are requested to provide a narrative that highlights their organization's best practices for each of the following three standards. An exhaustive list of interactions with every system partner the College engages is not required.*** ***Colleges may wish to provide Information that includes their key activities and outcomes for each best practice discussed with the ministry, or examples of system partnership that, while not specifically discussed, a College may wish to highlight as a result of that***

	dialogue. For the initial reporting cycle, information may be from the recent past, the reporting period, or is related to an ongoing activity (e.g., planned outcomes).
The three standards under this domain are not assessed based on measures and evidence like other domains, as there is no 'best practice' regarding the execution of these three standards. Instead, Colleges will report on key activities, outcomes, and next steps that have emerged through a dialogue with the Ministry of Health. Beyond discussing what Colleges have done, the dialogue might also identify other potential areas for alignment with other Colleges and system partners. **In preparation for their meetings with the ministry, Colleges have been asked to submit the following information:** • **Colleges should consider the questions pertaining to each standard and identify examples of initiatives and projects undertaken during the reporting period that demonstrate the three standards, and the dates on which these initiatives were undertaken.**	**Standard 5: The College actively engages with other health regulatory colleges and system partners to align oversight of the practice of the profession and support execution of its mandate.** Recognizing that a College determines entry to practice for the profession it governs, and that it sets ongoing standards of practice within a health system where the profession it regulates has multiple layers of oversight (e.g. by employers, different legislation, etc.), Standard 5 captures how the College works with other health regulatory colleges and other system partners to support and strengthen alignment of practice expectations, discipline processes, and quality improvement across all parts of the health system where the profession practices. In particular, a College is asked to report on: • *How it has engaged other health regulatory Colleges and other system partners to strengthen the execution of its oversight mandate and aligned practice expectations? Please provide details of initiatives undertaken, how engagement has shaped the outcome of the policy/program and identify the specific changes implemented at the College (e.g. joint standards of practice, common expectations in workplace settings, communications, policies, guidance, website etc.).* **System Collaboration is one of the five elements of CPSO's Strategic Plan. To achieve system collaboration, CPSO will continue to develop open and collaborative relationships that support a connected health system and promote interprofessional collaboration and share best practices.** **CPSO collaborates frequently with other health regulatory Colleges through the Health Profession Regulators of Ontario (HPRO), which is the collective group of health regulatory colleges across the province. Over the past year, we have been an active contributor through their regular meetings as well as through various working groups that addressed common issues such as Governance, Communications and Anti-BIPOC Racism. Where possible, opportunities to leverage existing efforts underway are explored and CPSO is often sharing resources and practices with and learning from other Colleges in an effort to achieve consistency in our regulatory function.** **All policy reviews including a jurisdictional scan looking at alignment with other health/medical regulatory authorities as appropriate. For example, the Delegation of Controlled Acts policy review included a review of other HPRO Colleges positions on delegation to promote alignment and consistency where possible. Particular efforts were made to work with the College of Nurses of Ontario to align as much as possible given the close working relationship between nurses/physicians. Click here to see an example (p. 114 footnote 1)** **CPSO administers and is the Chair of the Citizen Advisory Group, which is a partnership among 18 colleges and serves as a forum to consult with patients and public about various issues that the colleges are facing. The Citizen Advisory Group is consulted frequently on a variety of issues where the public voice would add tremendous value, an example from last year includes a symposium on virtual care that was hosted in October 2020 and included both physicians and patients. The feedback received directly influenced the initial work to review and update CPSO's policy on Telemedicine.**

<table>
<tr><td></td><td colspan="2">Initiated through the Health Profession Regulators of Ontario, CPSO engaged in some conversations with the Financial Services Regulatory Authority, which is an independent regulatory agency created to improve consumer and pension plan beneficiary protections in Ontario. Based on our early discussions, we identified a better way to communicate with them regarding findings against physicians who may be carrying out work for FSRA so that they are aware and can take appropriate measures to ensure protection of the public. The collaboration with FSRA is an example of how CPSO is identifying opportunities to achieve greater coordination between health care and other sectors where there may be common objectives to serve in the public interest.</td></tr>
<tr><td></td><td>Standard 6: The College maintains cooperative and collaborative relationships to ensure it is responsive to changing public/societal expectations.

The intent of standard 6 is to demonstrate that a College has formed the necessary relationships with system partners to ensure that it receives and contributes information about relevant changes to public expectations. This could include both relationships where the College is “pushed” information by system partners, or where the College proactively seeks information in a timely manner.

• Please provide some examples of partners the College regularly interacts with including patients/public and how the College leverages those relationships to ensure it can respond to changing public/societal expectations.
• In addition to the partners it regularly interacts with, the College is asked to include information about how it identifies relevant system partners, maintains relationships so that the College is able access relevant information from partners in a timely manner, and leverages the information obtained to respond (specific examples of when and how a College responded is requested in standard 7).

Below are some key examples of how CPSO works with health system stakeholders to respond to changing public expectations. While not an exhaustive list, a few different examples are included to highlight the breadth of organizations with whom CPSO engages.

Black Physicians’ Association of Ontario: Ongoing collaborative relationship to identify opportunities for targeted outreach so that that underrepresented groups can get engaged in CPSO’s work and that we are considering issues that are important to our common members</td><td>Standard 7: The College responds in a timely and effective manner to changing public expectations.

Standard 7 highlights successful achievements of when a College leveraged the system partner relationships outlined in Standard 6 to implement changes to College policies, programs, standards etc., demonstrating how the College responded to changing public expectations in a timely manner.

• How has the College responded to changing public expectations over the reporting period and how has this shaped the outcome of a College policy/program? How did the College engage the public/patients to inform changes to the relevant policy/program? (e.g. Instances where the College has taken the lead in strengthening interprofessional collaboration to improve patient experience, examples of how the College has signaled professional obligations and/or learning opportunities with respect to the treatment of opioid addictions, etc.).
• The College is asked to provide an example(s) of key successes and achievements from the reporting year.

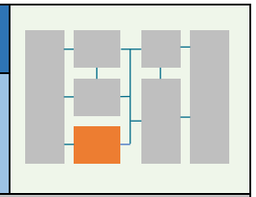
Meaningful Engagement is one of the five elements of CPSO’s Strategic Plan. To achieve meaningful engagement, CPSO will purposefully involve patients, the public and physicians to inform College decisions; and build awareness of our role, mandate and processes through clear and accessible information.

Below are some key examples of how CPSO is responsive to the evolving needs of the public. While not an exhaustive list, a few different examples are included to highlight the various strategies used.</td></tr>
</table>

	Indigenous Physicians Association of Canada: Ongoing collaborative relationship to identify opportunities for targeted outreach so that that underrepresented groups can get engaged in CPSO's work and that we are considering issues that are important to our common members **Ministry of Health: Foster positive relationships with various areas within the Ministry of Health to improve patient safety; recent examples include collaboration on Covid-19 response to ensure sufficient physician resources** **Minister's Office: Foster positive relationships with the Minister's Office; recent examples of collaboration include discussions pertaining to Physician Assistant regulation** **Nishnawbe Aski Nation: Initial discussions with Nishnawbe Aski Nation to identify concrete opportunities to better serve patients living in Indigenous communities** **Ontario Medical Association: Ongoing collaborative relationship to discuss issues of mutual interest given our common members; examples of collaboration last year include Covid-19 response, engagement in CPSO policy consultations, CPSO/OMA Task Force and Diversity, Equity and Inclusion work** **Ontario College of Family Physicians: Ongoing collaborative relationship to discuss issues of mutual interest given our common members; recent examples of collaboration include improved engagement in policy consultations** **Ontario College of Pharmacists: Ongoing collaborative relationship to discuss and ensure alignment throughout the COVID 19 pandemic on issues such as infection control (patients COVID 19 positive coming into pharmacies to pick up prescriptions; vaccine rollout and administration etc.)** **Ontario Hospital Association: Ongoing collaborative relationship to discuss issues of mutual interest given our members provide care within hospitals across the province; examples of collaboration last year include raised awareness of CPSO Quality Improvement Partnership which supports system collaboration and promotes right-touch regulation**	**The Citizen Advisory Group is a valuable resource that assists CPSO in responding to changing public expectations or emerging trends in a nimble and timely manner. As mentioned previously, consultations with the Citizen Advisory Group provide a direct line of sight into patient perspectives; this type of engagement provides rich information that informs policy development and other initiatives for CPSO and other Colleges.** **In February, CPSO conducted a focus group to discuss the draft policy on Complementary/Alternative Medicine.** **In May, CPSO conducted a focus group to discuss COVID-19 which also included 14 partner Colleges.** **Last year, CPSO co-designed a Continuity of Care Guide for Patients and Caregivers with members of the Citizen Advisory Group to reflect their perspectives on how patients can get engaged in their care and improve patient experience. The development of this resource was informed by multiple engagements with the Citizen Advisory Group (i.e. April/May/October) using various formats (i.e. focus groups, online survey).** **In January 2021, CPSO consulted with the Citizen Advisory Group regarding the importance of diversity among Council members; feedback was incorporated as part of the development of a Council Profile. Having a more diverse Council will enable CPSO to better capture the various perspectives of the public that we serve and will ultimately result in more effective regulation of the medical profession.** **From time to time, public polling is also conducted which provides a representative sample of Ontarians and their perspective son a given issue. CPSO engaged in two public polling initiatives in February 2020: Medical Education and Complementary/Alternative Medicine (representative sample of 800 Ontarians), Awareness and Reputational metrics (representative sample of 800 Ontarians). The polling results directly inform the policy development process.**

	Ontario Health: Ongoing collaborative relationship to ensure consistency regarding system wide health care issues (virtual care, etc) **Ontario Medical Students Association: CPSO Council regularly includes a representative from the Ontario Medical Students Association at its Council meetings to engage medical learners in conversations about the regulation of physicians in Ontario** **Patient and Family Advisory Councils: CPSO maintains positive relationships with various Patient and Family Advisory Councils across the province to gather input from patients, families and caregivers to inform key policies and initiatives** **Patient Ombudsman: CPSO and the Office of the Patient Ombudsman share a common mandate in serving the public interest; initiated discussions to explore opportunities to collaborate where appropriate** **Professional Association of Residents of Ontario: CPSO Council regularly includes a representative from the Professional Association of Residents of Ontario at its Council meetings to engage residents in conversations about the regulation of physicians in Ontario** **Rainbow Health Ontario: CPSO initiated discussions to explore how we can better serve LBTQ2S communities; we are developing an ongoing relationship with them as well as physicians involved in the care of LGBTQ2S patients** **Various Community Organizations: CPSO liaises with various community organizations to ensure their perspectives are considered when developing or implementing policies and other key initiatives; examples include Alliance for Healthier Communities** **Various Medical Education Institutions: CPSO maintains effective relationships with the various medical schools in Ontario to engage medical education providers in conversations about the regulation of physicians in Ontario**	**During the Covid-19 response, CPSO worked closely with government to provide and clarify information to assist with the province's response to the pandemic; CPSO was a critical source of information for physicians and many patients who were looking for guidance around what to expect regarding their care; CPSO continuously adapted to public expectations and provided the most current information to patients through the website. CPSO's responses to the FAQs were informed by feedback/needs assessment done with the Citizen Advisory Group.** **CPSO uses information gathered through its Patient Help Centre to understand where there could be gaps or challenges with respect to physician practice; this information is used to inform the review and development processes for policies, standards and strategic initiatives.**

DOMAIN 4: INFORMATION MANAGEMENT

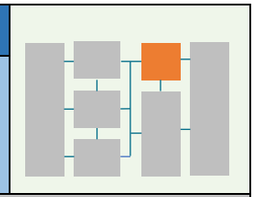


Standard 8

Information collected by the College is protected from unauthorized disclosure.

Measure	Required evidence	College response
8.1 The College demonstrates how it protects against unauthorized disclosure of information.	a. The College has and uses policies and processes to govern the collection, use, disclosure, and protection of information that is of a personal (both health and non-health) or sensitive nature that it holds	The College fulfills this requirement: **Yes**
		The approach of the CPSO to protect against unauthorized disclosure of information is multi-faceted, incorporating hardware, software and policy solutions. A summary of this approach including the policies and processes used to govern our information is summarized in the following document and was provided to the CPSO's Finance and Audit Committee in February 2021. Click here to access the summary of CPSO's approach.
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		Additional comments for clarification (optional)

DOMAIN 5: REGULATORY POLICIES



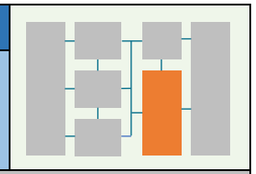
Standard 9

Policies, standards of practice, and practice guidelines are based in the best available evidence, reflect current best practices, are aligned with changing public expectations, and where appropriate aligned with other Colleges.

Measure	Required evidence	College response
9.1 All policies, standards of practice, and practice guidelines are up to date and relevant to the current practice environment (e.g. where appropriate, reflective of changing population health needs, public/societal expectations, models of care, clinical evidence, advances in technology).	a. The College has processes in place for evaluating its policies, standards of practice, and practice guidelines to determine whether they are appropriate, or require revisions, or if new direction or guidance is required based on the current practice environment.	The College fulfills this requirement: **Yes** • Insert a link to document(s) that outline how the College evaluates its policies, standards of practice, and practice guidelines to ensure they are up to date and relevant to the current practice environment ***OR*** describe in a few words the College's evaluation process (e.g. what triggers an evaluation, what steps are being taken, which stakeholders are being engaged in the evaluation and how). **CPSO policies are regularly reviewed and updated to ensure they are current. Generally, CPSO aims to initiate the review process for each policy every 5 years, with adjustments given changing priorities or areas of risk. CPSO Council receives a report at each meeting providing an update on the review status of all policies (see the Policy Report in the December 2020 Council materials as an example).** **The review process is multi-staged. Once a policy review is launched, a comprehensive literature review (including jurisdictional scan) is completed along with an analysis of any available data regarding complaints, investigations, or discipline findings. An external consultation is conducted giving all stakeholders, all physicians, and all members of the public an opportunity to provide feedback and inform the process. The consultation process involves broad and targeted announcements or direct invitations to participate via an internal database of interested parties. Regularly patient engagement activities are undertaken at this point as well. The research and feedback inform the development of a draft policy, which is then circulated for external consultation again. Revisions may then be made in response to feedback before receiving final approval from CPSO Council. All of this work is undertaken with the assistance of a Policy Review Working Group comprised of physician and public members of Council and CPSO staff.** *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐*

		Additional comments for clarification (optional)
	b. Provide information on when policies, standards, and practice guidelines have been newly developed or updated, and demonstrate how the College took into account the following components: i. evidence and data, ii. the risk posed to patients / the public, iii. the current practice environment, iv. alignment with other health regulatory Colleges (where appropriate, for example where practice matters overlap) v. expectations of the public, and vi. stakeholder views and feedback.	The College fulfills this requirement: **Yes**
		• For two recent new policies or amendments, either insert a link to document(s) that demonstrate how those components were taken into account in developing or amending the respective policy, standard or practice guideline (including with whom it engaged and how) ***OR*** describe it in a few words. **All CPSO draft policies must be approved by Council prior to external consultation and all revised policies must be approved by Council prior to becoming a policy of CPSO. Each decision point is supported by the development of a comprehensive briefing note highlighting the various factors considered for the key policy changes being proposed.** **Advertising: A new draft *Advertising* policy was developed in 2020 in response to an evolving practice environment, stakeholder feedback, and changing public attitudes. The briefing notes at each stage outline how this information was relied upon to inform the proposed revisions (Draft stage pg. 157; Final Approval, pg. 273)** **Medical Records: Significant updates to our Medical Records policies were made to address changing practice environments, to address issues emerging from the widespread adoption of EMRs, and to support patient access to their records in response to concerns raised externally and internally (Final Approval; pg. 94)**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		Additional comments for clarification (optional)

DOMAIN 6: SUITABILITY TO PRACTICE



Standard 10

The College has processes and procedures in place to assess the competency, safety, and ethics of the people it registers.

Measure	Required evidence	College response
10.1 Applicants meet all College requirements before they are able to practice.	a. Processes are in place to ensure that only those who meet the registration requirements receive a certificate to practice (e.g., how it operationalizes the registration of members, including the review and validation of submitted documentation to detect fraudulent documents, confirmation of information from supervisors, etc.)[3].	The College fulfills this requirement: **Yes.** **Requirements are set out in the Registration Regulation, in Policy, and in operations as processes/requirements set out as best practices in credentialing and assessment/source verification and complex credentialing. The CPSO are leaders in the complex assessment of qualifications.** **The purpose of assessment of qualifications is to establish authenticity. Complex Credentialing is the process of obtaining, verifying, and assessing qualifications. Credentials are documented evidence of licensure, education, training, experience, or other qualifications. Complex Credentialing cross references all of the documentation presenting as part of the application process to ensure:** • **consistency in information reported;** • **Validity of qualifications; and** • **completeness of record.** **Third party source documents are required from the source. We confirm validity of the source documents accessing our robust reference materials, performing a Quality Assurance check re-confirming the authenticity of the document directly with the third party.** **A variety of tools we utilize in assessing supporting documents sent by third party organizations vary depending on mode of receipt but includes: password protected documents sent from official institutions, documents sent through an email address verifiable through the organization's website, official sealed and stamped envelope from the source organization. Courier delivery is acceptable but documents inside the courier package must be in an official envelope that has been sealed by the source organization, verifying sender's address through organization's website, and our reference database.**

[3] This measure is intended to demonstrate how a College ensures an applicant meets every registration requirement set out in its registration regulation prior to engaging in the full scope of practice allowed under any certificate of registration, including whether an applicant is eligible to be granted an exemption from a particular requirement.

	b. The College periodically reviews its criteria and processes for determining whether an applicant meets its registration requirements, against best practices (e.g. how a College determines language proficiency).	The College fulfills this requirement: **Yes**
		• Insert a link that outlines the policies or processes in place for identifying best practices to assess whether an applicant meets registration requirements (e.g. how to assess English proficiency, suitability to practice etc.), link to Council meeting materials where these have been discussed and decided upon ***OR*** describe in a few words the process and checks that are carried out. • Provide the date when the criteria to assess registration requirements was last reviewed and updated. **Council recently reviewed Registration requirements at one of its meetings in 2020 and the relevant materials are accessible here**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		We form part of the Federation of Medical Regulatory Authorities of Canada (FMRAC) of which there is a registration specific special interest working group that meets to discuss, establish and review the registration landscape across Canada. **Additionally, each existing registration policy is regularly reviewed through a formalized multi-staged process.** **Finally, CPSO is subject to annual review by way of a Fair Registration Practices report from the Office of the Fairness Commissioner.**
		The College fulfills this requirement: **Yes**

10.2 Registrants continuously demonstrate they are competent and practice safely and ethically.	a. Checks are carried out to ensure that currency [4] and other ongoing requirements are continually met (e.g., good character, etc.).	• Insert a link to the regulation and/or internal policy document outlining how checks are carried out and what the currency and other requirements include, link to Council meeting materials where documents are found and have been discussed and decided upon ***OR*** provide a brief overview: • List the experts / stakeholders who were consulted on currency: • Identify the date when currency requirements were last reviewed and updated: • Describe how the College monitors that registrants meet currency requirements (e.g. self-declaration, audits, random audit etc.) and how frequently this is done.
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		In 2018, the College's Policy "Ensuring Competence: Changing Scope of Practice and /or Re-entering Practice" was revised and approved by Council. This policy sets out the College's expectations regarding scope of practice and defines currency of practice as being engaged in clinical practice or where scope is concerned a particular scope of practice in the proceeding 2 years. **Link: https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Ensuring-Competence** **Additionally the Quality Assurance Regulation https://www.ontario.ca/laws/regulation/940114#BK3 sets out the requirement of all members to participate in a program of continuing professional development (CPD) that includes a self-assessment component and that meets the requirements for continuing professional development. This requirement is captured in our annual membership renewal survey.** **Questions in the annual membership renewal survey help to determine whether members continually meet their membership requirements, including good character, etc.**
		The College fulfills this requirement: **Yes**

[4] A 'currency requirement' is a requirement for recent experience that demonstrates that a member's skills or related work experience is up-to-date. In the context of this measure, only those currency requirements assessed as part of registration processes are included (e.g. during renewal of a certificate of registration, or at any other time).

10.3 Registration practices are transparent, objective, impartial, and fair.	a. The College addressed all recommendations, actions for improvement and next steps from its most recent Audit by the Office of the Fairness Commissioner (OFC).	• Insert a link to the most recent assessment report by the OFC ***OR*** provide summary of outcome assessment report: **https://www.fairnesscommissioner.ca/en/Professions_and_Trades/Pages/Registration-Practices-Assessment-Report-2016---CPSO.aspx** • Where an action plan was issued, is it: Completed ☐ In Progress ☐ Not Started ☐ **No Action Plan Issued** ☐ *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐* *Additional comments for clarification (if needed)*

Standard 11

The College ensures the continued competence of all active registrants through its Quality Assurance processes. This includes an assessment of their competency, professionalism, ethical practice, and quality of care.

Measure	Required evidence	College response
11.1 The College supports registrants in applying the (new/revised) standards of practice and practice guidelines applicable to their practice.	a. Provide examples of how the College assists registrants in implementing required changes to standards of practice or practice guidelines (beyond communicating the existence of new standard, FAQs, or supporting documents).	The College fulfills this requirement: **Yes** • Provide a brief description of a recent example of how the College has assisted its registrants in the uptake of a new or amended standard: – Name of Standard – Duration of period that support was provided – Activities undertaken to support registrants – % of registrants reached/participated by each activity – Evaluation conducted on effectiveness of support provided • Does the College always provide this level of support: **Yes** *If not, please provide a brief explanation:* **Quality Care is one of the five components of CPSO's Strategic Plan. To achieve quality care, CPSO will use evidence to evaluate risk and address the greatest concerns for patient care; guide and support doctors throughout their careers; and respond to emerging trends and new technologies.**

		Each time a policy is updated, an announcement is made through CPSO's quarterly magazine *Dialogue* introducing the update and highlighting key changes. Additional announcements are made via email communication to the entire membership aimed at informing them of decisions made at Council meetings. CPSO policies are also regularly supported by companion *Advice to the Profession* resources that provide answers to frequently asked questions and identify some best practices. **Click here to access the Dialogue article regarding the newly approved Advertising Policy** **Click here to access the Advice to the Profession for the Medical Records Documentation Policy** **CPSO has a Physician Advisory Service that provides assistance to physicians regarding a variety of issues, including but not limited to: general practice issues, assistance in managing challenging situations, clarification of CPSO policies or government legislation and annual renewal, including clarification and/or guidance about specific questions, and help with various technical questions or issues. This service is available to physicians year-round and can be connected with trained and knowledgeable staff who can support them with implementing any required changes to standards of practice or practice guidelines.** *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐* *Additional comments for clarification (optional)*
11.2 The College effectively administers the assessment component(s) of its QA	a. The College has processes and policies in place outlining: i. how areas of practice that are evaluated in QA assessments are identified in order to ensure the most impact on the quality of a registrant's practice; ii. details of how the College uses a right touch, evidence informed approach to	The College fulfills this requirement: **Yes** • List the College's priority areas of focus for QA assessment and briefly describe how they have been identified ***OR*** link to website where this information can be found: **Right Touch Regulation is one of the five components of CPSO's Strategic Plan. To achieve right touch regulation, CPSO will apply a proportionate, consistent, targeted, transparent, accountable and agile approach to all aspects of medical regulation; work with government to align right touch regulation; continually measure, monitor and report on our progress towards more effective regulation.**

Program in a manner that is aligned with right touch regulation[5].	determine which registrants will undergo an assessment activity (and which type if multiple assessment activities); and iii. criteria that will inform the remediation activities a registrant must undergo based on the QA assessment, where necessary.	**In addition to the CPSO's QA Peer Assessment Program, we have recently implemented a Quality Improvement Program option for members. The goal is for every member to go through the QI program once every 5 years. Members who participate in the QI program are exempted from the QA peer assessment. There are 3 streams for the QI program: Individual members; Groups of physicians (e.g. Family Health Teams); and Partnerships with Hospitals.** **Members are asked to complete a number of tools aimed at evaluating their practice and then to identify practice improvement plans for their practice. QI coaches (physicians) evaluate the submission and offer coaching to those registrants who require support.** **Information about the new QI program can be found on the CPSO's webiste.** **All information regarding our Quality Peer Assessment program is available on CPSO's website and includes the peer assessment process as well as the assessment tools that are used so that the subject physician understands the process. In addition, this information is provided again to the subject physician when their notification package is sent out.** **The assessment tools are designed to be:** • **Discipline-specific (define quality from their discipline perspective; decide on evaluation criteria and define quality improvement priorities for their discipline; create appropriate quality improvement resources).** • **Purpose-driven (align the peer assessment program with its purpose to "promote continuous quality improvement by providing physicians with feedback to validate appropriate care and show opportunities for practice improvement")** • **Consistent (ensure consistency in assessor decision-making with well described assessment procedures (e.g., patient record selection) and use of a psychometrically sound measure of assessor agreement).** • **Transparent (make publicly available how the peer assessment defines, evaluates and seeks to improve "quality", i.e. post on CPSO website. Seek feedback from physician groups on the peer assessment content prior to finalization).** • **Relevant (link peer assessment to other quality initiatives (e.g., "Choosing Wisely" campaign; development of a provincial approach to diagnostic imaging peer review)).** • Is the process taken above for identifying priority areas codified in a policy: **No**

[5] "Right touch" regulation is an approach to regulatory oversight that applies the minimal amount of regulatory force required to achieve a desired outcome. (Professional Standards Authority. Right Touch Regulation. https://www.professionalstandards.org.uk/publications/right-touch-regulation).

		• Insert a link to document(s) outlining details of right touch approach and evidence used (e.g. data, literature, expert panel) to inform assessment approach ***OR*** describe right touch approach and evidence used: **Information to be provided** • Provide the year the right touch approach was implemented ***OR*** when it was evaluated/updated (if applicable): **Right Touch Regulation was included in CPSO's Strategic Plan which was implemented in early 2019 and is being operationalized across the organization. Engagement activities have been conducted on the new QI program extensively with our registrants and other stakeholders like the Ontario Medical Association, Ontario Hospital Association and College of Family Medicine** *If evaluated/updated, did the college engage the following stakeholders in the evaluation:* – *Public* ***No*** – *Employers* ***N/A*** – *Registrants* ***Yes*** – *other stakeholders* ***Yes*** Insert link to document that outlines criteria to inform remediation activities ***OR*** list criteria: **Registrants are provided an opportunity to address the Quality Assurance Committee prior to a final decision being rendered. There are 3 different ways that a member can address the Committee.** **1. Opportunity to Address – Written - This provides the member an opportunity to respond by writing to the Committee to address any of the deficiencies and provide examples of how those changes have been made. The member also has access to a CPSO Medical Advisor, if requested to assist with the written response.** **2. Opportunity to Address with a Medical Advisor – This is something that was initiated in 2019 and provide the member the opportunity to address the issues identified within the assessment report and provide a summary report which is agreed to by the member and forwarded to the QA Committee. This one-on-one approach has worked well since it has been implemented.** **3. Opportunity to Address In-Person – The Quality Assurance Committee can request that a member attend in front of the panel, in-person to address the deficiencies within the report. In 2020, the Quality Assurance Committee has moved away from this option since the introduction of the Medical Advisor role, which serves that function.**

		Additional comments for clarification (optional)
11.3The College effectively remediates and monitors registrants who demonstrate unsatisfactory knowledge, skills, and judgment.	a. The College tracks the results of remediation activities a registrant is directed to undertake as part of its QA Program and assesses whether the registrant subsequently demonstrates the required knowledge, skill and judgement while practising.	The College fulfills this requirement: **Yes** **The Quality Assurance Committee can request the member undergo a peer and practice reassessment that focuses on the areas of concern to ensure that the member has fulfilled the requirements. This is based on their response to the Opportunity to Address (OTA) avenues described above. These peer and practice reassessments happen within 12 months following the QAC decision.** **If there are clinical concerns identified following the OTA process and/or the physician has no insight to the deficiencies the QAC has the power under section 80.2 to resolve the matter via SCERP (Specified Continuous Educational Remediation Program). The SCERP is monitored by the College's Compliance Monitoring and Supervision area. Compliance will notify the QAC when the SCERP elements have been successfully completed and returns the matter to the QAC for a reassessment to ensure that the remediation plan has been successful.** **If the member wishes to resolve the matter by way of an Educational Undertaking, this undertaking is also monitored by the College's Compliance Monitoring and Supervision department. The Individual Education Plan is developed in consultation with the QAC which is attached as part of the Undertaking. In these situations, the reassessment is completed by the Compliance Monitoring and Supervision department. Outcomes of the reassessment are not conveyed to the QAC as these matters remain outside of the QAC "black box" of information.** • Insert a link to the College's process for determining whether a registrant has demonstrated the knowledge, skills and judgement following remediation ***OR*** describe the process: **https://www.cpso.on.ca/Physicians/Your-Practice/Quality-Management/Assessments/Peer-Assessment SCERP and Educational Undertakings are public information and placed on the CPSO website, under the physician's name. These are updated once a member has successfully completed their SCERP and the Educational Undertaking.** *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ* *Additional comments for clarification (if needed)*

Standard 12 **The complaints process is accessible and supportive.**		
Measure	**Required evidence**	**College response**
12.1The College enables and supports anyone who raises a concern about a registrant.	a. The different stages of the complaints process and all relevant supports available to complainants are clearly communicated and set out on the College's website and are communicated directly to complainants who are engaged in the complaints process, including what a complainant can expect at each stage and the supports available to them (e.g. funding for sexual abuse therapy).	The College fulfills this requirement: **Yes**
		• Does the College have policies and procedures in place to ensure that all relevant information is received during intake and at each stage of the complaints process: **Yes** • Does the College evaluate whether the information provided is clear and useful: **Yes** **A link to the complaints process can be accessed here.**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		While CPSO is meeting the requirements as described by the Ministry of Health, we are aware that there are equity seeking groups who feel that the complaints process is not accessible to them and does not provide a safe mechanism by which to raise their concerns. For example, there are many reports indicating that complaints processes need to be made accessible and safe for Indigenous people. **The FMRAC Working Group on anti-racism has specifically called on Medical Regulatory Authorities to examine complaints processes via an anti-racist lens. Similar experiences are often had by patients from Black communities, people of colour, and those identifying as LGBTQ2S. CPSO has begun to examine how it can better apply a diversity, equity and inclusion lens as well as anti-racism praxis to its various functions, policies and processes, including the complaints process. A Diversity, Equity and Inclusion Lead has been appointed to oversee this work across the organisation and we are also engaging with external experts. E.g. San'yas Indigenous Cultural Safety training for all staff.**
	b. The College responds to 90% of inquiries from the public within 5 business days, with follow-up timelines as necessary.	The College fulfills this requirement: **Yes.**
		The CPSO responds to inquiries from the public within 5 business days 97.7% of the time.

		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		Additional comments for clarification (optional)
	c. Examples of the activities the College has undertaken in supporting the public during the complaints process.	• List all the support available for public during complaints process: **Support available to the public during the complaints process includes:** • **Access to an assigned mediator or investigator throughout the entire process; able to communicate via email, telephone or Canada Post** • **Details of the complaints process on the CPSO website, including how to make a complaint, what to expect, consent and common Q&A** • **Concerns of the complainant are discussed and confirmed by the mediator/investigator at the initiation of the mediation/investigation** • **Language translation services are available; either in the moment through a translation service or by sending documents out for translation** • Most frequently provided supports in CY 2020: **Direct connection with a mediator/investigator for information or support throughout the process**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		Additional comments for clarification (optional)
12.2 All parties to a complaint and discipline process are kept up to date on the progress of their case, and complainants are supported to participate effectively in the process.	a. Provide details about how the College ensures that all parties are regularly updated on the progress of their complaint or discipline case and are supported to participate in the process.	The College fulfills this requirement: **Yes**
		• Insert a link to document(s) outlining how all parties will be kept up to date and support available at the various stages of the process ***OR*** provide a brief description: **An intake investigator contacts the complainant within 2 business days of receiving a public complaint; the intake investigator assesses the complaint for risk, reviews the complaints process with the complainant, explores the intention of their complaint and confirms their concerns. The intake investigator will identify cases appropriate for ADR; these cases are streamed to a mediator** **Within a week, the case is assigned to either a mediator or investigator who will contact the complainant to review the details of the complaint and to ensure all appropriate consents are on file**

		During an investigation, the complainant is kept up to date by the investigator every 3-4 weeks on the status of their complaint **The complainant is contacted when the investigation has been listed for ICRC review** **The complainant is sent a copy of the ICRC decision immediately upon release, which is usually within 6 weeks** **Once a matter is referred to discipline, the Witness Support Coordinator establishes and maintains regular contact with witnesses to assists in the coordination of scheduling witnesses for hearings and to provide direct support to those testifying at a hearing** **The Witness Support coordinator will follow up with witnesses regarding the outcome and decisions of the Discipline Committee; provide updates and involve witnesses in penalty hearings; provide some guidance and structure for witness impact statements if required**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		Additional comments for clarification (optional)

Standard 13

All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.

Measure	Required evidence	College response
13.1The College addresses complaints in a right touch manner.	a. The College has accessible, up-to-date, documented guidance setting out the framework for assessing risk and acting on complaints, including the prioritization of investigations, complaints, and reports (e.g.	The College fulfills this requirement: **Yes** • Insert a link to guidance document ***OR*** describe briefly the framework and how it is being applied: **Intake investigators assess each public complaint for risk by considering the following (the guide document is in the form a decision tree and a step by step process):** • **Patient safety/public interest**

	risk matrix, decision matrix/tree, triage protocol).	• **Physician's history with the CPSO, including registration status; previous investigations & outcomes** • **Isolated report vs. multiple sources with similar information** • **Another trusted organization is already investigating** • **Requirements of a public complaint met (e.g. concerns are regarding a physician)** • **Direction provided to investigations regarding decision making supports** • **Checks & balances in place when closing a file without an investigation (investigator -> manager -> registrar/delegate)** **Triage team assesses all incoming *reports* for risk and appropriate action, using the principles of right touch regulation** • Provide the year when it was implemented ***OR*** evaluated/updated (if applicable): **The decision tree guide document for assessing a public complaint was updated in February 2020** **The guide for risk assessment of reports used by the triage team was updated in March 2020**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		Right Touch Regulation is one of the five components of CPSO's Strategic Plan. To achieve right touch regulation, CPSO will apply a proportionate, consistent, targeted, transparent, accountable and agile approach to all aspects of medical regulation; work with government to align right touch regulation; continually measure, monitor and report on our progress towards more effective regulation.
Standard 14 **The College complaints process is coordinated and integrated.**		
Measure	**Required evidence**	**College response**
		The College fulfills this requirement: **Yes**

14.1 The College demonstrates that it shares concerns about a registrant with other relevant regulators and external system partners (e.g. law enforcement, government, etc.).	a. The College's policy outlining consistent criteria for disclosure and examples of the general circumstances and type of information that has been shared between the College and other relevant system partners, within the legal framework, about concerns with individuals and any results.	• Insert a link to policy ***OR*** describe briefly the policy: **Information to be provided** • Provide an overview of whom the College has shared information over the past year and purpose of sharing that information (i.e. general sectors of system partner, such as 'hospital', or 'long-term care home'). **Information to be provided** *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ* *Additional comments for clarification (if needed)*

DOMAIN 7: MEASUREMENT, REPORTING, AND IMPROVEMENT

Standard 15

The College monitors, reports on, and improves its performance.

Measure	Required evidence	College response
15.1 Council uses Key Performance Indicators (KPIs) in tracking and reviewing the College's performance and regularly reviews internal and external risks that could impact the College's performance.	a. Outline the College's KPI's, including a clear rationale for why each is important.	The College fulfills this requirement: **Yes** • Insert a link to document that list College's KPIs with an explanation for why these KPIs have been selected (including what the results the respective KPIs tells, and how it relates to the College meeting its strategic objectives and is therefore relevant to track), link to Council meeting materials where this information is included ***OR*** list KPIs and rationale for selection: **CPSO's initial set of Key Performance Indicators were discussed and approved by Council in December 2019 to accompany its Strategic Plan for 2020-2025. The Key Performance Indicators were selected based on how meaningful and relevant they were to the strategic plan and leveraging information that can be collected and monitored in a feasible and timely manner. CPSO successfully met its targets in 2020 and Council discussed and approved a new set of Key Performance Indicators for 2021. Click here to view the relevant Council materials (p. 157-171)**

		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		Continuous Improvement is one of the five elements of CPSO's Strategic Plan. To achieve continuous improvement, CPSO will foster a culture of continuous improvement and openness to change; and modernize all aspects of our work to fulfill our mission. Over the past year, staff have been completing training in the LEAN methodology so that it can be applied across all areas of the organization.
	b. Council uses performance and risk information to regularly assess the College's progress against stated strategic objectives and regulatory outcomes.	The College fulfills this requirement: **Yes**
		• Insert a link to last year's Council meetings materials where Council discussed the College's progress against stated strategic objectives, regulatory outcomes and risks that may impact the College's ability to meet its objectives and the corresponding meeting minutes: **CPSO publishes an annual report that highlights its accomplishments and its performance against its Strategic Plan. Click here to see the 2019 Annual Report. CPSO's Key Performance Indicators are presented quarterly to Council by the Registrar. Click here to access the presentation from December 2020 Council meeting where Key Performance Indicators were discussed.**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		Additional comments for clarification (if needed)
15.2 Council directs action in response to College performance on its KPIs and risk reviews.	a. Where relevant, demonstrate how performance and risk review findings have translated into improvement activities.	The College fulfills this requirement: **Yes**
		CPSO applies the LEAN methodology to its work in an effort to continuously improve and gain efficiencies. Below are two examples where the CPSO's assessment of its performance against the Key Performance Indicators resulted in improvement activities that were approved by Council: • **Approval of QI program in relation to strategic plan (p. 30)** • **Changes to Discipline Committee (p. 46)**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ

		CPSO participated in the Federation of Medical Regulatory Authorities of Canada Integrated Risk Management System (FIRMS) for the first time in 2020. This is a risk management tool used by all medical regulatory authorities across the country which enables benchmarking and identifying common risks among regulators so that common mitigation strategies may be developed where appropriate. This process will further assist CPSO with enhancing its performance.
15.3The College regularly reports publicly on its performance.	a. Performance results related to a College's strategic objectives and regulatory activities are made public on the College's website.	The College fulfills this requirement: **Yes**
		In 2020, CPSO reported on its performance in the following reports: **CPSO 2019 Annual Report - *Note that the 2020 Annual Report will be published in Spring 2020*** **COVID FAQs – This document was developed to provide guidance and information to the profession and the public on the CPSO's pandemic response** **E-dialogue – Provides information related to CPSO activities and performance in a publicly consumable format.**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (if needed)

PART 2: CONTEXT MEASURES

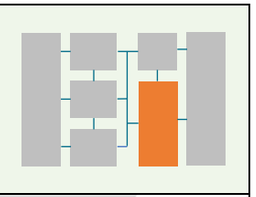
The following tables require Colleges to provide **statistical data** that will provide helpful context about a College's performance related to the standards. The context measures are non-directional, which means no conclusions can be drawn from the results in terms of whether they are 'good' or 'bad' without having a more in-depth understanding of what specifically drives those results.

In order to facilitate consistency in reporting, a recommended methodology to calculate the information is provided in the companion document "Technical Specifications for Quantitative College Performance Measurement Framework Measures." However, recognizing that at this point in time, the data may not be readily available for each College to calculate the context measure in the recommended manner (e.g. due to differences in definitions), a College can report the information in a manner that is conducive to its data infrastructure and availability.

In those instances where a College does not have the data or the ability to calculate the context measure at this point in time it should state: 'Nil' and indicate any plans to collect the data in the future.

Where deemed appropriate, Colleges are encouraged to provide additional information to ensure the context measure is properly contextualized to its unique situation. Finally, where a College chooses to report a context measure using methodology other than outlined in the following Technical Document, the College is asked to provide the methodology in order to understand how the College calculated the information provided.

DOMAIN 6: SUITABILITY TO PRACTICE



Standard 11

The College ensures the continued competence of all active registrants through its Quality Assurance processes. This includes an assessment of their competency, professionalism, ethical practice, and quality of care.

Statistical data collected in accordance with recommended methodology or College own methodology: Recommended Methodology

If College methodology, please specify rationale for reporting according to College methodology:

Context Measure (CM)

CM 1. Type and distribution of QA/QI activities and assessments used in CY 2020*

Type of QA/QI activity or assessment	#
i. QI: Practice Improvement Plan submitted	1535
ii. QI: Coaching	235
iii. QA: Peer assessment	344
iv. QA: Out of Hospital Premises Inspection	79
v. QA: Completion of a self-assessment questionnaire	337
vi. *<Insert QA activity or assessment>*	
vii. *<Insert QA activity or assessment>*	
viii. *<Insert QA activity or assessment>*	
ix. *<Insert QA activity or assessment>*	

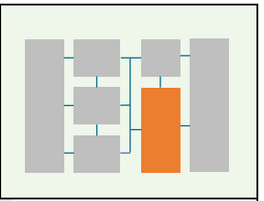
* *Registrants may be undergoing multiple QA activities over the course of the reporting period. While future iterations of the CPMF may evolve to capture the different permutations of pathways registrants may undergo as part of a College's QA Program, the requested statistical information recognizes the current limitations in data availability today and is therefore limited to type and distribution of QA/QI activities or assessments used in the reporting period.*

***NR** = Non-reportable: results are not shown due to < 5 cases*

What does this information tell us? *Quality assurance (QA) and Quality Improvement (QI) are critical components in ensuring that professionals provide care that is safe, effective, patient centred and ethical. In addition, health care professionals face a number of ongoing changes that might impact how they practice (e.g. changing roles and responsibilities, changing public expectations, legislative changes).*

The information provided here illustrates the diversity of QA activities the College undertook in assessing the competency of its registrants and the QA and QI activities its registrants undertook to maintain competency in CY 2020. The diversity of QA/QI activities and assessments is reflective of a College's risk-based approach in executing its QA program, whereby the frequency of assessment and activities to maintain competency are informed by the risk of a registrant not acting competently. Details of how the College determined the appropriateness of its assessment component of its QA program are described or referenced by the College in Measure 13(a) of Standard 11.

DOMAIN 6: SUITABILITY TO PRACTICE



Standard 11

The College ensures the continued competence of all active registrants through its Quality Assurance processes. This includes an assessment of their competency, professionalism, ethical practice, and quality of care

Statistical data collected in accordance with recommended methodology or College own methodology: Recommended Methodology

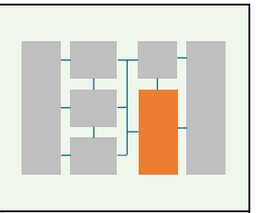
If College methodology, please specify rationale for reporting according to College methodology:

Context Measure (CM)			
	#	%	***What does this information tell us?*** *If a registrant's knowledge, skills and judgement to practice safely, effectively and ethically have been assessed or reassessed and found to be unsatisfactory or a registrant is non-compliant with a College's QA Program, the College may refer him or her to the College's QA Committee.* *The information provided here shows how many registrants who underwent an activity or assessment in CY 2020 as part of the QA program where the QA Committee deemed that their practice is unsatisfactory and as a result have been directed to participate in specified continuing education or remediation program.*
CM 2. Total number of registrants who participated in the QA Program CY 2020	681		
CM 3. Rate of registrants who were referred to the QA Committee as part of the QA Program in CY 2020 where the QA Committee directed the registrant to undertake remediation. *	53	7.8	

Additional comments for clarification (optional)

** NR = Non-reportable: results are not shown due to < 5 cases (for both # and %)*

DOMAIN 6: SUITABILITY TO PRACTICE



Standard 11

The College ensures the continued competence of all active registrants through its Quality Assurance processes. This includes an assessment of their competency, professionalism, ethical practice, and quality of care.

Statistical data collected in accordance with recommended methodology or College own methodology: **Recommended Methodology**

If College methodology, please specify rationale for reporting according to College methodology:

Context Measure (CM)			
CM 4. Outcome of remedial activities in CY 2020*:	#	%	***What does this information tell us?*** *This information provides insight into the outcome of the College's remedial activities directed by the QA Committee and may help a College evaluate the effectiveness of its "QA remediation activities". Without additional context no conclusions can be drawn on how successful the QA remediation activities are, as many factors may influence the practice and behaviour registrants (continue to) display.*
I. Registrants who demonstrated required knowledge, skills, and judgment following remediation**	28	52.8	
II. Registrants still undertaking remediation (i.e. remediation in progress)	25	47.2	

Additional comments for clarification (if needed)

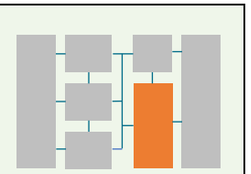
** NR = Non-reportable: results are not shown due to < 5 cases (for both # and %)*

*** This measure may include registrants who were directed to undertake remediation in the previous year and completed reassessment in CY2020.*

DOMAIN 6: SUITABILITY TO PRACTICE

Standard 13

All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.



Statistical data collected in accordance with recommended methodology or College own methodology: N/A

If College methodology, please specify rationale for reporting according to College methodology: The CPSO codes investigations upon closure of the file. The issues identified in an investigation is not available for ongoing cases.

Context Measure (CM)

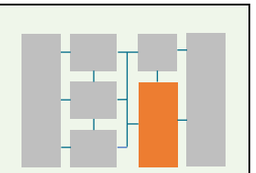
CM 5. Distribution of formal complaints* and Registrar's Investigations by theme in CY 2020	Formal Complaints received‡		Registrar Investigations initiated‡		
Themes:	#	%	#	%	
I. Advertising					***What does this information tell us?*** *This information facilitates transparency to the public, registrants and the ministry regarding the most prevalent themes identified in formal complaints received and Registrar's Investigations undertaken by a College.*
II. Billing and Fees					
III. Communication					
IV. Competence / Patient Care					
V. Fraud					
VI. Professional Conduct & Behaviour					
VII. Record keeping					
VIII. Sexual Abuse / Harassment / Boundary Violations					
IX. Unauthorized Practice					
X. Other <*please specify*>					
Total number of formal complaints and Registrar's Investigations**		**100%**		**100%**	

* ***Formal Complaint**: A statement received by a College in writing or in another acceptable form that contains the information required by the College to initiate an investigation. This excludes complaint inquires and other interactions with the College that do not result in a formally submitted complaint.* ***Registrar's Investigation**: Where a Registrar believes, on reasonable and probable grounds, that a registrant has committed an act of professional misconduct or is incompetent he/she can appoint an investigator upon ICRC approval of the appointment. In situations where the Registrar determines that the registrant exposes, or is likely to expose, his/her patient to harm or injury, the Registrar can appoint an investigator immediately without ICRC approval and must inform the ICRC of the appointment within five days.* ǂ ***NR** = Non-reportable: results are not shown due to < 5 cases (for both # and %)* ** *The requested statistical information (number and distribution by theme) recognizes that formal complaints and registrar's investigations may include allegations that fall under multiple themes identified above, therefore when added together the numbers set out per theme may not equal the total number of formal complaints or registrar's investigations.*	

Domain 6: Suitability to Practice

Standard 13

All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.



Statistical data collected in accordance with recommended methodology or College own methodology: Recommended

If College methodology, please specify rationale for reporting according to College methodology:

Context Measure (CM)			
CM 6. Total number of formal complaints that were brought forward to the ICRC in CY 2020	1890		
CM 7. Total number of ICRC matters brought forward as a result of a Registrars Investigation in CY 2020	200		
CM 8. Total number of requests or notifications for appointment of an investigator through a Registrar's Investigation brought forward to the ICRC that were approved in CY 2020	92		
CM 9. Of the formal complaints* received in CY 2020**:	#	%	
I. Formal complaints that proceeded to Alternative Dispute Resolution (ADR)ǂ	152	8.1	
II. Formal complaints that were resolved through ADR	126	6.7	
III. Formal complaints that were disposed** of by ICRC	1709		
IV. Formal complaints that proceeded to ICRC and are still pending	195	10.3	
V. Formal complaints withdrawn by Registrar at the request of a complainant Δ	359	16.0	
VI. Formal complaints that are disposed of by the ICRC as frivolous and vexatious	81	3.4	
VII. Formal complaints and Registrars Investigations that are disposed of by the ICRC as a referral to the Discipline Committee	41	2.2	

** ***Disposal:*** *The day upon which a decision was provided to the registrant and complainant by the College (i.e. the date the reasons are released and sent to the registrant and complainant).*

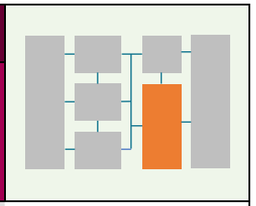
* ***Formal Complaints:*** *A statement received by a College in writing or in another acceptable form that contains the information required by the College to initiate an investigation. This excludes complaint inquires and other interactions with the College that do not result in a formally submitted complaint.*

ǂ ***ADR****: Means mediation, conciliation, negotiation, or any other means of facilitating the resolution of issues in dispute.*

What does this information tell us? *The information helps the public better understand how formal complaints filed with the College and Registrar's Investigations are disposed of or resolved. Furthermore, it provides transparency on key sources of concern that are being brought forward to the College's committee that investigates concerns about its registrants.*

D The Registrar may withdraw a formal complaint prior to any action being taken by a Panel of the ICRC, at the request of the complainant, where the Registrar believed that the withdrawal was in the public interest. *# May relate to Registrars Investigations that were brought to ICRC in the previous year.* *** The total number of formal complaints received may not equal the numbers from 9(i) to (vi) as complaints that proceed to ADR and are not resolved will be reviewed at ICRC, and complaints that the ICRC disposes of as frivolous and vexatious and a referral to the Discipline Committee will also be counted in total number of complaints disposed of by ICRC.* *ϕ **Registrar's Investigation:** Under s.75(1)(a) of the RHPA, where a Registrar believes, on reasonable and probable grounds, that a registrant has committed an act of professional misconduct or is incompetent he/she can appoint an investigator upon ICRC approval of the appointment. In situations where the Registrar determines that the registrant exposes, or is likely to expose, his/her patient to harm or injury, the Registrar can appoint an investigator immediately without ICRC approval and must inform the ICRC of the appointment within five days.* ***NR** = Non-reportable: results are not shown due to < 5 cases (for both # and %)*	
Additional comments for clarification (if needed)	

DOMAIN 6: SUITABILITY TO PRACTICE



Standard 13

All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.

Statistical data collected in accordance with recommended methodology or College own methodology: **Recommended Methodology**

If College methodology, please specify rationale for reporting according to College methodology:

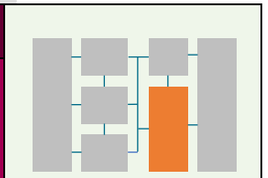
Context Measure (CM)							
CM 10. Total number of ICRC decisions in 2020							
Distribution of ICRC decisions by theme in 2020*	# of ICRC Decisions‡						
Nature of issue	Take no action	Proves advice or recommendations	Issues an oral caution	Orders a specified continuing education or remediation program	Agrees to undertaking	Refers specified allegations to the Discipline Committee	Takes any other action it considers appropriate that is not inconsistent with its governing legislation, regulations or by-laws.
I. Advertising	NR	NR	0	0	NR	NR	0
II. Billing and Fees	25	NR	6	NR	5	11	0
III. Communication	266	32	11	17	7	NR	0
IV. Competence / Patient Care	888	238	32	133	72	22	0
V. Fraud	11	0	0	0	NR	5	0
VI. Professional Conduct & Behaviour	128	21	21	6	9	17	0
VII. Record keeping	106	103	22	70	34	18	0
VIII. Sexual Abuse / Harassment / Boundary Violations	47	5	12	6	27	8	0
IX. Unauthorized Practice	9	NR	5	NR	6	5	0
X. Other: Accepting new patients and Termination	9	15	0	NR	0	0	0

** Number of decisions are corrected for formal complaints ICRC deemed frivolous and vexatious AND decisions can be regarding formal complaints and registrar's investigations brought forward prior to 2020.*

*‡ **NR** = Non-reportable: results are not shown due to < 5 cases.*

++ The requested statistical information (number and distribution by theme) recognizes that formal complaints and Registrar's Investigations may include allegations that fall under multiple themes identified above, therefore when added together the numbers set out per theme may not equal the total number of formal complaints or registrar's investigations, or findings.
What does this information tell us? *This information will help increase transparency on the type of decisions rendered by ICRC for different themes of formal complaints and Registrar's Investigation and the actions taken to protect the public. In addition, the information may assist in further informing the public regarding what the consequences for a registrant can be associated with a particular theme of complaint or Registrar investigation and could facilitate a dialogue with the public about the appropriateness of an outcome related to a particular formal complaint.*
Additional comments for clarification (if needed)

DOMAIN 6: SUITABILITY TO PRACTICE



Standard 13

All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.

Statistical data collected in accordance with recommended methodology or College own methodology: Recommended Methodology ϒ

If College methodology, please specify rationale for reporting according to College methodology:

Context Measure (CM)		
CM 11. 90th Percentile disposal* of:	Days	***What does this information tell us?*** *This information illustrates the maximum length of time in which 9 out of 10 formal complaints or Registrar's investigations are being disposed by the College.* *The information enhances transparency about the timeliness with which a College disposes of formal complaints or Registrar's investigations. As such, the information provides the public, ministry and other stakeholders with information regarding the approximate timelines they can expect for the disposal of a formal complaint filed with, or Registrar's investigation undertaken by, the College.*
I. A formal complaint in working days in CY 2020	241	
II. A Registrar's investigation in working days in CY 2020	908	

* ***Disposal Complaint:*** *The day where a decision was provided to the registrant and complainant by the College (i.e. the date the reasons are released and sent to the registrant and complainant).*

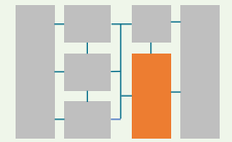
* ***Disposal Registrar's Investigation:*** *The day upon which a decision was provided to the registrant and complainant by the College (i.e. the date the reasons are released and sent to the registrant and complainant).*

Additional comments for clarification (if needed)

DOMAIN 6: SUITABILITY TO PRACTICE

Standard 13

All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.



Statistical data collected in accordance with recommended methodology or College own methodology: Recommended Methodology

If College methodology, please specify rationale for reporting according to College methodology:

Context Measure (CM)		
CM 12. 90th Percentile disposal* of:	Days	***What does this information tell us?*** *This information illustrates the maximum length of time in which 9 out of 10 uncontested discipline hearings and 9 out of 10 contested discipline hearings are being disposed. ** *The information enhances transparency about the timeliness with which a discipline hearing undertaken by a College is concluded. As such, the information provides the public, ministry and other stakeholders with information regarding the approximate timelines they can expect for the resolution of a discipline proceeding undertaken by the College.*
I. An uncontested^ discipline hearing in working days in CY 2020	541	
II. A contested# discipline hearing in working days in CY 2020	684	

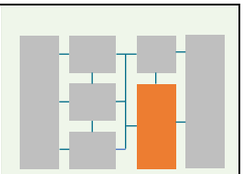
* ***Disposal:*** *Day where all relevant decisions were provided to the registrant and complainant by the College (i.e. the date the reasons are released and sent to the registrant and complainant, including both liability and penalty decisions, where relevant).*

^ ***Uncontested Discipline Hearing:*** *In an uncontested hearing, the College reads a statement of facts into the record which is either agreed to or uncontested by the Respondent. Subsequently, the College and the respondent may make a joint submission on penalty and costs or the College may make submissions which are uncontested by the Respondent.*

\# ***Contested Discipline Hearing:*** *In a contested hearing, the College and registrant disagree on some or all of the allegations, penalty and/or costs.*

Additional comments for clarification (if needed)

DOMAIN 6: SUITABILITY TO PRACTICE



Standard 13

All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.

Statistical data collected in accordance with recommended methodology or College own methodology: Recommended Methodology

If College methodology, please specify rationale for reporting according to College methodology: Note that we added the finding 'Suitability to Practice' in item (IV) below, due to numerous findings in 2020

Context Measure (CM)

CM 13. Distribution of Discipline finding by type*

Type		#
I.	Sexual abuse	NR
II.	Incompetence	5
III.	Fail to maintain Standard	9
IV.	Suitability to Practice	8
V.	Conduct unbecoming	NR
VI.	Dishonourable, disgraceful, unprofessional	30
VII.	Offence conviction	
VIII.	Contravene certificate restrictions	NR
IX.	Findings in another jurisdiction	
X.	Breach of orders and/or undertaking	
XI.	Falsifying records	
XII.	False or misleading document	NR
XIII.	Contravene relevant Acts	NR

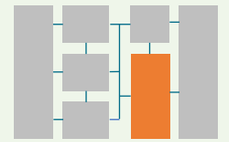
What does this information tell us? *This information facilitates transparency to the public, registrants and the ministry regarding the most prevalent discipline findings where a formal complaint or Registrar's Investigation is referred to the Discipline Committee by the ICRC.*

* *The requested statistical information recognizes that an individual discipline case may include multiple findings identified above, therefore when added together the number of findings may not equal the total number of discipline cases.*

***NR** = Non-reportable: results are not shown due to < 5 cases.*

Additional comments for clarification (if needed)

DOMAIN 6: SUITABILITY TO PRACTICE



Standard 13

All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.

Statistical data collected in accordance with recommended methodology or College own methodology: Recommended Methodology

If College methodology, please specify rationale for reporting according to College methodology:

Context Measure (CM)

CM 14. Distribution of Discipline orders by type*

Type		#
I.	Revocation+	8
II.	Suspension$	21
III.	Terms, Conditions and Limitations on a Certificate of Registration**	21
IV.	Reprimand^ and an Undertaking	NR
V.	Reprimand^	36

What does this information tell us? *This information will help strengthen transparency on the type of actions taken to protect the public through decisions rendered by the Discipline Committee. It is important to note that no conclusions can be drawn on the appropriateness of the discipline decisions without knowing intimate details of each case including the rationale behind the decision.*

* *The requested statistical information recognizes that an individual discipline case may include multiple findings identified above, therefore when added together the numbers set out for findings and orders may not be equal and may not equal the total number of discipline cases.*

\+ *Revocation of a registrant's certificate of registration occurs where the discipline or fitness to practice committee of a health regulatory college makes an order to "revoke" the certificate which terminates the registrant's registration with the college and therefore his/her ability to practice the profession.*

$ *A suspension of a registrant's certificate of registration occurs for a set period of time during which the registrant is not permitted to:*

- *Hold himself/herself out as a person qualified to practice the profession in Ontario, including using restricted titles (e.g. doctor, nurse),*
- *Practice the profession in Ontario, or*
- *Perform controlled acts restricted to the profession under the Regulated Health Professions Act, 1991.*

** *Terms, Conditions and Limitations on a Certificate of Registration are restrictions placed on a registrant's practice and are part of the Public Register posted on a health regulatory college's website.*

^ *A reprimand is where a registrant is required to attend publicly before a discipline panel of the College to hear the concerns that the panel has with his or her practice*

\# *An undertaking is a written promise from a registrant that he/she will carry out certain activities or meet specified conditions requested by the College committee.*

***NR** = Non-reportable: results are not shown due to < 5 cases*

Additional comments for clarification (if needed)

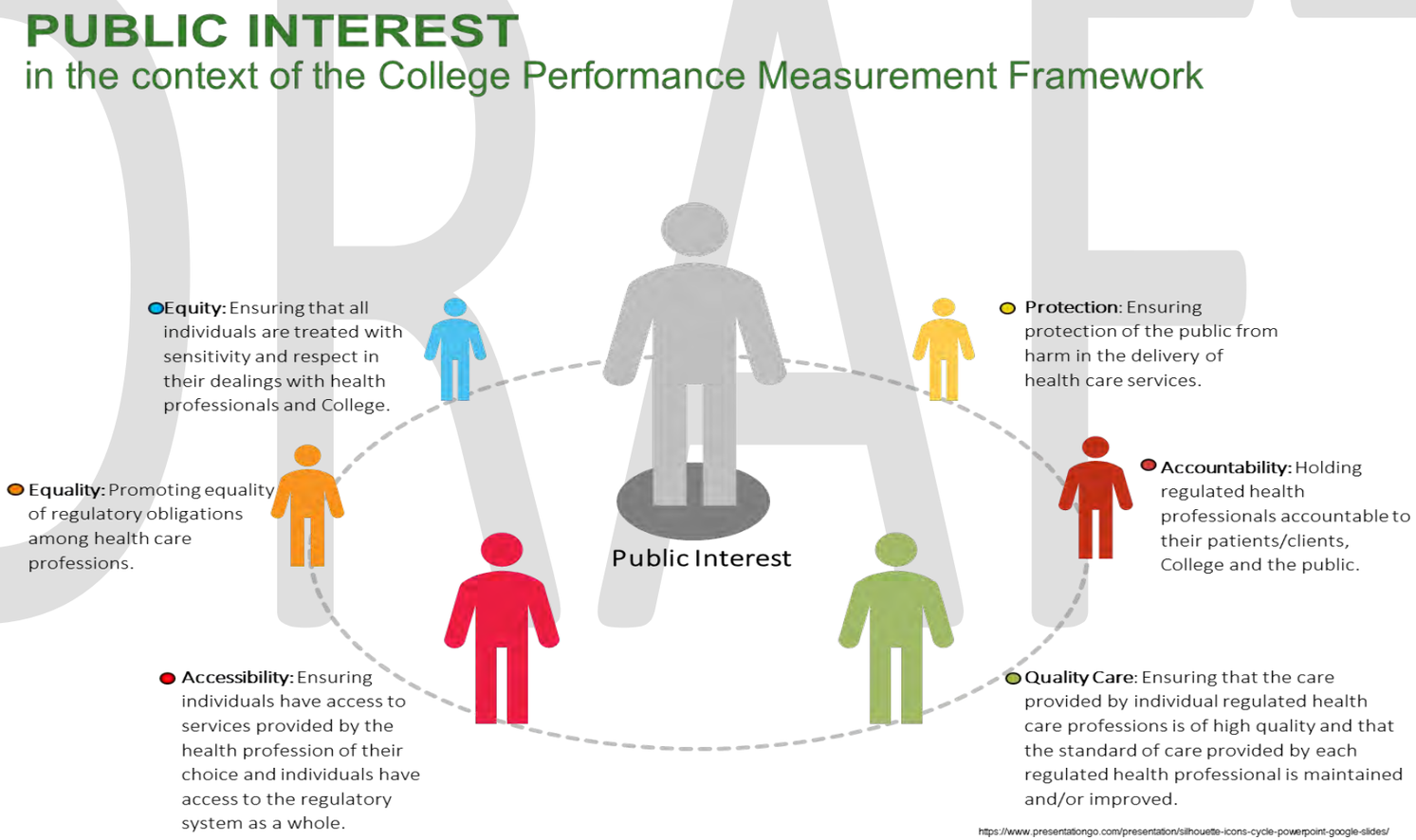
For questions and/or comments, or to request permission to use, adapt or reproduce the information in the CPMF please contact:

Regulatory Oversight and Performance Unit
Health Workforce Regulatory Oversight Branch
Strategic Policy, Planning & French Language Services Division
Ministry of Health
438 University Avenue, 10th floor
Toronto, ON M5G 2K8

E-mail: RegulatoryProjects@Ontario.ca

Appendix A: Public Interest

When contemplating public interest for the purposes of the CPMF, Colleges may wish to consider the following (please note that the ministry does not intend for this to define public interest with respect to College operations):



THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

POLICY STATEMENT

Methadone Maintenance Treatment for Opioid Dependence

APPROVED BY COUNCIL: May 2010

PUBLICATION DATE: *Dialogue*, Issue 2, 2010

Disclaimer:

As of May 19, 2018 physicians no longer require an exemption from Health Canada to prescribe methadone. This change is not yet reflected in the College's Methadone Maintenance Treatment for Opioid Dependence policy, but will be incorporated when the policy is next reviewed. In the meantime, prescribers who wish to administer methadone and/or delegate the administration of methadone must continue to meet all other existing requirements set out in policy. Relevant content in the policy includes:

- *Administration*
- *Responsibility for Doses*
- *Transportation and Transfer of Custody*
- *Destruction of Unused or Unserviceable Doses*
- *Safe and secure storage*
- *Reconciling Doses and Accounting for Lost or Stolen Dose*

The elimination of the exemption will also result in additional changes to the College's Methadone program. For more information, see the College's Methadone Program page.

Methadone Maintenance Treatment for Opioid Dependence

DEFINITIONS

Methadone maintenance treatment: The daily oral administration of methadone over a prolonged period as an oral substitute for heroin or other morphine-like drugs for patients who are dependent on or addicted to these drugs.

Methadone exemption: Methadone is a conntrolled drug under the *Controlled Drugs and Substances Act*, S.C. 1996, c. 16. Physicians who wish to provide methadone to their patients must obtain a special exemption from Health Canada. The exemption can apply to either methadone maintenance treatment for opioid dependence, or to the treatment of malignant and chronic non- malignant pain. Physicians who wish to provide methadone for both methadone maintenance treatment and pain must obtain separate exemptions.

Physicians who possess an exemption for methadone maintenance treatment may apply to the College of Physicians and Surgeons of Ontario for additional per- mission to delegate authority for the administration component of methadone maintenance treatment to other properly qualified health-care professionals.

Methadone administration: The provision of a dose of Methadone administration: methadone to a patient for consumption by the patient under direct observation in a medical office or clinic, or for delayed consumption by the patient (in the form of take-home or carry doses) for the treatment of opioid dependence.

Properly qualified health-care professional: In the context of this policy, these are regulated health-care professionals other than physicians who possess the appropriate knowledge, skill and judgment needed to safely administer methadone to patients, and who meet the additional minimum requirements set out in this policy.

BACKGROUND

Methadone maintenance treatment is an effective treatment for opioid dependence. In the interest of ensuring that methadone maintenance treatment is delivered in a safe and consistent manner, it is regulated by Health Canada through the *Controlled Drugs and Substances Act*, S.C. 1996, c. 16 (CDSA), in partnership with theprovince of Ontario, the College of Physicians andSurgeons of Ontario (CPSO) and the Ontario College ofPharmacists (OCP). Physicians who wish to providemethadone maintenance treatment must obtain ageneral methadone maintenance treatmentexemption from Health Canada under section 56 of theCDSA. The general exemption permits physicians toprescribe, administer or sell methadone. The generalexemption also permits the dispensing of methadonesubject to conditions and limitations, as set out in this policy.

Physicians in possession of the general exemption may apply to the CPSO for a "delegation exemption", which grants physicians permission to delegate authority for the administration component of methadone maintenance treatment to other properly qualified health-care professionals. This is intended to improve access to care.

In 2007, the CPSO and the OCP developed the Framework for the Implementation of the New "Delegation" Exemption: Safety, Security and Transfer of Methadone Doses, which sets out expectations for delegating authority for methadone administration pursuant to a "delegation exemption". That document was intended to complement the CPSO's Methadone Administration in the Treatment of Opioid Dependence policy. The present policy replaces both of those documents. In addition to this policy, physicians should consult the Methadone Maintenance Guidelines for further information. a change is significant and must be reported to the College please refer to Appendix 1.

PURPOSE

This policy articulates the CPSO's expectations of physicians who provide methadone maintenance treatment, including expectations for delegating the authority for methadone administration to other properly qualified health-care professionals.

SCOPE

This policy applies to physicians who, pursuant to a methadone maintenance treatment exemption under section 56 of the *CDSA*, deliver methadone maintenance treatment in medical offices or clinics outside a pharmacy. It also applies to physicians who, pursuant to a "delegation exemption" delegate authority for methadone administration to other properly qualified health-care professionals.

PRINCIPLES

1. Physicians should always act in patients' best interests to deliver safe and effective care.

2. Physicians should carry out methadone maintenance treatment in an appropriate manner. This includes following statutory provisions designed to ensure patient safety and clinical efficacy.

3. Physicians should collaborate with other health-care professionals as a means of delivering and increasing access to safe and effective care.

4. Physicians are accountable for other health-care professionals to whom they delegate aspects of treatment. Physicians should ensure that their delegates are properly qualified to deliver safe and effective care.

POLICY

1. Qualifications for the Delivery of Methadone Maintenance Treatment

Physicians may only deliver methadone maintenance treatment if they have obtained a general exemption for methadone maintenance treatment from Health Canada pursuant to Section 56 of the *CDSA*. Absent the additional "delegation exemption", physicians with the general exemption cannot delegate the administration of methadone to other qualified health-care professionals.

More information about delegation appears in subsection 7 – "Delegating Authority for Methadone Administration" and subsection 8 – "Properly Qualified Health-care Professionals" of this policy.

2. Prescription

Any new dose or change of dose of methadone requires a new prescription and must be dispensed by a pharmacist. Once dispensed by the pharmacist, a physician must not alter individually labeled doses.
In certain rare circumstances, a physician may dispense a dose of methadone, subject to the conditions and limitations outlined in subsection 6 – "Dispensing" below.

3. Administration

Physicians must follow the requirements for methadone administration outlined in the current CPSO Methadone Maintenance Guidelines, as well as those in this policy.

When administering methadone for methadone maintenance treatment, physicians must:

- Ensure that methadone is administered to their patients in the dose and manner that has been prescribed.

- Witness doses provided for immediate consumption.

- Confirm the patient's identity prior to administering doses for observed consumption or for providing carries in order to ensure that the methadone is given to the correct individual. The physician should also verbally confirm the expected dose with the patient.

Information about delegating authority for administering methadone appears in subsection 7 – "Delegating Authority for Methadone Administration" and subsection 8 – "Properly Qualified Health-care Professionals" of this policy.

Methadone Maintenance Treatment for Opioid Dependence

4. Responsibility for Doses

Under the OCP's Policy for Dispensing Methadone, a pharmacist is responsible for the safety and integrity of methadone until such time as he or she has dispensed directly to the patient or transferred custody of the methadone to an exempted physician or his or her delegate.

Transportation and Transfer of Custody

OCP policy requires a pharmacist to transfer custody of the individually labeled doses of methadone dispensed pursuant to a prescription in a secure, tamper-proof manner to a physician who signs that he or she has received each correct dose on a daily basis on a patient manifest. The pharmacist must either directly hand the doses of methadone to the physician or his or her dele- gate, or use a method of transportation that ensures that he or she is aware of and tracks who has had custody of the drug at any given time to ensure safekeeping of the methadone while in transit (i.e., a chain-of-signatures and tamper-proof boxes). All methadone must be trans- ported in such a manner as to avoid extremes in temperature or delays in transport which could compromise the drug.

Only the physician or his or her delegate may accept delivery of methadone doses. The physician who accepts the methadone must sign that he or she has received and has accepted custody of each dose. A record of the transfer of each dose must be maintained.

Once the physician has accepted custody of the methadone, the physician assumes responsibility for the safety and security of those methadone doses. The physician maintains responsibility and is fully accountable for all doses until provided to the patient for observed consumption, or as a carry. If a dose is unused, the physician maintains responsibility and is fully accountable until the dose is returned to the pharmacy.

Destruction of Unused or Unserviceable Doses

All unused or unserviceable doses must be returned to the dispensing pharmacy for destruction on a daily basis. These doses must be transferred in a secure manner in accordance with the guidelines for transportation and custody set out above. Once the pharmacist accepts custody of the unused or partially used doses, the pharmacist is responsible for the safety, security and destruction of those doses.

Safe and Secure Storage

Under section 55(f) of the federal Narcotic Control Regulations, physicians must take "adequate steps" to protect any quantities of methadone on the premises or under their control against theft or loss. The term "adequate" is not defined in the Narcotic Control Regulations, C.R.C., c. 1041. The CPSO is unable to offer advice on how this term may be interpreted. It is, however, the expectation of the CPSO that physicians will ensure that all methadone doses are stored in a locked cabinet or refrigerator in a secure area within the physician's office or clinic. Further, as required under s. 55(d) of the Narcotic Control Regulations, physicians must permit an inspector to check all stocks of narcotics in their office or clinic.

Reconciling Doses and Accounting for Lost or Stolen Doses

The physician or his or her delegate must conduct a daily reconciliation of doses received, administered and returned to the pharmacy. Preferably, this will occur both before the first dose and after the last dose for that day have been administered. Any loss of methadone (stolen or spilled) must be reported within 10 days of its discovery to the Compliance Monitoring Liaison Division, Office of Controlled Substances, by calling 613-954-1541, as required by section 55(g) of the Narcotic Control Regulations.

5. Documentation

Maintenance of accurate and complete medical records is a crucial component of methadone maintenance treatment. For general documentation requirements, physicians should refer to the CPSO's Medical Records policy.

Documentation requirements specific to methadone maintenance treatment are as follows:

- The patient's informed consent to methadone maintenance treatment.
- The patient's name, daily dose, and time and place where administration was observed.
- Results of assessment prior to methadone administration, including, where applicable, signs of intoxication, observed abnormal behaviour, and symptoms of over- medication with methadone.
- Record of urine sample, if provided, and results.
- The name of the health-care professional administering the dose.

- Sign-off of drink and/or carry doses, including the date and time when methadone was given.
- Missed doses, including refusal and vomiting of doses.
- Partial doses taken.
- Lost or stolen carry doses.
- Suspected diversion of doses.
- Guest dosing arrangements.
- Other prescribed medications that may interfere with methadone.

In addition to the foregoing, section 69 of the Narcotic Control Regulations requires physicians to keep and retain for a period of two years from the date of the making of the record, a record of:

- the date and quantity of methadone received;
- the name and address of the person from whom the methadone was received; and
- the particulars of the use to which the methadone was put.

Section 69 of the Narcotic Control Regulations also requires that physicians provide access to these records, as well as furnish any information respecting methadone as may be required by the federal Minister of Health.

Physicians must also ensure that all dosing information is provided to the pharmacy to ensure accuracy and completeness of patient history. This should be done with the consent of the patient.

Where a physician delegates authority for methadone administration to other properly qualified health-care professionals, the physician must ensure that the patient consents to the delegation. This consent should be obtained and recorded each time methadone is administered by the delegate. The physician should also document the delegate's qualifications and training.

6.Dispensing

Dispensing methadone is typically done by apharmacist. However, Health Canada recognizes thatin certain rare circumstances, it may be appropriatefor a physician to dispense methadone. These rarecircumstances are those wherein the physiciandetermines it is necessary to dispense methadone dueto a risk of withdrawal or over- dose, and nopharmacist is able to provide the necessary dose in aperiod of time which would not compromise patientsafety. For example, it may be appropriate for thephysician to dispense methadone when a patient hasalready missed three or more consecutive days ofdosing and requires stabilization to prevent furtherwithdrawal, or when a patient has vomited a doseunder direct observation, particularly in the case ofpregnant patients where withdrawal may compromisethe well-being of the fetus. Methadone for inductionwould not be viewed as a rare circumstance.

A physician who dispenses methadone in appropriate rare circumstances must do so in accordance with the requirements set out in the Drug and Pharmacies Regulation Act, R.S.O. 1990, c.H.4, this policy and the CPSO's Dispensing Drugspolicy. Additional guidance can be found in the OCP'sPolicy for Dispensing Methadone.[1]

Pre-measured doses of methadone must be purchased from an accredited pharmacy and mixed by the physician with the appropriate diluent (e.g., Tang beverage) prior to ingestion.

When dispensing methadone in appropriate rare circumstances, the physician must only administer one dose.

The physician must then immediately report to the pharmacy or clinic where the patient usually received methadone and ensure that the necessary arrangements are made for subsequent doses to be administered at the pharmacy.

7.Delegating Authority for MethadoneAdministration

Methadone administration is the only component ofmethadone maintenance treatment that may bedelegated. Authority for prescribing, dispensing andselling methadone cannot be delegated.

Where a physician delegates authority for methadone administration, the physician must adhere to the direction set out in the CPSO's Delegation of Controlled Acts policy and this policy.

1 http://www.ocpinfo.com/regulations-standards/policies-guidelines/methadone2/

Methadone Maintenance Treatment for Opioid Dependence

Accountability and responsibility for methadone administration rests with the physician at all times. The physician must ensure that if he or she delegates authority for methadone administration to other properly qualified health-care professionals, he or she must ensure that those delegates have the knowledge, skill and judgment to do so. This includes taking reasonable steps to ensure that delegates understand and comply with office or clinic policies and procedures regarding methadone administration. The physician must also provide the level of supervision necessary to ensure that delegates administer methadone safely and effectively.

Office/clinic policies and procedures for methadone administration must be accessible at all times and must clearly state that individuals administering methadone are charged with the following responsibilities:

i. To administer methadone only when the patients does not exhibit any signs of sedation or intoxication.
ii. Where direct observation is prescribed, to observe the patient consuming the methadone and ensure that the dose has been consumed.
iii. To administer methadone precisely as prescribed by the physician.

8. Properly Qualified Health-care Professionals

Properly qualified health-care professionals are those who possess the appropriate knowledge, skill and judgment needed to safely administer methadone to patients.

The following are the minimum requirements that individuals must possess:

Nurses

Individuals must:

i. Be either a Registered Practical Nurse or a Registered Nurse, including a Registered Nurse in the Extended Class.
ii. Have demonstrated to the satisfaction of the physician an understanding of methadone maintenance treatment, including the risks associated with it.

Other Health-care Professionals

Individuals must:

i. Be another health-care professional regulated under Ontario's *Regulated Health Professions Act*, 1991, SO. 1991, c. 18.
ii. Have successfully completed the Methadone Treatment Workshop at the Centre for Addiction and Mental Health or equivalent training approved by the CPSO in the safe and appropriate administration of methadone.
iii. Have demonstrated to the satisfaction of the physician an understanding of methadone maintenance treatment, including the risks associated with it.

Methadone Program

Methadone Maintenance Treatment
Program Standards and Clinical Guidelines

4th Edition February 2011

THE COLLEGE OF PHYSICIANS & SURGEONS OF ONTARIO

These guidelines are in effect as of February 2011

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The College of Physicians and Surgeons of Ontario

Vision Statement

Quality Professionals, Healthy System, Public Trust

Our Mandate

Build and maintain an effective system of self-governance.

The profession, through and with the College, has a duty to serve and protect the public interest by regulating the practice of the profession and governing in accordance with the Regulated Health Professions Act.

Our Vision Defined

Quality Professionals, Healthy System, Public Trust.

Our new vision is the framework by which we organize ourselves.
It guides our thinking and actions into the future. It defines not only who we are, but what we stand for, the role we see for ourselves, our critical relationships, in what system we work, and the outcomes we seek.

Each component of our vision is defined below:

Quality Professionals – as a profession and as professionals, we recognize and acknowledge our role and responsibility in attaining at a personal, professional, and at a system-level, the best possible patient outcomes.

We are committed to developing and maintaining professional competencies, taking a leadership position on critical issues that impact the performance of the system, and actively partner to provide tools, resources, measurement, to ensure the optimal performance at all levels of the system.

Healthy System – the trust and confidence of the public and our effectiveness as professionals is influenced by the system within which we operate. Therefore, we, as caring professionals, are actively involved in the design and function of an effective system including:

- accessibility
- the interdependence of all involved
- measurements and outcomes
- continued sustainability

Public Trust – as individual doctors garner the trust of their patients, as a profession we must aim to have the trust of the public by:

- building positive relationships with individuals
- acting in the interests of patients and communities
- advocating for our patients and a quality system

Our Guiding Principles

Integrity, accountability, leadership and cooperation

The public, through legislation, has empowered the profession to regulate itself through the College. Central to the practice of medicine is the physician-patient relationship and the support of healthy communities. As the physician has responsibility to the patient, the profession has the responsibility to serve the public through the health-care system.

To fulfill our vision of quality professionals, healthy system, public trust we will work to enhance the health of the public guided by professional competence and the following principles:

Integrity – in what we do and how we go about fulfilling our core mandate:

- Coherent alignment of goals, behaviours and outcomes;
- Steadfast adherence to a high ethical standard.

Accountability to the public and profession – we will achieve this through:

- An attitude of service;
- Accepting responsibility;
- Transparency of process;
- Dedicated to improvement.

Leadership – leading by proactively regulating our profession, managing risk and serving the public.

Cooperation – seeking out and working with our partners – other health-care institutions, associations and medical schools, etc. – to ensure collaborative commitment, focus and shared resources for the common good of the profession and public.

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Tables

Note: Throughout this document, Standards and Guidelines refers to "*MMT Program Standards and Clinical Guidelines*".

ACRONYMS

AA	Alcoholics Anonymous
AMA	Against Medical Advice
BZD	Benzodiazepine
CA	Cocaine Anonymous
CAGE	Cut-Down, Annoyed, Guilty, Eye-Opener Test
CAMH	Centre for Addiction and Mental Health
CBT	Cognitive Behavioural Therapy
CFPC	College of Family Physicians of Canada
CHC	Community Health Centre
CIHC	Canadian Interprofessional Health Collaborative
CNCP	Chronic Non-Cancer Pain
CNS	Central Nervous System
COPD	Chronic Obstuctive Pulmonary Disease
COWS	Clinical Opiate Withdrawal Scale
CPSO	College of Physicians and Surgeons of Ontario
CSC	Correctional Services of Canada
CWU	Chemical Withdrawal Unit
ECG	Electrocardiogram
EDDP	2-Ethylidene-1, 5 Dimethyl-3, 3-Diphenylpyrrolidine
EIA	Enzyme Immunoassay
EMIT	Enzyme Multiplied Immunoassay Technique
GAC	Guideline Advisory Committee
GHN	Growth Hormone Normal
HCV	Hepatitis C Virus
HIV/HCD	Humuan Immunodeficiency Virus
IPC	Inter-Professional Collaboration
LAAM	Levo-Alpha Acetyl Methadol
MI	Motivational Interviewing
MMT	Methadone Maintenance Treatment
MOHLTC	Ministry of Health and Long-Term Care
NA	Narcotics Anonymous
NAS	Neonatal Absence Syndrome
OAT	Opioid Agonist Therapy
ODT	Opiod Dependence Treatment
OCP	Ontario College of Pharmacists
OTN	Ontario Telemedicine Network
PAG	Patient Advisory Group
PHIPA	Personal Health Information Protection Act
PO	
POATS	Prescription Opioid Addiction Treatment Study
RCT	Randomized Controlled Trials
R.N.	Registered Nurse
SAMSHA	Substance Abuse and Mental Health Services Administration
TCA	Tricylic Antidepressant
THC	Tetrahydrocannabinol
TM	Telemedicine
UDS	Urine Drug Screen

1. Preface

1.1 Role of the CPSO in MMT

In 1996, the College of Physicians and Surgeons of Ontario (CPSO; the CPSO) began to administer a methadone program on behalf of the Ministry of Health and Long-Term Care (MOHLTC). The program goal is to improve the quality and accessibility of methadone maintenance treatment (MMT) in Ontario. This goal is achieved in cooperation with the Centre for Addiction and Mental Health (CAMH), and the Ontario College of Pharmacists (OCP). The profile of MMT in Ontario has been enhanced through outreach activities and the recruitment of physicians to prescribe methadone in the treatment of opioid dependence.

The CPSO is the body that regulates the practice of medicine to protect and serve the public interest. This system of self-regulation is based on the premise that the CPSO must act first and foremost in the interest of the public. *(www.cpso.on.ca)*

The Methadone Committee was established in June 1999 by the CPSO Council. The by-law states that the Committee shall administer the CPSO's methadone opioid agonist program, including:

- Brief programs of education in addiction medicine
- The establishment of guidelines or standards applicable generally to the use of opioid agonists in the management of opioid dependence
- A program to review prescribing opioid agonists by members in the management of opioid dependence; and
- Decision to issue or refuse to issue, or withdraw the exemption for a member to administer, prescribe or otherwise furnish opioid agonists for the management of opioid dependence

The Committee comprises physician and public members of the CPSO Council, non-Council members, and MMT physicians. Representatives of CAMH and the OCP are observer members. The Committee is subject to the Rules of Governance established by the CPSO Governance Committee.

1.2 Role of the Guideline Advisory Committee

The role of the Guideline Advisory Committee (GAC) is to update the 2005 Methadone Maintenance Treatment Guidelines. The GAC has been given the responsibility to ensure clarity around what will be considered "standards of practice" and those which are considered "best practice guidelines".

This document replaces the CPSO 2005, 2001, and 1996 MMT Guidelines, and Health Canada's *"The Use of Opioids in the Treatment of Opioid Dependence,"* published in 1992.

It is acknowledged that other healthcare professionals are involved in the care of opioid dependent patients. However, the intended audience for this document is MMT physicians. It is not intended as a comprehensive manual or to replace sound clinical judgment.

1.2.1 Guideline Advisory Group Members

Dr. Sharon Cirone, Chair, Community and Hospital-Based MMT Physician
Ms Nicole Balan, Ontario College of Pharmacists (OCP)
Ms Betty Dondertman, Centre for Addiction and Mental Health (CAMH)
Dr. Trevor Gillmore, Methadone Committee Member
Dr. Kumar Gupta, College of Physicians and Surgeons of Ontario Council Member
Ms Jan Holland, Correctional Services Canada (CSC)
Dr. Meldon Kahan, Methadone Committee Member and Hospital-based MMT Physician
Dr. Melissa Snider-Adler, Methadone Assessor
Mr. Sean Winger, Patient Advisory Group Member (PAG)

Note: The Guideline Advisory Committee members wish to acknowledge the contribution of Dr. Alice Ordean who provided the entire content for Section 13, MMT Considerations During Pregnancy and Dr. Anita Srivastava for her contribution to Section 12, Methadone Toxicity.

1.3 Role of the Research Advisory Group (RAG)

The Research Advisory Group was formed to work collaboratively with the Guidelines Advisory Group to complete the 2011 revision of the MMT Guidelines.

The primary role of the Research Advisory Group was to conduct a focused literature search to address specific questions, select and appraise the relevant literature and synthesize the evidence to assist the Guideline authors. Their secondary role was to review the program standards ands guidelines content created by the authors and ensure that:

- references cited in the program standards and guidelines were appropriate, i.e., they appropriately and adequately supported the material they were linked to,
- statements in the program standards and guidelines which required referencing were appropriately referenced, and,
- references from the focused literature search were used appropriately in the program standards and guidelines.

1.3.1 Research Advisory Group Members

Dr. Bruna Brands PhD., Team Lead, Office of Drug and Alcohol Research and Surveillance, Health Canada
Ms Sheila Lacroix, Senior Reference Librarian, Centre for Addiction and Mental Health
Dr. Thea Weisdorf, Physician Consultant and MMT Physician
Mr. Christopher Smith PhD., Research Assistant
Ms Gabriela Novotna, PhD, Research Assistant
Mr. Vlad Kushnir, MSc., Research Assistant

The Research Advisory Group also received support and advice from the College's Research and Evaluation Department.

1.4 Standards and Guidelines

Standards are regarded as generally accepted principles of patient management. Standards are based on a synthesis of current literature and a high level of consensus among the Guideline Advisory Committee. Standards are differentiated from Guidelines in that they refer to clinical practices that potentially relate to patient morbidity and mortality and to community safety. Standards may be modified only under exceptional circumstances and where the reasons for departure from the standards are clearly documented.

Guidelines are systematically developed recommendations and educational references that assist the MMT physician in making clinical decisions about patient care. Clinical guidelines are recommendations that are supported by a synthesis of current literature and clinical consensus. Guidelines may be adopted, modified, or rejected according to clinical needs, individual patient considerations, local resources, and physician discretion. Guidelines do not establish inflexible protocols for patient care nor are they meant to replace the professional judgment of physicians.

1.4.1 Evidence Synthesis Methods

In preparation for revision 2011, a mixed methods approach was decided upon, i.e. a blend of expert opinion (Guideline Advisory Committee) and evidence synthesis from a focused literature search. Limited time and resources meant that it was not feasible to conduct a systematic review of all potential topics. It was decided to create a list of research questions representing those clinical topics based on the information gathered from assessment of MMT physicians where there was believed to be the greatest variation in practice and/or divergence of clinical opinion. To determine the research questions, a survey was developed to poll Methadone Assessors, Methadone Committee and the Patient Advisory Group. Results of the survey were analyzed to determine the strongest trends, as well as having a balance between patient/public safety and patient retention. With the assistance of the Research Advisory Group, these were translated into questions suitable for a focused literature search. These questions included:

1. What is the impact of concurrent use of benzodiazepines on patient mortality?
2. How effective is methadone maintenance therapy (MMT)[1] in the treatment of addiction to prescription opioids?
3. What is the impact of the frequency of urine drug screening on patient retention?
4. What is the relative effectiveness of point-of-care versus chromatography urine drug screening?
5. What is the impact of methadone tapering on relapse or abstinence?
6. What is the effectiveness of medical detoxification?
7. How effective are take-home doses in achieving optimal MMT outcomes?
8. What is the effectiveness of MMT for special populations[2]?
9. How is clinical stability determined?

[1] MMT effectiveness defined as: patient retention and other outcomes

[2] Special populations defined as: pregnant patients; older people; younger people; psychiatric co-morbidity; cardiac conditions

1.4.2 Literature Search Methods:

A search for English language publications, 2000s onwards was conducted on databases:

- Medline (National Library of Medicine)
- Embase: Exerpta Medica
- PsychINFO (American Psychological Association)
- Scopus and others (recent literature)
- Cochrane Database of Systematic Reviews

Search strategies were database specific, based on the subject headings used to index these databases. Subject Heading search terms were combined with appropriate keywords. For databases not indexed with subject headings, such as Scopus and In Process Medline, only key word searches were conducted.

Grey Literature was also searched by: 1) targeting the websites of key organizations throughout the world for guidelines, evaluations and policy documents; and 2) searching library catalogues, such as the CAMH Library catalogue and 3) other MMT guidelines.

1.4.3 Rating Quality of Evidence

An adaptation of the Harbour and Miller (2001) system for grading recommendations in evidence based guidelines was used to grade evidence quality. Levels of evidence are based on study design and methodological quality of individual studies.

Hierarchy of Study Design	Strength of Evidence
I Systematic Reviews & Meta-analysis of Controlled Trials	Strong
II Randomized Control Trials	Strong
III Non- randomized intervention studies (pre-post study design; matched controls; time series)	Moderate
IV Observational studies (cohort studies; cross sectional, retrospective study designs)	Low
V Non-experimental designs (case reports; qualitative research)	Very low
VI Expert Opinion; reports of Expert Committees	Very low

1.4.4 Summary of Evidence Synthesis Key Findings

Question 1:
What is the impact of concurrent use of benzodiazepines on patient mortality?

- 32 articles were identified and 7 were excluded (5 not published in English and 2 unrelated to the topic)
- Studies investigating the use of benzodiazepines in MMT patients are for the most part observational and therefore the quality of evidence is low (Level IV).
- BZD use is associated with a variety of adverse consequences, such as increased psychological distress, risk for overdose, higher risk of suicidal behaviour, impaired attention and memory (Bleich et al. 2002: Brands et al. 2008; Caplehorn and Drummer, 2002; Darke etal. 2010; Darke et al 2009; Demaria et al. 200; Man Lan-Ho et al., 2004).

Question 2:
How effective is MMT in the treatment of addiction to prescription opioids?

- 4 studies that were relevant to this question were identified, all providing a low level of evidence (Level IV – Level VI).
    - Prescription opioid users can be treated at least as effectively as heroin users in MMT (Banta-Green et al. 2009).
    - Prescription-opioid users often have pain problems and obtain their opioids legally from a prescriber indicating that they were still under medical supervision for their pain; these patients were more likely to have psychiatric treatment and take sedatives/anxiolytics or anti-depressants (Brands et al. 2004)
- National Institute on Drug Abuse Clinical Trials Network launched the Prescription Opioid Addiction Treatment Study (POATS) to address the increasing rates of prescription opioid addiction. The study is taking place at 10 community treatment programs around the United States. Men and women age of 18 years or older will receive buprenorphine/naloxone. The results of this study should provide further understanding of the treatment of prescription opioid addiction (Weiss et al., 2010).

Question 3 and 4:
What is the impact of urine drug screening on patient retention?

- Only 8 studies were identified as relevant or somewhat relevant to the impact of urine drug screening on patient retention in MMT.
- One RCT showed that methadone take-home doses contingent on a minimum of monthly drug-free urines prevents declines in treatment outcomes; better results were achieved by weekly-urine testing (Chutuape et al. 2001).

Question 5:
What is the impact of methadone tapering on relapse or abstinence?

- Some of the studies that were reviewed overlapped somewhat with the studies that were related to the use of methadone for detoxification (research question #6).
- 3 studies were identified as being relevant to the impact of tapering on effectiveness of MMT: 1 systematic review, 1 RCT (moderate level of evidence due to small sample size), 1 observational study (low level of evidence)
- Systematic Review (somewhat relevant) evaluated the effectiveness of methadone tapers compared to *Levo-Alpha Acetyl Methadol* (LAAM), buprenorphine and clonidine in managing opioid withdrawal and on completion of detoxification. Overall methadone tapers were as effective as other pharmacological agents used for detoxification from opioids (Amato et al. 2004).

Question 6:
What is the effectiveness of methadone for medical detoxification?

- 22 studies identified as being relevant or somewhat relevant to the topic, of which 10 provided very low evidence on the utilization of methadone for detoxification from opioids (Level IV-V).
- 1 systematic review found that the overall effectiveness of a methadone taper was similar to other pharmacological agents (buprenorphine, LAAM, adrenergic agonists) used for detoxification from opioids (Amato et al. 2004).
- Another systematic review of the outcomes of planned detoxification from methadone found high relapse rates among those who completed therapeutically planned methadone tapers, particularly during the first year after the completed tapers (Magura and Rosenblum 2001).

Question 7:
How effective are take-home doses in achieving optimal MMT outcomes?

- 11 articles were identified as being relevant or somewhat relevant to the research question; they addressed various aspects of take-home dose regimes, such as criteria for take-home doses, safety issues and diversion, urine testing and take-home schedules.
- 9 articles were excluded (8 not relevant to the research question and 1 not published in English)
- Strong evidence that methadone take-home doses contingent on drug-free urines prevent decline in treatment outcomes (one study) (Chutuape et al., 2001).

Question 8:
What is the effectiveness of MMT for special populations?

- Pregnancy: strong evidence showing that MMT provides greater social stabilization and prenatal care (Binder and Vavrinkova 2008).
- HIV/HCV: strong evidence for beneficial effect of MMT on HIV risk behaviours and decreased mortality from overdoses (Farrell et al., 2005)
- Youth: 6 studies (low level of evidence)
  - One trial in the US compared 12 weeks of buprenorphine/naloxone to 14 day teper in opioid-dependent youth (6 community out-patient treatment programs). The authors found that continued buprenorphine treatment is more cost effective compared to brief detoxification (Polsky et al. 2010).
- Psychiatric Disorders: 43 studies relevant or somewhat relevant, more than half were of low or very low quality
  - Depressed patients can be more sensitive to opioid withdrawal (Astalset al. 2008; Cacciola et al. 2001; Callaly et al. 2001; Deyer et al. 2005; Elkader et al. 2009; McManus et al. 2007)

Question 9:
How is clinical stability determined?

- Various factors were identified as having an impact on clinical stability, such as treatment retention (15 studies); methadone dose (7 studies), other drug use (8), and impact of counselling and psychotherapy (4 studies).
  - Strong evidence (Level I) on the positive effects of MMT on retention, reduction of illicit opioid use and criminality (Johansson et al. 2007)
  - Meta-analysis (Strong evidence, Level I) reported that higher doses of methadone and individualization of doses are associated with better retention in MMT (Bao et al. 2009).
- Many studies and guidelines cite criteria for clinical stability originally published in the US Federal Register, vol. 66, no 11, Wednesday, Jan 17, 2001 (SAMSHA).

2. Introduction

2.1 History of MMT in the Treatment of Opioid Dependence

In the early 1900s in the United States, opioid dependence was treated in physicians' offices with morphine. However, as the social issues associated with opioid dependence became increasingly apparent, the government of the day initiated behavioural treatment approaches at "narcotics farms" and other hospital-like settings that confined and committed addicts to abstinence and

presumed recovery. Many of these programs proved costly and ineffective with high post-discharge relapse rates. Pharmacotherapy was a missing component.

During the Second World War, methadone, a long-acting pure mμ agonist, was developed by Bayer in Germany as an analgesic. It was considered to be a non-addictive alternative to morphine. In the 1940s, several studies conducted in the United Kingdom recognized methadone as an efficacious treatment of heroin withdrawal symptoms. In the 1950s and 60s, as opioid use became a serious concern in urban areas with resultant dramatic increases in crime and death rates, researchers and physicians became involved in trying to find a medical solution to opioid dependence. In late 1963 and early1964, the first methadone study was performed at The Rockefeller Institute for Medical Research by Drs. Dole and Nyswander in an attempt to develop a new pharmacotherapy for opiate dependence (Dole and Nyswander 1965; Dole and Nyswander 1966). Their research concluded that methadone prevented opioid withdrawal symptoms, blocked the euphoria of heroin, and decreased cravings in opioid-dependent individuals and thereby confirmed methadone efficacious as a maintenance medication for opioid dependence.

Meanwhile, it was actually a Canadian researcher, Dr. Robert Halliday from Vancouver, who set up what is believed to be the first MMT program in the world. Since that time, opioid agonist therapy with MMT has become an effective treatment option for opioid-dependent individuals worldwide. In many countries, including Canada, more people are seeking and receiving treatment with MMT.

In Canada, it is estimated that there are more than 80,000 regular illicit opioid users, 30,000 in Ontario (Popova et al. 2006**).** The multisite OPICAN study, with a cohort of regular untreated illicit opioid users from seven Canadian cities surveyed from 2001 until 2005, provides evidence suggesting that heroin has become an increasingly marginal form of drug use among illicit opioid users in Canada, and that instead, prescription opioids in varying forms have become the predominant form of illicit opioid use (Fisher et al. 2005)**.** A chart review of new admissions (1997-1999) to the MMT program at the Centre for Addiction and Mental Health (CAMH) revealed that 83% of patients had used prescription opioids ± heroin (Brands et al. 2004)**.** Also, between 1990 and 1994, there was a significant rise in individuals addicted to controlled-release oxycodone seeking treatment at CAMH (Sproule et al. 2009). The semi-synthetic oxycodone and full synthetic fentanyl have been linked to several deaths in Ontario (Dhalla 2009, Martin et al. 2006)**.**

Literature on the effectiveness of MMT in the treatment of prescription opioid addiction is sparse. Banta-Green, et al.reported that prescription opioid users can be treated at least as effectively as heroin users in MMT (Banta-Green et al. 2009). Prescription-opioid users often have pain problems and obtain their opioids legally from a prescriber indicating that they were still under medical supervision for their pain; these patients were more likely to have psychiatric treatment and take sedatives/anxiolytics or antidepressants (Brands et al. 2004).

MMT is based on a harm reduction philosophy and represents one component of a continuum of treatment approaches for opioid-dependent individuals. MMT is a substitution therapy that allows a return-to-normal physiological, psychological and societal functioning. It is one possible treatment for opioid dependence. For some people, MMT may continue for life, while others may be able to eventually discontinue MMT and remain abstinent while preserving the normal level of function they attained while on MMT. Each patient must be assessed, treated,

and monitored on an individual basis. Successful outcomes through MMT require knowledge, experience, vigilance, and diligence on the part of the MMT physician, the patient, and all of those involved in treatment.

Methadone alone does not constitute effective treatment of opioid dependency. Effective MMT services should comprise the following components:

- an appropriate methadone dose
- routine medical care
- treatment for other substance dependence
- counselling and support
- mental health services
- health promotion, disease prevention and education
- linkages to other community-based services
- outreach and advocacy.

2.2 Effectiveness of Methadone

Methadone has been extensively researched for safety and its efficacy to reduce morbidity and mortality in opioid dependent patients. The research data and medical literature shows that:

- MMT reduces morbidity and mortality associated with heroin addiction (Gunne and Gronbladh 1981; Kinlock et al. 2009; Newman and Whitehill 1979; Strain et al. 1993).One study found that patients were three times as likely to die without MMT than if they were maintained on treatment (Caplehorn et al. 1994). In addition, studies have shown that MMT can indirectly decrease mortality by decreasing the risk of HIV infection while on MMT (Ball et al. 1988; Caplehorn and Ross 1995). A Cochrane review (Mattick et al. 2009) of 11 randomized clinical trials found that methadone was more effective than non-pharmacological treatments with respect to the outcomes of treatment retention and suppression of heroin use. The great majority of trials were with heroin users.
- There is evidence that MMT reduces illicit opioid and other drug use (Gunne and Gronbladh 1981; Kinlock et al. 2009; Yancovitz et al. 1991). For example, an early trial found that compared to methadone, the control group was more than three times likely to test positive for heroin use at a one-month follow-up after treatment (Yancovitz et al. 1991). MMT also reduces other substance use. One large prospective study (Fairbank et al. 1993) of methadone patients found a reduction in the use of cocaine, amphetamines, illegal methadone, sedatives, and marijuana at follow-up. Other factors associated with decreased drug use include counselling, adequate dosing, contingency management strategies such as take-home doses, and harm reduction program orientation (Kletter 2003; Kraft et al. 1997; Ling et al. 1996; McLellan et al. 1993; Stitzer et al. 1992; Villano et al. 2002).
- There remain few studies on the effectiveness of MMT for prescription opioid (PO) abuse and dependence.
- Methadone is a ： receptor agonist with pharmacological properties similar to those of morphine. It exists as two isomers (d and 1 forms) but it is believed that most of the analgesic activity resides in the 1 isomer (Scott et al. 1948). However, most of the methadone used in clinics is a racemic mixture. Methadone has ideal properties for a

maintenance agent: it is orally active and long-acting (one dose suppresses symptoms of opoid withdrawal for 24-36 hours without producing euphoria, sedation and analgesia). This enables patients to function normally (i.e, without impairment) and experience normal pain and emotional responses. Another advantage of methadone is the ability to suppress craving (Lowinson et al. 2005).

Methadone is well absorbed after oral administration and levels are detectable at 30 minutes with peak concentrations occurring at 4 hours and it is 90% bound to plasma proteins. Methadone is extensively metabolized in the liver to pyrrolidines and pyrroline (via *N*-demethylation and cyclization) which are then excreted in urine and bile (Gutstein and Akil, 2006). The elimination half-life ($t_{1/2}$) of methadone is approximately 22 hours but there is considerable inter-indivdual variability and estimates range from 5-130 hours (Eap et al. 2002).

2.3 Professional Duties

MMT physicians are responsible for the following:

1. Provide professional, respectful and reliable services to patients
2. Provide back-up coverage for periods when on vacation or otherwise unavailable
3. Provide appropriate notice should they close their MMT practice
4. Assist in the transfer of patients to other MMT physicians
5. Provide or facilitate patient access to health and social services, such as counselling and primary health care
6. Remain current in practices and standards for MMT and the treatment of opioid dependence
7. Communicating and collaborating with pharmacists and other care providers for the benefit of the patient.

2.4 Interprofessional Collaboration (IPC)

2.4.1 Physician-Pharmacist Collaboration and Communication

Many problems in patient care have been found to be a direct result of lack of communication between MMT prescriber and pharmacist (CAMH, November 24th, 2010). To optimize patient care, communication between physicians and pharmacists is essential in the following:

- Determining at the outset of treatment whether a pharmacy is accepting new patients
- Discussing how and when the pharmacist is to contact the MMT prescriber
- Developing means for the pharmacist to reach the MMT prescriber for urgent issues after hours
- Documenting or relaying pertinent clinical information (e.g. pregnancy), missed doses, vomited doses.

Interprofessional collaboration is a principle supported by both CPSO and OCP. The pharmacist and the physician play an important role in MMT. This can include joint development of policies and procedures to ensure continuity of patient care and secure custody and storage of methadone. Collaboration and regular communication between

pharmacists and MMT prescribers can have positive impact on patient care and safety (OCP, September 2010).

2.4.2 Physician-Patient-Pharmacist 3-Way Treatment Agreements

In order to facilitate collaborative communication, 3-way agreements between the physician-patient-pharmacist are encouraged. These 3-way agreements are similar to current Treatment Agreements between the physician and the patient but include the pharmacist as well. (See Appendix G Sample Physician/Pharmacist/Patient Agreement Letter) The patient should always be given the opportunity to select their choice of pharmacy. Additionally, beyond the 3-way treatment agreements, a pharmacy will also have a Patient-Pharmacist Agreement (CAMH, 2004) to cover procedural issues specific to the pharmacy.

2.5 Conclusion

The medical literature supports that MMT is a well established and cost-effective treatment paradigm. MMT saves lives and reduces violent and non-violent crime; drug use; and the transmission of HIV, Hepatitis C, and other communicable diseases. The effectiveness of MMT is enhanced with contingency management and counselling.

3. MMT Physicians and Practice Settings

3.1 Overview

MMT is prescribed in different settings, using different models of care such as: primary care, MMT focused practices, community-based agencies, hospitals, chemical withdrawal units (CWU), residential addiction treatment centres, and correctional facilities. This section outlines the requirements of all MMT prescribers in these practice settings.

▶ Standard

S3.1	As of January 1, 2009, the MMT physician shall complete: 1) the Opioid Dependence Treatment Core Course prior to obtaining a methadone exemption, **and** 2) the full Opioid Dependence Certificate Program within 3 years of receiving an exemption.

3.2 Obtaining a Methadone Exemption

For an exemption to prescribe MMT, a physician must:

- Hold a certificate of registration in Ontario
- Be in good standing with the CPSO
- Complete an application form and agree to practice in accordance with the CPSO's expectation document (available at CPSO)
- Complete the Opioid Dependence Treatment Core Course through CAMH
- Complete two days of clinical training with a MMT physician approved by the CPSO.

The initial exemption is issued for one year with subsequent exemptions issued every three years. For more information contact the CPSO Methadone Program (416) 967-2661.

3.3 MMT Physician Practice Settings

3.3.1 Primary Care MMT Practice

General practitioners and family physicians may provide MMT in solo medical practice or group practices such as Family Health Teams, private medical clinics, hospital-based health clinics and community-based health centers, including chronic care centers. They may prescribe methadone either integrated with or separate from their medical practice. Some MMT patients in Ontario receive medical care as well as MMT from their primary-care physician. Some physicians in private practice provide psychotherapy as well as MMT and other medical services.

MMT based in primary practice has several advantages, such as being less stigmatizing and addressing previously unmet medical needs (Fiellin et al. 2001; King et al. 2002; Lewis and Bellis 2001; Merrill et al. 2005). However, patients may have to travel to receive pharmacy, laboratory, and other specialized addiction and support services. Group practices may have advantages over solo practice. Research by Strike et al. (2005) indicates that group practices

may have better retention rates than solo practitioners and the integration of primary-care services within group practices is likely to lead to better outcomes for MMT patients.

3.3.2 MMT-Focused Practice

MMT physicians who work in focused methadone clinics (both outpatient and inpatient) may be general practitioners, family physicians, or Royal College of Physicians and Surgeons Specialists. Such physicians have additional training or exam certification in Addiction Medicine and focus their clinical practices in MMT; their practices may consist entirely or predominantly of MMT patients. Many MMT patients in Ontario receive their care in this model.

MMT physicians in focused practices generally do not provide primary care to their patients. Patients may need to seek out primary care or psychosocial services in the community.

3.3.3 Community-Based MMT Practice

Community-based physicians may provide services through publicly-funded, community based clinics that integrate psycho-social care. Examples include HIV/AIDS services, mental health agencies, and clinics run by local public health departments. These clinics often specialize in serving specific populations or issues such as HIV/AIDS, Hep.C, marginalized, street-involved, or homeless populations. Many community-based clinics operate under a harm-reduction philosophy and involve a multi-disciplinary team (social workers, nurses, case managers, dieticians, pharmacists) in the patient's care.

These clinics usually offer a comprehensive MMT program that includes health and social supports. This kind of one-stop clinic model saves time and expenses for the patient and addresses the patients' quality of life issues. It also helps ensure better coordination and communication among the service providers.

3.3.4 Hospital and Corrections-Based MMT Practice

MMT physicians in hospitals and some residential addiction-treatment centres maintain patients on their community-based MMT program or may initiate MMT in some circumstances.

Hospital-based physicians providing care for MMT patients may apply for temporary methadone exemptions, one patient at a time, to manage admitted medical, surgical, and psychiatric patients. They may not have specialized knowledge of opioid dependence (see Section 15 Hospital-Based MMT).

Correctional facilities manage many patients with opioid dependence and may provide MMT (see Section 14: MMT in Federal/Provincial Correctional Facilities).

4. Pharmacotherapy Options other than MMT for Opioid Dependence

4.1 Overview

The main treatment options for opioid dependence are abstinence based treatments and opioid agonist therapy (also known as opioid substitution therapy) with methadone or buprenorphine. MMT physicians must be familiar with the indications, benefits, and risks of each option, in order to provide the safest and most effective treatment for their patients.

►Standards

S4.1	The MMT physician shall inform the patient of all the treatment options to treat opioid dependence, including risks and benefits, so they may make an informed decision about the use of MMT prior to initiation.
S4.2	Physicians who prescribe buprenorphine shall have the appropriate knowledge, skills, and judgment to do so.

►Guideline

G4.1	The MMT physician should be familiar with the individual patient factors to be taken into consideration in the choice for buprenorphine as an opioid agonist therapy.

4.2 Abstinence Based Treatments

Abstinence based treatment may consist of medically supervised withdrawal from opioids, followed by an inpatient or outpatient psychosocial treatment program, and/or 12 Step group participation (AA, CA, NA). While abstinence based treatment is less effective than MMT, patients may prefer a trial of abstinence before committing to long-term opioid agonist therapy (Richman et al. 1972).

Patients should be warned that after detoxification 1) as a result of losing their tolerance to opioids, they are at risk for overdose if they relapse to their usual opioid dose, and 2) emotional distress associated with opioid withdrawal may increase the risk of suicidal ideation. MMT physicians should take appropriate precautions to avoid these adverse outcomes.

Patients may choose naltrexone treatment after detoxification from opioids. Naltrexone, a long-acting opioid antagonist, may be prescribed to patients as a deterrent to opioid use. The MMT physician should be fully aware of the management issues for naltrexone treatment for opioid dependence prior to initiating such therapy.

4.2.1 Indications for Abstinence Based Treatment

Patient preference. Many patients prefer a trial of detoxification first, as some view opioid agonist treatment as inconvenient and time consuming.

Prior sustained response to abstinence based treatment. Patients may consider re-trying abstinence based treatment if they previously maintained a long period of abstinence following psychosocial treatment.

Good prognostic factors. Patients may be more prepared for medically supported withdrawal followed by abstinence if they are highly motivated for change and opioid abstinence, and have good prognostic factors for recovery from addiction. (e.g., socially stable, supportive social network, short duration of addiction, no major psychiatric co-morbidity, not addicted to other drugs) (Gossop et al. 1989; 1990; Rabinowitz et al. 1997; Unnithan et al. 1992; Washton et al. 1984).

4.2.2 Pharmacotherapy for the Systematic Treatment of Opioid Withdrawal

The most common drugs used to alleviate opioid withdrawal symptoms are alpha adrenergic agonist (e.g., clonidine), and opioid agonists (e.g., methadone and buprenorphine). See Table 01.

Table 01: Withdrawal Management

Drug	Dose	Opioid Withdrawal Symptoms
Clonidine	0.1 mg 1–2 tabs p.o. b.i.d.to q.i.d. p.r.n.	agitation, diaphoresis, and sympathetic overdrive
Dimenhydrinate	50 mg p.o. or p.r. p.r.n.	nausea
Ibuprofen	200 mg 1–2 tabs p.o. t.i.d. p.r.n.	myalgia
Immodium	2 mg p.o. p.r.n. (maximum 6 tabs/day)	diarrhea stool
Trazodone	50–100 mg p.o. q.h.s. p.r.n.	insomnia
Benzodiazepines	p.r.n. at MMT physician's discretion	anxiety

4.3 Opioid Agonist Treatment

Long-acting opioids used in the treatment of opioid dependence include buprenorphine and methadone. This section discusses the use of buprenorphine.

4.3.1 Buprenorphine

Buprenorphine-naloxone (Suboxone®) is a sublingual partial mμ agonist that, at the appropriate dose, relieves withdrawal symptoms and cravings for 24 hours or more. Because it has a ceiling effect, buprenorphine appears to be safer in overdose compared to methadone (Mattick et al. 2008; Veilleux et al. 2010). However, buprenorphine may also be somewhat less effective than methadone at retaining patients in treatment (Mattick et al 2008). The maximum dose for buprenorphine (24 mg) is probably less effective than methadone at doses above 60 or 80 mg, and thus, methadone may be more appropriate for patients who are dependent on large doses of opioids. Patients who have failed at buprenorphine treatment may be switched to MMT; switching from methadone to buprenorphine is clinically more difficult (Greenwald et al. 2003; Levin et al. 1997; Petitjean et al. 2001).

Buprenorphine is very unlikely to replace MMT, and the two medications should be viewed as complementary. Until further research is available, the choice between MMT or buprenorphine should be based on individual patient factors and patient preference.

4.3.2 Indications for Buprenorphine Treatment

While there is a lack of definitive evidence on the indications for choosing buprenorphine over methadone, MMT physicians may want to consider prescribing buprenorphine in the following particular patient groups:

- Patients with prolonged QTc interval secondary to methadone treatment or any other cause (Fanoe et al. 2007; Wedam et al. 2007).
- Patients at higher risk for methadone toxicity: Elderly patients, those taking benzodiazepines (Schottenfeld 1988) or other sedating drugs, with heavy alcohol consumption, COPD or other respiratory illness, and patients with lower tolerance to opioids (e.g., on codeine, or less than daily opioid use) (Corkery et al. 2004; Mikolaenko et al. 2002; Pergolizzi et al. 2008).
- Adolescent and young adult patients. Recent literature reports that buprenorphine with behavioural interventions is significantly more efficacious in the treatment of opioid-dependent adolescents compared to clonidine plus behavioural intervention (Marsch et al. 2005).
- Patients with good prognosis who may be able to successfully taper off opioid agonist treatment after 6-12 months. The literature indicates that buprenorphine has a milder withdrawal syndrome and may be easier to discontinue than methadone (Woody et al. 2008).
- Patients for whom methadone take-home restrictions may cause them to drop out of treatment because of lack of transportation or work or family commitments.
- Patients for whom methadone take-home restrictions may not be as necessary because they are at lower risk for overdose, misuse and diversion (e.g., they take prescription opioids orally from only one physician, are not abusing street drugs, and are not selling or buying their opioids).

4.3.3 Buprenorphine: Practical Issues

- In Canada, buprenorphine is available as Suboxone®, a buprenorphine/naloxone combination product.
- As with other opioids, buprenorphine is subject to federal Controlled Drugs and Substances Act.
- Patients will not be registered with the CPSO.
- Physicians do not need special authorization to prescribe; the CPSO expects physicians who prescribe buprenorphine to have the appropriate knowledge, skills and judgment to do so.

Guidelines for the provision of buprenorphine are under development at the Centre for Addiction and Mental Health (CAMH). The Guideline will provide recommendations on take-home dosing, urine drug screening (UDS) and other clinical practices. For any further information about training in buprenorphine prescribing, contact CAMH at (416) 535-8501 or www.camh.net.

4.4 Conclusion

Table 02: Consideration of Factors for Buprenorphine vs Methadone vs Abstinence-based Treatment

Abstinence-based treatment	Buprenorphine	Methadone
• Patient preference • Good prognostic factors • Has not tried abstinence-based treatment • Had a prolonged period of abstinence following previous abstinence-based treatment	• Failed or had adverse effects with methadone • Quickly relapsed after withdrawal management • Good prognosis; may not need long-term opioid agonist treatment • At higher risk for methadone toxicity	• Failed or had adverse effects with buprenorphine • Quickly relapsed after withdrawal management • Intravenous buprenorphine abuse • High risk for treatment drop-out

5. Initial Patient Assessment

5.1 Overview

Initial patient assessment for MMT involves assessing for suitability for MMT, a history and brief physical examination, urine drug screening and other investigations, and a discussion and review of treatment options and necessary documents pertinent to MMT.

►Standards

S5.1	The MMT physician shall establish that the patient meets the DSM IV criteria for opioid dependence prior to MMT initiation (see Appendix A).
S5.2	The MMT physician shall be knowledgeable of any potential risks for methadone toxicity prior to MMT initiation and manage the patient's care appropriately.
S5.3	The MMT physician shall register patients with the CPSO.

►Guidelines

G5.1	The MMT physician should consider abstinence based treatment and/or opioid substitution for withdrawal purposes for patient's under18 years of age with a shorter duration of opioid dependence.
G5.2	The MMT physician should consider MMT for patients under 18 years of age only after a thorough assessment and discussion about all treatment options.
G5.3	The MMT physician should ensure there has been a discussion with patients under 18 years of age (and other family members where possible) about potential issues with methadone including side effects, risks and difficulty withdrawing and tapering off of methadone.
G5.4	The MMT physician should seek and document consultations, formal or informal, with a methadone provider prior to initiating a patient under 18 years of age on MMT.
G5.5	For all patients that may be initiated on MMT, the physician should document the following in addition to a medical history: 1) pattern of use of all major drug classes (including tobacco and alcohol) 2) addiction treatment history and response 3) high-risk behaviour, such as needle sharing and sex trading 4) psychiatric history, current mental status (particularly suicidal ideation) 5) social situation (including child custody and the partner's drug use history) 6) details regarding chronic or recurrent pain.
G5.6	The MMT physician should conduct a focused physical examination prior to initiating MMT or within a reasonable amount of time (i.e. during the early stabilization phase)
G5.7	If an initial UDS for methadone is positive, the MMT physician should confirm that the patient is not on another MMT program by receiving approval from the CPSO prior to initiating MMT.
G5.8	The MMT physician should request bloodwork which includes HIV, and hepatitis B and C serology during initiation or within a reasonable amount of time after initiation on MMT.
G5.9	The MMT physician should test for pregnancy in female patients of childbearing potential prior to initiating MMT.
G5.10	The MMT physician may initiate MMT prior to receiving confirmation from CPSO if the initial UDS is not positive for methadone or EDDP.
G5.11	The MMT physician should have a written Treatment Agreement signed by the patient and documented in the chart. See Appendix D MMT Agreement

5.2 Suggested Criteria for MMT

The MMT physician should consider the suggested criteria for MMT prior to initiation:

1. Opioid use (a urine drug screen that is positive for opioids and verifies the patient's history).
2. Meets DSM IV criteria for opioid dependence.
3. Lower likelihood of benefit from non- MMT treatments.
4. Agreement to terms and conditions of the MMT program.

Patients may be suitable candidates for MMT even if it was unsuccessful or discontinued in the past.

5.2.1 Adolescents

Patients under 18 years of age may be considered for MMT, however abstinence based treatment and/or opioid substitution tapering should also be considered for adolescents, particularly those with a shorter duration of opioid dependence. Any treatment option involving withdrawal should be avoided if the patient is pregnant. Methadone should be considered after a thorough assessment and a discussion about all treatment options has taken place. The MMT physician should ensure that there has been a discussion with the adolescent (and other family members where possible) about potential issues with methadone including side effects, risks and difficulty of tapering off.

In cases where a MMT physician considers it appropriate to offer an adolescent MMT, it is recommended that the MMT physician consider seeking assistance by referral and may request a consultation (formal or informal) with another MMT physician.

Currently, there is a lack of evidence on the effectiveness of MMT in adolescents. However, several studies in the United States are investigating the use of buprenorphine-naloxone in opioid dependent youth (Chakrabarti et al.; Polsky et al. 2010; Subramaniam et al. 2009).

5.3 Assessing a Patient for MMT Initiation

See Appendix E for Patient Initiation to MMT Form.

5.3.1 Patient History

There are a number of important areas to concentrate on with regards to patient history for this population of patients. See Appendix C Initial Patient Assessment Form

1. Ensure the patient meets the DSM IV criteria for opioid dependence prior to MMT initiation.
2. Identify any potential risks for methadone toxicity prior to MMT initiation (see Table 03)
3. Pattern of use of all major drug classes (including tobacco and alcohol).
4. Previous addiction treatment history and response.
5. High risk behaviour such as needle sharing and sex trading.
6. Psychiatric history and current mental status including suicidal ideation.
7. Social situation including housing, supports, child custody, and partners drug-use history.
8. Details regarding chronic or recurrent pain.

Table 03: Patient Factors that Increase Risk of Methadone Toxicity

High Risk Patients
Recent benzodiazepine use
Use of other sedating drugs
Alcohol-dependent patients
Over 60 years old
Respiratory Illnesses
Taking drugs that inhibit methadone metabolism
Lower opioid tolerance
Decompensated hepatic disease
Recent discharge from inpatient rehabilitation facility
Recent incarceration

5.3.2 Elderly

One study showed that older adult MMT patients (> 55 years old) were more likely to report alcohol use and in general, their quality of life did not improve with aging and length of tenure in MMT (Rajaratnam et al. 2009). Firoz and Carlson did not find any differences between MMT patients older than 55 years and their younger counterparts in terms of medical, psychiatric or employment problems (Firoz and Carlson 2004). Schroeder et al provided strong evidence on the significantly higher rates of adverse events (infections, gastrointestinal, musculoskeletal) among female MMT patients, while participants over age 40 reported lower rates of adverse events (Schroeder et al. 2005). Tuchman reported that close correspondence of menopausal symptoms and opiate withdrawal/methadone symptoms can result in inadequate medical attention to problems related to methadone maintenance (Tuchman 2007; 2010).

5.3.3 Focused Physical Examination

The MMT physician should conduct a focused physical examination prior to initiating MMT or within a reasonable amount of time (i.e., during the early stabilization phase). Special attention should be given to signs of opioid withdrawal, malnutrition, jaundice, hepatosplenomegaly, cardiovascular and respiratory status, pupil size, needle tracks, and abscesses.

5.3.4. Urine Drug Screening (UDS)

Initial urine drug screening facilitates objective corroboration of the patient history of opioid drug use. Some particular UDS results need to be taken into consideration prior to MMT initiation.

5.3.4.1 Initial Opioid Positive Urine without Differentiating/Identifying the Specific Opioid

A patient may be appropriate for initiation on methadone even if their initial urine drug screen is positive for opioids, but does not identify the specific opioid that the patient has reported as their opioid of abuse, if the following circumstances are met:

1. the patient has signs and symptoms of obvious opioid withdrawal **OR**
2. the patient has obvious track marks **OR**
3. the patient has been on previous MMT **OR**
4. the physician has corroborating information from a previous opioid prescribing physician.

5.3.4.2 Methadone-Positive Initial UDS

There are many patients who come for an initial assessment for MMT who have previously tried/used methadone that was not prescribed for them. With a positive initial UDS for methadone or EDDP (a methadone metabolite), it is important to document the patient's history of methadone use. To avoid MMT duplication and toxicity, the MMT physician should also contact the CPSO to ensure that the patient is not on another MMT program and receive confirmation from the CPSO prior to initiating the patient on methadone.

5.3.5 Other Tests

In addition to UDS, the MMT physician should request bloodwork for HIV, Hepatitis B and C serology and any other relevant bloodwork during initiation or within a reasonable amount of time after initiation on MMT. Occasionally, patients refuse or will not comply with this directive. The MMT physician should discuss the concerns with the patient and document the discussion.

In females of childbearing potential, a urine pregnancy test should be done prior to initiating MMT.

5.4 MMT Program Documentation

5.4.1 CPSO Registration

Patients may not receive a prescription for methadone from more than one source at a time. For this reason, prior to initiating treatment, the MMT physician should register patients for treatment with the CPSO to ensure the patient does not receive treatment elsewhere. A clinical decision may be made to start MMT before receiving CPSO approval if there is a concern that a delay in initiation will cause the patient undue harm or cause the patient to drop out of treatment. (See Appendix E Patient Initiation to MMT Form) The MMT physician should await approval from the CPSO in the case of EDDP/methadone positive initial urine drug screen.

5.4.2. Treatment Agreement

Written Treatment Agreements, or Letters of Understanding, are documents that list expectations of involvement in a MMT program. The use of treatment agreements in MMT programs has proven beneficial to both the patient and the MMT physician. A signed Treatment Agreement is documentation of informed consent. (See Appendix D: Sample Methadone Maintenance Treatment Agreement).

Treatment Agreement should include:

- Patient and provider roles and responsibilities
- MMT program expectations and structure
- Doctor patient confidentiality and exceptions to this
- Expectations of communication with other appropriate providers (pharmacist, treating primary care physicians and consultants)
- General consent (e.g., access to patient charts for MMT physician assessment of their MMT practice).

It is recommended that the MMT physician communicate his/her expectations with the pharmacist at pharmacies where their patient's methadone is dispensed. This can be accomplished through one of the following:

1. Three way treatment agreement between the patient, the MMT physician and the pharmacist.
2. Letter to the pharmacist outlining details of your treatment agreement with your patient along with your expectations regarding missed doses, intoxication. This may also include your contact information in case of emergency. (See Appendix G: Sample Physician/Pharmacist/Patient Agreement Letter).
3. Verbal discussion with the pharmacist outlining the details of the MMT physician treatment agreement with the MMT patient along with the MMT physician's expectations regarding missed doses, intoxication. It may also include communicating the MMT physician contact information in case of emergency.

6. Dosing During Initiation, Stabilization and Maintenance

6.1 Overview

Patients are at a high risk of death from methadone overdose in the first two weeks of MMT**.** Recent prospective population studies from the UK and Australia have revealed that during the first two weeks of methadone treatment the crude mortality rate was 17 per 1000 person years (Cornish et al. 2010; Degenhardt et al. 2009). The risk of fatal methadone overdose during this time period is estimated to be 6.7 times higher than that of heroin addicts not in treatment, and 98 times higher than that of patients on maintenance doses of methadone in treatment for longer periods (Caplehorn and Drummer 1999). A single day's MMT dose can be lethal to non-tolerant individuals. (Harding-Pink, D 1993)**.** The ratio between the maximum recommended initial dose (30 mg) and a potentially fatal single dose is exceedingly narrow compared to other medications (Repchinsky 2003; Wolff 2002)**.**

The prolonged half life (as long as 55 hours in methadone naïve individuals) and slow bioaccumulation of methadone accounts for its insidious onset of overdose. During dose increases, serum levels accumulate over several days even if the dose is kept the same. Therefore, a dose that is barely adequate on day one can be toxic by day 3-5. This is particularily relevant during initiation on MMT. The patient may appear relatively alert during the day succumbing to an overdose during a nap or at night. Early signs of toxicity include ataxia, slurred speech, "nodding off," and emotional lability (Caplehorn and Drummer 2002).

Concurrent use of benzodiazepines, alcohol, and other sedating drugs substantially increases the risk of death from methadone toxicity. One study found evidence of polydrug use in 92% of methadone-related deaths (Zador and Sunjic 2000). Animal studies indicate that benzodiazepine use substantially increases the risk of fatal overdose (Caplehorn, JR and Drummer, OH, 2002.)

►Standards

S6.1	On the methadone prescription, the MMT physician shall specifiy: 1) Start and end dates 2) Days of week that are to be supervised 3) Number of take-home doses and days of week that are to be given as take-home doses 4) The dose written in numbers and words.
S6.2	The MMT physician shall counsel the patient on strategies to avoid methadone toxicity.
S6.3	The MMT physician shall not allow for any take-home doses during the first four weeks of treatment.
S6.4	The MMT physician shall ensure the reason for all dosage adjustments are documented.
S6.5	The MMT physician shall ensure that the starting methadone dose for all patients is 30 mg or less.
S6.6	The MMT physician shall ensure that the starting methadone dose for patients at higher risk for methadone toxicity is 20 mg or less.
S6.7	The MMT physician shall ensure that the starting methadone dose for patients who have been recently abstinent from opioids is 10 mg or less.
S6.8	The MMT physician shall assess the patient at least weekly during early stabilization.
S6.9	The MMT physician shall assess the patient in-person prior to each dose adjustment.
S6.10	For patients who are not at higher risk for methadone toxicity, the MMT physician shall prescribe dose increases of no more than 10-15 mg every 3-5 days during the early and late stabilization phases.
S6.11	For patients at higher risk of methadone toxicity, the MMT physician shall prescribe dose increases of no more than 5-10mg every 3-5 days during the early and late stabilization phases.
S6.12	For patients who have recently been abstinent, the MMT physician shall prescribe dose increases of no more than 5 mg every five or more days during the early and late stabilization phases.
S6.13	The MMT physician shall not increase the patient's dose more than 10 mg every 5- 7 days during the maintenance phase or once the patient has reached a dose of 80 mg.
S6.14	If the patient misses two or more consecutive doses during the early stabilization phase, the MMT physician shall cancel all subsequent doses, assess the patient in person, and restart the patient maintaining this dose for at least three consecutive days.
S6.15	The MMT physician shall reduce the dose to 30 mg or less when a patient has missed 4 or more doses of methadone during the late stabilization and maintenance phases.
S6.16	The MMT physician shall reduce the dose by 50% or to a dose of 30mg or less when a patient has missed 3 consecutive days during the late stabilization and maintenance phases.
S6.17	During the late stabilization phase, when the patient's dose of methadone is still changing, the MMT physician shall see and assess the patient at least once weekly. The MMT physician shall increase the dose by no more than 5-15 mg every 3-5 days, depending on the patient's cravings, opioid use, withdrawal symptoms, and underlying risk for toxicity.
S6.18	The MMT physician shall order an ECG with a calculated QTc interval for patients on doses above 150 mg.

►Guidelines

G6.1	During initiation and early stabilization, the MMT physician should avoid prescribing any sedating drugs. The MMT physician should also advise the patient to avoid any new sedating medications/drugs.
G6.2	For patients who are addicted to high daily doses of benzodiazepines, the MMT physician should taper either before MMT initiation, or small tapering doses should be given during initiation, preferably in a supervised setting in consultation with an addiction medicine physician.
G6.3	The MMT physician should ensure doses are only increased after the patient has been assessed in person, and it is determined that the patient is experiencing cravings or ongoing opioid use, and/or a constellation of withdrawal symptoms.
G6.4	During the Maintenance Phase, the MMT physician should assess patients weekly to monthly based on the recovery needs of the patient. Patients on contingency management should be assessed more frequently (i.e. weekly). Patients on contingency management with full take-home doses may be assessed less frequently than once a week with long term abstinence of 6 months of more. MMT physician assessments less frequently than once monthly may occur if the patient is well known to the MMT physician, has been clinically stable and abstinent for a long period of time (i.e. years), and is considered by the MMT physician to be a reliable historian.
G6.5	The MMT physician should identify and manage risk factors for Torsades de Pointes arrhythmias, and should obtain an ECG above 120 mg for patients with these risk factors.
G6.6	The MMT physician should repeat the ECG if the patient is at a dose approaching 180–200 mg.
G6.7	The MMT should consider tapering the dose if it is high and if the patient reports sedation or other cognitive effects.
G6.8	When considering assessing a patient for a dose increase, the MMT physician should assess the patient for other conditions that are commonly confused with withdrawal symptoms.
G6.9	If the patient has emesis after taking methadone, the MMT physician should not replace the dose unless the emesis was witnessed by the pharmacist or staff, and it occurred less than 15 minutes after consumption. The replacement dose must be no more than 50% of the regular dose.

6.2 Writing a Methadone Prescription

Safe dispensing of methadone begins with a well-written prescription. Collaboration and communication between the physician and the pharmacist help to enhance patient safety. See Appendix F Sample Prescription Form.

The prescription shall specify all of the following:

1) Start and end dates
2) Days of week that are to be supervised
3) Take Home doses: number of take-home doses and days of week that are to be given as take-home doses
4) Methadone dose: written in both numbers and words to help to prevent tampering of prescriptions.

6.3 Strategies to Reduce Risk of Overdose

- **Patient education.**
  1) Explain to the patient that it takes several weeks to reach the optimal dose of methadone, and it may be dangerous to try to relieve withdrawal symptoms with benzodiazepines, illicit methadone or other drugs.
  2) Advise the patient to:
     - limit his or her driving or use of machinery after a dose increase, particularly in the first few hours after dosing.
     - take the methadone dose in the morning, since the risk of overdose is increased at night (Wolff 2002).
  3) Whenever feasible (with the patient's consent), a family member or significant other should be educated about the symptoms of overdose with clear instructions to seek urgent medical help at the first sign of toxicity. A patient information guide may be used for this purpose (see Appendix I Managing Potential Methadone Overdose)**.**

- **Frequency of visits.**
  Schedule patient visits at least every 1-2 weeks. However, twice-weekly visits during the first two weeks of treatment are recommended, particularly if the patient is at increased risk for methadone toxicity. The physician can schedule an assessment of the patient two to six hours after the methadone dose if there are concerns about sedation with the dose. The physician should inquire about sedation and other side effects.
- **Take-home doses during initial titration.**
  No take-home doses shall be granted during the first month of treatment including Sunday take-home doses, holiday carries, pharmacy closure (see Section 8.0 Take-Home Doses).

- **Sedating Drugs.**
  Avoid prescribing sedating drugs and warn the patient to avoid using them. This includes alcohol, benzodiazepines, non-benzodiazepine hypnotics, antipsychotics, antidepressants, gravol and sedating antihistamines. Even moderate, therapeutic doses of these drugs may increase the risk of overdose if they are initiated at the same time as methadone and the patient is not fully tolerant to their sedating effects. Patients should also be advised to avoid alcohol during MMT initiation.

- **High-dose Benzodiazepine users.**
  Benzodiazepine abuse and dependence are common in this population. As with opioids, it is difficult to accurately judge a patient's benzodiazepine use and tolerance, therefore, benzodiazepine tapering, while difficult on its own, can be very complicated and potentially unsafe (due to oversedation) when attempted with methadone initiation. If possible, patients addicted to high doses (50 mg of diazepam equivalent per day) should be tapered prior to methadone initiation. Otherwise, benzodiazepine tapering**,** during initiation should be considered, with monitoring in a medically supervised setting. Only small benzodiazepine doses should be used, just enough to prevent severe withdrawal. Consultation with an addiction medicine physician is advised.

- **Communication with the pharmacist.**
  Written treatment agreements and regular verbal communication about the patient's clinical presentation to both providers and pharmacists may enhance patient safety.

- **Intoxication or sedation at the pharmacy.**
  At any stage of MMT, the pharmacist should be instructed to hold the methadone and alert the physician if the patient appears sedated or intoxicated.

- **Careful assessment prior to dose increases.**
  Several criteria should be considered increasing the dose of methadone.

6.3.1 Clinical Criteria for Dose Adjustment

The physician should consider increasing the dose if the patient has daily cravings, ongoing opioid use, or opioid withdrawal symptoms. See Appendix H Sample Addiction Medicine Clinical Note. Withdrawal symptoms vary between patients. See Table 04. Most patients report a combination of the following:

Table 04: Withdrawal Symptoms

Physical Symptoms	Psychological Symptoms
Myalgia	Insomnia
Sweating	Fatigue
Yawning	Anxiety
Rhinitis	Irritability
Restlessness	Nausea

Symptoms usually begin a predictable number of hours after the methadone dose, although there may be some daily variation with the patient's activity level and other factors. With each dose increase, the onset of symptoms is delayed and their severity is lessened. Alternative explanations should be sought if the patient has one isolated symptom (such as insomnia or nausea), or if the patient reports that the onset of symptoms is not related to the time of the dose.

The physician should also enquire about side effects, such as constipation and sedation, as this may affect dosing decisions.

6.3.2 Documentation for Dose Adjustments

At visits where the dose is adjusted, the physician should document:

1) Cluster of withdrawal symptoms
2) Timing of withdrawal symptoms (what time of day they appear)

3) Ongoing drug use and timing of drug use:
   - opioid use at the end of the day may indicate inadequate methadone dose.
   - Use of alcohol or benzodiazepines may indicate the need for caution in dose adjustment.
4) Changes in mood and daily activities.

6.4 The Initial Methadone Dose

The physician should base the initial dose on the patient's underlying risk for methadone toxicity. The following factors increase this risk see Table 03: Patient Factors that Increase Risk of Methadone Toxicity (Albion et al. 2010; Srivastava and Kahan 2006).

Sedating drugs include over-the-counter medication such as gravol, prescribed medications such as antipsychotics and sedating antidepressants, or drugs of abuse such as ketamine and GHB. Even therapeutic doses of benzodiazepines can increase risk of methadone toxicity. The MMT physician should look for evidence of benzodiazepine use in the initial drug screen.

Opioid tolerance is difficult to establish by history, so, if in doubt, it is safer to initiate on a lower dose. Lowered tolerance is likely in patients who report non-daily opioid use, daily use of codeine, or daily use of oral opioids at moderate doses. Typically, patients who use opioids intranasally (ie snorting) have a lower tolerance than patients who inject opioids. Tolerance is lower in patients who have been abstinent for more than a few days, e.g., patients who have been recently discharged from a correctional facility, withdrawal management centre or treatment centre. See Table 05.

Table 05: Initial Methadone Dose

Patient Factors	Initial Dose
Higher risk for methadone toxicity	20 mg or less
Recent abstinence from opioids	10 mg or less
No risk factors or recent abstinence	30 mg or less

6.5 Early Stabilization Phase (0-2 weeks)

Dose increases during the early stabilization phase should take place only after an in-person MMT physician assessment and for patients who are experiencing cravings, ongoing opioid use, and/or a cluster of opioid withdrawals symptoms. MMT physicians should assess patients at least once weekly during this phase. See Table 06.

Table 06: Dosing During Early and Late Stabilization Phase

Patient Factors	Dose Increase	Frequency
Higher risk for methadone toxicity	5-10 mg	Every 3-5 days
Recent abstinence from opioids	5 mg or less	Every 5 days or more
No risk factors or recent abstinence	10-15 mg	Every 3-5 days

6.5.1. Missed Doses During Early Stabilization Phase (0-2 weeks)

During the early stabilization phase, patients should be on the same dose for at least 3 consecutive days with no missed doses before an increase. The pharmacists should be advised to contact the MMT physician if the patient misses any doses. If two consecutive doses are missed during the early stabilization phase, the pharmacist should be advised to cancel the prescription until the patient can be reassessed by the physician. Collaborative communication between the physician and pharmacist if the patient misses any doses during early stabilization is essential. The patient must be reassessed in person by the physician and restarted at 30 mg or less.

6.6 Late Stabilization Phase (2-6 Weeks)

Most patients in the late stabilization phase are taking between 50–80 mg of methadone. Most patients during this phase are experiencing only partial relief of withdrawal symptoms, and they often continue to use opioids sporadically.

Dose increases during the late stabilization phase shall be the same as during early stabilization phase (see Table 06) until a dose of 80 mg is reached. Dose increases during the late stabilization phase should take place with an in person MMT physician assessment and for patients who are experiencing cravings, ongoing opioid use, and/or a cluster of opioid withdrawal symptoms. MMT physicians should assess patients at least once weekly during this phase.

6.6.1 Dosing During Late Stabilization Phase

See Table 06: Dosing During Early and Late Stabilization Phase.

6.6.2. Missed Doses During Late Stabilization Phase

If three or more consecutive doses are missed during the late stabilization phase, the pharmacist should be advised to cancel the prescription until the patient can be reassessed by the MMT physician. The patient must be reassessed in person by the MMT physician. After 3 consecutive days missed, the dose should be decreased to 50% of the current dose or 30mg. After 4 or more consecutive days missed, the dose should be decreased to 30 mg or less.

See Table 08 Management of Missed Doses.

6.7 Maintenance Phase (6+ Weeks): The Optimal Methadone Dose

The optimal maintenance dose of methadone will relieve withdrawal symptoms, block opioid-induced euphoria and reduce opioid cravings for 24 hours, without causing sedation or other significant side effects. With experience, the MMT physician can reach this dose for the majority of their patients within 2-8 weeks of initiating MMT. The optimal dose range for most MMT patients is 60-120 mg (Bao et al. 2009; Department of Health (England) 2007; WHO 2009). A meta-analysis by Bao et al reported that doses of methadone between 60-120 mg and individualization of doses are associated with better retention in MMT (Bao et al. 2009).

During the maintenance phase (when the dose is 80 mg or more) the MMT physician shall increase the dose by no more than 5-10 mg every 5-7 days.

Dose increases during the maintenance phase should take place with an in person MMT physician assessment and for patients who are experiencing cravings, ongoing opioid use, and/or a cluster of opioid withdrawal symptoms. MMT physicians should assess patients once weekly when ongoing dose adjustments are occurring and less frequently thereafter if required.

6.7.1. Missed Doses During Maintenance Phase

Standards for missed doses during maintenance are the same as those for late stabilization. See Section 6.9 Managing Missed Doses and Table 08 Management of Missed Doses.

6.7.2 Doses Below 60 mg

There is evidence that methadone doses of 60–100 mg are more effective than doses below 60 mg in reducing heroin use and retaining patients in treatment (Bao et al. 2009; Caplehorn and Bell 1991; Faggiano et al. 2003). However, maintenance doses below 60 mg are justified for patients who have no unauthorized opioid use, report no significant withdrawal symptoms or cravings, are at high-risk for methadone toxicity, or are on a tapering protocol.

6.7.3 Doses Above 120 mg

6.7.3.1 Risks of High Methadone Doses

Opioids such as methadone have several side effects that may be dose related, including sedation, overdose leading to death, sleep apnea and sexual dysfunction. High methadone doses are also associated with prolonged QT interval, which can cause Torsades de Pointes, a ventricular arrhythmia (Abramson et al. 2008; Pimentel and Mayo 2008). One study found that approximately 5% of patients on MMT had QTc > 500 msec, the value associated with increased mortality. All of these patients were on doses in excess of 120 mg (Anchersen et al 2009). Other risk factors for Torsades include, use of cocaine and other stimulants, heavy alcohol consumption, cardiomyopathy, previous MI or valvular abnormalities, a family history of long QT syndrome, liver dysfunction, electrolyte disturbances and medications that affect methadone levels or the QT interval (Abramson et al. 2008; Ehret et al. 2006; Fareed et al. 2010; Justo et al. 2006; Krantz et al. 2009). See Table 07.

6.7.3.2. Assessment and Monitoring

High doses of methadone can sometimes have sedating effects that may not be apparent in the physician's office. The MMT physician should inquire about whether the patient or the patient's family has observed cognitive effects such as 'nodding off,' lethargy, diminished concentration or memory.

At baseline, the physician should identify risk factors for torsades, such as heart disease, family history of sudden cardiac death, or concurrent use of medications that affect QT interval (See Table 07 Risk Factors for QTc Prolongation in Patients on Methadone). An ECG shall be done on patients whose dose is greater than150 mg (Byrne 2009; Girgis 2009) and repeated for doses of 180-200 mg. Patients with known risk factors for Torsades should have an ECG at a dose above 120 mg.

Table 07: Risk Factors for QTc Prolongation in Patients on Methadone

Adapted from: Methadone – associated QTc prolongation: A case report and review of the literature. (Abramson DW, Quinn DK, Stern TA. Prim Care Companin J Clinic Psychiatric 2008; 10(6): 470-476

Risk Factor	Examples
Older Age	
Structural heart disease	Myocardial infarction, congestive heart failure, valvular disease, cardiomyopathy
HIV infection	
Low potassium level	On drugs that lower potassium eg. Diuretics
Low prothrombin level	
On medications that inhibit Cytochrome p450 3A4	HIV antivirals e.g. indinavir Antifungals e.g., Fluconazole, ketoconazole Calcium channel blockers e.g., Diltiazem, verapamil Antimicrobials e.g., Norfloxacin Antidepressants e.g., Fluvoxamine Contraceptives e.g., Mifepristone Foods: e.g., grapefruit juice
Alcohol use	
Cocaine use	
Family or past history of long QT syndrome	History of syncope or sudden cardiac death in the family
On medications that prolong QTc	Cardiac medications e.g., amiodarone, sotalol Antipsychotics e.g., chlorpromazine, haloperidol, pimozide, thioridazine Antibiotics e.g., clarithromycin, erythromycin Anti-nausea drugs e.g., domperidone

6.7.3.3 Management of High Doses

A trial of tapering is indicated for patients who report sedation when on high doses. Clinical experience suggests that tapering to an overall dose decrease of 20-40 mg is tolerated well, and patients often report that they feel more alert and energetic.

The patient should be closely monitored if the QT interval is elevated (> 450 msec for men, > 470 msec for women). Cardiology referral and/or methadone dose reduction should be considered when the QTc exceeds 500 msec, and the MMT physician should take steps to modify risk factors when possible.

6.7.3.4. Ongoing Withdrawal Symptoms in Patients on High Doses

Patients with ongoing withdrawal symptoms despite high methadone doses require ongoing assessment by the MMT physician. Possible causes include:

Rapid metabolism of methadone

- Although controversial, peak and trough levels might be useful in patients who continue to report withdrawal symptoms despite doses of 120 mg or higher.

Use of medications that increase the metabolism of methadone

- Medications suchs as Phenytoin, chronic alcohol use.

Continued opioid use

- Causes increased tolerance and withdrawal symptoms on opioid cessation.

Dose diversion

- The patient consumes some of his/her take-home dose and sells the rest.

Pseudonormalization

- After a methadone dose increase, some patients experience very mild mood elevation. They develop tolerance to this effect after a few weeks, prompting them to seek another dose increase.

Insomnia, anxiety, fatigue and other psychiatric symptoms

- Because psychiatric symptoms are such a prominent feature of opioid withdrawal, patients may incorrectly attribute these symptoms to withdrawal.

Cocaine use

- Cocaine is a methadone inducer (increases the metabolism of methadone) especially when used in large doses. Ongoing use of cocaine may result in the patient complaining of the need for a dose increase. The physician may want to discuss the benefits of abstinence from cocaine.

Pregnancy

- See Section 13: MMT During Pregnancy.

6.8 Split Doses

Split dosing is commonly used during the management of pregnancy or chronic pain, or in patients on medications that induce rapid metabolism of methadone (See Sections 11.2.4, 11.2.5, 11.2.5.2, 13.3.2.2 and Appendix B).

6.9 Managing Missed Doses

Missed doses may indicate a variety of problems, including relapse to alcohol or other drug use. Therefore, the physician should reassess the patient's clinical stability. Pharmacists should report missed doses to the MMT physician in a timely fashion. A clinically significant loss of tolerance to opioids may occur within as little as 3 days without methadone; therefore the MMTphysician should reduce the methadone dose in patients who have missed three consecutive days. The dose can be rapidly increased once the response to the lower dose is assessed. See Table 08 Management of Missed Doses.

Table 08: Management of Missed Doses

Phase of Treatment	Missed Doses	Action	Dose Change
Early Stabilization (0-2) weeks	1 day missed	No dose increase	• Resume same dose. • Do not increase dose until 3 consecutive days at the same dose.
	2 consecutive days missed	• Reassess patient in person. • Cancel remainder of prescription	• Restart at initial dose (10-30 mg) for at least 3 days • Reassess after 3rd consecutive dose.
Late Stabilization/ Maintenance	1-2 days missed	• Provide usual prescribed dose if patient is not intoxicated. • Assess patient in 1-2 weeks to determine clinical stability	• No change
Late Stabilization/ Maintenance	3 consecutive days missed	• Reassess patient in person • Cancel remainder of prescription • Reassess every 3-4 days if dose is increased daily	• Restarted at 50% of regular dose or decrease to 30 mg • Then increase dose to no more than 10 mg daily for maximum of 3 days, then reassess by day 3-4. • There after, dose increase of 10-15 mg every 3 -5 days until 80 mg • Then 10 mg every 5-7 days for dose increases above 80 mg
Late Stabilization/ Maintenance	4 or more consecutive days missed	• Re-assess patient in person • Cancel remainder of prescription	• Restart at 30 mg or less • Then increase dose no more than 10-15 mg every 3-4 days until 80 mg • Then increase 10 mg every 5-7 days for dose increases above 80 mg.

6.10 Vomited Doses

Vomited methadone doses are not replaced unless a health professional or staff member directly observes emesis. If the emesis was witnessed by the pharmacist or staff, and it occurred less than 15 minutes after consumption, the dose can be replaced at no more than 50% of the regular dose.

Repeated dosing (i.e. replacement) creates a risk of inadvertent overdose. Underlying causes of the vomiting should be addressed. For pregnant patients or patients with underlying medical

conditions (eg cancer or HIV), the MMT physician may decide to prescribe a replacement dose even if the pharmacy or clinic staff did not observe emesis (See Section 13.3.2.4).

7.0 Urine Drug Screening (UDS)

7.1 Overview

UDS results are one tool to verify patients' self reported substance use, assess response to MMT and determine suitability for take-home doses. Giving take-home doses to methadone patients with drug-free UDS is an effective strategy for reducing opioid and other drug use (contingency management) (Chutuape et al. 1999a; Chutuape et al. 1999b; Iguchi et al. 1988; Preston et al. 2002; Schmitz et al. 1998; Stitzer et al. 1992).

UDS combined with a patient's self-reported drug use are more accurate than either alone. (Perrone et al. 2001; Ries et al. 2002). Frequent UDS may be more likely to detect drug use than occasional UDS (Chutuape et al. 2001, Wasserman et al. 1999). The results of a RCT conducted (Chutuape et al 2001) showed that methadone take-home doses contingent on a minimum of monthly drug-free urines prevents declines in treatment outcomes (38.9% were abstinent for opiates and cocaine for > 8 weeks); better results were achieved by weekly-urine testing (56.6% were abstinent). However, ongoing frequent UDS is costly.

►Standards

S7.1	The MMT physician shall use either point-of-care immunoassay, or chromatography or both for routine screening of illicit opioid use, cocaine, and benzodiazepines.
S7.2	The MMT physician shall obtain and interpret a UDS prior to MMT initiation.
S7.3	The MMT physician shall ensure that each UDS (including UDS collected between office visits) is interpreted in a timely fashion by the MMT physician for the purpose of monitoring and managing the patient.

►Guidelines

G7.1	The MMT physician should consider chromatography testing if the patient uses substances that are difficult to detect with immunoassays (e.g., fentanyl, amphetamines), if the patient disputes the test results, or if the patient faces serious consequences for a positive test (e.g., child custody).
G7.2	The MMT physician should have the UDS collection supervised, if possible, to verify the integrity of the UDS specimen.
G7.3	If supervision is not possible, the MMT physician should ensure other measures such as creatinine or temperature monitoring are implemented.
G7.4	The MMT physician may conduct UDS on a fixed or random schedule.
G7.5	The MMT physician should order frequent (4 times or more per month) UDS: 1) when adjusting the dose during stabilization 2) for contingency management with patients who continue to use drugs but who also wish to eventually achieve take-home doses. 3) for contingency management with patients who have already achieved abstinence and are in the take-home dose acquisition phase.
G7.6	The MMT physician may order less frequent UDS (1-3 times per month) if the patient has abstained consistently from illicit drug use for at least 6 months or for patients not working toward take-home doses (e.g., due to ongoing drug use or homelessness). In some circumstances, less than monthly urine testing may be acceptable.
G7.7	The MMT physician should take into consideration treatment benefits as well as the effect on treatment retention where weekly UDS is used during the Maintenance Phase.
G7.8	For patients on take-home doses who meet the criteria for less frequent UDS, the MMT physician should consider increasing the frequency of UDS (4 times or more per month) for 1 to 3 months if the patient shows signs of lapse or relapse, for the purpose of contingency management and ongoing adjustment of take-home doses. The frequency may be reduced accordingly based on the response of the patient.

7.2 Initial UDS

Initial UDS results should confirm the presence of opioids and, whenever possible, identify the patient's primary opioid of abuse. Either a broad-spectrum initial analysis or an opioid-specific immunoassay may be used. If immunoassay is used, it should test for the specific opioid abused by the patient. However, a general opioid immunoassay that fails to identify a patient's specific opioid may be sufficient to initiate a patient on methadone if there is strong clinical evidence that the patient is opioid dependent (e.g., obvious opioid withdrawal signs and symptoms and/or IV track marks, corroborating information from a physician, or previous MMT). See Table 09.

If the initial UDS is inconsistent with the patient's reported opioid use (e.g. the patient reports daily oxycodone use and the oxycodone is negative in the UDS), the MMT physician should conduct a more thorough assessment to confirm a diagnosis of opioid dependence prior to initiating MMT.

Table 09: Point-of-Care Testing (EMIT) vs Chromatography

Test	Advantages	Disadvantages
Point-of-Care Testing (EMIT)	• More sensitive than chromatography • Detects opioids for 2-4 days • Immediate results	• Does not distinguish or differentiate specific types of opioids, except for oxycodone • Synthetic opioids, such as fentanyl, are often missed.
Chromatography	• Can identify specific opioids; • More specific than immunoassay; • Can identify TCA, antipsychotic, gravol.	• Detects opioids for 1-2 days; • Less sensitive than immunoassay • Delayed results

7.3 UDS Collection Schedule

7.3.1 Frequent UDS during Stabilization Phase

Frequent UDS is defined as 4 times per month or more.

Frequent urines may be collected once to twice a week during the stabilization phase. Twice weekly urines will more likely detect sporadic drug use and in some patients might facilitate more accurate self disclosure. The MMT physician should ensure that frequent twice weekly urines do not interfere with the patient's work or family obligations.

7.3.2 Frequency of UDS during Maintenance Phase

Many patients in maintenance phase benefit from ongoing weekly UDS for the purpose of ongoing monitoring and management of their addiction disease which is characterized by periods of abstinence and relapse. Frequent UDS may be collected once to twice per week during the maintenance phase for patients who are interested in having take-home doses or who are in the take-home dose acquisition phase. Take-home doses are an essential component of long term success for patients during the maintenance phase. The UDS result combined with counselling can be an effective tool to help curtail illicit drug use especially during the take-home acquisition phase.

Once full take-home doses have been achieved, or the patient has been consistently abstinent for 6 months or more, the frequency of UDS may decrease to twice to once monthly depending on the recovery needs of the patient.

Some patients who have achieved full take-home doses may benefit from more frequent UDS as they consider it integral to their sustained abstinence. The MMT physician should balance these issues with the consideration that collecting weekly UDS may be inconvenient to the

patient and therefore may lead to a reduction in treatment retention. Collecting more than 4 urines per month for patients on full take-home doses is not indicated.

Less frequent than weekly urine testing may also occur for patients on chronic prescribed benzodiazepines who are not eligible for more than one take-home dose.

In occasional circumstances, patients including those who have take-home doses, may provide UDS less often than once monthly if they are well known to the MMT physician over a number of years, they have long established clinical stability and drug use abstinence and are considered by the MMTphysician to be reliable historians. Less than monthly urine testing may also occur for patients who have ongoing drug use or who are chronically homeless and will not be seeking take-home doses.

7.3.3. UDS Frequency during Relapse or Return to Drug Use for Patients on Take-home Doses

If the patient slips or relapses after a prolonged period of abstinence, the frequency of UDS should be increased to weekly for one to three months and take-home doses should be reassessed (see Section 8.6). Contingency management combined with counselling and support is essential in helping patients quickly recover from a relapse and preventing it from becoming sustained.

8.0 Take-Home Doses

8.1 Overview

Take-home doses are key to the success of MMT. Controlled trials have demonstrated that MMT patients markedly reduce their use of heroin and cocaine when given take-home doses for UDS free of illicit drugs (contingency management) (Chutuape et al. 1999a; Chutuape et al. 1999b; 2001; Iguchi et al. 1988; Preston et al. 2002; Schmitz et al. 1998; Stitzer et al. 1992). There is strong evidence that methadone take-home doses contingent on drug-free UDS prevent the decline in treatment outcomes over time. Abstinence can be sustained with UDS conducted monthly; weekly UDS produces even better results (Chutuape et al. 2001) Surveys and observational studies have found that patients strongly value take-home doses, and treatment retention rates are lower in clinics with restrictive take-home policies (Amass et al. 1996; Amass et al. 2001; Pani et al. 1996).

►Standards

S8.1	When prescribing take-home doses, the MMT physician shall ensure that patients understand how to store their methadone securely, that they understand the risks of diverted methadone, and that they agree never to give or sell even part of their dose to others.
S8.2	The MMT physician shall not prescribe take-home doses if: 1) the patient is at risk of taking more than prescribed, due to an untreated mental illness or cognitive impairment 2) the patient is not able to safely store the methadone 3) there is reasonable evidence that the patient is diverting methadone 4) the patient does not understand the risks of methadone diversion.
S8.3	The MMT physician shall prescribe an accelerated take-home schedule only if: 1) prolonged daily pick-up is likely to cause the patient to drop out of treatment because of lack of transportation or work or family commitments 2) the patient is able to safely store the medication 3) the patient does not have an active addiction or mental illness that increases the risk of methadone misuse or diversion.
S8.4.	The physician may prescribe a Sunday take-home dose after four weeks (rather than eight weeks) only if the patient: 1) is able to safely store the medication 2) does not have an active addiction or mental illness that increases the risk of methadone misuse or diversion 3) lives in a community that does not have a pharmacy that is open on Sunday 4) has no hospital available for Sunday dispensing 5) does not have transportation to a pharmacy in a different community.
S8.5	The MMT physician shall prescribe take-home doses that are exceptions to the take-home dose schedule ("special carries") only if: 1) the patient is able to safely store the medication and has good insight for carry safety issues 2) the patient is emotionally stable and displays good judgment to recognize the risks for methadone misuse or diversion
S8.6	The MMT physician shall reduce the level of take-home doses if the patient has a sustained relapse to problematic substance use.
S8.7	The MMT physician shall cancel all take-home doses abruptly in the circumstances listed below. The daily observed dose should be reduced if the MMT physician suspects the patient may not have been taking the full take-home dose. 1) There is reasonably strong evidence that the patient has diverted their methadone dose, or has tampered with their UDS. 2) The patient has missed 3 or more days of methadone (except in unavoidable circumstances such as hospitalization). 3) The patient has become homeless or in unstable housing, and can no longer safely store their methadone. 4) The patient is actively suicidal, cognitively impaired, psychotic, or is otherwise at high risk for misuse of their methadone dose. 5) The patient has recently been released from jail when incarcerated for prolonged periods of greater than 3 months.

►Guidelines

G8.1	Prior to prescribing the first take-home dose, the MMT physician should instruct the patient to show a locked box that will be used for the transportation and storing of take-home doses.
G8.2	The MMT physician should ensure the first weekly take-home dose is prescribed only after the patient has been in the program for two months, and prior to take-home dose acquisition the patient has had at least one week without problematic substance use, as determined by history and UDS.
G8.3	The MMT physician should prescribe additional take-home doses at a rate of no more than one dose per week every four weeks, to a maximum of six take-home doses per week. Each additional take-home dose should be prescribed only after the patient has had at least four weeks without problematic substance use. (see Table 10 Problematic versus Non-Problematic Drug Use)
G8.4	In the accelerated schedule, the MMT physician may prescribe the first carry after four weeks, and subsequent carries at a rate of no more than one extra take-home dose per week, every 2-3 weeks, to a maximum of six take-home doses per week.
G8.5	In the accelerated schedule, the MMT physician should prescribe the extra weekly take-home dose only if the patient has had at least two consecutive weeks without problematic drug use.
G8.6	The MMT physician should prescribe the Sunday dose at an alternate pharmacy if the patient's regular pharmacy is closed on Sunday.
G8.7	The MMT physician should instruct the patient to bring a receipt to the alternate pharmacy to verify that they received their doses.
G8.8	MMT physicians working in communities without a pharmacy open seven days per week should consider negotiating with the local hospital to provide Sunday dispensing, or arranging for a nurse or pharmacist to dispense the methadone at the MMT Clinic (Delegation Exemption).
G8.9	The MMT physician may give special carries only on compassionate grounds for patients who are not yet receiving take-home doses. The patient should be on MMT for at least one month, and a maximum of seven carries should be given at a time.
G8.10	The MMT physician may give special carries for sound personal reasons or holidays for patients who have markedly reduced their substance use, are approaching a stable methadone dose, and are receiving 1-2 take-home doses/week. A maximum of seven carries should be given at a time. The MMT physician should ensure that the previous carry level is resumed after the period of special carries.
G8.11	The MMT physician may give special carries for work or vacation travel for patients who have not had problematic drug use for months, are clinically stable and receiving 3-6 take-home doses per week. A maximum of 2-4 weeks may be given at a time. The MMT physician should ensure that the previous carry level is resumed after the period of special carries.
G8.12	During a relapse, the MMT physician should gradually reduce the take-home doses at a rate of one take-home dose per week for each week of problematic substance use, as determined by history or UDS. Take-home doses may be reinstated at the same rate, one dose per week for each week without problematic substance use.
G8.13	MMT physicians may prescribe a single take-home dose per week to patients who continue to use substances if they meet all of the following criteria: 1) They are deemed by the MMT physician to be clinically stable. 2) They are able to safely store their medication. 3) They are at a low risk of diversion. 4) Their methadone dose is stable. 5) In the MMT physician's judgment, the drug use does not appear to be causing significant medical, psychiatric or social problems.

G8.14	The MMT physician should consider reducing take-home doses for patients who repeatedly consume them early, or who repeatedly report lost or stolen take-home doses.
G8.15	The MMT physician may reinstate take-home doses immediately for patients who remain clinically stable without problematic drug use, and: 1) had take-home doses cancelled due only to missed doses 2) have been incarcerated for less than 3 months.
G8.16	For patients who have tampered with their UDS in an attempt to conceal a relapse, the MMT physician may reinstate take-home doses after a one month period at a rate of one take-home dose per week to one take-home dose per month depending on the patient's reliability and clinical stability.
G8.17	The MMT physician may decide to restrict carries indefinitely if there has been proven diversion. A second opinion with another MMT physician should be considered before reinstituting the carries.
G8.18	The MMT physician may give at least one take-home dose per week to clinically stable patients who are being prescribed benzodiazepines or opioids.
G8.19	The MMT physician may provide more than one take-home dose per week if the patient: 1) has a medical or psychiatric diagnosis that warrants the use of the benzodiazepine or opioid 2) is on a low-to-moderate therapeutic dose of the benzodiazepine or opioid 3) has not shown signs of benzodiazepine or opioid misuse or toxicity 4) provides consent for the MMT physician to discuss their management with their opioid or benzodiazepine prescriber 5) is prescribed and dispensed the medications in a controlled dispensing fashion 6) meets all other criteria for take-home dose eligibility.
G8.20	The MMT physician should limit the take-home doses of patients who refuse consent to communicate with their opioid or benzodiazepine prescriber.
G8.21	Patients may be given 13 days of take-home doses, if the following criteria are met: 1) They have a documented history of full take-home doses and clinical stability, while on MMT, for 5 years or more. 2) There have been no past reported mishaps with lost or stolen carries. 3) They are working, in school or have daily family commitments that make weekly attendance at a pharmacy difficult. 4) They have been abstinent and clinically stable for most of their time in the program, and they are reliable historians. 5) The methadone dose is 120mg or less.

8.2 Take-Home Doses: Risks

8.2.1 Diversion

Diversion of take-home doses is a serious public health problem. The use of methadone for analgesia has increased sharply in the US, with a seven-fold rise from 1997 to 2004. This has been accompanied by a 17-fold increase in methadone-related deaths (Sims et al. 2007).

The risk of diversion and accidental or intentional misuse increases in patients who:

- have suicidal ideation or cognitive impairment
- are homeless, living in a shelter or transiently housed
- are actively addicted to alcohol, cocaine, benzodiazepines or other drugs.

The last group is at higher risk because they may sell their methadone in order to pay for their drug use, and are at greater risk for overdose due to interactions between methadone and their drug of abuse.

8.2.2 Locked Box

To increase the safety of storing methadone at home, patients can be asked to use locked-boxes (Breslin and Malone 2006).

Before take-home doses are prescribed, the physician should ask patients to bring in a locked box to demonstrate that they are able to store methadone safely. This is particularly important for patients who have children, adolescents or young adults living at home. It is not necessary for patients to bring locked boxes to every pharmacy or clinic visit.

8.3 Take-Home Doses: Criteria

The criteria for determining appropriateness for take-home doses are based on patient and community safety and on clinical stability, where clinical stability can be defined by:

1. Stable dose of methadone (with allowances for occasional dose increases)
2. No recent problematic drug or alcohol use. See Table 10.
3. Compliance with treatment directives
4. Stable housing
5. Emotional stability and good insight into carry safety issues.

Collaborative communication with the pharmacist will facilitate and provide information about the patient's daily clinical presentation and stability.

Table 10: Problematic versus Non-problematic Drug Use

Type	Definition	Patient Behaviour and Symptoms
Problematic Drug Use	Ongoing drug use with negative emotional, social, or financial consequences for the patient.	Unstable mood and relationships; unsafe or illegal activities
Non-problematic Drug Use	Intermittent sporadic drug use without significant adverse consequences	Stable mood and relationships, productive activities (work, family, school).

Prior to prescribing take-home doses, the physician should carefully explain the risks of methadone diversion or misuse, and the patient's responsibility to store and use their dose safely.

A written take-home dose agreement is highly recommended (See Appendix K Take-Home Dose Agreement).

8.4 Take-Home Dose Acquisition Schedules

8.4.1 First Take-Home Dose

Patients are typically eligible for their first weekly take-home dose after at least two months in MMT treatment if they meet the criteria for clinical stability and prior to take-home dose acquisition the patient has had at least one week without problematic substance use, as determined by history and UDS.

8.4.2 Sunday Dosing

For patients with no take-home doses, if the patient's regular pharmacy is closed on Sunday, an alternate pharmacy may be used. The patient should be instructed to present a receipt verifying that they have received their daily doses at the regular pharmacy. This will ensure that patients who have missed doses at the regular pharmacy are not given their full dose at the Sunday pharmacy. Ideally, the physician would collaboratively communicate with the Sunday pharmacist ahead of time to pre-arrange the beginning of take-home dosing on Sundays for their patient.

Some communities do not have a pharmacy that is open on Sunday, forcing patients to travel to a pharmacy in a different community. This can be disruptive and costly, and it may cause some patients to drop out of treatment. Yet any take-home dose in the first few weeks of MMT can be hazardous; unstable patients may take the extra carry early, putting them at high risk for toxicity.

In an attempt to promote treatment retention while reducing the risk of toxicity, the guideline allows for Sunday carries after only four weeks for patients who do not have access to a Sunday pharmacy.

MMT physicians who work in communities without a Sunday pharmacy are encouraged to arrange Sunday dispensing with their local hospital, or to arrange for delegated dispensing. In delegated dispensing, the methadone doses are delivered in advance to the MMT clinic. The clinic opens for 1-2 hours on Sunday, and the methadone doses are dispensed by the clinic nurse or pharmacist according to CPSO policy.

8.4.3 Subsequent Take–Home Dose Acquisition

Subsequent increases in take-home doses occur every 4 weeks with evidence of clinical stability as per Guidelines 8.2 and 8.3. Occasional dose adjustment/increases may occur during take-home dose acquisition provided the patient is clinically stable.

8.4.4 Accelerated Take-Home Schedule

Patients who have regular work, full-time educational programs or family commitments may find it difficult to attend the pharmacy daily, causing them to drop out of MMT. These patients may receive take-home doses at an accelerated rate if they are at lower risk for misuse of their take-home doses, i.e. they are clinically stable, are not currently addicted to other substances and do not have a concurrent active mental illness. The first accelerated take-home dose may be given after one month, with one additional weekly dose every 2-4 weeks. Patients should have at least two consecutive weeks of non-problematic substance use before receiving the next additional take-home dose. Only a minority of MMT patients will likely require accelerated doses.

8.5 Take-Home Doses in Exceptional Circumstances ("Special Carries")

Before prescribing take-home doses for exceptional circumstances, the MMT physician should attempt to verify the patient's personal or family crisis (with corroborating information from a third party) or travel plans, particularly if the MMT physician doesn't know the patient well or is unsure about the patient's reliability. The MMT physician may choose to communicate with the pharmacist to get corroborating information recent patient stability in preparation for "special carries". The previous take-home dose level should be resumed after the period of "special carries". The following criteria are suggested for prescribing exceptional take-home doses. See Table 11.

Table 11: Criteria for Prescribing Exceptional Take-Home Doses

IF:	THEN:
Patient has been on MMT for at least one month but is not yet eligible for any take-home doses.	• Give take-home doses on compassionate grounds only, e.g., a personal crisis or family matters. • Give no more than 7 take-home doses at a time.
Patient has markedly reduced substance use, is approaching a stable methadone dose, and is receiving 1-2 take-home doses/week.	• Give take-home doses for sound personal reasons only e.g., vacation / holidays. • Give no more than 7 take-home doses.
Patient has not had problematic drug use for months, is clinically stable and receiving 3- 6 take-home doses per week.	• Give up to 2-4 weeks take-home doses for travel purposes. • If more than 4 weeks of take-home doses is required, a second opinion with another MMT physician is suggested.

8.6 Reducing Take-Home Doses

8.6.1 Relapse to Problematic Drug Use

A "slip", or a single episode of drug use, does not necessarily require a reduction in take-home doses, unless the patient shows other signs of clinical instability. However, take-home doses should be reduced during a sustained relapse. A contingency management approach,

combined with increased counselling and supportive care, may help the patient recover from a relapse before it causes serious physical or social damage. With contingency management, the frequency of UDS is increased to weekly, the intensity of counselling and follow-up is increased, and take-home doses are reinstated at a gradual rate of one take-home dose per week as the relapse resolves.

Patients who have had a prolonged relapse of greater than twelve months and have now stopped problematic drug use should have take-home doses introduced at the same rate as new patients, i.e. one take-home dose per week per month.

8.6.2 Reducing or Cessating Take-Home Doses for Reasons Other than Substance Use

The MMT physician should consider reducing take-home doses if the patient repeatedly consumes take-home doses early, or repeatedly reports lost or stolen take-home doses. Some patients, especially those with mental health issues, or addiction recovery needs, may benefit from increased structure of observed dosing at the pharmacy, and therefore decreased take home doses.

If the patient has tampered with their UDS in an attempt to conceal a relapse, the physician should cancel take-home doses immediately, and reinstate the take-home doses after a one month period at a rate of one take-home dose per week to one take-home dose per month depending on the reliability of the patient, and demonstrated abstinence.

Patients for whom there is strong evidence of diversion should have their take-home doses restricted indefinitely, as there is no reliable method to prevent diversion if their take-home doses are reinstated. A second opinion with another MMT physician should be sought prior to reintroduction of the take-home doses.

Take-home doses should also be cancelled in patients who no longer have stable housing, have missed three or more days of methadone (except in unavoidable circumstances), or they have a mental illness that places them at high risk for misuse of take-home doses. Because patients who have been incarcerated for prolonged periods (3 months or more) are often clinically unstable on release, they should have daily dispensing of methadone in the first week after discharge from jail even if they had take-home doses prior to their incarceration. Once clinical stability has been reestablished, the take-home doses may be reinstated at a rate of one take-home dose per week.

In certain circumstances, take-home doses may be reinstated at the previous level one week later if the doses were abruptly cancelled because the patient missed three or more doses, or because the patient was incarcerated for less than 3 months. In either case, the take-home doses should only be reinstated if the patient remains clinically stable and is not using drugs problematically.

8.7 Take-Home Doses for Patients on Benzodiazepines or Opioids

At least one take-home dose per week may be prescribed to clinically stable patients who are on benzodiazepines or opioids. More than one-take-home dose per week may be prescribed under circumstances listed above in Guidelines 8.18, 8.19 and 8.20.

Regardless of the level of take-home doses, the MMT physician should periodically attempt to taper the benzodiazepine or opioid, particularly if the dose is high (daily equivalent of diazepam 50 mg/day, or morphine 200 mg per day) see Section 11.4 Benzodiazepines.

MMT physicians should not prescribe take-home doses for patients who refuse consent to contact the opioid or benzodiazepine prescriber. The MMT physician may also taper and discontinue the methadone if there is a strong possibility that the patient is misusing the medications or is on an unsafe combination. The MMT physician may contact the other non-MMT prescriber without the patient's consent if there is an imminent risk of harm.

8.8 Routine 13 Day Take-Home Doses for Work Commitments

In occasional circumstances, some patients who are on six take-home doses, who have work schedules that make it difficult to go to the pharmacy for weekly dispensing may benefit from extended two week take-home doses on a regular basis if the criteria in Guideline 8.21 are met.

9.0 Voluntary and Involuntary Withdrawal from MMT

9.1 Overview

Withdrawal from MMT is most likely to be successful if the patient has been abstinent from illicit substances for a substantial period of time, does not have current or untreated psychiatric co-morbidity, and has strong social supports and counselling (Magura and Rosenblum 2001). The patient should have a major role in deciding the rate of the taper. A systematic review by Amato et al., evaluated the effectiveness of methadone tapers compared to LAAM, buprenorphine and clonidine in managing opioid withdrawal and on completion of detoxification. Overall methadone tapers were as effective as other pharmacological agents used for detoxification from opioids (Amato et al. 2005).

►Standard

None for this section

►Guidelines

G9.1	For voluntary tapers, the MMT physician should taper patients slowly. The rate of the taper should be patient driven, even if the patient desires a more rapid taper.
G9.2	The MMT physician should attempt to decrease the dose more slowly at doses below 20-30 mg, as withdrawal symptoms become more pronounced.
G9.3	The MMT physician should identify patients who are good candidates for a successful methadone withdrawal, and discuss the risks and benefits of withdrawal with them.
G9.4	The MMT physician should decrease the methadone dose slowly. The decrease should be stopped or reversed at patient request or if the patient experiences severe dysphoria, cravings, or withdrawal symptoms, or relapses to opioids or other drugs.
G9.5	The MMT physician should see the patient regularly during the decrease, to assess the patient's mood and withdrawal symptoms, and to provide supportive counselling.
G9.6	The MMT physician should offer to follow the patient for at least a few months after completion of the decrease.
G9.7	The MMT physician should warn the patient about the loss of tolerance and the risk of toxicity if they relapse to opioids.
G9.8	The MMT physician should offer to reinstate MMT if the patient requests it during voluntary withdrawal.
G9.9	The MMT physician may transfer or cessate a patient from MMT if: a) the patient has been threatening or disruptive b) the patient is consistently non-compliant with the treatment agreement c) the patient is at high risk for methadone overdose and attempts to reduce the risk have failed.
G9.10	The MMT physician should explain the reasons for cessation and offer to transfer the patient to another MMT physician.
G9.11	The MMT physician should decrease the methadone dose and assist the patient in seeking alternate care (e.g., an abstinence based program) if a transfer is not feasible.
G9.12	For an involuntary taper, the MMT physician should decrease the methadone dose at a rate of no more than 10 mg every three to four days.
G9.13	The MMT physician may use pharmacotherapy in the final 1-2 weeks of the decrease to relieve withdrawal symptoms.
G9.14	The MMT physician should encourage the patient to engage with another health care professional or addiction treatment program for counselling and support.

9.2 Voluntary Withdrawal

Patient-centered tapering has reasonably good success rates. In one study, 46% of subjects remained abstinent after an average of 2.4 years post-MMT (Cushman, 1978). Success rates are higher for patients who have been on MMT for two years or more (Cushman 1981; Hubbard et al. 2003; Stimmel et al. 1978). Factors that increase the chances of success are:

- long-standing abstinence from drugs of abuse
- no current mental illness
- a supportive social network.

The rate of the taper should be negotiated with the patient, and should be stopped or reversed at the patient's request if the patient experiences severe cravings, dysphoria, withdrawal symptoms, or relapse to substance use. In general, slow tapers are more successful than rapid tapers (Senay et al. 1977). The daily dose should generally be decreased by no more than 5 mg to 10 mg every 1-2 weeks, or decrease 10% of previous dose.

Withdrawal can trigger an organic mood syndrome, which may become more severe as the dose falls below 20-30 mg/day (Kanof et al., 1993). In this case a gradual decrease of 1-2 mg every few weeks can be used.

9.3 Involuntary Withdrawal

9.3.1 Indications for Involuntary Withdrawal

The decision to transfer or cessate a patient should be documented in detail. The cessation should be based on reliable information, not hearsay or rumor. Indications for cessation include:

- threats to staff members or others
- disruptive behaviour at the methadone clinic
- violent behaviour towards a staff member or others
- non-compliance with patient treatment agreement and program expectations
- diversion of methadone
- high risk for methadone overdose and attempts to reduce the risk have failed. For example, the patient continues to use high doses of benzodiazepines or alcohol, has shown signs of sedation or has required medical treatment for an overdose, and refuses appropriate interventions (e.g. inpatient or outpatient benzodiazepine tapering).

9.3.2 Process for Involuntarily Withdrawing a Patient

Recommendations to effectively end the doctor-patient relationship where MMT is being provided are as follows:

1. If possible, arrange a transfer to another MMT physician.
2. Communicate your decision clearly to the patient. This should include the details of a tapering schedule and/or end date of their methadone prescription.
3. Give the patient a reasonable amount of time to find another MMT physician. This time will vary according to location and circumstances, but should be at least one month.
4. Provide the patient with reasonable help to find another MMT physician. Provide the patient with the CPSO Methadone Program phone number for MMT physicians accepting new patients.
5. Have the patient sign acknowledgement that he or she is aware of the MMT termination or send the patient a registered letter, confirming termination with a return receipt requested and keep a copy in the medical record.

See CPSO Policy entitled *Ending the Physician-Patient Relationship*
http://www.cpso.on.ca/policies/policies/default.aspx?ID=1592

MMT patients who feel that they have been wrongfully dismissed can contact the CPSO Public and Physician Advisory Service to lodge a complaint. The potential for dispute will be reduced if the MMT rules are made clear at the commencement of treatment.

10.0 Counselling and Case Management

10.1 Overview

MMT is more than a pharmacotherapy: it is well documented that case management and counselling services integrated into MMT have positive effects on treatment outcomes (Australian Department of Health and Ageing, 2003; Collège des médecins du Québec & Ordre des pharmaciens du Québec, 2000; Currie, 2001; Farrell et al., 1996; McCann et al., 1994; NIDA, 1999). Counselling enhances treatment retention, decreases patients' use of illegal opioids and other substances and improves patients' overall functioning in terms of criminality, homelessness, mental health and vocational and educational involvement. (Health Canada, 2002)

►Standards

S10.1	The MMT physician shall provide counselling to willing patients or refer them to counselling services in the community while on MMT.
S10.2	The MMT physician shall regularly document how the patient is doing in terms of their overall functioning.

►Guideline

None for this section.

10.2 Treatment Team

Collaborative practice in MMT is considered best practice. Ideally, the MMT patient should have access to a team that includes physicians, nurses, social workers, therapists, psychologists, case managers, peer support workers and pharmacists. Although not all settings and communities are this ideal, the MMT treatment team (at minimum physician and pharmacist) can strive to achieve the best possible outcomes through a collaborative, interprofessional approach.

The Canadian Interprofessional Health Collaborative (CIHC) has published a framework and resources to support interprofessional collaboration. "Interprofessional collaboration is the process of developing and maintaining effective interprofessional working relationships with learners, practitioners, patients/clients/families and communities to enable optimal health outcomes. Elements of collaboration include respect, trust, shared decision-making and partnerships."(CIHC 2010)

Further, the recently released recommendations for mental health and addictions services, the Select Committee on Mental Health and Addictions recommended "Mental Health and Addictions Ontario should ensure that institutional and community-based service providers actively seek to involve peer support workers in all aspects of service delivery. .."(Ontario Select Committee, August 2010)

The CIHC National Interprofessional Competency Framework defines six competency domains for interprofessional collaboration, as follows:

1. Interprofessional communication
2. Patient/client/family/community-centered care
3. Role clarification
4. Team functioning
5. Collaborative leadership
6. Interprofessional conflict resolution

Collaborative patient-centered practice improves outcomes for patients on MMT, as in any other area of health care practice.

10.3 Case Management

Case Management Services are defined as "a process that includes the designation of a primary worker whose responsibilities include the ongoing assessment of the patient and his/her problems, ongoing adjustment of the treatment plan, linking to and coordination of required services, monitoring and support, developing and implementing the discharge plan, and advocating for the patient"(Tschakovsky, 2009).

Case management services are offered regardless where the individual is in the system (Ontario Addiction Services Advisory Council 2000). A case manager's role includes a range of activities including:

1. Coordinating access to treatment
2. Providing information
3. Helping patients gain access to additional health and social services and
4. Advocating for the patient.

10.4 Therapeutic Factors

Methadone alone does not lead to recovery, to be effective, MMT must be an integrated treatment approach that includes counselling and other supports that address the determinants of health.

The factors that lead to successful change have been studied and weighted by Lambert (1992):

1) 40% of a patient's ability to exhibit positive change is attributable to **extra-therapeutic factors** (e.g. safe and stable housing, secure employment, adequate financial resources, positive interactions, supports in the community).
2) 30% is attributable to a patient's experience of the **therapeutic relationship** (e.g. a health care provider's non-judgmental attitude, warmth, respect and caring).
3) 15% is attributable to a patient's sense of hope and expectation for **recovery.**
4) 15% is attributable to the provider's **techniques and skills** (e.g. cognitive-behavioural therapy, mindfulness-based stress reduction).

The rest of this section briefly addresses these four factors.

10.4.1 Extra Therapeutic Factors

Social determinants of health (extra-therapeutic factors), such as housing, income and social support networks, can greatly affect a person's mental health (Tschakovsky, 2009). Providing counselling and case management to MMT patients can be complex: Patients may need help making changes in how they use substances; they may have financial, housing, legal and health problems; and many have histories of trauma, mental health problems or relationship difficulties.

Instability or difficulty in one or more of the following areas may indicate a need for more intensive counselling and help:

Medical and wellness issues may include:

1) Identification and treatment of concurrent mental illness
2) Chronic physical health problems (HCV, HIV, birth control)
3) Pregnancy
4) Issues of abuse – physical, sexual, emotional – and trauma
5) Parenting and family counselling
6) Changing drug and alcohol use
7) Lifestyle changes such as smoking, nutrition, exercise, leisure time.

Life skills and practical help may include:

1) Securing basic necessities, such as housing, food, clothing
2) Legal issues
3) Life skills
4) Coping with stress
5) Social isolation
6) Chaotic lifestyle (frequently missed appointments or doses)
7) Stopping drug use and preventing relapse.

Practical support may include:

1) Support and someone to talk to; general counselling
2) Help with referrals to community resources, filling out forms and applications, providing letters.

10.4.2 Therapeutic Relationship

Research shows that a positive therapeutic relationship between a MMT physician and a patient has a helpful impact. Therapeutic approaches are most successful when there is a strong therapeutic alliance (Gossop et al. 2006; Martin et al. 2000; Tschakovsky 2009). This involves the MMT physician creating a non-judgmental, collaborative environment whereby patients feel safe to discuss their feelings and concerns. Particularly where there are complex psychosocial problems, the MMT physician will need to draw on the support of formal and informal referral and realize the limits of what they can provide. If a MMT physician is not able or prepared to provide counselling, it is essential to connect the patient with services in the community.

10.4.3 Concepts of Recovery

Recovery refers to the ways in which people with mental health and/or addiction problems experience their lives through focusing on positives: health, hope, choices, equity, respect, supports and optimizing their quality of life. More specifically, recovery is about empowerment (having control over one's life); self-determination and personal responsibility; having one's expertise valued; reaching one's potential; engaging in meaningful activities, such as education and work; being included in community life; and having a voice in one's treatment plans.

Excerpted from Overview of health promotion (© 2009 CAMH), accessed on CAMH Knowledge Exchange portal December 2010.
http://knowledgex.camh.net/amhspecialists/promotion/Pages/recovery.aspx

10.4.4 Counselling Techniques and Skills

The evidence for the impact of counselling is very strong. Drucker et al. (2007) recommends that MMT physicians be willing and able to provide counselling to their MMT patients. In a recent survey of MMT patients in Ontario (Tschakovsky, 2009), 27% indicated they received counselling from MMT physicians (either alone or in addition to other support), 18% received counselling from a nurse and 12% received counselling from a psychiatrist (either alone or in addition to services from another agency).

Counselling happens across the continuum of care, from screening and assessment through treatment and relapse prevention. Most change happens in early treatment. Types of counselling that have proven effective in addictions work include Motivational Interviewing (MI) and Cognitive Behaviour Therapy (CBT).

Motivational interviewing is a counselling style that recognizes and resolves patient ambivalence in order to prepare patients to change addictive behaviours. MI elicits change statements and goals from the patient, rather than the counselor. Motivational interviewing has been shown to be particularly helpful in working with people who use substances (Burke 2002). This method focuses on patient's experiences; draws on their concerns, perspectives and values; and encourages patients to evaluate their own life choices and explore the consequences of their choices in a non-judgmental way.

Cognitive-behavioural therapy (CBT) is a talk therapy that leads to understanding the relationship between thoughts, behaviours and feelings is increasingly identified as the "gold standard" (CAMH 2008). CBT has been shown to be effective for people of all ages and for people of different levels of education and income and various cultural backgrounds. It has also been shown to be effective in either individual or group formats.

If appropriately educated and supported, the family can be a valuable resource for the patient and their MMT physician. The MMT physician can also play a valuable role in encouraging and facilitating access to supports and services, such as relapse prevention programs in the community.

10.5 Community Resources

ConnexOntario Health Services Information exists to improve access to alcohol and drug, gambling and mental health services for the people of Ontario. (See Resource Section)

The Drug and Alcohol Registry of Treatment (DART) provides information about drug and alcohol treatment services in Ontario. (See Resource Section)

ACCS, the Addiction Clinical Consultation Service is designed to serve Health and Social Service professionals including physicians, nurses, psychologists, occupational health staff, social workers, correctional staff, addiction workers and others who care for patients who have alcohol and drug problems. Addiction Clinical Consultation team includes experienced clinicians from medical, psychosocial and pharmacy areas. (See www.camh.net) Contact 1-888-720-ACCS (2227), or (416) 595-6968 in the Toronto area.

11.0 MMT with Concurrent Mental and Physical Disorders

11.1 Overview

MMT physicians need to be skilled in the identification and management of conditions that are common in opioid-dependent patients, such as medical and mental health disorders. All patients should have an identified primary care physician. The MMT physician should encourage the patient to see their primary care physician regularly for ongoing preventive care, screening and chronic disease management.

▶ Standard

S11.1	The MMT physician shall not prescribe methadone for pain without a Health Canada exemption, unless the primary focus of the patient's care is treatment of opioid dependence rather than pain management. In this circumstance, CPSO MMT Program Standards and Guidelines should be followed with appropriate modification for split dosing.

▶ Guidelines

G11.1	The MMT physician should encourage patients to attend a primary care physician or team for ongoing age-appropriate screening and chronic disease management.
G11.2	The MMT physician should have open and regular communication with the patient's primary-care physician.
G11.3	MMT physicians should screen patients for hepatitis C and HIV, and offer referral and treatment when clinically indicated.
G11.4	The MMT physician should assess patients periodically for alcohol use through an alcohol consumption history. Screening questionnaires and laboratory measures might also be considered.
G11.5	For patients with acute pain that warrants short-term opioid therapy, MMT physicians may temporarily split the methadone dose with an additional 10-15 mg evening dose, or prescribe opioids in addition to methadone (See Section 6.8 Split Doses).
G11.6	If opioids are prescribed for acute pain, the MMT physician should choose an opioid that the patient has not misused in the past, and dispense the opioid in small amounts (controlled dispensing). The MMT physician should limit the prescription to the number of days that opioids are typically needed for that particular acute pain condition.
G11.7	The MMT physician should become familiar with the *Canadian Guideline for Safe and Effective Opioid Use in Chronic Non-Cancer Pain* (**http://nationalpaincentre.mcmcaster.ca/opioid/**)
G11.8	The MMT physician may prescribe methadone in split doses for patients with severe chronic pain who require opioids. Usually this should only be done after the patient is on a stable once-daily dose and is receiving 5-6 take-home doses per week.
G11.9	The MMT physician should only attempt long-term opioid therapy for methadone patients with chronic non-cancer pain if: 1) the patient has severe pain from a well-documented diagnosis of a serious nocioceptive or neuropathic condition that would usually require opioid analgesics. Note: *Common conditions such as fibromyaglia or low back pain do not warrant combination methadone and opioid therapy.* 2) the patient has had insufficient analgesic benefit from an adequate trial of non-opioid treatments and from a trial of split methadone dosing.
G11.10	If opioids are prescribed in addition to methadone, the recommended opioids for most patients are codeine and tramadol, followed by morphine. The MMT physician should use strategies to minimize diversion and misuse. The MMT physician should periodically attempt a trial of opioid tapering, particularly in patients on higher opioid doses who continue to report severe pain.
G11.11	The MMT physician should periodically screen and assess MMT patients for anxiety and mood disorders and refer to a mental healthcare professional if they have failed to respond to primary-care treatments.
G11.12	The MMT physician should attempt to decrease long-term benzodiazepine treatment to a lower dose for MMT patients, particularly if they: 1) are on multiple daily doses 2) show signs of misuse 3) are elderly 4) are on a high methadone dose 5) are on other sedating drugs.

11.2 Physical Disorders

11.2.1 Infectious Disease

11.2.1.1 Hepatitis C and HIV

Hepatitis C treatment with interferon and ribavirin can be successfully integrated into MMT. Adherence to anti-retroviral treatment for HIV is higher in patients on MMT than those not receiving MMT (Harris et al. 2010, Uhlmann et al. 2010).

11.2.2 At-Risk Drinking

At-risk drinking and alcohol dependence are common among MMT patients (Backmund et al., 2003, Hillebrand et al. 2001). Excessive alcohol use accelerates liver damage in patients with Hepatitis C (Szabo et al., 2010), although the impact of moderate alcohol consumption is not well understood (Cheung et al., 2010). Alcohol also contributes to substance-induced mood, anxiety and sleep disorders. Alcohol interacts with methadone causing sedation, risk of overdose, aspiration, accidents, violence, and other adverse events.

Methadone treatment does not appear to significantly reduce alcohol consumption in the long-term (Anchersen et al. 2009; Caputo et al. 2002; Srivastava et al. 2008), which suggests that methadone programs do not pay enough attention to the issue. Evidence suggests that counselling about alcohol use is effective in methadone patients (McCusker 2001).

MMT physicians should be aware of special considerations involved in managing alcohol problems, such as:

Low-risk drinking guidelines
The current guidelines recommend no more than 14 standard drinks per week for men and 9 per week for women. Lower limits are recommended for patients with Hepatitis C.

Pharmacotherapy
The first-line medication used to treat alcohol dependence, naltrexone (ReVia ®) is contraindicated in patients on methadone. Available alternatives include disulfiram and acamprosate.

Alcohol withdrawal
To avoid benzodiazepine toxicity, methadone patients in alcohol withdrawal should be given smaller doses of lorazepam (e.g., 1-2 mg) rather than diazepam.

11.2.3 Hepatic, Renal, and Respiratory Disease

Hepatic Disease

- While stable liver dysfunction does not appear to affect methadone levels (Beauverie et al., 2001; Novick et al. 1985), MMT physicians have seen methadone patients who have become very sedated when admitted for acute decompensated cirrhosis. The MMT physician should consider decreasing the dose in this circumstance, and

benzodiazepines should be avoided. The half-life of benzodiazepines can be prolonged in hepatic dysfunction, and benzodiazepines can trigger encephalopathy. The QT interval should be monitored as liver dysfunction is a risk factor for Torsades de Pointes arrhythmias. (Ehret et al. 2006).

Renal Disease

- Evidence suggests that the metabolism of methadone is not affected by renal insufficiency (Kreek et al., 1980, Murtagh et al, 2007)**.** Nonetheless, patients in acute renal failure should be monitored closely for signs of methadone toxicity.

Respiratory Disease

- Tolerance to the respiratory depressant effects of methadone develops very slowly and incompletely. Methadone patients who develop an acute, serious respiratory illness (e.g., pneumonia, COPD exacerbation) should be closely monitored for both worsening respiratory function and methadone toxicity. Abrupt cessation of methadone should be avoided, as withdrawal may cause cardiorespiratory complications due to anxiety and agitation (Friedman et al. 2003; Kienbaum et al. 1998).

Cardiac Disease

- Patients who have cardiomyopathy due to ischemia or other causes are often at higher risk for arrhythmias, therefore their QT interval should be closely monitored and their dose adjusted if necessary. Rapid methadone tapering should be avoided in patients with coronary artery disease as it can trigger cardiorespiratory instability.

11.2.4 Acute Pain

MMT patients are tolerant to the analgesic effects of opioids (Doverty et al., 2001), so if they experience severe acute pain they may require opioids in higher or more frequent doses than non-tolerant patients.

In MMT patients who are eligible for take-home doses and have severe pain unresponsive to non-opioid treatments, temporarily adding an afternoon or evening methadone daily dose (e.g., 10-15 mg) may be helpful. If this is ineffective or not advisable, then the physician might consider a short-term opioid prescription. MMT patients' views on opioid use should be discussed before prescribing; some MMT patients are concerned that opioids will trigger a relapse and would prefer non-opioid analgesics. If possible, the MMT physician should avoid the MMT patient's previous opioid of abuse or an opioid commonly abused in the community. For most MMT patients, morphine is preferred over oxycodone or hydromorphone.

11.2.5 Chronic Non-Cancer Pain

Chronic non-cancer pain is common in MMT patients (Rosenblum et al., 2003). MMT physicians who prescribe methadone are encouraged to become familiar with the *Canadian Guideline for Safe and Effective Opioid Use in Chronic Non-Cancer Pain* (http://nationalpaincentre.mcmaster.ca/opioid/). However MMTpatients with CNCP present clinical challenges that require special consideration when prescribing opioids.

Table 12: Overview of Pain Management

Pain Condition	Management
Mild to moderate Common conditions such as fibromyalgia, low back pain.	Non-opioid treatments
Severe nocioceptive or neuropathic pain condition that usually requires opioid therapy.	First-line: Non-opioid treatments Second-line: Split methadone dose Third-line: Codeine or tramadol Fourth-line: Potent opioids e.g., morphine.

11.2.5.1 Methadone for Analgesia

MMT physicians cannot prescribe methadone as an analgesic for non-addicted patients with chronic pain, unless they have a special exemption from Health Canada. This exemption is independent of the exemption for methadone as a treatment of addiction.

MMT physicians with the Health Canada addiction exemption can prescribe methadone both as an analgesic and as an opioid substitution therapy for patients who have concurrent addiction and acute pain. However for chronic pain management, where, over time, the treatment of pain, rather than that of opioid dependence, becomes the primary focus of the patient's care, the MMT physician requires an exemption to prescribe methadone for pain and the patient should be taken off from the CPSO MMT Patient Registry for opioid dependence.

Controlled trials have found that methadone is of comparable effectiveness to morphine as an analgesic (Bruera et al. 2004; Mercadante et al. 2008). While the duration of analgesic action of methadone is no more than eight hours (Grochow et al., 1989), an initial trial of once daily dosing is suggested. Patients with concurrent pain and opioid addiction often experience substantial pain relief once methadone treatment is initiated. When an optimal dose is reached, the dose may be split if the patient continues to experience severe pain unrelated to withdrawal several hours after the morning dose. Patients should be eligible for 5-6 take-home doses before receiving a split dose. Consultation with a physician experienced in methadone and pain should be considered.

11.2.5.2 Opioids in Combination with Methadone

Research to date has not examined the safety or effectiveness of methadone in combination with other opioids for opioid-dependent patients with chronic non-cancer pain. Furthermore, long-term opioid prescribing in MMT patients makes it difficult to prevent and detect opioid misuse and diversion. Therefore opioids should only be used if there is strong likelihood of benefit, (i.e. patients with serious, well-defined nociceptive or neuropathic conditions who have not responded to first-line non-opioid treatments or to split methadone dosing). Use of opioids is not justified in MMT patients with common pain conditions such as fibromyalgia or low back pain.

If split methadone doses are ineffective, then codeine or tramadol can be tried. If more potent opioids are required, in many cases the MMT physician should consider using

morphine rather than oxycodone or hydromorphone (Rauck et al. 2007). Evidence suggests that oxycodone and hydromorphone have a higher risk of addiction and overdose than morphine, and therefore the latter is preferred in high risk patients. Oxycodone is a common drug of abuse in Ontario, and it is the most common opioid involved in fatal opioid overdoses (Dhalla et al, 2009). See *Canadian Guideline for the Safe and Effective Opioid Use in Chronic Non-Cancer Pain.* http://nationalpaincentre.mcmaster.ca/opioid/).

11.2.5.3 Preventing Misuse and Diversion in Patients on both Methadone and Opioids

MMT patients do not always inform their MMT physician if they are receiving opioids from another physician. Collaboration and communication between the MMT physician and pharmacist can enhance knowledge of other medications the MMT patient may be taking. For some MMT patients, ongoing UDS provides appropriate structure while on regularly prescribed opioids. Until the prescription opioid monitoring system is in place, MMT physicians have few options other than to:

- insist on communicating with the patient's non-MMT physicians
- obtain records from emergency department visits and hospitalization
- advise non-MMT physicians to order UDS for methadone when prescribing opioids, particularly if they do not know the patient well or if the patient is at high risk for opioid misuse.

If the MMT physician knows that another physician is prescribing opioids for the patient, several strategies can be implemented to minimize opioid diversion and misuse. The opioid can be dispensed along with the methadone take-home doses. Pill counts and regular urine drug screening can also be helpful. Close communication with the patient's opioid prescriber is advised to prevent dangerous drug combinations.

11.5.3.3 Opioid Tapering

Tapering is indicated for patients who report severe pain and pain-related disability despite reasonable opioid doses. Research has demonstrated that these patients experience reduced pain and improved mood and functioning with opioid tapering (Baron et al. 2006, Crisostomo et al. 2008, Hooten et al. 2007).

11.3 Mental Illness

11.3.1 Anxiety and Mood Disorders

The prevalence of anxiety and mood disorders is several times higher in MMT patients than in the general population (Callaly et al. 2001; Mason et al. 1998). Co-occurrence of substance abuse and psychiatric problems is frequently diagnosed in patients in MMT, particularly Axis I and Axis II disorders and depressed MMT patients can be more sensitive to opioid withdrawal (Astals et al. 2008; Cacciola et al. 2001; Callaly et al. 2001; Elkader et al. 2009). To date there is little evidence to support the use of antidepressants in treating mood disorders in MMT patients (Carpenter et al. 2004; Dean et al. 2002). Therefore MMT physicians might consider referring MMT patients for more intensive assessment and

treatment if they have persistent depression and anxiety despite an initial trial of pharmacotherapy.

11.4 Benzodiazepines

Benzodiazepine use in MMT patients is associated with increased psychological distress, risk for overdose, higher risk of suicidal behaviour, violence, impaired attention and memory, impaired driving and risk for continuing poly-drug use (Bleich et al. 2002; Brands et al. 2008; Caplehorn & Drummer, 2002; Darke et al. 2010; Darke et al. 2009; DeMaria et al. 2000; Man Lan-Ho et al. 2004) Furthermore inconsistent results regarding the impact of benzodiazepine use on treatment retention have been reported; negative impact (Peles et al. 2010) or no impact on treatment retention (Kellogg et al. 2006). As well, an observational study documented reduced symptoms of depression in MMT patients who were tapered off benzodiazepines and started on antidepressant therapy (Schreiber et al. 2008).

WHO Guidelines (2009) suggest that gradual withdrawal from benzodiazepines may be necessary for benzodiazepine users in MMT programs.

12.0 Methadone Toxicity

12.1 Overview

Methadone toxicity presents a serious challenge to MMT physicians.

Opioid toxicity leading to overdose is characterized by a decreased level of consciousness, respiratory depression and pinpoint pupils. Two features of methadone toxicity make interpretation of these signs difficult:

1. Definite signs of methadone toxicity may not become apparent for 5-9 hours after the overdose (Caplehorn and Drummer 2002; Lovecchio et al. 2007).
2. MMT patients who have had an overdose may appear relatively alert during conversation, succumbing to respiratory depression during sleep (Caplehorn 1999).

►Standard

None for this section.

►Guidelines

G12.1	The MMT physician should assess patients in person or refer them to the emergency department if they might have taken a dose above and beyond what would be considered a safe dose, given their underlying tolerance, concurrent medication use, and health status.
G12.2	If, after assessment, the MMT physician is concerned that the patient is at imminent risk for methadone toxicity, the MMT physician should take the following steps: ▪ explain the risks of methadone overdose, including respiratory depression and death, and advise the patient that an ambulance is being called ▪ ensure a staff member keeps the patient awake until the ambulance arrives ▪ arrange an involuntary mental health assessment if the patient refuses to attend the emergency department

12.2 Dosing and Assessment for Possible Methadone Toxicity

Definition of a toxic dose

Reasonable dose increases usually range between 10-15 mg every 3-5 days (See Section 6.5 Table 06). For example, if a patient has consistently been on 50 mg/day for several weeks and then receives 65 mg by mistake, this would be considered within the range of a "reasonable" dose increase for that patient. However, if the patient was just initiated on 30 mg the day before and then receives 45 mg on the second day, they could be at risk of methadone toxicity.

If the exact amount ingested is not known with certainty, it is safest to manage the patient as if they took an overdose, even if the patient reports that he/she is alert and only took a "small amount".

The risk of toxicity is determined not just by the amount of the extra dose but by the patient's underlying tolerance and underlying health status. Even 'small'extra doses of 15-20 mg can cause toxicity during the first two weeks of methadone titration, or if the patient is elderly or has a respiratory illness. See Table 03, Section 6.1 and 6.3.

Assessment of the MMT patient who may have taken a toxic dose

If the patient is currently at the clinic, the MMT physician should engage the patient in conversation for at least five minutes, as an overdosed patient will have trouble maintaining alertness for more than a few minutes. During the conversation, observe for sweating, emotional lability, slurred or drawling speech, and "nodding off". If possible, the patient should also be observed when not engaged in conversation. Falling asleep, 'dozing' or 'napping' could indicate toxicity even if the patient is easily rousable. Remember that the peak effect of the methadone is apparent several hours after ingestion (Wolff 2002).

If the patient is at home, ask family members to describe the patient's sleep. Loud snoring and apneic episodes during sleep could indicate a life-threatening overdose.

12.3 Patient Referral to the Emergency Department for Overdose

The information sheet in Appendix I(v) should be completed, and given to the paramedics or faxed to the emergency department. If possible, the MMT physician should speak directly with the attending emergency department physician or nurse, advising them that:

1. the patient should be observed for a minimum of 10 hours.
2. the patient should be discharged only if they have not displayed any signs of lethargy or sedation during that time.

If the MMT physician decides not to call the ambulance, a reliable adult should accompany the patient to the emergency department. The person must understand the life-threatening nature of the overdose and the dangers of refusing emergency department management.

If the MMT physician is uncertain about appropriate management, contact the Ontario Poison Centre.
http://www.ontariopoisoncentre.com/poisoncentre/
or call 1-800-268-9017 or (416) 813-5900

12.4 Refusal to go to Emergency Department

If the patient refuses to go the emergency department, then it is appropriate to fill out a Form 1, which allows an involuntary assessment of the patient. Many MMT physicians are reluctant to complete a Form 1 on a patient who is alert and coherent. However, methadone overdose meets the requirements for a Form 1 because:

1) The patient is at imminent risk of bodily harm.
2) The patient has a mental health diagnosis (addiction) that makes it difficult for them to appreciate the need for medical treatment. (Clinical experience suggests methadone patients tend to be far more concerned about methadone withdrawal than intoxication. The MMT patient might be worried that they will receive naloxone in the ED or that their next methadone dose will be reduced or delayed.)

If the patient refuses to go to the emergency department and a clinical decision is made to not complete a Form 1 (e.g., no MMT physician available onsite or the MMT physician is speaking to the patient by phone and have not assessed the patient in the preceding week as required by a Form 1), then it is reasonable to send an ambulance or police to the patient's home.

If the MMT physician decides not to complete a Form 1 or to call emergency services, then the patient should be asked to sign an "AMA or Against Medical Advice" form (if the patient is in the clinic). Explain to the patient and their partner or family member if available that the patient is at risk of respiratory depression and death, especially if they fall asleep. Advise the patient not to use any other substances or medications.

13.0 MMT Considerations during Pregnancy

13.1 Overview

Pregnant opioid-dependent women are at increased risk of obstetrical and medical complications due to repeated cycles of opioid intoxication and withdrawal. Pregnant opioid-dependent women have higher rates of premature delivery and infants with low birth weight leading to higher rates of infant morbidity and mortality (Finnegan 1978; Hulse et al. 1997, 1998; Kandall et al. 1977; Little et al. 1990; Rementeria and Nunag 1973; Stern 1966; Stimmel et al. 1982; Vucinovic et al. 2008; Wilson et al. 1981). Morbidity and mortality have been attributed to the direct effect of the drug itself, but are also secondary to other associated lifestyle factors such as poor nutrition, inadequate prenatal care attendance and concomitant substance use such as alcohol and tobacco (Fricker and Segal 1978, Hulse et al. 1997, Vucinovic et al. 2008).

The benefits of MMT during pregnancy include improved prenatal care, nutritional status and social stability leading to increased likelihood of maternal custody, as well as, reduced incidence of pre-term delivery, low birth weight and infant mortality (Chang et al. 1992; Kaltenback and Finnegan 1992; Wilson et al. 1981).

►Standard

S13.1	The MMT physician shall offer MMT to opioid-dependant pregnant patients on an urgent basis.

►Guidelines

G13.1	MMT physicians should ensure pregnant opioid-dependent patients are counselled regarding the risks and benefits of MMT during pregnancy.
G13.2	The MMT physician should consider inpatient initiation during pregnancy in order to monitor for withdrawal severity and fetal distress.
G13.3	The MMT physician should aim for a maintenance dose of methadone that keeps the patient comfortable for 24 hours and helps maintain abstinence.
G13.4	MMT physicians should consider split dosing during pregnancy as an alternative strategy to increasing the methadone dose in the third trimester.
G13.5	The MMT physician should assess the MMT dose for adjustments, especially for dose increases during the third trimester of pregnancy to prevent maternal withdrawal symptoms.
G13.6	The MMT physician should consider dose replacement after reported emesis in pregnant women.
G13.7	The MMT physician should consider tapering and detoxification in selected patients based on clinical and social stability, previous good response to tapering, and no concurrent psychiatric disorders or addiction to other substances.
G13.8	The MMT physician should assist the MMT patient in obtaining adequate prenatal care by referring for obstetrical care as soon as pregnancy is identified.
G13.9	The MMT physician should ensure there is open communication between the methadone and obstetrical physician regarding the use of MMT during pregnancy and planning for labour and delivery.
G13.10	During labour and delivery the MMT physician should ensure the pregnant MMT patient receives her regular daily methadone dose.

G13.11	The MMT physician should monitor the MMT patient closely for symptoms of methadone intoxication and mood disorders during the postpartum period.
G13.12	The MMT physician may need additional visits with the patient during the immediate postpartum period to provide support during this transition phase.
G13.13	The MMT physician should encourage breastfeeding during MMT.
G13.14	The MMT physician should consider referring to a child protection agency, depending on the mother's length of time in treatment, the stability of substance use, and social situation.

13.2 Effects of Methadone during Pregnancy

Methadone crosses the placenta, but has not been found to be teratogenic. There is weak evidence linking strabismus to opioid use during pregnancy, especially with methadone exposure in utero (Gill et al. 2003; Nelson et al. 1987).

To date, no conclusive long-term study has been published about the long-term effects of neonatal exposure to methadone (Chasnoff et al. 1982; Hans 1989; Hunt et al. 2008; Kaltenbach and Finnegan 1987; Lifschitz et al. 1985). Environmental factors and caregivers can play a significant role in mediating these effects of methadone exposure on infants' growth and development.

The most significant risk of methadone exposure during pregnancy is neonatal withdrawal also known as neonatal abstinence syndrome (NAS) (Kaltenbach & Finnegan 1986). Up to 85% of newborns exposed to methadone experience withdrawal symptoms and signs (Bell and Lau 1995; Finnegan et al. 1975) such as:

1) central nervous system (CNS) hyperirritability (high-pitched cry, increased muscle tone, sleep disturbances, tremors, seizures)
2) gastrointestinal dysfunction (poor feeding, regurgitation, vomiting, loose stools)
3) metabolic, vasomotor, and respiratory disturbances (sweating, recurrent sneezing, yawning, fever).

Withdrawal usually begins within 72 hours of birth, but late presentations (up to 2-4 weeks after birth) have been reported (Finnegan amd Kaltenbach 1992) and symptoms may last for several weeks or months.

13.3 MMT during Pregnancy

13.3.1 Inpatient vs Outpatient

See Appendix L: Protocols for MMT and Pregnancy.

There are no studies to demonstrate the efficacy and safety of inpatient over outpatient stabilization. However, inpatient stays allow for investigations of maternal health and prenatal status and referral to others (e.g., social worker, obstetrical care provider).

Inpatient initiation is not always feasible due to personal factors (e.g., fear of medical personnel and hospitals, child care issues and lack of support from family or partner) or

systemic factors (e.g., unavailability of methadone in the hospital and limited staff experience). However, if a pregnant woman complains of uterine irritability (e.g., abdominal cramping and bleeding) during outpatient initiation, hospital admission is indicated.

13.3.2 Methadone Dosing During Pregnancy

13.3.2.1 Establishing a Maintenance Dose

An appropriate maintenance dose should be determined for each individual. A clear relationship between maternal methadone dose and the severity of Neonatal Abstinence Syndrome (NAS) has not been established (Berghella et al. 2003; Dashe et al. 2002; Doberczak et al. 1993; Kaltenbach and Comfort 1997) due to the potential effect of other factors such as concomitant drug use (e.g. cocaine, benzodiazepines) on neonatal withdrawal (Berghella et al. 2003; Mayes and Carroll 1996). The risks of illicit opioid use outweigh the potential risks of higher methadone doses.

13.3.2.2 Dose Splitting During Pregnancy

Twice-daily methadone dosing has been associated with sustained plasma methadone levels and fewer withdrawal symptoms resulting in improved treatment compliance and decreased use of other illicit substances (Swift et al. 1989, Wittmann and Segal 1991). Split doses have also been shown to cause less suppression of fetal behaviour than with single daily dosing which has demonstrated decreases in both fetal movements and fetal breathing after dosing (Jansson et al. 2009; Wittmann and Segal 1991). Therefore, when pregnant women continue to experience withdrawal symptoms with single daily dosing, split dosing (i.e., every 12 hours) can be considered. Women need to meet stability criteria (See Section 8.3 Take Home Dose Criteria) for take-home doses or arrangements can be made with the pharmacy to provide an evening observed dose.

13.3.2.3 Dose Adjustments During Pregnancy

Women in MMT prior to conception can continue on their pre-pregnancy dose during the first and second trimesters (Finnegan 1991). Methadone clearance rates gradually increases from the first to the third trimester resulting in lower mean serum methadone levels as the pregnancy progresses (Drozdick et al. 2002; Jarvis et al. 1999; Wolff et al. 2005). This change in methadone clearance has been attributed to different factors such as increased methadone metabolism during pregnancy, increased maternal renal elimination, increased volume of distribution and tissue binding, and additional metabolism by placenta and fetus (Pond et al. 1985, Swift et al. 1989). Small increments in methadone dose later in pregnancy will be required.

13.3.2.4 Managing Vomited Doses

See Section 6.10 Vomited Doses.

13.4 MMT Tapering or Withdrawal during Pregnancy

Recent clinical experience with MMT detoxification (i.e., methadone-assisted withdrawal) has not demonstrated any increased incidence of obstetrical complications or adverse neonatal outcomes during the first, second or third trimesters (Blinick et al. 1969; Dashe et al. 1998; Jones et al. 2008; Luty et al. 2003; Maas et al. 1990). However, MMT detoxification has been associated with clinical instability and a high risk of relapse to substance use requiring resumption of MMT.

There is limited guidance in terms of the rate of methadone tapering or detoxification. Some studies have proposed reducing the dose by 1-2 mg/day as an inpatient or by 2-10 mg every 1-2 weeks as an outpatient (Archie 1998; Finnegan 1991; Jarvis and Schnoll 1994; Kandall et al. 1999). However, these numbers are not based on systematic studies. In pregnancy, the dose should be decreased slowly by 5-10% per week. This process should be stopped if the pregnant woman reports any adverse outcomes such as relapse to drug use, increased cravings, intolerable withdrawal symptoms or obstetrical complications.

Motivated women who have a short addiction history, are medically and socially stable with a good support network and have no concurrent psychiatric disorder may have better outcomes following detoxification.

13.5 Prenatal Care for MMT Pregnant Patients

The addition of on-site prenatal care has been shown to improve attendance and pregnancy outcomes (Chang et al. 1992). Binder & Vavrinkova showed that methadone substitution treatment provides pregnant women with greater social stabilization and prenatal care (Binder and Vavrinkova 2008). Therefore, comprehensive care which provides MMT and prenatal care is the most effective approach in increasing patient retention and reducing adverse neonatal outcomes (Ellwood et al. 1987).

13.6 Intrapartum Management for MMT Pregnant Patients

Methadone will not provide pain relief during labour and additional analgesia will be required.

13.7 Postpartum Management for MMT Patients

13.7.1 Dosing

A few days or weeks postpartum, the MMT patient may find her established dose of methadone is too high. If so, it should be decreased by 5-10 mg every week based on clinical symptoms until a new stable dose is reached. The MMT physician should consider the risk of relapse to illicit opioids prior to beginning the decrease.

13.7.2 Support

Mothers often feel extremely guilty if the infant exhibits symptoms of opioid withdrawal requiring treatment and an extended hospital stay. The services of public health nurses and

attendance at drop-in centers and parenting classes (e.g., Ontario Early Years Centers) should be encouraged.

13.7.3 Breastfeeding

Methadone enters the breast milk in very small amounts that are unlikely to be clinically significant (Glatstein et al. 2008; Jansson et al. 2004). The mean daily amount of methadone ingested by infants ranges between 0.01 and 0.05 mg depending on the maternal methadone dose. This amount is not sufficient to prevent neonatal absence syndrome (NAS) and the infant still requires additional opioid treatment for NAS.

13.7.3.1 Breastfeeding and Hepatitis C

No studies have demonstrated transmission of HCV through breast milk alone to infants (Wong and Lee, 2006). Breastfeeding by women who are infected with hepatitis C (HCV) is considered safe.

13.8 Reporting to Child Protection Agencies

In Ontario, the Child and Family Services Act outlines a legal responsibility to promote the well-being and protection of children. Any health care professional who has reasonable grounds to suspect that a child is, or may be, in need of protection has a legal duty to report this suspicion. In Canada, the fetus is not legally recognized as a person and as such, the obligation to report only applies once the child is born. Prenatally, health care providers may contact child protection services after discussion and with consent from the pregnant woman. Patients should be encouraged to self-report during the prenatal period in order to increase self-efficacy, dignity and stability while promoting an open and informed decision-making by child protection authorities. Consider immediate referral if the pregnant woman has children in her care and there is a child protection concern.

14.0 MMT in Federal/Provincial Correctional Facilities

14.1 Overview

MMT in correctional facilities is unique and provides good quality care that meets a standard. The controlled environment, imperatives for security, and the governance of correctional policy may affect the institutional MMT physician's ability to provide patient-centered care at community standards. The trusting therapeutic relationship between MMT physicians and patients must remain the focus of treatment.

High risk behaviour such as injection opioid use can be seen within correctional facilities. The prevalence of HIV and viral hepatitis is high in the correctional population due in part to the prevalence of needle sharing.

Incarcerated opioid-dependent individuals should be offered ongoing MMT or initiation of MMT.

►Standards

S14.1	The institutional MMT physician shall ensure a Treatment Agreement is signed by the patient.
S14.2	The institutional MMT physician shall ensure the Treatment Agreement and medical history is kept as part of the medical file.
S14.3	The institutional MMT physician shall ensure healthcare staff contacts the previous MMT physician and/or pharmacy to determine the patient's current dose, the date/time of the last dose received to ensure that three or more doses were not missed.
S14.4	The institutional MMT physician shall ensure that protocols to treat a known or suspected opioid overdose are available to all health care staff. NARCAN® must be available.
S14.5	The institutional MMT physician shall ensure arrangements are made for methadone pick-up at a community pharmacy in the event of an outside pass.
S14.6	The institutional MMT physician shall make every attempt to educate the patient of potential for relapse and the dangers of overdose, and encourage adherence to treatment.
S14.7	The institutional MMT physician shall not prescribe take-home doses to a patient upon release from the correctional facility.

►Guidelines

G14.1	The institutional MMT physician should ensure program rules and expectations are in writing and verbally described to each patient.
G14.2	The institutional MMT physician should ensure dispensing times are clearly defined.
G14.3	The institutional MMT physician should clearly describe the expectations regarding provision of UDS samples, appointments with the MMT physician, and general behaviour at the onset of treatment.
G14.4	The institutional MMT physician should ensure UDS results are maintained in the medical chart.
G14.5	The institutional MMT physician should ensure UDS results are not shared with non-medical staff except when there is a safety issue and that if shared should not be used for punitive purposes.
G14.6	The institutional MMT physician should ensure UDS are performed at intake and periodically thereafter, particularly if the patient shows evidence of intoxication, injection drug use or diversion of methadone.
G14.7	The institutional MMT physician should assess patients in person or via telemedicine for dose increases.
G14.8	In exceptional circumstances due to facility constraints, (e.g. lockdown or inmate movement issues) when the institutional MMT physician cannot assess a patient, the institutional MMT physician should designate a nurse to assess the patient for dose increases. A single dose increase of no more than 10 mg can be given by the nurse prior to the assessment of the facility physician.
G14.9	The institutional MMT physician should ensure a process is in place for the safe administration of methadone for patients.
G14.10	The institutional MMT physician should ensure a safe process is in place to initiate patients on MMT, if feasible.
G14.11	The institutional MMT physician should ensure every effort is made to provide continuity of care with a community physician.
G14.12	Prior to release from the facility, the institutional MMT physician should slowly decrease (taper) the methadone dose if the patient is going to a community with no available MMT physician. This should be done only as a last resort.
G14.13	The institutional MMT physician should ensure a bridging prescription is faxed to a community pharmacy until the patient's next appointment if there is a gap of time from the date of release to the scheduled appointment with the community MMT physician. Details of the prescription should be communicated with the community MMT physician.
G14.14	The institutional MMT physician should ensure counselling and support is provided throughout the involuntary taper process and that the opportunity for the patient to reapply for MMT is available if they can adhere to program requirements.

14.2 Approaches to Treatment in a Correctional Facility

14.2.1 Approach to Treatment

It must be clear that the interests of the patient are the priority of the institutional MMT physician. A multidisciplinary team approach to the provision of MMT is essential in this

setting and should include clinical staff, substance abuse counselors (where available), and persons responsible for the patients MMT in the community.

Confidentiality is extremely important in the correctional system, as in all medical interactions. Conflicts are often avoidable when the structure of the treatment is conveyed to both patients and staff.

14.2.2 UDS

It is essential that urine toxicology screening results used in MMT correctional facilities is for therapeutic purposes and results should be maintained in the medical chart.

14.2.3 Missed or Vomited Doses

Correctional facilities may have specific procedures in place to handle missed or vomited doses.

14.3 Continuing Ongoing MMT

11.3.1 Issues Unique to Providing MMT in Correctional Facilities

14.3.1.1 Methadone Brought With a Patient

Methadone accompanying any patient should be discarded unless continuity of handling can be proven, such as in a transfer from another correctional facility. (See Correctional policies for the discarding of narcotics).

14.3.1.2 Treatment Agreement

The institutional MMT physician shall ensure a treatment agreement is signed by the patient and ensure that the treatment agreement and medical history are kept as part of the medical file.

14.3.1.3 Dosing on Admission

Confirmation must be obtained about whether a patient is enrolled in and attending a community MMT program upon admission to the correctional facility and prior to dispensing the first methadone dose.

Often institutional MMT physicians are not available on the weekend to maintain patients on MMT if incarceration occurs after hours, leaving patients at risk for destabilization. For patients who mostly have observed ingestion at the pharmacy with less than or equal to three carries per week, a nurse may assess the patient (vitals signs, appearance and level of alertness, symptoms of withdrawal and intoxication and presence of EDDP in their urine) to allow MMT to continue at the same dose. The institutional MMT physician may then fax a methadone prescription to the pharmacy at the correctional facility for the same dose or a lower dose. Alternatively the patient's community MMT physician may provide a prescription for a bridging dose until the institutional MMT is available.

In order to provide safe MMT, institutional MMT physicians must use their clinical judgment to determine the appropriate dose (e.g., 50% of the stated dose if diversion of take-home doses is suspected, or of a high maintenance dose, e.g., the dose is greater than or equal to 150 mg). If the dose is reduced, the institutional MMT physician should re-assess the patient frequently for symptoms of withdrawal and intoxication, and appropriate dose changes should be made. Benzodiazepines, or sedating sleep aids should be used cautiously if at all until the institutional MMT physician has done an appropriate assessment of the patient. If the patient appears intoxicated from the nurse's assessment, in these circumstances, the patient should be assessed within a reasonable amount of time to avoid further discomfort of withdrawal. The Opioid Detoxification Protocol should be followed.

See Section 6.9 Table 08 for protocols on management of missed doses. For patients with "take-home privileges", the physician may wish to verify recent ingestion of methadone by testing for evidence of EDDP in their urine.

14.3.1.4 Dose Increases

In exceptional circumstances due to facility constraints, (e.g., lockdown or offender movement issues) when the institutional MMT physician cannot assess an inmate, the institutional MMT physician should designate a nurse to assess a patient for dose increases. A single dose increase of no more than 10 mg can be given by the nurse prior to the assessment of the institutional/MMT physician.

The nurse's assessment is documented in the chart and includes the following:

1) The reason why the assessment is being performed by the R.N. and not the physician
2) Any obvious signs of withdrawal noted by the R.N.
3) When the withdrawal symptoms begin in relation to the dose (i.e., 8 hours before the next dose, or 16 hours after the dose)
4) Time of use
5) Drug cravings
6) Time and amount of last dose
7) Mental status
8) Sign and symptoms of sedation
9) Any ongoing opioid use (drug name, amount used, and route of use).

14.4 Observed Administration

It is not uncommon for MMT patients to be under considerable pressure from other patients to divert their medication. Adequate steps to avoid diversion are critical to ensure MMT patients safety within the facility.

Below are suggested recommendations that can be incorporated into the facilities administration process:

- MMT patients to show proper identification.
- MMT patients receiving methadone should be isolated from other patients during administration process.
- Drink water following administration.
- Nurse can inspect mouth before and/or after.
- No wearing of bulky clothing (i.e., parkas, hoodies)
- No bringing cups or containers into the administration area.
- Frisking MMT patients before entering and/or upon leaving administration area.
- Limit access to water post ingestion (fountains, bathrooms).
- A 20 minute direct observation should follow immediately.

14.5 Initiating MMT in a Correctional Facility

If a patient is not receiving methadone at the time of incarceration, the following conditions should be met:

1) The patient must meet or have met in the past the DSM-IV diagnostic criteria for opioid substance dependence.
2) A UDS must be interpreted and a complete assessment performed prior to initiation.
3) The usual reporting procedure to the CPSO must be followed.
4) Patients not currently using opioids, but where their documented history clearly shows a pattern of long-term opioid dependence continuing until the time of incarceration, should be considered for initiation on methadone while in the correctional facility. (See Section 5.3.4.1)
5) Pregnant patients currently using opioids must be offered MMT while incarcerated. Patients with HIV infection, or hepatitis B or C should be made a high priority for being offered methadone treatment while incarcerated.

14.6 Accidental Overdose of Methadone

Patients should be transported to a community hospital emergency department for assessment and observation. If returned to the institution, a procedure for close observation for at least 24 hours should be in place. Naloxone (Narcan®) must be available in all correctional facility health centers.

14.7 Out-of-Facility Pass

The institutional MMT physician shall ensure that arrangements are made for methadone pick-up at a community pharmacy in the event of an outside pass.

14.8 Treatment Planning for Release

It is imperative that every attempt to provide good discharge planning is done prior to release. Patients are at highest risk of overdose after release from a correctional facility if an appropriate release plan is not made. However, release dates are not always known and patients may be unexpectedly released precipitously and/or directly from court.

14.8.1 Treatment Planning—Release Date Known

When the release date of the patient is known arrangements should be made in advance. An appointment should be scheduled with the community MMT physician and appropriate clinical information should be sent.

14.8.2 Treatment planning - Release Date Unknown or Unexpected

Patients are often released from custody directly from Court or on very short notice without the knowledge of the facility healthcare staff. Therefore where possible:

1. Patients should receive their daily dose of Methadone prior to leaving the facility.
2. Patients should be further advised to contact the facility healthcare staff if they are released directly from court without the benefit of a release plan.

If a patient is released without a community MMT physician, every effort should be made to find one for the patient by contacting the Methadone Program at the CPSO.

If assistance is required by the facility in finding a local pharmacy that dispenses methadone, contact the Ontario College of Pharmacists.

14.9 Take-Home Doses

The institutional MMT physician shall not prescribe take-home doses to a patient upon release from the correctional facility.

14.10 Involuntary Withdrawal

See Section 9.3.

15. Hospital-Based MMT

Attending Physician (or Most Responsible Physician [MRP]): the physician who is responsible for the overall care of the patient, and who must approve all orders written by other physicians.

Hospital MMT Physician: the physician who prescribes methadone. This is usually a different physician than the MRP. For example, when a patient on a stable dose of methadone is admitted to the hospital with pneumonia, the attending physician will manage the pneumonia and the hospital MMT physician will order the methadone.

15.1 Overview

Physicians without a methadone exemption are not allowed to order or prescribe methadone unless they receive a special exemption from Health Canada. Temporary exemptions are only valid for one specific patient, and only for the duration of that patient's stay in hospital. Exemptions can be obtained by calling Health Canada, Office of Controlled Substances.

In many cases, hospital physicians know little about MMT and must rely on the expertise of an MMT physician. General or psychiatric hospitals should identify at least one methadone physician, on staff or in the community, who has agreed to be available for telephone consultations. If feasible, the community methadone physician should seek out active hospital privileges so that he or she may write hospital orders for methadone.

►Standard

None for this section.

►Guidelines

G15.1	General hospitals should have at least one MMT physician who is on their medical staff and available for consultation. Methadone should be on the hospital formulary.
G15.2	The hospital MMT physician should verify the patient's current dose and date it was last dispensed with the patient's pharmacy.
G15.3	The hospital MMT physician should ensure the prescription at the community pharmacy is cancelled for the duration of the patient's hospital stay.
G15.4	The hospital MMT physician should conduct a focused assessment with these objectives: 1. Identify acute risk factors for methadone toxicity. 2. Obtain a history of methadone use. 3. Order a UDS if clinically unstable. 4. Order an ECG if patient is on a high dose or has risk factors for arrhythmias.
G15.5	The hospital methadone order should specify that the dose is to be mixed in orange juice, and dispensed daily under the observation of a nurse. The order should also specify dispensing dates, and should direct nurses to withhold the dose if the patient shows signs of sedation or intoxication.
G15.6	If the patient is n.p.o., the hospital MMT physician may allow the methadone to be mixed in water (or clear juice, with the attending physician's approval).
G15.7	The hospital MMT physician should prescribe oral or parenteral opioids to minimize withdrawal symptoms if methadone is not available or is contraindicated (e.g. prolonged QT interval).
G15.8	To avoid methadone toxicity, the hospital MMT physician should monitor for the emergence of risk factors during the patient's hospital stay, such as co-prescribing of sedating drugs. The methadone dose should be adjusted accordingly.
G15.9	On discharge, the hospital MMT physician may write a prescription for the patient's community pharmacy to last for several days until the patient can see their community MMT physician. A hospital prescription may not be necessary if the patient has take-home doses at home (at the same dose as that provided in hospital).
G15.10	MMT may be initiated in-hospital for pregnant patients, and for patients requiring prolonged hospitalization, who might leave if their acute opioid-withdrawal symptoms are not treated.

15.2 Guidelines for Hospital Pharmacies and Medical Administrators

All hospitals are encouraged to have methadone on their formulary. If methadone is not on the formulary, the patient may bring their take-home doses if available, or a community pharmacy may deliver methadone to the hospital. A take-home bottle should only be used if it is properly labeled and unopened. Methadone should be stored in a locked narcotic cupboard and dispensed under the supervision of a nurse.

15.3 MMT Physicians Working in a Hospital

15.3.1 Verifying the Community Dose

It is not safe to rely solely on the patient's history or the community MMT physician's office for verification of the dose. Only the dispensing pharmacist is able to verify with certainty whether the patient has filled their methadone prescription. If the pharmacy is closed and the dose cannot be verified, a safe dose (e.g., 20-30 mg) can be given to ameliorate withdrawal symptoms. If feasible, the urine should be tested to confirm that the patient has recently taken methadone. The hospital MMT physician should cancel the methadone prescription for the community pharmacy for the anticipated duration of the hospital stay.

15.3.2 In-Hospital Assessment of the Patient

A focused assessment will identify acute risk factors for methadone toxicity. The following should be included in the assessment:

History:

- Methadone dose, recent changes in dose, missed doses, number of take-home doses per week, and exact date and time of the last dose.
- Recent alcohol and substance use.

Chart review:

- Reason for hospital admission
- Out-patient and in-hospital medications
- Cardiorespiratory, hepatic and renal status.

Investigations:

- Baseline UDS
- ECG if on dose above 120 mg or risk factors for QT prolongation, e.g., electrolyte disturbances.

15.3.3 Hospital Methadone Order

The order should be similar to community prescriptions, specifying that the dose is to be mixed in juice and ingestion is to be observed by a nurse. Start and end dates should be specified in the order and nurses should be instructed to hold the dose if the patient shows signs of sedation or intoxication.

15.3.4 Patients on "Nothing by Mouth" (n.p.o)

If the patient is unable to take oral medications or fluids, withdrawal can be lessened with scheduled doses of parental morphine or hydromorphone. If possible, peripheral and central lines should be avoided in patients who have recently been using injection drugs.

15.3.5 Adjusting the Dose

There have been case reports of serious toxicity in hospitalized patients on methadone, caused by drug interactions or the patient's medical condition. Close monitoring is required if the patient has:

1) medications introduced that are sedating or that inhibit methadone metabolism (See Appendix B)
2) a decreased level of consciousness
3) an acute cardiorespiratory illness
4) missed methadone doses prior to hospitalization
5) has worsening hepatic or renal function.

In these circumstances, frequent observation should be ordered, specifying that the dose is to be withheld if the patient shows signs of sedation or intoxication.

When adjusting the dose the hospital MMT physician should keep in mind that acute methadone withdrawal can have serious medical consequences in patients with medical illness. Even intubated patients in a coma will undergo withdrawal if MMT is abruptly discontinued which can cause agitation and cardiorespiratory instability (Friedman et al. 2003; Kienbaum et al. 1998)**.** Therefore methadone should not be rapidly tapered or discontinued unless the patient is experiencing methadone-induced intoxication, sedation, or arrhythmias. If it is rapidly tapered, the dose should be carefully readjusted as withdrawal symptoms emerge.

15.3.6 Initiating MMT in Hospital

The treating physician may initiate MMT in hospital for pregnant patients, and for seriously ill patients who require prolonged hospitalization and who might leave against medical advice if their withdrawal is not promptly treated (Aszalos et al. 1999). Vigilance is required, as overdose deaths have occurred even in an inpatient setting. (See Section 12.0 Methadone Toxicity)

15.3.7 Opioid Detoxification with Methadone

Inpatient methadone detoxification should only be done by experienced MMT providers in a setting which provides 24 hour nursing and medical coverage. As the patient is closely monitored before and after dosing small p.r.n. doses can be used (e.g., 5 mg q.8.H. no more than 10-15 mg per day). The fixed morning dose can be increased by 10 mg every 2-3 days if the patient requires regular p.r.n. doses. The severity of their withdrawal can be measured using the Clinical Opiate Withdrawal Scale (COWS). Concurrent use of benzodiazepines or other sedating drugs should be avoided.

15.3.8 Discharge from Hospital

If the dose has been adjusted during hospitalization, the hospital MMT physician should advise the community MMT physician and the patient should be advised to return the pre-hospitalization take-home doses to the pharmacy.

16. Telemedicine in the Delivery of MMT

16.1 Overview

"Telemedicine" (TM) is the delivery of health-related services and information using telecommunications technologies such as two-way videoconferencing systems and tele-diagnostic instruments such as digital stethoscopes, otoscopes and patient examination cameras. The main provider of telemedicine infrastructure in Ontario is the Ontario Telemedicine Network (OTN), an independent, not-for-profit organization funded by the Government of Ontario.

In general TM allows the physician using the services of the OTN to interact with patients through a video monitor in a remote location.

TM appears to work best for patients who have achieved stability with their treatment plan and who have already developed a good working relationship with their MMT physician.

There is recognition that remote communities face special challenges accessing MMT and those specific strategies need to be considered to ensure the success of MMT in these communities.

It is the position of the Methadone Committee of the College that while TM can support treatment in communities where none exists, it is not a replacement for face-to-face interaction.

According to the CPSO, the use of TM by MMT physicians to provide MMT to patients in areas generally not able to access MMT is growing.

►Standards

For the best care to patients receiving MMT via TM, MMT physicians shall ensure the following:

S16.1	The site where the service is provided must be an accredited OTN site which means the videoconferencing equipment has been implemented according to OTN's network architecture, security and training standards to ensure conformance with the high technical and quality videoconferencing standards necessary for clinical care and PHIPA.
S16.2	At the MMT TM, site there must be a nurse with training specific to MMT to work with the patient to ensure their UDS is collected for the purpose of MMT physician interpretation.
S16.3	Supportive counselling and case management must be available to the MMT patient in-person onsite.
S16.4	Each location using delegation to administer methadone adheres to the CPSO policy entitled: *Methadone Maintenance Treatment for Opioid Dependence* (available at www.cpso.on.ca.)
S16.5	All patients must be assigned a most responsible MMT physician.
S16.6	The initial visit is conducted in-person with the results of a focused physical assessment available prior to initiation of MMT. In extenuating circumstances where the MMT physician is not able to see the patient in person and delaying treatment may result in harm to the patient, the MMT physician may do the initiation via TM but must see the patient in person within a reasonable time period (i.e., 4 -6 weeks).

When initiating MMT in remote communities, MMT physicians must consider sustainability, which includes planning and collaboration regarding local supports, secondary impacts on local health and social services, and transportation of methadone into the communities.

►Guidelines

G16.1	When initiating MMT in remote communities, the MMT physician should ensure the following: 1) Support of a local clinic team that is skilled and knowledgeable about MMT, is available to the patient 2) Face-to-face interaction 3) Partnerships with interdisciplinary services in the community to support patients on MMT are established 4) Arrangements with local hospitals and other healthcare providers are in place for patients to handle emergencies such as overdose 5) Appropriate methadone is available in advance of offering the service – ideally in the form of a local pharmacy and pharmacists who are part of the healthcare team in the community 6) Where methadone is shipped in for dispensing at the clinic, back up arrangements are in place with a local pharmacy in case of emergency such as delivery problems during bad weather.

Appendix A: Diagnostic Criteria for Substance Dependence

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

1. Tolerance, as defined by either of the following:
    a) the need for markedly increased amounts of the substance to achieve intoxication or the desired effect;
    b) markedly diminished effect with continued use of the same amount of the substance.
2. Withdrawal, as manifested by either of the following:
    a) the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for withdrawal from the specific substances);
    b) the same (or a closely related) substance is taken to relieve (or avoid) withdrawal symptoms.
3. The substance is often taken in larger amounts or over a longer period than was intended.
4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.
5. A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple physicians or driving long distances), use the substance (e.g., chain smoking), or recover from its effects.
6. Important social, occupational or recreational activities are given up or reduced because of substance use.
7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was worsened by alcohol consumption).

Specify if:

With Physiological Dependence: evidence of tolerance or withdrawal (e.g., either Item 1 or 2 is present).

Without Physiological Dependence: no evidence of tolerance or withdrawal (e.g., neither Item 1 nor 2 is present).

Appendix B: Drug to Drug Interactions

Physicians need to be aware of common methadone-drug interactions. Many of these interactions involve the cytochrome P450 (CYP450) enzymes. While there are more than 28 CYP enzymes (Flexner and Piscitelli 2000; Shannon 1997; Wilkinson 2005, as cited in Levitt, 2005) the most important enzymes in methadone metabolism are CYP3A4 and CYP2B6. As Levitt (2005) points out, some P450 interactions may be potential (i.e. theoretical), others are currently being investigated to confirm their clinical significance.

Of importance to physicians is how the substances that interact with the CYP450 system work to increase or decrease the level of methadone. Substances may act as substrates, inhibitors or inducers, as outlined in the table below:

Substrates, Inhibitors and Inducers

Substrate	Any drug metabolized by one or more CYP enzymes
Inhibitor	Any drug that slows the metabolism of drugs that are substrates, which may result in excessively high drug levels
Inducer	Boosts the activity of specific CYP enzymes resulting in more rapid metabolism of substrate drugs, which may result in lower than expected levels of substrate drugs.

Pharmacodynamic

Additive effects of:

- Another central nervous system (CNS) depressents, e.g., alcohol, benzodiazepines, other sedating medications e.g. dimenhydrinate, clonidine, when combined with methadone
  - High risk patients for toxicity on initiation
  - Risk of CNS depression during treatment.

- Medications causing similar effects e.g., constipation or urinary retention by anticholinergics.

- Medications causing prolongation of QTc interval e.g., tricyclic antidepressants, cocaine (see http://www/azcert.org/medical-pros/drug-lists/printable-drug-list.cfm and other websites).

Pharmacokinetic

Methadone is metabolized by several CYPs, predominantly by 3A4 enzyme system and to a lesser extent CYP 2B6, 2D6 and 1A2. Others may also be involved.

Important Considerations in Methadone Interactions

Some important considerations in methadone interactions are noted in the table below:

With Medications that are 3A4 Inhibitors	With Medications that are 3A4 Inducers
Fast onset	Slower onset
Possible increase in methadone effects including toxicity and overdose	Can result in decreased methadone effects and withdrawal symptoms
Extra care required during initiation of methadone	

Clinicians should take special care when medications are started or discontinued.

The following websites may be consulted:

http://www.atforum.com/SiteRoot/pages/addiction_resources/Drug_Interactions.pdf)
www.hivclinic.ca/man/drugs_interact.html

Appendix C: Initial Patient Assessment Form

ABOUT YOURSELF:

Please complete the following questionnaire as accurately and honestly as possible so that we can determine what kind of treatment would serve you best.

NAME _____ _____
(first) (last)
DATE _____
HEALTH CARD # _____ VERSION CODE: _____
DATE OF BIRTH _____
(year/month/day)
ADDRESS _____ APT # _____
CITY_____ POSTAL CODE _____
PHONE day ( ) _____ evening ( ) _____

CONTACT IN CASE OF EMERGENCY (state relationship)
_____

CONTACT'S PHONE ( ) _____

WHO REFERRED YOU? _____

GENDER: ❑ male ❑ female

DRUG HISTORY:

DRUG	AMOUNT USED	HOW LONG DAILY USER	ROUTE TAKEN	FIRST USED	LAST USED
Heroin					
Other Narcotics					
Cocaine					
Barbiturates (Fiorinal)					
Amphetamines					
Alcohol					
Cannabis (Pot, Hash)					
Cigarettes (packs per day)					
Benzodiazepines (Valium, Ativan)					

PRESCRIPTION MEDICATIONS:

(Any medications you regularly take or are prescribed, amount and frequency): none ❑
or, give details_____
_____
_____

Are you now or have you ever been prescribed narcotics (e.g., Tylenol #3, Percodan, Percocet, Dilaudid, Talwin, morphine) for an extended period of time (e.g., for more than four weeks?) ❑ yes ❑ no narcotic name _____

Amount prescribed _____ For how long?_____
(per week/month) (weeks/months/years)

For what reason was it prescribed?
_____
_____

If it has been discontinued, when and why? _____
_____

DRUG ALLERGIES:

none ❑ or, give details:
_____
_____

(any medications you can't take, and WHY NOT?)_____
_____

PAST MEDICAL HISTORY: (circle and give year)

Hepatitis A..... …neg/pos/never tested/don't know
Hepatitis B.....neg/pos/immune/vaccinated/carrier/never tested/don't know
Hepatitis C.....neg/pos/never tested/don't know
HIV..... ……...neg/pos (_____)/never tested/don't know
date of last test
Tuberculosis skin test..... neg/pos (_____)/never tested/don't know
date of last test
For the above questions, where was the test done, and where are the results now?
_____
_____

Year of first i.v. drug use . . (_____)/never
History of needle sharing. . yes/no
(including cotton, spoons, filters, etc.)
overdoses . . . . . yes/no
asthma . . . . . yes/no
seizures . . . . . yes/no
operations . . . . . yes/no
migraines . . . . . yes/no
back problems . . . . . .yes/no
ulcers . . . . . yes/no
heart problems . . . . . .yes/no
car accidents . . . . . yes/no
other: _____
(give year and type): _____

Name and address of your family doctor: _____

Is your doctor aware of your drug problem? ❑ yes ❑ no

WOMEN ONLY:

1. When was the first day of your last menstrual period ?_____
2. Current method of contraception ? The Pill/condoms/other:_____
3. Is there any chance you might be pregnant ? ❑ yes ❑ no

EMOTIONAL HEALTH:

Have you ever been treated by a family doctor or psychiatrist for:

anxiety? ❑ yes ❑ no

depression? ❑ yes ❑ no

Have been admitted to a psychiatric facility? ❑ yes ❑ no

Received treatment for any other emotional problems? ❑ yes ❑ no

Were you abused? (mentally, sexually or physically?) ❑ yes ❑ no

Have you ever attempted suicide? ❑ yes ❑ no

Are you currently depressed or suicidal? ❑ yes ❑ no

FAMILY HISTORY:

(Any family history of medical problems like alcohol or drug abuse, depression, heart disease etc.)

mother: _____ father:_____
(age) (age)
brothers, sisters, others _____

DRUG TREATMENT PROGRAMS:

(Including attempts at detox), program name, when, how long did you stay clean/ why failed?
1. _____
2. _____
3. _____

SOCIAL HISTORY:

Are you: married/single/separated/divorced/common-law/widowed
Children?_____ Whose custody are the children in? _____

Who lives in your household? _____

Do they abuse alcohol/drugs? ❑ yes ❑ no

Are the people close to you aware of your drug problem? ❑ yes ❑ no

Usual occupation: _____ Are you currently employed ? ❑ yes ❑ no

Last job held: _____ From when _____ to _____

Highest level of education: _____

Are you receiving: welfare/FBA/pension/UI/none/other?

Do you drive a car? ❑ yes ❑ no

LEGAL STATUS:

1. Are you currently on probation or parole? ❑ yes ❑ no
if yes, until when ? _____

2. Is treatment a condition of your probation? ❑ yes ❑ no
if yes, when ? _____

3. Do you have any Court dates pending? ❑ yes ❑ no
if yes, when ? _____

4. Do you have previous convictions? ❑ yes ❑ no
if yes, for what ?_____

5. Have you been incarcerated? ❑ yes ❑ no
if yes, for what ?_____

6. How long have you been in jail for in total? _____

7. Have you been charged with impaired driving? ❑ yes ❑ no

8. Have you been charged with a crime that included a weapon or violence? ❑ yes ❑ no

ABOUT YOUR ADDICTION:

In the last 12 months:
Do you need more and more of the drug you are using to get the same effect? ❑ yes ❑ no
Describe what symptoms you experience if you suddenly stop taking the drug:
_____
_____

Do you frequently take more drugs than you planned, or use it for longer than you planned to? ❑ yes ❑ no

Have you had many unsuccessful attempts to cut down on your drug use? ❑ yes ❑ no

Do you spend a lot of your day getting, using, and recovering from the effects of drugs? ❑ yes ❑ no

Have you given up work, social or other things you used to do because of your drug use? ❑ yes ❑ no

Do you keep taking drugs, despite the harm and problems it is causing you? ❑ yes ❑ no

Why have you come for treatment at this time? _____
_____

What type of treatment do you feel that you need?_____
_____

What are your goals for treatment? _____
_____

PHYSICAL EXAM:

Name: _____ Date of exam: _____

GENERAL _____ BP_____ /_____
HR _____ /min
PUPILS: normal/pinned/dilated FUNDI
CHEST: clear/other
CVS: murmur/other
ABDO: tender enlarged liver/spleen other
SKIN: tracks abscess tattoos piercing other

LYMPHADENOPATHY: ❑ yes ❑ no

OTHER: _____

ASSESSMENT:
Meets criteria for opioid dependence: _____
Suitable for medical detoxification:_____
Suitable for methadone: _____
Co-morbidity: _____
Psychiatric: _____
Medical: _____

Concurrent substance abuse: Benzo/Cocaine/Crack/Etoh/Barbs/Amp/THC

PLAN:
1. MEDICAL DETOX – discussed risks/ handout given/ patient declined detox
2. BLOOD WORK – including pretest counselling for HIV, Hepatitis B, C
3. METHADONE BENEFITS/DRAWBACKS – discussed
4. LETTER OF UNDERSTANDING COPY GIVEN REVIEWED SIGNED
5. UDS DRUG SCREENS FOR TOXICOLOGY
6. RELEASE OF INFORMATION SIGNED
7. REFERRED FOR SECOND ASSESSMENT (if needed)
8. RETURN FOR CPE ON: _____
9. OTHER:_____

Physician's signature: _____ Date: _____

Appendix D: Sample Methadone Maintenance Treatment Agreement

The prescribing and dispensing of methadone is regulated by provincial guidelines, as well as policies unique to Dr. _____'s practice. This contract has been prepared to both inform you about methadone maintenance therapy, as well as to document that you agree to the rules/ obligations contained in this agreement.

MMT Program Rules

It is important that the patient receive clear information about the MMT program rules and expectations. Policies on take-home doses, urine drug screens, appointments, and treatment withdrawl should be specified. The MMT physician should provide a copy of the treatment agreement to the patient and revisit it once the patient is stabilized.

Acknowledgments:

I acknowledge that:

1. Methadone is an opioid (opioids are drugs like heroin, codeine, morphine, Percocet, etc.), and that I will develop a physical dependence to this medication. Sudden decreases in dose or discontinuation of this medication will likely lead to symptoms of opioid withdrawal.

2. I am already physically dependent on at least one form of opioid and I'm unable to discontinue the use of opioids.

3. I have tried to the best of my ability other possible treatments for opioid dependence, and these attempts have been unsuccessful.

4. Taking any mood altering substance with methadone can be potentially dangerous. There have been reported deaths caused by the combination of methadone with alcohol, opioids, cocaine, barbiturates, and/or tranquillizers.

5. I may voluntarily withdraw from the methadone treatment program at any time.

6. It is important to inform my physician/dentist who is prescribing an opioid that I am taking methadone. I understand that a failure to do so is considered double doctoring, which is a criminal offence.

7. Regarding pregnancy, I understand that there can be effects on the developing fetus caused by methadone, and that specialized care will be required to reduce any harm to my fetus if I am or become pregnant while on methadone.

8. It is unsafe to drive a motor vehicle or operate machinery during the stabilization period after starting methadone and during dose adjustments.

9. Poppy seeds and certain over-the-counter medication may result in a positive drug UDS drug screen screen.

10. The common side effects of methadone are sweating, constipation, decreased sexual function, drowsiness, increased weight, and water retention. These are usually mild and can be lessened with assistance from my doctor. There are no known serious long-term effects from taking methadone.

11. I acknowledge that Dr. _____ is not my family doctor.

12. Methadone treatment will be discontinued or tapered if my physician determines that it has become medically unsuitable (i.e., the treatment is not effective or I develop a medical condition that could be made worse by methadone administration).

Behaviour while in our clinic

I understand the following behaviour is not acceptable in the clinic and may result in the termination of treatment:

1. Any violence or threatened violence directed toward the staff or other patients.

2. Disruptive behaviour in the clinic or the surrounding vicinity of the methadone clinic.

3. Any illegal activity, which includes selling or distribution of any kind of illicit drug in the clinic or the surrounding vicinity of the methadone clinic.

4. Any behaviour that disturbs the peace of the clinic or the surrounding vicinity of the methadone clinic.

I agree to maintain positive, respectful behaviour towards other program patients and staff at all times when in the clinic. Threats, racist or sexist remarks, physical violence, theft, property vandalism or mischief, the possession of weapons, and selling or buying illicit substances while on clinic property are extremely serious program violations and may result in the termination of my treatment.

Obligations of being on this program

1. I agree to take only one dose of methadone a day, and to have the ingestion of my dose witnessed on those days that I don't have carries (take-home methadone).

2. It is important to inform any prescribing physician or dentist who may treat me for any medical or psychiatric condition that I am receiving methadone, so my treatment can be tailored to prevent potentially dangerous interactions with methadone. I will bring any prescriptions and/or medication bottles that I receive from other doctors to appointments with Dr._____.

3. I agree to provide a supervised UDS drug screen sample for a drug screen when I receive a prescription for methadone.

4. Failure to provide a UDS drug screen sample may mean that my record will be marked as a sample assumed to contain drugs and that this could reduce my level of carries.

5. I understand that tampering with my UDS drug screen sample in any way is a serious violation of the program, and it may affect my future status in the program.

6. I understand that counselling is highly recommended while I am in the program.

7. I agree to keep all my appointments with the physician who is prescribing methadone for me. Repeatedly missing appointments may result in the reduction of my carry status and could interfere with the doctor-patient relationship. The physician is not obligated to fax a methadone prescription without an assessment.

I understand that I will not be given a dose of methadone if I:

1. Appear to be intoxicated or under the influence of some other substance. I may be asked to see a physician. For the sake of my own physical safety, I may be asked to wait before receiving my dose, or refused a dose for that day.

2. Arrive late, after the clinic/pharmacy hours.

3. Exhibit threatening or disruptive behaviour towards any staff member or another patient.

4. Do not show proper identification before receiving methadone, if asked for identification.

5. Miss more than three doses of methadone in a row.

Consents

1. I allow my physician to report to the CPSO of Physicians and Surgeons of Ontario (CPSO) my name, date of birth, OHIP number, city of residence, and the date methadone was initiated. The CPSO will keep this information confidential. This is done to prevent double doctoring.

2. I allow the CPSO or its designate permission to review my medical chart. This is done to assess the care provided by my physician and is not meant to judge my recovery.

3. I allow my methadone prescribing physician to speak to other doctors or health care professionals about my care.

4. I allow the clinic's pharmacist and nursing staff to speak to pharmacists or other health care providers to verify my recent methadone dose(s), which I received in another pharmacy or facility.

Confidentiality

Everything that you tell the clinic staff is confidential, although it is important to realize that under exceptional circumstances we can be obliged to report something you tell us to the appropriate authority. This can occur under the following conditions:

1. If we suspect that a child is at risk of emotional or physical harm or neglect, under the Child and Family Services Act, it is the law that we report this information.
2. If you become suicidal, homicidal, or are unable to take care of yourself due to a psychiatric condition, you might be held to be assessed by a psychiatrist against your will.
3. If you reveal to the staff that you intend to harm another person, we will be obliged to protect that person by notifying the appropriate authority.
4. If a Court subpoenas your medical chart, we must release it in accordance with the subpoena.
5. If it is suspected that you are unable to drive an automobile due to a medical condition (which includes intoxification from alcohol or drugs), we are obliged to notify the Ministry of Transportation of this.
6. Certain infections must be reported to the local public health department, e.g., tuberculosis, HIV.

I agree to respect the confidentiality of other patients in the program. My signature below indicates that I agree to follow the obligations and responsibilities outlined in this agreement. Should I fail to meet the terms of this agreement, I understand that I may be asked to leave the methadone program. *I have had an opportunity to discuss and review this agreement with my attending physician and my questions (if any) have been answered to my satisfaction.*

_____ _____ _____

Dated (dd/mm/yyyy) Patient's Name Patient's Signature

_____ _____ _____

Dated (dd/mm/yyyy) Physician's Name Physician's Signature

Appendix E: Patient Initiation to MMT Form

Instructions to complete the Patient Initiation to MMT Form

Section A

- This section must be completed in full for all patients.
- Any forms that do not have all information filled out will NOT be processed.

Section B

- The physician starting treatment must identify their last name and treatment site.
- Please check the appropriate practice type box to ensure the patient is started at the correct treatment site in the database.
- This section must be signed and dated by the physician initiating treatment.
- Stamped signatures are acceptable however the physician is responsible for any records that may be false in this case.

Section C

- This section can only be filled out if the patient is being transferred to another physician **within the same treatment site**.
- A patient cannot be transferred to another clinic location using the transfer section – a cessation must be submitted in this case.
- A patient cannot be transferred to another clinic location with the same physician using the transfer section – a cessation must be submitted in this case.
- Both physician signatures must be provided otherwise the form will not be processed.

Section D

- This section must be signed by a physician within the same clinic.
- Please ensure the cessation date is not BEFORE the initiation date.

After completing the form on the following page, print out – one page only – add signatures and

Fax to the College at: 416-967-2635

A. Patient Information

Fax to the College at: 416-967-2635

This section must be completed for all patients					
Has this patient been on a methadone program before?	◯ Yes	◯ No			
Last name		First/middle names			
Date of birth		Gender	◯ Male ◯ Female	City of residence	
Does the patient have insurance?	◯ Yes	◯ No			
OHIP number					
Other provincial card number		Province			
I, the Patient, give consent to the following: The College of Physicians and Surgeons of Ontario will respect the confidentiality of my medical information The College of Physicians and Surgeons of Ontario will maintain the information in a database The information on this form will be used for statistical purposes					
Patient signature		Date			

B. Initiation Information

Date patient is starting treatment with you					
Practice type:	◯ Independent Practice	◯ Correctional	◯ Community Clinic		
Name of treatment site					
Treating physician name		CPSO#			
Treating physician signature:		Date			
Telephone		Fax			

C. Transfer Information – Please use this section ONLY for transfers within the same treatment site

Current provider name/location			
Date of transfer			
Current physician signature:		Date	
New provider name			
New physician signature		Date	

D. Cessation Information

Date of last dose under your care			
Reason for cessation			
Physician name			
Physician signature:		Date	

Print out this page only, add signatures and Fax to the College at: 416-967-2635

Print Form **Save** **Clear form**

Appendix F: Sample Prescription Form

Methadone Prescription Form

Name	Date	File #

Rx Methadone _____ mg _____
p.o. dispensed daily mixed in orange drink. Dose in words

Start Date: _____ End Date: _____ Inclusive

Drink observed in the pharmacy on days circled:

Mon Tue Wed Thur Fri Sat Sun

The following doses are to be dispensed as take-home doses:

Mon Tue Wed Thur Fri Sat Sun

Special Instructions:

Contact prescriber before filling this prescription if dose is increased by more than 15 mg, unless noted above. Hold prescription if more than three consecutive doses are missed, and contact prescriber. Notify the prescriber if a dose is missed. Fax a copy of this prescription to the prescriber if there are any concerns about this prescription.

_____ _____ M.D.
Signature Print Name

Prepared by	Date	Dispensed by

Appendix G Sample Physician/Pharmacist/Patient Agreement Letter

DR. XXXXXXXXXX
XXXXXXXXX Clinic
Address
Tel:# Fax#

Dear Pharmacist,

Our patient has requested to attend your pharmacy for Methadone Maintenance Treatment. We encourage an active communication between pharmacist and physician. The following safety measures, methadone dispensing practices, and clinic policies have been discussed with the patient. Please feel free to contact me to discuss any of these matters or any further suggestions that your team may have for this patient's clinical care. You may call/page me at _____. PLEASE DO NOT GIVE THIS PAGER/PHONE NUMBER TO THE PATIENT.

1. Patients are required to drink methadone dispensed in approximately 100 cc orange juice or orange juice substitute in front of the pharmacist. **The ingestion of methadone must be observed. Ask the patient to speak after their drink to ensure that it is being swallowed.**

2. The pharmacy team shall inform the methadone physician of any information or observed evidence of diversion of methadone.

3. The pharmacist shall inform the methadone physician of missed methadone doses by the patient. **In the first two weeks of treatment, if the patient misses 2 or more doses, the methadone dose must be withheld to prevent overdose.** The patient must be reassessed by the methadone physician before methadone is restarted.

4. **After the first two weeks of treatment, if three or more doses are missed in a row, the methadone dose must be withheld from the patient to prevent an overdose.** The patient must be re-assessed by the methadone physician before methadone is restarted. The pharmacy team shall inform the methadone provider of missed doses.

5. If there is any evidence of intoxication or sedation (slurred speech, stumbling gait, disorientation) **the methadone dose must be withheld** from the patient to prevent a possible overdose. The patient must be re-assessed by the methadone physician before methadone is restarted. The pharmacy team may contact the methadone physician to inform them of the observation of sedation.
   If the pharmacist observes evidence of an overdose, the patient will be advised that urgent medical care is required. The pharmacist may call 911 for transport to hospital. The pharmacist will contact the physician directly to inform them of the overdose and treatment directives.

6. Take-home doses should be dispensed in childproof bottles. Patients are advised to transport any take-home doses in a locked metal box to ensure community safety (i.e., to avoid

misplacement/loss and consumption of methadone by someone other than to whom it is prescribed). The pharmacist may request that the locked box be presented prior to issuing take-home doses.

7. Any doses of methadone vomited can only be replaced if the pharmacist or a member of the pharmacy team has witnessed the vomiting within 15 minutes of ingestion and informs the methadone provider of such.

8. The pharmacist or methadone physician may request that take-home dose bottles be returned to the pharmacy.

Thank you, _____

Appendix H: Sample Addiction Medicine Clinical Note

Name: _____
Date: _____

Current Methadone Dose: _____mg
Number of Take-home Doses: _____
Missed doses: Yes – No _____

Supervised UDS:
Methadone: _____
Cocaine: _____
Opiates: _____
Benzodiazepines: _____
Oxycodone: _____
Creatinine: Normal/Abnormal
Interpretation of UDS_____
Patient stated drug/alcohol use & route
Since last visit:
Opiates: Yes – No _____
Cocaine: Yes – No _____

Benzodiazepines: Yes – No _____
Alcohol: Yes – No _____

Other problematic drug use: Yes – No _____

Opioid Cravings: _____
None – Mild – Moderate – Severe

Opioid Withdrawal:
None – Mild – Moderate – Severe

Opiate Withdrawal Symptoms:
None – Insomnia – Anxiety – Dysphoria – Nausea - Diarrhea - Hot flashes – Irritably Myalgia - Restlessness – Rhinorrhea – Sneezing – Sweats - Yawning - Pupil dilated – Malaise – Abdominal Cramping – Piloerection

Timing of Withdrawal from Last Dose: _____

Counselling/Clinical Notes:

Psychological Issues Update:
Mood: Normal - Other
Sleep: Normal - Insomnia
Anxiety: Absent - Present
Energy: Normal – Other _____
Suicidal Ideation: Absent - Present - NA

O/E:
Appearance: Alert – Intoxicated
Behaviour: Normal – Abnormal
Gait: Normal – Abnormal
Speech: Normal – Abnormal
Eye contact: Normal – Abnormal

Reported methadone sedation: Yes – No

Reported methadone withdrawal: Yes – No

Take-home dose safety issues discussed: Yes – No – NA

Reviewed dangers of methadone diversion: Yes – No – NA

Clinically stable: Yes – No

Take-home doses locked up in a box: Yes – No – NA

Safe with take-home doses: Yes – No

Stable housing: Yes – No

Stable employment/ social support: Yes – No
Reported methadone withdrawal: Yes – No

Plan:
Rx: Methadone _____ mg po od from _____ to _____

Take-home doses: M T W T F S S for _____ week (s) RTC _____day/week

Appendix I: Managing Potential Methadone Overdose

This appendix includes documents to assist physicians in handling a potential methadone overdose. These materials are also intended to provide advice to patients and emergency room staff, and ensure that physicians who prescribe methadone have taken the necessary steps to avoid an adverse outcome in a methadone overdose scenario.

Reducing Risk of Toxicity During Initiation

Patient education

- The patient is to limit driving or use of machinery after a dose increase, particularly in the first few hours after dosing.
- The patient is to take the methadone dose in the morning, since the risk of overdose is increased at night.
- Whenever feasible (with the patient's consent), a family member or significant other should be educated about the symptoms of toxicity with instructions to go to the emergency department immediately at the first sign of toxicity. A patient information guide may be used for this purpose (See Appendix I (ii)).

Explain the risks of diverted methadone

- A single dose of methadone can be fatal.
- Patients are responsible for the safe storage of their methadone (See Appendix K).

Frequency of visits

- The MMT physician shall see the patient at least every one to two weeks.
- Twice-weekly visits during the first two weeks of treatment are recommended, particularly if the patient is at increased risk for methadone toxicity or cannot be stabilized at a low dose. If possible, the visits should be scheduled for two to six hours after the methadone dose. The MMT physician should inquire about sedation and other side effects.

Take-home doses

- No take-home doses shall be granted during the first month of treatment.
- It is recommended that no take-home doses be given for the first two months unless necessary (undue hardship, pharmacy closed on Sunday) and the reason for this should be documented in the patient's chart.

Avoid prescribing any sedating drugs

- Includes benzodiazepines, non-benzodiazepine hypnotics, antipsychotics, antidepressants, and sedating antihistamines. Even moderate, therapeutic doses of these drugs may increase the risk of toxicity if they are initiated at the

same time as methadone and the patient is not fully tolerant to their sedating effects.

- Patients should also be advised to avoid alcohol and over-the-counter sedating drugs.

Tapering High-dose benzodiazepine user

- Benzodiazepine abuse and dependence are common in this population.
- As with opioids, it is difficult to accurately judge a patient's benzodiazepine use and tolerance.
- Benzodiazepine tapering, while difficult on its own, can be very complicated and potentially unsafe when attempted with MMT initiation.

Intoxication or sedation

- At any stage of MMT, the pharmacist should be instructed to alert the MMT physician if the patient appears sedated or intoxicated.
- Intoxicated patients should not be medicated until assessed by their MMT physician.
- If signs of intoxication are observed after ingestion of methadone, the patient should be sent to the hospital by ambulance for assessment.

ii) Patient Information Sheet on Methadone Overdose

Methadone overdose (receiving a larger dose of methadone than intended) is a serious medical emergency.

Methadone is a long-acting medication and can stay in your body for many hours.

Even if you have been on methadone for a long time, taking more methadone than your body is used to can be dangerous. Even what may seem like a small dose increase can be dangerous.

If you are new to methadone or have not been taking your regular dose, even for a few days, **you are at increased risk of overdose**.

Taking too much methadone can result in difficulty breathing (slow or shallow breathing), drowsiness, small pupils, and, in some cases, coma and death.

For this reason, your nurse, pharmacist or MMT physician has deemed that **IT IS ESSENTIAL THAT YOU GO TO THE EMERGENCY DEPARTMENT** to be observed for a minimum of 10 hours, and maybe longer, depending on your symptoms.

There is good treatment available in the emergency department that can reverse the effects that you may get from taking too much methadone.

iii) Avoiding Overdose in the First Two Weeks of Methadone Treatment: A Guide for Patients and Their Families

Methadone is a very safe drug, but accidental overdoses sometimes happen, particularly in the first two weeks of treatment. The questions and answers below will help you get through this period safely. Share this information sheet with a friend or family member.

Why can't my doctor increase my dose more quickly?

When you first start methadone, you want to get on the right dose as soon as possible. But your doctor has to increase your dose slowly over several weeks, because your body takes time to adjust to methadone, and (unlike other narcotics), methadone builds up slowly in your bloodstream over several days. A dose that may feel like too little on a Monday could put you in hospital by Thursday.

What can I take to relieve withdrawal and help me sleep until the methadone begins to work?

Substances that make you relaxed or sleepy can be dangerous. This includes alcohol, opioids, benzodiazepines (Ativan, Valium, Rivotril, etc.), antihistamines such as Gravol or Benadryl, and certain types of antidepressants and tranquilizers.

Even certain antibiotics can be dangerous, by blocking the breakdown of methadone in the body. So make sure to check all your medications with your methadone physician

Isn't methadone supposed to make you sleepy?

No. You are supposed to feel normal on methadone, not high or sleepy. Methadone builds up so slowly that someone can feel sleepy during the day, lie down for a nap and not wake up.

How do I know if my methadone dose is too high?

- You may feel sleepy, and nod off several times during the day;
- You may be forgetful;
- You may be difficult to wake up from your sleep;
- You may experience slurred speech, stumbling walk, or appear drunk.

If these things occur you must call your doctor immediately or go to Emergency.

What precautions can I take to prevent overdose?

- Only take your methadone in the morning.
- See your doctor twice a week for the first two weeks.
- Don't take benzodiazepines, alcohol or other sedating drugs
- Discuss your methadone treatment with a close friend or family member. If they see that you're drowsy, they must call your methadone doctor or an ambulance.

I've been offered a small amount of methadone by a methadone patient at the pharmacy. This can't hurt — I know I need 80 mg and I'm only at 45 mg.

Above all, don't take any extra methadone. It's probably safe for your friend, but could be lethal for you. You took 80 mg **once** and were okay. If you had taken 80 mg every day for three or four days, you might have died. Remember, it takes five days for a certain dose to build up in your blood.

I'm receiving take-home doses. Is it safe to give a small amount of methadone occasionally to a friend who's not on methadone treatment, when he goes into withdrawal?

No it isn't safe, because your friend is not tolerant to methadone. A dose that is just right for you could be fatal for your friend.

iv) Emergency Department Management of Methadone Overdose

* NOTE: The methadone prescriber may send this form to the ED to assist them in managing a patient with a suspected methadone overdose.

Patient: _____

Physician:_____

Poison Centre Phone #: _____Physician Phone #:_____

Relevant details (to be completed by methadone provider):

- Usual methadone dose
- Dose of the suspected overdose (if known):
- Concurrent alcohol, benzodiazepine or other drug use
- Medications
- Relevant medical/psychiatric history
- Circumstances of the overdose (intentional or accidental):

Clinical Features of methadone overdose:

Methadone acts for at least 24 hours, much longer than other opioids. Symptoms begin up to 10 hours after the overdose. Early symptoms include nodding off, drowsiness, slurred speech and emotional lability. Respiratory depression occurs later.

ED protocol for managing suspected methadone overdose

Monitoring:

- Check frequently for vital signs, respiratory rate and O2 sat
- Hold a brief conversation to assess alertness.
- ECG and cardiac monitoring to check for prolonged QT interval and ventricular arrhythmias (methadone can cause toursades de pointes).

Medical Management with intubation or naloxone

Naloxone is a safe treatment in patients who are not physically dependent on opioids (e.g., patients not in methadone therapy who took methadone at a party). For methadone- or opioid-dependent patients, intubation avoids risks of naloxone-induced withdrawal. Intubation is necessary if:

- RR < 12; hypercapnia; persistent desaturation despite supplemental oxygen
- Patient fails to respond to naloxone within 2 min

Naloxone precautions:

- Ventricular dysrhythmias and cardiac arrest can occur with naloxone-induced withdrawal, especially if patients are withdrawing from other substances.
- Patients in naloxone-induced withdrawal may become agitated and leave against medical advice.
- Naloxone can induce emesis.

Above risks are avoided with intubation.

Naloxone dosing

- If the patient has severe respiratory depression, give 2.0 mg naloxone IV.
- If there is minimal respiratory depression, give 0.01 mg/kg weight to avoid precipitating withdrawal.
- If there is no response after the initial dose, repeat naloxone 2–4 mg every 2–3 min.
- If there is no response after 10–20 mg naloxone, search for other causes for the coma.
- If the patient responds to naloxone, infuse at 2/3 of the effective dose per hour.
- Give a bolus of 1/2 the effective dose 15–20 min after starting infusion.
- Titrate dose to avoid withdrawal, while maintaining adequate non-assisted respirations.

Recommended ED observation periods

- Observe for at least 10 hours post-overdose.
- Discharge if patient is completely asymptomatic during that time.
- If patient becomes symptomatic at any time during the 10 hours, monitor for at least 24 hours post-overdose.
- If patient is intubated or on naloxone, continue intubation/naloxone for at least 24 hours post-overdose.
- Monitor for at least **6 hours** after naloxone or intubation is discontinued.

Departure AMA: If the physician feels the patient is not safe to leave, a Form I should be completed and the patient should be forced to stay.

Discharge instructions: Tell patient not to take any methadone, alcohol or sedating drugs until seen by methadone physician the next day. Have a family member or support person observe overnight, and call an ambulance if the patient appears more drowsy, is difficult to arouse or snores much more loudly than usual.

v) Against Medical Advice (AMA)

Date:_____

I,_____ , acknowledge that _____ explained my condition to me and advised me of the potential risks and/or complications which could or would arise from refusal of medical care. I have also been advised that other unknown risks and/or complications are possible. Being aware that there are known and unknown potential risks and/or complications, it is still my desire to refuse the advised medical care.

I do hereby release _____ and _____ _____ *(clinic name)* from all liability resulting from any adverse medical condition(s) caused by my refusal of the recommended medical care.

Signature of Patient/Parent/Legal Guardian:
_____

Date_____

Witness _____

If witness acted as translator, check here _____

Name of translator_____

Appendix J: Opioid Withdrawal and Tolerance

Physicians titrating methadone must be familiar with the clinical features of opioid withdrawal.

Opioid Withdrawal

Opioid withdrawal peaks at 2–3 days after the last use. Physical symptoms largely resolve by 5–10 days, although psychological symptoms can continue for weeks or months.

Serious complications of withdrawal include miscarriage, premature labour, suicide, and overdose or relapse due to loss of tolerance.

Opioid Withdrawal Signs and Symptoms

Physical Symptoms	Psychological Symptoms	Physical Signs
Myalgia Abdominal cramps Nausea Chills Hot flashes Electric or uncomfortable feeling Yawning	Restlessness Dysphoria Insomnia Anxiety Irritability Fatigue Drug craving (the insomnia and anxiety may be severe and distressing)	Lacrimation Rhinorrhea Dilated pupils Abdominal tenderness Vomiting Diarrhea Sweating Chills Piloerection Tachycardia Hypertension

The patient on inadequate doses of methadone will describe a characteristic set of symptoms. The symptoms appear a certain number of hours after the methadone dose, although there may be some variation with the patient's activity level and other factors. The onset of symptoms is delayed with each dose increase.

Alternative explanations should be sought if the patient:

- gives an inconsistent history of withdrawal symptoms;
- has one isolated symptom (such as insomnia or nausea);
- advises the onset of symptoms is not related to the time of the dose; or
- has been taking a stable dose and suddenly complains of withdrawal (see below).

A dose might be considered acceptable if the patient sleeps comfortably at night and only has mild withdrawal symptoms on awakening, which are tolerable to the patient.

Conditions Commonly Confused with Withdrawal

The clinician should determine why the patient continues to report withdrawal symptoms despite dosage adjustment. Common reasons for ongoing withdrawal include:

- medication use that speeds methadone metabolism (such as phenytoin, chronic alcohol use)
- opioid use
- diverting doses

Physicians should consider a medication review with the pharmacist. The following conditions cause symptoms that are confused with withdrawal.

Pseudonormalization should be suspected if the patient regularly complains some weeks after a dose increase that it is no longer 'working.' Patients who are mildly intoxicated on opioids feel more enthusiastic and energetic. As they develop tolerance, they may feel they need a dose increase to recreate this effect, which they view as both desirable and normal.

Insomnia is often the dominant symptom of opioid withdrawal. Other causes should be ruled out if the patient reports insomnia that isn't accompanied by other withdrawal symptoms and is not relieved by a dose increase. Depression, anxiety, and use of alcohol and cocaine are common causes of insomnia in this population. A careful sleep history will identify day-night reversal, daytime napping and other causes of nighttime insomnia. Careful instruction in sleep hygiene should be undertaken. Medication should be used only when the patient is on a stable dose of methadone and sleep hygiene counselling has failed. Trazodone or other non-benzodiazepine hypnotics are the treatments of choice.

Sedation and Withdrawal Symptoms: Occasionally patients report sedation several hours after dosing, with withdrawal symptoms and insomnia at night. This can be difficult to sort out. The sedation may simply represent the onset of sleep following a night of insomnia due to withdrawal. The methadone dose might be too high, causing excessive sleep during the day and inadequate sleep at night. The patient may have day-night reversal, independent of the methadone dose.

Other conditions*:* Patients may be anticipating that an increase in their dose will manage symptoms that have little to do with withdrawal. Common examples include depression, anxiety, irritable bowel syndrome, and some forms of chronic pain. The physician should identify these symptoms, explain to the patient the limitations of MMT, and assist the patient in finding an appropriate management strategy.

Diagnostic Criteria for Opioid Withdrawal

A. Either of the following:

1) cessation of (or reduction in) opioid use that has been heavy and prolonged (several weeks or longer)
2) administration of an opioid antagonist after a period of opioid use

B. Three (or more) of the following: developing within minutes to several days after Criterion A:

1) dysphoric mood
2) nausea or vomiting
3) muscle aches
4) lacrimation or rhinorrhea
5) papillary dilation, piloerection or sweating
6) diarrhea
7) yawning
8) fever
9) insomnia

C. The symptoms in Criterion B cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

D. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

Medical Treatment of Acute Opioid Withdrawal

Buprenorphine

Buprenorphine tapering is substantially more effective than clonidine and other non-opioid treatments in reducing opioid withdrawal symptoms and retaining patients in treatment.

Protocol:

- Initial dose – similar to maintenance protocol (4-8 mg/day)
- Increase dose by 2-4 mg daily until therapeutic dose achieved (usual range 8-16 mg)
- Inpatients: Reduce dose by 2 mg every 1–3 days
- Outpatients: reduce dose by 2 mg every week
- Use adjuvant medications as necessary, eg antidiarrheals and anti-inflammatories (see below)

Clonidine

Outpatients:

- Clonidine 0.1 mg PO bid to tid
- May increase to 0.2 mg bid to tid after first day;
- Continue bid to tid for 3–5 days then PRN for 3–5 more days.

Inpatients:

- Check BP prior to each dose;
- Hold if BP < 90/60 or marked postural drop;
- May increase to 0.3 mg bid to tid.

Adjuvant medications:

- NSAID or acetaminophen for myalgia;
- Loperamide for diarrhea;
- Gravol or other antinauseant;
- Trazodone 50–100 mg HS for insomnia.

Precautions:

- Do not prescribe clonidine if BP < 90/60, patient pregnant, on antihypertensives or has heart disease.
- Warn patients about postural symptoms and drowsiness. Postural symptoms are dose-related, so be cautious with higher doses.
- Warn about mixing with opioids, or having prolonged hot bath (both can cause hypotension).
- Don't prescribe for longer than 2 weeks (rebound hypertension).
- Warn patients they're at risk for overdose if they relapse to their usual dose; always combine clonidine protocol with a documented treatment plan.

Tolerance

Tolerance is said to occur when higher doses are required over time to achieve the same effect, and the same dose has less effect over time. Tolerance to the psychoactive effects of opioids develops within days, and is lost within days.

Appendix K: Take-Home Dose Agreement

Methadone is a potent medication. A single dose taken be a person not used to taking Methadone or by someone using or abusing other medications or drugs can be fatal, especially if taken by a child. For this reason, I agree to the following:

1. I will store my take-home doses in a locked box, in a location where it is unlikely to be stolen or accidentally taken by another person. I will show this locked box to my physician is and when requested.
2. I will consume my dose(s) on the day(s) they are prescribed only. I will consume my Methadone dose in the appropriate manner (a full dose taken once every 24 hours orally).
3. I agree not to give, lend or sell my take-home doses to anyone. I understand that selling methadone is a criminal offence as well as a danger to the community.
4. Take-home doses are a privilege and not a right. These are granted by my physician in accordance with the clinic policies, the College of Physicians and Surgeons of Ontario MMT Program Standards and Clinical Guidelines and at the discretion of my prescribing physician.
5. Take-home doses are continued and increased once every 4 weeks so long as I continue to remain clinically stable and able to be responsible for the care of my take-home doses. This is again at the discretion of my prescribing physician.
6. Take-home doses may be cancelled or decreased if I do not remain clinically stable and able to be responsible for the care of my take-home doses.
7. Lost, spilled, vomited or stolen take-home doses may not necessarily be replaced. Lost or stolen take-home doses must be reported to the local police department.
8. I am aware that I can be called in for a random check of my take-home doses and on this occasion will bring my used and unused Methadone bottles to the pharmacy or clinic when asked to do so by my physician, pharmacist or clinic staff.
9. I will advise the clinic of any change in my contact information (phone number or address).

My signature below indicates that I agree to follow the obligations and responsibilities outlined in this agreement. Should I fail to meet the terms of this agreement, I understand that this will affect my ability to be able to partake in take-home dose program.
I have had an opportunity to discuss and review this agreement with my prescribing physician and my questions have been answered to my satisfaction.

_____	_____	_____
Patient's Name	Patient's Signature	Date
_____	_____	_____
Witness's Name	Witness's Signature	Date

Appendix L: Protocols for MMT and Pregnancy

Protocol for Inpatient Initiation (Finnegan 1991, Kaltenbach et al. 1998)

Methadone initiation should begin at the first sign of withdrawal. Based on our experience, the expected length of stay is approximately 5-7 days.

On day 1: Provide 10-20mg of methadone as an initial dose at onset of withdrawal symptoms, followed by supplemental 5mg every 4-6 hours if withdrawal symptoms are present.

On day 2: Provide previous day's total dose as a single morning dose, followed by supplemental 5mg doses every 4-6 hours for withdrawal symptoms

On subsequent days: continue as above until comfortable on one daily dose with no supplemental medications over a 24 hour period.

Most patients will be controlled on a daily dose of between 20-35mg of methadone after the first 2-3 days.

Subsequent dose increases will be needed as outpatients.

Protocol for Outpatient Initiation

If patient declines to be monitored on a daily basis for methadone dosing, follow the CPSO protocol for initiation of non-pregnant individuals. Frequent office visits every 3 days are recommended until the patient is stabilized on a maintenance dose.

1. Administer 10-20mg initial dose for first 3 days
2. Further dose increases of 5-15mg can occur every 3-5 days based on persistent withdrawal symptoms.

Alternatively, if patient can be re-assessed repeatedly during the day, the following outpatient protocol developed by Hoegerman and Schnoll (1991) can be considered.

1. Patient is advised to arrive at the clinic for first appointment of the morning.
2. On day 1: Assess for withdrawal. If withdrawal is mild to moderate, administer a starting dose of 15mg of methadone and observe for several hours for intoxication. Patient returns in the afternoon and is re-assessed for withdrawal. An additional 5-10mg of methadone may be provided.
3. On day 2: Administer previous day's total dose as a single dose in the morning and consider increasing dose by 10mg if still experiencing withdrawal. Additional doses for later on the day may still be needed.
4. On subsequent days: Administer methadone as above until patient can be converted to a single dose of methadone.
5. Do not exceed 35mg by day 3.

Maintaining a pregnant woman on methadone can continue as with any other patient. The patient should be seen every 1-2 weeks to re-assess her methadone dose.

Appendix M: Resources

1. Health Canada Office of Controlled Substances (613) 946-5139 or 1-866-358-0453 www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hecs-dgsesc/dscsp-psasc/index-eng.php

2. CPSO Methadone Program (416) 967-2661

3. The Drug and Alcohol Registry of Treatment (DART) 1-800-565-8603 or http://www.dart.on.ca.

4. ConnexOntario www.connexontario.ca

5. Ontario Poison Information Centre 1-800- 268-9017 or www.ontariopoisoncentre.com/poisoncentre

6. Ontario College of Pharmacists (416) 962-4861 or www.ocpinfo.com

7. Methadone Drug Interactions: www.atforum.com and/or www.drug-interactions.com

Glossary

Abuse, drug
Any use of an illegal drug, or the intentional self-administration of a medication for a non-medical purpose such as altering one's state of consciousness, e.g., "getting high." (Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-cancer Pain 2010)

Addiction
A primary, chronic, neurobiological disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviours that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving. (Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-cancer Pain 2010)

Agonist
Drugs that interact with receptor sites to cause the same effect that natural chemicals would case at these sites. Karch, A, M. (2008). *Focus on nursing in pharmacology*. (4th ed.). Philadelphia: Wolters Kluwer/Lippincott Williams & Wilkins.

Agonist (Adopted 99.10.14)
A substance that acts at a neuronal receptor to produce effects similar to those of a reference psychoactive substance, e.g. methadone is an agonist at the opioid receptors.

Antagonist
Drugs that combine with receptors that do not begin a change in cell function. When antagonists bind to receptors, agonists are prevented from binding and causing an action. Gutierrez, K. (2008). *Pharmacotherapeutics: Clinical reasoning in primary care* (2nd ed.). Saunders: St. Louis.

Antagonist (Adopted Canadian Society of Addiction Medicine October 14, 1999)
A substance that counteracts the effects of a reference psychoactive substance by inhibiting or reversing its effects at a neuronal receptor site, e.g. naltrexone acts as an antagonist at the opioid receptor.

Concurrent Disorders (Adopted Canadian Society of Addiction Medicine October 14, 1999)
The presence of one or more primary, physical and/or psychiatric disorders that have an interactive effect on the course of Substance Dependence and require specific diagnosis and treatment in order to achieve stabilization and/or recovery.

Controlled Substance
There are many controlled substances listed under the *Controlled Substance Act.* These drugs are grouped under schedules. Below are examples of some of the better known drugs within each Schedule:

- Schedule I contains drugs made from the opium poppy such as heroin, codeine; drugs made from coca such as cocaine; and synthetically derived drugs such as methadone.
- Schedule II contains cannabis (marijuana) and its derivatives.
- Schedule III contains drugs such as amphetamines and lysergic acid diethylamide (LDS).

- Schedule IV contains drugs such as benzodiazepines and barbiturates.
- Schedule V and VI contain precursors required to produce controlled substances (National Association of Pharmacy Regulatory Authorities, 2002-2004).

Craving (Adopted Canadian Society of Addiction Medicine October 14, 1999)
A bio-psychological arousal and urge to return to addictive behaviour, characterized by a strong desire, pre-occupation and possible impulsivity.

Contingency Management
A type of treatment used in the mental health and substance abuse fields. Patients are rewarded (or less often, punished) for their behaviour; generally, adherence to or failure to adhere to program rules and regulations or their treatment plan.

Dependence, Physical
A state of adaptation manifested by a drug class-specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist. (Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-cancer Pain 2010)

Diversion
The intentional transfer of a controlled substance from legitimate distribution and dispensing channels. (Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-cancer Pain 2010)

Dose, stable
A "pharmacologically stable dose" is one that produces a fairly steady plasma level; it is established when the total daily dose is fixed for at least two weeks and:
1) frequency is scheduled and spread throughout the day, AND/OR
2) at least 70% of the prescribed opioid is controlled release.

Double-doctoring
Receiving a prescription for a narcotic, and then seeking and receiving another prescription or narcotic from a different practitioner without disclosing to that practitioner particulars of every prescription or narcotic obtained within the previous 30 days.(Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-cancer Pain 2010)

Half-life
The time required for half of the total drug amount to be eliminated from the body. Generally after five half-lives, 97% of a drug will be eliminated.

Pharmacotherapeutics for Advanced Practice – A Practical Approach, Virginia Poole Arcangelo and Andrew M. Petersen, Second Edition, 2006.

Harm Reduction
A continuum of services that represent a philosophical, pragmatic approach to providing care while minimizing the negative outcomes associated with substance use. The focus is goal oriented,

humanistic and in keeping with a cost benefit awareness. (Pauly, Goldstone, McCall, Gold & Pyne, 2007). Pauly, B., Goldstone, I., McCall, J., Gold, F., & Payne, S. (2007). The ethical, legal and social context of harm reductions. *Canadian Nurse, 103,* 19–23.

Maintenance Therapy (Adopted 01.10.19)

Treatment of Substance Dependence by a prescription drug, to prevent withdrawal and reduce the harm associated with a particular method of administration, attendant dangers to health and/or social consequences, e.g. methadone for Opioid Dependence or nicotine replacement therapy (NRT) for tobacco.

Misuse, opioid

Use of an opioid in ways other than those intended by the prescribing physician (sometimes also called problematic opioid use).(Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-cancer Pain 2010)

Narcotic

Any drug included in the "Schedule" under the Controlled Drugs and Substances Act: Narcotic Control Regulations. (Minister of Justice)

Opiate

A naturally-occurring or semi-synthetic compound derived from the opium poppy (papaver somnifer) (College of Physicians and Surgeons of Alberta, 2005).

Opioid

A compound having actions or properties similar to opiates. A broader term encompassing all opiates (such as heroin, morphine and codeine), as well as synthetic opiate-like compounds (such as methadone and fentenyl) (College of Physicians and Surgeons of Alberta, 2005).

A family of drugs that act by attaching to endogenous mu, kappa and delta receptors in the brain and share a common set of clinical effects, including analgesia, sedation, constipation, and respiratory depression. **Note**: Reference throughout this document to specific pharmaceutical products as examples does not imply endorsement of any of these products.

Pharmacodynamics

The set of processes by which drugs produce specific biochemical or physiological changes in the body-how the drug acts on the body

Pharmacotherapeutics for Advanced Practice – A Practical Approach, Virginia Poole Arcangelo and Andrew M. Petersen, Second Edition, 2006 (Archangelo & Peterson, 2006).

Pharmacokinetics

Examining the absorption, distribution, metabolism and excretion of a drug, the onset of action, the half life, peak effect and duration of effects – how the body acts on the drug.

Karch, A, M. (2008). *Focus on nursing in pharmacology.* (4th ed.). Philadelphia: Wolters Kluwer/Lippincott Williams & Wilkins.

Split doses
An alternative way of providing methadone to clients, consisting of two or more doses per day (so it is not ingested all at one time). It is used for clients who have demonstrated "rapid metabolism" of their once daily methadone dose (e.g. during third trimester of pregnancy) or are on medications that have been shown to induce rapid metabolism of methadone (i.e. certain HIV medications). A consultation with a experienced MMT provider should be considered in these circumstances. Split doses do not necessarily have to be equal; twice-daily observed ingestion may be necessary

(College of Physicians and Surgeons of Alberta, 2005).

Stable daily dose
Optimal daily dose of methadone that will relieve withdrawal symptoms, block opioid-induced euphoria and reduce drug cravings without sedation or other significant side effects

(College of Physicians and Surgeons Ontario, 2005).

Steady state
A constant mean concentration of a drug in the body, there are peaks and troughs in the drug level, but the fluctuations remain within a constant range

Pharmacotherapeutics for Advanced Practice – A Practical Approach, Virginia Poole Arcangelo and Andrew M. Petersen, Second Edition, 2006. (Archangelo & Peterson, 2006).

Substance
Any drug with pleasant psychoactive effects and addiction potential, including alcohol, illegal drugs, and prescription drugs.

(Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-cancer Pain 2010)

Substance abuse (American Psychiatric Association, 1994)

- **A.** A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12 month period:
    1. recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g. repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household).
    2. recurrent substance use in situations in which it is physically hazardous (e.g. driving an automobile or operating a machine when impaired by substance use).
    3. recurrent substance-related legal problems (e.g. arrests for substance-related disorderly conduct)
    4. continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g. arguments with spouse about consequences of intoxication, physical fights)
- **B.** The symptoms have never met the criteria of Substance Dependence for this class of substance.

Substance dependence
See addiction.

Substance dependence
A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12 month period (American Psychiatric Association, 1994)

A .Tolerance, as defined by either of the following:
i. a need for markedly increased amounts of the substance to achieve intoxication or desired effect; or
ii. markedly diminished effect with continued use of the same amount of the substance.

B.Withdrawal, as manifested by either of the following:
i. the characteristic withdrawal syndrome for the substance; or
ii. the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.

C. The substance is often taken in larger amounts or over a longer period than was intended.
D. There is a persistent desire or unsuccessful efforts to cut down or control substance use.
E. A great deal of time is spent in activities necessary to obtain the substance (e.g. visiting multiple doctors or driving long distances), use the substance (e.g. chain-smoking), or recover from its effects.
F. Important social, occupational, or recreational activities are given up or reduced because of substance use.
G. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g. current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

With physiological dependence: evidence of tolerance or withdrawal (i.e. either Item 1 or 2 is present).
Without physiological dependence: no evidence of tolerance or withdrawal (i.e. neither Item 1 nor 2 is present).

Substance misuse
The use of a psychoactive substance (drug or alcohol) for a purpose other than that for which it was intended, and that cause's physical, social, and psychological harm. The term is also used to represent the pattern of use: experimental, recreational and dependent (Rassool, 2002).

Rassol, G. (2002) Substance misuse and mental health: An Overview. Nursing Standard, 16, 46-52.

Substance tolerance
A neurological adaptation to the psychoactive effects of a substance; more of the drug is required to achieve the same effect. Tolerance develops quickly to the psychoactive effects of alcohol and opioids. Highly tolerant clients can behave almost normally after consuming opioid doses that would be fatal in non-tolerant clients (Kahan & Wilson, 2002). Tolerance to the psychoactive effects of opioids develops within days, and is lost within days (CPSO, 2005).

A state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more opioid effects over time.

(Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-cancer Pain 2010)

Substance Use Disorders (Adopted Canadian Society of Addiction Medicine October 17, 2003)
A category of two disorders, namely, Substance Abuse and Substance Dependence, as in DSM IV.

Substance withdrawal
Characteristic syndrome produced by abrupt cessation of a drug.

(Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-cancer Pain 2010)

Tapering
A gradual decrease in a dose of a drug; could result in a lower daily dose or cessation of the drug.

(Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-cancer Pain 2010)

Titration
A technique of adjusting a dose until a stable/optimal dose is reached; usually means gradually increasing the dose to allow the body to develop tolerance and minimize adverse effects.

(Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-cancer Pain 2010)

Tolerance
A state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more opioid effects over time.

(Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-cancer Pain 2010)

Withdrawal
Characteristic syndrome produced by abrupt cessation of a drug.

(Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-cancer Pain 2010)

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Council Briefing Note

June 2021

Topic:	Executive Committee Report
Purpose:	For Information
Main Contact:	Lisa Brownstone, Chief Legal Officer
Attachment:	Appendix A: Blacklined Version of the Medical Assistance in Dying Policy

5-EX-April-2021 On a motion, moved by B. Copps, seconded by J. Fisk, and unanimously carried, that the Executive Committee approves the extended timeline for the Annual Membership Renewal date from June 1 to July 20.

11-EX-April-2021 On a motion, moved by P. Pielsticker, seconded by J. Fisk, and unanimously carried, the Executive Committee approves the revisions to the Medical Assistance in Dying policy as set out in Appendix A to Report 11-EX-April 2021.

Contact: Judith Plante, President
Lisa Brownstone, Chief Legal Officer

Date: June 3, 2021

Medical Assistance in Dying

Policies of the College of Physicians and Surgeons of Ontario (the "College") set out expectations for the professional conduct of physicians practising in Ontario. Together with the *Practice Guide* and relevant legislation and case law, they will be used by the College and its Committees when considering physician practice or conduct.

Within policies, the terms 'must' and 'advised' are used to articulate the College's expectations. When 'advised' is used, it indicates that physicians can use reasonable discretion when applying this expectation to practice.

Definitions

Capacity: A person is capable with respect to a treatment if they are able to understand the information that is relevant to making a decision or lack of decision and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.[1] Capacity to consent to a treatment can change over time, and varies according to the individual patient and the complexity of the specific treatment decision.

Effective Referral: taking positive action to ensure the patient is connected[2] to a non-objecting, available, and accessible[3] physician, other health-care professional, or agency.[4] For more information about an effective referral, see the companion *Advice to Profession* document.

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

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

[1] Section 4(1) of the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A. (hereinafter *HCCA*).
[2] An effective referral does not necessarily, but may in certain circumstances, involve a 'referral' in the formal clinical sense, nor does it necessarily require that the physician conduct an assessment of the patient to determine whether they are a suitable candidate for the treatment to which they object (in the context of MAID, this means that the physician is not required to assess whether the patient is eligible for MAID prior to making the effective referral).
[3] 'Available and accessible' means that the health-care provider must be in a location the patient can access, and operating and/or accepting patients at the time the effective referral is made.
[4] In the hospital setting, practices may vary in accordance with hospital policies and procedures.

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

Policy

Federal legislation establishes the legal framework for MAID in Canada, including eligibility criteria and safeguards that must be satisfied prior to providing MAID.[5,6]

1. Physicians **must** manage all requests for MAID in accordance with the legal requirements[7] and expectations set out in this policy.[8]

Criteria for Medical Assistance in Dying

The federal legislation sets out the criteria that must be met in order for an individual to be eligible to access MAID, along with safeguards that must be met before providing MAID. The eligibility criteria are set out here and in the 'Process Map' below, and the safeguards are set out in the 'Process Map'.

2. Before providing MAID, physicians **must** be satisfied that the patient meets all of the eligibility criteria set out in federal legislation, which requires that the patient:
    a. be eligible for publicly funded health-services,
    b. be capable and at least 18 years of age,
    c. have a grievous and irremediable medical condition,
    d. make a request for MAID voluntarily and not as a result of external pressure, and
    e. provide informed consent to receive MAID after having been informed of the means available to relieve their suffering, including palliative care.

[5] The framework was enabled through amendments to the *Criminal Code*, R.S.C., 1985, c. C-46 (hereinafter, "*Criminal Code*").
[6] For more information and resources on MAID, see the Ontario Ministry of Health's website: https://www.ontario.ca/page/medical-assistance-dying-and-end-life-decisions
[7] This includes: Sections 241.1-241.4 of the *Criminal Code*, *Regulation for the Monitoring of Medical Assistance in Dying*, SOR/2018-166, enacted under the *Criminal Code*, and Section 10.1 of the *Coroners Act*, R.S.O. 1990, c. C.37 (hereinafter, "*Coroners Act*").
[8] This policy will refer to nurse practitioners and pharmacists, where relevant, in order to reflect the language of the federal law. The policy does not set professional expectations and accountabilities for members of the College of Nurses of Ontario or members of the Ontario College of Pharmacists. For information on the professional accountabilities of nurse practitioners and other members of the College of Nurses of Ontario, please see the College of Nurses of Ontario document titled: Guidance on Nurses' Roles in Medical Assistance in Dying. For information on the professional accountabilities for members of the Ontario College of Pharmacists, please see the Ontario College of Pharmacists document titled: Medical Assistance in Dying: Guidance to Pharmacists and Pharmacy Technicians.

3. In order to assess the patient against the federal eligibility criteria, physicians **must** use their professional judgement.

Additional information and expectations relating to each criterion are set out below.

The individual must be eligible for publicly funded health services

4. As the activities involved in assessing patients for and providing MAID are insured services,[9] physicians **must not** charge patients directly for MAID or associated activities. Physicians are **advised** to refer to the OHIP Schedule of Benefits for further information.

The individual must be capable and at least 18 years of age[10]

5. Physicians **must** ensure the patient is able to understand and appreciate the history and prognosis of their medical condition, treatment options, the risks and benefits of their treatment options, and the certainty of death upon self-administering or having a physician administer the fatal dose of medication.
    a. As capacity is fluid and may change over time, physicians **must** be alert to potential changes in a patient's capacity.
    b. Physicians are **advised** to rely on existing practices and procedures for capacity assessments.

The individual's medical condition must be grievous and irremediable

According to the federal legislation, an individual has a grievous and irremediable medical condition only if:

- they have a serious and incurable illness, disease, or disability that is not a mental illness;[11]
- they are in an advance state of irreversible decline in capability; and
- their illness, disease, disability, or state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions they consider acceptable.

[9] For example, counselling and prescribing.
[10] This is notably different than Ontario's *HCCA*, which does not specify an 'age of consent'.
[11] Section 241.2 (2.1) of the *Criminal Code* specifically excludes a mental illness as an illness, disease or disability that makes an individual eligible for MAID. For clarity, an individual suffering **solely** from a mental illness is not eligible for MAID but an individual with a mental illness may also have a serious and incurable illness, disease, or disability that makes them eligible for MAID provided all of the other eligibility criteria are met. For more information, see the *Advice to the Profession* document.

6. As the definition of grievous and irremediable does not follow terminology typically used in a clinical context, physicians **must** use their professional judgment when assessing a patient for a grievous and irremediable medical condition.[12]
    a. Physicians are **advised** to obtain independent legal advice if they are uncertain about whether a patient meets this eligibility criterion.

The individual's request must be voluntary and not as a result of external pressure

7. Physicians **must** be satisfied that the patient's decision has been made freely, without undue influence from family members, health care providers, or others, and that they have made the request themselves, thoughtfully, and in a free and informed manner.

The individual must provide informed consent

8. As MAID can only be provided to a capable adult, physicians **must** obtain informed consent[13] directly from the patient, not the substitute decision-maker of an incapable patient.

9. As part of obtaining informed consent, physicians **must:**
    a. Discuss all treatment options with patients, including the associated risks and side effects, which includes informing patients of means that are available to relieve their suffering, including palliative care.[14]
    b. Inform the patient whose natural death is not reasonably foreseeable of the means available to relieve their suffering,[15] including, where appropriate, counselling services, mental health and disability support services, community services and palliative care and offer consultations with relevant professionals who provide those services or that care.
    c. Inform the patient who is indicating a preference for self-administered MAID:

[12] Further details on interpreting the statutory definition of a grievous and irremediable medical condition can be found in companion resources authored by the federal government: https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html

[13] The process and requirements for obtaining informed consent in other medical decision-making contexts are also applicable to MAID. More information on consent requirements can be found in the College's *Consent to Treatment* policy, which outlines the legal requirements of valid consent as set out in the *HCCA*. In particular, in order for consent to be valid it must be related to the treatment, informed, given voluntarily, and not obtained through misrepresentation or fraud.

[14] The College's *Planning for and Providing Quality End-of-Life Care* policy sets out the College's expectations of physicians regarding planning for and providing quality care at the end of life, including proposing and/or providing palliative care where appropriate.

[15] If the MAID provider and other physician or nurse practitioner who confirmed the patient meets the eligibility criteria do not have expertise in the condition that is causing the patient's suffering, one of them must consult with a physician or nurse practitioner who has that expertise and must share the results of the consultation with the other the second physician or nurse practitioner.

i. of the potential complications associated with this option, including the possibility that death may not be achieved;
ii. that should the patient's death be prolonged or not achieved, it will not be possible for the physician to intervene and administer a substance causing their death unless the patient is capable and can provide consent immediately prior to administering, or the patient has entered into a written arrangement providing advance consent for physician-administered MAID.[16]

d. Inform patients that they may, at any time and in any manner, withdraw their request for MAID, and that patients will be given an opportunity to withdraw their request immediately before MAID is provided.

Final Express Consent to Receiving MAID and Written Arrangements Waiving Final Express Consent

10. In certain circumstances,[17] individuals may enter into written arrangements with a MAID provider that waives the requirement that they give express consent immediately prior to receiving MAID. Physicians **must** obtain final express consent immediately before providing MAID unless they have entered into a written arrangement with the patient and comply with the steps in provision 11.

11. Physicians **must** only administer MAID in accordance with a written arrangement waiving the patient's final express consent in the following circumstances:
    a. The patient's natural death is reasonably foreseeable and:
        i. before the patient lost capacity to consent to MAID:
            (a) the patient met the eligibility criteria and all safeguards relevant for patients whose natural death is reasonably foreseeable;
            (b) the patient and the MAID provider entered into a written arrangement that the provider would administer MAID on a specified day;
            (c) the patient was informed by the MAID provider of the risk of losing the capacity to consent to receive MAID prior to the day specified in the written arrangement; and
            (d) the written arrangement provides the patient's consent for the provider to administer MAID on or before the day specified in

[16] For more information about self-administration, see provision 11b and the *Advice to the Profession* document.
[17] Individuals whose natural death is reasonably foreseeable can enter into written arrangements waiving the requirement of final express consent in the event they lose capacity to consent after becoming eligible for MAID. Individuals who choose to self-administer MAID may enter into written arrangements allowing for practitioner-administered MAID in the event of complications following self-administration.

the arrangement if they lose their capacity to consent prior to that day;

ii. the patient has lost the capacity to consent to receiving MAID;

iii. the patient does not demonstrate, by words, sounds or gestures, refusal to have the substance administered or resistance to its administration; [18,19] and

iv. the MAID provider administers MAID to the patient in accordance with the terms of the written arrangement.

b. The patient has chosen self-administered MAID[20] and:

i. before the patient lost their capacity to consent to receive MAID, the patient and MAID provider entered into a written arrangement that:

(a) states the MAID provider will be present when the patient is self-administering MAID;

(b) provides consent for the MAID provider to administer a second substance causing death if self-administration fails, i.e., if the patient does not die within a specified period and loses their capacity to consent; and

(c) specifies the time period after which the MAID provider may administer the second substance, if self-administration fails;

ii. the patient loses capacity after self-administering MAID and does not die within the time period specified in the written arrangement; and

iii. the MAID provider administers MAID to the patient in accordance with the terms of the written arrangement.

Conscientious Objection

The College recognizes that physicians have the right to limit the health services they provide for reasons of conscience or religion. For clarity, the College does not require physicians who have a conscientious or religious objection to MAID to provide MAID under any circumstances.[21]

However, physicians' freedom of conscience and religion must be balanced against the right of existing and potential patients to access care. The Supreme Court of Canada noted, in the *Carter*[22] case, that the rights of physicians and patients would have to be reconciled in any regime governing MAID. The Court of Appeal for Ontario has

[18] Involuntary words, sounds or gestures made in response to contact do not constitute a demonstration of refusal or resistance.

[19] Once the patient demonstrates, by words, sounds or gestures refusal or resistance MAID can no longer be provided on the basis of the patient's consent in the written arrangement.

[20] Regardless of whether or not their natural death is reasonably foreseeable.

[21] The College also does not consider a request for MAID to be an emergency.

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

confirmed that where an irreconcilable conflict arises between a physician's interest and a patient's interest, physicians' professional obligations and fiduciary duty require that the interest of the patient prevails.[23]

While the federal legislation does not address the conscientious objections of health care providers, the College has outlined expectations, set out below, for physicians who have a conscientious or religious objection to MAID. These expectations accommodate the rights of objecting physicians to the greatest extent possible, while ensuring that patients' access to health care is not impeded.

12. Consistent with the expectations set out in the College's *Professional Obligations and Human Rights* policy, physicians who decline to provide MAID due to a conscientious objection:
    a. **must** do so in a manner that respects patient dignity and **must not** impede access to MAID.
    b. **must** communicate their objection to the patient directly and with sensitivity, informing the patient that the objection is due to personal and not clinical reasons.
    c. **must not** express personal moral judgments about the beliefs, lifestyle, identity or characteristics of the patient.
    d. **must** provide the patient with information about all options for care that may be available or appropriate to meet their clinical needs, concerns, and/or wishes and **must not** withhold information about the existence of any procedure or treatment because it conflicts with their conscience or religious beliefs.
    e. **must not** abandon the patient and **must** provide the patient with an effective referral.[24,25]
        i. Physicians **must** make the effective referral in a timely manner and **must not** expose patients to adverse clinical outcomes due to a delay in making the effective referral.

Involvement of Postgraduate Medical Trainees

[23] See para. 187 *Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario, 2019 ONCA 393*

[24] See the definition of effective referral provided in this policy and the companion *Advice to the Profession* document for more information and examples of what constitutes an 'effective referral'.

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

13. Postgraduate medical trainees can participate in the MAID process, but **must** do so within the terms, conditions, and limitations of their certificate of registration.[26]

14. Postgraduate medical trainees and other physician assessor involved in assessing a patient's eligibility for MAID **must** pay particular attention to ensuring that there is independence between the assessors. Specifically, the requirement for independence between the two assessors of a patient's eligibility for MAID is not satisfied if one assessor is a mentor or supervisor to the other.

Reporting Obligations

Depending on the circumstances, physicians who receive a written request for MAID, conduct an eligibility assessment[27], or provide MAID have reporting obligations to both Health Canada and the Office of the Chief Coroner for Ontario (OCC).

15. When a written request for MAID is received from the patient (in any form, including email or text message, although not necessarily the written request required by the safeguard in the *Criminal Code*[28]), or an eligibility assessment[29] is conducted, and a medically assisted death *does not* occur, physicians **must** make a report to Health Canada[30] when they:
    a. Find the patient to be ineligible for MAID;
    b. Refer the patient to another practitioner or care coordination service;
    c. Become aware that the patient died from another cause;
    d. Become aware that the patient withdrew their request for MAID; or
    e. Prescribe a substance for MAID that to their knowledge did not result in a medically assisted death within the prescribed timeframe.

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

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

[27] Including a preliminary assessment of whether a patient meets the eligibility criteria.

[28] The written request that is required as a safeguard in the *Criminal Code* must be duly signed, dated, and witnessed. The written request that triggers reporting requirements need not take this form.

[29] Including a preliminary assessment of whether a patient meets the eligibility criteria.

[30] For more information on physicians' reporting obligations, including reporting deadlines, please visit the Ministry of Health and Long-Term Care website: http://health.gov.on.ca/en/pro/programs/maid/#regulations

16. Physicians **must** report any of the situations set out in provision 15 (a-d) to Health Canada within 30 days, with the exception of provision 15 (e), in which case a report must be made between 90 and 120 days after the substance is prescribed. Physicians **must** make their report using the Canadian MAID Data Collection Portal.[31]

17. Physicians who provide MAID **must** report medically assisted deaths to the OCC.[32, 33]
    a. Physicians **must** provide the OCC with any information about the facts and circumstances related to the medically assisted death that the OCC considers necessary to form an opinion as to whether the death ought to be investigated. Typically, providing the patient's medical record pertaining to the medically assisted death will suffice.

Medical Record Keeping

18. Physicians **must** comply with the expectations set out in the College's *Medical Records Documentation* policy. In particular, physicians **must**:
    a. document each physician-patient encounter in the medical record, including encounters relating to MAID, which will include, where indicated:
        i. a focused relevant history;
        ii. an assessment and appropriate focused physical exam;
        iii. a diagnosis and/or differential diagnosis; and
        iv. a management plan, including advice given to patients and/or caregivers;
    b. ensure that the medical record is legible and the information is understandable to other health care professionals; and
    c. ensure that the author of each entry in the medical record is identifiable.

19. Physicians **must**:

[31] The Canadian MAID Data Collection Portal may be accessed via the Health Canada website: https://www.canada.ca/en/health-canada/services/medical-assistance-dying/guidance-reporting-summary.html.
[32] While the Office of the Chief Coroner for Ontario (OCC) must be notified of all medically assisted deaths, an investigation is not required unless the OCC deems one to be necessary. See Section 10.1(1) of the *Coroners Act*.
[33] Following the provision of MAID, the physician must notify a coroner by contacting provincial dispatch. Provincial dispatch will then contact the on-duty member of the OCC MAID Review Team, who will obtain information from the reporting physician regarding the facts and circumstances relating to the death. Documentation pertaining to the medically assisted death is to be faxed, as soon as is reasonably possible, to the MAID review team at 416-848-7791.

a. document all oral and written requests for MAID, the dates they were made, and include a copy of the patient's written request in the medical record;[34]
b. document each element of the patient's assessment in accordance with the criteria for MAID; and
c. include a copy of their written opinion in the medical record.

20. Where MAID is provided, physicians **must** document:
    a. the analysis undertaken to determine whether the patient's natural death was or was not reasonably foreseeable;
    b. the steps taken to satisfy themselves that the relevant procedural safeguards were met;
    c. the medication protocol used (i.e., drug type(s) and dosages);
    d. the time of the patient's death; and
    e. any additional information needed to comply with their reporting obligations to the OCC when MAID is provided.

21. Physicians who decline to provide MAID **must** document that an effective referral was made, the date it was made, and the physician, practitioner, and/or agency to which the referral was made.

Completion of Death Certificate

22. If, after reviewing the report provided, the OCC determines that no investigation is needed, physicians who provided MAID **must** complete the medical certificate of death.[35]

23. When completing the death certificate[36] physicians:
    a. **must** list the illness, disease, or disability leading to the request for MAID as the cause of death; and
    b. **must not** make any reference to MAID or the drugs administered on the death certificate.

Process Map

[34] The Ministry of Health and Long-Term Care (MOHLTC) has developed clinician aids to support the provision of MAID. These include forms to: (a) assist patients who request MAID (http://bit.ly/29Sovs0); (b) assist physicians who provide MAID (http://bit.ly/2a9M8Pf); and
(c) assist physicians who provide a written opinion confirming that the patient meets the eligibility criteria to receive MAID (http://bit.ly/29Spk3Y).
[35] If the OCC initiates an investigation, they will complete a replacement death certificate.
[36] Instructions on completing the Medical Certificate of Death reflect joint guidance developed by the Ministry of Health, the Ministry of Government and Consumer Services, and the Office of the Chief Coroner.

The process map that follows details the steps that physicians must undertake in relation to MAID. It complies with federal legislation and outlines safeguards that must be adhered to, by law, prior to the provision of MAID.[37]

The federal legislation sets out safeguards that must be met before MAID is provided. The applicability of some of the safeguards depend on whether or not the individual's natural death is reasonably foreseeable. The process map that follows provides an illustration of how MAID may be carried out, from initial patient inquiry to provision, in compliance with the federal legislation.

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

Physicians and nurse practitioners, along with those who support them, are protected from liability if acting in compliance with the federal legislation and any applicable provincial or territorial laws, standards or rules.[38]

Initial Inquiry for Medical Assistance in Dying

Patient makes initial inquiry for MAID to a physician or nurse practitioner.

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

Safeguards for Medical Assistance in Dying

Before physicians provide MAID, they must ensure all relevant safeguards have been adhered to.

The applicability of some of the safeguards depend on whether or not the individual's natural death is reasonably foreseeable. As such, physicians providing MAID must first

[37] In the event of any inconsistency or conflict between the 'Process Map' and the legal requirements set out in the *Criminal Code* or Regulations, physicians must follow the legal requirements.

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

determine whether the patient's natural death is reasonably foreseeable.[39] Then, physicians will be able to determine which safeguards apply.

The safeguards set out below apply in all circumstances unless specifically noted.

Physician or nurse practitioner providing MAID ("MAID provider") assesses the patient against eligibility criteria for MAID.

The MAID provider must ensure that the patient meets the criteria for MAID. As described above, the patient must:

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

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

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

- They have a serious and incurable illness, disease or disability that is not a mental illness;[40]
- They are in an advanced state of irreversible decline in capability; and
- That illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable.

If the MAID provider concludes that the patient does not meet the criteria for MAID as outlined above, the patient is entitled to make a request for MAID to another physician or nurse practitioner who would again assess the patient using the above criteria.

[39] For more information on determining whether or not a patient's natural death is reasonably foreseeable, see the *Advice to the Profession* document.

[40] Section 241.2 (2.1) of the *Criminal Code* specifically excludes a mental illness as an illness, disease or disability that makes an individual eligible for MAID. For clarity, an individual suffering **solely** from a mental illness is not eligible for MAID but an individual with a mental illness may also have a serious and incurable illness, disease, or disability that makes them eligible for MAID provided all of the other eligibility criteria are met.

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

Patient makes written request for MAID before an independent witness.

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

Physicians are advised that a patient may have been informed that they have a grievous and irremediable medical condition by a physician who is not involved in assessing their eligibility for MAID. The federal legislation does not require that a patient be informed that they have a grievous and irremediable medical condition in the context of an eligibility assessment for MAID. As long as the patient was informed that their condition is grievous and irremediable before making a formal written request for MAID, these requirements of the federal legislation are met.

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

The MAID provider must ensure the patient's request for MAID is signed and dated before an independent witness, who then must also sign and date the request. An independent witness is someone who is at least 18 years of age, and who understands the nature of the request for MAID.

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

An individual may not act as an independent witness if they are directly involved in providing the patient health care services or personal care, unless they provide health care services or personal care as their primary occupation and are paid to provide that care to the patient. However, the physician or nurse practitioner who conducted an eligibility assessment for MAID, provided a consultation in light of their expertise in the condition causing the patient's suffering, or who will provide MAID to the patient may not act as an independent witness.

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

MAID provider must remind the patient of his/her ability to rescind the request at any time.

The MAID provider must remind the patient that they may, at any time and in any manner, withdraw their request.

MAID provider must take all necessary measures to provide a reliable means by which the patient may understand the information that is provided to them and communicate their decision if the patient has difficulty communicating.

Another physician or nurse practitioner confirms, in writing, that the patient meets the eligibility criteria for MAID.

The MAID provider must ensure that another physician or nurse practitioner has assessed the patient in accordance with the criteria provided above, and provided their written opinion confirming that the requisite criteria for MAID have been met.

The MAID provider must be satisfied that they and the other physician or nurse practitioner assessing a patient's eligibility for MAID are independent of each other and of the patient. This means that they must not:

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

If the other physician or nurse practitioner concludes that the patient does not meet the criteria for MAID as outlined above, the patient is entitled to have another physician or nurse practitioner assess them against the criteria.

Additional safeguards where natural death is not reasonably foreseeable:

In addition to the safeguards above, physicians must also ensure the following safeguards are met for patients whose natural death is not reasonably foreseeable.[41]

If the MAID provider and other physician or nurse practitioner who confirmed the patient meets the eligibility criteria do not have expertise in the condition that is causing the patient's suffering, one of them must consult with a physician or nurse practitioner who has that expertise and must share the results of the consultation with the other physician or nurse practitioner.

The MAID provider must ensure the patient has been informed of the means available to relieve their suffering, including, where appropriate: counselling services, mental health and disability support services, community services and palliative care and has been offered consultations with relevant professionals who provide those services or that care.

The MAID provider must ensure that they and the physician or nurse practitioner who confirmed the patient meets the eligibility criteria have discussed with the patient the reasonable and available means to relieve the patient's suffering and both agree with the patient that the patient has given serious consideration to those means.

The MAID provider must ensure there are at least 90 clear days[42] between the date of the first eligibility assessment for MAID and the date MAID is provided unless both they and the physician or nurse practitioner who confirmed the patient meets the eligibility criteria are of the opinion that the loss of the patient's capacity to provide consent to receive MAID is imminent and the MAID provider thinks a shorter period is appropriate in the circumstances. Physicians will have to use their professional judgement in determining a shorter period.

Physicians must document the start and end-date of the 90-day assessment period in the medical record, and their rationale for shortening the 90-day assessment period if applicable.

Preparing for Medical Assistance in Dying

MAID includes both situations where the MAID provider writes a prescription for medication that the patient self-administers, and situations where the MAID provider is directly involved in administering a substance to end the patient's life.

The MAID provider must inform the pharmacist of the purpose for which the substance is intended before the pharmacist dispenses the substance.

[41] For more information on each of these safeguards, see the *Advice to the Profession* document.
[42] The term "clear days" is defined as the number of days, from one day to another, excluding both the first and the last day.

Physicians are advised to notify the pharmacist as early as possible that medications for MAID will likely be required. This will provide the pharmacist with sufficient time to obtain the required medications.

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

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

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

Providing Medical Assistance in Dying

Immediately before providing MAID, the MAID provider must give the patient an opportunity to withdraw the request and if the patient wishes to proceed, confirm that the patient has provided express consent. This must occur either immediately before the medication is administered, or immediately before the prescription is provided.

MAID providers can only administer MAID without obtaining final express consent if an eligible patient entered into a written arrangement with the MAID provider waiving this requirement and if the provider administers MAID in accordance with that arrangement, as set out in provision 11.

Where MAID is administered, physicians must document the patient's time of death in the medical record.

MAID providers, and those who assist them throughout the process, are protected from liability if they are acting in compliance with the federal legislation and any applicable provincial or territorial laws, standards or rules. These protections would extend, for example, to pharmacists, any individual who supports a MAID provider (not limited to regulated health professionals), or individuals who aid a patient to self-administer the fatal dose of medication.

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

is self-administering in the event it fails so that the MAID provider can provide MAID, as outlined above.[43]

Further, physicians must ensure that patients and caregivers are educated and prepared for what to expect, and what to do when the patient is about to die or has just died and the physician is not present. This includes ensuring that caregivers are instructed regarding whom to contact at the time of death. For further information, physicians are advised to consult the College's *Planning for and Providing Quality End-of-Life Care* policy.

Reporting Requirements and Certification of Death

MAID providers must report the medically assisted death to the Office of the Chief Coroner for Ontario (OCC).[44, 45] Upon notification, the OCC will determine whether the death ought to be investigated. If the OCC determines that an investigation is not required, the MAID provider completes the death certificate. If the OCC is of the opinion that an investigation is required, the OCC would complete the death certificate.[46]

When completing the death certificate for a medically assisted death, the illness, disease, or disability leading to the request for MAID must be recorded as the underlying cause of death. The death certificate must not make reference to MAID, or the drugs administered to achieve MAID.[47]

[43] For more information about self-administration, see the *Advice to the Profession* document.
[44] Section 10.1(2) of the *Coroners Act*.
[45] Physicians notify the OCC of a medically assisted death by contacting provincial dispatch. Provincial dispatch will then contact the on-duty member of the OCC MAID Review Team, who will obtain information from the reporting physician regarding the facts and circumstances relating to the death. Documentation pertaining to the medically assisted death is to be faxed, as soon as is reasonably possible, to the MAID review team at 416-848-7791.
[46] Section 21(7) of the *Vital Statistics Act*, R.S.O. 1990, c. V.4.
[47] Instructions on completing the Medical Certificate of Death reflect joint guidance developed by the Ministry of Health and Long-Term Care, the Ministry of Government and Consumer Services, and the Office of the Chief Coroner.

Council Briefing Note

CPSO

June 2021

Topic:	Discipline Committee Report of Completed Cases – February 6 to May 24, 2021
Purpose:	For Information
Relevance to Strategic Plan:	Right-Touch Regulation
Public Interest Rationale:	**Accountability:** Holding regulated health professionals accountable to their patients/clients, the College and the public **Protection:** Ensuring the protection of the public from harm in the delivery of health care services
Main Contacts:	Moira Calderwood, Tribunal Counsel
Attachments:	None

Issue

- This report summarizes the Discipline Committee reasons for decision released between February 6 and May 24, 2021, including reasons on discipline hearings (liability and/or penalty) and reasons on motions brought before the Discipline Committee.

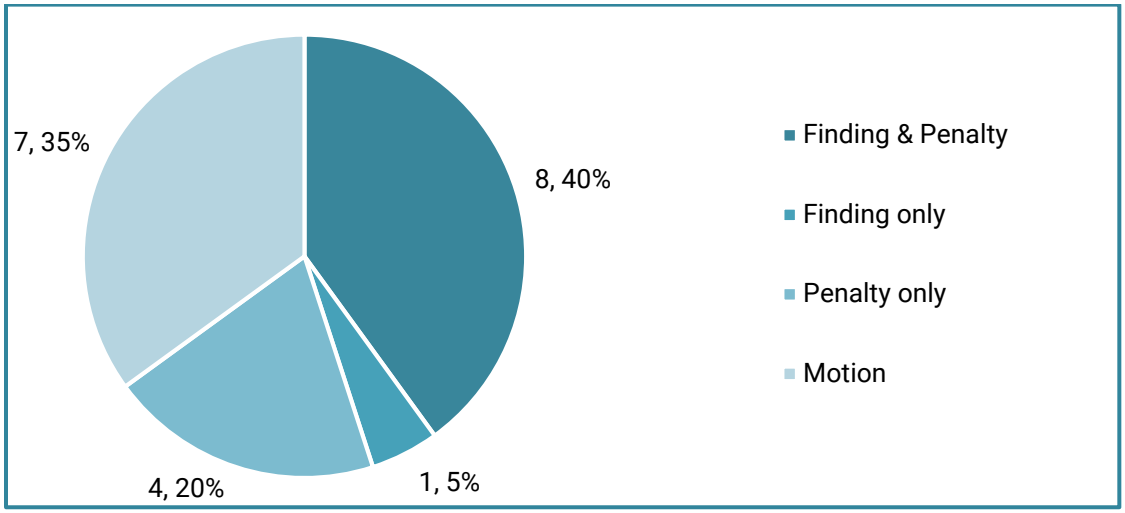
- This report is for information.

Current Status and Analysis

In the period reported, the Discipline Committee released 20 reasons for decision:

- 8 reasons on findings (liability) and penalty
- 1 reasons on findings only
- 4 reasons on penalty only and
- 7 reasons on motions

Figure 1: Types of reasons issued for this period



Liability findings included:

- 1 sexual abuse finding
- 5 findings of failing to maintain the standard of practice
- 8 findings of disgraceful, dishonourable or unprofessional conduct
- 1 finding of contravening a term, condition or limitation

Penalty and costs orders included:

- 3 revocations
- 12 reprimands
- 8 suspensions
- 6 impositions of terms, conditions or limitations on the physician's Certificate of Registration.

The Committee imposed a costs order on the physician in all penalty reasons. The maximum costs ordered was $124,440 and the minimum costs ordered was $6,000.

For the period reported, the Discipline Committee released seven orders and reasons for decision on motions. Three motion orders and reasons dismissed the motion, three granted the motion and one granted the motion in part.

Figure 2: Findings in the nine reasons on findings issued in this period.
Note: Some cases had more than one finding

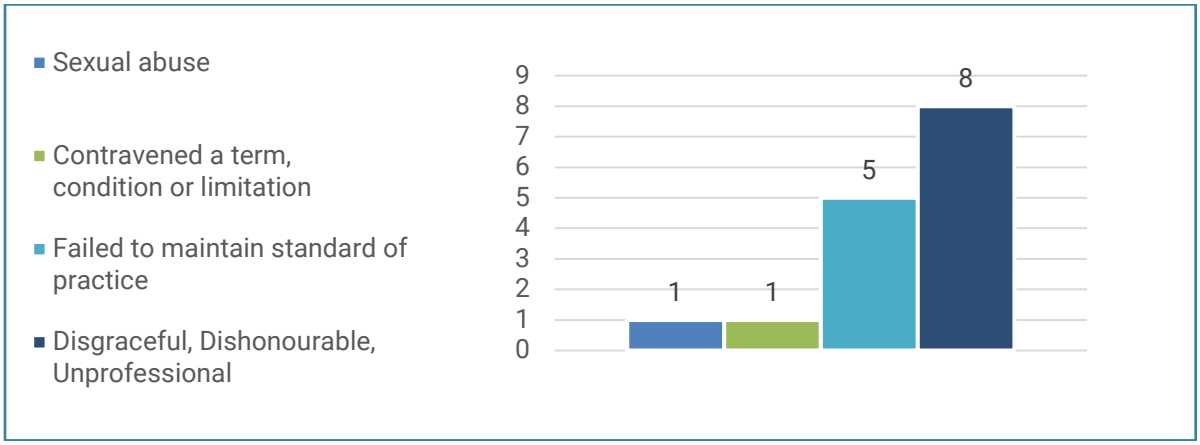


Figure 3: Penalties ordered in the 12 reasons on penalty issued in this period.
Note: Each case had more than one aspect to penalty

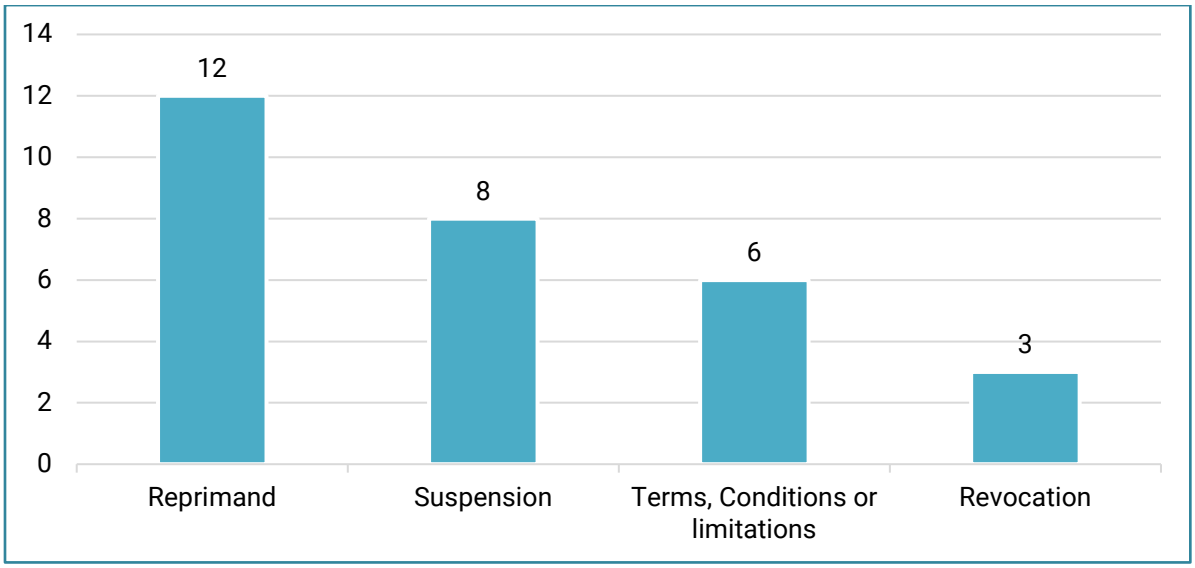


TABLE 1: DISCIPLINE DECISIONS – FINDINGS (February 6 to May 24, 2021)

Citation and hyperlink to published reasons	Physician	Date of Reasons	Sexual abuse	Disgraceful, Dishonourable, Unprofessional	Failed to maintain standard of practice	Other
2021 ONCPSD 9	Innocent Chukwudumebi Okafor	2021-02-17	Y	Y		
2021 ONCPSD 10	Ravi Kakar	2021-02-18			Y	
2021 ONCPSD 11	Kenneth Werezak Adams	2021-02-26		Y	Y	
2021 ONCPSD 12	Young, James Wen	2021-03-03		Y	Y	
2021 ONCPSD 13	Emad Mikhail Guirguis	2021-03-08		Y		Contravened the *Medicine Act*, 1991, the *Regulated Health Professions Act*, 1991 or the regulations under either of those acts.
2021 ONCPSD 14	Suneel Upadhye	2021-04-09		Y	Y	
2021 ONCPSD 19	Emad Samir Luka Guirguis	2021-05-03		Y		Contravened a term, condition or limitation on his certificate of registration
2021 ONCPSD 20	Christopher Michael Anjema	2021-05-07		Y	Y	
2021 ONCPSD 22	Martin Jugenburg	2021-05-11		Y		
TOTAL			**1**	**8**	**5**	**2**

TABLE 2: DISCIPLINE DECISIONS - PENALTIES (February 6 to May 24, 2021)

Citation and hyperlink to published reasons	Physician	Date of reasons	Penalty (TCL = Term, Condition or Limitation)	Length of suspension in months	Costs	Reimbursement for funding provided to patients under s. 85.7 of the Code
2021 ONCPSD 10	Ravi Kakar	2021-02-18	Reprimand, Suspension	4	$10,370.00	
2021 ONCPSD 11	Kenneth Werezak Adams	2021-02-26	Reprimand, Suspension	4	$6,000.00	
2021 ONCPSD 12	James Wen Young	2021-03-03	Reprimand, Suspension, TCL	3	$6,000.00	
2021 ONCPSD 13	Emad Mikhail Guirguis*	2021-03-08	Reprimand		$6,000.00	
2021 ONCPSD 14	Suneel Upadhye	2021-04-09	Reprimand, Suspension, TCL	4	$6,000.00	
2021 ONCPSD 16	Harmander Singh Gill	2021-04-13	Reprimand, Revocation		$124,440.00	
2021 ONCPSD 17	John Patrick Taliano	2021-04-15	Reprimand, Revocation, Comply with policy re closing practice		$124,440.00	$17,370.00
2021 ONCPSD 18	Neilank Kumar Jha	2021-04-16	Reprimand, Suspension	3	$51,850.00	
2021 ONCPSD 19	Emad Samir Luka Guirguis	2021-05-03	Reprimand, Suspension, TCL	9	$6,000.00	
2021 ONCPSD 20	Christopher Michael Anjema	2021-05-07	Reprimand, Suspension, TCL	4	$10,370.00	
2021 ONCPSD 22	Martin Jugenburg**	2021-05-11	Reprimand, Suspension, TCL	6	$31,110.00	
2021 ONCPSD 24	Chukwudumebi Okafor	2021-05-20	Reprimand, Revocation, TCL		$51,850.00	$17,370.00

* Note: the physician signed an undertaking never to reapply.
** Penalty relates to two files. Finding relates to one. Finding in the second file was made in December 2020. The Chair ordered the matters to be combined.

TABLE 3: DISCIPLINE DECISIONS - MOTIONS (February 6 to May 24, 2021)

Citation and hyperlink to published reasons	Physician	Date of Reasons	Motion Outcome	Nature of Motion
2021 ONCPSD 8	Harvey Stephen Pasternak	2021-02-08	Dismissed	Motion for Production of Third-Party Records
2021 ONCPSD 15	Harmander Singh Gill	2021-04-13	Dismissed	Motion to adjourn penalty hearing
2021 ONCPSD 21	Harvey Stephen Pasternak	2021-05-10	Dismissed	Motion for non-disclosure of expert report
2021 ONCPSD 23	Ayokunle Fagbemigun	2021-05-17	Granted in part	Motion to prevent admission of evidence due to unlawful search and seizure. Motion is granted in part. The following data is inadmissible at the hearing on the merits: • Data from the five computer terminals imaged on December 10, 2018 and • Data on the five hard drives removed from Dr. Fagbemigun's office on December 10, 2018
Unpublished	Christopher Michael Anjema	2021-03-22	Granted	Motion under Rule 12.03 of the Committee's Rules of Procedure by members of the public (a Toronto Star reporter) for access to exhibits from the hearing
Unpublished	Christopher Michael Anjema	2021-04-27	Granted	Motion under Rule 12.03 of the Committee's Rules of Procedure by a member of the public (an individual) for access to exhibits from the hearing
Unpublished	Jeffrey Scott Sloka	2021-05-14	Granted	Motion under Rule 12.03 of the Committee's Rules of Procedure by a member of the public (Crown Law Office) for access to exhibits from the hearing

Council Briefing Note

June 2021

Topic:	Government Relations Report
Purpose:	For Information
Relevance to Strategic Plan:	Right-Touch Regulation Continuous Improvement
Public Interest Rationale:	Quality Care: Government Relations supports CPSO to regulate in a more effective, efficient, and coordinated manner.
Main Contacts:	Miriam Barna, Senior Government Relations Advisor Danna Aranda, Government Relations Coordinator
Attachment:	N/A

Ontario's Political Environment

- On May 30, it was announced that Dr. David Williams, who has been the Chief Medical Officer of Health for Ontario since 2016, will be stepping down from his role. Dr. Kieran Moore, who has served as the Medical Officer of Health for Kingston, Frontenac, Lennox & Addington Public Health since 2017, has been appointed as the new Chief Medical Officer for the province effective June 26, 2021. Dr. Moore is well-respected and widely well-regarded for his work during the pandemic.

- Notwithstanding months of reproach from the opposition parties, the recent rise in vaccination rates, and plummeting case numbers, have somewhat tempered the criticism faced by the PCs.

- With the next election scheduled for June 2, 2022, and a formal campaign start date of May 4, 2022, all political parties have turned their attention to the development of election strategies, fundraising, and platforms.

- On May 31, media began reporting on the Premier's plans for significant change to his cabinet in the coming weeks. These reports indicated that the Premier was prepared to shuffle out a number of veteran cabinet ministers and promote a number of more junior ministers in an attempt to refresh prior to the next election.

- Several public opinion polls are currently showing dissatisfaction with how Doug Ford's government is managing COVID-19 in the province—at odds with Ford's soaring poll

numbers in the earlier months of the pandemic. However, these polling numbers may not translate into defeat in 2022 particularly as no opposition party is currently leading ahead of the PCs.

Legislative Agenda

- While the spring legislative session initially moved at a sluggish pace, the second half of the session saw a packed government agenda where bills were introduced and expeditiously passed through the House.

- The legislature is expected to adjourn for its summer break on June 3 and return for the fall legislative session on September 13.

- For CPSO, the most notable development of the spring legislative session was the introduction and swift passage of Bill 283, Advancing Oversight and Planning in Ontario's Health System Act . Among other measures, Schedule 3 of this bill introduces the legislative framework needed to regulate physician assistants under CPSO. Council is provided with a separate briefing note that details the contents of Schedule 3 but is provided with a brief overview of the other schedules below.

    - Schedule 1—the only schedule of the bill that came into force upon passage in the Legislature—requires the reporting of COVID-19 vaccine-related data to the Ministry of Health.

    - Schedule 2 of the bill, once enacted, would provide new oversight for personal support workers through the establishment of a new entity outside of the *Regulated Health Professions Act (RHPA),* called the Health and Supportive Care Providers Oversight Authority (the "Authority").

        - Similar to the *RHPA*, the Authority will establish educational and skills-based qualifications for registrants, establish a registration and renewal process, as well as a process for complaints, investigations, and discipline.

        - Unlike the *RHPA,* registration will be voluntary and those that choose not to register can continue working as a PSW. PSWs will also be prohibited from serving on the Board, however, the Board can establish an advisory committee for each class of registrant (currently only PSWs).

        - This schedule of the bill received the greatest amount of attention both in the debates in the Legislature and in the Committee hearings on the bill. Many stakeholders felt that the new Authority had significant shortcomings and that government should instead be addressing issues such as the working conditions, wages, recruitment, and retention of PSWs.

    - Finally, Schedule 4, once enacted, will see behaviour analysts regulated as a new profession under the College of Psychologists of Ontario.

- Among the other Bills government introduced this session with some relevance to CPSO include:

    - Bill 269, Protecting the People of Ontario Act (Budget Measures): Schedule 9 of the bill is relevant to CPSO's governance modernization efforts and those related to the Discipline Committee, as it expands the Ontario Securities Commission's (OSC) mandate, reconfigures its internal governance structure, and delineates the regulatory and adjudicative functions of the OSC. Bill 269 received Royal Assent on April 27.

    - Bill 276, Supporting Recovery and Competitiveness Act: Schedule 25 of this bill eliminates the Health Professions Regulatory Advisory Council (HPRAC). Schedule 27 adds a new section to the *Statutory Powers Procedure Act* that empowers hearing tribunals, like discipline committees, to make orders preventing the recording and dissemination of recordings and pictures of hearings. The bill was being debated at Third Reading at the time this note was written.

    - Government also expeditiously introduced and passed Bill 284, COVID-19 Putting Workers First Act on April 29 following months of pressure from opposition parties and medical experts for a paid sick-leave program. The bill amends the *Employment Standards Act* and provides three paid sick days for workers who have less than three paid days through their employer.

Issues of Interest

Governance Modernization

- We understand that government will likely undertake a consultation in the coming months on potential governance modernization changes to the *RHPA* and profession-specific statutes.

- Staff will be seeking the direction of Council on proposed legislative changes, through a separate briefing note and presentation.

Public Member Update

- While we are still awaiting the reappointment decision for Rob Payne whose appointment is set to expire in October, the Public Appointment Secretariat has recently shared with us the Order in Council for Shannon Weber's three-year reappointment.

- CPSO currently has 13 public members appointed to Council, and staff continue to advocate for the full complement of 15 public members be appointed to Council.

Interactions with Government

- While the pace of meetings with Members of Provincial Parliament (MPP) slowed last year due to the pandemic, these meetings have resumed in 2021. The purpose of these meetings is to build good relationships with government and opposition parties, provide MPPs with information about our mandate and recent work, and ensure MPPs have a line of contact at CPSO should relevant questions arise.

    - Over the last four months, the College President has met with the Ontario Liberal party Leader, Steven Del Duca; NDP Health Critic, France Gélinas; the Ontario Green Party Leader, Mike Schreiner; and most recently, the Parliamentary Assistant to the Minister of Health, PC Robin Martin.

- Over the last number of months, staff have remained in contact with government stakeholders with regards to ongoing issues related to COVID-19. The government relations activity related to physician assistant regulation and Bill 283 has also been substantial.

- Staff anticipate a busy summer with the development of regulations to support the implementation of physician assistant regulation as well as potential activity surrounding governance modernization.

Council Briefing Note

June 2021

Topic:	Finance Report
Purpose:	For Information
Main Contacts:	Dr. Thomas Bertoia, Chair Finance and Audit Committee Nathalie Novak, CTO Douglas Anderson, CSO Leslee Frampton, Manager, Finance
Attachment:	N/A

Issue

- The Finance and Audit Committee met on April 8, 2021 and has the following summary for the June 2021 Council meeting

Background

The Finance and Audit Committee addressed the following agenda items:

- Review of the budget for the Communication Department
- The Committee discussed the 2021 work plan
- The Committee reviewed the year-end 2020 Financial Statements and Variance Analysis
- Tinkham LLP Chartered Professional Accountants presented the 2020 Audited Financial Statements with the Committee
- The Committee held an in-camera meeting with the auditors
- Nathalie Novak provided the Finance and Audit Committee with a fulsome update on Vault, Solis, and the Finance and Operations systems
- Joanne Noble from HIROC gave the Committee a detailed update on FIRMS
- Laurie Cabanas provided the Committee with information on the Per Diem for Council and Committee Members
- The Committee discussed the budget objectives for 2022
- David Macey from Infrastructure Ontario (IO) presented an update on space.

Council Briefing Note

June 2021

Topic:	Policy Report
Purpose:	For Information
Relevance to Strategic Plan:	Right-Touch Regulation Meaningful Engagement
Public Interest Rationale:	Keeping Council apprised of ongoing policy-related issues and activities for monitoring and transparency purposes.
Main Contact(s):	Craig Roxborough, Director, Policy
Attachment(s):	Appendix A: Policy Status Report

Issue

- An update on recent policy-related activities is provided to Council for information.

Current Status

1. *Medical Assistance in Dying (MAID)* – Bill C-7 Update

- In September 2019, the Superior Court of Quebec struck down the eligibility criterion for MAID that required an individual's natural death be reasonably foreseeable. In response to the Court decision, the federal government expanded access to MAID to individuals whose natural deaths are not reasonably foreseeable by passing Bill C-7 on March 17, 2021.

- Council was provided with an overview of Bill C-7 at its meetings in March 2020 and December 2020, and an update on the status of the Bill at its meeting in March 2021.

- Since then, a few additional amendments were made to the Bill before it received Royal Assent, including the following:
    - Individuals whose only medical condition is a mental illness, and who otherwise meet all eligibility criteria, will not be eligible for MAID until March 17, 2023.[1]

[1] Recommendations on protocols, guidance, and safeguards for MAID for individuals suffering from mental illness will be provided via an expert review by March 17, 2022.

  - Regulation-making power to expand data collection related to race, Indigenous identity, and disability, and to determine the presence of individual or systemic inequality or disadvantage with respect to MAID.[2]

- Shortly after the Bill received Royal Assent, the College's *MAID* policy and *Advice to the Profession* document (*Advice* document) were updated to reflect the new legal framework.

- The updated *MAID* policy was approved by the Executive Committee at its April 2021 meeting. Key changes included the following:

  - The requirement that an individual's natural death be reasonably foreseeable was deleted and the exclusion of mental illness as the sole condition that makes an individual eligible for MAID has been added.

  - The new circumstances where patients can enter into a written arrangement that waives the requirement that the MAID provider obtain their final express consent immediately prior to the patient receiving MAID were added.

  - The procedural safeguards for MAID were updated to reflect the two-track approach (i.e., the safeguards would depend on whether or not the patient's natural death is reasonably foreseeable).

    - Existing safeguards were maintained or eased for individuals whose natural death is reasonably foreseeable (e.g., eliminating the ten-day reflection period).

    - New and strengthened safeguards were established for individuals whose natural death is not reasonably foreseeable (e.g., a 90-day assessment period before receiving MAID).

- The updated *Advice to the Profession: MAID* document addresses the following: key changes to the legal framework, the transitional period, mental illness, written arrangements waiving final express consent, "reasonably foreseeable natural death," and the new safeguards for natural deaths that are not reasonably foreseeable.

- The *MAID* policy and Advice document are being reviewed as part of the regular policy review cycle and the preliminary consultation on the current documents recently closed.

2. Facilities Accreditation – Modernization Update

- The Out-of-Hospital Premises Inspection Program (OHPIP) develops and maintains standards for the provision of procedures requiring anesthesia performed in Ontario out-of-

[2] These regulations have not been developed and the federal government expects it will take two years to do so.

hospital premises (OHPs) and inspects and assesses such premises for safety and quality of care.

  - The OHPIP was originally intended as a short-term solution to address significant concerns that emerged as an increasing number of procedures traditionally provided in hospitals moved into community settings and outside of the already established Independent Health Facilities regulatory regime.

  - A regulatory amendment to the *General Regulation* under the *Medicine Act*, *1991* enabled CPSO to establish a quality and inspection regime focused on premises where procedures are being performed under general anesthesia, parenteral sedation, or regional anesthesia along with a number of more specific categories of procedure performed with local anesthetic.

  - It has been over a decade since the OHPIP was created. The program standards have been updated periodically over this time, while no substantive changes have been made to the program as a whole.

- In keeping with CPSO's Strategic Plan, and in particular the commitment to implementing right-touch regulation, the OHPIP is being re-evaluated with an aim to update and modernize the program standards and regulatory approach. This work will involve examining the effectiveness of the status quo and identifying opportunities for improvement and modernization, to ensure our approach is fit for purpose.

- Initial analysis and feedback have identified a few key points of concern and principles that will help inform and shape how the modernization of this program area will unfold.

  - It is not possible for any regulatory approach to prevent or mitigate all risks to patients. Rather, the aim of our regulatory approach is to support and enable the provision of quality care and to take appropriate action when concerning conduct is identified.

  - Rather than duplicate or repurpose external clinical standards, the program can refer to and/or rely on clinical practice guidelines and standards that exist external to CPSO.

  - The prescriptive and detailed approach of the current program standards may not be well-aligned with CPSO's broader regulatory approach, which seeks to adopt more principle-based approaches to regulating physician conduct.

  - Replicating similar structures in hospital, there is an opportunity to leverage and expand the requirements for medical directors to ensure the appropriate policies and procedures are in place within OHPs.

  - An opportunity exists to re-evaluate how the various regulatory tools of CPSO can be used and combined to better regulate this practice environment. This can include

exploring new ways of strengthening our approach by better relying on each line of defense available (e.g., at the level of the individual physician, the medical director, the Premises Inspection Committee [PIC] and the program area, and the Inquiries, Complaints, and Reports Committee).

- PIC has been engaged in initial discussions about the modernization and their feedback will inform this work.

- Consultation with OHPs is also underway in the form of a survey to medical directors and physicians practising in OHPs, requesting feedback about the current OHP program and potential opportunities for improvement.

- Council will be kept apprised as this work progresses and will ultimately be sought to implement any of the proposed changes that will flow from this work.

3. Policy Consultation Update

- Several policy consultations were launched following the December 2020 Council Meeting. Recognizing the impact of the pandemic on the profession and key stakeholders, the consultation period was initially extended beyond the typical 60-day period to ensure there was ample opportunity for participation. In response to requests for extensions and the disproportionate impact of the pandemic on the specialties to whom the consultations would be most relevant, the consultation periods were extended multiple times.

- While all CPSO consultations are open and broad invitations to participate are distributed, specific effort was made to connect with and engage stakeholders representing or advocating for the interests of diverse and/or vulnerable groups and was also promoted through CPSO's website and social media platforms.

- A brief overview of each consultation and the key themes that emerged in the feedback is provided below.

Complementary and Alternative Medicine

- The consultation received 3,032 responses: 1,331 through written feedback and 1,701 through the online survey.[3] The majority of responses received were from members of the public as part of an organized letter-writing campaign.[4]

- While there was some support for the draft policy, many respondents expressed concern about what they perceived to be CPSO attempting to limit or restrict access to complementary and alternative medicine (CAM). Some of the key comments and concerns identified in the feedback included:

    - While respondents generally supported the draft policy's goal to strike the right balance between patient safety, patient autonomy, and medical innovation, some respondents felt that the overall tone and language overstated the risks of CAM treatments and implied that CAM physicians are inherently exploitative;

    - It is problematic to treat off-label prescribing with CAM treatments that have little to no evidence to support their use under the scope of the draft policy;

    - CAM physicians should not be required to repeat a comprehensive conventional assessment prior to offering CAM treatments and instead the draft policy should permit physicians to rely on another physician's professional judgment;

    - The draft expectation requiring that any CAM treatment must be "supported by" evidence and scientific reasoning is biased against CAM, as many treatments have not been the subject of large clinical trials (some respondents suggested amending the language back to "informed by"); and

    - The proposed documentation requirements are overly burdensome and seem to hold CAM physicians to a higher standard than for conventional physicians.

[3] Organizational responses included: Academic Consortium for Integrative Medicine & Health; Action Life Ottawa; American Board of Integrative Medicine; Canadian Lyme Disease Foundation; Canadian On Paper Society for Immigrant Physicians Equality, Foundation for International Medical Graduates, and Create a PATH for International Medical Specialists to practice in Canada; Christian Legal Fellowship; College of Physicians and Surgeons of Alberta (CPSA); Cleveland Clinic Canada; Environmental Sensitivities Coalition of Canada; Hamilton Health Science; Myalgic Encephalomyelitis Association of Ontario; Ontario Association of Naturopathic Doctors; Ontario Chiropractic Association; Ontario Lyme Alliance; Ontario Medical Association (OMA) Section on Addiction; OMA: Complementary and Integrative Medicine (CIM) Section CAM Policy Task Force; OMA: CIM Executive; Professional Association of Residents of Ontario (PARO); and Thyroid Patients.

[4] During the consultation period, CPSO received 741 form letter responses from individual respondents containing similar content with varying levels of personal content or information included. While each response was not posted on the online discussion board, these responses are being read and considered as part of the public consultation.

- Roughly half of survey respondents felt the draft policy is easy to understand and clearly written. Some constructive suggestions to improve the draft policy included:
    - Include a list of examples of CAM treatments that the draft policy applies to (some respondents suggested differentiating between different types of CAM);
    - Expand and clarify what would meet the threshold for "supported by evidence and scientific reasoning";
    - Define "conventional" medicine; and
    - Include references to collaboration and inter-professional care and referrals;
- All feedback is currently being reviewed in detail and will help inform revisions to the draft policy.

Medical Assistance in Dying

- The consultation received 4,885 responses: 4,168 through written feedback and 717 through the online survey.[5] The majority of responses received were from members of the public as part of an organized letter-writing campaign.[6]
- Although there was some support for the current policy, a number of respondents provided specific suggestions on how to improve the clarity and usefulness of the policy and expressed concerns regarding the legal framework for MAID and the effective referral policy requirement. Some specific comments and concerns expressed included:
    - Rewrite the policy using plain language and include tools/resources to aid physicians;
    - Clarify the definition of "effective referral" and consider using a term other than "referral;"

[5] Organizational responses included: Action Life Ottawa; Association for Reformed Political Action (ARPA) Canada; Canadian Centre for Christian Charities; Canadian Medical Protective Association (CMPA); Canadian Physicians for Life; Canadian Psychiatric Association; Canadian Society of Palliative Care Physicians (CSPCP); Catholic Health Association of Ontario; Christian Legal Fellowship; Christian Medical and Dental Association of Canada (CMDA); College of Nurses of Ontario (CNO); Council of Canadians with Disabilities; Dignity Denied; Dying with Dignity Canada; Evangelical Fellowship of Canada; Information and Privacy Commissioner of Ontario (IPC); Living with Dignity; Ontario Association for ACT and FACT; Ontario College of Family Physicians (OCFP); OMA; Orthodox Rabbis of Ontario; Physicians Together With Vulnerable Canadians; PARO; Protection of Conscience Project; Resurrection Lutheran Church – CALC, LCMC; Syrian Canadian Foundation; and Toronto Board of Rabbis.

[6] During the consultation period, CPSO received 4,008 form letter responses from individual respondents containing similar content with varying levels of personal content or information included. While each response was not posted on the online discussion board, these responses are being read and considered as part of the public consultation.

- Patients should initiate discussions regarding MAID because if physicians raise MAID as an option, it may induce or coerce patients to pursue MAID;
- Provide guidance on how physicians should navigate requests for MAID, and in particular, how to explore and address the underlying issues that led to the request;
- Clarify how to interpret and apply the new procedural safeguards;
- Some felt physicians should be obligated to make an effective referral, and others felt very strongly that it was inappropriate for various reasons, including: MAID is unethical and not in patients' best interests, it would make physicians inherently complicit in the act, and it would discourage those with strong beliefs from going into medicine or staying in medicine;
- The cause of death on death certificates should be MAID, not the underlying medical condition that led to MAID; and
- Address additional issues in the policy, including: mental illness, education and training for physicians who provide MAID, institutional objections to MAID (e.g., religious hospitals), and criminal liability.

- All feedback is currently being reviewed in detail and will help inform revisions to the draft policy.

Professional Obligations and Human Rights

- The consultation received 268 responses: 46 through written feedback and 222 through the online survey. [7] The majority of respondents were physicians.

- Although there was some support for the current policy, a number of respondents provided specific suggestions on how to improve the clarity and comprehensiveness of the policy and expressed opposing views regarding the effective referral requirement. Specific comments included:
  - Address systemic discrimination and unconscious bias, and include other grounds of discrimination (e.g., weight, socioeconomic status, immigration status, etc.);

[7] Organizational responses included: Abortion Rights Coalition of Canada (ARCC); Action Canada for Sexual Health and Rights; CMPA; Canadian Society of Palliative Care Physicians (CSPCP); Catholic Health Association of Ontario; Christian Medical and Dental Association of Canada (CMDA); CNO; Council of Canadians with Disabilities; Hamilton Trans Health Coalition; IPC; MAX Ottawa; Ontario Association for ACT and FACT; OMA; Orthodox Rabbis of Ontario; Physicians Together with Vulnerable Canadians; PARO; Protection of Conscience Project; Society for Canadians Studying Medicine Abroad; William Osler Health System Ethics Quality Improvement Lab; and Youth With a Mission.

  - Clarify the meaning of “adverse clinical outcome” and “impede access to care” in relation to effective referrals as some respondents felt these concepts were vague;

  - Clarify what is and is not considered an “effective referral,” including specifying the difference between an “effective referral” and “referral;”

    - Several respondents thought that physicians should not be required to make a referral unless they believe the treatment is clinically appropriate.

  - There was a difference in opinion as to whether conscientious objection itself is a form of discrimination;

  - Some felt that conscientious objection is harmful to patients and the effective referral requirement is appropriate, while others felt physicians should not be required to make an effective referral because there are other acceptable options for patients (e.g., Telehealth, clinics, hospitals, etc.); and

  - Include refusal to treat patients for reasons other than clinical competence or conscience or religious beliefs (e.g., physicians may not have the capacity to take on new patients or may choose to only treat a particular demographic or specific medical condition).

- All feedback is currently being reviewed in detail and will help inform revisions to the draft policy.

Planning for and Providing Quality End-of-Life Care

- The consultation received 122 responses: 16 through written feedback and 106 through the online survey.[8] The majority of respondents were physicians.

- Respondents were generally supportive of the current policy, though there were a number of physicians and organizational respondents who had concerns about the current policy’s expectations related to potentially life-saving and life-sustaining treatments, particularly no-CPR orders (also known as Do Not Resuscitate orders):

  - There is a concern that the current expectations obligate physicians to perform CPR even when there is little chance for recovery if a patient’s loved ones and/or substitute decision-maker do not agree with a no-CPR order;

  - The current policy does not align with recent case law which indicates that physicians do not require consent to withhold CPR that they believe to be medically inappropriate;

[8] Organizational responses included: Canadian Critical Care Society (CCCS); CMPA; Catholic Health Association of Ontario; CNO; Medico-Legal Society of Toronto; OCFP; OMA; and PARO.

  - Some respondents also highlighted that physicians do not require consent to withhold or not offer other treatments that they deem to be inappropriate and the current policy treats CPR as exceptional relative to other treatments (e.g., a surgeon wouldn't be forced to perform surgery that isn't clinically indicated);
  - Clearer guidance is needed regarding the conflict resolution process, as some respondents were of the view that the Consent and Capacity Board and the courts are not well-suited for this task;
  - While all survey respondents agreed that it was important for physicians to recognize that patients may have values that lead to a different conclusion about the appropriateness of potentially life-saving and life-sustaining treatment, several respondents indicated that these values should be balanced against the physician's judgment and the standard of care, and not ultimately drive decision-making;
  - Clearly define the "standard of care" in relation to CPR and other potentially life-saving and life-sustaining treatments (i.e., describe circumstances for when treatment can be withheld and include a definition of "medically futile"); and
  - Emphasize the importance of clear communication between the patient, the patient's loved ones (including substitute decision-makers), and the physician and health care team (some requested information on how to navigate cultural and/or communication barriers, including supports for those with intellectual disabilities).

- The vast majority of survey respondents agreed that physicians should be required to discuss advance care planning with patients (including choosing a substitute decision-maker), provide necessary medical information and opportunity for discussion, and encourage patients to review existing advance care planning when their condition changes.
  - Notwithstanding this, some respondents felt that advance care planning discussions should be encouraged but not required.
- All feedback is currently being reviewed in detail and will help inform revisions to the draft policy.

Table 1: Current Reviews

Policy	Launch	Stage of Policy Review Cycle						Target Comp.	Notes
		Prelim. Consult	Drafting	Approval to Consult	Consult on Draft Policy	Revising Draft Policy	Final Approval		
Professional Obligations and Human Rights	Dec-20		✓					**2023**	
Medical Assistance in Dying	Dec-20		✓					**2023**	
Planning for and Providing Quality End-of-Life Care	Dec-20		✓					**2023**	
Telemedicine	Sep-20		✓					**2022**	
Social Media: Appropriate Use by Physicians **(Statement)**	Apr-20			✓				**2021**	A review is underway to review and update the statement.
Statements & Positions Redesign	Jan-20		✓					**2021**	All CPSO *Statements & Positions* are being evaluated for relevance and currency.
Professional Responsibilities in Postgraduate Medical Education **&** ***Undergraduate Medical Education***	Dec-19						✓	**2021**	The two policies have been combined into one draft policy titled *Professional Responsibilities in Medical Education*.
Medical Expert **&** ***Third Party Reports***	Dec-19						✓	**2021**	The two policies have been combined into one draft policy titled *Third Party Medical Reports*.
Complementary / Alternative Medicine	Mar-19					✓		**2022**	

Table 2: Policy Review Schedule

Policy	Target Review	Policy	Target Review
Female Genital Cutting (Mutilation)	2016/17	*Public Health Emergencies*	2023/24
Dispensing Drugs	2016/17	*Closing a Medical Practice*	2024/25
Mandatory and Permissive Reporting	2017/18[1]	*Availability and Coverage*	2024/25
Providing Physician Services During Job Actions	2018/19	*Managing Tests*	2024/25
Physicians' Relationships with Industry: Practice, Education and Research	2019/20	*Transitions in Care*	2024/25
Cannabis for Medical Purposes	2020/21	*Walk-in Clinics*	2024/25
Consent to Treatment	2020/21	*Disclosure of Harm*	2024/25
Blood Borne Viruses	2021/22	*Prescribing Drugs*	2024/25
Physician Treatment of Self, Family Members, or Others Close to Them	2021/22	*Boundary Violations*	2024/25
Physician Behaviour in the Professional Environment	2021/22	*Medical Records Documentation*	2025/26
Accepting New Patients	2022/23	*Medical Records Management*	2025/26
Ending the Physician-Patient Relationship	2022/23	*Confidentiality of Personal Health Information*	2025/26
Uninsured Services: Billing and Block Fees	2022/23	*Advertising*	2025/26
Ensuring Competence: Changing Scope of Practice and Re-entering Practice	2023/24	*Delegation of Controlled Acts*	2025/26

[1] A comprehensive update to this policy was completed as part of the Policy Redesign process. Council approved this updated version in September 2019.

Ontario Medical Students Association
CPSO Council Update
June 17 - 18, 2021

Presented by:
Ushma Purohit, President
Angie Salomon, President-Elect

OMSA Ontario Medical Students Association
AÉMO Association des étudiant·e·s de médecine de l'Ontario

Thank you once again to the CPSO for inviting representatives from the Ontario Medical Students Association (OMSA) to observe and participate in your June Council meeting.

Over the past two months, Ontario's medical students have celebrated some significant milestones. CaRMS match results were released on April 20 (first iteration) and May 20 (second iteration). This is a very exciting time for our graduating class and we're incredibly proud of their accomplishments. We wish them all the best of luck as they start their new chapters and look forward to seeing them represented by PARO within the next few months.

We also extend our support to the students from the 2021 graduating class who went unmatched after these two CaRMS iterations. OMSA continues to advocate for the creation of an adequate number of residency positions to ensure students graduating from Canadian medical schools can continue with postgraduate training.

This has also been an eventful few months for our preclerkship students who are now ending their school years and starting their summer breaks. Our preclerkship students are an especially resilient group of future physicians. They have faced countless challenges associated with virtual medical education and continue to find creative solutions to overcome them. Additionally, medical students across the province continue to make meaningful contributions to their communities in the face of COVID-19, including advocating for paid sick leave and volunteering in vaccination and assessment clinics.

Finally, our own organization has undergone a change in leadership since our last update.. At the OMSA AGM on May 16th, we elected and announced our new 2021-2022 Council. With that change, we have a new President & President-Elect representing OMSA at this CPSO Council meeting. Our new Council aims to continue to foster the relationship between OMSA & the CPSO, as we collaboratively represent the interests of medical students and encourage them to become involved early in their medical careers.

Thank you for welcoming medical students to the table and we look forward to continuing to work with the CPSO.

PARO

Inspired by our love of medicine

CPSO Council June 2021

PARO champions the issues that create the conditions for residents to be their best and ensure optimal patient care. We have determined that to fulfill this mission we must achieve three key goals.

Optimal training - so that residents feel confident to succeed and competent to achieve excellence in patient care.

Optimal working conditions - where residents enjoy working and learning in a safe, respectful, and healthy environment.

Optimal transitions – into residency, through residency, and into practice – so that residents are able to make informed career choices, have equitable access to practice opportunities, and acquire practice management skills for residency and beyond.

We are pleased to submit this update on some organizational projects, info related to COVID-19 as well as some strategic initiatives at PARO.

COVID-19, Examinations & Licensing

In February, I attended the CPSO Council special meeting to consider an MCCQE2 exam pandemic exemption policy and the meeting in March when that exemption was confirmed by CPSO Council. I can tell you that your decision brought much comfort and gratitude to many members and recent graduates.

We thank the CPSO for demonstrating bold leadership in ensuring that Ontario patients can be treated by this cohort of doctors. It is significant that this proposed policy recognizes that the lack of the QE2 exam is not an impediment to the provision of high-quality competent care by these recent graduates.

The careful analysis by the CPSO that the MCC would not be able to deliver a high-fidelity virtual exam this spring has been shown to be correct. In fact, there were so many challenges with the exam that the MCC Governing Council voted to suspend the exam and provide a refund and apology to all registered candidates. We understand that many individuals will be receiving their LMCC without having to sit the QE2 exam. The future of the QE2 now seems in question. We are very pleased by this result but also remain concerned about two groups of individuals for whom we hope to find clarity. The first group includes those individuals who have previously had an unsuccessful attempt at the exam. Given that there is no timeline or even certainty that this exam will be reconstituted, we are hoping that the CPSO will provide a route for independent licensure to this cohort. The other group are residents who did sit the recent exam who will not have their exam marked and who are in the first few years of their Royal College training. There is also uncertainty for these individuals given that they don't know whether they will receive their LMCC or if they will be held hostage to sitting some exam in the future. For these individuals, every year that passes where they become more specialized, the relevance of a general exam like the QE2 lessens. We hope that the CPSO will also provide a route for independent licensure

to this cohort. We hope that the CPSO will provide assurance to all current residents, whether they won the lottery to be registered to sit the exam or not, that there will be a route to independent licensure irrespective of what the MCC might ultimately decide to do with respect to their exams.

Finally, PARO is in agreement with all the PG Deans across the country who have written recently to the Medical Regulatory Associations and Registrars that the utility of the QE2 exam is called into question.

Optimal Working Conditions

New Collective Agreement between PARO & the Ontario Teaching Hospitals
The term of PARO's Collective Agreement with our employer ended on June 30, 2020. This round, we had to bargain in the face of Bill 124, which limits any increase in compensation to 1% in each of three years. Our goal was to creatively utilize every penny permitted under the restrictions imposed by Bill 124.

We were able to reach agreement on most items and jointly decided that we should take the outstanding items to mediation. Both sides met with our Mediator/Arbitrator, Mr. William Kaplan, on Saturday May 15th and presented our respective arguments. Mr. Kaplan is one of the most respected Arbitrators in Ontario and we have now received his decision, which is binding to both parties.

Optimal Training

Integration of Virtual Care in Medicine
The PARO Board determined last September that we investigate how a virtual care curriculum might be optimally developed and integrated into medical education to create the conditions for resident training to be enhanced. Although PARO is not in a position to directly influence curriculum development and implementation, we can play a valuable role by providing the resident perspective and highlighting how this is an opportunity to streamline and leverage current training. We held a focus group session comprised of General Council representatives in January 1 to gather information about the resident experience with virtual care to-date and how PARO might best support our members in this area. We also did an outreach to external stakeholders who may have begun work in this area. The Team is bringing a framework through our internal approval process.

PARO Teaching to Teach Program
We are particularly proud of PARO's Teaching to Teach Program this year - delivering content by transitioning it to a virtual session. Over the last year, despite interruptions due to COVID, we facilitated six workshops with over 205 participants including 70 Western Family Medicine residents. We also hosted a "Train the Trainer" session resulting in 3 newly trained facilitators.

Optimal Transitions

Transition to Residency

PARO Community Building Fund
The PARO Board learned from our Site Chairs that the current PGY1s are feeling particularly isolated. This is not surprising given that as students they were off for months before starting and since then haven't had any ability be meet each other in person to be able to bond. Our Site Chairs and GC reps are our eyes and ears on the ground and beautifully identified this particularly vulnerable group of members and the impact of COVID on their PGY1 experience.

To mitigate this elevated challenge for the PGY1 cohort, the Board set up a targeted *Community Building Fund* that sites apply for to organize events for their PGY1s. Though the other funding available to sites must be for events open to all residents, this targeted Community Fund can be events for all PGY1s or for specific groups of PGY1. The Site Chairs, with their teams are in the best position to determine how to organize the groupings.

Organizational Initiatives

PARO Bylaws Renewal Process

This year we embarked on a renewal process with an articulated vision of success to:

- update our PARO Bylaws to reflect current practices that are designed to endure 10+ years;
- articulate the definition of "*member*" and "*member in good standing*";
- describe and map the distributed leadership model and roles and accountability identified for members with clear language on definition of professionalism;
- develop process for addressing situations regarding "good standing" and "professionalism" of members; and,
- integrate current *best practices* for not-for-profit organizations.

We are now in the approval process through the levels required under our current bylaws.

Ontario Government's Medical Resident Redeployment Program

As the third wave of the COVID-19 pandemic slammed Ontario, we were acutely aware of the increasing numbers of very sick patients and the demands on our health care system. We received frequent calls from Hospitals and Program Directors how residents could be mobilized to help with the increased patient care needs. And, we had many enquiries from residents asking how they might expedite their application for the Ontario Restricted Registration program (RR license). We also heard many reports of residents being asked to volunteer to cover extra call and shifts.

After significant work by our CEO, Staff and consultants we very pleased when Government announced this Program to enable residents to provide the much-needed additional service and to obtain payment in the amount of $50 per hour.

A priority was to ensure that there is a way for all residents to be eligible to participate, and to ensure that they will receive extra pay for doing so, as a tangible way of recognizing their contribution. We thank the CPSO, CMPA, CAHO and the OHA, and all of the PG Deans for their solution-oriented collaboration to make this program happen.

PARO Equity Diversity and Inclusion

Our PARO EDI framework guides our work to create a medical culture that is diverse, equitable and inclusive where we make room for it, speak up for it, show it and show up for it, and share it so people can see it. We do this by:

- creating psychological safety
- having an equitable advocacy system
- showcasing and celebrating equity
- having equitable representation of membership of PARO.

We want to highlight two specific initiatives bringing our EDI initiative to life:

EDI & PARO Events for Members
Earlier this year, we enlisted our Site Teams assistance in helping us to implement one of our EDI objectives: for each of our sites to hold at least one EDI event each year. Based PARO's EDI framework we created:

- a guide for hosting EDI-focused events and
- inclusion principles to ensure that all PARO events are planned in a way that all our members feel welcome at them.

EDI & Awards
We have been drawing on the experience of our PARO Awards Selection Committee to help us consider how to integrate EDI practices into the PARO Awards with the goal of identifying recommendations.

Respectfully submitted,

Brendan Lew, MD
PARO Board of Directors

June 2nd, 2021

Council Briefing Note

June 2021

Topic:	Update on Council Decisions
Purpose:	For Information
Relevance to Strategic Plan:	Right Touch Regulation, Quality Care, Meaningful Engagement, System Collaboration, Continuous Improvement
Public Interest Rationale:	**Accountability:** Holding Council and the College accountable for the decisions made during the Council meetings.
Main Contacts:	Lisa Brownstone, Chief Legal Officer Craig Roxborough, Director of Policy Adrianna Bogris, Council Administrator
Attachment(s):	N/A

Issue

- To promote accountability and ensure that Council is informed about the status of the decisions it makes, an update on the implementation of Council decisions is provided below.

Current Status

- Council held a meeting on March 4 and 5, 2021. The motions carried and the implementation status of those decisions are outlined in Table 1.

Table 1: Council Decisions from March Meeting

Reference	Motions Carried	Status
01-C-03-2021	The Council approves the items outlined in the consent agenda, which include in their entirety: • The Council meeting agenda for March 4 & 5, 2021 • The minutes from Council held December 3-4, 2020 • The minutes of a Special Meeting of Council held February 9, 2021	Completed.

Reference	Motions Carried	Status
	Items for information: o Executive Committee Report o Discipline Committee Report o Government Relations Report o Finance Report o Policy Report o Medical Learners Report	
02-C-03-2021	The Council approves the policy "Requirement for Successful Completion of Part 2 of the MCCQE – Pandemic Exemption", (a copy of which forms Appendix "B" to the minutes of this meeting).	Completed.
03-C-03-2021	1) The Council of the College of Physicians and Surgeons approves the recruitment of four to five experienced adjudicators to be put forward to Council for appointment to the Discipline Committee. 2) The Council of the College of Physicians and Surgeons of Ontario makes the following bylaw No. 141, to take effect on a date to be determined by the Executive Committee: By-law No. 141 (1) The General By-law is amended by adding the following: **Discipline Committee** 40b. The Discipline Committee shall be known as the Ontario Physicians and Surgeons Discipline Tribunal (OPSDT) in English and Tribunal de discipline des médecins et chirurgiens de l'Ontario (TDMCO) in French, and each reference to the Ontario Physicians and Surgeons Discipline Tribunal or the Tribunal de discipline des Médecins et chirurgiens de l'Ontario, whether orally or in writing, shall be deemed to be a reference to the Discipline Committee of CPSO as specified in the Health Professions Procedural Code, Schedule 2 to the Regulated Health Professions Act, 1991.	In Process. 1) An update will be provided at this June Council meeting 2) The Executive Committee set the effective date as September 1, 2021.
04-C-03-2021	The Council approves the revised policy *"Alternative Pathways to Registration"*, (a copy of which forms Appendix "C" & "D" to the minutes of this meeting).	Completed.

Reference	Motions Carried	Status
05-C-03-2021	The Council approves the revised policy "Delegation of Controlled Acts", (a copy of which forms Appendix "E" to the minutes of this meeting).	Completed.
06-C-03-2021	The Council approves the adoption of the Council Profile (a copy of which forms Appendix "F" to the minutes of this meeting).	In Progress. Will be discussed at a future meeting.
07-C-03-2021	The Council approves the College Performance Management Framework Report (a copy of which forms Appendix "G" to the minutes of this meeting) for submission to the Ministry of Health by March 31, 2021.	Completed.
08-C-03-2021	The Council rescind the College's: a) Methadone Maintenance Treatment for Opioid Dependence policy (a copy of which forms Appendix "H" to the minutes of this meeting); and b) Methadone Maintenance Treatment Program Standards and Guidelines (a copy of which forms Appendix "I" to the minutes of this meeting).	Completed.
09-C-03-2021	The Council appoints the following committee members to the Quality Assurance Committee from April 1, 2021 to December 10, 2021: Dr. Steven Bodley Dr. Jacques Dostaler Dr. Ken Lee Dr. Camille Lemieux Dr. Michael Franklyn Mr. Paul Malette Mr. Peter Pielsticker Dr. Patrick Safieh Dr. Ashraf Sefin Dr. Robert Smith Dr. Tina Tao	Completed.

Council Briefing Note

June 2021

Topic:	Update on Physician Assistant Regulation
Purpose:	For Information
Relevance to Strategic Plan:	Right-Touch Regulation System Collaboration
Public Interest Rationale:	Bringing physician assistants under the authority of CPSO will ensure the protection of patients and work to fulfill our public interest mandate.
Main Contacts:	Miriam Barna, Senior Government Relations Advisor Craig Roxborough, Director Policy
Attachment:	Appendix A: Letter on Physician Assistant Regulation to Minister of Health, October 2019

Issue

- Legislation that would enable the regulation of physician assistants under CPSO was called for a final vote in the Legislature and passed on June 1, 2021. However, the legislation and CPSO's oversight of PAs will not be enacted until a later, currently unknown, date.

- Council is provided with an overview of the history of physician assistant regulation, a summary of the legislation that will enable it, and anticipated next steps regarding the process for implementing regulatory oversight of this profession.

Background

- Physician assistants (PAs) are health-care professionals that work exclusively under the supervision of a physician and act as physician-extenders. PAs perform controlled acts only through delegation and their scope of practice is therefore highly dependent on the individual PA-to-physician relationship.

- PAs have been working in the Canadian Armed Forces for the past 40 years. However, their integration into the non-military health-care system is more recent.

- In Ontario, PAs were introduced into the provincial health-care system in 2007. As of 2019, there were more than 500 PAs practicing in Ontario, with just under 800 in practice across the country.[1]

- PAs also work in Manitoba, New Brunswick, Alberta, and Nova Scotia and are regulated by their province's medical regulatory college in all these provinces other than Nova Scotia, where they are unregulated health-care providers.

- Over the last decade, successive provincial governments have explored with the College different forms of oversight of PAs – ranging from a voluntary registry, the development of a prototype medical directive to PAs, to a full regulatory regime.

- In 2019, government re-initiated conversations with CPSO and indicated that they were interested in pursuing a more robust form of regulation. Government asked the College to revisit its previous proposals and consider a preferred approach to regulation.

    - In October 2019, CPSO wrote to the Minister of Health and proposed that PAs become a new class of member and be subject to a comprehensive regulatory regime as set out by the *Regulated Health Professions Act, 1991* (see Appendix A).

    - In February 2020, government formally requested we work with them to develop a framework to regulate PAs and provide input on legislative change. Between February and June 2020, CPSO staff worked with Ministry staff to help build a framework of regulation and to advocate for the position's set out in our October 2019 letter.

    - In September and December 2020, representatives from the Ministry of Health spoke to Council about their initial plans for regulation and the proposed framework.

Current Status

- As anticipated, government introduced a bill in the spring legislative that included the amendments necessary to bring PAs under CPSO's regulatory authority.

- This bill progressed at an accelerated rate, with just over a month between the bill's introduction and passage.

- With the accelerated timeline, staff worked quickly to analyze the bill, and when concerns were identified, advocate for changes to it. Council was kept in the know through three updates sent via email.

[1] Canadian Institute for Health Information, "Canada's Health Care Providers, 2015 to 2019". Available at: https://www.cihi.ca/en/health-workforce.

- An overview of the bill, the pending framework for regulating PAs, and the next steps are outlined below for Council's information.

Overview of Legislation to Regulate PAs

- Bill 283, Advancing Oversight and Planning in Ontario's Health System Act, 2021 is an omnibus bill and Schedule 3 brings forward amendments to the *Medicine Act* that will regulate physician assistants under CPSO. Information on the other three schedules of Bill 283 are provided in the Government Relations Report.

- Government's framework to regulate physician assistants under CPSO would, once enacted:

    - establish a new physician assistant class of member under CPSO;

    - create title protection for "physician assistant";

    - ensure physician assistants cannot use the title of physician or psychotherapist and are not inadvertently captured in the powers/obligations of a physician in statute outside the *RHPA* or the *Medicine Act;*

    - restrict physician assistants from performing a controlled act unless permitted or in accordance with regulations made by CPSO; and

    - create a new ground of professional misconduct should physician assistants contravene the restrictions on controlled acts.

- It is notable that the bill did not include an obligation to have a physician assistant member of Council.

- In spite of significant advocacy on the part of CPSO staff, and initial assurances that we would see movement on the issue of governance modernization as part of this legislation, government chose not to include any amendments related to CPSO's governance structure.

    - We understand that government has an interest in exploring more comprehensive governance modernization in the coming months (Council is provided with additional information on this in a separate briefing note).

Concerns with Bill 283 and Committee Process

- Overall, Bill 283 brought forward the expected regime for regulatory oversight and in alignment with CPSO's October 2019 proposal, other than the changes related to CPSO's governance structure.

- However, the original version of the legislation, contained one area of significant concern. This version appeared to be moving away from a delegation model of care to one of 'ordering controlled acts'.

    - 'Ordering controlled acts' is a concept that is used in multiple profession-specific acts under the *RHPA* including the *Nursing Act*.

    - Under an 'ordering' framework, the regulated health-care professional is granted the authority to perform the controlled act through legislation and only needs a triggering mechanism to perform it (i.e., an 'order' from another member).

- Currently, and in contrast, PAs are only able to perform controlled acts through delegation – where a physician temporarily transfers their authority to a PA and ultimately the physician remains accountable and responsible for patient care. The model of delegation is also employed in all other provinces that regulate PAs.

- The introduction of the 'ordering framework' was not only unexpected, it also significantly departed from the conversations we have had with government over the past few years.

    - Council may also recall that the Ministry specifically assured Council, when they spoke at the September and December 2020 meetings, that the delegation model would continue under PA regulation.

- It is certainly the view of the College that the existing framework of delegation best reflects and supports how physicians and PAs work together, protects patients' best interests, and has functioned well in CPSO policy and practice to date.

- With the support of the Executive Committee, CPSO President Judith Plante and Registrar Nancy Whitmore expressed these concerns to the Standing Committee on Social Policy, which was considering Bill 283.

    - In the Committee, it was noted that this 'ordering framework' deviates from the model of delegation currently employed in all three provinces that regulate PAs.

    - Further, CPSO expressed concern that this deviation will create significant uncertainty, cause considerable confusion both in practice and in regulation, and will compromise our ability to quickly implement the regulatory framework needed to support the enactment of this legislation.

- CPSO proposed an amendment to the bill that would preserve the delegation framework, ensure alignment with other jurisdictions that regulate PAs, and allow for the nimble development of the necessary regulatory structure.

- Government and the opposition parties recognized the validity of our concerns and our proposal to amend the legislation was supported by the Social Policy Committee and the

concept of 'ordering' has been deleted from the bill. As a result, PAs will continue to practice under delegation.

Implementation

- While Bill 283 has received passage in the Legislature, the legislative changes that will enable CPSO to regulate physician assistants will not come into force until a later date.
    - At this time, we understand that the time period for implementation will be one to two years.
    - Staff continue to seek confirmation from government on their anticipated timeline and updates will be shared with Council as they become available.
- To support implementation, both regulatory and operational work is required. As of now, the following work has been identified:
    - The development of regulations including, but not limited to, those setting out entry to practice requirements (registration) and the performance of controlled acts (delegation). Regulations will need to be drafted, approved by Council, circulated for consultation by both CPSO and government, and ultimately approved and enacted by government.
    - The development of new or modified operational processes including those for registration and practice assessments as well as those related to IT system changes, website modifications, and policy.
    - Collaboration and consultation with PAs and the Canadian Association of Physician Assistants (CAPA), physicians, government, and broader stakeholders.
- To expedite the process and to improve consistency across jurisdictions, CPSO will look to the practices of the other colleges that currently regulate PAs and, wherever possible, seek to align our standards and approach. This work will be guided by the philosophy and tenets of right-touch regulation.
- CPSO has committed to moving forward in a timely manner and opportunities to expedite implementation will be sought.

Next Steps

- Council will be provided with updates on implementation activities and details regarding this timeline as they become available.

October 21, 2019

The Honourable Christine Elliott, MPP
Deputy Premier and Minister of Health
5th Floor, College Park
777 Bay Street
Toronto, ON M7A 2J3

Dear Minister,

RE: Regulation of Physician Assistants

Thank you for the opportunity to provide you with perspectives from the College of Physicians and Surgeons of Ontario (CPSO) regarding the regulation of physician assistants ("PAs"). The CPSO has been in contact with the regulatory branch of the Ministry on this matter and is pleased to work with your team toward the objective of PA regulation.

Since non-military PAs were introduced in Ontario in 2006, the CPSO has provided feedback and a number of different proposals regarding the oversight of PAs, both to the Health Professions Regulatory Advisory Council and the Ministry. Having evaluated the merits of the various proposals over that time, it has been determined that a registry, particularly a voluntary one, is unlikely to achieve the level of oversight desired by government and other stakeholders.

At the same time, there continues to be a relatively small number of PAs in clinical practice in Ontario and we understand that the creation of a stand-alone health regulatory college is viewed to be impractical. We further understand that status for PAs as regulated health professionals is desired to address certain barriers that are perceived to limit them from providing care to the full extent of their abilities.

However, the status of PAs as regulated health professionals would be unique in Ontario for the key reason that PAs are only permitted to provide care under the supervision of a physician who oversees their clinical practice. Unlike regulated health professionals, PAs may not work independently; since their introduction in 2006, the primary oversight mechanism for PAs has been the supervisory relationship between the PA and the supervising physician(s).

This supervisory relationship is a key reason PAs are effective in their role on the health care team as physician-extenders, where their scope of practice to perform controlled acts flows entirely via delegation and is highly dependent on the individual PA-to-physician relationship. The relationship also brings a level of accountability that would not apply to the role of other regulated health professionals. In essence, PAs practice differently than other regulated health professionals and their regulation must be viewed through this lens.

Proposal to Create a New Class of Associate Member

Given this context, we suggest the creation of a new class of "associate member" for PAs under the *RHPA*, similar to the framework that has been adopted in Manitoba and New Brunswick. In our view, the creation of an associate member class for PAs will require a range of regulatory elements, including:

- a mandatory registry;
- title protection;
- entry to practice (registration) requirements;
- continuing professional development requirements;
- policy development relating to the practice of physicians in the context of their relationship with PAs; and
- professional liability protection.

However, given the distinct nature of PA practice as highlighted above, it is unnecessary in our view for the full investigation and disciplinary process for physicians to apply to PAs in all cases. It is proposed that the CPSO receive complaints regarding PA care and conduct, but be enabled to refer those complaints, where appropriate, to the supervising physician(s) for management. Pursuant to the College's *Delegation of Controlled Acts* policy, supervising physicians are already subject to extensive expectations regarding the oversight and assurance of the quality of care provided via delegation, including ensuring that there is ongoing monitoring and evaluation of the acts that are routinely delegated and periodic evaluation of the delegation process itself to ensure its safety and effectiveness.

We anticipate that resources and policies will need to be developed setting out expectations and guidance for supervising physicians around managing complaints against PAs. Where a PA is suspended or terminated from their employment as a result of a complaint or finding, it is anticipated that the supervising physician and the PA would be required to notify the CPSO so that the PA's standing on the register may be updated as a result.

This process will eliminate a layer of unnecessary regulatory oversight and promote the efficient management of complaints at the practice level. While the CPSO will necessarily continue to manage certain kinds of investigations – allegations of boundary violations and sexual abuse, concerns arising out of criminal charges, concerns arising from a pattern of non-compliance with College expectations, etc. – certain complaints will be triaged at an early stage for prompt resolution by the supervising physician(s).

These elements will require further development by the CPSO, assuming this proposal is supportable, but the CPSO will benefit from the experience of other Colleges and jurisdictions as we develop this activity.

Finally, physicians in Ontario currently pay an annual registration fee to support the costs of regulation. If incorporated as associate members of the CPSO, PAs will be expected to bear a similar fee, as well as additional costs associated with initial implementation barring financial contribution from another source.

Alignment with Regulatory Modernization

Implementing the proposal as described above will require legislative and regulatory changes, which we believe presents a greater opportunity to achieve regulatory modernization. As your government moves forward with health system transformation, the CPSO has been pleased to offer initial recommendations

to reduce red tape and achieve a more efficient regulatory structure for health regulatory colleges. This includes modernizing the structure of the CPSO's Council and providing the CPSO with the power to effect change through rules, rather than by regulation, on issues within its core mandate.

In our view, it is imperative that the regulatory framework governing the health professions modernize alongside the rest of the health care system in order for bodies like the CPSO to remain responsive and nimble in a rapidly evolving environment. Incorporating a new class of associate member highlights the need to simplify the time-consuming and cumbersome regulatory development process to better enable health regulatory colleges to effectively manage emerging issues. We look forward to further discussions with your team about how these two projects – regulation of PAs and overall regulatory simplification – can move forward together in a way that maximizes process efficiency and the modernization of the health regulatory college framework.

Next Steps

We look forward to your response to our proposal, as well as further discussions with the Ministry regarding implementation. If you have any questions or wish to discuss further, please contact Laurie Cabanas, Director of Governance and Policy (lcabanas@cpso.on.ca).

Yours truly,

Peeter Poldre, MD, EdD, FRCPC
President

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

c. Helen Angus, Deputy Minister of Health
Heather Watt, Chief of Staff, Minister of Health
Patrick Dicerni, Assistant Deputy Minister, Strategic Policy, Planning & French Language Services Division

Council Briefing Note

June 2021

Topic:	Council Award Recipient
Purpose:	For Information
Relevance to Strategic Plan:	Quality Care Continuous Improvement
Public Interest Rationale:	**Quality Care**: Ensuring that the care provided by individual regulated health professions is of high quality and that the standard of care provided by each regulated health professional is maintained and/or improved
Main Contact:	Janet Eide, Governance Coordinator
Attachment:	None

Issue

- At the June 17, 2021 meeting of Council, **Dr. Sharon Bal** from Cambridge will receive the CPSO Council Award.

Background

- The CPSO Council Award recognizes physicians who demonstrate the ideal qualities that are required to effectively meet the health-care needs of the people they serve. These abilities are articulated in the Royal College of Physicians and Surgeons of Canada's CANMEDS Framework which consist of seven roles:
    - The physician as medical expert (the integrating role)
    - The physician as communicator
    - The physician as collaborator
    - The physician as leader
    - The physician as health advocate
    - The physician as scholar
    - The physician as professional

- A competent physician seamlessly integrates the competencies of all seven CPSO Council Award qualities.

Current Status and Analysis

- Council member Ms. Joan Fisk will present the award.

SOCIETY OF Rural Physicians OF CANADA
SOCIÉTÉ DE LA Médecine Rurale DU CANADA

May 27, 2021

Re: National Approach to Licensure

Honourable _____,

Canada's healthcare system is in crisis. Mobility of health care professionals across jurisdictions must be addressed. We are one country, and all of Canada deserves the best health care in times of crisis but also in regular circumstances.

The COVID pandemic has revealed our healthcare system's pre-existing gaps and weaknesses. As we contend with the third wave of the pandemic, hard hit jurisdictions such as the Greater Toronto area are now requiring "rescue teams" of healthcare professionals including doctors and nurses to travel from other provinces, such as Newfoundland and Labrador, to relieve burned-out local health care providers. The mobilization of out-of-province help was not easy. The Government of Ontario enacted the Emergency Management and Civil Protection Act Regulation 305/21 so that fully licensed professionals from other provinces were able to begin work immediately in Ontario. Without this regulation, out-of-province health care professionals would have needed to comply with the lengthy and expensive process of licensure in another province.

The time is now to explore and pursue a national approach to licensure – as the current segmented regulatory framework is an impediment to the sustainability of Canada's health care system.

Healthcare is a provincial jurisdiction. Each province and territory has their own regulatory college to license healthcare professionals such as physicians and nurses. Physicians and nurses licensed in one province cannot work in another province without going through an application process that can take months and thousands of dollars in fees (over $12,000 if one wishes to be able to work in all 13 provinces/territories). The process requires re-submitting documentation such as high school grades, medical degree, criminal record checks, multiple reference letters, certificates of professional conduct from every jurisdiction the applicant has worked (often even if it was decades ago), and national specialty certification.

Prior to the pandemic, many rural hospitals across the country were already struggling to maintain their human resources so that their programs, such as obstetrical care, emergency care, surgical care, and other specialty care could continue. For example, some surgical programs are kept open by **one** single

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surgeon on-call 24 hours a day, 7 days a week. This is not sustainable. Canadians need access to healthcare practitioners, irrespective of where they live. National licensure would allow health care professionals to work anywhere in Canada. This would promote and support access to care for patients and coverage for providers. As the pandemic continues, burnout of healthcare practitioners is increasing and many are leaving their chosen profession which increases wait times for patients.

A recent (2019) national survey by the Canadian Medical Association confirmed that 91% of physicians supported national licensure and believed it would improve care for patients. Forty-five percent of physicians reported that, if national licensure existed, they would work in other provinces to support their colleagues in times of need, 42% said they were willing to go to rural-remote regions, and 30% said they would do it on an ongoing basis. Even the Canadian Forces feel the full force of regulatory diversity when caring for military patients, whether locally, domestically or internationally. Those health providers who wish to work in their new home province's civilian medical system must apply for a new license. The Federation of Medical Regulatory Authorities of Canada (FMRAC), which includes all the provincial and territorial licensing colleges, advises that no license portability is possible without provincial government legislation that allows it.

We can look to other jurisdictions to address this issue and find a new path forward. Just over 20 years ago, the Australia federal government and all the states cooperated to enact national registration allowing for providers to work anywhere in the country, leading to patient care improvement. We believe this is possible in Canada.

COVID has shown us that the time to act is now. The provision of healthcare to all Canadians needs a national approach to licensure.

We respectfully urge you to take action to enable a national approach to licensure. It is long overdue.

Sincerely,

Dr. Gabe Woollam, MD CCFP FCFP FRRMS
President, Society of Rural Physicians of Canada

Dr. E. Ann Collins, BSc MD
President, Canadian Medical Association

Dr. Catherine Cervin, MD CCFP FCFP MAEd
President, College of Family Physicians

Richard K. Reznick, MD, FRCSC, FACS, FRCSEd (hon), FRCSI (hon), FRCS (hon)
President Royal College of Physicians and Surgeons of Canada

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Dr. Esther Kim
President, Resident Doctors of Canada

Joe Carr, BN/RN, C-CCN, ENC(C)
President - National Emergency Nurses Association

Mr. Joseph Boyle
Interim-President, Canadian Federation of Medical Students

Mark Walsh, MS, MD, FRCSC, FACS
President, Canadian Association of General Surgeons

Dr. Sam Wong, MD LMCC FRCPC
President, Canadian Paediatric Society

Dr. Judy Morris, M.D., M. Sc., FRCPC
President, Association des Médecins D'Urgence du Quebec

Council Briefing Note

June 2021

Topic:	Interprofessional Collaboration: Proposal to Replace Three Statements with One Broader Statement
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation System Collaboration
Public Interest Rationale:	Promoting interprofessional collaboration to ensure patients have access to services and receive high quality health care
Main Contact(s):	Rachel Bernstein, Policy Analyst
Attachment(s):	Appendix A: Draft Statement on Interprofessional Collaboration

Issue

- As part of CPSO's commitment to Right-Touch Regulation and continued modernization, work is being undertaken to evaluate all existing CPSO Statements and Positions to determine if they should be retained, revised or rescinded.

- Three statements related to interprofessional collaboration, *Fostering Collaborative Relationships with Nurse Practitioners* (*Nurse Practitioners* statement), *Physician Working Relations with Pharmacists* (*Pharmacists* statement), and *Midwives*, were identified as being both duplicative and overly narrow in scope.

- Council is provided with a proposal and asked whether these statements can be rescinded and replaced with one broader statement that supports interprofessional collaboration with all health-care professionals more generally.

Background

- Interprofessional collaboration means approaching patient care from a multidisciplinary, team-based perspective, rather than through exclusive domains of practice. It has long been recognized that patients are best served by health professionals who work together to provide quality care.

- In response to changes and/or challenges that were present in the external medical environment in the past, statements promoting collaborative relationships between physicians and nurse practitioners, midwives, and pharmacists were developed and approved by Council to help advance CPSO's goal of improving access to and advocating for quality health care.

    - The *Nurse Practitioners* statement was developed in 2003 to encourage collaborative working relationships between nurse practitioners and physicians following the creation of hundreds of nurse practitioner positions in Ontario.

    - The *Pharmacists* statement was developed in 2005 to support new pharmacy practice models and to highlight how those kinds of initiatives created opportunities for pharmacists and physicians to work together. In addition, once pharmacists were permitted to renew and/or adapt prescriptions for patients in 2012, CPSO also posted a letter[1] reminding pharmacists and physicians to collaborate with one another.

    - The College of Midwives of Ontario and CPSO developed the joint *Midwives* statement in 2010 to emphasize the importance of building positive working relationships between midwives and physicians in response to challenges midwives were facing in their interactions with physicians when delivering maternal care.

Current Status and Analysis

- In keeping with CPSO's commitment to Right-Touch Regulation and continued modernization, all existing CPSO statements are being evaluated to determine if they are still relevant and necessary.

- The evaluation revealed that while the overall message in the *Nurse Practitioners*, *Midwives* and *Pharmacists* statements is important, having one broader statement that promotes interprofessional collaboration more generally would better reflect the realities of practice where all health-care professionals are working in tandem.

- As a result, a proposal has been developed to rescind the *Nurse Practitioners*, *Midwives* and *Pharmacists* statements and replace them with a single statement that promotes interprofessional collaboration more generally.

- The draft statement, attached as **Appendix A**, outlines the importance of interprofessional collaboration and its impact on patient care, reminds physicians of their responsibility to work effectively with health-care professionals from all disciplines, and reaffirms CPSO's commitment to working with other regulators to support and promote these relationships.

[1] The joint letter was from CPSO, the Ontario Medical Association, the Ontario College of Pharmacists, and the Ontario Pharmacists Association, but is on only CPSO's website.

- Rescinding the *Nurse Practitioners*, *Midwives* and *Pharmacists* statements and replacing them with one broader statement would:
    - Remove duplicative content from CPSO's website.
        - While the external medical environment has evolved since these statements were developed and the roles of nurse practitioners, midwives and pharmacists are becoming more well-established, in keeping with CPSO's strategic priority of system collaboration, it is necessary to continue promoting the importance of interprofessional collaboration.
        - However, CPSO could get this message across without having three separate statements that all centre around the same common theme.
    - Support developing collaborative relationships with all health-care professionals more generally.
        - Delivering the best health care to patients means physicians must work with a range of different health-care professionals, not only nurse practitioners, midwives, and pharmacists.
        - A broader statement on interprofessional collaboration would convey that it is essential to work effectively with *all* health-care professionals. It would also formally capture CPSO's intent to work collaboratively with all other regulators and reinforce this message to members.[2]
        - Having a few specific statements on CPSO's website that single out three distinct types of health-care professionals may inadvertently show less regard for other providers and may set an expectation that CPSO ought to develop similar statements with all individual regulators.

Next Steps

- Should Council rescind the *Nurse Practitioners*, *Midwives* and *Pharmacists* statements and replace them with a broader interprofessional collaboration statement, it will be announced to the profession via *Dialogue* and other communication channels, and the new statement will be published on CPSO's website.
    - If Council approves the decision to replace the three statements with a broader interprofessional collaboration statement, the statement will be reviewed for currency periodically.

[2] According to s. 3(1) of the the *Health Professions Procedural Code*, which is Schedule 2 to the *Regulated Health Professions Act*, 1991, S.O. 1991, c.18, CPSO has a number of objects, including to promote interprofessional collaboration with other health profession colleges.

Questions for Council

1. Does Council approve rescinding the *Fostering Collaborative Relationships with Nurse Practitioners*, *Midwives*, and *Physician Working Relations with Pharmacists* statements and replacing them with a broader statement on interprofessional collaboration?

Appendix A

Interprofessional Collaboration: Working Together to Provide Quality Care

The College of Physicians and Surgeons of Ontario (CPSO) is committed to supporting and promoting interprofessional collaboration to improve both the quality of and access to health care in Ontario.

Interprofessional collaboration means approaching patient care from a multidisciplinary, team-based perspective, rather than through exclusive domains of practice. At its core, interprofessional collaboration involves recognizing and valuing the individual roles and contributions of all health-care professionals and fostering relationships that are built on trust and mutual respect. Among other things, working collaboratively involves communicating and exchanging information effectively; encouraging openness and transparency; working together to solve complex problems; developing guidelines and policies that are reflective of each professional's scope of practice; cultivating positive relationships at the institutional level; and sharing decision-making, where appropriate and in the patient's best interest.

Working in collaboration maximizes and utilizes the skills of each contributing health-care professional, which leads to a stronger and more connected health-care system that reduces inefficiencies, increases access to care, and ultimately improves patient outcomes.[1]

CPSO strongly believes that physicians deliver the highest quality of care when working effectively with health-care professionals from different disciplines, including those they work with most, such as midwives, pharmacists, and nurses of all classes. Physicians have a responsibility to collaborate with all health-care professionals, and CPSO is committed to serving the public interest by working with other regulators to support and promote these relationships.

[1] WHO, HRH, HPN. Framework for Action on Interprofessional Education & Collaborative Practice. Geneva: WHO 2010. Available at: https://apps.who.int/iris/bitstream/handle/10665/70185/WHO_HRH_HPN_10.3_eng.pdf;jsessionid=631ABD47231CEF32BE7441F096D62BB8?sequence=1 Accessed December 8, 2020.

Council Motion

Motion Title	Interprofessional Collaboration – Proposal to Replace Three Statements with One Broader Statement
Date of Meeting	June 17, 2021

It is moved by_____, and seconded by_____, that:

The Council rescind the College's:

a) *Fostering Collaborative Relationships with Nurse Practitioners* statement (a copy of which forms Appendix " " to the minutes of this meeting);
b) *Physician Working Relations with Pharmacists* statement (a copy of which forms Appendix " " to the minutes of this meeting); and
c) *Midwives* statement (a copy of which forms Appendix " " to the minutes of this meeting);

and replace them with the new *Interprofessional Collaboration: Working Together to Provide Quality Care* statement (a copy of which forms Appendix " " to the minutes of this meeting).

Council Briefing Note

June 2021

Topic:	Ontario Physicians and Surgeons Discipline Tribunal Logo
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation Meaningful Engagement Continuous Improvement
Public Interest Rationale:	**Accountability**: Holding regulated health professionals accountable to their patients/clients, the College and the public **Protection**: Ensuring the protection of the public from harm in the delivery of health care services **Fairness**: Ensuring that regulatory processes are fair, independent and neutral and perceived to be so by the public, members and other stakeholders **Transparency**: Promoting the clarity and understandability to the public and the profession of discipline processes and decisions
Main Contacts:	David Wright, Tribunal Director and Chair, Discipline Committee Fiona Hill-Hinrichs, Director, Communications and Media
Attachment:	Appendix A: Proposed Logos

Issue

- Council is asked to select a logo for the Ontario Physicians and Surgeons Discipline Tribunal.

Background

- At its March 2021 meeting, Council approved a package of enhancements to the Discipline Committee that included a change in name to the Ontario Physicians and Surgeons Discipline Tribunal (OPSDT) on a date to be determined by the Executive Committee.

- At its May 2021 meeting, the Executive Committee set September 1, 2021 as the date for the name change.

- A central purpose of the change is to signal the independence of the Tribunal from the College, given that the College is the prosecutor and a party before the Tribunal.

- A new and distinct visual identity, to be used on the OPSDT's new website, correspondence, and other communications will highlight the Tribunal's independence for members, the media and the public. A distinct logo is central part of that identity.

Current Status and Analysis

- A branding and design expert within the College's Communications team has developed two draft logos. Council is asked to select one of these as the OPSDT logo.

- Each option is designed in English, French and bilingual versions. As with the CPSO logo, the Communications Department will develop a visual identity guide detailing when each should be used.

- Information behind the branding decisions:

    - The proposed new logos represent the Tribunal's new modern approach – fairness and independence from the CPSO. They are modern, clean, and neutral. Overall, we believe we've created a fresh new brand that the public can trust.

    - The sans serif fonts were chosen as they convey simplicity, modernity and have become the most prevalent for text on computers. They are also the most accessible fonts for people with visual impairments and are viewed as more approachable because of their simplicity.

    - The pillar is a common icon in law and represents peace and security, human rights, and development. The Rod of Aslepius is wielded by the Greek god Asclepius, a deity associated with healing and medicine. It conveys that this is a tribunal for adjudicating cases for physicians and surgeons, specifically.

    - The colour blue was chosen as it symbolizes serenity, stability, trust, and wisdom.

Next Steps

The selected logo will be used in designing the OPSDT's website, templates, documents and forms. The brand for the OPSDT will become the foundation and the logo will become the trademark of the brand. A logo identity system and a strong branding system are both crucial when marketing and promoting a consistent image and voice.

Question for Council

1. Which of the two logos in Appendix A does Council prefer?

english

french

combination english/french

Council Briefing Note

June 2021

Topic:	Proposal for Legislative Change – Governance Modernization and Red-Tape Reduction
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation Continuous Improvement
Public Interest Rationale:	The following changes for governance modernization and red-tape reduction would improve CPSO's ability to effectively regulate and serve in the public interest.
Main Contact(s):	Miriam Barna, Senior Government Relations Advisor Lisa Brownstone, Chief Legal Officer Marcia Cooper, Senior Corporate Counsel and Privacy Officer
Attachment(s):	N/A

Issue

- Government has indicated that they will be initiating a consultation with health regulatory colleges regarding governance modernization over the coming months.

- In anticipation of this upcoming consultation, Council is asked whether it continues to support the previously approved legislative agenda of governance modernization and red-tape reduction and whether there is support for strengthening a number of these proposals.

Background

- Governance modernization has been an area of activity for CPSO since 2016 and a significant priority since 2018.

- In 2018, the Governance Review Working Group (GRWG) was formed and consisted of members from the Executive Committee and Governance Committee. Its objective was to "set governance principles and best-practice structural changes to update and strengthen the integrity of the regulatory system and mandate to ensure public protection".

- The GRWG considered governance best practices, including characteristics of high-performing boards and committees, governance structures of similar organizations, and the external environment. This research led to the establishment of high-level objectives for governance reform that were supported by Council.[1]

- Staff began working on a plan to implement reforms that could be made without legislative change and instead through Council approval of changes to by-law (including term limits and removal of standing committees).

- However, many of the identified reforms required legislative or regulatory change. In March 2019, a proposal for legislative and regulatory change was submitted to the Minister of Health and Long-Term Care and staff was given a mandate to support these conversations with government.

- Since then, staff has been working with government to advocate for the adoption of these suggested changes.

- Over the past year, CPSO has tied advocacy for these changes to government's plan to regulate physician assistants (PAs).

    - Although government had expressed interest in bringing forward some aspects of governance modernization as part of PA regulation, they ultimately did not include these changes in the legislative scheme for PAs.

- We understand that one of government's reasons for not moving forward with governance modernization as part of the legislation to regulate PAs was its view that governance modernization is needed across all health regulatory colleges, and these changes should move forward in a coordinated manner.

- Government has told us it is planning to initiate a consultation on comprehensive governance modernization—achieved through amending the *Regulated Health Professions Act, 1991* (*RHPA)* and profession-specific statutes—over the coming months.

    - It is possible that government may also consider broader red-tape reduction changes to regulatory colleges at this time as well.

- While there is uncertainty whether this work will move forward given the ongoing pandemic, government's competing priorities, and the next election being a year away, this consultation may provide an opportunity to bring forward transformative change, and CPSO needs a clear agenda of change to lead and shape these conversations.

[1] For more information on the work of the Governance Review Working Group and the evidence to support the priorities for reform, see the May 2018 Briefing Note to Council (starting on page 131 of materials).

Current Status and Analysis

- Council is provided with a brief reminder of each proposal, as well as any suggested changes to the previous recommendation, and is asked whether it supports each recommendation.

- Staff will use the recommendations supported by Council as the basis for any upcoming discussions with government.

Governance Modernization Recommendations

- The following represents a catalogue of the governance modernization changes that have been previously supported along with any changes in the analysis that has led to an adjustment in the recommendation.

- Council is asked to consider each in turn and provide direction on the position that should be adopted.

- The intent is to provide CPSO with direction to help shape the government's governance modernization agenda and inform the necessary legislative and regulatory changes.

- Of note, the first three recommendations set out below, must be adopted as a package in order to bring forward meaningful change.

1. Reduce the size of the board

- Currently, CPSO Council is comprised of 34 to 37 members, unevenly split between members of the profession (elected or appointed) and members of the public appointed by the LGIC.

- A range of research and literature has consistently supported a finding that high-performing boards consist of a maximum size of 12 members. Smaller boards have been found to be more efficient in satisfying its mission and better supporting teamwork, participation, communication, decision-making, and flexibility.[2]

- Previously Council supported a range of 12 to 16 board members, however:

    - Best practices continue to support a lower ceiling of 12 members. Recently, we have seen organizations move to a smaller board size, including the Ontario Medical Association, that reduced its board from 26 to 11 directors.

    - Other regulatory colleges continue to support a range up to 12;

[2] For further details on the evidence supporting smaller boards, see the December 2018 Briefing Note to Council (starting on page 87 of materials).

  - The new Health and Supportive Care Providers Oversight Authority, which will govern personal support workers (PSWs) in Ontario, will have a board of 8 to 12 people. This is a good indication of the size of the board, which government will be seeking to implement for health colleges as well.

- As a result, in order to promote alignment with external factors and best practices, a proposal to consider a board of 12 members is being put forward. However, in order to ensure that the board remains constituted should Council members resign or government lapse in a public appointment, it is suggested that a range of 8 to 12 members, rather than a fixed required number, be sought in legislation.

  Decision:
  Does Council support pursuing a board size of 12 with a minimum number of 8 members?

2. Implement a competency-based board selection process

- Currently, Council is composed of a mix of elected and appointed members. Council in turn appoints many non-Council Committee members.

- A competency-based selection process is considered a best practice, as it supports the right mix of knowledge, skills and experience amongst board members to ensure the board is able to effectively discharge its functions.

- In 2018, Council indicated that it preferred a hybrid model that would see some physician Council members appointed and others elected.

- However, since 2018, there is, externally, a growing consensus on the value of competency-based appointments:

  - Recent changes to the Ontario College of Teacher's governance structure will move them to a completely appointment-based model.

  - Competency-based selection for board members continues to be supported by other health colleges, including the College of Nurses of Ontario.

  Decision
  Does Council support pursuing a competency-based appointment process for all members of the board?

3. Eliminate overlap between board and statutory committee membership

- Separation between the board and statutory committees is considered a best practice.
    - Board and statutory committees, other than the Executive Committee, have very different roles (oversight/strategic for the board vs. more detailed, member- and case-specific work for statutory committees), and this separation helps clarify this difference.
- Existing quorum requirements require board member participation on some statutory committees. These requirements are particularly onerous for public members and sometimes make it challenging to establish quorum.
- Separating committee membership from the board will enhance the integrity and independence of the board and statutory committees and help strengthen public confidence in the regulatory system.
- This is an essential change should the board size be reduced to 12.

Decision
Does Council continue to support the elimination of overlap in membership between the board and statutory committees?

4. Equal composition of public and professional members on board

- A board with an equal number of public and professional members is recognized internationally as a governance best practice. Currently, public members occupy less than half of Council.
- Ensuring a balance between public and professional members will allow for a broader range of expertise and competencies on Council and help strengthen public confidence in the regulatory system.

Decision
Does Council continue to support the equal composition of public and professional members on Council?

5. *Allow CPSO to compensate public members*

- CPSO has long argued that government's compensation scheme for public members is inadequate and unbalanced against the compensation received by physician members of Council.

- CPSO compensates physician members of Council and has sought the ability to compensate public members as well. Legislative change is required for CPSO to be able to do this. Like that for physician members of Council, the rate of compensation would be set in by-law.

  Decision
  Does Council continue to support CPSO's ability to compensate public members?

6. *Eliminate the Executive Committee*

- The previous legislative change submission recommended keeping the option of an Executive Committee should the board have 16 members.

- If Council were reduced to 12 members, the need for an Executive Committee would be further diminished.

- This proposal aligns with governance best practices outlined in the above noted materials, and the recommendations of the College of Nurses of Ontario.

  Decision
  Does Council support eliminating the Executive Committee should Council be reduced to 12 members?

7. *Presidential term*

- One-year terms are not considered best practice and instead are seen as hyper-rotation.

- In keeping with ongoing considerations and discussion regarding this issue, legislative change would promote stability and enable flexibility regarding the length and appointment process for the Presidential and Vice-Presidential terms. This would enable CPSO and other Colleges to determine the approach that works best for them.

- There are a number of models that can be implemented. Ideally, the model in legislation would not be prescriptive, but would allow for by-laws to be created to address this issue.

- Council is also asked to consider whether it supports changing the terminology of President/Vice-President to Chair/Vice-Chair. This language is in keeping with board nomenclature more broadly and clarifies the role of Council as the governing board.

Decision
Does Council support the ability to have greater flexibility in the Presidential and Vice-Presidential terms by seeking the power to set term length and appointment process via by-law? Does Council support a change in terminology to Chair and Vice-Chair?

8. Urge government to address title protection for "osteopath"

- *The Medicine Act* provides title protection for "osteopath". This has led to significant confusion as osteopathy is not a regulated profession in Ontario.

- There are a small number of members of CPSO whose undergraduate medical degrees are Doctor of Osteopathic Medicine, a degree granted by some American institutions.

- Currently, only these members of the College can use the title "osteopath".

- However, in spite of this restriction, there are a great number of people in Ontario who are not a Doctor of Osteopathic Medicine but who refer to themselves as osteopaths.

- Government could take a number of possible approaches to rectify the confusion surrounding title protection of "osteopath" and clarifying CPSO's role in protecting the title.

Decision
Does Council support advocacy to encourage government to better address use of the title "osteopath"?

Red-Tape Reduction Recommendations

- While not specific to governance modernization, many previously recommended changes support or enhance our regulatory function.

- Government may be willing to consider these changes as part of its broader modernization effort because they intersect with or are restricted by the *RHPA* and *the Medicine Act*.

9. Allow CPSO to make rules relating to its core functions

- Updating and maintaining regulations under the *RHPA/Code* is onerous on government and health Colleges. Many matters that fall within CPSO's core regulatory mandate must be addressed through regulation change. This process is duplicative, time-consuming, and inefficient.

- CPSO recommends that the College's regulation-making powers under the Code including, but not limited to, registration, promotion and advertising, standards of practices, and quality assurance be moved to either College by-law authority or another instrument at the discretion of Council.

- This would avoid the inefficient regulation approval process and enable both government and the College to be more agile and responsive in serving the public interest.

  Decision
  Does Council support enabling CPSO to utilize internal tools (e.g. by-law and policy) to address matters relating to our core functions?

10. Expand CPSO's discretion to investigate complaints

- CPSO requires greater discretion to manage complaints unrelated to patient care and professional conduct in order to focus our regulatory actions on the most serious patient safety concerns.

- By defining the definition of complaint more narrowly, matters that fall outside the definition would be considered as "reports" and the registrar would exercise discretion as to whether the matters warrant investigation.

- CPSO recommends that changes are needed to the definition of complaint in order to direct resources to investigations that serve the public interest.

  Decision
  Does Council support this approach to expanding CPSO's discretion to investigate complaints?

11. *Streamline the handling of frivolous, vexatious complaints*

- The process by which the Inquiries Complaints and Reports Committee (ICRC) is required to give notice if it intends to take no action on the basis that a complaint is frivolous, vexatious, etc., is lengthy and requires at least two ICRC meetings.

- CPSO proposes that this process be simplified so that either the Registrar or Committee can give the initial notice (currently only the Committee can provide that notice). If neither party responds, the matter shall be at an end. If one or both parties respond, it would go back to the Committee to decide whether the matter is indeed frivolous or vexatious.

- The right to appeal to HPARB from the Committee's final decision would remain.

  Decision
  Does Council support this approach to streamlining frivolous, vexatious complaints?

12. Enable CPSO to share information with hospitals

- In most circumstances, CPSO is circumscribed in sharing information regarding an investigation with a doctor's privileging hospital(s). *The Public Hospitals Act* is not listed as an act that is exempted from our confidentiality requirements.

- This unnecessary barrier poses a threat to patient safety, can lead to duplicative investigations, and result in delayed action on a systemic issue.

  Decision
  Does Council support amendments to support better information sharing with hospitals?

13. Clarify the application of the *Mental Health Act* in CPSO hearings

- The *Mental Health Act* contains language that acts as a significant barrier to College discipline proceedings.

- The legislation has the potential to shield physicians working in a mental health facility from having their quality of care and conduct reviewed in the same way as physicians working in other settings.

- Although the College can review the records in an investigation, it cannot proceed to a hearing without making separate applications to the Divisional Court or notifying each patient whose records were reviewed and seeking their permission

- CPSO proposes the legislation be amended to clarify the *Mental Health Act's* application to college proceedings.

  Decision
  Does Council support an exemption to this portion of the *Mental Health Act* with regard to CPSO proceedings?

Next Steps

- Staff will engage in the government's consultation process and keep the Executive Committee and Council apprised on the progress of these conversations.

Council Motion

Motion Title: Proposal for Legislative Change – Governance Modernization and Red-Tape Reduction

Date of Meeting: June 17, 2021

It is moved by_____, and seconded by_____, that:

The Council authorizes discussions with government for legislative change based on the content of the briefing note regarding governance modernization and red-tape reduction (a copy of which forms Appendix “” to the minutes of this meeting).

Council Briefing Note

June 2021

Topic:	*Female Genital Cutting (Mutilation)* Policy – Approval to Rescind or Replace the Policy with a Statement
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation Continuous Improvement
Public Interest Rationale:	Serving the people of Ontario by adopting a proportionate and agile regulatory approach.
Main Contact(s):	Courtney Brown, Policy Analyst Rachel Bernstein, Policy Analyst
Attachment(s):	Appendix A: Draft Statement on Female Genital Cutting (Mutilation)

Issue

- The *Female Genital Cutting (Mutilation)* (FGC/M) policy is overdue for a full policy review. Prior to initiating this review, a needs assessment was conducted to determine whether the FGC/M policy is in keeping with CPSO's commitment to Right-Touch Regulation and continued modernization.

- The evaluation identified that the FGC/M policy may no longer be needed, and Council is provided with an overview of options for how to proceed.

- Council is asked whether the FGC/M policy can be replaced with a statement opposing the practice and reminding physicians of their legal obligations in relation to FGC/M, or in the alternative, rescinded outright.

Background

- The FGC/M policy, which outlines physicians' obligations with respect to FGC/M, was first approved by Council in 2001 and last reviewed and updated in 2011.[1]

[1] Although CPSO aims to initiate policy reviews approximately five years after each policy was last approved, the FGC/M policy has been historically deprioritized in order to support other policy or organizational initiatives.

- As part of CPSO's commitment to Right-Touch Regulation and policy modernization, work was undertaken in 2018 to evaluate all existing CPSO policies in order to identify those that were no longer required.
    - This initial analysis identified three policies, including the FGC/M policy, for possible rescission.
- In December 2018, Council was provided with a detailed overview of the analysis undertaken and asked whether these policies could be rescinded. Specifically, in relation to FGC/M, they were provided with the following information:
    - Under Canada's *Criminal Code*, the performance of FGC/M procedures is considered aggravated assault. Further, the Ontario Human Rights Commission recognizes that FGC/M violates the basic human rights and human dignity of women and girls.
    - It is an act of professional misconduct under the *Medicine Act, 1991* to contravene a federal law (e.g. the *Criminal Code*), where the purpose of the law is to protect the public's health or the contravention is relevant to the member's suitability to practise. The performance of or referral for FGC/M procedures would, therefore, be regarded as professional misconduct.
    - To support physicians who encounter instances or potential instances of FGC/M in a clinical environment, the Society of Obstetricians and Gynecologists of Canada has developed a comprehensive clinical guideline (SOGC Guideline).[2]
- While Council approved rescinding the other two policies under consideration in December 2018,[3] Council had concerns with rescinding the FGC/M policy and deferred the decision.
    - While Council was receptive to the rationale for rescinding the FGC/M policy, they expressed concern that rescinding it could erroneously indicate that CPSO was retracting its disapproval of the practice.
    - Council felt it was important for CPSO to clearly denounce FGC/M, and the policy had value in this regard even if it was not required in order to effectively regulate physician conduct.

Current Status and Analysis

- The FGC/M policy is currently overdue for a full policy review. Before proceeding with a full review, policy staff sought to revisit the needs assessment undertaken in 2018, informed by

[2] For more information please see the SOGC's Clinical Practice Guideline No. 395-Female Genital Cutting.
[3] The *Anabolic Steroids, Substances and Methods Prohibited in Sport* and the *Fetal Ultrasound for Non-Medical Reasons* policies were both rescinded.

the feedback provided by Council.

- The evaluation revealed that the reasons the FGC/M policy was identified for possible rescission in 2018 are still true today.
    - It reiterates expectations and obligations that are already established in legislation or other policies;
    - Other resources that set out the relevant standards/guidelines for physicians with respect to FGC/M already exist elsewhere; and
    - Internal data indicates that the policy is accessed infrequently and has not been the subject of significant physician or public engagement.[4]
- In light of this, Council is provided with an overview of two different options:
    - (1) Rescinding the policy and replacing it with a statement; or
    - (2) Rescinding the policy outright.

Option 1: Replace the FGC/M Policy with a New FGC/M Statement

- In response to Council's feedback, a new proposal was developed to address Council's concerns while fulfilling CPSO's commitment to Right-Touch Regulation and continued modernization. More specifically, the proposal includes rescinding the current policy and replacing it with a statement on CPSO's website.
- The draft statement, attached as **Appendix A**, expressly denounces the practice of FGC/M and reminds physicians that performing, assisting in, or referring patients for FGC/M procedures is a criminal offence and constitutes professional misconduct. It also outlines physicians' reporting obligations with respect to FGC/M, and directs physicians to helpful resources, including the SOGC Guideline.
    - Replacing the policy with a statement fulfills Council's desire to clearly denounce the practice of FGC/M and the harm it can cause, but ensures this denunciation is achieved through the appropriate regulatory tool.
    - As noted above, prohibitions on the practice already exist in legislation and other resources are available which set out expectations for physicians regarding FGC/M.

[4] As noted in the December 2018 Council Briefing Note, the FGC/M policy had not been cited in decisions of the Inquiries, Complaints, and Reports Committee (ICRC) since 2012; Public and Physician Advisory Services had not received a sufficient number of inquiries to enable data reporting in this area; and the FGC/M policy had had 521 views, which accounted for 0.01% of visits to the policy section of the website, between September 2017 and August 2018. In addition, between January 2019 and April 2021, neither Physician nor Public Advisory Services has documented any calls about FGC/M; the FGC/M policy has had 1,399 views, which accounts for only 1.6% of visits to the Policy section of CPSO's website; and the FGC/M policy has not been cited in decisions of the ICRC.

As a result, a policy adds no additional regulatory function, and the primary intent of the policy – a denunciation – can be effectively achieved through a statement.

Option 2: Rescind the FGC/M Policy Outright

- Upon being presented with the above option and analysis, the Executive Committee recommended that Council also be invited to once again consider rescinding the policy outright rather than replacing it with a statement.

- From a regulatory perspective, the FGC/M policy is not necessary to guide the profession, as the expectations and obligations with respect to the practice are already clearly set out in law and elsewhere. Replacing the policy with a statement could also be seen as duplicative for the same reason.

- Keeping the FGC/M policy on CPSO's website or replacing it with a statement would also treat FGC/M as exceptional relative to other criminal acts and human rights violations.

    - It may suggest that CPSO ought to develop similar policies or statements reminding physicians of other criminal acts, such as assaulting patients, and/or denouncing other human rights violations, such as forced sterilization, which similarly warrant a clear denunciation.

Next Steps

- Should Council rescind the current policy, Council's decision will be announced to the profession via *Dialogue* and other communication channels, and should Council replace the FGC/M policy with the new FGC/M statement, it will be published on CPSO's website.

    - If Council wishes to replace the FGC/M policy with a statement, the statement will be reviewed for currency periodically.

Questions for Council

Does Council:

a) approve rescinding the current FGC/M policy?

- OR -

b) approve rescinding and replacing the FGC/M policy with the new FGC/M statement?

Appendix A

Female Genital Cutting (Mutilation)

Female genital cutting/mutilation (FGC/M) is internationally recognized as a harmful practice that results in the violation of human rights. [1] FGC/M refers to procedures that involve the infibulation, excision or mutilation, in whole or in part, of the labia majora, labia minora or clitoris.[2]

Performing, assisting in or referring patients for FGC/M procedures is illegal in Canada, as the *Criminal Code* identifies FGC/M as aggravated assault. It is also a criminal act to remove a child under the age of 18 from Canada to perform FGC/M on them.[3] Performing or contemplating performing FGC/M on anyone under the age of 18 raises child protection concerns, and physicians have a legal obligation to notify child protection authorities if they have reasonable grounds to believe that any child under the age of 18 has undergone, or is at risk of undergoing, an FGC/M procedure, regardless of where the procedure has been or may be undertaken.[4] Physicians who have reasonable grounds to believe that another physician is performing FGC/M procedures must also report this information to the College of Physicians and Surgeons of Ontario (CPSO).[5]

Many international, national, and regional bodies, including the Ontario Human Rights Commission, the World Medical Association and The Society of Obstetricians and Gynaecologists of Canada (SOGC), have released statements opposing the practice and participation of physicians in FGC/M.

CPSO strongly condemns the practice of FGC/M and recognizes it as a form of gender-based violence that violates physical integrity and psychological well-being. Physicians will be subject to disciplinary measures if they perform, assist in or refer patients for FGC/M procedures.[6]

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[1] OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO. Eliminating female genital mutilation: an interagency statement. Geneva: WHO 2008: 22–7. Available at: https://apps.who.int/iris/bitstream/handle/10665/43839/9789241596442_eng.pdf?sequence=1 Accessed December 13, 2019 (hereinafter, Interagency Statement).

[2] Except where performed for the benefit of the physical health of the person or for the purpose of the person having normal reproductive function, sexual appearance or function, or the person is at least 18 years of age and there is no resulting bodily harm. See s. 268(3) of the *Criminal Code*, R.S.C., 1985, c. C-46 (hereinafter, *Criminal Code*).

[3] See ss. 268(3), 21-22 and 273.3(1) of the *Criminal Code*.

[4] See s. 125(1) of the *Child, Youth and Family Services Act, 2017*, S.O. 2017, c. 14, Sched. 1 and s. 273.3(1) of the *Criminal Code*, as well as the College's policy, Mandatory and Permissive Reporting.

[5] See the Mandatory and Permissive Reporting Policy.

[6] Among other things, under to the *Medicine Act, 1991*, it is an act of professional misconduct for a physician to contravene a federal law (e.g., the *Criminal Code*) if the purpose of the law is to protect public

Physicians play an important role in opposing and denouncing the practice of FGC/M. Physicians can support patients by educating themselves on how to properly manage possible complications related to FGC/M, and by providing culturally sensitive counseling to families about the dangers of the practice.

Physicians who encounter patients who have undergone FGC/M can obtain guidance from sources such as the SOGC's comprehensive Clinical Practice Guideline (the Guideline).[7] Among other things, the Guideline provides direction on legal issues related to the practice, as well as guidance for the management of obstetrical and gynaecological complications related to FGC/M. Physicians can also consult the interagency statement, *Eliminating Female Genital Mutilation*, to strengthen their knowledge and understanding of the practice of FGC/M.[8]

health, or the contravention is relevant to the member's suitability to practise medicine. Furthermore, according to s. 51(1)(a) of the *Health Professions Procedural Code*, which is Schedule 2 to the *Regulated Health Professions Act*, 1991, S.O. 1991, c.18, a panel shall find that a member has committed an act of professional misconduct if the member has been found guilty of an offence that is relevant to the member's suitability to practice, such as the FGC/M-related provisions of the *Criminal Code*.

[7] For more information, please see the SOGC's Clinical Practice Guideline: Female Genital Cutting.

[8] Interagency Statement.

Council Motion

Motion Title	Female Genital Cutting (Mutilation) – Approval to Rescind or Replace the Policy with a Statement
Date of Meeting	June 17, 2021

It is moved by_____, and seconded by_____, that:

The Council rescind the College's *Female Genital Cutting (Mutilation)* policy (a copy of which forms Appendix " " to the minutes of this meeting).

- OR -

The Council rescind the College's *Female Genital Cutting (Mutilation) policy* (a copy of which forms Appendix " " to the minutes of this meeting) and replace it with the new *Female Genital Cutting (Mutilation)* statement (a copy of which forms Appendix " " to the minutes of this meeting).

Council Briefing Note

June 2021

Topic:	Academic Registration Policy
Purpose:	For Decision
Relevance to Strategic Plan:	• Right-Touch Regulation • Continuous Improvement
Public Interest Rationale:	**Accessibility:** Ensuring individuals have access to services provided by the health profession of their choice and individuals have access to the regulatory system as a whole
Main Contact(s):	Samantha Tulipano, Director, Registration & Membership Services, ext. 709
Attachment(s):	Appendix A: *Academic Registration* – Existing Policy Appendix B: *Academic Registration* – Revised Draft Policy

Issue

- Council is being asked to approve the Registration Committee's recommendations to the existing policy on Academic Registration.

Background

- The Registration Regulation provides for the issuance of a certificate of registration authorizing Academic Practice provided the applicant holds a geographical full-time teaching and/or research appointment to the academic staff of an accredited medical school in Ontario at the rank of Full or Associate Professor.
- Additionally, the applicant must hold certification by the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College of Family Physicians of Canada (CFPC).
- No time limit is imposed. The certificate terminates only when the candidate no longer holds an academic appointment or is no longer certified by the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada.
- Like other certificates that meet the Regulation requirements, approval from the Registration Committee is not required.

Academic Policy for Assistant Professors

- In 2002, Council approved the Academic policy for Assistant Professors, which provided issuance of a certificate of registration for Junior Professors should the applicant have a geographical full-time teaching and/or research appointment to the academic staff of an accredited medical school in Ontario.
- The policy provided an exemption from the *Registration Regulation* requirements of (1) holding certification by the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada provided the applicants hold specialist certification from a recognized jurisdiction and (2) being appointed at the rank of Full or Associate Professor.
- The certificate of registration automatically expires seven years from the date of issuance or when the physician no longer holds the academic appointment.
- Additionally, the medical school offering the appointment is required to assess the assistant professor's clinical and academic performance and submit annual reports to the Registration Committee in a form that is satisfactory to the College.

Academic policy for Full or Associate Professors

- In 2007, Council approved the Academic policy for Full or Associate Professors which provided issuance of a certificate of registration for Associate/Full Professors who did not hold specialist certification from the Royal College of Physicians and Surgeons of Canada as required under the Registration Regulation.
- The certificates approved under the policy for Full or Associate Professors do not carry a term of expiry and expires only when the candidate no longer holds and academic appointment.
- Additionally, the medical school offering the appointment is not required to provide reports to the College.

Current Status and Analysis

- Prior to reviewing the specific changes being proposed, it is important to note some key features of an academic practice:

    - An academic setting has an infrastructure in place for review of clinical and academic performance of all staff;
    - An academic appointment includes a combination of clinical and academic work;
    - The academic practice certificate permits an individual to practice medicine only within an academic environment.

1. Specialist Recognition

- The eligibility requirements under the policy currently stipulate that an individual will be deemed eligible to apply under the Academic Registration Policy provided the applicant:

    (i) holds specialist certification by the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada,
    (ii) holds specialist certification by a board in the US that is a regular member of the American Board of Medical Specialties, or
    (iii) is recognized as a specialist by an organization outside of North America that recognizes medical specialists.

    Clause (iii) can be problematic in application, as individuals can obtain certification by means other than examination, and from organizations that have been deemed to not have the same standards that we employ.

RECOMMENDATION:

Amending clause (iii) of the policy as follows:

    iii. Are recognized as a specialist in the jurisdiction where you practice medicine by an organization outside of North America that recognizes medical specialties, and the organization which recognized you as a medical specialist did so using standards that are substantially similar to the standards of the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada;

- Additionally, it has been the practice of the Registration Committee when granting registration under the policy to indicate that physicians must be recognized as a specialist in the same discipline they are being recruited for appointment in Ontario, however this information is not stated in the policy. We suggest adding this stipulation to eligibility requirements to provide increased transparency.

2. Academic Professors Requesting a Practice Assessment

- After a minimum of five years of practice in an academic setting, a physician may apply to undergo a practice assessment by the College.
- Upon satisfactory completion of the practice assessment the physician will be eligible for a restricted certificate of registration to practice independently in the scope of practice assessed.

- Currently, the policy states that the academic physician must first apply to the Registration Committee to request approval to undergo a practice assessment, even though the assessment is already permitted under the policy and the terms of the certificate.

RECOMMENDATION:

- It is recommended that the policy be amended to state that after five years of practice in an academic setting, a physician "may apply to the **College** to undergo a practice assessment".
- This would transfer the initiation of the assessment from the Registration Committee to the College, provide increased clarity and streamline the overall process.
- The Registration Committee would still consider the final assessment report.

3. Simple Language Redesign

- In 2018, Council approved a proposal to redesign all policies to be clearer and more concise, without meaningfully altering the core content of the policy themselves.

RECOMMENDATION

- It is recommended that the simplified language changes be adopted alongside the previous recommendations.

Questions for Council

1. Does Council agree that this issue supports the strategic plan and our role in serving the public interest?

2. Does Council approve the Registration Committee's recommendations to the existing policy on Academic Registration?

ACADEMIC REGISTRATION

Approved by Council: November 2009

Enables CPSO registration for academic practice for eligible applicants who do not meet the regulatory requirements (e.g. certification by examination by the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada) for a regular Academic Practice Certificate.

Purpose

This policy sets out the registration requirements for individuals who are being recruited by medical schools in Ontario for an academic position at the rank of assistant, associate or full professor and who do not meet the requirements for a certificate of registration authorizing academic practice set out in Ontario Regulation 865/93 under the *Medicine Act, 1991*.

Definitions

Full Time Clinical Academic Appointment:[1] an academic appointment that includes a combination of clinical and academic work

Academic Setting: a setting that has an infrastructure in place for reporting clinical and academic performance

Policy

Junior Faculty

Assistant Professors

The Registration Committee may direct the Registrar to issue a certificate of registration authorizing academic practice to an applicant,

1. If the applicant has degree in medicine as defined in Ontario Regulation 865/93 under the *Medicine Act, 1991*;
2. If the applicant:
    1. holds specialist certification by the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada,
    2. holds specialist certification by a board in the United States of America that is a regular member of a board of the American Board of Medical Specialties, or
    3. is recognized as a specialist by an organization outside of North America that recognizes medical specialists;
3. If the applicant has been offered a full time clinical academic appointment to the faculty of an accredited medical school in Ontario at the rank of assistant professor;
4. If the applicant has agreed to a written job description, which provides that the applicant will be involved in clinical practice, teaching, research, administration, or clinical development and evaluation or some combination of these; and,
5. If the medical school offering the appointment agrees to assess the applicant's clinical and academic performance and to submit annual reports to the Registration Committee in a form that is satisfactory to the College.[2]

The following terms, conditions and limitations will be attached to a certificate of registration authorizing academic practice for assistant professors:

1. The physician may practise medicine only,
    1. in a setting that is approved by the Chair of the department in which the physician holds an academic appointment at the rank of assistant professor, and
    2. in accordance with the requirements of their academic appointment.

2. The certificate of registration automatically expires seven years from the date of issuance, or when the physician no longer holds the academic appointment at the rank of assistant professor.
3. The certificate of registration automatically expires, but may be renewed by the Registration Committee, with or without additional or other terms, conditions and limitations, if:
    1. the Registration Committee receives a report indicating that the physician's clinical performance, knowledge, skill, judgment, professional conduct, or academic progress is unsatisfactory, or
    2. the Registration Committee does not receive an annual report or receives a report that is unsatisfactory in form or content.

Senior Faculty

Full or Associate Professors

The Registration Committee may direct the Registrar to issue a certificate of registration authorizing academic practice, to an applicant:

1. If the applicant has a degree in medicine as defined in Ontario Regulation 865/93 under the *Medicine Act, 1991*;
2. If the applicant:
    1. holds specialist certification by the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada,
    2. holds specialist certification by a board in the United States of America that is a regular member of a board of the American Board of Medical Specialties, or
    3. is recognized as a specialist by an organization outside of North America that recognizes medical specialists; and
3. If the applicant has been offered a full time clinical faculty appointment to the academic staff of an accredited medical school in Ontario at the rank of full or associate professor.

The following terms, conditions and limitations will be attached to a certificate of registration authorizing academic practice for full or associate professors:

1. The physician may practise medicine only,
    1. in a setting that is approved by the Chair of the department in which the applicant holds an academic appointment at the rank of full or associate professor, and
    2. in accordance with the requirements of their academic appointment.
2. The certificate of registration automatically expires when the physician no longer holds the academic appointment.

Application for a Restricted Certificate of Registration

After a minimum of five years of practice in an academic setting, a physician may apply to the Registration Committee to undergo a practice assessment by the College. Upon satisfactory completion of the practice assessment, the physician will be eligible to apply for a restricted certificate of registration.

Endnotes

[1] In this document, Full Time Clinical Academic Appointment does not require that the individual must practice a certain number of hours per week. The individual, however, must hold a full time clinical academic appointment and may only practice medicine in an academic setting, under the aegis of the academic head.

[2] Report is to be provided by the Chair of the Department where the applicant has the appointment, except for the Northern Ontario School of Medicine (NOSM), where the Department Chair or equivalent may submit the report to the College. In situations where the Chief of the Clinical Department is a separate person from the Chair of the Department, the College expects that the Chair in preparing the report to the College will obtain feedback on the clinical performance of the physician from the Chief of the clinical department where the physician is practising.

1. Academic Registration

Find guidance for applicants who do not meet the requirements for a regular academic practice certificate.

This policy is for applicants recruited by an Ontario medical school for an academic position, but who do not meet the usual requirements for an academic practice certificate. (The usual requirements include certification by the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada.) **This policy applies for positions of assistant, associate or full professor**.

Requirements

You may be issued a certificate of registration authorizing academic practice if:

1. you have a degree in medicine as defined in Ontario Regulation 865/93 under the *Medicine Act, 1991*;
2. you:
    i. hold specialist certification by the Royal College of Physicians and Surgeons of Canada ("RCPSC") or the College of Family Physicians of Canada ("CFPC"), **or**
    ii. hold specialist certification by a board in the United States of America that is a regular member of a board of the American Board of Medical Specialties, **or**
    iii. are recognized as a specialist in the jurisdiction where you practice medicine by an organization outside of North America that recognizes medical specialties, and the organization which recognized you as a medical specialist did so using standards that are substantially similar to the standards of the RCPSC or the CFPC;
3. you have been offered a full time clinical academic appointment to the faculty of an accredited medical school in Ontario at the rank of assistant, associate or full professor; and
4. you are recognized in the same discipline you are being recruited for appointment in Ontario.

There are additional requirements for assistant professors:

1. A written job description stating that you will be involved in clinical practice, teaching, research, administration, or clinical development and evaluation or some combination of these; and
2. An agreement from the medical school to assess your clinical and academic performance and to submit annual reports in a form that is satisfactory to the CPSO.

Terms, conditions and limitations

1. The following terms, conditions and limitations will be attached to a certificate of registration authorizing academic practice for all professors: You may practise medicine

only in a setting that is approved by the Chair of the department in which you hold an academic appointment at the rank of assistant, associate, or full professor, and in accordance with the requirements of your academic appointment.
2. The certificate automatically expires when you no longer hold the academic appointment.

In addition, for assistant professors:

1. The certificate of registration automatically expires seven years from the date of issuance, or when you no longer hold the academic appointment at the rank of assistant professor.
2. The certificate of registration automatically expires, but may be renewed by the Registration Committee, with or without terms, conditions and limitations, if the Registration Committee:

    i. receives a report indicating that your clinical performance, knowledge, skill, judgment, professional conduct, or academic progress is unsatisfactory, or
    ii. does not receive an annual report, or
    iii. receives a report that is unsatisfactory in form or content.

Application for a restricted certificate of registration

After a minimum of five years of practice in an academic setting, you may apply to the College to undergo a practice assessment. Upon satisfactory completion of this assessment, you will be eligible to apply for a restricted certificate of registration limited to the area of practice that was assessed.

End Notes:

Full Time Clinical Academic Appointment: an academic appointment that includes a combination of clinical and academic work. In this document, Full Time Clinical Academic Appointment does not require that the individual must practice a certain number of hours per week. The individual, however, must hold a full time clinical academic appointment and may only practice medicine in an academic setting, under the aegis of the academic head.

Academic Setting: a setting that has an infrastructure in place for reporting clinical and academic performance.

Council Motion

Motion Title	Academic Registration
Date of Meeting	June 17, 2021

It is moved by_____, and seconded by_____, that:

The Council approves the revised policy “Academic Registration”, (a copy of which forms Appendix “ ” to the minutes of this meeting).

Council Briefing Note

June 2021

Topic:	*Professional Responsibilities in Medical Education* – Revised Draft Policy for Final Approval
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation Quality Care
Public Interest Rationale:	Ensuring that patients receive quality care from learners and that physicians are accountable for providing supervision to learners.
Main Contact(s):	Lynn Kirshin, Senior Policy Analyst
Attachment(s):	Appendix A: Revised draft *Professional Responsibilities in Medical Education* policy Appendix B: Revised draft *Advice to the Profession: Professional Responsibilities in Medical Education* document

Issue

- The College's *Professional Responsibilities in Undergraduate Medical Education* and *Professional Responsibilities in Postgraduate Medical Education* policies are currently under review. A new consolidated draft policy, *Professional Responsibilities in Medical Education*, was released for external consultation in September 2020, along with a companion *Advice to the Profession* document (*Advice*). That draft policy and *Advice* have been revised in light of the feedback received through this engagement activity.

- Council is provided with an overview of the key issues considered by the Working Group as well as the proposed revisions to the draft policy and is asked whether the revised draft policy can be approved as a policy of the College.

Background

- The current *Professional Responsibilities in Undergraduate Medical Education* policy and *Professional Responsibilities in Postgraduate Medical Education* policy were last reviewed and approved by Council in 2021 and 2011, respectively.

- Following extensive research[1] and a preliminary consultation[2], a new consolidated draft policy was developed with direction from the standing Policy Review Working Group[3]. Additional support was provided by Sayran Sulevani (Legal Counsel) and Nathan Roth (Medical Advisor).

- The draft policy was approved for external consultation by Council in September 2020. The accompanying *Advice* was also released at this time.

    - A total of 130 responses were received as part of the consultation[4]. The majority of respondents were physicians, along with 11 organizational stakeholders.[5]

    - Overall, the majority of the feedback was supportive of the draft policy. Respondents described the draft policy as easy to understand and well-organized. All of the consultation feedback received has been posted on a dedicated page of the College's website.[6]

- With respect to the expectations regarding consent for medical student and postgraduate trainee involvement in care, by and large they were supported by the consultation feedback. However, significant and divergent perspectives emerged as part of the discussion:

    - Many consultation responses showed strong support of the importance of respecting patient autonomy and choice in the context of involving learners. However, many respondents (including physicians and organizations) raised significant concerns with the implications of requiring express consent for learner participation. Most notably, the Council of Faculties of Medicine (COFM) undergraduate and postgraduate Deans were concerned that these expectations might conflict with existing institutional approaches to education, which could lead to barriers to care and the disruption of learning environments.
    - As well, respondents acknowledged that in learning environments there are instances where it is appropriate for medical students to see the patient

[1] This included a literature review of scholarly articles and research papers; a jurisdictional review of Canadian medical regulatory authorities, medical schools and relevant physician organizations; relevant statistical information and review of cases from the Inquiries, Complaints, and Reports Committee; and feedback on the current policies from the College's Public and Physician Advisory Service and the Education Advisory Group.
[2] 96 responses were received in total (24 through the online discussion page, and 72 via the online survey). An overview of the feedback was provided to Council in the March 2020 Policy Report.
[3] At the time, the standing Policy Review Working Group consisted of Brenda Copps (Chair), Ellen Mary Mills, and Janet van Vlymen, as well as Medical Advisors Angela Carol and Keith Hay.
[4] 39 responses were received through the online discussion page, and 91 through the online survey. 94% of the survey respondents were physicians (including some postgraduate trainees), 3% were members of the public, and 3% were other health-care professionals.
[5] Organizational respondents included: the Faculty of the Department of Medicine at the University of Ottawa, the Office of the Information and Privacy Commissioner of Ontario; Professional Association of Residents of Ontario, Society for Canadians Studying Medicine Abroad, Ontario Trial Lawyers Association, the Ontario Medical Association (OMA), the OMA Section on Plastic Surgery, the Royal College of Physicians and Surgeons of Canada, #MedicineToo, and the Council of Faculties of Medicine – Undergraduate and Postgraduate Committees.
[6] A preliminary overview of the feedback was provided to Council in the December 2020 Policy Report.

first (e.g., overnight supervision by residents in academic hospitals; emergency departments) and therefore more flexibility is needed in terms of who might obtain consent from patients.

Current Status and Analysis

- Revisions have been made to both the draft *Professional Responsibilities in Medical Education* policy (**Appendix A**) and the *Advice to the Profession* document (**Appendix B**), in response to feedback obtained during the external consultation.

- The revisions were developed based on feedback and direction from the new Policy Review Working Group[7]. Legal Counsel, Sayran Sulevani and Nathan Roth, Medial Advisor, have continued to support this review.

- The revised draft policy expectations are largely consistent with the draft policy that went out for consultation, with one exception concerning the issue of consent for medical student and postgraduate trainee participation in care. Other updates have been made to enhance clarity and ensure compliance with privacy legislation.

- An overview of the key issues considered by the Working Group along with any corresponding revisions is set out below.

Obtaining Consent

- In response to stakeholder feedback that the consent requirements would significantly and negatively impact the delivery of patient care in educational settings, the Working Group directed that a number of changes be made to the draft policy. In making these revisions, the Working Group sought to balance the realities of practice with respect for patient preferences.

- The preamble in the revised draft policy has been updated to make it clear that respect for patient autonomy ***may*** warrant obtaining consent to the involvement of medical students and postgraduate trainees and that consent can be implied or express depending on the circumstances.

- The revised draft policy maintains the expectation that consent be obtained where medical students or postgraduate trainees are involved in patient care solely for their own education (e.g., when observing or performing examinations unrelated to the provision of patient care) (Provision #7).

    - The revised draft policy does not require that the consent be express, rather it can be implied or express.

[7] Now comprised of Brenda Copps, Janet van Vlymen, Lydia Miljan, Peter Pielsticker, Sarah Reid, Karen Saperson, and Keith Hay.

  - The revised draft policy states that any member of the health-care team can obtain consent, including the medical student or postgraduate trainee, adding flexibility to this provision.

- Where medical students are participating in patient care, the revised draft policy does not require that consent be obtained in all circumstances as was the case in the draft policy. Consent needs to be obtained in appropriate circumstances and this determination must be made taking into account a number of factors (Provision #8).

  - The factors that must be considered include: the type of examination, procedure or care being provided, a patient's characteristics, the increasing responsibilities that medical students have in patient care, the level of involvement of the MRP/supervisor, and the best interests of the patient.

  - Flexibility has also been added to this provision, allowing for a medical student to obtain consent.

  - The *Advice* contains examples of when it would be appropriate to obtain consent for medical student participation.

- The expectation requiring MRPs and/or supervisors to use their professional judgment to determine whether to obtain express consent from patients when postgraduate trainees participate in patient care has been removed.

  - This is a change from the current *Professional Responsibilities in Postgraduate Medical Education* policy, which requires express consent to be obtained where possible when a significant component, or all, of a medical procedure is to be performed by a postgraduate trainee without direct supervision.

  - It is the Working Group's view that postgraduate trainees are viewed as full members of the health-care team and asking for consent for participation in their care, undermines their role as physicians and members of the team.

  - As set out in the revised draft policy, patients must be informed that postgraduate trainees are part of the health-care team and that there is an MRP that is responsible for their care.

  - The revised draft policy also has a requirement that MRPs/supervisors must provide appropriate supervision to postgraduate trainees and delineates what that entails.

- The *Advice* has also been expanded and contains guidance about how to obtain consent and what to do if patients are reluctant to have medical students or postgraduate trainees participate in their care.

Professional Relationships/Boundaries

- The draft policy was revised to better capture the instances where a pre-existing relationship between an MRP/supervisor and a medical student/postgraduate trainee might require disclosure and to clarify the content of the disclosure (Provision #16).

    - The Information and Privacy Commissioner of Ontario had concerns that the draft policy required disclosure of personal health information (e.g., disclosure of a pre-existing clinical relationship) so the policy was revised to require that disclosure complies with privacy legislation.

    - The draft policy required disclosure even where physicians might only be "indirectly responsible" for mentoring, teaching, supervising and evaluating medical students and/or postgraduate trainees, but feedback suggested that this was confusing and overly broad, so this was removed to narrow the focus of this obligation. A similar revision was made to Provision #15 which prohibits MRPs/supervisors from entering into sexual or other relationships with medical students and/or postgraduate trainees.

Violence, Harassment and Discrimination

- Intimidation has been added to the revised policy as a specific example of harassment in order to respond to some comments received during the external consultation as well as from Council members at the September Council meeting (Provision #12). Examples of discrimination have also been added to this provision.

Supervision of Medical Students and Postgraduate Trainees

- To address feedback concerning the requirement for MRPs and/or supervisors to be familiar with individual learning plans and competencies and program objectives, this expectation has been removed, and instead information about Competency-Based Medical Education has been added to the Resources section of the *Advice*.

- Reference to MRPs/supervisors determining that medical students and postgraduate trainees have the requisite competence to participate in patient care has been removed to address feedback received stating that this is not the specific role of MRPs/supervisors and that there are multiple factors that go into determining competence, including input from medical schools, postgraduate medical education programs and Competency Committees. MRPs and supervisors are still required to assess the abilities of medical students and postgraduate trainees.

- References to "competence (knowledge, skill and judgment)" and "willingness" and have been replaced with "ability" and "readiness" to align with the changes made above and some concerns raised in the feedback around clarity of wording (Provision #2 and #3).

Next Steps

- Should Council approve the revised draft policy, it will be announced in *Dialogue* and added to the College's website.

Questions for Council

1. Does Council approve the revised draft *Professional Responsibilities in Medical Education* policy as a policy of the College?

Professional Responsibilities in Medical Education

Policies of the College of Physicians and Surgeons of Ontario (the "College") set out expectations for the professional conduct of physicians practising in Ontario. Together with the *Practice Guide* and relevant legislation and case law, they will be used by the College and its Committees when considering physician practice or conduct.

Within policies, the terms 'must' and 'advised' are used to articulate the College's expectations. When 'advised' is used, it indicates that physicians can use reasonable discretion when applying this expectation to practice.

Additional information, general advice, and/or best practices can be found in companion resources, such as *Advice to the Profession* documents.

Definitions

Undergraduate medical students ("medical students"): Students enrolled in an undergraduate medical education program. They are not members of the College of Physicians and Surgeons of Ontario.[1]

Postgraduate trainees[2]: Physicians who hold a degree in medicine and are continuing in postgraduate medical education (commonly referred to as "residents" or "fellows" in most teaching sites). Postgraduate trainees often serve in the role of supervisors but do not act as the most responsible physician for patient care. If postgraduate trainees are supervisors, then the provisions of the policy regarding supervisors apply to them.

Most responsible physicians ("MRP"): Physicians who have overall responsibility for directing and coordinating the care and management of a patient at a specific point in time, regardless of the amount of involvement that a medical student or postgraduate trainee has in that patient's care.

Supervisors: Physicians who have taken on the responsibility to observe, teach, and evaluate medical students and/or postgraduate trainees. The supervisor of a medical

[1] The *Regulated Health Professions Act, 1991*, S.O. 1991, c.18 (*RHPA*) permits students to participate in the delivery of health care by allowing them to carry out controlled acts "while fulfilling the requirements to become a member of a health profession and the act is within the scope of practice of the profession and is done under the supervision or direction of a member of the profession".

[2] The majority of postgraduate trainees in Ontario hold a certificate of registration authorizing postgraduate education, but regardless of the class of certificate of registration held, postgraduate trainees cannot practise independently in the discipline in which they are currently training.

student or postgraduate trainee who is involved in the care of a patient may or may not be the most responsible physician for that patient.

Policy

Supervision of Medical Students

1. MRPs and/or supervisors[3] **must** provide appropriate supervision to medical students which is proportionate to the medical student's level of training and experience. This includes:
   a. assessing interactions (which may include observation) between medical students and patients to determine:
      i. whether a medical student has the ability and readiness to safely participate in a patient's care without compromising that care;
      ii. a medical student's performance, abilities, and educational needs; and
      iii. whether a medical student is capable of safely interacting with patients in circumstances where the supervisor is not present in the room;
   b. meeting at appropriate intervals with a medical student to discuss their assessments of patients and any care provided to them;
   c. ensuring that a medical student only engages in patient care based on previously agreed-upon arrangements with the MRP and/or supervisor;
   d. reviewing and providing feedback on a medical student's documentation, including any progress notes written by a medical student;
   e. subject to any institutional policies, using their professional judgment to determine whether to countersign a medical student's documentation;
   f. countersigning all orders written under the supervision or direction of a physician;[4] and
   g. managing and documenting patient care, regardless of the level of involvement of medical students.

Supervision of Postgraduate Trainees

2. MRPs and/or supervisors **must** provide appropriate supervision to postgraduate trainees. This includes:

[3] A postgraduate trainee may also be a supervisor.
[4] Prescriptions, telephone or other transmitted orders may be transcribed by the medical student but must be countersigned.

a. regularly assessing a postgraduate trainee's ability and learning needs, and assigning graduated responsibility accordingly;
b. ensuring that relevant clinical information is made available to a postgraduate trainee;
c. communicating regularly with a postgraduate trainee to discuss and review their patient assessments, management, and documentation of patient care in the medical record; and
d. directly assessing the patient as appropriate.

3. Postgraduate trainees **must**:
a. only take on clinical responsibility in a graduated manner, proportionate with their abilities, although never completely independent of appropriate supervision;
b. communicate with a supervisor and/or MRP:
i. in accordance with the guidelines of their postgraduate program and/or clinical placement setting;
ii. about their clinical findings, investigations, and treatment plans;
iii. in a timely manner, urgently if necessary, when there is a significant change in a patient's condition;
iv. when the postgraduate trainee is considering a significant change in a patient's treatment plan or has a question about the proper treatment plan;
v. about a patient discharge;
vi. when a patient or family expresses concerns; or
vii. in an emergency or when there is significant risk to the patient's well-being;
c. document their clinical findings and treatment plans; and
d. identify the MRP or supervisor who has reviewed their consultation reports and indicate the MRP's or supervisor's approval of the report.

Availability of MRP and/or Supervisor

7. MRPs and/or supervisors **must** ensure that that they are identified and available to assist medical students and/or postgraduate trainees when they are not directly supervising them (i.e., in the same room) or if unavailable, they **must** ensure that an appropriate alternative supervisor is available and has agreed to provide supervision.

5. The degree of availability of an MRP and/or supervisor and the means of availability (by phone, pager or in-person) **must** be appropriate and reflective of the following factors:

a. the patient's specific circumstances (e.g., clinical status, specific health-care needs);
b. the setting where the care will be provided and the available resources and environmental supports in place; and
c. the education, training and experience of the medical student and/or postgraduate trainee.

Involvement in Patient Care

Informing Patients about the Health-Care Team

6. MRPs or supervisors **must** ensure that patients[5] are informed of their name and roles, the fact that the MRP is ultimately responsible for their care, and that patient care often relies on a collaborative, team-based approach involving both medical students and postgraduate trainees.
   a. As medical students or postgraduate trainees are often the first point of contact with a patient, the information above can be provided by them where appropriate.

Obtaining Consent

Medical student and postgraduate trainee involvement in patient care are necessary elements of medical education and training, as well as essential components of how care is delivered in teaching hospitals and other affiliated sites. Respect for patient autonomy may warrant obtaining consent to the involvement of medical students and postgraduate trainees. Whether the consent is implied or express[6] will depend on the circumstances.

7. In situations where medical students or postgraduate trainees are involved in patient care solely for their own education (e.g., observation, examinations unrelated to the provision of patient care[7], etc.), physicians responsible for providing that care **must** ensure consent to medical student or postgraduate trainee participation is obtained, either by obtaining consent themselves or, where

[5] Throughout this policy, where "patient" is referred to, it should be interpreted as "patient or substitute decision-maker" where applicable.
[6] Express consent is direct, explicit, and unequivocal, and can be given orally or in writing. Implied consent can be inferred from the words or behaviour of the patient, or the surrounding circumstances, such that a reasonable person would believe that consent has been given, although no direct, explicit, and unequivocal words of agreement have been given. Obtaining consent for involvement of medical students and postgraduate trainees is different than that of obtaining consent in the context of the *Health Care Consent Act* regarding treatment decisions. More information is provided in the *Advice*.
[7] See *Advice* for examples.

appropriate, by another member of the health care team (including the medical student or postgraduate trainee involved).

8. Where medical students provide care to patients, physicians responsible for that care **must** ensure that consent for the participation of the medical student is obtained in appropriate circumstances, and **must** determine who from the health-care team (including the medical student) will obtain it, taking into account the:
   a. type of examination, procedure or care that is being provided (e.g. complexity, intrusiveness, sensitivity);
   b. patient's characteristics/attributes, including their vulnerability;
   c. increasing responsibilities medical students have in participating in patient care;
   d. level of involvement of the MRP/supervisor in the care being provided; and
   e. best interests of the patient.

Professional Behaviour

9. MRPs and supervisors **must** demonstrate a model of compassionate and ethical care while educating and training medical students and postgraduate trainees.

10. MRPs, supervisors, and postgraduate trainees **must** demonstrate professional behaviour in their interactions with:
    a. each other
    b. medical students,
    c. patients and their families,
    d. colleagues, and
    e. support staff.

11. MRPs, supervisors, and postgraduate trainees **must not** engage in disruptive behaviour that interferes with or is likely to interfere with quality health-care delivery or quality medical education (e.g., the use of inappropriate words, actions, or inactions that interfere with a physician's ability to function well with others.[8])

Violence, Harassment, and Discrimination

12. Physicians (including MRPs, supervisors, and postgraduate trainees) involved in medical education and/or training **must not** engage in violence, harassment

[8] For more information, please refer to the College policy on *Physician Behaviour in the Professional Environment*, as well as the Guidebook for Managing Disruptive Physician Behaviour.

(including intimidation) or discrimination (e.g., racism, transphobia, sexism) against medical students and/or postgraduate trainees.

13. Physicians **must** take reasonable steps to stop violence, harassment or discrimination (e.g., racism, transphobia, sexism) against medical students and/or postgraduate trainees if they see it occurring in the learning environment and **must** take any other steps as may be required under applicable legislation[9], policies, institutional codes of conduct or by-laws.

14. MRPs and/or supervisors **must** provide medical students and/or postgraduate trainees with support and direction in addressing disruptive behaviour (including violence, harassment and discrimination) in the learning environment, including but not limited to taking any steps as may be required under applicable legislation[10], policies, institutional codes of conduct or by-laws.

Professional Relationships/Boundaries

15. MRPs and supervisors **must not**:
    a. enter into a sexual relationship with a medical student and/or postgraduate trainee while responsible for mentoring, teaching, supervising or evaluating the medical student and/or postgraduate trainee; or
    b. enter into a relationship[11] with a medical student and/or postgraduate trainee that could present a risk of bias, coercion, or actual or perceived conflict of interest, while responsible for mentoring, teaching, supervising or evaluating the medical student and/or postgraduate trainee.

16. MRPs and/or supervisors (including postgraduate trainees who are supervisors) **must**, subject to applicable privacy legislation[12], disclose any sexual or other relationship[13] between themselves and a medical student and/or postgraduate trainee which pre-dates the mentoring, teaching, supervising or evaluating role of the MRP and/or supervisor to the appropriate member of faculty

[9] For example, the obligations set out in the *Occupational Health and Safety Act*, R.S.O. 1990, c.0.1 ("*OHSA*") and the *Human Rights Code*, R.S.O. 1990, c. H.19 (the "*Code*").
[10] Physicians may have other obligations under *OHSA* and the *Code* in regard to their own behaviour in the workplace, as well as specific obligations if they are employers as defined by *OHSA* or the *Code*.
[11] Including but not limited to, family, dating, business, treating/clinical, and close personal relationships.
[12] If the relevant information to be disclosed contains personal health information or is otherwise protected by privacy legislation, the MRP and/or supervisor may either obtain consent from the medical student and/or postgraduate trainee to disclose this information or state that alternate arrangements are warranted.
[13] Including but not limited to family, dating, business, treating/clinical and close personal relationships.

(e.g., the department or division head or undergraduate/postgraduate program director) in order for the faculty member to decide whether alternate arrangements are warranted.

Reporting Responsibilities

17. Physicians (including MRPs, supervisors and postgraduate trainees) involved in the education and/or training of medical students and/or postgraduate trainees **must** report to the medical school and/or to the health-care institution, if applicable, when a medical student and/or postgraduate trainee:
    a. exhibits behaviours that would suggest incompetence, incapacity, or abuse of a patient;
    b. fails to behave professionally and ethically in interactions with patients and their families, supervisors, and/or colleagues; or
    c. otherwise engages in inappropriate behaviour.[14]

18. Physicians involved in administration at medical schools, or health-care institutions that train physicians **must** contribute to providing**:**
    a. a safe and supportive environment that allows medical students and/or postgraduate trainees to make a report if they believe the MRP and/or their supervisor:
        i. exhibits any behaviours that would suggest incompetence, incapacity, or abuse of a patient;
        ii. fails to behave professionally and ethically in interactions with patients and their families, supervisors or colleagues; or
        iii. otherwise engages in inappropriate behaviour, including violence, harassment, and discrimination against medical students and/or postgraduate trainees; and
    b. an environment where medical students and/or postgraduate trainees will not face intimidation or academic penalties for reporting such behaviours.

Supervision of Medical Students for Educational Experiences not Part of an Ontario Undergraduate Medical Education Program

[14] The College's *Disclosure of Harm* policy also contains expectations which may be relevant to these circumstances.

19. In addition to fulfilling the expectations set out above, physicians who choose to supervise medical students for educational experiences that are not part of an Ontario undergraduate medical education program **must**:
    a. comply with the *Delegation of Controlled Acts* policy,[15]
    b. ensure that they have liability protection for that student to be in the office,
    c. ensure that the student:
        i. is enrolled in and in good standing at an undergraduate medical education program at an acceptable medical school,[16]
        ii. has liability protection that provides coverage for the educational experience,
        iii. has personal health coverage in Ontario, and
        iv. has up-to-date immunizations.[17]

20. Where physicians do not have experience supervising medical students or are unable to fulfill the expectations outlined above, they **must** limit the activities of the medical student to the observation of patient care only.

[15] The College's *Delegation of Controlled Acts* policy applies to any physician who supervises:
1. an Ontario medical student completing an extra rotation that is not part of their MD program, and
2. a student from outside Ontario completing an Ontario educational experience where the student will be performing controlled acts.

[16] For the purposes of this policy, an "acceptable medical school" is a medical school that is accredited by the Committee on Accreditation of Canadian Medical Schools or by the Liaison Committee on Medical Education of the United States of America, or is listed in either the World Health Organization's Directory of Medical Schools: http://www.who.int/hrh/wdms/en/, or the World Directory of Medical School's online registry: https://www.wdoms.org/.

[17] Please refer to the Council of Ontario Faculties of Medicine's Immunization policy: https://cou.ca/wp-content/uploads/2016/06/COFM-Immunization-Policy-2019.pdf.

Advice to the Profession: Professional Responsibilities in Medical Education

Advice to the Profession companion documents are intended to provide physicians with additional information and general advice in order to support their understanding and implementation of the expectations set out in policies. They may also identify some additional best practices regarding specific practice issues.

The *Professional Responsibilities in Medical Education* policy sets out expectations for physicians involved in medical education and training, including most responsible physicians (MRPs), supervisors, and postgraduate trainees. This *Advice to the Profession (Advice)* document is intended to help physicians interpret their obligations as set out in this policy and to provide guidance around how these obligations may be effectively discharged. In addition, this document provides links to relevant resources.

Does an MRP and/or Supervisor need to provide direct supervision at all times?

An MRP and/or supervisor do not need to provide direct supervision at all times; however, as the policy states, MRPs and/or supervisors must ensure that they are identified and available to assist medical students and/or postgraduate trainees when they are not directly supervising them (i.e. in the same room). If unavailable, they must ensure that an appropriate alternative supervisor is available and has agreed to provide supervision.

If an MRP and/or supervisor is not available in person and they are called or paged, the MRP and/or supervisor's responsiveness needs to be appropriate to the circumstances. What is appropriate will depend on a number of factors including: the level of training and experience of the medical student and/or postgraduate trainee, the clinical status of the patient, other available support, etc.

It may also be beneficial to ensure that on-call schedules be structured to provide continuous supervision to medical students. For postgraduate trainees, it may be beneficial to provide guidance with respect to on-call interactions as sometimes postgraduate trainees are off-service and may not know what is expected of them. For example, it may be helpful to have a phone call/in-person meeting at the start of a shift to determine the postgraduate trainee's PGY level, home program, how long they have been on the particular service, what procedures they have done, when staff would like to be called overnight, etc.

It is also important for medical students and postgraduate trainees to develop awareness of their limitations and inform the Most Responsible Physician and/or supervisor and, seek appropriate assistance when necessary if they are unable to carry out their duties. Good communication is vital to facilitating appropriate supervision and optimal patient care.

How can physicians demonstrate a model of compassionate and ethical care to medical students and trainees?

Medical students and postgraduate trainees often gain knowledge and develop attitudes about professionalism through role modeling. MRPs and supervisors have a duty to lead by example and to translate into action the principles of professionalism taught to medical students and postgraduate trainees.

Characteristics of effective role models are well established. They include availability, clinical excellence, empathy, good communication skills, interest in teaching, self-reflection, transparency and respect for others.[1] Being an effective role model is not only beneficial to medical students and postgraduate trainees, but it is also an important part of ensuring the best possible care for patients.

Engaging in favouritism of medical students and/or postgraduate trainees is detrimental to the learning environment. In addition, predatory behaviour is unacceptable anywhere, but it is particularly problematic in a learning environment where medical students and postgraduate trainees model the behaviour of their teachers. For these reasons, it is imperative that clinical teachers consistently uphold and display the highest values of the medical profession.

The policy requires physicians to not engage in disruptive behaviour including, violence, harassment, and discrimination against medical students and postgraduate trainees. These behaviours are the antithesis to being a positive role model and physicians must not engage in them.

What does the policy say about intimidation?

Expectations around harassment are an important addition to this policy. Both the *Ontario Human Rights Code* and the *Occupational Health and Safety Act* (*OHSA)* set out definitions of harassment. Harassment means engaging in a course of vexatious

[1] *Canadian Family Physician*, Vol.66. February 2020, e55-61.

comment or conduct that is known or ought to be reasonably known to be unwelcome. Harassment can include behaviour that intimidates.

Unfortunately, intimidation of medical students and postgraduate trainees is still an issue that arises in medical school education. Increasingly, the culture of medical education, and prevalence of bullying and harassment are contributing to the rise of depression, anxiety, burnout and suicidality amongst medical students and postgraduate trainees. The policy is clear that physicians must not engage in this type of behaviour.

In what situations will patients need to be asked for consent to have medical students participate in their care?

The policy requires consent to be obtained when the participation of medical students (or postgraduate trainees) is solely for their own education (e.g. observation, examinations unnecessary for patient care, etc.).

Where medical students provide care to patients, the policy requires consent to be obtained in appropriate circumstances, taking into account: the type of examination, the patient's characteristics, the increasing responsibilities medical students have in patient care, the level of involvement of the MRP/supervisor, and the best interests of the patient.

While the factors listed are general in nature and are meant to capture a variety of scenarios, some specific examples of when it would be appropriate to obtain consent include, but are not limited to the following:

- Medical student will be performing a sensitive examination e.g. pelvic or genital examinations.[2]
- Patient is a member of a vulnerable population who may have had negative experiences in health care system.
- Patient has experienced trauma.
- Patient is fearful of the examination, investigation or procedure.
- Medical student is early on in their medical school education.
- Examination, investigation or procedure is invasive or painful.
- Supervisor or Most Responsible Physician will not be present.

[2] For further information about medical students performing pelvic examinations, please see the Society of Obstetricians and Gynaecologists of Canada's Guideline #246.

If the medical student's involvement is minimal or the task is very low risk, such as taking a patient history, consent may not be required.

Is posting a sign informing patients that medical students and/or postgraduate trainees may be involved in their care sufficient?

Having a sign posted in a teaching hospital or other clinical placement setting is helpful and promotes patient education and understanding, but it is not sufficient in terms of meeting the policy expectations.

How can consent be obtained for medical student and/or postgraduate trainee participation in patient care?

Obtaining patient consent is not meant to be burdensome or time-consuming. Depending on the circumstances, simply explaining what you will be doing and why in a concise, easily understood, and non-coercive manner, and then asking, "is this okay?" may be sufficient.

If asking to participate in their care, it may be helpful to let the patient know that they can ask the Most Responsible Physician/supervisor or the physician responsible for providing their care questions after you participate in their care – this may be very helpful for patients and may contribute to their willingness to have you to participate in their care.

It is good practice to document in the patient's medical record whether the patient consented to the participation of the medical student and/or postgraduate trainee in their care.[3]

What if patients are reluctant to have medical students and/or postgraduate trainees participate in their care?

Research shows that it's unlikely that this will happen, but when it does it is important to respect a patient's preferences. A patient's care should not be jeopardized as a result of their refusal. In addition, if a patient does consent, they may at some point change their mind.

If a patient does not want to be involved in any activity that would be solely for the medical student's or postgraduate trainee's education, for example, observation of care, the medical student or postgraduate trainee can leave the room. It is more likely than not that another patient would be willing to have them observe the same procedure,

[3] For more information about medical record keeping, please see CPSO's *Medical Records Documentation* policy.

examination, investigation at another time. Medical students and/or postgraduate trainees can also discuss the fact that they were not able to observe a procedure, examination or investigation with the MRP/supervisor for guidance about other ways to learn about the procedure, examination or investigation.

If patients do not consent to have medical students participate in their care, the MRP or supervisor may want to indicate that the involvement of medical student is within the medical student's responsibilities and it will be difficult to simply not involve them without, for example, delaying access to care. This can be sensitively explained to patients.

There may be additional considerations when postgraduate trainees participate in care. The *Professional Responsibilities in Medical Education* policy does not require that consent be obtained for their participation, but it requires MRPs or supervisors to ensure patients are informed that their care relies on a team-based approach involving both medical students and postgraduate trainees. In rare circumstances, when patients initially decline or appear ambivalent about having postgraduate trainees involved in their care, formalizing the consent process may be prudent.

What are some examples of procedures/exams/investigations unrelated to the provision of patient care?

This happens often with learners, especially medical students - a physician performs a procedure/exam/investigation and then the medical student and/or postgraduate trainee repeats it. For example, learners can be asked to examine a skin rash, check peripheral circulation, or do an eye or ear exam for educational purposes. If a patient has an unusual history, learners may be asked to question and/or examine the patient for educational purposes. Intimate examinations are also sometimes done by medical students and postgraduate trainees and can be unnecessary for the provision of patient care.

Resources

The information below provides additional information related to professional responsibilities in medical education as well as information that may be helpful to medical students and/or postgraduate trainees. It is important for MRPs and/or supervisors to encourage medical students, who are not yet members of the CPSO, to become familiar with this information.

Medical schools and institutions where learning takes place also have relevant policies, guidelines, statements and procedures which are relevant to medical students and/or

postgraduate trainees. MRPs and/or supervisors are advised to be familiar with this information and direct their medical students and/or postgraduate trainees to it.

Dialogue Articles

Dialogue, the College's quarterly publication for members, regularly addresses themes or issues relating medical education.

CPSO's Professionalism and Practice Program

How a physician delivers care is just as important as the care provided. To that end, the CPSO has partnered with medical schools across Ontario to develop modules on key professionalism topics. These modules include PowerPoint presentations, and case studies ground in real life issues and trends seen by the CPSO. They are also grounded in relevant frameworks, such as CanMEDs. We encourage medical students and postgraduate trainees — and anyone else interested in medical professionalism — to visit the Professionalism and Practice area on our website and to download the modules.

Competency-Based Medical Education

Competency-based medical education (CBME) is the current approach being used within Canadian medical education with the objective of having physicians graduate with the competencies required to meet local health needs. It aims to enhance patient care by improving learning and assessment in residency. For more information about CBME in Canada please see the following resources:

Royal College of Physicians and Surgeons of Canada – Competence by Design

College of Family Physicians of Canada – Triple C Competency-Based Curriculum

Canadian Medical Protective Association (CMPA)

The CMPA is a national organization and provides broad advice about a number of medico-legal issues. For Ontario specific information physicians are advised to look at the CPSO policy and advice document regarding professional responsibilities in medical education. However, the CMPA has a number of resources on the issues generally that physicians may find helpful.

For example:
Delegation and Supervision of Medical Trainees
Responsibilities of Physicians as Teachers

Council Motion

Motion Title	Professional Responsibilities in Medical Education – Revised Draft Policy for Final Approval
Date of Meeting	June 18, 2021

It is moved by_____, and seconded by_____, that:

The Council approves the “Professional Responsibilities in Medical Education” policy, (a copy of which forms Appendix “ ” to the minutes of this meeting), formerly the “Professional Responsibilities in Undergraduate Medical Education” and “Professional Responsibilities in Postgraduate Medical Education” policies.

Council Briefing Note

June 2021

Topic:	Governance Committee Report: 17.1 Committee Education Sessions Update 17.2 Recruitment: Updated Timing – September Appointments 17.3 Executive Committee Elections Update 17.4 Update on Council Elections
Purpose:	For Information
Relevance to Strategic Plan:	Meaningful Engagement
Public Interest Rationale:	Ensuring good governance practices for education and appointment of Council and Committee members
Main Contact(s):	Brenda Copps, Chair, Governance Committee Janet Eide, Governance Coordinator

17.1 Committee Education Sessions Update

- Historically, Council and Committee Education have occurred in full-day sessions at the College, usually combined with the March Council meeting. In order to improve education and training, these sessions were changed to be spread over the year in a series of modules.

- In keeping with the College's equity, diversity, and inclusion work, the focus for this year is Anti-Indigenous Racism and Implicit Bias. To date, we have presented;
  - Dr. Lisa Richardson's talk on Anti-Indigenous Racism at the March Council meeting
  - Dr. Javeed Sekhara's talk on Implicit Bias in a stand-alone session in April
  - Dr. Lisa Richardson's expanded talk on Anti-Indigenous Racism in a stand-alone session in May

- In recognition of the unique time pressures that Council and Committee members are currently experiencing, the stand-alone sessions for July and August have been cancelled. The planned sessions for the remainder of 2021 are:

  - Anna Dewar Gully from Tidal Equality will speak to us about Equity, Diversity, and Inclusion at the September Council Meeting with a follow-up presentation at the December Council meeting.
  - Dr. Stephanie Nixon will speak to us about Anti-Indigenous Racism at a stand-alone session in October
  - Dr. Nixon will return with Elder Dr. Ed Connors to follow-up on their presentation at a stand-alone session in November

- The focus for 2022 will be Anti-Black Racism and LGBTQ2S Health.

17.2 Recruitment: Updated Timing – September Appointments

- A Committee Recruitment process is currently underway in order to fill expected physician vacancies across the Inquiries, Complaints, and Report, Quality Assurance, and Premises Inspection Committees.

  - In keeping with good governance practices, the Governance and Executive Committee have recommended committee appointments be made by Council at the September Council meeting. The committee appointments made at the September Council meeting will commence following the annual meeting of Council in December.

- The original deadline for applications for committee work of May 28, 2021 has been extended to June 11, 2021, and it is anticipated that interviews with committee candidates will be taking place mid-June to early July 2021.

- This timing will align the committee appointment process with other committee election/appointment processes that will take place at the September Council meeting, as well as provide more preparation time for new committee members to complete their orientation and training, and to arrange their schedules to accommodate committee work prior to participating on a committee.

17.3 Executive Committee Elections Update

- The annual process of electing members to the Executive Committee has been adjusted to take place at the September Council meeting.

- Council will vote for elected positions: 1 President, 1 Vice President and 3 Executive Member Representatives.

- Council will receive information regarding the nomination/election process over the summer to support decision-making regarding nominations and to prepare for the election in September.

- Executive Committee appointments, made by Council at the September Council meeting, will commence following the annual meeting of Council in December.

17.4 Update on Council Elections

- The 2021 election cycle for physician members of Council captured Districts 6, 7, 8, and 9.

- Nominations were solicited from members in these districts over the spring with a deadline of May 4, 2021.

- At the close of the nomination process, the vacancies in Districts 8 and 9 were acclaimed with full elections occurring in Districts 6 and 7.
  - **District 6: 1 position open - ELECTION**
    - Counties: Frontenac, Haliburton, Hastings, Leeds and Grenville, Lennox and Addington, Northumberland, Peterborough, Prince Edward, and Victoria
      - Andrew Hamilton
      - Rupa Patel
      - John Rapin
  - **District 7: 2 positions open - ELECTION**
    - Counties: Dundas, Glengarry, Lanark, Prescott, Renfrew, Russell, and Stormont Regional Municipality: Ottawa-Carleton
      - Judith Plante
      - Sarah Reid
      - Stephen Whittaker
  - **District 8: 1 position open - ACCLAMATION**
    - Territorial Districts: Algoma, Cochrane, Manitoulin, Nipissing, Parry Sound, Sudbury, Timiskaming
      - Lionel Marks de Chabris
  - **District 9: 1 position open – ACCLAMATION**
    - Territorial Districts: Kenora, Rainy River, Thunder Bay
      - Andrew Turner

- Voting opened on June 1, 2021 and will close on June 22, 2021. Council will be kept apprised of the results of the elections.

- For more information, please visit the Council Elections webpage.

Council Briefing Note

June 2021

Topic:	Governance Committee Report: 17.5 Committee Appointments
Purpose:	For Decision
Relevance to Strategic Plan:	Meaningful Engagement
Public Interest Rationale:	Ensuring appointment of qualified Committee Members to carry out the work of Committees
Main Contact(s):	Brenda Copps, Chair, Governance Committee

17.5 Committee Appointments

Issue

- Council members are asked to appoint Dr. Catherine Grenier, an Emergency physician with French language skills, to the Discipline and Fitness to Practise Committees for a term that expires at the end of the annual meeting of Council in December 2023.

Background

- There is a vacancy on the Discipline and Fitness to Practise Committees for a physician with French language skills, due to a recent resignation.
- Dr. Grenier participated in the committee candidate interview process in 2020 and has met the competency/skills requirements to fill the position.
- Dr. Grenier was recommended for appointment to the Discipline and Fitness to Practise Committees by the Governance and Executive Committees at a meeting held on June 8, 2021.
- The Discipline Committee appointment will automatically become an appointment to the Ontario Physicians and Surgeons Discipline Tribunal (OPSDT) on September 1, 2021.

Question for Council

1. Does Council appoint Dr. Catherine Grenier to the Discipline Committee (Ontario Physicians and Surgeons Discipline Tribunal) and Fitness to Practise Committee for a term that expires at the end of the annual meeting of Council in December 2023?

Council Briefing Note

June 2021

Topic:	Requests for Exceptional Circumstances
Purpose:	For Decision
Relevance to Strategic Plan:	Meaningful Engagement
Public Interest Rationale:	Ensuring Committees have the right mix of members, whose skills together, will effectively discharge the responsibilities of the Committee in alignment with CPSO's mandate
Main Contact(s):	Laurie Cabanas, Director of Governance Suzanne Mascarenhas, Governance Analyst Marcia Cooper, Senior Corporate Counsel & Privacy Officer
Attachment(s):	Appendix A: Requests for Exceptional Circumstances

Issue

- The Executive Committees reviewed and approved five requests for Exceptional Circumstances, as recommended by the Governance Committee, and is forwarding the recommendations to Council for approval.

Background

- The Governance Committee continues to encourage Committee Chairs to revisit succession plans at least twice a year to ensure they have members with the knowledge, skills and commitment needed to effectively execute the mandate of the Committee.

- Since December 2020, term limits have come into effect for Committees. Committee members may serve on a Committee no more than 9 years, and no more than 18 years on Council and Committees combined.

- The Exceptional Circumstances provision in the General By-Law allows a member's appointment to a committee to exceed applicable term limits if Council determines it is necessary to do so due to exceptional circumstances in order to ensure that the composition and quorum requirements for the committee can be met or that the committee

can function properly and in a stable manner. Considerations for whether there are exceptional circumstances include but are not limited to:
  - a member is very experienced compared to other Committee members and is critical to maintaining stability and for the effective functioning of the Committee
  - a member's expertise is proving difficult to replace

- Exceptional Circumstances are approved for one year at a time and must be accompanied by a plan for knowledge transfer within the one-year extension; there is a possibility of making additional 1-year requests if necessary, in accordance with the exceptional circumstances of By-law provision.

- In 2020, the Governance Committee launched a Committee Mentoring Program to provide further stability for Committees and accelerate the onboarding process for new members.

- In December 2020, a total of 29 members transitioned off Committees due to term limits and 15 requests for exceptional circumstances were approved.

Current Status and Analysis

- In December 2021, a total of 7 members will transition off Committees due to term limits and 13 members due to the expiry of their one-year appointment under the Exceptional Circumstances clause.

- Below is a summary of the 5 requests to extend the committee terms of certain members to December 2022 under the Exceptional Circumstances clause. The detailed requests are found in Appendix A.

Committee	Committee Member	Years of Service as of Dec 2021	Rationale and Succession Plan
Ontario Physicians and Surgeons Discipline Tribunal (Discipline)	Pierre Giroux	9	o First request o Public appointment set to expire in December 2022 o Very experienced and active member who chairs o He will mentor public members who sit on panels with him
Premises Inspection	Dr. Gillian Oliver	8.6 years	o First request o Currently the Chair leading Committee through transformation, her expertise and leadership is required to manage the change successfully

Committee	Committee Member	Years of Service as of Dec 2021	Rationale and Succession Plan
Quality Assurance	Dr. Patrick Safieh	13.8 years	o There has been unprecedented change on QAC in the past several months with a number of members transitioning off in 2021 o He will provide stability and mentorship to committee members including the Vice-Chair who will move to the Chair role in 2022
Registration	Dr. Bob Byrick	11 years	o Second request o A number of new members were recruited this year to meet the needs of the Committee; he provides needed expertise for newer members o Will provide training, onboarding and knowledge transfer to new members and permit the optimal functioning of the Committee
	Dr. Barbara Lent	10 years	o Second request o A number of new members were recruited this year to meet the needs of the Committee; she provides needed expertise for newer members o Will provide training, onboarding and knowledge transfer to new members and permit the optimal functioning of the Committee

Question for Council

1. Does Council approve the requests for Exceptional Circumstances?

Appendix A

Exceptional Circumstances Request Form

Name of Committee	Ontario Physicians and Surgeons Discipline Tribunal	
Committee Member	Pierre Giroux	
# of Yrs. on Committee	End of 2020: 9 years	**Total Years of Service: 9 years**
Number of submissions for Committee Member/Year Requested	First submission for this member Date: April 20, 2020	**The Governance Committee will approve requests for one year at a time** **Pierre Giroux's public appointment will expire in December 2022**
Committee Member's Specific Knowledge, Skills or Experience	• Mr. Giroux is a very experienced Tribunal member who has sat on, and chaired, many cases during his time on the Tribunal (formerly the Discipline Committee). • The Health Professions Procedural Code requires two public members of Council on each panel. There are currently eight public members of Council, which sometimes poses challenges in composing panels given members' availability. It is desirable to have as many public members on the Tribunal as possible.	
Mentoring Strategy	• Mr. Giroux will be encouraged to mentor other public members who sit on panels with him. • The new experienced adjudicator Tribunal members will also mentor public members, particularly newer ones, in adjudicative skills.	
Requested Length of Extension	I year	
Description of Recruitment Strategy and/or Succession Plan	• Governance will continue to engage with government to encourage appointments of public members who are well-suited for adjudicative work and who will increase the diversity among Tribunal members.	

Exceptional Circumstances Request Form

Name of Committee	Premises Inspection Committee	
Committee Member	Dr. Gillian Oliver	
# of Yrs. on Committee	End of 2021: 8 years and 7 months	**Total Years of Service: 8 years and 7 months**
Number of submissions for Committee Member/Year Requested	First submission for this member Date: April 20, 2021	**The Governance Committee will approve requests for one year at a time**
Committee Member's Specific Knowledge, Skills or Experience	• We are creating specialty panels, her expertise and leadership for the OB/Fertility panel would be invaluable	
Mentoring Strategy	• Leader for the OBS/Fertility/Abortion specialty panel	
Requested Length of Extension	1 year	
Description of Recruitment Strategy and/or Succession Plan	• Will require OBS physician for December 2022	

Exceptional Circumstances Request Form

Name of Committee	Quality Assurance Committee	
Committee Member	Dr. Patrick Safieh	
# of Yrs. on Committee	End of 2021: 13.8 years	**Total Years of Service: 13.8 years**
Number of submissions for Committee Member/Year Requested	First submission for this member Date: November 3, 2020; Second submission April 2021	**The Governance Committee will approve requests for one year at a time**
Committee Member's Specific Knowledge, Skills or Experience	**Family Medicine** • Patrick has been with the QAC for several years and even as Co-chair of this committee. He has a great understanding of what QA is and is often looked to for guidance on approaches. • He is very fair in his committee work and he is someone who keeps his cool under pressure. There were some confrontational interviews with subject physicians. He has a wonderful calm demeanor which assists in de-escalating the situations. He is well respected by his fellow QAC members. • For a period, he was a QA representative for the IHF Review Panels, and again, he was quick to get well versed in the IHFA program and different panel members. He was great in asking questions to further educate himself on these processes and was able to bring that knowledge to the QAC meetings when certain IHF Assessments were referred to the QAC. • Patrick works very well with the QA Committee Support team and again his personality is very welcoming. • Patrick was the only physician who took the opportunity to do the QI program when other members did not take up that opportunity. He provided positive feedback and conveyed the positive aspects of this new program and he even admitted that there were process improvements in his own practice he identified through this QI program that he had never considered. • Given all the concerns raised in 2020 with the QAC, Patrick has been very professional and when asked to speak on the QI program does not hesitate to offer his thoughts. While his time on committee has been exceeded, he has already provided mentoring support to both the Chair and Vice-Chair. Patrick understands the College's strategic plan and has embraced Right Touch Regulation. This will be important when the Chair steps down to fulfill her College President role in 2022 and Dr. Reid steps into the role of Chair.	
Mentoring Strategy	• Given the number of years on the QAC, Patrick continued to mentors many of the new QAC members who have come on board. When he is notified of new members joining, he takes the time to reach out to the new member and will avail himself to clarify any questions the new member has. This year he met with Dr. Reid and went over the cases she needed to present at an MSI. Dr. Reid commented that Patrick was of great assistance. This again is a good example of how Patrick avails himself to the committee members.	

	• When he Chairs an MSI meeting and there are new members joining in an observation capacity, Patrick takes the time to go over how the meeting will proceed and encourages the new members to ask any questions regarding any material reviewed and/or decisions made. He does not rush and takes the time for the new members to be comfortable with how the committee functions. He also advises that the Committee support staff are great and always available to support the new member. • There has been a number of changes in the QAC since early 2021 with 3 members resigning at the end of March 2021. As stated above, Dr. Reid will be moving into the role of Chair in 2022, Patrick comes with experience to support Sarah as well as any new recruits that the QAC will need in 2022. • Dr. Sarah Reid has smoothly transitioned into her role on the QAC based on Patrick's approach, his gentle demeanor and good sense of humor.
Requested Length of Extension	1 year
Description of Recruitment Strategy and/or Succession Plan	Patrick will support and provide recruitment advice to both the Chair and Vice-Chair. This year still represents a transition year for the QAC after the turmoil experienced in 2020. Having Patrick appointed for an additional year for 2022 will provide QAC with a sufficient amount of time to ensure all members have continued consistent mentoring as well as provide supportive training to any new members who are yet to be recruited.

Exceptional Circumstances Request Form

Name of Committee	Registration Committee		
Committee Member	Dr. Bob Byrick		
# of Yrs. on Committee	5 (10 when combined with previous experience)	**Total Years of Service**	10
Number of submissions for Committee Member/Year Requested	1st submission for this member Date: Feb 24, 2020 2nd submission for this member Date: April 20, 2021	**The Governance Committee will approve requests for one year at a time**	
Committee Member's Specific Knowledge, Skills or Experience	• Extensive experience with Committee and education (as former Vice Dean of postgraduate medicine at U of T) • Past Chair of Registration Committee • Anesthetist (surgical) • Reviews and approves Orders with Reasons • Chairs panels		
Approaches used to find a suitable replacement for this Committee member	With the appointment of 4 new members in 2021 we have a relatively new Committee with half of the members being newly appointed. The additional time will allow for training, on-boarding and knowledge transfer to the new members and permit the optimal functioning of the Committee. The additional year will allow for a more sustainable succession plan.		
Requested Length of Extension	1 year		
Description of Recruitment Strategy and/or Succession Plan	With an additional year of experience Dr. Turner will be a suitable replacement for Dr. Byrick. This additional year will also position Dr. Turner for as an ideal candidate for a future Chair position.		

Exceptional Circumstances Request Form

Name of Committee	Registration Committee	
Committee Member	Dr. Barbara Lent	
# of Yrs. on Committee	10 years	**Total Years of Service:** 10
Number of submissions for Committee Member/Year Requested	1st submission for this member Date: Feb 24, 2020 2nd submission for this member Date: April 20, 2021	**The Governance Committee will approve requests for one year at a time**
Committee Member's Specific Knowledge, Skills or Experience	• Extensive experience with Committee and education (as former program director of family medicine at Western University) • Past Chair of Registration Committee • Family Physician • Reviews and approves Orders with Reasons • Chairs panels	
Approaches used to find a suitable replacement for this Committee member	With the appointment of 4 new members in 2021 we have a relatively new Committee with half of the members being newly appointed. The additional time will allow for training, on-boarding and knowledge transfer to the new members and permit the optimal functioning of the Committee. The additional year will allow for a more sustainable succession plan.	
Requested Length of Extension	1 year	
Description of Recruitment Strategy and/or Succession Plan	We should increase efforts to recruit an appropriate replacement for Dr. Lent in the coming year. Ideally, this would be a family physician with academic experience. The additional year will permit consistency within the Committee (via precedent) and will allow for knowledge transfer and mentoring between Dr. Lent and a new member. Based on the Committee's current membership where we have seen an unprecedented and unexpected high turnover in 2020 - the additional year of service will allow us to groom new members and provide necessary experience to the members currently appointed to position Dr. Turner as an ideal for a future Chair position.	

Council Motion

Motion Title	Requests for Exceptional Circumstances
Date of Meeting	June 18, 2021

It is moved by_____, and seconded by_____, that:

The Council approves the application of the exceptional circumstances clause in subsection 37(8) of the General By-law in respect of the following members of the committees indicated below, when the terms of their current appointments to such committees expire at the 2021 Annual General Meeting of Council in December 2021:

Pierre Giroux – Ontario Physicians and Surgeons Discipline Tribunal (Discipline Committee)
Dr. Gillian Oliver – Premises Inspection Committee
Dr. Patrick Safieh – Quality Assurance Committee
Dr. Bob Byrick – Registration Committee
Dr. Barbara Lent – Registration Committee

Council Briefing Note

June 2021

Topic:	Audited Financial Statements for the 2020 Year
Purpose:	For Decision
Main Contact(s):	Dr. Thomas Bertoia, Chair, Finance and Audit Committee Ms. Nathalie Novak, Chief Transformation Officer Mr. Douglas Anderson, Corporate Services Officer Ms. Leslee Frampton, Manager, Finance
Attachment(s):	Appendix A: Draft Audited Financial Statements for the Year Ended December 31, 2020

Issue

- Audited Financial Statements – Year ended December 31, 2020
- Appointment of the Auditor for the 2021 fiscal year

Background

- Mr. Mike Rooke, of Tinkham LLP Chartered Professional Accountants, reviewed the audited financial statements for the year ended December 31, 2020 for the Finance and Audit Committee.

- Mr. Rooke 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 accompanying financial statements present fairly, in all material respects, the financial position of the College as at December 31, 2020, 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 organization."

- So that the College does not find itself in the technical debt encountered in 2018 and in consultation with our external auditors, the Committee is recommending the establishment of an intangible asset fund for IT Infrastructure development and improvements. This fund will be comprised of $8,116,895.00, of which $6,116,895.00 was approved in the 2020 budget for Solis, Vault and F&O. The balance of $2,000,000.00 is for future development and improvements.

- In keeping with the direction of Council, the remainder of the surplus was transferred to the Building Reserve.

- 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, 2020, be accepted as presented by Tinkham LLP Chartered Professional Accountants.

  The Finance and Audit Committee recommends to Council the establishment of an internally restricted intangible asset fund for the purposes of future IT infrastructure development and improvements.

  The Finance and Audit Committee recommends to Council that $8,116,895.00 be transferred to the internally restricted intangible asset fund and that $6,116,895.00 has been approved for expenditures as of December 31, 2020.

  The Finance and Audit Committee recommends to Council that the balance of the unrestricted net assets as of December 31, 2020 be transferred to the Building Reserve.

  The Finance and Audit Committee recommends to Council that the firm of Tinkham LLP Chartered Professional Accountants be appointed as the College's auditors for the fiscal year 2021.

- 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. As well, the auditor told the Committee that the College's books were in impeccable shape.

Questions for Council

1. Does Council approve the audited financial statements for the year ended December 31, 2020 as presented?

2. Does Council approve the recommendation that the firm of Tinkham LLP Chartered Professional Accountants be reappointed as the College's auditors for the year 2021?

Financial statements of the

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 31, 2020

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 ("College"), which comprise the statement of financial position as at December 31, 2020 and the statements of operations and changes in unrestricted net assets and cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the College as at December 31, 2020, 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.

Basis for Opinion

We conducted our audit in accordance with Canadian generally accepted auditing standards. Our responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of our report. We are independent of the College in accordance with the ethical requirements that are relevant to our audit of the financial statements in Canada, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide basis for our opinion.

Responsibilities of Management and Those Charged with Governance for the Financial Statements

Management is responsible for the preparation and fair presentation of the 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.

In preparing the financial statements, management is responsible for assessing the College's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless management either intends to liquidate the College or to cease operations, or has no realistic alternative but to do so.

Those charged with governance are responsible for overseeing the College’s financial reporting process.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Canadian generally accepted auditing standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with Canadian generally accepted auditing standards, we exercise professional judgment and maintain professional skepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit 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 College's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast doubt on the College's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the College to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

TORONTO, Ontario
DATE

Licensed Public Accountants

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
Statement of Financial Position

As at December 31	2020	2019
Assets		
Current		
Cash	**$ 57,723,392**	$ 50,087,897
Accounts receivable	**1,626,007**	1,260,091
Prepaid expenses	**1,143,913**	1,832,420
	60,493,312	53,180,408
Investments (note 3)	**50,000,000**	51,375,478
Tangible assets (note 4)	**9,205,442**	9,206,810
Intangible assets (note 4)	**5,771,532**	-
	$125,470,286	$113,762,696
Liabilities		
Current		
Accounts payable and accrued liabilities	**$ 9,222,798**	$ 10,473,824
Current portion of obligations under capital leases (note 7)	**837,439**	572,095
	10,060,237	11,045,919
Deferred revenue (note 5)	**33,250,440**	32,858,647
	43,310,677	43,904,566
Accrued pension cost (note 6)	**5,319,798**	4,976,768
Obligations under capital leases (note 7)	**786,489**	664,349
	49,416,964	49,545,683
Net assets		
Internally restricted (note 8)		
Invested in tangible assets	**7,581,514**	7,970,366
Invested in intangible assets	**5,771,532**	-
Building Fund	**60,700,276**	56,246,647
Intangible Asset Fund	**2,000,000**	-
Pension remeasurements (note 6)	**(1,173,107)**	(689,281)
Unrestricted	**1,173,107**	689,281
	76,053,322	64,217,013
	$125,470,286	$113,762,696

Commitments and contingencies (notes 9 and 10, respectively)

Approved on behalf of the Council

_____

_____

See accompanying notes to the financial statements.

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Statement of Operations and Changes in Unrestricted Net Assets

Year ended December 31	**2020**	2019
Revenue		
Membership fees		
General and educational (note 5)	**$ 66,676,837**	$ 65,695,176
Penalty fee	**1,026**	178,723
	66,677,863	65,873,899
Application fees	**7,933,273**	8,699,775
OHPIP annual and assessment fees (note 5)	**939,982**	808,331
IHF annual and assessment fees (note 5)	**1,243,292**	891,207
OHPIP, IHF application fees and penalties	**39,914**	53,985
Cost recoveries and other income	**1,913,672**	2,529,529
Interest income	**680,745**	1,219,884
	79,428,741	80,076,610
Expenses		
Committee costs (schedule I)	**9,005,343**	11,900,411
Staffing costs (schedule II)	**47,889,503**	49,427,463
Department costs (schedule III)	**8,025,007**	10,197,032
Depreciation of capital assets	**1,874,590**	1,224,169
Occupancy (schedule IV)	**2,373,431**	2,832,618
	69,167,874	75,581,693
Excess of revenue over expenses before undernoted items	**10,260,867**	4,494,917
Investment income	**2,059,268**	2,797,036
Excess of revenue over expenses for the year	**12,320,135**	7,291,953
Unrestricted net assets, beginning of year	**689,281**	509,379
Less: Invested in tangible and intangible capital assets (net)	**(5,382,680)**	655,121
Less: Transfer to Building Fund	**(4,453,629)**	(7,767,172)
Less: Transfer to Intangible Asset Fund	**(2,000,000)**	-
Unrestricted net assets, end of year	**$ 1,173,107**	$ 689,281

See accompanying notes to the financial statements.

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
Statement of Cash Flows

Year ended December 31	**2020**	2019
Cash flows from operating activities:		
Excess of revenue over expenses for the year	**$ 12,320,135**	$ 7,291,953
Depreciation of capital assets	**1,874,590**	1,224,169
	14,194,725	8,516,122
Net change in non-cash working capital items:		
Accounts receivable	**(365,916)**	(857,159)
Prepaid expenses	**688,507**	(866,789)
Accrued interest receivable	**1,375,478**	(354,013)
Accounts payable and accrued liabilities	**(1,251,026)**	2,946,232
Deferred revenue	**391,793**	1,577,475
Pension cost	**(140,796)**	(678,012)
Cash provided by operating activities	**14,892,765**	10,283,856
Cash flows used by investing activities:		
Purchase of tangible capital assets	**(265,018)**	(7,806)
Purchase of intangible capital assets	**(6,116,805)**	-
Cash used by investing activities	**(6,381,823)**	(7,806)
Cash flows used by financing activities:		
Payment of capital lease obligations	**(875,447)**	(561,242)
Net increase in cash	**7,635,495**	9,714,808
Cash, beginning of year	**50,087,897**	40,373,089
Cash, end of year	**$ 57,723,392**	$ 50,087,897

See accompanying notes to the financial statements.

1 Organization

College of Physicians and Surgeons of Ontario ("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.

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 carried 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.

When conditions indicate a capital asset no longer contributes to the College's ability to provide services or that the value of future economic benefits or service potential associated with the capital asset is less than its net carrying amount, its net carrying amount is written down to its fair value or replacement costs. As at December 31, 2020, no such impairment exists.

(i) Tangible assets

Tangible assets are measured at cost less accumulated amortization and accumulated.

Amortization is provided for, upon the commencement of the utilization of the assets, on a straight-line basis over their estimated lives as follows:

Building	10 - 25 years	Computer and other equipment	3 - 5 years
Furniture and fixtures	10 years	Computer equipment under capital lease	2 - 4 years

(ii) Intangible assets

Intangible assets, consisting of separately acquired computer application software, are measured at cost less accumulated amortization.

Amortization is provided for, upon the commencement of the utilization of the assets, on a straight-line basis over their estimated useful lives of four years.

2 Significant accounting policies continued

(d) Pension plan

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 accounting 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.

(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) Cost recoveries

Cost recoveries are recognized at the same rate as the related costs are expensed.

(iv) Other income

Other income is recognized as the services are provided, the amount is known and collection is reasonably assured.

(v) Interest and investment income

Interest income is comprised of interest on cash deposits held in an interest bearing account at a major financial institution. Investment income is comprised of income on guaranteed investment certificates.

Interest and investment income are recognized when earned. Income on guaranteed growth investment certificates is determined at maturity based on the percentage change in price of an equally weighted portfolio of five Canadian bank's shares. Interest is accrued at the minimum guaranteed rates.

2 Significant accounting policies continued

(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 Investments

As at December 31	**2020**	2019
Cash	**$ 50,000,000**	$ -
Guaranteed Investment Certificates (GIC)		
National Bank, 2.01%, due December 22, 2020	**-**	10,000,000
Manulife Bank, 2.20%, due November 16, 2020	**-**	10,000,000
BMO, 3.17%, due November 16, 2020	**-**	10,000,000
CIBC, guaranteed growth, minimum 0.60% annual return, due November 13, 2020	**-**	10,000,000
CIBC, guaranteed growth, minimum 0.50% annual return, due November 13, 2019	**-**	10,000,000
Accrued interest	**-**	1,375,478
	$ 50,000,000	$ 51,375,478

On January 29, 2021 the College purchased $25,000,000 NBC Canadian Bank Portfolio Flex GIC maturing on January 29, 2026 earning a return determined at maturity based on the percentage change in price of an equally weighted portfolio of five Canadian bank's shares.

On February 1, 2021 the College purchased $25,000,000 BMO Extendible GIC earning 1.45% with a maturity date of February 1, 2022.

4 Capital assets

As at December 31	2020		2019	
	Cost	**Accumulated Amortization**	Cost	Accumulated Amortization
Tangible assets				
Land	**$ 2,142,903**	**$ -**	$ 2,142,903	$ -
Building and building improvements	**21,089,134**	**16,136,035**	20,834,320	15,639,748
Furniture and fixtures	**4,493,281**	**4,014,251**	4,483,078	3,861,951
Computer and other equipment	**1,943,244**	**1,936,762**	1,282,395	1,270,631
Computer equipment under capital lease	**3,839,472**	**2,215,544**	3,410,753	2,174,309
Leasehold improvements	**33,508,034**	**24,302,592**	32,153,449	22,946,639
Net book value		**$ 9,205,442**		$ 9,206,810
Intangible assets				
Computer application software	**$ 6,116,805**	**$ 345,273**	$ -	$ -
Net book value		**$ 5,771,532**		$ -

5 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**	**2020 Total**	2019 Total
Balance, beginning of year	**$ 28,372,112**	**$ 3,256,375**	**$ 1,230,160**	**$ 32,858,647**	$ 31,281,172
Amounts billed during the year	**66,572,045**	**1,408,544**	**1,271,315**	**69,251,904**	68,972,189
Less: Recognized as revenue	**(66,676,837)**	**(1,243,292)**	**(939,982)**	**(68,860,111)**	(67,394,714)
Balance, end of year	**$ 28,267,320**	**$ 3,421,627**	**$ 1,561,493**	**$ 33,250,440**	$ 32,858,647

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

6 Employee future benefits

(a) Pension plan

(i) Plan description

The College maintains a defined contribution pension plan for the benefit of some of its employees.

On September 30, 2019 the Employees' Retirement Savings Plan for the College of Physicians and Surgeons of Ontario was terminated. Effective October 1, 2019 the College established the CPSO Retirement Savings Plan 2019, a new defined contribution pension plan.

Employees who were eligible to participate in the Employees' Retirement Savings Plan for the College of Physicians and Surgeons of Ontario had the option to join the CPSO Retirement Savings Plan 2019 or join the Healthcare of Ontario Pension Plan ("HOOPP"). Employees of the College hired after August 30, 2019 are required to join HOOPP.

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 Income Tax Act (Canada).

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**	**2020 Total**	2019 Total
Plan assets at fair value	**$ 2,845,069**	**$ -**	**$ 2,845,069**	$ 2,951,102
Accrued pension obligations	**(3,790,392)**	**(4,374,475)**	**(8,164,867)**	(7,927,870)
Funded status - deficit	**$ (945,323)**	**$ (4,374,475)**	**$ (5,319,798)**	$ (4,976,768)

(iii) Pension plan assets

Defined Benefit Plan	**Funded Plan**	**Unfunded Plan**	**2020 Total**	2019 Total
Fair value, beginning of year	**$ 2,951,102**	**$ -**	**$ 2,951,102**	$ 2,417,973
Interest income	**88,533**	**-**	**88,533**	90,674
Return on plan assets (excluding interest)	**125,409**	**-**	**125,409**	164,438
Employer contributions	**-**	**290,099**	**290,099**	883,320
Benefits paid	**(319,975)**	**(290,099)**	**(610,074)**	(605,303)
Fair value, end of year	**$ 2,845,069**	**$ -**	**$ 2,845,069**	$ 2,951,102

6 Employee future benefits (continued)

(a) Pension plan (continued)

(iv) Accrued pension obligations

Defined Benefit Plan	**Funded Plan**	**Unfunded Plan**	**2020 Total**	2019 Total
Balance, beginning of year	**$ 3,708,356**	**$ 4,219,514**	**$ 7,927,870**	$ 7,892,851
Interest cost on accrued pension obligations	**111,251**	**126,585**	**237,836**	295,982
Benefits paid	**(319,975)**	**(290,099)**	**(610,074)**	(605,303)
Actuarial (gains) losses	**290,760**	**318,475**	**609,235**	344,340
	$ 3,790,392	**$ 4,374,475**	**$ 8,164,867**	$ 7,927,870

The most recent actuarial valuation of the pension plan for funding purposes was made effective December 31, 2018. The next required actuarial valuation for funding purposes must be as of a date no later than December 31, 2021.

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

	2020	2019
Funded defined benefit plan	**$ 22,718**	$ 49,005
Unfunded supplementary defined benefit plan	**126,585**	156,303
Defined contribution plan	**966,883**	2,857,903
Healthcare of Ontario Pension Plan	**2,514,591**	854,500
	$ 3,630,777	$ 3,917,711

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

Defined Benefit Plan	**Funded Plan**	**Unfunded Plan**	**2020 Total**	2019 Total
Interest cost on accrued pension obligations	**$ 111,251**	**$ 126,585**	**$ 237,836**	$ 295,982
Interest income on pension assets	**(88,533)**	**-**	**(88,533)**	(90,674)
Pension expense recognized	**$ 22,718**	**$ 126,585**	**$ 149,303**	$ 205,308

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

Defined Benefit Plan	**Funded Plan**	**Unfunded Plan**	**2020 Total**	2019 Total
Actuarial losses	**$ 290,760**	**$ 318,475**	**$ 609,235**	$ 344,340
Return on plan assets (excluding interest)	**(125,409)**	**-**	**(125,409)**	(164,438)
Charge to net assets	**$ 165,351**	**$ 318,475**	**$ 483,826**	$ 179,902

6 Employee future benefits (continued)

(a) Pension plan (continued)

(viii) Actuarial assumptions

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

	2020	2019
Discount rate	**2.20 %**	3.00 %

(b) Restructuring benefits

The College restructured its affairs during the year for the purpose of achieving long-term savings, which resulted in severance benefits to employees in the amount of $2,266,872 (2019 - $4,195,252), which has been included in staffing costs.

7 Obligations under capital leases

The College has entered into capital leases for computer equipment. The following is a schedule of the future minimum lease payments over the term of the leases:

2021	$ 837,439
2022	648,518
2023	137,971
	1,623,928
Less: current portion	837,439
	$ 786,489

8 Internally restricted net assets

2020	Invested in Capital Assets	Intangible Asset Fund	Building Fund	Pension Re-measurement
Balance, January 1	**$ 7,970,366**	**$ -**	**$ 56,246,647**	**$ (689,281)**
Excess (deficiency) of revenue over expenses for the year	**(1,874,590)**	**-**	**2,059,268**	**-**
Transfer to Intangible Asset Fund	**-**	**8,116,805**	-	-
Actuarial remeasurement for pensions	**-**	**-**	**-**	**(483,826)**
Transfer to Invested in Capital Assets	**7,257,270**	**(6,116,805)**	-	-
Transfer to Building Fund	**-**	**-**	**2,394,361**	**-**
Balance, December 31	**$ 13,353,046**	**$ 2,000,000**	**$ 60,700,276**	**$ (1,173,107)**

2019	Invested in Capital Assets	Intangible Asset Fund	Building Fund	Pension Re-measurement
Balance, January 1	$ 8,625,487	$ -	$ 48,479,475	$ (509,379)
Excess (deficiency) of revenue over expenses for the year	(1,224,169)	-	2,797,036	-
Actuarial remeasurement for pension	-	-	-	(179,902)
Transfer to Building Fund	569,048	-	4,970,136	-
Balance, December 31	$ 7,970,366	$ -	$ 56,246,647	$ (689,281)

The College has transferred $2,394,361 (2019 - $4,970,136) to the building fund and $2,000,000 (2019 - $nil) to the Intangible Asset Fund from unrestricted net assets.

Net assets invested in capital assets is calculated as follows:

As at December 31	2020	2019
Net book value of capital assets	**$ 5,771,532**	$ -
Net book value of intangible assets	**9,205,442**	-
Less: obligations under capital leases	**(1,623,928)**	(1,236,444)
	$ 13,353,046	$ (1,236,444)

9 Commitments

The College has a lease for additional office space which extends to February 28, 2023 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 year of the current term are estimated as follows:

2021	$ 721,733
2022	729,920
2023	123,045
Total	$ 1,574,698

10 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.

11 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.

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
Schedule I
Committee Costs

Year ended December 31	2020	2019
Attendance	**$ 2,521,677**	$ 3,587,606
Preparation time	**2,722,037**	3,213,832
Decision writing	**1,030,050**	962,996
Travel time	**434,246**	1,355,342
HST on per diems	**378,951**	532,614
Legal costs	**1,471,356**	981,253
Audit fees	**53,901**	62,498
Sustenance	**67,377**	227,118
Accommodations	**108,424**	311,956
Travel expenses	**208,921**	619,754
Witness expenses	**8,403**	45,442
	$ 9,005,343	$ 11,900,411

Schedule II
Staffing Costs

Year ended December 31	2020	2019
Salaries	**$ 37,932,315**	$ 38,762,403
Employee benefits	**5,163,570**	5,498,703
Pension (note 6)	**3,630,777**	3,917,711
Training, conferences and employee engagement	**479,431**	864,169
Personnel, placement and pension consultants	**683,410**	384,477
	$ 47,889,503	$ 49,427,463

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
Schedule III
Department Costs

Year ended December 31	2020	2019
Consultant fees	**$ 1,440,687**	$ 3,909,288
Credit card service charges	**1,540,401**	1,521,195
Software	**1,445,462**	875,862
Equipment leasing	**89,030**	65,674
Equipment maintenance	**5,378**	15,089
Miscellaneous	**516,259**	493,799
Photocopying	**210,566**	285,769
Printing	**2,962**	8,537
Postage	**98,159**	206,983
Members dialogue	**296,598**	388,540
Courier	**24,789**	31,978
Telephone	**269,185**	273,750
Office supplies	**514,652**	246,693
Reporting and transcripts	**272,120**	312,036
Professional fees - staff	**153,466**	139,961
FMRAC membership fee	**454,528**	445,616
Publications and subscriptions	**185,741**	206,111
Travel	**172,814**	238,765
Survivors' Fund	**293,966**	391,089
Grants	**38,244**	140,297
	$ 8,025,007	$ 10,197,032

Schedule IV
Occupancy

Year ended December 31	2020	2019
Building maintenance and repairs	**$ 871,572**	$ 1,243,562
Insurance	**592,234**	545,263
Realty taxes	**108,101**	102,593
Utilities	**159,937**	213,845
Rent	**641,587**	727,355
	$ 2,373,431	$ 2,832,618

Council Motion

Motion Title	Approval of the Audited Financial Statements for 2020
Date of Meeting	June 18, 2021

It is moved by_____, and seconded by_____, that:

The Council approves the financial statements for the fiscal year ended December 31, 2020 as presented (a copy of which form Appendix "…" to the minutes of this meeting).

Council Motion

Motion Title	Appointment of the Auditors
Date of Meeting	June 18, 2021

It is moved by_____, and seconded by_____, that:

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

Council Motion

Motion Title	Establishment of an internally restricted intangible asset fund and asset transfer
Date of Meeting	June 18 2021

It is moved by_____, and seconded by_____, that:

1. The Council approves the establishment of an internally restricted intangible asset fund for the purposes of future information technology infrastructure development and improvements; and

2. The Council approves that $8,116,895.00 dollars be transferred to the internally restricted intangible asset fund.

Council Briefing Note

CPSO

June 2021

Topic:	Remuneration for Council and Committee Members
Purpose:	For Information
Relevance to Strategic Plan:	Continuous Improvement
Main Contact(s):	Laurie Cabanas, Director of Governance Douglas Anderson, Corporate Services Officer
Attachment(s):	N/A

Issue

- The ability for physician members to bill for the greater of actual time spent or booked for a meeting. This would remove the six-hour maximum requirement as indicated on the Statement of Services Rendered Form (SSR)

Background

- Over the past few months, the Governance Office has received feedback from Council and Committee members regarding the SSR, particularly the maximum allowable hours for meeting attendance (six hours).

- Since COVID-19, there have been instances where a meeting was scheduled for longer than six hours or where a physician member participated in multiple meetings in one day totaling more than six hours.

- A proposal was presented to the Finance and Audit Committee at its April 8th meeting to remove the six-hour maximum, inclusive of lunch; the Committee felt that the proposal was reasonable as it would have limited impact on the budget.

Council Briefing Note

June 2021

Topic:	*Third Party Medical Reports* – Revised Draft Policy for Final Approval
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation Quality Care Meaningful Engagement System Collaboration
Public Interest Rationale:	Helps ensure physicians provide high quality and timely examinations, reports and testimony for third party purposes.
Main Contact(s):	Michelle Cabrero Gauley, Senior Policy Analyst
Attachment(s):	Appendix A: *Third Party Medical Reports* Policy Appendix B: *Advice to the Profession: Third Party Medical Reports*

Issue

- The College's *Third Party Reports* and *Medical Expert: Reports and Testimony* policies are currently under review. A new consolidated draft policy, *Third Party Medical Reports*, was released for external consultation in September 2020, along with a companion *Advice to the Profession* document (*Advice*). The draft policy and *Advice* have been revised in light of the feedback received through this engagement activity.

- Council is provided with an overview of the key issues considered by the Working Group as well as the proposed revisions and is asked whether the revised draft policy can be approved as a policy of the College.

Background

- The current *Third Party Reports* policy was first approved by Council in 2002 and was last reviewed and updated in May 2012.[1] The current *Medical Expert: Reports and Testimony* policy was first approved by Council in December 2012.

[1] Minor updates were made to the policy in May 2018 to accurately reflect the provisions in Bill 87, the *Protecting Patients Act, 2017*, that came into force on May 1, 2018.

- Following extensive research[2] and a preliminary consultation[3], a new consolidated draft policy was developed with direction from the standing Policy Review Working Group[4]. Additional support was provided by Amy Block and Ruth Ainsworth (Legal Counsel) and Ted Everson (Medical Advisor).

- The draft policy was approved for external consultation by Council in September 2020. The accompanying draft *Advice* was also released at this time.

    - A total of 95 responses were received as part of this external consultation.[5] The majority of respondents were physicians (73%), followed by 10 organizational respondents (11%)[6]. All feedback received has been posted on a dedicated page of the College's website.

    - Overall, feedback on the draft policy was largely positive. Most respondents found the draft policy clearly written, easy to understand, and comprehensive, and feedback around the draft expectations was largely supportive.

    - However, some respondents expressed concern regarding a few of the new draft expectations, mainly the requirement to have an active certificate of registration and be actively practising in order to accept a request to conduct an independent medical examination (IME) and act as a medical expert.

Current Status and Analysis

- Revisions have been made to both the draft *Third Party Medical Reports* policy (**Appendix A**) and *Advice* (**Appendix B**), predominantly in response to feedback obtained during the external consultation.

[2] This included a literature review of scholarly articles and research papers; a jurisdictional review of Canadian and International medical regulatory authorities and Ontario health profession regulators; relevant statistical information regarding matters before the Inquiries, Complaints, and Reports Committee (ICRC); and feedback on the current policy from the College's Public and Physician Advisory Service (PPAS).
[3] The consultation was held from December 2019 to February 2020 and garnered a total of 210 responses: 52 through written feedback and 158 via the online consultation survey. A high-level summary of the feedback received can be found in the March 2020 Council materials.
[4] At the time, the standing Policy Review Working Group consisted of Brenda Copps (Chair), Ellen Mary Mills, and Janet van Vlymen, as well as Medical Advisors Angela Carol and Keith Hay.
[5] 24 responses were received through the online discussion page and 71 through the online survey.
[6] Organizational respondents included: Canadian Medical Protective Association (CMPA); FAIR Association of Victims for Accident Insurance Reform (FAIR); Insurance Bureau of Canada (IBC); Medico-Legal Society of Toronto (MLST); Office of the Information and Privacy Commissioner of Ontario (IPC); Ontario Medical Association (OMA); OMA Section on Plastic Surgery (OMA SPS); Ontario Homeopathic Medical Association (OHMA); Ontario Trial Lawyers Association (OTLA); Professional Association of Residents of Ontario (PARO).

- The revisions were developed based on feedback and direction from the new Policy Review Working Group.[7] Legal Counsel, Amy Block and Ruth Ainsworth, and Medical Advisor, Ted Everson, have continued to support this review.

- It is notable that the revised draft policy retains the existing content from the current policies and addresses new issues, while achieving a 30% reduction in word count when compared to the two existing policies.

- While the revised draft policy expectations are largely consistent with those of the draft policy that went out for consultation, some updates have been made to improve clarity and brevity, and address the concerns raised by consultation respondents.

- An overview of the key issues considered by the Working Group, along with any corresponding revisions, are set out below.

Treating Physicians' Obligations

- The draft policy requirement for treating physicians to provide testimony when requested or ordered (e.g., by subpoena or summons) has been revised to require that they provide testimony only when ordered (Provision #2b).

    - The Working Group made this revision in response to consultation feedback suggesting that physicians may receive requests to testify when their evidence is irrelevant or unnecessary. The Working Group felt it would be more appropriate to require that treating physicians testify only when ordered, as there would be some level of oversight to ensure their testimony would be relevant and necessary.

Active Certificate of Registration and Active Practice

- The draft policy requirement for physicians to have an active certificate of registration to accept a request to conduct an IME and act as a medical expert has been revised to require an active certificate of registration only for IMEs (Provision #5a).

    - The Working Group believed this revision would address the concerns raised by consultation respondents regarding the appropriateness of requiring licensure for medical experts when it may not be relevant in all cases and it is ultimately up to an adjudicative body to determine whether or not an expert is qualified.

- The draft policy requirement for physicians to be in active practice to accept a request to conduct IMEs and act as medical experts was removed and replaced with the following new requirements: physicians must only accept a request if the matter falls within their scope of practice and area of expertise; and they have the requisite knowledge, skill, and judgment (Provisions #5b-c and #6).

[7] Now comprised of Brenda Copps, Janet van Vlymen, Lydia Miljan, Peter Pielsticker, Sarah Reid, Karen Saperson, and Keith Hay.

- After much discussion, the Working Group determined that these revisions would be just as effective at ensuring that physicians only accept requests to conduct IMEs and act as medical experts if they have the appropriate experience and expertise.

- The Working Group decided to include "active practice" in the *Advice* as a factor that physicians can consider when determining whether they meet the policy requirements.

- These revisions address the concerns raised by consultation respondents regarding the appropriateness of requiring "active practice" for IMEs and medical expert work when it may not be relevant in all cases and it is ultimately up to an adjudicative body to determine whether or not an expert is qualified.

Privacy and Consent

- The draft policy requirement for physicians to obtain express consent in all circumstances has been qualified to acknowledge there may be some circumstances where it would be unreasonable to obtain consent (Provision #9).

    - Although there was broad support for the express consent requirement in the draft policy, the Working Group agreed with the consultation respondents who suggested that there may be some circumstances where physicians may be permitted or required by law to proceed without consent and it would be unreasonable to obtain express consent (e.g., in the context of a regulatory investigation).

Transparent

- The draft policy requirement for physicians to be transparent about who assisted them with the IME and third party medical report has been maintained, but the following has been added: a new requirement for physicians to ensure that any statements and/or opinions expressed are their own (Provision #22b); and the circumstances where it may be inappropriate for physicians to get assistance as set out in the case law (Footnote #18).

    - After much discussion, the Working Group confirmed the policy position should be maintained as it may be appropriate, and in some cases beneficial, for physicians to get assistance (which there was support for in the consultation feedback), but decided to make these additions to address the concerns raised by some consultation respondents regarding the appropriateness of physicians getting assistance with IMEs and third party medical reports in all circumstances given the case law.

Timely

- The draft policy requirements for physicians to provide third party medical reports that require IMEs within 60 days (Provision #24a), and third party medical reports that do not require IMEs within 45 days (Provision #24b) have been maintained.

- The Working Group considered the consultation feedback which indicated most respondents thought 60 days would be reasonable for *all* third party medical reports, but felt 45 days for third party medical reports that do not require IMEs should be maintained as there was a significant amount of support for this timeframe in the consultation feedback[8] and third party medical reports that do not require IMEs tend to be less complex.

Observers

- The draft policy requirements for observers have been revised to: align with the College's *Boundary Violations* policy requirement for intimate examinations (Provision #29a); and require that observers be permitted when physicians are of the view that the observer's presence will likely not impact the examination (Provision #29b).

    - The Working Group felt strongly that requests for observers must be permitted, when appropriate, as subjects may feel uncomfortable and/or vulnerable being examined by a physician they do not have a treating relationship with. These revisions are consistent with the consultation feedback received.

Clinically Significant Findings

- The draft policy requirements for clinically significant findings have been retained in substance but reframed to help clarify that physicians are required to do *something* if they discover a clinically significant finding, but they can choose *what* to do from a list of options depending on the circumstances (Provisions #31-32). In addition, the draft policy was amended to give physicians discretion as to whether they communicate the finding to the subject *or* the subject's primary health-care provider when the subject is *not* at imminent risk of harm (Provision #32a).

    - The Working Group felt strongly about maintaining the draft policy expectations but thought reframing would address the concern raised by a consultation respondent regarding the duty of care that may be created if a physician treats a subject. The Working Group thought reframing would clarify that physicians do not have to provide the necessary care if they take other steps to ensure the clinically significant finding is appropriately disclosed and managed, but there is nothing in the revised draft policy that would restrict them from doing so if they felt the situation was so emergent or urgent they need to provide care right then and there.

    - The Working Group thought it would be reasonable and consistent with the College's *Walk-in Clinics* policy to allow physicians to use their professional judgement to determine *who* to disclose the clinically significant finding to (subject *or* primary health-care provider) when the subject is *not* at imminent risk of harm.

[8] 54% of survey respondents thought it was reasonable.

Next Steps

- Should Council approve the revised draft policy, it will be announced in *Dialogue* and added to the College's website.

Question for Council

1. Does Council approve the revised draft *Third Party Medical Reports* policy as a policy of the College?

Third Party Medical Reports

Policies of the College of Physicians and Surgeons of Ontario (the "College") set out expectations for the professional conduct of physicians practising in Ontario. Together with the *Practice Guide* and relevant legislation and case law, they will be used by the College and its Committees when considering physician practice or conduct.

Within policies, the terms 'must' and 'advised' are used to articulate the College's expectations. When 'advised' is used, it indicates that physicians can use reasonable discretion when applying this expectation to practice.

Additional information, general advice, and/or best practices can be found in companion resources, such as *Advice to the Profession* documents.

Definitions

Third party: Any person or organization other than the physician and subject (e.g., insurer, government, employer, educational institution, lawyer, etc.).

Third party processes: Processes that relate to insurance benefits, government benefits and programs, employment, educational programs, legal proceedings, etc.

Independent medical examinations (IME): Examinations that are conducted on individuals[1] strictly for the purpose of a third party process and *not* for the provision of health care. IMEs can include a file review (e.g., reviewing medical records, reports, etc.) and/or examination (e.g., physical, psychological, functional, etc.) of the individual.

Third party medical reports and testimony: Information and/or opinions that are provided by treating and non-treating physicians in writing (e.g., note, form, letter, or report) and/or orally for a third party or third party process.

Subjects: Patients or individuals who are the subject of an IME, third party medical report, and/or testimony.[2]

Medical experts: Physicians who, by virtue of their medical education, training, skill and/or experience, have specialized knowledge and expertise on medical issues. They are retained by or on behalf of a party to provide opinion evidence in relation to a legal

[1] The College will consider individuals who are the subject of an IME, third party medical report, or testimony to be patients for the purposes of the sexual abuse provisions set out in the *Health Professions Procedural Code,* Schedule 2 of the *Regulated Health Professions Act, 1991*, S.O. 1991, c.18.
[2] Throughout this policy, where "subject" is referred to, it should be interpreted as "subject or substitute decision-maker" where applicable.

proceeding. Expert opinions are communicated by physicians in third party medical reports and/or testimony.

Policy

1. Physicians **must** comply with the expectations set out in this policy and any other specific legal principles and requirements that may apply to the IME, third party medical report, and/or testimony.[3]

Physicians' Obligations

2. Treating physicians **must** provide:
    a. Third party medical reports about their current and former patients when requested, unless they no longer have an active certificate of registration[4]; and
    b. Testimony about their current and former patients when ordered (e.g., by subpoena or summons).

3. Before accepting a request to conduct an IME or act as a medical expert, physicians **must** disclose to the requesting party (i.e., the third party that requested the IME, third party medical report, and/or testimony) any perceived or potential conflicts of interest[5,6] and the physician **must**, in consultation with the requesting party, determine no conflict exists.[7]

[3] For example, this can include, but is not limited to: the principles of solicitor-client and litigation privilege; requirements found in the *Personal Health Information Protection Act, 2004,* S.O. 2004, c.3, Sched A. (hereinafter *PHIPA*), and the *Personal Information Protection and Electronic Documents Act,* S.C. 2000, c 5 (hereinafter *PIPEDA*); requirements found in the *Courts of Justice Act*, R.S.O. 1990, c. C.43, the *Insurance Act*, R.S.O. 1990, c. I.8, the *Workplace Safety and Insurance Act, 1997*, S.O. 1997, c.16, Sched. A., and the *Occupational Health and Safety Act*, R.S.O. 1990, c.O.1; and the relevant regulations enacted under these Acts. Physicians may want to seek independent legal advice regarding the specific legal principles and requirements that apply to their circumstances.

[4] In accordance with provision 18 in the College's *Closing a Medical Practice* policy.

[5] An example of where a conflict of interest may arise is when physicians have a personal or professional relationship with one of the parties (or their representatives) involved in the third party process.

[6] Even the fact that the physician has or had a treating relationship with a patient is considered personal health information and therefore any disclosure must be made in accordance with the 'Privacy and Consent' section of the policy.

[7] It may be possible to proceed notwithstanding a conflict if the following conditions are met:

- the conflict has been disclosed to all parties;
- all parties expressly waive the conflict; and
- the physician has determined the conflict would not affect their objectivity or impartiality.

4. Physicians **must** discharge provisions 2-3 in accordance with the 'Privacy and Consent' section of the policy.

5. Physicians are not obligated to conduct IMEs and **must** only accept a request to do so if:
    a. they currently have an active certificate of registration;
    b. the matter falls within their scope of practice and area of expertise; and
    c. they have the requisite knowledge, skill, and judgment to conduct the IME.

6. Physicians are not obligated to act as medical experts and **must** only accept a request to do so if:
    a. the matter falls within their scope of practice and area of expertise; and
    b. they have the requisite knowledge, skill, and judgement to provide the expert opinion.

7. When accepting a request to conduct an IME and/or provide a third party medical report and testimony, physicians **must**:
    a. know who the requesting party is;
    b. understand what they are being asked to do, including the scope of their role and responsibilities and the specific questions they are being asked to answer; and
    c. only enter into contracts with the requesting party (e.g., outlining scope, purpose, timelines, fee arrangements, etc.,) that comply with the expectations set out in this policy.

Physicians' Role

8. Physicians **must** understand and communicate the nature of their role to subjects[8] they interact directly with, which includes that their role:
    a. is to *provide* information and/or opinions for the third party or third party process and not to *decide* how the information and/or opinions will be used by the third party or the relevant decision-makers in the third party process;
    b. may involve collecting, using, and disclosing personal information and/or personal health information to a third party; and
    c. if applicable, may involve conducting an IME for the purpose of a third party process and *not* for the provision of health care.

[8] Patients may be confused about the nature of the physician's role when it is their own treating physician that is involved in the third party process.

Privacy and Consent

9. Unless permitted or required by law to proceed without consent and it would be unreasonable in the circumstances to obtain consent,[9] physicians **must** ensure express consent[10] has been obtained from the subject to:
    a. Collect, use, or disclose the subject's personal information to a third party,[11] and
    b. Conduct an IME.

10. While the consent process will vary depending on the circumstances, at minimum, physicians **must** ensure the following points are conveyed as part of obtaining consent:
    a. the purpose, scope, and rationale of the IME, if applicable;
    b. that consent can be withdrawn at any time; however, this may prevent the physician from completing the IME and/or third party medical report and providing testimony;
    c. that limits may be placed on the information that physicians can disclose in writing and/or orally; however, such limitations may prevent the physician from providing the third party report and/or testimony; and
    d. if consent is withdrawn or limited by the subject, physicians may still be permitted or required by law to collect, use, or disclose the subject's personal information and/or personal health information.[12]

Fees

11. Physicians **must** discuss any requirements or arrangements with respect to fees (including cancellation fees for missed appointments) with the requesting party before conducting the IME and providing the third party report and testimony.

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[9] Where *PIPEDA* or *PHIPA* apply, there are some exceptions to the general requirement that a subject's consent be obtained to collect, use, or disclose their information (see Division 1, Section 7 of *PIPEDA* and Part IV of *PHIPA*). In other circumstances, neither *PIPEDA* nor *PHIPA* may apply. Physicians are responsible for determining whether the subject's consent is required by law in the circumstances, and whether it would be unreasonable to proceed without the subject's express consent, even if not required by law.

[10] Express consent is direct, explicit, and unequivocal, and can be given in writing or orally.

[11] A subpoena or summons does not grant physicians the authority to speak to anyone about the patient or disclose their medical records without the patient's (or their substitute decision-maker's) consent, unless permitted or required by law (e.g., court order). For more information, see: Canadian Medical Protective Association. (2009). *Subpoenas-What are a physician's responsibilities*.

[12] See footnote 9.

12. Physicians **must** comply with any specific legal requirements in relation to fees for IMEs, third party medical reports, and testimony.

13. In the absence of any specific legal requirements, physicians **must** ensure their fees are reasonable in accordance with the College's *Uninsured Services: Billing and Block Fees* policy and regulation.[13]

Requirements for Independent Medical Examinations, Third Party Medical Reports, and Testimony

14. Physicians **must** conduct IMEs and provide third party medical reports and testimony that are:
    a. within their scope of practice and area of expertise;
    b. comprehensive and relevant;
    c. fair, objective, and non-partisan;
    d. transparent, accurate[14], and clear; and
    e. timely.

Additional information relating to each requirement is set out below.

Within Scope of Practice & Area of Expertise

15. Physicians **must:**
    a. accurately represent their scope of practice and area of expertise, including their qualifications, in accordance with relevant College policy and regulation;[15] and
    b. restrict their IMEs, statements and/or opinions to matters that are within their scope of practice and area of expertise.

[13] Section 1(1), paragraphs 21 and 22 of *Professional Misconduct*, O. Reg., 856/93, enacted under the *Medicine Act, 1991*, S.O. 1991, c. 30 (hereinafter *Medicine Act, Professional Misconduct Regulation*).
[14] Section 1(1), paragraph 18 of the *Medicine Act, Professional Misconduct Regulation*.
[15] College's registration policy on *Specialist Recognition Criteria in Ontario* (also see the *Cosmetic Surgery FAQ* and *Advertising FAQ*); and section 9(1) of *General*, O. Reg 114/94, enacted under the *Medicine Act, 1991*, S.O. 1991, c. 30.

Comprehensive & Relevant

16. Physicians **must** take reasonable steps to obtain[16] and review all relevant clinical information and opinions relating to the subject that could impact their statements and/or opinions.

17. Physicians **must** clearly identify any limitations on the comprehensiveness of the IMEs they conduct and the third party medical reports and testimony they provide, including:
    a. if they are unable to fulfil an element of the third party's request because the information and/or opinion requested is beyond their scope of practice and area of expertise;
    b. if after taking reasonable steps they are unable to obtain all relevant clinical information and opinions relating to the subject that could impact their statements and/or opinions;
    c. if consent has been withdrawn;
    d. if limits have been placed by the subject on the information that can be disclosed to the third party; and
    e. the impact that a-d have had on the statements and/or opinions they provide.

18. Physicians **must not** deliberately leave out relevant information and/or opinions in any third party medical reports and testimony they provide unless that limitation has been identified in accordance with provision 17.

19. Physicians **must not** make any unrelated or unnecessary comments during IMEs and **must** only provide information and/or opinions in third party medical reports and testimony that are relevant to request.

Fair, Objective & Non-Partisan

20. Physicians **must**:
    a. provide statements and/or opinions that are reasonable and substantiated by fact, scientific knowledge and evidence, and sound clinical judgment; and
    b. ensure the statements and/or opinions they provide are not influenced by prejudice or bias, the party who requests or pays for their services, or the potential outcome of the third party process.

[16] Indirectly via medical records or reports and/or directly via examination of the subject.

Transparent, Accurate & Clear

21. For any third party medical reports and testimony provided, physicians **must**:
    a. Clearly state what they have been asked to do and by whom.
    b. Describe the basis or rationale for their statements and/or opinions, including:
        i. the facts or factual assumptions their statements and/or opinions are based on;
        ii. what clinical information and opinions they obtained and reviewed and who the source was; and
        iii. any research or literature they relied upon.[17]
    c. Indicate the extent to which there is professional consensus regarding the statements and/or opinions expressed (e.g., if there is a range of opinions on an issue, and if their statements and/or opinions are contrary to the accepted views of the profession).
    d. Communicate any of the following to the third party: errors they subsequently become aware of, new information they become aware of that impacts their statements and/or opinions, and changes to their statements and/or opinions.

22. If physicians receive assistance with an IME and/or third party medical report, they **must:**
    a. clearly identify in the third party medical report and testimony who assisted them and specify the nature of the assistance; and
    b. ensure any statements and/or opinions expressed are their own.[18]

23. Where possible, physicians **must** use language and terminology that will be readily understood by the audience.
    a. When physicians use abbreviations and medical or technical terminology, they **must** explain the meaning.

[17] If acting as a medical expert, see Rule 53.03(2.1) of the *Rules of Civil Procedure,* O. Reg. 194, enacted under the *Courts of Justice Act*, R.S.O. 1990, c. C.43 (hereinafter *Courts of Justice Act, Rules of Civil Procedure*) for specific information required in an expert report.

[18] Case law suggests that it is inappropriate for physicians to get assistance with the preparation of third party medical reports in circumstances where physicians have not disclosed the fact that they had assistance, have not reviewed the work that has been done on their behalf, or cannot confirm that the statements or opinions expressed are truly their own. Where an expert is court-appointed, some courts have prohibited assistance altogether.

Timely

IMEs and Third Party Medical Reports (Outside of Legal Proceedings)

24. Absent a specific legal requirement, physicians **must** conduct IMEs and/or provide third party medical reports in a timely manner,[19] but no later than:
    a. 60 days after receiving the request to conduct an IME and report on the findings; and
    b. 45 days after receiving the request to provide a third party medical report.

25. If physicians are not able to meet the timeframes set out in provision 24, physicians **must** discuss the matter with the requesting party and reach an agreement for a reasonable extension.[20]
    a. Physicians **must** ensure the subject is informed of the new timeframe.

Expert Opinions in Legal Proceedings

26. Physicians who are acting as medical experts in the context of a legal proceeding **must:**
    a. reach an agreement with the requesting party regarding the timeframe for providing third party medical reports and any subsequent extensions; and
    b. provide third party medical reports within the agreed upon timeframe.

Testimony

27. Physicians **must** respond to any requests or orders (e.g., subpoenas or summons) to provide testimony in a timely manner.

[19] What is considered timely will depend on the nature of the request, taking into consideration the complexity and urgency of the request. For example, third party medical reports that relate to income or the necessities of life would need to be completed urgently.

[20] Section 1(1), paragraph 17 of the *Medicine Act, Professional Misconduct Regulation*.

Independent Medical Examinations

Observers & Audio/Video Recordings

28. Physicians **must** comply with any legal requirements regarding the presence of observers[21] and recordings that apply to the examination being conducted.

29. In the absence of any legal requirements, physicians **must**:
    a. give subjects the option of having an observer present during an intimate examination[22], including bringing their own observer if the physician does not have one;[23]
    b. permit subjects to have an observer present during an examination, unless physicians are of the view that the observer's presence will likely impact the examination;
    c. inform any observer who is present during the examination that they cannot interfere or intervene in any way during examination;
    d. ensure any arrangements with respect to recordings are mutually agreeable to all the parties involved; and
    e. ensure consent with respect to observers or recordings has been obtained from all the parties involved.

Clinically Significant Findings

30. If physicians are conducting an IME and become aware of a clinically significant finding[24] that may not have been previously identified, they **must** determine if the subject is at imminent risk of serious harm and requires emergent or urgent medical intervention.

31. If the subject is at imminent risk of serious harm and requires emergent or urgent medical intervention, physicians **must** ensure the clinically significant finding is appropriately disclosed and managed by:

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[21] For example, for court-ordered examinations, Rule 33.05 of the *Courts of Justice Act, Rules of Civil Procedure* states that no person other than the person being examined, the examining health practitioner and such assistants as the practitioner requires for the purpose of the examination shall be present during examinations, unless the court orders otherwise.

[22] Intimate examinations include: breast, pelvic, genital, perineal, perianal, and rectal examinations.

[23] This requirement is consistent with the College's *Boundary Violations* policy.

[24] An unexpected clinically significant finding, a condition which raises serious concern, or a symptom or condition which requires essential intervention. This includes, but is not limited to, undiagnosed conditions and conditions for which immediate intervention is required.

a. disclosing the finding to the subject; and
b. communicating the finding to the subject's primary health-care provider for any necessary care or follow-up, if there is one and consent to do so has been obtained; or
c. if the subject does not consent to communicating the finding to their primary health-care provider or they do not have a primary health-care provider,
    i. providing any necessary care that is within the physician's scope of practice[25] and connecting them to another health-care provider for any follow-up; or
    ii. directing the subject to the emergency department or to another health-care provider that is available to provide any necessary care and follow-up.

32. If the subject is *not* at imminent risk of serious harm and does *not* require emergent or urgent medical intervention, physicians **must** take the steps outlined in a or b, depending on the context in which the IME is being conducted and/or who hired the physician.
    a. If the IME is not being conducted in the context of a legal proceeding or the subject hired the physician to conduct the IME in the context of a legal proceeding, physicians **must:**
        i. disclose the finding to the subject and advise them to see a health-care provider for any necessary care and follow-up; or
        ii. communicate the finding to the subject's primary health-care provider for any necessary care or follow-up, if there is one and consent to do so has been obtained.
    b. If a third party (not the subject) hired the physician to conduct the IME in the context of a legal proceeding,[26] physicians **must**:
        i. seek independent legal advice regarding the disclosure of the finding; and

[25] Providing emergent or urgent care may create a physician-patient relationship with the legal and professional responsibilities that flow from that relationship. A physician-patient relationship may compromise the physician's independence and therefore may disqualify them from providing the third party medical report and/or testimony.

[26] If a third party (not the subject) hired the physician to conduct an IME in the context of a legal proceeding, legal privilege may apply and may be an impediment to disclosure when the subject is not at imminent risk of serious harm and does not require emergent or urgent medical intervention. The purpose of seeking independent legal advice is to determine whether any such impediment to disclosure exists in the circumstances.

ii. consult with the third party to determine whether the third party waives any impediment to disclosure.

33. If the clinically significant finding is disclosed, physicians **must** only provide clinical information that is directly relevant to the finding.

Documentation, Retention, and Access

34. Physicians **must** document the following for all professional encounters or services provided for a third party or third party process, where applicable:
    a. identification of the subject and their contact information;
    b. identification of the requesting party;
    c. date of professional encounter or service;
    d. consent that has been obtained for the collection, use, or disclosure of information;
    e. consent that has been obtained for examinations;
    f. information regarding the IMEs that have been conducted;
    g. consent that has been obtained with respect to the presence of observers and/or recordings of examinations; and
    h. any clinically significant findings and any action taken with respect to the findings.

35. Physicians' documentation of the information in provision 34 **must** be:
    a. legible;
    b. accurate;
    c. complete and comprehensive;
    d. identifiable, containing a signature or audit trail that identifies the author;
    e. written in either English or French; and
    f. organized in a chronological or systematic manner.

36. In addition to documenting the information in provision 34, physicians **must** retain any related materials including, where applicable:
    a. contracts with the requesting party (e.g., outlining scope, purpose, timelines, fee arrangements, etc.);
    b. clinical information or opinions not created by the physician, which the physician relied upon;
    c. audio or video recordings of examinations; and
    d. third party medical reports.

37. Physicians **must** retain and provide access to the information and related materials in provisions 34 and 36 in accordance with the legal requirements that apply to the specific circumstances.[27]

[27] For example, retention requirements would depend on whether or not the information or related materials are retained as part of a patient's medical record, and access requirements would depend on what the purpose of the examination/report was (e.g., if the report was for a commercial purpose and is subject to *PIPEDA*).

Advice to the Profession: Third Party Medical Reports

Advice to the Profession companion documents are intended to provide physicians with additional information and general advice in order to support their understanding and implementation of the expectations set out in policies. They may also identify some additional best practices regarding specific practice issues.

Physicians play an important role when conducting independent medical examinations (IMEs) and providing third party medical reports and testimony. Expectations regarding this role are set out in the College's *Third Party Medical Reports* policy. This document is intended to help physicians interpret their obligations in this policy and to provide guidance around how these obligations may be effectively discharged.

Definitions

Are both litigation experts and participant experts captured by the 'medical expert' definition in the policy?

In the policy, we use the term 'medical experts' to generally mean physicians who are retained by a party to provide independent opinions and do not have a prior treating relationship with a patient. They may be referred to in legal proceedings as 'litigation experts'. The purpose of their opinions is to assist those involved in the legal proceeding understand the medical issues. Treating physicians may also be called upon to provide their opinions in a legal proceeding and are referred to as 'participant experts'. Further information regarding 'litigation experts' and 'participant experts' is provided below.

Physicians' Obligations

Do family physicians have an obligation to provide third party medical reports about patients when the information relates to care provided by a specialist?

If the third party is requesting information about care provided by a specialist, the family physician may not have the information, or the information may be outside of the family physician's scope of practice and area of expertise. As such, family physicians would only be obligated to provide the third party with the relevant information they have, and the information that is within their scope of practice and area of expertise.

In these circumstances, it may be in the patient's best interest for the family physician and specialist to discuss how to proceed with the request, as providing the requested

information may require some collaboration between the family physician and specialist.

As a treating physician, may I be called upon to provide opinion evidence in legal proceedings?

Yes. A treating physician may be called upon to provide opinion evidence in a legal proceeding as a 'participant expert'.

Participant experts are treating physicians who have personal, first-hand knowledge about the matter at issue and who form expert opinions based on their participation in the underlying events. The participant expert forms their opinions in the ordinary exercise of their skill, knowledge, training, and/or experience while observing or participating in the underlying events.

Participant experts may be asked or ordered (e.g., by subpoena or summons) to provide information, including the opinions they formed, in a legal proceeding. This may include factual information, such as: what symptoms the patient reported, what examinations were undertaken, and what observations the physician made, and may include opinions, such as: what the diagnosis was, and what treatments the physician determined would be appropriate to offer the patient. In some cases, participant experts may be examined and cross-examined under oath about the information recorded in their medical records and/or provided in third party medical reports.

When would it be appropriate to accept a request to conduct an IME?

Physicians must only accept a request to conduct an IME if they meet the requirements set out in provision 5 in the policy. In determining whether the physician meets the policy requirements, the following considerations are relevant:

- Whether they have proficient knowledge of the relevant clinical practice guidelines.
- Whether they have current or recent experience (within the last two years) practising within the scope of practice and area of expertise the matter requires.[1]

Physicians who have not been engaged in practice[2] for a period of two consecutive years must comply with the reporting and re-entry process in the College's *Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice* policy before accepting a request to conduct an IME.

[1] A physician's scope of practice and area of expertise may include conducting IMEs.
[2] A physician's practice may include conducting IMEs.

What qualifies a physician to act as a medical expert? When would it be appropriate to accept a request to act as a medical expert?

In a legal proceeding, an expert is someone with demonstrated specialized knowledge beyond that of the ordinary person. Specialized knowledge may be gained through academic study, professional qualification, training, and/or experience. The adjudicative body uses the *Mohan/White Burgess* framework[3] to decide whether or not a physician is qualified to provide an expert opinion in a given case. If the physician is qualified as an expert, the adjudicative body will typically set parameters on the scope of the expert opinion that is admissible in the legal proceeding.

In general terms, the following factors may be relevant to an adjudicative body's determination of whether a physician is qualified to provide an expert opinion in a given case:

- the education and training they have completed;
- any additional qualifications they hold;
- their knowledge of the relevant clinical practice guidelines in place at the material time;
- the experience and proficiency they have in performing the relevant aspects of their practice;
- the length of time they have been practicing in the requisite scope of practice and area of expertise and whether they were in practice at the material time;
- teaching roles they have held;
- the relevant research, articles, and/or textbooks they have published and presentations they have given;
- the awards or other recognition they have received;
- the uniqueness of their scope of practice and area of expertise;
- the status of their certificate of registration at the time of the legal proceeding and at the material time;
- the complaints and/or discipline history they have with the College; and
- the civil and/or criminal actions against them.

In determining whether it is appropriate to act an expert, it is important for physicians to consider the nature of the opinion they are being asked to provide and the factors set out above to ascertain whether the subject matter of the opinion falls within their scope of practice and area of expertise and whether they have the requisite knowledge, skill,

[3] *R. v. Mohan*, [1994] 2 S.C.R. 9 and *White Burgess Langille Inman v. Abbott and Haliburton Co.*, 2015 SCC 23, [2015] 2 S.C.R. 182.

and judgment to provide the opinion. Physicians must only accept a request to act as a medical expert if they meet the requirements set out in provision 6 in the policy.

What am I permitted to do after I retire?

Treating physicians

- Treating physicians:
  - may only start preparing new third party medical reports if they have an active certificate of registration; and
  - may be required to testify in a court proceeding after they resigned their certificate of registration (e.g., regarding the care they provided to a patient while they held an active certificate of registration).

IMEs

- Physicians:
  - may only conduct IMEs if they have an active certificate of registration (and meet the other requirements set out in provision 5 in the policy); and
  - may be required to testify about an IME they conducted or third party medical report they wrote while they had an active certificate of registration.

Medical experts

- Physicians:
  - May only accept a request to act as a medical expert if they meet the requirements in provision 6 in the policy.
    - An active certificate of registration from the College and current or recent practice experience (within the last two years) in the area for which the physician will be providing an opinion will often be relevant in determining whether the physician meets the policy requirements (i.e., when the opinion is regarding current medical standards or practices).[4] This may be less relevant when the opinion relates to what the standard of practice was in the past.

[4] The Ontario Superior Court has indicated that physicians are only permitted to provide the court with an expert opinion involving the assessment of a plaintiff or the diagnosis of a plaintiff's condition because they are licensed to practice medicine (*Klassen v. College of Physicians and Surgeons of Ontario*, 2002 CanLII 6156 (Ont. S.C.), at para. 19).

    - May only perform controlled acts or hold themselves out as physicians qualified to practice medicine in Ontario if they have an active certificate of registration in Ontario.[5,6]
- The adjudicative body ultimately determines who is qualified to give opinion evidence and who is permitted to testify in a legal proceeding.

All physicians are advised to be clear in third party medical reports and testimony regarding their registration status in Ontario and any limitations resulting from their registration status.

Privacy and Consent

What privacy and consent legislation applies to me?

Physicians conducting IMEs and providing third party medical reports and testimony may be subject to legislation governing the collection, use, and disclosure of personal information and/or personal health information. The *Personal Information Protection and Electronic Documents Act (PIPEDA)* applies to "personal information" collected, used, or disclosed in the course of commercial activities and to information about federally regulated employees.[7] The *Personal Health Information Protection Act, 2004* (*PHIPA*) applies to "health information custodians"[8] or persons who receive personal health information from a health information custodian, in respect of that information.[9] In some cases, neither *PIPEDA* nor *PHIPA* may apply, but other legislation may impose consent or confidentiality requirements on physicians engaged in third party processes.[10] Physicians can seek independent legal advice if they are unsure what legislation, if any, applies to their specific circumstances.

[5] Section 27(1) and Section 33(1) of the *Regulated Health Professions Act, 1991*, S.O. 1991, c.18 (hereinafter *RHPA*), and Section 9(3) of the *Medicine Act, 1991*, S.O. 1991, c. 30.

[6] This applies to all physicians, including those licensed in other jurisdictions who provide expert opinions in legal proceedings in Ontario.

[7] Section 4(1) of *Personal Information Protection and Electronic Documents Act*, S.C. 2000, c 5 (hereinafter *PIPEDA*).

[8] The Information and Privacy Commissioner has indicated that individuals are only "health information custodians" when the service they provide is for a "health-related purpose". See *Morris (Re)*, 2015 CanLII 54751 (ON IPC).

[9] Section 7(1) of *Personal Health Information Protection Act, 2004,* S.O. 2004, c.3, Sched A. (hereinafter *PHIPA*).

[10] For example, assessors retained by health regulatory bodies are not health information custodians, nor are they engaged in a commercial activity, but they may be subject to Section 36 of the *RHPA*.

Can I rely on consent obtained by someone else? Can I rely on pre-signed consent forms?

Yes. Consent to collect, use, or disclose the subject's personal information and/or personal health information, or consent to conduct an IME, may be obtained by someone else (e.g., a lawyer, employer, insurer, etc.). In addition, physicians can rely on pre-signed consent forms if they are satisfied that the consent applies to and authorizes the full spectrum of acts they will conduct in order to prepare the third party medical report (e.g., to collect, use, and disclose personal information and/or personal health information, to conduct an IME).

If physicians have any doubts as to the validity or scope of the consent obtained by someone else or the pre-signed consent form, they can raise their concern with the requesting party and consider obtaining consent from the subject directly.

Is consent time-limited? Do I need to ensure consent has been obtained again if some time has passed since consent was first obtained?

Consent does not expire after a certain period of time (unless an expiry date is explicitly stated in a consent form), but it can be withdrawn.[11] Some third party processes may take a long time and it is recommended that physicians make a reasonable effort to ensure that the consent obtained at the beginning of the third party process is still valid and hasn't been withdrawn.

For example, if physicians are asked to provide an addendum report some time after the initial third party medical report was provided, they may want to confirm whether consent is required for the physician to use and disclose the subject's personal information and/or personal health information in the addendum report, and if so, confirm whether there is consent to do so.

Fees

What requirements and considerations are there when charging for third party medical reports?

As per the College's *Uninsured Services: Billing and Block Fees* policy, physicians must consider the patient's ability to pay when charging for uninsured services. Providing third party medical reports is considered an uninsured service.

[11] Clause 4.3.8, Schedule 1 of *PIPEDA* and Section 19 of *PHIPA*.

When patients are paying out-of-pocket for the third party medical report, physicians may want to consider the type of report they are being asked to provide when determining fees and whether prepayment is required. For example, if the report is related to income or the necessities of life, it may be a financial burden for the patient to pay for the report, particularly if payment is required before they receive any benefits. Physicians may want to discuss this with patients to help them determine the patient's ability to pay for the third party medical report.

Requirements for Independent Medical Examinations, Third Party Medical Reports, and Testimony

What steps do I have to take to obtain and review all relevant clinical information and opinions relating to the subject?

What steps are reasonable would depend on the specifics of the case but could include something as simple as asking the third party what relevant clinical information and opinions they are expected to obtain and review. The third party may provide the physician with a copy of the medical records and that may be sufficient. If, however, physicians notice that something relevant is missing (e.g., test results or a consultation report is missing from the medical record), physicians could raise this with the third party and take reasonable steps to obtain a copy.

Alternatively, taking reasonable steps to obtain and review relevant clinical information and opinions could include the physician directly getting this information by examining the subject themselves and reviewing it in the context of preparing the third party medical report.

What does it mean to be fair, objective, and non-partisan?

Even though physicians may be asked to be medical experts by a party involved in the legal proceeding (e.g., Crown prosecutor in a criminal case), medical experts are not advocates for either side. Physicians cannot be "hired guns" for any party in a third party process as their duty is solely to the adjudicative body.[12] A medical expert's role is to assist the adjudicative body by providing a fair, objective, and non-partisan opinion.

[12] Any medical expert called in a civil proceeding under the Rules of Civil Procedure must complete Form 53 of the *Rules of Civil Procedure* R.R.O. 1990, Reg. 194, enacted under the *Courts of Justice Act*, R.S.O. 1990, c. C.43 (hereinafter *Courts of Justice Act, Rules of Civil Procedure*). Participant experts are not typically required to complete the Acknowledgement of Expert's Duty form, but the court may require it if the participant expert offers an opinion that goes beyond the scope of the opinion formed in the course of treatment or observation.

What will I need to do if the requesting party does not give me a reasonable extension?

If the requesting party does not provide a reasonable extension for an IME, physicians could decline to conduct the IME.

If the requesting party does not provide a reasonable extension for a third party medical report and physicians do not have an obligation to provide the third party medical report (i.e., they are not treating physicians), they could decline to provide the third party medical report.

If physicians do have an obligation to provide the third party medical report (i.e., they are treating physicians), they could consider whether they are able to provide a 'preliminary' report within 45 days, as long as they are clear about the nature of the report, its limitations, and that their statements and/or opinions could change in the final report.

Independent Medical Examinations

When might an observer attend an examination? When might the examination be recorded?

In the absence of any legal requirements with respect to observers,[13] physicians may want to consider having an observer present and/or recording the examination in circumstances where the subject is particularly vulnerable (e.g., if they are cognitively impaired or are a child) and consent has been obtained.

What will I need to do if the subject does not consent to the presence of an observer, or if an agreement with respect to recordings cannot be reached?

There may be situations where the physician wishes to have an observer present during an examination. If the examination is court-ordered, the physician does not need to obtain consent to have an assistant present.[14] If the examination is not court-ordered, the physician must obtain consent to have an observer present from all parties involved. If the parties disagree about the presence of an observer in these situations, or whether an examination will be recorded, physicians can postpone the examination until these matters can be discussed further so that a resolution can be reached. If a resolution can't be reached after further discussion, the physician could decline to conduct the examination and a different physician could be sought to conduct the examination.

To prevent possible disagreements that may delay the examination, physicians may want to consider making arrangements with respect to observers and/or recordings in

[13] See footnote 21 in the policy.

[14] Unless the court orders otherwise. See Rule 33.05 of the *Courts of Justice Act, Rules of Civil Procedure*.

advance of the examination. This would give all parties an opportunity to consider the matter and if necessary, discuss it with someone (e.g., family member, friend, lawyer, etc.) before the subject attends the examination.

Is it appropriate to form a physician-patient relationship with an individual who is the subject of an IME?

It depends.

Physicians will want to wait until after the third party process concludes to form a physician-patient relationship with the individual, as forming a physician-patient relationship could compromise the physician's independence and may disqualify them from providing the third party medical report and/or testimony. However in some cases, it may be appropriate to begin treating the individual before the third party process concludes if no other physician is available. In these cases, it's good practice for the physician to notify the requesting party of any change in status of their relationship with the individual's consent.

Regardless of whether or not a treating relationship is formed, it is important for physicians to clearly communicate with the individual what the nature of the physician's role will be (e.g., if they will solely do an IME and/or will form a treating relationship).

Documentation, Retention, and Access

How long do I need to retain the information I document and any related materials for, and can the subject access the information and related materials?

If the subject is a patient, physicians must comply with the retention requirements set out in the College's *Medical Records Management* policy. If the subject is not a patient, then retention requirements set out in the in the College's *Medical Records Management* policy likely would not apply.

Subjects may inquire about accessing third party medical reports or physicians may want to proactively discuss the issue of access with subjects when preparing third party medical reports. Access requirements can be particularly complex if the subject is not a patient and physicians may want to review the Canadian Medical Protective Association's article *Providing access to independent medical examinations* for more information.

If physicians are uncertain about the retention and/or access requirements that apply to their specific circumstances, they may want to seek independent legal advice.

Resources

There are a number of different resources to assist physicians who conduct IMEs and provide third party medical reports and testimony. Please see the following for more information:

Canadian Medical Protective Association (CMPA):

CMPA. (2019). *Treating physician reports, IME reports, and expert opinions: The way forward*.
CMPA. (2021). *Medical-Legal Handbook for Physicians in Canada*.
CMPA. (2009). *Subpoenas-What are a physician's responsibilities*.
CMPA. (2018). *Testifying-What it involves and how to do it effectively*.
CMPA. (2018). *Providing access to independent medical examinations*.
CMPA. (2020). *Writing with Care*.
CMPA. (2021). *eLearning Modules*.

Canadian Society of Medical Evaluators. (2013). *Guide to Third Party Medical Evaluation*.

Medico-Legal Society of Toronto. (2020). *The Medico-Legal Report, 2020*.

There are some additional resources regarding bias and using professional and inclusive language when communicating that may also be helpful to physicians. Please see the College's Equity, Diversity and Inclusion webpage and the following for more information:

Canadian Public Health Association. (2019). *Language Matters-Using respectful language in relation to sexual health, substance use, STBBIs and intersecting sources of stigma*.

National Institute for Health and Care Excellence. (2019). *NICE style guide: Talking about people, including deaf and blind, age, faith, family origin, gender*.

O'Sullivan, E.D., & Schofield, S.J. (2018). Cognitive bias in clinical medicine. *Journal of the Royal College of Physicians of Edinburgh, 48*(3), 225-232. https://www.rcpe.ac.uk/sites/default/files/jrcpe_48_3_osullivan.pdf

Council Motion

Motion Title	Third Party Medical Reports-Revised Draft Policy for Final Approval
Date of Meeting	June 18, 2021

It is moved by_____, and seconded by_____, that:

The Council approves the policy “Third Party Medical Reports”, formerly the “Third Party Reports” and “Medical Expert: Reports and Testimony” policies, (a copy of which forms Appendix “ ” to the minutes of this meeting).

Council Briefing Note

June 2021

Topic:	Psychotherapy Regulation – Proposal to Not Proceed
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation
Public Interest Rationale:	Holding physicians accountable and ensuring the protection of the public from harm through appropriate mechanisms.
Main Contact:	Lynn Kirshin, Senior Policy Analyst

Issue

- In May 2018, Council approved a draft regulation extending the duration of the physician-patient relationship when psychotherapy that is more than minor or insubstantial has been provided, for the purposes of the sexual abuse provisions of the *Regulated Health Professions Act, 1991* (*RHPA*). At the time the draft regulation was approved, a decision was made to wait until the provincial election underway was completed and more information regarding government support was known before submitting the draft regulation to government.

- Given the change of government and its current priorities, the evolution of the CPSO's priorities in terms of approaching regulation, and the recent approval of the Boundary Violations policy that includes a provision regarding sexual relations after the physician-patient relationship has ended when psychotherapy has been provided, Council is being asked whether it wants to not pursue the psychotherapy regulation it originally approved in May 2018.

Background

Sexual Abuse Task Force

- Beginning in 2014, the former provincial government undertook an analysis of sexual abuse occurring in the health regulatory landscape. As part of this work, CPSO provided detailed information about the actions it had taken and proposed actions to help prevent and more strongly address sexual abuse of patients by their physicians.

- The provincial government's work culminated in the introduction of Bill 87, the *Protecting Patients Act*, which included many proposed amendments to the *RHPA* in order to strengthen sexual abuse provisions, increase the transparency of health regulatory colleges' operations, and improve the colleges' complaints, investigation and discipline processes.

- Among those changes was the introduction of a new statutory definition of "patient" which states that "an individual will be a patient for one year after the termination of the physician-patient relationship." This change means that a physician who engages in a sexual relationship with a former patient within one year of the end of the physician-patient relationship will be considered to have engaged in sexual abuse and will be subject to mandatory revocation.

- The Bill also enabled Colleges to create a regulation to extend the physician-patient relationship for a period longer than one year.

- At the time, the College participated in the government's consultation on proposed new regulations under the *RHPA*, expressing support for the overall objectives of the new definition and the regulation making authority to extend the physician-patient relationship.

Proposed Regulation

- In May 2018, Council approved proposing to the government that a regulation be made extending the physician-patient relationship to five years where psychotherapy that is more than minor or insubstantial is provided. More specifically:

> ***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.***

- If approved by government, the enactment of the regulation would mean that a physician who had a sexual relationship with a former psychotherapy patient within five years of termination, when the psychotherapy provided is more than minor or insubstantial, would be subject to mandatory revocation.

- Given the change in government due to the election in June 2018 and corresponding changes in government priorities (external factors), as well as changing CPSO organizational leadership (internal factors), the development and submission of the regulation proposal was purposefully paused in order to evaluate and identify the appropriate timing to proceed.

- With the rapid transformation happening within CPSO in the resulting years, submission of this draft regulation was deprioritized while organization-wide modernization was brought in, including the redesign of all College policies.

- During that time, a policy approach was identified to address this issue (see more information below), so the regulation proposal submission was paused again.

- At the same time, broader regulatory modernization continued to unfold at CPSO with a new strategic plan, setting out a commitment to implementing Right-Touch Regulation with an emphasis on becoming more nimble and flexible in our approach to regulation. This included a corresponding and broader move away from exercising our authority through regulations, instead focusing on using internal tools to conduct our work where the same ends can be achieved.

- The pandemic and ensuing priorities also resulted in a reprioritization of this work and a delay in bringing this issue back to Council for consideration.

Boundary Violations policy

- The College's *Boundary Violations* policy was last reviewed and approved in December 2019. During the policy review process, efforts were made to achieve a similar effect of the proposed regulation, but through a policy solution.

- In particular, a provision was added that states "where psychotherapy that is more than minor or insubstantial has been provided, physicians must not engage in sexual relations or engage in sexual behavior or make remarks of a sexual nature towards their patient for a minimum of five years after the date upon which the individual ceased to be the physician's patient".

- The *Advice to the Profession* companion document provides clarification with respect to what could be considered psychotherapy that is more than minor or insubstantial, and states that it is important for physicians to use their professional judgment when making this determination. Factors that physicians can consider include the nature of issues discussed and the period of time for which the psychotherapy was provided.

Current Status and Analysis

- In keeping with CPSO's commitment to continued modernization, it is proposed that CPSO not pursue the regulation (i.e., submit to government for approval) and that the policy provisions be relied upon to regulate this conduct.

- Having a regulation would result in setting an expectation that has the force of law. A physician would be subject to mandatory revocation if they had a sexual relationship with a patient within five years of when the physician-patient relationship would have ordinarily ended, if psychotherapy that was more than minor or insubstantial was provided.

- While the *Boundary Violations* policy provision does not have the force of law without a regulation, it can be used as evidence of professional expectations to support a finding of professional misconduct.

- Notably, this enables the Discipline Committee to make appropriate findings of professional misconduct (a finding of disgraceful, dishonourable or unprofessional conduct but not sexual abuse). Although this would not enable the Discipline Committee to use the remedy of mandatory revocation, they would still have a discretionary remedy where they could revoke a certificate of registration where appropriate.

- In addition, pursuing a regulation at this time may not be consistent with both the internal and external factors described above.

    - Organizationally, CPSO is prioritizing regulatory change in other areas (e.g. governance) that are more central to the College's strategic plan;

    - It is unclear given government priorities at this time whether there will be appetite to proceed with this regulation but by all indications this government appears to be uninterested in the projects of the previous government, including other changes with respect to Bill 87 and is focused more on our governance modernization goals;

    - Even with support from government (which is uncertain) it would take significant work and time (approximately two years) for this regulation to be approved; and

    - There would be very minimal practical effect if this regulation is passed given the number of cases which would fall under this regulation.

Next Steps

- If Council agrees to not pursue the draft regulation, an article will be written in *Dialogue* to inform members and the public.

Questions for Council

1. Does Council agree not to pursue the draft psychotherapy regulation originally approved in May 2018, given the changes in government and policy since that time?

Council Motion

Motion Title	Psychotherapy Regulation – Proposal to Not Proceed
Date of Meeting	June 18, 2021

It is moved by_____, and seconded by_____, that:

Council not pursue the Psychotherapy Regulation it originally approved in May 2018, the text of which is attached as Appendix “” to the minutes of this meeting, given changes in government and policy since that time.

Council Briefing Note

June 2021

Topic:	*Social Media* – Draft Policy for Consultation
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation Meaningful Engagement
Public Interest Rationale:	Setting clear expectations and guidance for physicians to support responsible and professional use of social media that upholds the reputation of the profession and maintains public trust
Main Contact:	Alexandra Wong, Policy Analyst
Attachments:	Appendix A: Draft *Social Media* policy Appendix B: Draft *Advice to the Profession: Social Media*

Issue

- The College's *Social Media – Appropriate Use by Physicians* statement ("Social Media statement" or "statement") is currently under review. A new draft *Social Media* policy has been developed to set out professional expectations for physicians using social media. A companion draft *Advice to the Profession* document ("*Advice*") has also been developed to clarify issues around the expectations set out in the policy.

- Council is asked whether the draft policy can be released for external consultation and engagement.

Background

- The current Social Media statement was introduced in 2013. At the time, the Executive Committee and Council adopted an approach of setting out general guidance in a statement rather than creating a new policy, as social media was a newly emerging area of interest for the College and understanding of the issue was still evolving.

- Since then, social media use among physicians has increased significantly and presents new risks and challenges for physicians to navigate, indicating an opportunity for the College to review and update guidance for physicians in this area.

- While statements are not typically reviewed in the same way as policies, given the evolution of this context, a review of the statement was undertaken in accordance with the

usual policy review process. This included a literature review; jurisdictional scan; a review of decisions from the Inquiries, Complaints, and Reports Committee (ICRC), the Discipline Committee, and the Health Professions Appeal and Review Board (HPARB); and review of inquiries and feedback from staff in Public Advisory Services (PAS).

- A preliminary consultation on the current Social Media statement took place from July to September 2020. A total of 366 responses were received as part of this external consultation, with the majority of respondents being physicians. All feedback has been posted on a dedicated page of the College's website. Additional engagement was undertaken in the form of an online survey with the Citizen Advisory Group.[1]

- The draft policy was developed based on direction from the Policy Review Working Group[2] and was informed by the above-mentioned research and consultation feedback. Additional support on this review was provided by Saroo Sharda (Medical Advisor and Equity, Diversity, Inclusion Lead) and Sayran Sulevani (Legal Counsel), recently replaced by Ruth Ainsworth (Legal Counsel).

Current Status and Analysis

- The draft policy creates new expectations for physicians using social media. The development of these expectations was informed by the current Social Media statement, which highlights existing professional expectations and makes recommendations around physicians' use of social media.

- An overview of the key draft policy expectations and *Advice* guidance is provided below.

Key Expectations in the Draft *Social Media* Policy

Professionalism: Disruptive behaviours

- In the consultation, respondents provided feedback expressing concern about unprofessional behaviours on social media and that the concepts of professionalism and unprofessionalism in the current statement were too vague. In response, the draft policy adopts the definition of "disruptive behaviours"[3] and articulates examples of unprofessional behaviour in the social media context.

[1] This survey involved 16 participants providing responses to hypothetical scenarios presented to get perspectives on what members of the public would find low risk or high risk and unprofessional or professional conduct by physicians on social media.
[2] The Working Group is currently composed of Brenda Copps, Janet van Vlymen, Sarah Reid, Karen Saperson, Peter Pielsticker, and Lydia Miljan, and Medical Advisor Keith Hay.
[3] The concept of "disruptive behaviours" is also found in the College's *Physician Behaviour in the Professional Environment* policy and the *Guidebook for Managing Disruptive Physician Behaviour* (2008) developed by the College and Ontario Hospital Association.

- In considering equity, diversity, and inclusion issues, the draft policy includes a preamble regarding professionalism and how it involves upholding the values of compassion, service, altruism, and trustworthiness, and through demonstrating cultural humility and safety.

- The draft policy also indicates that discrimination and comments that may be perceived as discriminatory may be unprofessional behaviours. The draft *Advice* document expands on these concepts, including microaggressions.

Professionalism: Advocacy

- The draft policy recognizes the importance of advocacy as part of a physician's role, while also reminding physicians that they must be professional while engaging in advocacy. This is in line with the *Physician Behaviour in the Professional Environment* policy.

    - The topic of advocacy is a new addition to the draft policy as it is not specifically discussed in the current statement. The Working Group wanted to specifically acknowledge the importance of physician advocacy while setting an expectation that these activities be done respectfully and professionally.

Professionalism: Sharing health-related information

- The draft policy includes new requirements around disseminating general health information, recognizing the concerning spread of misinformation on social media in past years (e.g. anti-vaccination views, misinformation related to COVID-19). The draft requires that physicians only share evidence-based information and to not misrepresent their qualifications when making specific medical, scientific, or clinical claims.

- As in the current statement, the draft policy cautions physicians against providing clinical advice on social media. Recognizing the potential blurring of social media platforms, e-communication modalities, and telemedicine, it additionally identifies that providing specific clinical advice may constitute providing telemedicine in certain situations and the expectations of that policy would therefore apply.

Professional Relationships and Boundaries

- The draft policy takes a principled approach towards maintaining appropriate boundaries on social media, requiring physicians to consider the impact on the physician-patient relationship and to not exploit the power imbalance inherent in the relationship.
    - This approach is in keeping with the *Boundary Violations* policy and recognizes the contextual nature of determining appropriate boundaries (e.g., relationships in a rural vs. urban context).
    - The draft *Advice* document expands on how physicians can maintain appropriate boundaries with patients on social media, which might mean refraining from connecting with patients and persons closely associated with them on social media.
- The draft policy also adds a requirement to maintain appropriate boundaries in the context of medical education between physician educators and students/postgraduate trainees.

Privacy and Confidentiality: Protecting patient privacy, seeking out patient information

- The draft policy sets requirements to de-identify information and/or obtain and document express and valid consent when posting information online relating to a patient. The consent requirements in the draft policy mirror those found in the new *Advertising* policy for posting before and after photos/videos.
- The draft policy amends the recommendation in the current statement to physicians to refrain from seeking out patient information that may be available online without prior consent, recognizing that there may be limited circumstances where there may be an appropriate clinical rationale related to safety concerns and the information cannot be obtained in another manner.

Next Steps

- Subject to Council's approval, the draft policy will be released for external consultation and engagement.
- Feedback received as part of these activities will be shared with the Executive Committee and Council at a future meeting and used to further refine the draft.

Questions for Council

1. Does Council approve the draft policy for external consultation and engagement?

Social Media

Policies of the College of Physicians and Surgeons of Ontario (the "College") set out expectations for the professional conduct of physicians practising in Ontario. Together with the *Practice Guide* and relevant legislation and case law, they will be used by the College and its Committees when considering physician practice or conduct.

Within policies, the terms 'must' and 'advised' are used to articulate the College's expectations. When 'advised' is used, it indicates that physicians can use reasonable discretion when applying this expectation to practice.

Additional information, general advice, and/or best practices can be found in companion resources, such as *Advice to the Profession* documents.

Definitions

Social Media: Online platforms, technologies, and practices that people use to share content, opinions, insights, experiences, and perspectives. Examples of social media include Twitter, Facebook, YouTube, Instagram, LinkedIn, blogging sites, and discussion forums, among many others.[1]

Policy

1. Physicians **must** comply with the expectations set out in this policy, other College policies,[2] and other relevant legislative and regulatory requirements[3] when using social media.

Professionalism

Physicians hold a respected position in society and, in turn, have responsibilities not only to themselves, but to patients, colleagues, the public, and the profession. Medical professionalism involves upholding the values of compassion, service, altruism, and

[1] See the *Advice to the Profession* document for more information on what may captured by this policy.
[2] Relevant expectations are set out in other College policies, including *Advertising*, *Boundary Violations*, *Physician Behaviour in the Professional Environment*, *Professional Obligations and Human Rights*, and *Protecting Personal Health Information*.
[3] Including, but not limited to the *Personal Health Information Protection Act, 2004*, S.O. 2004, the *Medicine Act, 1991* and its regulations, and the *Copyright Act*.

trustworthiness, and demonstrating cultural humility and safety in everyday interactions with others.[4]

2. Physicians **must** conduct themselves in a respectful and professional manner while using social media.

3. Physicians **must** consider the potential impact of their conduct on their own reputation, the reputation of the profession, and the public trust.

4. Advocacy for patients and for an improved health care system is an important component of the physician's role. While advocacy may sometimes lead to disagreement or conflict with others, physicians **must** continue to demonstrate professional behaviour and act respectfully while using social media for advocacy.

5. Physicians **must not** engage in disruptive behaviour that interferes with or is likely to interfere with the physician's ability to collaborate with others, the delivery of quality health-care, or the safety or perceived safety of others while using social media.[5] Disruptive behaviour in the context of using social media may include, but is not limited to:
    - profane, disrespectful, insulting, demeaning, intimidating, or abusive language;
    - behaviour that others would describe as bullying, attacking, or harassing; and
    - comments that may be perceived as discriminatory (for example, related to race, ethnicity, religion, gender, sexual orientation, age, social class, economic status, disability, weight, or level of education).

6. Including when engaging in advocacy, physicians **must** avoid communicating and/or behaving on social media in a manner that involves:
    - disparaging others and/or making personal attacks;
    - unsubstantiated and/or defamatory[6] statements;

[4] The *Practice Guide* articulates the profession's values and the principles of medical practice in more detail. Cultural humility refers to a process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. Cultural safety is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system.

[5] The *Guidebook for Managing Disruptive Physician Behaviour*, developed in association with the Ontario Hospital Association, provides more information on disruptive behaviour. See also the *Physician Behavior in the Professional Environment* policy.

[6] Defamation is a civil action that can lead to an award of damages. Statements can be found defamatory under the *Libel and Slander Act*, RSO 1990, c. L. 12.

- hate speech; and/or
- discrimination (for example, racism, transphobia, sexism).

Health-related information and clinical advice

7. When disseminating general health information on social media for educational or information-sharing purposes, physicians **must:**
   a. disseminate information that is:
      i. verifiable and supported by available evidence and science; and
      ii. **not** misleading or deceptive.
   b. be aware of and transparent about the limits of their knowledge and expertise; and
   c. **not** misrepresent their qualifications when sharing content related to scientific, medical, or clinical claims.

8. When disseminating information on social media, physicians **must** be mindful of the risks of creating a physician-patient relationship or creating the reasonable perception that a physician-patient relationship exists.[7]
   a. Unless they are able and willing to meet the professional obligations that apply to a physician-patient relationship and the requirements in the *Telemedicine* policy, physicians **must not** provide specific clinical advice to others on social media.[8]

Professional Relationships and Boundaries

9. Physicians **must** maintain professional and respectful relationships and boundaries with patients, persons closely associated with patients, and colleagues while using social media.[9]

10. While using social media, physicians **must** consider the impact on and **must not** exploit the power imbalance inherent in:

[7] For example, by providing information in a manner that would lead a reasonable person to rely on it as clinical advice. If asked a medical question, physicians can direct individuals to the appropriate channels to obtain care. For more information see the *Advice* document.
[8] The provision of clinical advice through information and communication technologies is considered telemedicine. Physicians must continue to meet the standard of care, which can include performing a comprehensive assessment, considering risks and benefits of treatment options, obtaining consent, etc.
[9] Boundaries can be sexual, financial/business, social, or other. For the definition of a "patient", see the *Boundary Violations* policy.

a. the physician-patient relationship when engaging with a patient or persons closely associated with them;[10] and
b. any relationship with a medical student and/or postgraduate trainee while responsible for mentoring, teaching, supervising or evaluating a medical student and/or trainee.[11]

Privacy and Confidentiality

11. Physicians **must** comply with the legislative requirements set out in the *Personal Health Information Protection Act, 2004* regarding the collection, use and disclosure of personal health information and the expectations set out in the College's *Protecting Personal Health Information* policy while using social media.

Posting patient health information

12. If a physician is posting original content on social media[12] containing health information about a patient, physicians **must**:
    a. de-identify the patient information, including when there is any doubt that the anonymity of a patient can be maintained;[13] and/or
    b. obtain and document express and valid consent from the patient or substitute decision-maker (SDM) for the publication of the content on social media.

13. In fulfilling the requirement to obtain express and valid consent from the patient or SDM, physicians **must**:
    a. show them the content to be published;
    b. inform them that consent to publication can be withdrawn at any point;
    c. inform them about the risks of publication of the content (for example, that once posted on social media it may be unable to be completely withdrawn);
    d. engage in a dialogue with them about the publication of the content, such as the purposes of posting the content, where it will be posted, and any other relevant information, regardless of whether supporting documents (such as consent forms, patient education materials or pamphlets) are used; and

[10] For example, it may be inappropriate for a physician to connect with patients on personal social media accounts. For more information see the *Advice* document.
[11] For more information see the College's *Professional Responsibilities in Medical Education* policy.
[12] For content posted for the purposes of advertising, physicians must comply with the General Regulation under the *Medicine Act, 1991*, S.O. 1991 and the College's *Advertising* policy.
[13] A privacy breach can occur if the sum of the information available is sufficient for the patient to be identified, even if only by themselves. For more information on de-identification see the *Advice* document.

e. consider how the power imbalance inherent in the physician-patient relationship could cause patients to feel pressured to consent and take reasonable steps to mitigate this potential effect (for example, by informing the patient that if they do not consent, it will not impact their care).

Seeking out patient health information

14. Physicians **must** refrain from seeking out a patient's health information online without a patient's consent unless:
    a. there is an appropriate clinical rationale related to safety concerns;
    b. the information cannot be obtained in another manner;
    c. they have considered whether it is appropriate to ask the patient for consent to seek out the information online; and
    d. they have considered how the search may impact the physician-patient relationship (for example, whether it would lead to a breakdown in trust).

15. Physicians **must** document the rationale for conducting the search and any other relevant information (for example, search findings and the nature of search) in the patient's record.

16. Physicians relying on patient health information found online for clinical decision-making **must**:
    a. take reasonable steps to confirm the accuracy of the information prior to using the information; and
    b. if it is safe and appropriate to do so, disclose to the patient the source of the information, the clinical rationale for obtaining the information, and any other relevant information.

Conflicts of Interest

17. Physicians **must** avoid or recognize and appropriately manage (for example, by disclosing) actual or perceived conflicts of interest (i.e., where their personal or professional interests are at odds with their professional obligations) when using social media.[14]

[14] For more information see the *Practice Guide* and the *Physician's Relationships with Industry: Practice, Education and Research* policy. While Part IV of O. Reg., 114/94 under the *Medicine Act, 1991*, S.O. 1991 discusses conflicts of interest, this policy is not limited in its scope to those situations.

Advice to the Profession: Social Media

Advice to the Profession companion documents are intended to provide physicians with additional information and general advice in order to support their understanding and implementation of the expectations set out in policies. They may also identify some additional best practices regarding specific practice issues.

Many physicians use social media to interact with others, share content with a broad audience, and seek out medical information online. Social media can present important opportunities for physicians to enhance patient care, medical education, professional competence, collegiality, and advocacy, among other benefits.

Whether engaging in social media for personal or professional use, the use of these platforms, which are constantly evolving, highly accessible, informal, and fast-paced, raise questions about how physicians can uphold their professional obligations. This companion Advice document provides further guidance around how the expectations in the policy can be met.

General Use of Social Media

Why is CPSO setting out professional expectations for physician's use of social media?

As members of the medical profession, physicians are held to a professional standard, even when engaging on social media. The policy aims to set parameters for appropriate and responsible use and to clarify a physician's professional responsibilities and obligations in this context. It is not intended to inhibit physicians from using social media.

Do these professional expectations apply to my personal use of social media?

Physicians may have both professional (for example, LinkedIn to connect with colleagues, or maintaining a business page) and personal (for example, Facebook to interact with family and friends) accounts. However, it is important to keep in mind that the professional and personal are not always easily separated. For instance, even when posting in a personal capacity or not identifying yourself as a physician, others may know of or be able to learn of your status as a physician. Depending on your social media activity, your conduct can have negative or positive impacts on your reputation, the reputation of the profession, and of the institutions or organizations you work for and/or represent. Conduct that interferes with your ability to collaborate with others, quality health-care delivery, or the safety or perceived safety of others can become a

matter of concern. As such, physicians are expected to maintain professionalism in both personal and professional contexts.

Are forms of electronic communications such as emails, text messaging, video conferencing, and messaging applications considered social media?

While these are not traditionally considered social media, it is important to consider the context in which they are used and their potential impact. For instance, responding to an email list can reach a wide network of people online, similar in effect to commenting on a private online forum or posting in a group chat on social media. Physicians are expected to act professionally in all cases.

Interacting with patients and colleagues is considered engaging in professional activities and expectations in the College's *Physician Behaviour in the Professional Environment* policy apply when interacting with them online. Physicians must also continue to meet their obligations around protecting patient privacy and confidentiality, as outlined in the College's *Protecting Personal Health Information* policy.

Professionalism

Are there limits on how I can express my personal views or on my ability to advocate as a physician on social media?

CPSO, as well as the Royal College of Physicians and Surgeons of Canada's CanMEDS framework, recognizes that advocacy is an key component of a physician's role. It is important for physicians, who have greater knowledge of and experience within the health-care system, to be able to discuss issues and provide fair and constructive feedback in order to create positive change.

As a physician, while you can express your personal views or show support for opinions expressed by others online, your conduct will need to be guided by the values of the profession articulated in the *Practice Guide* and the expectations set out in the policy. Physicians must also ensure that their social media use, including for advocacy, does not interfere with their ability to collaborate with others, the delivery of quality health-care delivery, or the safety or perceived safety of others.

In some circumstances, physicians expressing opinions that contradict generally accepted views can cause confusion and mistrust among the public and impact overall public health and safety. While physicians may choose to express their personal views, professionalism involves being aware of and transparent about the limits of your knowledge and expertise when discussing general health information online.

The *Practice Guide* also reminds physicians to demonstrate cultural sensitivity in their communication with patients and families and an awareness of their own values and how their values relate to or differ from those of their patients and families. In the context of social media, it is important for physicians to be mindful of how their conduct on social media (including by showing support by liking, sharing, or commenting on other content) could lead patients to feel uncomfortable, judged, or marginalized, and impact patient trust and their willingness to access care. For example, microaggressions are everyday comments or actions that subtly express a stereotype of, or prejudice towards, a marginalized group. While microaggressions can be inadvertent and unintentional, their impact can be harmful by undermining trust or creating an unwelcoming environment, and lead to worse health outcomes. For more information about microaggressions and their impact and health care, visit the Temerty Faculty of Medicine's page on Microaggressions and Allyship.

The policy states that physicians must consider the potential impact on the "reputation of the profession" when using social media. What does CPSO mean by this?

The determination of the potential impact of a physician's conduct on the reputation of the profession will differ and depend on the circumstances and context in which it occurred. In making this determination, CPSO will be guided and informed by its policies and the values and principles of the profession, as articulated in the *Practice Guide*, and other professional resources such as the CMA Code of Ethics and Professionalism and CANMeds Framework. A physician's conduct would be concerning where it violates these standards, values, and principles, and such conduct could be found to harm the reputation of the profession if it undermines public trust in the profession.

What can I do about content posted by others that may be unprofessional?

You may come across content posted by colleagues that raise concerns, whether about others (for example, violating patient privacy) or themselves. In these cases, use your professional judgment and consider how you can appropriately raise your concerns, for instance, by contacting that individual privately so that they can take action by removing or correcting the information, or bringing it to the attention of others to whom they report, if appropriate.

In other situations, you may have the ability to moderate comments made by others (for example, comments responding to a post that you have made). While being careful not to censor or silence others is important, you may need to decide how to appropriately manage comments to foster professional and respectful debate. For instance, it may be appropriate for you to remove comments containing personal attacks and hate speech.

What is the difference between providing clinical advice and sharing general health information online?

General health information refers to information that is intended for general education or information sharing; it is not patient-specific. For example, information on a physician's blog on diabetic self-care or information on a business page that encourages patients to get a seasonal flu shot, are accessible to a wide audience and not intended as a substitute for a physician's clinical advice. Clinical advice refers to individualized advice given to a specific patient for a particular health concern.

What do I do if an individual reaches out to me on social media with a medical question?

You can respond to questions without providing specific clinical advice. You can inform the individual that you do not provide advice on social media and direct the individual to make an appointment through the appropriate channels, or you can provide information for emergency or urgent care services, if applicable.

What do I have to keep in mind when sharing general health information on social media?

It is important to keep in mind that the impact of your statements has the potential to be very influential given the nature of social media and your status as a physician. Statements you make, particularly those containing health-related information, are likely to be perceived as more credible and legitimate and spread more easily online as a result, regardless of whether you are speaking about an issue outside your expertise or scope of practice. Where there is reasonable debate or uncertainty around scientific, medical, or clinical issues, it may be appropriate to indicate this to avoid making statements that are misleading.

Professional Relationships and Boundaries

How can I maintain appropriate boundaries with patients on social media?

Physicians must comply with the expectations in the *Boundary Violations* policy when engaging with patients and persons closely associated with patients on social media.

As a physician, it is important to be aware of the increased risk associated with managing a dual relationship with a patient, including the potential for compromised professional judgment and/or unreasonable patient expectations. Personal information is more readily available and accessible on social media and connecting online can lead to inappropriate self-disclosure by patients or physicians.

Maintaining appropriate boundaries may mean refraining from connecting with patients and persons closely associated with them on social media. Patients may feel pressured or coerced into accepting an invitation from their physician due to the inherent power imbalance in the physician-patient relationship. If a patient or a person closely associated with them has sent an invitation to you to connect on social media, you must consider the potential impact on the physician-patient relationship. Relevant factors can include the type of clinical care provided, the length and intensity of the professional relationship, and the vulnerability of the patient. When declining an invitation, you can discuss with the patient why you decided to do so to avoid damaging the physician-patient relationship.

Having a separate professional account can help you maintain appropriate boundaries on social media. Since personal content is generally limited on a professional account, you may be able to connect with patients without compromising the therapeutic relationship.

Privacy and Confidentiality

How do I de-identify information if I want to post about a patient on social media?

De-identified information is information that cannot be used to identify an individual, either directly or indirectly. De-identification involves removing any information that identifies an individual, or for which there is a reasonable expectation that the information could be used, either alone or with other information, to identify an individual.

An unnamed patient may still be identified through a range of information, such as a description of their clinical condition, or the date, time, and/or location of a clinical event. When posting photographs, even if a patient is not directly pictured, other details such as the time and date, and/or location of the post (which can also be found in a photograph's metadata), can be used to reveal information about an individual. Even if only the patient can identify themselves from the information available, that may be deemed a breach of confidentiality.

Given the increased risks of identification and the highly accessible and permanent nature of social media, protection of patient privacy is paramount when posting on social media, and physicians might wish to consider obtaining a patient's consent for posting even de-identified information on social media whenever possible. The policy requires physicians to obtain and document consent before publishing patient information where there is any doubt that the patient can be kept anonymous (for

example, posting a photograph with an identifiable part of a patient's body for educational purposes).

Why must I refrain from seeking out patient information online without a clinical rationale if it is publicly available?

Patients have a reasonable expectation of privacy. Some patients may choose not to disclose certain information to their physician, even if it is publicly available online. If a patient finds out their physician has sought out information about them online, they may perceive this to be a boundary violation, or feel that the physician does not trust them or respect their autonomy, which may lead to a breakdown in trust in the physician-patient relationship. Physicians can preserve patient trust and protect the physician-patient relationship by refraining from seeking out patient information online without a patient's knowledge and without a clinical rationale.

What is considered an appropriate clinical rationale related to safety concerns?

Situations where there is a risk of serious bodily harm to a patient or to others and danger is imminent would most clearly establish an appropriate clinical rationale related to safety concerns. However, in this policy, safety is defined more broadly and is not limited in scope to these specific situations. There are other situations not involving an imminent risk of serious bodily harm which, in the physician's judgment, may have as their core concern the safety of the patient or of others and be considered an appropriate clinical rationale to conduct an online search.

What can I do to protect my privacy when using social media?

It is important to keep in mind that privacy and confidentiality can never be fully guaranteed online, even when posting in a private forum or direct messaging someone. Posts can potentially be shared more widely than was originally intended (for example, others can take screenshots and share them on other platforms or in the media) and can be hard to remove once placed online.

Physicians can regularly review their account privacy settings and choose stricter settings to better protect, maintain control over, and limit access to their personal information when posting for personal purposes. Resources from the Office of the Privacy Commissioner of Canada with useful guidance on how to protect your personal information are available below.

Resources

Canadian Medical Protective Association

Social media: The opportunities, the realities
Top 10 tips for using social media in professional practice
Good Practice Guide: Social Media

Office of the Privacy Commissioner of Canada

Staying safe on social media
Privacy and social media in the workplace
Tips for using privacy settings
De-identification Centre

Council Motion

Motion Title	*Social Media* - Draft Policy for Consultation
Date of Meeting	June 18, 2021

It is moved by_____, and seconded by_____, that:

The Council engage in the consultation process in respect of the draft policy “Social Media”, (a copy of which forms Appendix “ “ to the minutes of this meeting).

Council Briefing Note

June 2021

Topic:	Policy Redesign – Registration Policies
Purpose:	For Decision
Relevance to Strategic Plan:	• Right-Touch Regulation • Continuous Improvement
Public Interest Rationale:	**Accessibility:** Ensuring individuals have access to services provided by the health profession of their choice and individuals have access to the regulatory system as a whole
Main Contact(s):	Samantha Tulipano, Director, Registration & Membership Services
Attachment(s):	Appendix A: *Current Registration Policies – Current Policies* Appendix B: *Redesigned Registration Policies – Revised Policies*

Issue

- At its meeting in December 2018, Council approved a proposal to redesign College policies in order to enhance their utility for physicians. In keeping with this commitment ongoing work has been undertaken to redesign Registration policies, retaining current expectations while improving the clarity of the stated requirements.

- Council is presented with a batch of four Registration policies that have been redesigned in this manner and approved by the Registration Committee. Council is being asked to approve the Registration Committee's recommendations.

Background

- In response to feedback that College policies can be difficult to read and understand, Council approved a proposal to redesign all policies to be clearer and more concise.

- The proposal was clear that the core content would be retained and not be meaningfully altered through the redesign process. Instead, the focus would be on enhancing the clarity of policies through changes in drafting conventions (e.g. using a numbered list format; using

formatting to better identify and delineate instructions vs. requirements, etc.) and simplified language.

- At its meeting in March 2019, Council accepted the first of these language revisions, as part of the Registration Committee's directives to the Registrar regarding certain registration requirements.

Current Status and Analysis

- The following remaining registration policies have been revised as part of the redesign process, without any substantive changes to the existing policies:

1. Acceptable Qualifying Examinations Policy	3. Recognition of Certification without Examination Issued by CFPC Policy
2. Alternative to the MCCQE 2 Examination Policy	4. Restricted Exam Eligible Policy

- Approval is being sought on the suite of policies, rather than a detailed review of each as the requirements or positions of the policies cannot be altered without additional consultation and engagement. Copies of the current (Appendix A) and redesigned (Appendix B) policies are provided for Council's consideration.

Questions for Council

1. Does Council approve the Registration Committee's recommendations to the existing Registration policies?

ACCEPTABLE QUALIFYING EXAMINATIONS

Alternatives to the Medical Council of Canada Examinations Parts 1 and 2

Applicants who are not licentiates of the Medical Council of Canada but who have successfully completed one of the following examinations:

1. USMLE Steps 1, 2 and 3. Step 2 Clinical Skills (CS) is required if Step 2 was taken **after June 12, 2004**.
2. ECFMG certification plus USMLE Step 3. Applies to international medical school graduates who passed USMLE Step 2 Clinical Skills Assessment (CSA) between July 1, 1998 to June 14, 2004.
3. FLEX component 1 and component 2 successfully completed (score of 75 on each component) between January 1, 1992 and December 31, 1994.
4. NBME Part 1, 2 and 3, successfully completed between January 1, 1992 and December 31, 1994.
5. The Comprehensive Osteopathic Licensing Examination (COMLEX-USA) Levels 1, 2 and 3. COMLEX-USA Level 2 Performance Evaluation (PE) component is required if Level 2 was completed **after September 2004**. (Applies to graduates of osteopathic schools accredited by the American Osteopathic Association.)
6. Examen Clinique Objectif Structuré (ECOS) of the Collège des Médecins du Québec passed between January 1, 1992 and December 31, 2000.

may be eligible for a certificate of registration with the following conditions, provided the applicant meets all other criteria for registration:

1. The physician must practice with a mentor and/or supervisor until he or she has successfully completed an assessment.
2. The physician must undergo an assessment after completing a minimum of one year of practice in Ontario. The certificate of registration automatically expires 18 months from the date of issuance, but may be renewed by the Registration Committee, with or without additional or other terms, conditions and limitations.

All applications submitted under this policy require review and approval by the College's Registration Committee.

Appendix A - Current Policies

ALTERNATIVE TO THE MCCQE 2 EXAMINATION

Approved by Council: February 2008
Reviewed and Updated: September 2015

This policy sets out the criteria under which an applicant for a certificate of registration may apply to the College to undergo a practice assessment as an alternative to the requirement of completing Part 2 of the Medical Council of Canada Qualifying Examination (MCCQE).

An applicant may apply to the College for a practice assessment, if the applicant has:

1. Five or more years of independent practice experience;
2. Certification by examination from the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada; or recognized as a specialist by the College of Physicians and Surgeons of Ontario
3. MCCQE Part 1, or an acceptable alternative;
4. One year of successful practice in Ontario under supervision, demonstrated by the supervisor's reports to the College.

The Registration Committee considers each case individually. The Committee will consider the nature and scope of practice as well as the applicant's attempts at writing MCCQE Part 2 when considering each application. The Committee expects that applicants will have attempted the MCCQE Part 2 before applying for a practice assessment under this policy.

Candidates who fulfil the aforementioned criteria may be permitted to undergo a practice assessment by the College. The Registration Committee will consider the practice assessment report and if the Committee finds the assessment report satisfactory, it will direct the Registrar to:

- Issue the candidate a restricted certificate of registration authorizing independent practice, limited to their specialty or scope of practice.

The applicant must pay all cost associated with the assessment.

Appendix A - Current Policies

RECOGNITION OF CERTIFICATION WITHOUT EXAMINATION ISSUED BY CFPC

Approved by Council: November 2009, February 2010, September 2013

The College of Physicians and Surgeons of Ontario (CPSO) and the College of Family Physicians of Canada (CFPC) have been working together to improve access and reduce barriers for qualified physicians.

A joint statement prepared by the CPSO and the CFPC provides some general information about the application process. For further information, please contact the relevant College.

Preamble

The College's registration regulation sets out the requirements which must be met in order for an applicant to be issued a certificate of registration.

If an applicant does not meet the requirements set out in the regulation it may still be possible for an applicant to qualify pursuant to one of the exemption policies.

Please note if you currently hold a certificate of registration in any Canadian jurisdiction except Nunavut you may be eligible for registration in Ontario under new provisions of the *Health Professions Procedural Code* (the "Code"). Please refer to sections 22.15 to 22.23 of the Code.

Please see Legislation and By-Laws for more details.

All applicants must be able to demonstrate that their past and present conduct indicates that they are mentally competent to practise medicine; will practise with decency, integrity and honesty and in accordance with the law; have sufficient knowledge, skill and judgment to engage in the kind of practice authorized by the certificate and can communicate effectively; and will display an appropriately professional attitude.

In addition to the registration regulation and policies, all applicants will also be subject to other CPSO policies and regulations which apply to current registrants. In particular, the Changing Scope of Practice and Re-entering Practice policies, and the regulation pertaining to the use of specialist titles may have relevance for new applicants. All applicants will also be subject to the College's expectations with respect to continuing professional development.

All applicants may choose to proceed through any other applicable registration policy. In such instances, the provisions in this policy will not apply.

Policy

1. Certification without examination and completed an Acceptable Qualifying Examination:

The Registration Committee may direct the Registrar to issue a **restricted certificate** of registration to an applicant who has a medical degree from an acceptable medical school, if the applicant has:

1. Successfully obtained certification without examination by the CFPC;
2. Successfully completed an **acceptable qualifying examination** as defined in the College's Policy on Acceptable Qualifying Examinations;

The following conditions will be placed on the certificate of registration:

1. The physician must practice with a mentor and/or supervisor until he or she has successfully completed an assessment.
2. The physician must undergo an assessment after completing a minimum of one year of practice in Ontario. The certificate of registration automatically expires 18 months from the date of issuance, but may be renewed by the Registration Committee, with or without additional or other terms, conditions and limitations.

2. Certification without examination and completed Parts 1 & 2 of the Medical Council of Canada Qualifying Examination:

The Registration Committee may direct the Registrar to issue a certificate of registration authorizing **independent practice** to an applicant who has a medical degree from an acceptable medical school, if the applicant has:

1. Successfully obtained certification without examination by the CFPC;
2. Successfully completed Parts 1 & 2 of the Medical Council of Canada Qualifying Examination.

RESTRICTED CERTIFICATE OF REGISTRATION FOR EXAM ELIGIBLE CANDIDATES

Approved by Council: November 2003
Reviewed and Updated: November 2011; December 2016

The policy permits the issuance of a time-limited, restricted certificate to physicians who are missing Medical Council of Canada Qualifying Examination Parts 1 and 2 , and/or Royal College of Physicians and Surgeons of Canada or College of Family Physicians of Canada certification, but are officially eligible to take these examinations. The Registration Committee may direct the Registrar to issue a restricted certificate of registration, to individuals who have provided the College with proof of:

1. having completed the certification exam of the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada, but who have not yet completed parts 1 and 2 of the MCCQE, or
2. being currently eligible *without pre-condition* to take the certification exam of the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada. The individual may or may not have yet completed Parts 1 & 2 of the MCCQE.

Candidates who are issued a restricted certificate of registration based on this policy willonly practise in prescribed circumstances under monitoring or supervisory arrangements, with accountability to the College for full compliance with the arrangements and for completing all examinations as required.

The issuance of a restricted certificate of registration is subject to the followingconditions:

1. The physician must practice with a supervisor until s/he has completed all outstanding examinations.
2. The restricted certificate of registration will expire within a reasonable number ofyears, not to exceed three years from the date that the restricted certificate of registration is issued; if
    a. the candidate does not successfully complete all outstanding MCC examinations; and
    b. the candidate does not receive certification by examination by either the RCPSCor by the CFPC.

Only in exceptional circumstances will candidates be considered for a renewal of their restricted certificate of registration after the expiration date.

1. Acceptable Qualifying Examinations

Learn about alternatives to the Medical Council of Canada Exams Parts 1 and 2.

Even if you are not a licentiate of the Medical Council of Canada, you may be eligible for a restricted certificate of registration. This may be the case if you have successfully completed one of the following exams:

1. **USMLE Steps 1, 2 and 3**. We require Step 2 Clinical Skills (CS) if you took Step 2 **after June 12, 2004.**
2. **ECFMG certification plus USMLE Step 3**. This applies to international medical graduates (IMGs) who passed USMLE Step 2 Clinical Skills Assessment (CSA) between July 1, 1998 and June 14, 2004.
3. **FLEX component 1 and component 2,** successfully completed (score of 75 on each component) between January 1, 1992 and December 31, 1994.
4. **NBME Part 1, 2 and 3**, successfully completed between January 1, 1992 and December 31, 1994.
5. **The Comprehensive Osteopathic Licensing Examination (COMLEX-USA) Levels 1, 2 and 3**. We require the COMLEX-USA Level 2 Performance Evaluation (PE) component if you completed Level 2 **after September 2004**. (This applies to graduates of osteopathic schools accredited by the American Osteopathic Association.)
6. **Examen Clinique Objectif Structuré (ECOS) of the Collège des Médecins du Québec** passed between January 1, 1992 and December 31, 2000.

Your certificate would come with the following terms, conditions and limitations, provided you meet all other criteria for registration:

1. You must practice with a mentor and/or supervisor until you have successfully completed an assessment.
2. You must undergo an assessment after completing a minimum of one year of practice in Ontario. The certificate of registration automatically expires 18 months from the date of issuance, but the Registration Committee may renew it with or without terms, conditions and limitations.

The CPSO's Registration Committee must review all applications submitted under this policy before approval.

2. Alternative to the MCCQE 2 Examination

Learn how you can undergo a practice assessment as an alternative to completing part 2 of the Medical Council of Canada Qualifying Exam

If you are applying to practice medicine in Ontario, there is an option to undergo a practice assessment as an alternative to completing Part 2 of the Medical Council of Canada Qualifying Examination (MCCQE).

You can apply for this practice assessment if you have:

i. Five or more years of independent practice experience;
ii. Certification by examination from the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada or are recognized as a specialist by the College of Physicians and Surgeons of Ontario;
iii. Successfully completed MCCQE Part 1, or an acceptable alternative;
iv. One year of successful practice in Ontario under supervision, demonstrated by the supervisor's reports to the CPSO.

Our Registration Committee considers each case individually. We will look at the nature and scope of your practice as well as your attempts at writing MCCQE Part 2. The Committee expects applicants to attempt the exam before applying for this practice assessment. Applicants must pay all costs associated with the assessment.

If you meet the criteria above, you may be permitted to undergo a practice assessment by the College. If we find your assessment report satisfactory, we will direct the Registrar to issue you a restricted certificate of registration. This will authorize independent practice, limited to your specialty or scope of practice.

3. Recognition of Certification without Examination Issued by CFPC

We have been working with **the College of Family Physicians of Canada to improve access and reduce barriers for qualified physicians.**

There are two scenarios in which the CPSO will recognize your certification in lieu of a CFPC examination. They are:

1. Certification without examination and completed an acceptable qualifying exam:

You may be issued a **restricted certificate** of registration if you have a medical degree from an acceptable medical school and have:

1. Successfully obtained certification without examination by the CFPC; and

2. Successfully completed an **acceptable qualifying examination** as defined in the College's Policy on Acceptable Qualifying Examinations.

The following conditions will be placed on the certificate:

1. You must practice with a mentor and/or supervisor until you have successfully completed an assessment.

2. You must undergo an assessment after completing a minimum of one year of practice in Ontario. The certificate of registration automatically expires 18 months from the date of
issuance, but we may renew it, with or without additional or other terms, conditions and limitations.

2. Certification without examination and completed Parts 1 & 2 of the Medical Council of Canada Qualifying Examination:

We may issue you a certificate of registration authorizing **independent practice** if you have a medical degree from an acceptable medical school and have:

1. Successfully obtained certification without examination by the CFPC; and

2. Successfully completed Parts 1 & 2 of the Medical Council of Canada Qualifying Examination.

4. Restricted Certificate of Registration for Exam Eligible Candidates

Learn how you may qualify for this type of licensure in Ontario.

The CPSO can issue a time-limited, restricted certificate of registration to physicians. This certificate is for those who are missing Medical Council of Canada Qualifying Examination (MCCQE) Parts 1 and 2, and/or Royal College of Physicians and Surgeons of Canada (RCPSC) or College of Family Physicians of Canada (CFPC) certification, but are officially eligible to take these exams. You may be issued a restricted certificate if you have provided proof that you:

1. have completed the certification exam of the RCPSC or the CFPC, but you have not yet completed parts 1 and 2 of the MCCQE, or
2. are currently eligible *without pre-condition* to take the RCPSC or CFPC certification exam. You may or may not have yet completed Parts 1 & 2 of the MCCQE.

This restricted certificate is subject to the following conditions:

1. You must practice with a supervisor until you have completed all outstanding exams.
2. Your restricted certificate will expire within a reasonable number of years, not to exceed three years from the date it is issued, if:
    a. you do not successfully complete all outstanding MCC examinations; and
    b. you do not receive certification by exam by either the RCPSC or by the CFPC.

Only in exceptional circumstances will we consider candidates for a renewal of their restricted certificate of registration after the expiration date.

Council Motion

Motion Title	Policy Redesign – Registration Policies
Date of Meeting	June 18, 2021

It is moved by_____, and seconded by_____, that:

The Council approves the revised policies “Acceptable Qualifying Examinations Policy”, “Alternative to the MCCQE 2 Examination Policy”, “Recognition of Certification without Examination Issued by CFPC Policy”, and “Restricted Exam Eligible Policy” (copies of which forms Appendix “ ” to the minutes of this meeting).