CPSO

Meeting of Council

September 13 & 14, 2021

CPSO

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 September 13 & 14, 2021. 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

August 19, 2021

Council Meeting Agenda
September 13-14, 2021

CPSO

MONDAY, SEPTEMBER 13, 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 June 17, 2021 and June 18, 2021**	Approval (with motion)	1-84
3	**9:20 am** (10 mins)	**Items for information:** 3.1 Executive Committee Report 3.2 Ontario Physicians and Surgeons Discipline Tribunal 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 3.8 2022 Council Meeting Dates	Information	 85 86-91 92-98 99-106 107-117 118-120 121 122
4	**9:30 am** (60 mins)	**CEO/Registrar's Report** (N. Whitmore)	Discussion	**N/A**
5	**10:30 am** (10 mins)	**President's Report** (J. Plante)	Discussion	**N/A**
*	**10:40 am** (20 mins)	**NUTRITION BREAK**		
6	**11:00 am** (15 mins)	**COUNCIL AWARD PRESENTATION** (S. Reid) Celebrate the achievements of Dr. Elizabeth Hollington Shouldice, Ottawa		
7	**11:15 am** (35 mins)	**Virtual Care – Draft Policy for Consultation** (S. Reid / T. Terzis) • Consider approving the draft Virtual Care policy for external consultation.	Decision (with motion)	123-141
8	**11:50 am**	**Motion to Go in Camera** (J. Plante)	Decision (with motion)	142

Item	Time	Topic and Objective(s)	Purpose	Page No.
*	**11:50 am** (60 mins)	**LUNCH**		
*	**12:50 pm** (30 mins)	**In-Camera Items**		
9	**1:20 pm** (65 mins)	**Governance Committee Report** 9.1 Election of 2021-2022 Academic Representatives on Council 9.2 Executive Committee Elections 9.3 Request for Exceptional Circumstances 9.4 Nominations and Appointments to Committees 9.5 Chair / Vice-Chair Appointments	 Decision Decision Decision Decision Decision	 143-144 145-153 154-158 159-176 177-186
*	**2:25 pm** (20 mins)	**NUTRITION BREAK**		
10	**2:45 pm** (75 mins)	**Return to Work and 2022 Priorities** (N. Novak / N. Whitmore / J. Plante) • An overview is provided on back to work plans including updates on the College Vaccination Policy and a hybrid approach to conducting both remote and in-person Committee and Operational work • Council is asked to consider supporting direction regarding building retrofit	 Information Decision	Presentation at time of meeting
11	**4:00 pm**	**Adjournment Day 1** (J. Plante)	N/A	

TUESDAY, SEPTEMBER 14, 2021

Item	Time	Topic and Objective(s)	Purpose	Page No.
*	**8:30 am**	**INFORMAL NETWORKING**		
12	**9:00 am** (10 mins)	**Call to Order** (J. Plante) • Participate in roll call and declare any conflicts of interest	Discussion	**N/A**
13	**9:10 am** (60 mins)	**Council Education: Equity Diversity and Inclusion** (A. Dewar Gully – Tidal Equality)	Information	-
14	**10:10 am** (20 mins)	**Licentiate of the Medical Council of Canada (LMCC) Policy** (S. Tulipano / L. Brownstone / C. Silver) • Consider approving the draft LMCC Policy for circulation to the Ministry and the MRAs across Canada	Decision (with motion)	187-203
*	**10:30 am** (15 mins)	**NUTRITION BREAK**		
15	**10:45 am** (60 mins)	**Council Education: Governance Best Practices** (J. Dinner)	Information	-
16	**11:45 am** (20 mins)	**Physician Assistant Regulation** (M. Barna / D. Aranda / C. Roxborough) • An update is provided on Physician Assistant Regulation	Information	204-208
*	**12:05 pm** (60 mins)	**LUNCH**		
17	**1:05 pm** (30 mins)	**Complementary and Alternative Medicine – Revised Draft Policy for Final Approval** (J. van Vlymen / C. Brown) • Consider the revised draft Complementary and Alternative Medicine policy for final approval	Decision (with motion)	209-229
18	**1:35 pm** (20 mins)	**By-law for Declaration of Emergency** (M. Cooper / L. Brownstone) • Consider ending the declaration of emergency under the By-law	Decision (with motion)	230-235
19	**1:55 pm** (10 mins)	**Housekeeping By-law Amendments re Terms of Academic Representatives** (M. Cooper) • Consider approving the revisions to clarify terms of Academic Representatives on Council	Decision (with motion)	236-240
20	**2:05 pm** (30 mins)	**[Placeholder - Additional information relating to Governance Modernization]** • Pending new developments that occur prior to Council Meeting		-

Item	Time	Topic and Objective(s)	Purpose	Page No.
21	**2:35 pm** (5 mins)	**Adjournment Day 2** (J. Plante) • Reminder that the next meeting is scheduled on December 9-10, 2021	N/A	**N/A**
*	**2:35 pm**	**Meeting Reflection Session** (J. Plante) • Share observations about the effectiveness of the meeting and engagement of Council members	Discussion	**N/A**

DRAFT PROCEEDINGS OF THE MEETING OF COUNCIL
June 17 and 18, 2021

June 17, 2021

Attendees

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

Non-Voting Academic Representatives on Council Present:

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

Regrets:
Dr. Deborah Hellyer
Ms. Catherine Kerr

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.

A. Turner provided the land acknowledgement as a demonstration of recognition and respect for Indigenous peoples.

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

2. Consent Agenda

J. Plante noted the following additions were made to the agenda following distribution:

- A briefing note was added regarding Item 7 – National Licensure for Rural Locums;
- Item 17.5 Committee Appointments briefing note was added as a late submission; and
- Item 17.7 Election versus selection for the Governance Committee was added to the Governance Committee Report.

01-C-06-2021

The following motion was moved by L. Miljan, seconded by J. Rosenblum and carried (with J. Plante and K. Pirzada abstaining), 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, as amended; and
- The minutes from Council held March 4 & 5, 2021

CARRIED

3. For Information

The following items were included in Council's package 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 Reports
3.7 Update on Council Action Items

4. Chief Executive Officer / Registrar's Report

Dr. N. Whitmore, Chief Executive Officer / Registrar, presented her report and shared the CPSO's vision. Updates were provided on the CPSO's Quality Improvement program, Key

Performance Indicators, College Performance Measurement Framework, CPSO's Social Media Update including engagement activities with the public and profession. Highlights were provided on Governance Modernization as well as an update on Physician Assistant Regulation. Dr. Whitmore highlighted several continuous improvement updates, including an update on key technology enhancements and system collaboration, and CPSO's Diversity, Equity, and Inclusion Strategy.

5. President's Report

Dr. J. Plante presented her report to Council and provide highlights from recent meetings with MPP's to introduce CPSO and its work. She discussed key takeaways from her presentations at recent medical school convocation ceremonies.

Management provided a brief update on recent Cyber attacks affecting the health care community.

6. Council Award Presentation

Ms. Joan Fisk, Council Member, presented the Council Award to Dr. Sharon Kular Bal of Cambridge for her leadership in the area of family practice. Dr. Bal was recognized for her work in system collaboration as it relates to patient equity. Dr. Bal expressed her gratitude to the CPSO, the selection committee as well as a number of mentors.

7. Member Topics: National Locum Licensure

Dr. R. Kirkpatrick, Council Member, raised the topic, National Locum Licensure for discussion. A recent letter sent out to ministers of health and politicians regarding National Licensure for Rural Locums was included in the meeting package. Discussion ensued about possible ways of moving the conversation forward about national locum licensure.

8. Interprofessional Collaboration

R. Bernstein, Policy Analyst, provided Council with an overview of a proposal to rescind three statements related to interprofessional collaboration and replace them with one broader statement that supports interprofessional collaboration with all health-care professionals.

02-C-06-2021

The following motion was moved by D. Robertson, seconded by S. Reid and carried, that:

The Council rescind the College's:

a) *Fostering Collaborative Relationships with Nurse Practitioners* statement (a copy of which forms Appendix "A" to the minutes of this meeting);
b) *Physician Working Relations with Pharmacists* statement (a copy of which forms Appendix "B" to the minutes of this meeting); and
c) *Midwives* statement (a copy of which forms Appendix "C" 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 "D" to the minutes of this meeting).

CARRIED

9. Ontario Physicians and Surgeons Discipline Tribunal (OPSDT) Logo

D. Wright, Tribunal Director and Chair of the Discipline Committee and Hearings Office and F. Hill-Hinrichs, Director of Communications and Media provided an overview of two options for OPSDT Logos being presented to Council for decision. Following discussion, Council voted on Option 1 as the new OPSDT Logo.

03-C-06-2021

The following motion was moved by S. Chaudhry, seconded by K. Pirzada and carried, that:

The Council select option 1 for the Ontario Physicians and Surgeons Discipline Tribunal logo a copy which is attached as Appendix "E".

CARRIED

10. Motion to move in-camera

J. Plante requested that the motion to move in camera be considered before the lunch break.

04-C-06-2021

It was moved by J. Fisk, seconded by L. Miljan and carried, that:

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

CARRIED

Council entered into an in-camera session at 1:10 pm and returned to open session at 1:40 pm.

11. Proposal for Legislative Change – Governance Modernization and Red-Tape Reduction

M. Barna, Senior Government Relations Advisor and L. Brownstone, Chief Legal Officer provided an overview of the following proposals for legislative change:

1. ***Reduce the size of the board***
2. ***Implement a competency-based board selection process***
3. ***Eliminate overlap between board and statutory committee membership***
4. ***Equal composition of public and professional members on board***
5. ***Allow CPSO to compensate public members***
6. ***Eliminate the Executive Committee***
7. ***Allow for flexibility of presidential term and change of presidential and vice-presidential titles***
8. ***Address title protection for "osteopath"***

Red-Tape Reduction Recommendations

9. Allow CPSO to make rules relating to specific core functions
10. Expand CPSO's discretion to investigate complaints
11. Streamline the handling of frivolous and vexatious complaints
12. Enable CPSO to more freely share information with hospitals
13. Clarify the application of the Mental Health Act in CPSO hearings

Discussion ensued on the proposals.

05-C-06-2021

The following motion was moved by S. Weber, seconded by I. Preyra and carried, 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 "F" to the minutes of this meeting).

CARRIED

12. Female Genital Cutting / Mutilation (FGC/M)

C. Brown, Policy Analyst and R. Bernstein, Policy Analyst, provided an overview of the Female Genital Cutting / Mutilation (FGC/M) policy. Council considered whether to rescind the FGC/M policy and replace with a statement or rescind the policy altogether. Following discussion, Council expressed that it would be appropriate to rescind the FGC/M Policy and replace with a statement.

06-C-06-2021

The following motion was moved by D. Robertson, seconded by J. Rosenblum and carried, that:

The Council rescind the College's Female Genital Cutting (Mutilation) policy (a copy of which forms Appendix "G" to the minutes of this meeting) and replace it with the new Female Genital Cutting (Mutilation) statement (a copy of which forms Appendix "H" to the minutes of this meeting).

CARRIED

13. Academic Registration Policy

S. Tulipano, Director of Registration and Membership Services provided an overview of the changes to the Academic Registration Policy noting that such changes add clarity to the current policy. Following discussion and further clarification, Council expressed support with respect to the proposed changes to the policy.

07-C-06-2021

The following motion was moved by G. Bandiera, seconded by S. Reid and carried, that:

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

CARRIED

14. Adjournment Day 1

J. Plante adjourned day 1 of the meeting at 3:48 pm.

June 18, 2021

Attendees

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

Non-Voting Academic Representatives on Council Present:

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

Regrets:
Dr. Deborah Hellyer
Ms. Catherine Kerr

15. Call to Order

J. Plante called the meeting to order at 9:00 am and welcomed everyone back to the meeting. A roll call was conducted.

16. Professional Responsibilities in Medical Education – Revised Draft Policy for Final Approval

Dr. K. Saperson Academic Representative from McMaster together with L. Kirshin, Senior Policy Analyst provided an overview of the changes to the Professional Responsibilities in Medical Education Policy being brought to Council for review and final approval. Background was provided on the final policy noting that the Policy is a product of two policies collapsed into one in order to streamline the policy. Highlights were provided on key revisions made. Following discussion, Council expressed support for the revised draft policy.

08-C-06-2021

The following motion was moved by P. Pielsticker, seconded by B. Copps and carried, that:

The Council approves the "Professional Responsibilities in Medical Education" policy, (a copy of which forms Appendix "J" to the minutes of this meeting), formerly the "Professional Responsibilities in Undergraduate Medical Education" and "Professional Responsibilities in Postgraduate Medical Education" policies.

CARRIED

17. Governance Committee Report

Dr. B. Copps, Chair of the Governance Committee provided the Governance Committee Report. An update was provided on two public member re-appointments. The skills matrix will be brought back to Council to obtain a more accurate measure of skills on Council in order to assess Council skillset and identify any gaps.

17.1 Committee Education Sessions Update

Committee Education Sessions have been paused over the summer months and will commence in September. An overview was provided on upcoming Committee education sessions.

17.2 Recruitment: Updated Timing – September Appointments

An update was provided on recruitment timing. Committee recruitment has been moved up to September. Committee members will be appointed in September and will officially commence their term in December 2021. The interview process is underway.

17.3 Executive Committee Elections Update

Executive Committee Elections will be moved to September.

17.4 Update on Council Elections

An update was provided on Council elections, noting that there is 1 position open in District 6, District 7 has 2 positions open and Districts 8 and 9 have been acclaimed. Council will be kept apprised of ongoing developments.

17.5 Committee Appointments

Dr. I. Preyra declared a conflict and recused himself for this item.

The appointment of five adjudicators and one physician to the Discipline Committee were presented to Council for its decision.

09-C-06-2021

The following motion was moved by P. Hendry, seconded by P. Malette and carried, that:

The Council appoints Raj Anand, Shayne Kert, Sherry Liang, Sophie Martel, Jennifer Scott and Dr. Catherine Grenier for a term that expires at the end of the annual general meeting of Council in December 2023, to the Discipline Committee (Ontario Physicians and Surgeons Discipline Tribunal) and Fitness to Practise Committee.

CARRIED

17.6 Requests for Exceptional Circumstances

An overview was provided on the five requests made to apply the Exceptional Circumstances provision in the General By-law to allow the terms of five committee members to be extended for an additional year, exceeding the applicable term limits.

10-C-06-2021

The following motion was moved by S. Chaudhry, seconded by J. Rapin and carried, 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

CARRIED

18. Finance and Audit Committee

Dr. Bertoia, Chair of the Finance and Audit Committee, provided the Finance and Audit Committee Report to Council.

18.1 Audited Financial Statements for the 2020 Year

P. Brocklesby, the Auditor from Tinkham LLP provided an overview of the audited financial statements for the December 31, 2020 financial year end.

18.2 Approval of the Audited Financial Statements for 2020

11-C-06-2021

The following motion was moved by P. Pielsticker, seconded by I. Preyra and carried, that:

The Council approves the financial statements for the fiscal year ended December 31, 2020 as presented (a copy of which form Appendix “K” to the minutes of this meeting).

CARRIED

18.3 Appointment of the Auditor for 2021 fiscal year

An overview was provided on the Appointment of the Auditor for the 2021 fiscal year.

12-C-06-2021

The following motion was moved by K. Pirzada, seconded by L. Miljan and carried, that:

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

CARRIED

18.4 Establishment of an internally restricted Intangible Asset Fund and Asset Transfer

Dr. Bertoia provided background on the establishment of an internally restricted Intangible Asset Fund and Asset Transfer as set out in the briefing note. Management advised that Council will be receiving a presentation on Workplace Strategy at the next Council meeting. The presentation will provide highlights on the past, present and future of the information technology infrastructure. Following discussion, Council expressed support of the motion.

13-C-06-2021

The following motions were moved by S. Chaudhry, seconded by R. Gratton and carried, that:

The Council approves the establishment of an internally restricted intangible asset fund for the purposes of future information technology infrastructure development and improvements; and

The Council approves that $8,116,895.00 dollars be transferred to the internally restricted intangible asset fund.

CARRIED

18.5 Remuneration for Council and Committee Members

Council received an update on remuneration for Council and Committee Members from discussions that took place at the Finance and Governance Committees. The six-hour maximum meeting cap will be removed. Such changes are effective as of June 17, 2021.

17.7 Election versus Selection for Governance Committee – New Item

J. Plante advised that the item, Election versus Selection for the Governance Committee will be deferred to line up with the other election items.

19. Third Party Medical Reports – Revised Draft Policy for Final Approval

Dr. T. Everson, Medical Advisor and M. Cabrero Gauley, Senior Policy Analyst presented to Council the revised draft policy, Third Party Medical Reports for final approval. Background was provided on the final policy noting that the Policy is a product of two policies collapsed into one in order to streamline the policy. Highlights were provided on key revisions made. Following discussion, Council expressed support for the revised draft policy.

14-C-06-2021

The following motion was moved by P. Malette, seconded by J. Fisk and carried, 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 “L” to the minutes of this meeting).

CARRIED

20. Psychotherapy Regulation

L. Kirshin, Senior Policy Analyst presented to Council a proposal not to proceed with a draft regulation change regarding the duration of a physician-patient relationship where psychotherapy is provided. Background on the draft regulation was provided. It was noted in the briefing note that if Council agrees to not pursue the draft regulation, an article will be written in *Dialogue* to inform members and the public. Following discussion, Council was informed that the article was felt unnecessary and was therefore cancelled.

15-C-06-2021

The following motion was moved by B. Copps, seconded by J. Fisk and carried, that:

The Council not pursue the Psychotherapy Regulation it originally approved in May 2018, the text of which is attached as Appendix “M” to the minutes of this meeting, given changes in government and policy since that time.

CARRIED

21. Social Media – Draft Policy for Consultation

Dr. J. van Vlymen, Council Member and A. Wong, Policy Analyst presented to Council the draft policy for consultation on Social Media. Following distribution of the materials, further amendments were made to the draft Social Media policy. An overview of the amendments was provided to Council and such amendments have been incorporated into Appendix "N" to the minutes. The draft policy will go to a number of stakeholders, including medical students and will be available on social media sources for consultation. Feedback on the draft policy will be reported to Council.

16-C-06-2021

The following motion was moved by D. Robertson, seconded by R. Payne and carried, that:

The Council engage in the consultation process in respect of the draft policy "Social Media", (a copy of which forms Appendix "N" to the minutes of this meeting).

CARRIED

22. Registration Policies Redesign

S. Tulipano, Director of Registration and Membership Services provided an overview of the Registration Policies Redesign noting that no substantive changes have been made. The policies were revised to include plain language updates.

17-C-06-2021

The following motion was moved by J. Rosenblum, seconded by R. Payne and carried, 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 "O" to the minutes of this meeting).

CARRIED

23. Adjournment Day 2

J. Plante adjourned day 2 of the meeting at 11:34 am.

Chair

Recording Secretary

Appendix A

FOSTERING COLLABORATIVE RELATIONSHIPS WITH NURSE PRACTITIONERS

The College of Physicians and Surgeons of Ontario recognizes that our health care system is changing; in order to better meet patient needs, health care has evolved such that delivery of care no longer takes place through exclusive domains of practice but through multidisciplinary teams. The creation of an Extended Class of Registered Nurses (nurse practitioners) is an example of how the roles of health professionals are changing and complementing one another.

We believe that collaborating with nurse practitioners advances the College's goal of working in partnership with other stakeholders to advocate for quality health care. Part of ensuring that the people of Ontario receive quality health care is improving access to this valuable resource and it is our belief that this partnership will contribute to this objective.

We are committed to fostering a collaborative relationship built on trust and mutual respect with our colleagues in the nursing profession and we look forward to working together in the interests of the people of Ontario.

Approved by Council: May 2003

Appendix B

PHYSICIAN WORKING RELATIONS WITH PHARMACISTS

Pharmacists Renewing and/or Adapting Prescriptions

A joint letter from the OCP, CPSO, OPA, and OMA

December 10, 2012

On October 9, 2012, new expanded scope regulations came into effect for pharmacists in Ontario.

View letter to members here

Interprofessional Collaboration

College Statement

The College of Physicians and Surgeons of Ontario recognizes that our health care system is changing; in order to better meet patient needs, health care has evolved such that delivery of care no longer takes place through exclusive domains of practice but rather through multidisciplinary teams. The development of medication management programs and other related programs by Ontario pharmacists is an example of how the roles of health professionals are changing and complementing one another.

We believe that collaborating with pharmacists advances the College's goal of working in partnership with other stakeholders to advocate for quality health care. Part of ensuring that the people of Ontario receive quality health care is improving access to this valuable resource and it is our belief that this partnership will contribute to this objective.

We are committed to fostering a collaborative relationship built on trust and mutual respect with our colleagues in pharmacy and we look forward to working together in the interests of the people of Ontario.

Approved by Council: February 2005

MIDWIVES

Position statement: Joint statement from the College and the College of Midwives of Ontario

CPSO and CMO Statement on Interprofessional Collaboration

The College of Physicians and Surgeons of Ontario (CPSO) and the College of Midwives of Ontario (CMO) are committed to interprofessional collaboration. This commitment is made in order to support their members in meeting the primary maternity care needs of Ontario's women and families.

Both the CPSO and CMO recognize the value of collaboration at the regulatory level to coordinate and plan for the future of maternity care service delivery in the province. We are further committed to supporting our members in fostering collaborative relationships that are built on trust and mutual respect for each other's role in the provision of care to pregnant women and infants.

The CPSO and CMO will regularly consult with one another regarding health system issues that could impact the provision of maternity care services and commit to an open and collegial working relationship that places the safety of Ontario's women and families at the forefront.

The CPSO and CMO look forward to working together in the interests of the people of Ontario.

Approved by Council June 2010

Appendix D

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.

Option #1

OPSDT
Ontario Physicians and Surgeons
Discipline Tribunal

TDMCO
Tribunal de discipline des médecins
et chirurgiens de l'Ontario

Option #2

OPSDT
Ontario Physicians and Surgeons
Discipline Tribunal

TDMCO
Tribunal de discipline des médecins
et chirurgiens de l'Ontario

CPSO

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.

Appendix G

FEMALE GENITAL CUTTING (MUTILATION)

Approved by Council: February 2001
Reviewed and Updated: November 2004, September 2011

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

Female genital cutting/mutilation: Involves the cutting and removal of the female genitalia, and permanent mutilation of the sexual organs of young females for non-medical reasons.[1]

Policy

Patient Care

1. Physicians **must not** perform or refer patients to any person for the performance of any female genital cutting/mutilation (FGC/M) procedures.[2]
2. During the course of a vaginal delivery of a woman who has been previously subjected to an FGC/M procedure, it may be necessary to surgically disrupt the scar tissue resulting from the earlier procedure. In this circumstance, at the conclusion of the delivery, the physician **must** confine activities to repairing the surgical incision or laceration required during the delivery, and **must not**, for example, endeavor to reconstruct an infibulation.
3. Wherever possible physicians **must** inform the patient of this limitation prior to delivery, although are **advised** to do so prior to pregnancy or during the course of prenatal care.
4. Where there is doubt about whether a procedure is considered to be FGC/M, physicians are **advised** to seek independent legal advice.
5. Physicians are **advised** to:
    a. provide culturally sensitive counseling regarding the dangers related to performing FGC/M, and
    b. educate themselves on the appropriate management of possible complications in order to provide appropriate counsel and care when they encounter patients subjected to FGC/M.

Reporting

6. Physicians who have reasonable grounds to believe that another physician is performing FGC/M procedures **must** immediately bring the issue to the attention of the College.
7. Physicians who have reasonable grounds to believe that an FGC/M procedure has been performed on, or is being contemplated for, any

female under the age of 18, **must** notify the appropriate child protection authorities, regardless of where the procedure has been or will be undertaken.[3]

Endnotes

1. Ontario Human Rights Commission. Policy on Female Genital Mutilation. See also Section 268.3(a-b) of the *Criminal Code,* R.S.C., 1985, c. C-46 (hereinafter, *Criminal Code)*, which defines the act as involving the infibulation, excision or mutilation, in whole or in part, of the labia majora, labia minora or clitoris of a person, except where performed 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.

2. The *Criminal Code* prohibits the performance of or referral for FGC/M (see Sections 268(3), 21-22 and 273.3(1)). Physicians are reminded that it is an act of professional misconduct to contravene a federal law, 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 (See Section 1(1) par. 28 of the *Professional Misconduct*, O. Reg. 856/93 enacted under the *Medicine Act*, 1991, S.O. 1991, C.30).

3. Pursuant to *Child and Family Services Act,* R.S.O. 1990, c. C.11, s.72(1) and Section 273.3(1) of the *Criminal Code*, as well as the College's *Mandatory and Permissive Reporting* policy.

Appendix H

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.

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.

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.

Financial statements of the

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 31, 2020

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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

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See accompanying notes to the financial statements. 2

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. 4

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 Cost	2020 Accumulated Amortization	2019 Cost	2019 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

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*).

CPSO

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?

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.

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	Council Meeting Consent Agenda
Date of Meeting	September 13, 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 September 13 & 14, 2021
- The minutes from the meeting of Council held June 17 & 18, 2021

Council Briefing Note

CPSO

September 2021

Topic:	Executive Committee Report
Purpose:	For Information
Main Contact:	Lisa Brownstone, Chief Legal Officer
Attachment:	N/A

05-EX-May-2021 The Executive Committee supports the nomination of N. Whitmore as President of The Federation of Medical Regulatory Authorities of Canada (FMRAC) effective as of June 2022. A letter of support will be provided from J. Plante to FMRAC supporting the nomination of N. Whitmore as President of FMRAC.

08-EX-May-2021 Upon a motion by P. Pielsticker, seconded by J. Fisk and carried, that the Executive Committee approves deferring the Executive Committee elections to the September Council meeting.

Note: R. Gratton abstained from voting and discussion

09-EX-May-2021 Upon a motion by J. Fisk, seconded by J. van Vlymen and unanimously carried, that the Executive Committee approves the requests to rescind Discipline and Fitness to Practise Committee Appointments for three Committee member appointments as set out in the Report.

11-IC-EX-May-2021 Upon a motion by J. Fisk, seconded by R. Gratton and unanimously carried, that the Executive Committee approves the appointment of P. Malette to fill the Governance Committee public member vacancy.

Contact: Judith Plante, President
Lisa Brownstone, Chief Legal Officer

Date: August 31, 2021

Council Briefing Note

September 2021

Topic:	**Ontario Physicians and Surgeons Discipline Tribunal Report of Completed Cases – May 25 to August 27, 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 Ontario Physicians and Surgeons Discipline Tribunal (formerly, the Discipline Committee of the College of Physicians and Surgeons of Ontario) reasons for decision released between May 25 and August 27, 2021, including reasons on discipline hearings (liability and/or penalty) and reasons on motions brought before the Tribunal.

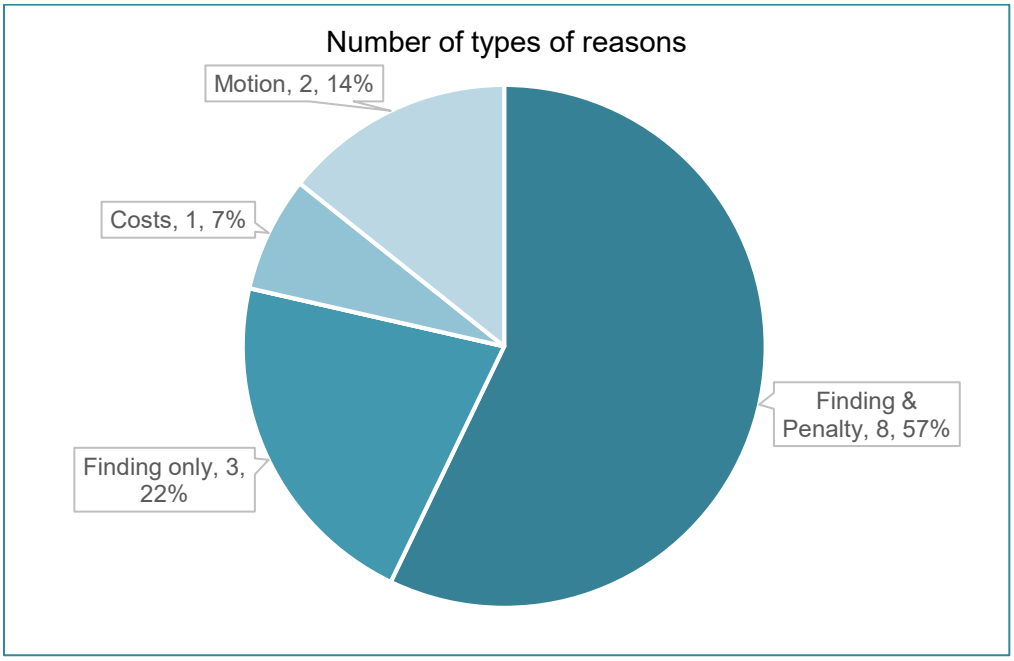
- This report is for information.

Current Status and Analysis

In the period reported, the Tribunal released 14 reasons for decision:

- 8 reasons on findings (liability) and penalty
- 3 reasons on findings only
- 1 reasons on costs only and
- 2 reasons on motions.

Figure 1: Types of reasons issued for this period

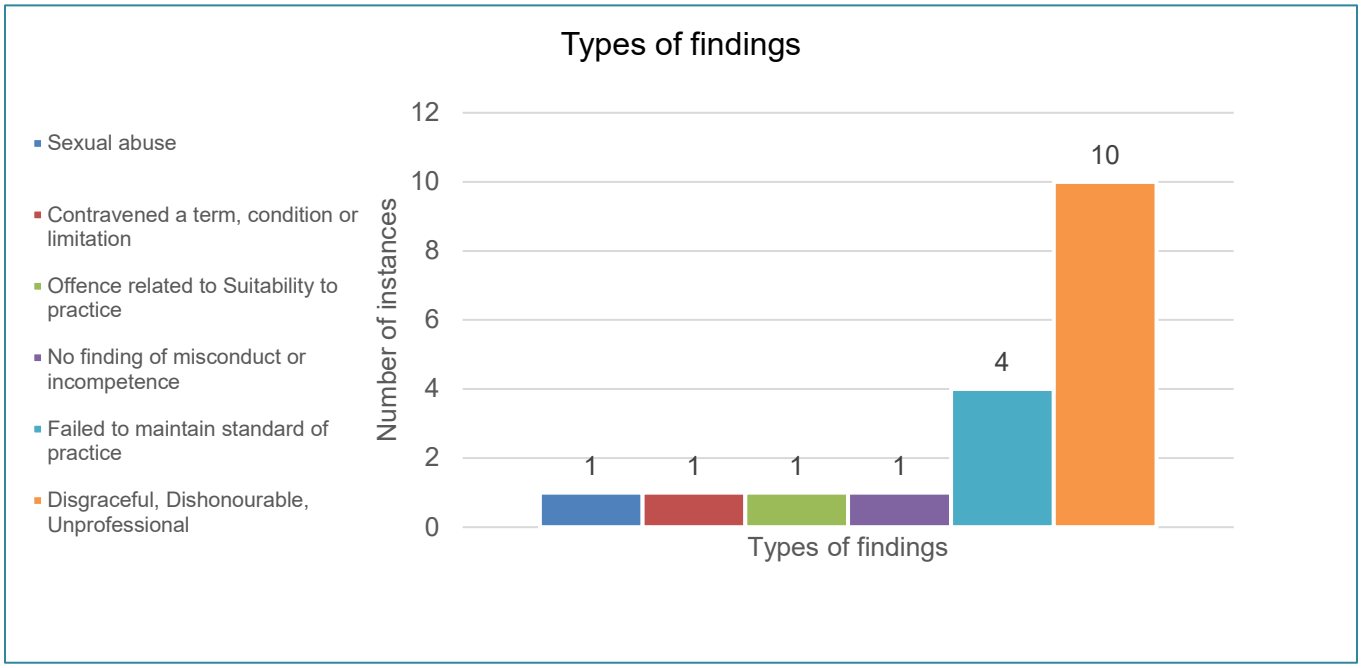


Findings

Liability findings included:

- 10 findings of disgraceful, dishonourable or unprofessional conduct
- 4 findings of failing to maintain the standard of practice
- 1 sexual abuse finding
- 1 finding of contravening a term, condition or limitation on the certificate of registration
- 1 finding of being found guilty of an offence relevant to suitability to practise
- 1 no findings decision

Figure 2: Findings in the 11 reasons on findings issued in this period.
Note: Some cases had more than one finding



Penalty

Penalty orders included:

- 8 reprimands
- 8 suspensions
- 8 impositions of terms, conditions or limitations on the physician's Certificate of Registration.

Costs

The Tribunal imposed a costs order on the physician in all penalty reasons. The maximum costs ordered was $15,555 and the minimum costs ordered was $6,000.

Motions

For the period reported, the Tribunal released two orders and reasons for decision on motions. Both motion orders and reasons dismissed the motion.

TABLE 1: DISCIPLINE DECISIONS – FINDINGS (May 25 to August 27, 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 25	Romeo Banzon Tan	2021-06-02	Y	Y		
2021 ONCPSD 27	William Hu	2021-06-03		Y		
2021 ONCPSD 28	Parag Kanaiyalal Vora	2021-06-10				No finding
2021 ONCPSD 29	Wameed Ateyah	2021-06-18		Y	Y	Contravened a term, condition or limitation on his certificate of registration
2021 ONCPSD 30	Suzanne Marie Beauchemin	2021-06-18		Y		
2021 ONCPSD 31	Fady Rizk Masoud Ghaly	2021-06-23		Y		Tribunal found Court's finding of guilty was relevant to suitability to practice
2021 ONCPSD 32	Mohammed Asif Hameed Khan	2021-06-25		Y	Y	
2021 ONCPSD 34	Nina Leah Desjardins	2021-07-16		Y	Y	
2021 ONCPSD 35	Thomas Albert Botly Bell	2021-07-26		Y	Y	
2021 ONCPSD 36	Shawn Chi Wai Seit	2021-08-11		Y		
2021 ONCPSD 37	Harmander Singh Gill	2021-08-18		Y		
TOTAL	**11**		**1**	**10**	**4**	

TABLE 2: DISCIPLINE DECISIONS - PENALTIES (May 25 to August 27, 2021)

Citation and hyperlink to published reasons	Physician	Date of reasons	Penalty (TCL = Term, Condition or Limitation)	Length of suspension in months	Costs
2021 ONCPSD 27	William Hu	2021-06-03	Reprimand, suspension, TCLs	12	$10,350
2021 ONCPSD 29	Wameed Ateyah	2021-06-18	Reprimand, suspension, TCLs	12	$6,000
2021 ONCPSD 30	Suzanne Marie Beauchemin	2021-06-18	Reprimand, suspension, TCLs	5*	$6,000
2021 ONCPSD 31 (finding and penalty) 2021 ONCPSD 33 (costs)	Fady Rizk Masoud Ghaly	2021-06-23 (finding and penalty) 2021-07-13 (costs)	Reprimand, suspension, TCLs	14	$15,555
2021 ONCPSD 32	Mohammed Asif Hameed Khan	2021-06-25	Reprimand, suspension, TCLs	3	$6,000
2021 ONCPSD 34	Nina Leah Desjardins	2021-07-16	Reprimand, suspension, TCLs	12	$6,000
2021 ONCPSD 35	Thomas Albert Botly Bell	2021-07-26	Reprimand, suspension, TCLs	3	$6,000
2021 ONCPSD 36	Shawn Chi Wai Seit	2021-08-11	Reprimand, suspension, TCLs	2	$6,000
Total	**8**				

*The later of 5 months or the date on which Dr. Beauchemin provides proof of completion of certain requirements.

TABLE 3: DISCIPLINE DECISIONS - MOTIONS (May 25 to August 27, 2021)

Citation and hyperlink to published reasons	Physician	Date of Reasons	Motion Outcome	Nature of Motion
2021 ONCPSD 26	Romeo Banzon Tan	2021-06-02	Dismissed	Motion to reopen hearing and introduce fresh evidence
2021 ONCPSD 38	Boutros Behnam Metry Mikhail	2021-08-23	Dismissed	Motion to hold in-person hearing or to adjourn until in-person hearing could be held
Total	**2**			

Council Briefing Note

September 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 Contact(s):	Miriam Barna, Senior Government Relations Advisor Danna Aranda, Government Relations Coordinator
Attachment(s):	Appendix A: June 29 letter to government re: governance modernization and red-tape reduction

Ontario's Political Environment

- After a three-month hiatus, the legislature is scheduled to resume for its fall session on September 13. This will be the last full session of legislative business prior to the 2022 provincial election.

- The Ford government is going into the legislative session with a new cabinet, following a major shuffle on June 18.

    - Among the noteworthy changes, former Finance Minister Rod Philipps was appointed as the new Minister of Long-Term Care, replacing Merrilee Fullerton, now the Minister of Children, Community, and Social Services.

    - The shuffle impacted 15 MPPs, many of them long-serving MPPs and Cabinet Ministers. With these changes, Ford was seeking to introduce a more geographically and ethnically diverse cabinet in advance of the upcoming election.

- On August 19, Rick Nicholls became the sixth PC MPP to become an Independent member since the 2018 election. Nicholls was removed from the PC caucus for his refusal to be vaccinated against COVID-19. PC MPP Christina Mitas, also unvaccinated, was permitted to stay in the party after reportedly receiving a medical exemption.

  - This leaves the PCs with 70 members, still well above the minimum 63 seats needed for a majority.

- The next provincial election is scheduled for June 2, 2022, with an expected formal campaign start date of May 4, 2022.

- While the Ontario PC government has been criticized for their management of the pandemic, public opinion polls still suggest the Ontario PCs hold the lead over opposition parties.

- In Federal politics, Prime Minister Trudeau sought for the dissolution of Parliament on August 15, with an election date of September 20.

  - Early in the campaign, health-care providers conscience rights became an issue of focus. The Conservative Party's platform states that "we will protect the conscience rights of healthcare professionals" – however after days of media attention, O'Toole clarified that he is supportive of physicians being obligated to refer for services they object to, commenting that this was "striking a reasonable balance".

- Vaccine passports and mandatory vaccination policies have also become a contentious matter that has shaped and will likely continue to shape both federal and provincial politics and elections.

  - Where Trudeau's government is currently working to introduce vaccine passports for foreign travel this fall, in Ontario, the Ford government has yet to commit to a proof-of-vaccination system, in spite of pressure from opposition parties and some municipal governments.

Issues of Interest

Governance Modernization

- As Council will recall, at its June meeting, a package of legislative changes regarding governance modernization and red-tape reduction was approved.

- On June 29, a letter from CPSO's President and Registrar/CEO was sent to government outlining these proposed legislative changes (see Appendix A).

- We understand that this letter was well-received by government and is in close alignment with the changes requested by the College of Nurses of Ontario.

- We continue to anticipate that government will introduce legislation in the fall session that could bring forward these proposed changes.

- As updates on this file become available, staff will share them with Council.

Public Member Update

- Rob Payne, whose appointment was set to expire in October, was recently reappointed for a 3-year term.
- In August, CPSO also welcomed a new appointee, Lucy Becker of Toronto, who has been appointed for a 5-month term.
- Staff will continue to advocate for the full complement of 15 public members.

Interactions with Government

- Over the last number of months, staff have remained in contact with government stakeholders with regards to ongoing issues related to COVID-19.
- Staff anticipate a busy fall season with the development of regulations to support the implementation of physician assistant regulation as well as potential activity surrounding governance modernization and red-tape reduction.
- With the return of the legislature, our regular meetings with MPPs will also resume.

June 29, 2021

Sean Court, Assistant Deputy Minister
Strategic Policy, Planning & French Language Services Division
Ministry of Health
438 University Avenue, 10th Floor
Toronto, ON M7A 2A5

Via Email: Sean.Court@ontario.ca

Dear Sean,

Further to your letter of June 8th, we welcome the opportunity to share our recommended changes under the *Regulated Health Professions Act, 1991* and the *Medicine Act, 1991.* As you know, governance modernization and red-tape reduction have been priorities of the College of Physicians and Surgeons of Ontario (CPSO) for many years.

In 2018, CPSO's Council made bold recommendations to modernize its governance structure and transform its approach to regulation in order to better serve the public interest and implement the principles of right-touch regulation. In June 2021, CPSO Council reaffirmed its commitment to these previous proposals and articulated a renewed vision that would continue to keep our organization at the leading edge of regulation.

Below is an overview of CPSO Council's recommended changes, followed by a more detailed explanation of each proposal. We are eager to work with government on a shared vision of modernization, efficiency, and excellence, for CPSO and Ontario's regulatory colleges.

Governance Modernization

1) Triad of core governance proposals:
   a) Reduce the size of the board to 12 members
   b) Implement a competency-based board selection process
   c) Eliminate the overlap in membership between the board and statutory committees
2) Eliminate the Executive Committee
3) Ensure equal composition of public and professional members on the board
4) Allow CPSO to compensate public members
5) Allow for greater flexibility in the Presidential and Vice-Presidential Terms and change the terminology to Chair and Vice-Chair of the board
6) Address protection for the use of the title "osteopath"

Red-Tape Reduction

7) Allow CPSO to make rules relating to its core functions
8) Expand CPSO's discretion to investigate complaints
9) Streamline the handling of frivolous, vexatious complaints
10) Enable CPSO to share information more freely with hospitals

11) Clarify the application of the *Mental Health Act* in CPSO hearings

Governance Modernization

1) **Triad of core governance proposals**
   Meaningful governance modernization is dependent on adopting this package of three proposals.

   a) **Reduce CPSO's Council to 12 members, with a minimum of 8**
      The first pillar of modernization is a reduction in CPSO Council size from the current 34-37 members to 12 members, with a minimum of 8. This aligns with best practices and recent trends in Ontario, including the new Health and Supportive Care Providers Oversight Authority. A smaller board would also allow for better effectiveness, participation, decision-making and flexibility.

   b) **Competency-based board selection process**
      A smaller 12-member board can only function properly with a competency-based selection process that ensures the right mix of skills, knowledge, diversity and experience. Moving from the current election process to a competency-based process is a best practice and is in keeping with recent changes to the Ontario College of Teachers and standards in the Ministry of Health's College Performance Measurement Framework.

   c) **Separate the membership of Council and statutory committees**
      Separation of Council and statutory committees is an essential next step to ensure that a smaller board can function. Not only is this a best practice, but this change would allow the board to focus on oversight and strategic direction, enhance the integrity and independence of both the board and statutory committees, and reduce the time commitment burden on CPSO's public Council members.

2) **Eliminate the Executive Committee**
   Stemming from government's adoption of this triad of changes – and specifically the reduction of Council 12 members – CPSO Council proposes the elimination of the Executive Committee. This change is in alignment with governance best practices.

3) **Equal composition of public and professional board members**
   In alignment with best practices, CPSO is seeking parity of public and professional members on Council. Public members currently account for fewer than half of the seats on Council. Through our public engagement activities, including polling and several discussions with the Citizen Advisory Group, we know that increased public representation on the board would be seen by the public as a meaningful change and increase their confidence in CPSO.

4) **Allow CPSO to compensate public members**
CPSO's Council continues to seek legislative change that would allow our organization to compensate public members directly. Although public members of Council play an invaluable role, their compensation rate has not been raised in more than two decades, and they are paid markedly less than physician members of Council.

5) **Presidential and Vice-Presidential Terms and Terminology**
Council is seeking changes that would allow for flexibility in the Presidential and Vice-Presidential terms – ideally set out in CPSO by-law. The *Medicine Act* currently requires that the President and Vice-President be elected annually from among Council members. This provision promotes "hyper-rotation" of these offices and would not be considered a best practice for a governing board.

Additionally, Council recommends changing the terminology of President/Vice-President to Chair/Vice-Chair to clarify the role of Council as the governing board and align with standard board nomenclature.

6) **Address protection for the use of the title "osteopath"**
The *Medicine Act* contains title protection for "osteopath" but there is widespread confusion on who can use this title and CPSO's role in enforcing title use. As such, Council recommends that government take steps to rectify the confusion surrounding "osteopath" title protection.

Red-Tape Reduction

CPSO is seeking a series of red-tape reduction changes including, but not limited to, those set out below. These changes align with the philosophy of right-touch regulation and will enable CPSO to better meet its public interest mandate.

7) **Allow CPSO to make rules relating to its core functions**
The current process for updating and maintaining regulations under the *RHPA* and the *Code* is onerous for health colleges and government and does not provide the ability to respond to emerging needs. The frailties of this structure were evident during the COVID-19 pandemic when changes were needed to the College's Registration regulation in response to emerging issues with the Medical Council of Canada Qualifying Examination Part II (MCCQE Part II), but could not be made within a reasonable timeline. In light of long-standing problems as well as the lessons learned from the pandemic, CPSO recommends that the College's regulation-making powers under the Code including, but not limited to, registration, standards of practices, and quality assurance, be moved to either College by-law authority or another agile instrument, such as policy.

8) **Expand CPSO's discretion to investigate complaints**
Over the last two years, CPSO has taken significant steps to improve the efficiency of the complaints process and implement a more proportionate approach. However, government support is needed to address a number of long-standing issues related to the management

of complaints. One way government could help would be to provide CPSO greater discretion to manage complaints unrelated to patient care and professional conduct. To ensure that resources are focused on investigations that serve the public interest, a complaint could be more narrowly defined as a concern brought by or on behalf of a patient, relating to patient care or professionalism. Matters that third parties wish to raise would be considered a "report". This change would allow the Registrar to exercise discretion regarding whether the matter reported by a third-party warrants investigation.

9) **Streamline the handling of frivolous, vexatious complaints**
Government could also support efficiency in the complaints process by streamlining the handling of frivolous, vexatious complaints. The current process by which the Inquiries, Complaints and Reports Committee (ICRC) handles frivolous, vexatious complaints is lengthy and requires at least two ICRC meetings, requiring more Committee resources than a straightforward investigation. This process could be streamlined to allow **either** the Registrar **or** the Committee to give the initial notice that the Committee may decide that the matter is frivolous, vexatious or an abuse of its process.

10) **Enable CPSO to share information more freely with hospitals**
Currently, CPSO is limited in sharing information regarding an investigation with a doctor's privileging hospital(s). This barrier poses a threat to patient safety, can lead to duplicate investigations, and may result in delayed action on a systemic issue. Therefore, Council recommends that the *Public Hospitals Act* be explicitly exempted from confidentiality requirements under the *RHPA*.

11) **Clarify the application of the Mental Health Act in CPSO hearings**
Finally, 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. It is therefore recommended that government clarify the application of the *Mental Health Act* to CPSO hearings.

Our recommendations to reduce red tape and modernize Ontario's health regulatory structure will help to better serve patients and bolster the integrity of Ontario's health regulatory system. CPSO staff is available to work with your team, including the provision of specific drafting suggestions, to support this important work.

Sincerely,

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

Judith Plante, MDCM, CCFP, FCFP
President

Cc. Allison Henry (Allison.Henry@ontario.ca)

Statement of Operations

College of Physicians and Surgeons of Ontario

Reporting as of: Jun, 2021

	CURRENT YEAR					COMPARATIVE YEAR			
	ACTUALS TO DATE	BUD2021 TO DATE	YTD VARIANCE	ANNUAL BUDGET	% OF BUD2021 Used 50.00%	YTD ACTUALS 2020	YEAR END ACTUALS 2020	% OF ACTUAL USED	VARIANCE COMMENTARY
REVENUE									
MEMBERSHIP FEES									
Independent Practice - Renewal	29,350,795	30,989,064	-1,638,269	62,521,188	46.95%	30,435,151	61,240,613	49.70%	With the conversion to Solis, revenue is recognized when the payment is rec'd. This results in a timing lag since members have until Sept 27th to pay. TD
Independent Practice - New	1,527,130	1,564,477	-37,347	3,132,600	48.75%	1,564,589	3,114,169	50.24%	
Post Graduate - Renewal	876,575	775,810	100,765	1,641,165	53.41%	775,860	1,571,258	49.38%	Revenue is recognized throughout the year as payments are rec'd. TD
Post Graduate - New	500,856	380,247	120,609	763,830	65.57%	380,333	750,797	50.66%	Timing of Applications. TD
Penalty Fees	0	682,463	-682,463	408,353	0.00%	1,841	1,026	179.53%	The deadline for annual membership renewal has been extended so revenue will be recognized later in the year. TD
Credit Card Service Charges	-830,649	-1,240,862	410,213	-1,526,423	54.42%	-1,093,423	-1,540,401	70.98%	Lower member dues revenue due to the extended deadline. TD
TOTAL MEMBERSHIP FEES	**31,424,706**	**33,151,199**	**-1,726,493**	**66,940,712**	**46.94%**	**32,064,352**	**65,137,462**	**49.23%**	
APPLICATION FEES									
New Independent Practice	1,935,191	1,598,337	336,855	2,425,005	79.80%	1,606,579	2,458,901	65.34%	There has been a change in registration reqd's (removal of exam qualification) resulting in more applicants than expected. PD
New Post Graduate Educational	976,345	994,523	-18,178	1,218,522	80.13%	1,001,286	1,254,861	79.79%	
IP & SD - Expedited Review Fees	77,625	62,659	14,966	110,286	70.39%	33,465	79,824	41.92%	
PG - Expedited Review Fee	72,193	79,947	-7,754	114,916	62.82%	42,238	67,452	62.62%	
Certificates of Professional Conduct	0		0		0.00%	146,740	146,740	100.00%	
Certificates of Incorporation	2,168,425	1,872,016	296,409	3,985,275	54.41%	1,549,384	3,925,495	39.47%	Timing of billing (re: Solis rollout) resulted in some 2020 renewals being deferred to 2021 resulting in additional revenue in the period than budgeted. PD
TOTAL APPLICATION FEES	**5,229,779**	**4,607,482**	**622,297**	**7,854,004**	**66.59%**	**4,379,692**	**7,933,273**	**55.21%**	
OTHER									
Investment Income	402,876	548,882	-146,006	2,038,000	19.77%	862,330	2,740,013	31.47%	Interest on Linked Flex GIC will not be recorded until maturity. PD
Miscellaneous Services	-6,042	8,319	-14,362	28,425	-21.26%	27,322	19,763	138.25%	
Discipline Costs Recovered	592,460	245,037	347,423	455,000	130.21%	259,470	367,616	70.58%	3 very large payments rec'd in April & May. PD
Court Costs Awarded	6,500		6,500		0.00%	0	15,000	0.00%	
Prior Year Items	456	12,489	-12,032	73,454	0.62%	44,806	53,111	84.36%	
TOTAL OTHER	**996,250**	**814,727**	**181,523**	**2,594,878**	**38.39%**	**1,193,928**	**3,195,503**	**37.36%**	
REVENUE BEFORE COST RECOVERIES	**37,650,734**	**38,573,407**	**-922,673**	**77,389,595**	**48.65%**	**37,637,972**	**76,266,237**	**49.35%**	
EXPENDITURES									
REGISTRAR									

Executive Department	792,931	893,797	-100,866	2,037,202	38.92%	739,627	1,380,461	53.58%	A headcount included in the budget but is being charged to the Hearings office. PD
REGISTRAR	792,931	893,797	-100,866	2,037,202	38.92%	739,627	1,380,461	53.58%	
CHIEF MEDICAL ADVISOR									
CHIEF MEDICAL ADVISOR									
Chief Medical Advisor	0	250,741	-250,741	536,750	0.00%	1,515,422	3,349,480	45.24%	This area is being reorganized. PD
CHIEF MEDICAL ADVISOR	0	250,741	-250,741	536,750	0.00%	1,515,422	3,349,480	45.24%	
CHIEF MEDICAL ADVISOR	0	250,741	-250,741	536,750	0.00%	1,515,422	3,349,480	45.24%	
QUALITY MANAGEMENT									
Assessor Bi-Annual Meeting	0	40,361	-40,361	80,722	0.00%	55,605	36,573	152.04%	
Assessor Networks	3,181	0	3,181	43,244	7.36%	5,147	5,317	96.80%	
Assessor Training	9,541	39,599	-30,058	65,122	14.65%	24,763	34,928	70.90%	
Changing Scope Working Group	0	0	0	0	0.00%	0	0	0.00%	
Education Committee	12,062	18,178	-6,116	29,043	41.53%	1,413	10,669	13.24%	
Peer Assessment Program	352,733	430,415	-77,682	852,244	41.39%	51,461	394,098	13.06%	Many peer assessments are being done virtually therefore saving on travel expenses. PD
QA/QI Department	1,696,068	1,781,508	-85,440	4,006,649	42.33%	1,481,531	2,593,904	57.12%	3 positions on LOA, 2 positions will not be replaced.
Quality Assurance Committee	76,684	314,336	-237,651	598,595	12.81%	78,371	170,555	45.95%	Due to COVID, all QAC meetings are being held virtually therefore savings due to associated travel costs etc. PD
Quality Improvement Program	228,577	688,995	-460,418	1,235,668	18.50%	132,191	436,554	30.28%	Due to COVID, onsite peer assessments are being conducted virtually resulting in savings associated with travel costs etc. The QI coaches expenses were being assigned to a different cost centre. They will now all be coming out of this CC. PD
Quality Management Department	0	0	0	0	0.00%	158,033	569,595	27.74%	
Registration Pathways Evaluati	0	0	0	0	0.00%	0	0	0.00%	
QUALITY MANAGEMENT	2,378,846	3,313,391	-934,545	6,911,285	34.42%	1,988,516	4,252,194	46.76%	
REGISTRATION & MEMBERSHIP SERVICES									
Annual Membership Survey	0	0	0	0	0.00%	207	207	100.00%	
Applications and Credentials	2,438,555	2,168,147	270,407	4,353,805	56.01%	1,548,532	3,366,171	46.00%	Contract & temporary staff required to support call centre from the Solis rollout. PD
Corporations Department	0	0	0	0	0.00%	369,226	680,133	54.29%	
Membership Department	0	0	0	0	0.00%	353,258	905,235	39.02%	
Registration Committee	124,781	75,798	48,983	177,302	70.38%	42,963	126,975	33.84%	
REGISTRATION & MEMBERSHIP SERVICES	2,563,336	2,243,945	319,390	4,531,107	56.57%	2,314,186	5,078,722	45.57%	
COMMUNICATIONS & MEDIA									
Communications Department	935,897	630,894	305,003	1,753,220	53.38%	668,531	1,524,609	43.85%	LF - The way the budget is spread is creating the variance as only 31% of the budget is recorded. Recording 50% of the annual budget to the end of June results in a variance of $20K. TD
Outreach Program	1,392	16,385	-14,993	25,000	5.57%	2,142	2,142	100.00%	
COMMUNICATIONS & MEDIA	937,289	647,279	290,010	1,778,220	52.71%	670,674	1,526,751	43.93%	
TRANSFORMATION OFFICE									
INFORMATION TECHNOLOGY									

Enterprise Systems	1,158,985	2,363,943	-1,204,957	4,727,885	24.51%	3,053,106	432,566	705.81%	LF - Change in accounting policy to capitalize IT software projects results in lower consultant fees and higher depreciation. PD
Infrastructure	1,991,987	1,651,148	340,840	2,982,512	66.79%	1,728,054	2,756,544	62.69%	Microsoft licenses for software were budgetted evenly throughout the year while the actual expenses occurred in the 1st quarter and this accounts for 50% of the variance. Some ongoing costs from projects were not anticipated. TD & PD
IT Support	1,668,643	1,234,004	434,639	3,200,909	52.13%	1,538,095	3,373,973	45.59%	LF - The way the budget is spread is creating the variance as only 38% of the budget is recorded. Recording 50% of the annual budget to the end of June results in a variance of $17K. TD
Operations and Support	0	0	0	0	0.00%	271	0	##########	
INFORMATION TECHNOLOGY	**4,819,615**	**5,249,094**	**-429,479**	**10,911,306**	**44.17%**	**6,319,526**	**6,563,083**	**96.29%**	
CORPORATE SERVICES									
800 Bay Street	424,120	363,000	61,120	725,500	58.46%	352,284	641,952	54.88%	
Control Accounts	0	0	0	0	0.00%	2,328	0	##########	
Facility Services	443,660	459,720	-16,059	934,484	47.48%	476,987	980,169	48.66%	
Finance Committee	12,787	18,811	-6,024	66,627	19.19%	6,281	68,849	9.12%	
Finance Department	1,238,666	827,548	411,117	1,765,640	70.15%	963,874	2,071,084	46.54%	Additional consulting costs related to Wind down of the DC Pension Plan. PD
Occupancy	1,349,040	1,486,236	-137,195	3,042,345	44.34%	1,175,592	2,292,704	51.28%	G/L expenses in Occupancy accounts are all appropriate. It appears that the insurance expenses for the year have been charged in the first 5 months. Utlities, taxes and other G/L items are all appropriate. Again this may have to do with distribution of the amounts throughout the year. TD
CORPORATE SERVICES	**3,468,273**	**3,155,315**	**312,958**	**6,534,596**	**53.08%**	**2,977,345**	**6,054,758**	**49.17%**	
PEOPLE & ORGANIZATIONAL DEVELOPMENT									
Continuous Improvement	1,464,558	1,329,730	134,827	2,659,461	55.07%	727,939	2,045,465	35.59%	2 additional employees for systems implementations. 2 additional hired to replace employees on leave. 1 employee has been transferred to this department but budget resides in I&R Admin. PD
Human Resources Department	719,531	651,577	67,954	1,274,792	56.44%	477,796	1,545,880	30.91%	
Training & Documentation	445,649	388,832	56,817	777,664	57.31%	100,827	504,751	19.98%	
PEOPLE & ORGANIZATIONAL DEVELOPMENT	**2,629,738**	**2,370,139**	**259,599**	**4,711,917**	**55.81%**	**1,306,561**	**4,096,096**	**31.90%**	
INFORMATION MANAGEMENT & BUSINESS ANALYTICS									
AD&D Support Department	725,974	669,489	56,486	1,295,431	56.04%	547,676	1,179,880	46.42%	
AD&D Support Projects	0	0	0	0	0.00%	10,977	11,265	97.44%	
Education Program Development	3,573	40,800	-37,227	81,600	4.38%	0	11,741	0.00%	
INFORMATION MANAGEMENT & BUSINESS ANALYTICS	**729,548**	**710,289**	**19,259**	**1,377,031**	**52.98%**	**558,653**	**1,202,886**	**46.44%**	
DOCUMENTS & RECORDS MANAGEMENT									
Business Services	0	0	0	0	0.00%	142,495	101,947	139.77%	
Records Management	774,285	740,243	34,041	1,446,304	53.54%	673,111	1,452,875	46.33%	
DOCUMENTS & RECORDS MANAGEMENT	**774,285**	**740,243**	**34,041**	**1,446,304**	**53.54%**	**815,606**	**1,554,822**	**52.46%**	
TRANSFORMATION OFFICE	**12,421,458**	**12,225,080**	**196,378**	**24,981,154**	**49.72%**	**11,977,691**	**19,471,645**	**61.51%**	
LEGAL OFFICE									
Legal Services	2,665,817	2,626,045	39,772	5,684,130	46.90%	2,712,273	5,450,469	49.76%	

LEGAL OFFICE	**2,665,817**	**2,626,045**	**39,772**	**5,684,130**	**46.90%**	**2,712,273**	**5,450,469**	**49.76%**	
COMPLAINTS									
I & R ADMINISTRATION									
I&R Administration	1,044,526	1,197,613	-153,087	2,457,545	42.50%	286,185	775,676	36.89%	1 vacant position. PD
I & R ADMINISTRATION	**1,044,526**	**1,197,613**	**-153,087**	**2,457,545**	**42.50%**	**286,185**	**775,676**	**36.89%**	
TEAMS 1 - 3									
Health Assessments	17,593	3,110	14,483	148,772	11.83%	25,903	73,047	35.46%	
Incapacity Investigations	0	0	0	0	0.00%	1,434	6,117	23.44%	
Medical Assessors (MIs)	166,217	56,528	109,689	643,886	25.81%	193,831	401,529	48.27%	Variance due to: - RI appointments are down - Travel, meals & accommodation expenses are down due to the increase use of Virtual Meetings No budget has been included YTD. It will resolve by the end of the year (TD)
PC Investigations	0	0	0	0	0.00%	38,793	75,729	51.23%	
PC Resolutions	4,185,429	4,350,214	-164,785	10,079,995	41.52%	4,406,757	8,599,546	51.24%	Variances due to: - parental leaves and secondments. Two staff returning in September from parental leaves. One staff leave is to the end of the year. - Over in Training/Conferences due to share of Solis-Va ult April- June Training charges. - Travel & Other down to due the increase use of Virtual Meetings (PD)
Peer Opinions (IOs)	94,946	0	94,946	200,452	47.37%	63,329	122,444	51.72%	47% of the budget for this cost centre has been spent in the first 6 months (TD)
Registrar's Investigations	0	0	0	0	0.00%	41,311	102,704	40.22%	
Sexual Impropriety Investigati	0	0	0	0	0.00%	46,301	96,708	47.88%	
TEAMS 1 - 3	**4,464,185**	**4,409,852**	**54,334**	**11,073,104**	**40.32%**	**4,817,658**	**9,477,825**	**50.83%**	
ICRC									
Business, Leadership, Training	44,772	118,782	-74,010	209,039	21.42%	32,721	110,426	29.63%	Variance related to savings in attendance, preparation, travel,catering, accommodation with business and leadership team meetings being held remote and also shortened from full days to half days. PD
Caution Panels	22,580	32,486	-9,907	85,021	26.56%	18,034	42,793	42.14%	
Gen,Hybrid,Teleconfs,Ad-Hocs	387,401	534,670	-147,269	1,168,864	33.14%	362,373	758,346	47.78%	Variance relates to savings in preparation, attendance, travel, catering, accommodations with panels being held remotely and also due shorter meetings (1-3 hours per meeting vs full days). Fewer cases also streamed to these panels with matters being resolved with ADR. PD
ICR Committee Support	936,159	1,359,698	-423,540	2,735,691	34.22%	964,846	1,968,114	49.02%	A vacant Coordinator position accounts for some temporary variance until this position is filled. TD for this position. There are 7 vacant positions to the end of June. PD
ICRC - Health Inquiry Panels	5,253	14,079	-8,826	46,240	11.36%	13,020	30,125	43.22%	
ICRC - Specialty Panels	463,847	424,137	39,710	944,115	49.13%	339,919	825,539	41.18%	
ICRC	**1,860,013**	**2,483,854**	**-623,841**	**5,188,970**	**35.85%**	**1,730,913**	**3,735,343**	**46.34%**	

COMPLIANCE									
Compliance Monitoring	944,518	971,918	-27,400	1,934,947	48.81%	979,595	1,965,871	49.83%	
Training - Non-Staff	11,452	29,114	-17,663	48,000	23.86%	1,632	2,632	62.01%	
COMPLIANCE	**955,970**	**1,001,033**	**-45,063**	**1,982,947**	**48.21%**	**981,228**	**1,968,504**	**49.85%**	
PPAS									
Advisory Services Department	532,598	654,736	-122,138	1,354,797	39.31%	730,277	1,272,969	57.37%	Vacancy and working from home - TD
PPAS	**532,598**	**654,736**	**-122,138**	**1,354,797**	**39.31%**	**730,277**	**1,272,969**	**57.37%**	
COMPLAINTS	**8,857,292**	**9,747,088**	**-889,796**	**22,057,364**	**40.16%**	**8,546,261**	**17,230,316**	**49.60%**	
HEARINGS									
Discipline Committee Case Mana	85,177	144,234	-59,057	245,675	34.67%	110,696	190,591	58.08%	
Discipline Committee Hearings	975,592	686,438	289,154	1,707,033	57.15%	780,287	1,851,850	42.14%	Bad Debt write-off for 3 uncollectible accounts totalling $259K (PD). While hearings are down, increased expenses include support for electronic hearings by Arbitration Place and some decision writers who have spent very large amounts of time writing particular decisions. TD
Discipline Committee Policy/Tr	62,400	128,893	-66,493	411,260	15.17%	53,475	184,111	29.04%	
Fitness to Practice Committee	0	0	0	0	0.00%	0	204	0.00%	
Hearings Office	489,856	212,181	277,675	554,112	88.40%	286,563	570,276	50.25%	Staffing changes contributed to this variance which will be permanent. We have also put all legal fees in this department rather than splitting them up as before. PD
HEARINGS	**1,613,024**	**1,171,745**	**441,279**	**2,918,081**	**55.28%**	**1,231,020**	**2,797,033**	**44.01%**	
GOVERNANCE									
Council	153,718	167,022	-13,304	499,923	30.75%	215,610	379,781	56.77%	
Council Elections	3,340	0	3,340	6,500	51.38%	0	5,600	0.00%	
Executive Committee	23,007	58,811	-35,805	125,311	18.36%	25,028	51,032	49.04%	
FMRAC	454,528	460,000	-5,472	460,000	98.81%	454,528	454,528	100.00%	
Governance	644,140	705,392	-61,252	1,410,784	45.66%	438,290	977,214	44.85%	
Governance Committee	42,531	70,841	-28,310	157,007	27.09%	25,987	91,493	28.40%	
Government Relations	0	508,783	-508,783	1,017,565	0.00%	0	0	0.00%	The variance for this line item is primarily related to the implementation of PA Regulation. We currently await the draft PA legislation from the ministry. TD
President's Expenses	27,165	78,208	-51,043	156,587	17.35%	51,049	87,197	58.54%	
Strategic Planning Project	0	0	0	0	0.00%	5,015	5,009	100.12%	
GOVERNANCE	**1,348,429**	**2,049,057**	**-700,628**	**3,833,677**	**35.17%**	**1,215,508**	**2,051,854**	**59.24%**	
POLICY									
Patient Relations Program	26,956	31,663	-4,707	120,569	22.36%	20,698	327,629	6.32%	
Policy	557,506	647,464	-89,958	1,059,526	52.62%	492,988	979,751	50.32%	Primarily consultant fees which is partially COVID related but sizeable expenditures planned for fall. TD
Policy Working Group	39,010	32,448	6,561	97,535	40.00%	62,421	69,740	89.50%	
POLICY	**623,472**	**711,575**	**-88,103**	**1,277,630**	**48.80%**	**576,106**	**1,377,120**	**41.83%**	
EXPENDITURES BEFORE COST RECOVERIES	**34,201,894**	**35,879,743**	**-1,677,849**	**76,546,599**	**44.68%**	**33,487,282**	**63,966,045**	**52.35%**	
NET REV/(EXPS) BEFORE COST RECOVERIES	**3,448,841**	**2,693,664**	**755,176**	**842,996**		**4,150,690**	**12,300,192**		
COST RECOVERY COST CENTRES									
Out of Hospital Premise Inspection Program									
Revenue	806,436	946,541	-140,105	1,703,059	47.35%	354,937	972,070	36.51%	

OHP - Administration	628,547	700,081	-71,534	1,100,769	57.10%	238,181	694,789	34.28%
OHP - Dental			0		0.00%	1,843	4,570	40.33%
OHP - Level 1	3,901	9,689	-5,788	21,871	17.84%	7,669	8,313	92.26%
OHP - Level 2	116,638	138,362	-21,724	291,781	39.97%	52,726	127,162	41.46%
OHP - Level 3	26,356	31,486	-5,130	99,306	26.54%	13,193	50,893	25.92%
Premises Inspection Committee	30,995	66,923	-35,929	189,332	16.37%	41,324	86,344	47.86%
Net Surplus/(Deficit)	**0**	**0**	**0**	**0**		**0**	**0**	
Independent Health Facilities								
Revenue	505,281	433,607	71,675	1,000,596	50.50%	481,410	1,251,119	38.48%
Ambulatory	6,420	7,837	-1,417	15,675	40.96%		14,883	0.00%
Diagnostic Imaging	89,775	42,657	47,118	286,917	31.29%	121,213	308,101	39.34%
Facility Review Panel	20,738	20,688	50	38,544	53.80%	30,248	66,198	45.69%
IHF - Administration	385,177	304,172	81,004	590,075	65.28%	296,893	807,567	36.76%
IHF Task Forces	340		340		0.00%	3,171	3,815	83.13%
Ophthalmology	-85	5,849	-5,934	6,695	-1.27%		5,989	0.00%
Sleep Medicine	2,917	52,402	-49,486	62,689	4.65%	29,885	44,567	67.06%
Net Surplus/(Deficit)	**0**	**0**	**0**	**0**		**0**	**0**	
Out of Hospital Reassessments								
Revenue	18,645		18,645			6,472	20,486	
Expense	-18,645		-18,645			-6,472	-20,486	
Net Surplus/(Deficit)	**0**	**0**	**0**	**0**		**0**	**0**	
OHP Equipment Assessment								
Revenue	0		0			0	0	
Net Surplus/(Deficit)	**0**	**0**	**0**	**0**		**0**	**0**	
IHF Reassessments								
Revenue	37,392		37,392			4,721	12,067	
Expense	-37,392		-37,392			-4,721	-12,067	
Net Surplus/(Deficit)	**0**	**0**	**0**	**0**		**0**	**0**	
IHF Expansions								
Revenue	555		555			756	1,792	
Expense	-555		-555			-756	-1,792	
Net Surplus/(Deficit)	**0**	**0**	**0**	**0**		**0**	**0**	
Peer Assessments Recoverable								
Revenue	0		0			0	0	
Net Surplus/(Deficit)	**0**	**0**	**0**	**0**		**0**	**0**	
Sec and Subs Peer Reassessments								
Revenue	17,400		17,400			11,600	20,300	
Expense	-12,952		-12,952			-7,094	-16,795	
Net Surplus/(Deficit)	**4,448**	**0**	**4,448**	**0**		**4,506**	**3,505**	
Comp Practice Assessments								
Revenue	0		0			0	0	
Net Surplus/(Deficit)	**0**	**0**	**0**	**0**		**0**	**0**	
Scope Assessments								
Revenue	80,400		80,400			30,150	60,300	
Expense	-65,560		-65,560			-21,652	-43,862	
Net Surplus/(Deficit)	**14,840**	**0**	**14,840**	**0**		**8,498**	**16,438**	
Remediation								

Revenue	0		0		0	0
Net Surplus/(Deficit)	**0**	**0**	**0**	**0**	**0**	**0**
Citizens Advisory Group						
Revenue	26,390		26,390		29,231	40,088
Expense	-26,390		-26,390		-29,231	-40,088
Net Surplus/(Deficit)	**0**	**0**	**0**	**0**	**0**	**0**
Reg Comm Assessment Fees						
Revenue	336,228		336,228		218,635	404,126
Expense	-336,228		-336,228		-218,635	-404,126
Net Surplus/(Deficit)	**0**	**0**	**0**	**0**	**0**	**0**
I&R Reassessments						
Revenue	214,701		214,701		495,457	771,526
Expense	-214,701		-214,701		-495,457	-771,526
Net Surplus/(Deficit)	**0**	**0**	**0**	**0**	**0**	**0**
Reg Comm Individualized Training						
Revenue	2,331		2,331		2,331	12,601
Expense	-2,331		-2,331		-2,331	-12,601
Net (Surplus)/Deficit	**0**	**0**	**0**	**0**	**0**	**0**
I&R Individualized Training						
Revenue	47,877		47,877		96,099	114,895
Expense	-47,877		-47,877		-96,099	-114,895
Net Surplus/(Deficit)	**0**	**0**	**0**	**0**	**0**	**0**
NET GAIN/(LOSS) ON COST RECOVERIES	**19,287**	**0**	**19,288**	**0**	**13,004**	**19,943**
EXCESS OF REVENUE OVER EXPENDITURES	**3,468,128**	**2,693,664**	**774,464**	**842,996**	**4,163,693**	**12,320,135**

Statement of Financial Position

College of Physicians and Surgeons of Ontario

Reporting as of: Jun 2021

	CURRENT YEAR BALANCE	PRIOR PERIOD BALANCE	PREVIOUS YEAR BALANCE
ASSETS			
CURRENT ASSETS			
Cash	71,652,565	63,716,648	79,653,329
Receivables	1,146,490	1,112,598	7,040,858
Prepaid Expenses	275,601	151,286	283,626
TOTAL CURRENT ASSETS	**73,074,655**	**64,980,532**	**86,977,813**
LONG TERM ASSETS			
Long Term Investments	50,148,973	50,119,178	51,893,056
Owned Capital Assets	14,737,327	14,150,028	7,649,689
Leased Capital Assets	1,189,114	1,270,110	1,895,949
TOTAL LONG TERM ASSETS	**66,075,413**	**65,539,316**	**61,438,695**
TOTAL ASSETS	**139,150,069**	**130,519,848**	**148,416,508**
LIABILITIES AND NET ASSETS			
CURRENT LIABILITIES			
Accounts Payable and Accrued Liabilities	5,799,953	5,900,824	6,916,897
Deferred Revenue	47,365,656	37,262,727	66,289,409
TOTAL CURRENT LIABILITES	**53,165,609**	**43,163,551**	**73,206,307**
LONG TERM LIABILITIES			
Leased Capital Asset Obligation	1,189,114	1,270,110	1,895,949
Accrued DB Pension Cost	5,273,893	5,279,680	4,933,544
TOTAL LONG TERM LIABILITES	6,463,007	6,549,790	6,829,493
TOTAL LIABILITIES	**59,628,616**	**49,713,341**	**80,035,800**
NET ASSETS			
Capital Asset Fund	14,737,327	14,150,028	7,649,689
Intangible Asset Fund	2,000,000	2,000,000	0
Internally Restricted	60,700,277	60,700,277	56,246,650
Unrestricted			
Year to Date Surplus/(Deficit)	3,468,128	4,753,183	4,163,693
Transfer (to)/from Capital Fund	-1,384,280	-796,981	320,676
Total Unrestricted	**2,083,849**	**3,956,202**	**4,484,370**
TOTAL NET ASSETS	**79,521,452**	**80,806,507**	**68,380,708**
TOTAL LIABILITIES & NET ASSETS	**139,150,069**	**130,519,848**	**148,416,508**

Council Briefing Note

September 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: CPSO Response – *Modernizing Privacy in Ontario* White Paper Public Consultation Appendix B: Policy Status Report

Issue

- An update on recent policy-related activities is provided to Council for information.

Current Status

1. Ministry of Government and Consumer Services *Modernizing Privacy in Ontario* White Paper Public Consultation – CPSO Response

- In June 2021, the Ministry of Government and Consumer Services (MGCS) released a white paper for public consultation, *Modernizing Privacy in Ontario*, discussing proposed legislation that would create new privacy rights for Ontarians and new requirements for organizations around the collection, use, and disclosure of personal information in the private sector.

- The MGCS white paper discusses proposed Ontario legislation that would apply in Ontario in place of the *federal Personal Information Protection and Electronic Documents Act (PIPEDA)* and would be broader in scope, applying to all private sector organizations whether or not they carry on commercial activities. Accordingly, non-profit organizations, such as CPSO, would be subject to the new legislation.

- The legislation would establish a fundamental right to privacy, supported by introducing individual data rights of mobility, disposal, access, correction and the right to be forgotten. It would introduce an overarching requirement that organizations only collect use and disclose individuals' personal information for purposes that are objectively fair and appropriate in the circumstances and that the individual would reasonably expect, regardless of the legal authority relied upon by the organization.

- The proposal includes very high penalties for non-compliance with the legislation.

CPSO Response:

- The white paper was reviewed by legal and policy staff, and a formal submission was prepared outlining CPSO's comments. CPSO's letter was submitted to MGCS following approval from the Executive Committee (see **Appendix A** for a copy of the consultation response).

- CPSO's submission details specific ways in which the proposed legislation may impose significant regulatory burdens that would not be necessary or appropriate for CPSO's context.

- The submission outlines the need for a clear exemption from the application of the proposed legislation, recognizing that CPSO is already subject to a broad confidentiality framework under the *Regulated Health Professions Act, 1991 (RHPA)*, which is tailored to health profession regulators. The proposed legislation does not recognize the professional regulatory context and CPSO's unique needs as a regulator, and not exempting CPSO would significantly hinder CPSO's ability to carry out its various regulatory activities and fulfil its mandate to serve and protect in the public interest.

- Alternatively, if a broad exemption is not provided, the submission suggests that the proposed legislation clearly recognize CPSO's regulatory mandate and activities to better enable CPSO to collect, use and disclose information under the new framework in order to fulfil our public interest mandate.

Next steps:

- Council will be kept apprised of any further developments.

2. Policy Consultation Update

Social Media

- Council approved the draft *Social Media* policy and *Advice* document for public consultation in June 2021.

- Notice of the consultation was sent to the membership and external stakeholders, including those representing or advocating for the interests of diverse and/or vulnerable groups, and was also promoted through CPSO's website and social media platforms.

- As of the Council submission deadline, the consultation received 596 responses: 97 through written feedback and 499 via the online survey.[1] The majority of responses received were from physicians.

- A brief overview of the key themes that have emerged to date in the feedback is provided below.

- Overall, a majority of physician respondents to the consultation survey agreed that they would benefit from a policy that sets out specific expectations around social media use and were more likely than other respondents to show greater support for the policy expectations.

- In contrast, a significant portion of public member respondents indicated that any regulation of physicians' conduct on social media would be an overreach by CPSO and expressed concern that CPSO has been censoring physicians with minority or dissenting views about the COVID-19 pandemic, vaccines, and treatment.

- There was general support for the proposed policy provisions. Respondents were overall supportive of the provisions related to sharing general health information on social media. Respondents were also supportive of the provisions related to seeking out patient health information on social media, but some respondents indicated that they were unsure of when such situations would arise, reflecting that these provisions are relevant to a smaller proportion of physicians and patients.

- While feedback on the provisions related to professionalism was more mixed, there was overall support for the provisions and stronger support for these provisions from physician respondents compared to other respondents.

    - Concerns tended to relate less to the specific expectations but related more to the potential interpretation and application of the policy. Among feedback received were concerns about use of subjective language (e.g., "others would perceive as," and "could be perceived as"); lack of definitions for terms and how terms would be interpreted, including "professional," "respectful," "hate speech," "disparaging," and "discrimination;" and the inclusion of "unsubstantiated" statements and "profane" language as unprofessional or "disruptive behaviour."

[1] Organizational responses included: Canadian Medical Protective Association (CMPA); Chabad Waterloo; College of Dietitians of Ontario (CDO); Doctors Against Racism and Antisemitism (DARA); Information and Privacy Commissioner of Ontario (IPC); Ontario Homeopathic Medical Association (OHMA); Ontario Medical Association (OMA) Section on Plastic Surgery; and Professional Association of Residents of Ontario (PARO).

- Physician respondents expressed a need for a clearer delineation between personal and professional use of social media, based on the belief that personal use or conduct outside of work should not be regulated by CPSO.

- Others expressed the belief that existing laws sufficiently capture unprofessional behaviours, such laws against hate speech, defamation, and discrimination, and additional regulation by CPSO was not necessary.

- All feedback is currently being reviewed in detail and will help inform revisions to the draft policy. Council will be provided with further detail about the results at future meetings.

Dispensing Drugs

- CPSO is undertaking an expedited review of our *Dispensing Drugs* policy to determine whether the guidance is current for physicians who dispense drugs and whether additional guidance is needed.

    - This policy is based on the general premise that physicians should meet the same standards for dispensing as pharmacists and sets out expectations around the procurement, storage, record keeping, packaging, labelling, and disposal of drugs.

    - This policy previously underwent minor housekeeping amendments in November 2011 and November 2018 and was part of the second batch of redesigned policies in September 2019, but it has not undergone a formal policy review since it was originally consulted on in fall 2008 and then later approved by Council in May 2010.

- A 30-day public consultation will launch following September Council via CPSO's regular communication and social media channels inviting external stakeholders and membership.

- Council will be provided with further detail about the results of this accelerated review at future meetings.

3. Policy Status Table

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

CPSO

Trusted Doctors
Providing Great Care

August 18, 2021

Marlene McRae
Manager of Access and Privacy Strategy and Policy Unit
Ministry of Government and Consumer Services
Enterprise Recordkeeping, Access and Privacy Branch
134 Ian Macdonald Blvd.
Toronto, ON M7A 2C5

Via email: access.privacy@ontario.ca

Re: White Paper – Modernizing Privacy in Ontario

Dear Marlene McRae,

The College of Physicians and Surgeons of Ontario (CPSO) welcomes the opportunity to provide its submission on the Ministry of Government and Consumer Services' white paper, *Modernizing Privacy in Ontario: Empowering Ontarians and Enabling the Digital Economy*. Below are CPSO's comments on the proposed private sector privacy legislation.

General comments

While CPSO can only speak on its own behalf, the following considerations may apply to other health profession regulators governed by the *Regulated Health Professions Act, 1991* (*RHPA*).

CPSO is subject to a broad confidentiality framework under the *RHPA*, which is structured and tailored to address the needs and mandate of the health profession regulators. Under the *RHPA*, CPSO has a statutory duty to serve and protect the public interest. To fulfil this regulatory mandate, CPSO routinely needs to collect, use, and disclose personal information about individuals.

The proposed legislation does not appear to recognize the professional regulatory context and unique needs of regulators in collecting, using, disclosing, and retaining personal information of physicians, patients/complainants, and other applicable persons. It would provide rights and protections to individuals that are not necessary or appropriate in the context of professional regulation. We expect it would impose a significant regulatory burden and have the effect of hindering CPSO's ability to fulfill its regulatory mandate and duty to serve and protect in the public interest. CPSO submits that the private sector privacy legislation should expressly exempt or simply not apply to health regulators (other than with respect to employee personal information).

Ontario's current health privacy framework recognizes an exception for the activities of CPSO and other regulators under paragraph 9(2)(e) of the *Personal Health Information Protection Act, 2004* (PHIPA), which reads: "Nothing in this Act shall be construed to interfere with […] (e) the regulatory activities of a College under the *Regulated Health Professions Act, 1991* […]"

There should be, at a minimum, a similar provision in the proposed legislation. However, such a provision alone may be insufficient as it could still be subject to interpretation as to what would be construed to interfere with regulatory activities in the context of personal information. This would likely lead to ambiguity, inconsistency, and future challenges and disputes.

An alternative would be to *clearly and broadly* state in the legislation that the regulatory mandate of regulators constitutes a "fair and appropriate purpose" and is a "legitimate need" to allow CPSO to collect, use, and disclose personal information without consent. The regulatory mandate should be defined broadly to capture all aspects of regulation, that is, not only investigations and proceedings, but registration, compliance, quality assurance/quality improvement, and other activities. However, this approach would still impose regulatory burdens on CPSO that would not be necessary or appropriate for our context as a professional health regulator.

While the above proposals would help support CPSO's regulatory functions, given the potential challenges and regulatory burden, a clear exemption from the proposed legislation is preferable.

Specific comments on the proposed privacy legislation provisions

Re: Fair and Appropriate Purposes

- **The *RHPA*, including Schedule 2, the *Health Professions Procedural Code* (the Code) addresses the collection, use, and disclosure of information by all health regulatory colleges, including CPSO.** The *RHPA* requires CPSO to collect, and CPSO members (i.e. physicians registered with CPSO) to provide, various types of personal information about members. CPSO also requires members to provide additional personal information under CPSO's by-laws, made pursuant to specific by-law making authority under the Code for collection of additional personal information.

- **It is important that CPSO be able to use this personal information for all its regulatory needs.** While we believe collection of this personal information is objectively fair and appropriate, it would be burdensome, disruptive, and divert resources from CPSO's regulatory mandate to respond to queries and challenges about whether personal information (particularly that collected under the by-laws) is fair and appropriate, and whether CPSO collects more personal information than is necessary to carry out its purposes.

Re: Grounds for Collection, Use, and Disclosure of Personal Information

- **If the "legitimate needs" ground is not applied broadly to the regulatory mandate, as submitted, CPSO would have to obtain consent to collection of personal information for regulatory purposes, which would be impractical in many circumstances** (particularly, with

a membership of over 40,000 physicians). Additionally, the list of permitted categories proposed may be insufficient to capture all of CPSO's regulatory purposes for the collection, use, and disclosure of personal information.

- **If CPSO is not able to obtain personal information about complainants and/or patients indirectly (i.e. without consent), the ability to conduct investigations and/or proceedings and otherwise fulfil CPSO's regulatory mandate would be significantly hindered.** Sometimes personal information about complainants and/or patients can be collected directly, but in other circumstances, it would be impractical or unfeasible. The requirement for parental consent for children and youth may similarly affect CPSO's ability to obtain needed information and may not serve the interests of children and youth in this context.

- **The requirement that an organization "determine at or before the time of the collection of any personal information each of the purposes for which the information is to be collected, used, or disclosed and record those purposes" would not provide appropriate flexibility for all of CPSO's regulatory purposes that may become necessary over time and may go beyond the original purposes for which the personal information was collected.**

    - For example, personal information collected through the annual renewal process may be used in connection with a subsequent investigation; however, this purpose would not be known at the time of collection. It would be burdensome to obtain consent from members for additional uses related to regulation. Further, a member would likely be unwilling to consent to use their personal information for the purposes of an investigation, which would significantly hinder CPSO's ability to carry out its mandate.

    - Personal information obtained with consent that is subject to withdrawal of that consent would be an obstacle for similar reasons.

Re: Right to access and correction

- **Certain personal information provided by members is already accessible to members** as it is required by statute or by-law to be posted on CPSO's public register (available on its website). The *RHPA* also provides a right to correct information contained in the public register.

- **CPSO may have incorrect information about a member or other individual, but the fact that the information is incorrect may be important to maintain.** For example, if a member provides a false statement on an annual renewal survey or during an investigation or proceeding, this could serve an evidentiary purpose and be relevant to determining their

truthfulness or capacity. As noted above, the *RHPA* already provides a mechanism for members to request a correction to information.

- **It may be overly burdensome to redact information that is not the personal information of the individual requesting access in order to provide the requester their personal information.** Members' files typically contain not only personal information about the members but personal information and other confidential information about others (such as patients) in addition to CPSO's own work product (such as memoranda and investigative notes) which would not be appropriate to share with members or other individuals.

- **A broad right of access to information may hinder the ability of CPSO to fulfill its regulatory mandate.** For example, advising a member of an investigation in the early stages may lead to interference with obtaining evidence. CPSO makes appropriate disclosures as part of the investigative or hearing process, taking into consideration relevant factors, such as the stage of the investigative or hearing process and requirements of procedural fairness.

- **It is not always appropriate or feasible to disclose the names or types of third parties to whom disclosure of personal information was made without consent.** Currently, CPSO discloses personal information of individuals (including patients and members) in the course of investigations, proceedings, and other circumstances, as permitted by the *RHPA* and as required by law.

Re: Right to transfer (data mobility or data portability)

- **Due to the confidential nature of much of the personal information in CPSO's custody, the right to transfer information may not be appropriate.** It is also unlikely the information CPSO has (other than what is on the public register, which is accessible and can be provided) would need to be transferred.

Re: Right of disposal (right to erasure or deletion)

- **The Code sets out limited circumstances when members may request that information on the public register be deleted.** Generally, it is in the public interest for this information to be displayed on the register, even after a physician is no longer a member, so that the public is aware of the status of their license to practice medicine. It is unlikely CPSO would approve requests for disposal of personal information outside of the prescribed circumstances, and it would be burdensome and divert resources for CPSO to have to respond to requests for disposal and appeals of denials.

- **It is critical that CPSO retain personal information of its members over the course of their careers for regulatory purposes**. For example, a record of a member's regulatory history with CPSO may serve an evidentiary purpose in subsequent investigations or proceedings.

CPSO supports the government's goal towards modernizing privacy in Ontario, harmonizing with Ontario's other privacy laws, and minimizing regulatory burden for Ontario organizations. Our submissions reflect the need for Ontario's privacy framework to support CPSO's regulatory mandate to serve and protect the public. It is essential that modernization continue in a manner that appropriately addresses the professional regulatory context, recognizing that the balance between the needs of a regulator serving in the public interest and the proposed privacy rights of individuals is very different than in a commercial context. CPSO is available to answer any questions you may have and support this important work.

Sincerely,

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

Judith Plante, MDCM, CCFP, FCFP
President

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		
Dispensing Drugs	Sep-21	✓						**2022**	An expedited review of this policy is being undertaken.
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**	The draft policy has been retitled to *Virtual Care* and is being considered for approval to consult externally.
Social Media: Appropriate Use by Physicians (Statement)	Apr-20					✓		**2021**	A draft policy was approved by Council for external consultation and is being revised in response to the feedback received.
Statements & Positions Redesign	Jan-20		✓					**2022**	All CPSO *Statements & Positions* are being evaluated for relevance and currency.
Complementary / Alternative Medicine	Mar-19						✓	**2022**	A retitled and revised *Complementary and Alternative Medicine* draft policy is being considered for final approval.

Table 2: Policy Review Schedule

Policy	Target Review	Policy	Target Review
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
Public Health Emergencies	2023/24	*Professional Responsibilities in Medical Education*	2025/26
Closing a Medical Practice	2024/25	*Third Party Medical Reports*	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.

PARO

Inspired by our love of medicine

CPSO Council August 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 strategic initiatives at PARO.

Optimal Working Conditions

Arbitration Award on Pandemic Pay

Since the beginning of the pandemic, PARO has been acutely aware of how our members have stepped up to provide 24/7 coverage, often putting themselves and their families at risk in the service of others. We have worked around the clock to deal with the myriad of issues that have arisen to ensure to the best of our ability that your well-being, working conditions and education was optimized. We have had many successes and have built enduring partnerships that will positively affect resident training and the way we work, and are taught and examined, that will last beyond the pandemic.

When pandemic pay was announced by the Ontario Government, we were shocked that our members were not on the list. We mobilized countless allies who wrote the Government advocating on our behalf, including our employer, the Ontario Teaching Hospitals.

We pursued every conceivable route to help the Government understand the critical role that residents play in our healthcare system.

We were determined to not give up and as we entered the recent round of negotiations, knowing that we were limited by Bill 124 to a maximum of 1% per year for three years, we searched for a way to make the request for pandemic pay. Thanks to the diligence and brilliance of our legal team and an exhaustive review of the flurry of Government regulations during the pandemic, we believed that we had found the legislative framework to make the legal case for our much-deserved pandemic pay.

During negotiations we were able to reach agreement on every issue with the exception of pandemic pay. As a result, we took this sole issue to Arbitration.

Both sides met with Arbitrator Kaplan and we advanced a compelling narrative filled with stories of the extraordinary commitment of our members and the degree to which we have all stepped up during the pandemic. We presented data on the number and intensity of hours that residents have worked and the need for us to be redeployed to meet the needs of the initial wave, the second wave and the third wave of this pandemic. And we presented our compelling legal argument that we felt created the ability for the Arbitrator to have jurisdiction on this issue and award pandemic pay despite that exceeding the 1% compensation cap imposed by Bill 124 that otherwise restrained the rest of our contract negotiations.

We were very pleased when Mr. William Kaplan, one of Ontario's most respected Arbitrators, released his decision awarding us with pandemic pay.

PARO is working with our Employer and the paymasters to determine when this payment will be made.

Optimal Training

Integration of Virtual Care in Medicine

In Fall 2020, the PARO Board directed a team to determine 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 can also empower residents to understand existing best practices, such as to respect privacy standards and to promote resident safety. Virtual care encompasses all the ways that healthcare providers remotely interact with their patients.

In January 2021, we brought together a group of residents comprised of GC reps and general members for a facilitated session. The group worked through a series of exercises to clarify the issues related to virtual care and discuss how PARO might best support members. The input was summarized and the team met again in early May 2021 to review/provide feedback as well as ideate how PARO could champion the development of standards, so residents can competently provide virtual care. Concurrently, we reached out to stakeholders including the OMA and CPSO to enquire about work they are doing in this area. We look forward to working with RDOC and the other PHOs as our collective work progresses provincially and nationally.

In June an overview of the strategic framework for the initiative and next steps were presented and the PARO Board who endorsed the framework. In addition, a divergent exercise to learn more about the Ontario resident experience with virtual care was facilitated at our PARO General Council meeting later that day.

PARO Teaching to Teach Program

We are particularly proud of PARO's *Teaching to Teach* Program this year.

These past few months we have continued to tweak Zoom-based delivery of the PARO *Teaching to Teach* workshop and implement improvements based on facilitator and participant feedback. In 2020/21, workshops were delivered to seven residency training programs with over 175 participants.

An important requirement to ensure the success of the teaching to teach program is a comprehensive training component for the resident facilitators. This academic year, we hosted two successful train the trainer sessions resulting in eight newly trained facilitators.

Optimal Transitions

Transition to Residency

Many of PARO's Transition into Residency program offerings are well established and managed at the site and/or staff level. This year, due to COVID19, much of the work done by the *Transition Into Residency* PARO Site Leads, Site Chairs and PARO Staff revolved around how to best deliver our welcome to residency programs and events virtually.

Site Specific Orientation Activities

Transition into Residency Site Leads, with the assistance of other GC reps, provided a PARO presentation at their university orientation. They also planned and hosted virtual social events to welcome incoming residents. PARO call kits were shipped to sites and distributed with the assistance of the PGME office, Program Directors/Administrators, Chief Residents or Site Coordinators.

New Resident Welcome Program

The goal of this program is to provide personal one-to-one assistance to incoming PGY1s.

- The program was promoted to incoming PGY 1s in the PARO President's welcome message sent in May.
- 15 PARO GC reps volunteered to personally assist the 10 newly matched residents who reached out for assistance.

Touchstone Institute Presentations

- PARO GC reps were recruited to present at three virtual orientation sessions for International Medical Graduate residents.
- There were over 150 participants who were very engaged, leading to lively Q&A discussions.
- Feedback from both participants and presenters was very positive.

PGY 1 Email Series

- A series of email messages were sent to incoming residents, scheduled at times when they need the information the most (May-June).
- Topics included PARO President welcome message, before starting residency tips, important information about long term disability and site-specific emails about orientation events.

Respectfully submitted,

Brendan Lew, MD
PARO Board of Directors

August 24, 2021

Council Briefing Note

CPSO

September 2021

The Update on Council Decisions will follow under separate cover.

PROPOSED 2022 MEETING DATES

Jan-2022				
M	T	W	T	F
3	4	5	6	7
10	11 EC	12	13	14
17	18	19	20	21
24	25 GC	26	27	28
31				

Feb-2022				
M	T	W	T	F
	1	2	3	4
7	8 EC	9	10	11
14	15	16	17	18
21 Family Day	22	23	24	25
28				

Mar-2022				
M	T	W	T	F
	1	2	3 C	4 C
7	8	9	10	11
14	15	16	17	18
		March Break		
21	22	23	24	25
28	29 GC	30	31	

Apr-2022				
M	T	W	T	F
				1
4	5	6	7	8
11	12 EC	13	14	15 Good Fri
18 Easter Mon	19	20	21	22
25	26	27	28 FSMB, New Orleans	29

May-2022				
M	T	W	T	F
2	3 GC	4	5	6
9	10	11	12	13
16	17 EC	18	19	20
23 Victoria Day	24	25	26	27
30	31			

Jun-2022				
M	T	W	T	F
		1	2	3
		CLEAR, Ireland		
6	7	8	9	10 FMRAC, QC
13 FMRAC, QC	14	15	16 C	17 C
20	21	22	23	24
27	28	29	30	

Jul-2022				
M	T	W	T	F
				1 Cda Day
4	5	6	7	8
11	12	13	14	15
18	19	20	21	22
25	26 GC	27	28	29

Aug-2022				
M	T	W	T	F
1 Civic Holiday	2	3	4	5
8	9	10	11	12
15 CMPA, Van	16 EC	17	18	19
22	23	24	25	26
29	30	31		

Sep-2022				
M	T	W	T	F
			1	2
5 Labour Day	6	7	8 TIFF	9
12 TIFF	13	14	15	16
		CLEAR, Kentucky		
19	20 GC	21	22 C	23 C
26 Rosh Hashannah	27	28	29	30

Oct-2022				
M	T	W	T	F
3	4 EC	5 Yom Kippur	6	7
10 Thanksgiving	11	12	13	14
17	18	19	20	21
	ISQua, Australia			
24	25	26	27	28
	CNAR, PEI			
31				

Nov-2022				
M	T	W	T	F
	1 GC	2	3	4
7	8	9	10	11 Rem Day
14	15	16	17	18
	IAMRA, South Africa			
21	22 EC	23	24	25
28	29	30		

Dec-2022				
M	T	W	T	F
			1	2
5	6	7	8 C	9 C
12	13	14	15	16
19	20	21	22	23
		Hanukkah		
26 Hanukkah	27	28	29	30

C Council

EC Executive (7)

GC Governance (6)

Stat holidays/Mar break/Jewish Holy days

Conference/AGM

Last updated: 2021-08-105:27 PM

Council Briefing Note

September 2021

Topic:	*Virtual Care* – Draft Policy for Consultation
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation Quality Care Meaningful Engagement
Public Interest Rationale:	Setting clear expectations and guidance for physicians to support access to high quality and safe virtual care.
Main Contact(s):	Tanya Terzis, Senior Policy Analyst Kaitlin McWhinney, Junior Policy Analyst
Attachment (s):	Appendix A: Draft *Virtual Care* policy Appendix B: Draft *Advice to the Profession: Virtual Care* document

Issue

- CPSO's *Telemedicine* policy is currently under review. A newly titled draft *Virtual Care* policy has been developed along with a companion *Advice to the Profession* document (*Advice*).
- Council is asked whether the draft policy can be released for external consultation and engagement.

Background

- The current *Telemedicine* policy was last reviewed and approved by Council in 2014.
- The policy review kicked off at September 2020 Council with an interactive presentation and discussion meant to inform the strategic direction of the review.
- A preliminary consultation on the current *Telemedicine* policy took place from September to November 2020.

- A total of 220 responses were received as part of this external consultation. The majority of respondents were physicians and seven organizational responses[1] were received. All feedback has been posted on a dedicated page of CPSO's website.

- A Virtual Care Symposium bringing patients and physicians together to discuss what quality virtual care looks like from both perspectives was held in October 2020.[2]

- The draft policy was developed based on direction from the Policy Review Working Group[3] and was informed by the consultation feedback and research. Additional support was provided by Kirk Maijala and Carolyn Silver (Legal Counsel).[4]

Current Status and Analysis

- The draft *Virtual Care* policy (**Appendix A**) retains the core expectations of the current *Telemedicine* policy while some substantive changes have been made to reflect the current virtual care landscape and requests for direction on key issues.

  - Most notably, the draft policy continues to be principle-based and premised on the expectation that the standard of care must continue to be met, with new expectations intended to clarify when and how to provide virtual care appropriately.

- An overview of the key revisions made in the draft policy and *Advice* (**Appendix B**) is set out below.

Policy title and definition

- In response to consultation feedback, including from key organizational stakeholders (e.g., CMPA and IPC), the draft policy now refers to "virtual care" instead of "telemedicine." Accordingly, the draft policy has been retitled "Virtual Care" and has adapted the definition used in the Virtual Care Task Force's report[5].

  - Telemedicine and virtual care have essentially the same meaning. Outside of regulators, hospitals and the healthcare sector more broadly, now more commonly refer to "virtual care" in relation to the activities captured by the *Telemedicine* policy.

[1] The organizational respondents included: Canadian Medical Protective Association (CMPA); Information and Privacy Commissioner of Ontario (IPC); Ontario Medical Association (OMA); OMA Section on Rheumatology and the Ontario Rheumatology Association; OMA Section on Plastic Surgery; Ontario Trial Lawyers Association; and Professional Association of Residents of Ontario (PARO).
[2] A high-level overview of the feedback received from these engagement activities was provided in the December 2020 Council Materials (Policy Report; pp.39—41).
[3] The Working Group is currently composed of Council Members Brenda Copps, Lydia Miljan, Peter Pielsticker, Sarah Reid, Karen Saperson, and Janet van Vlymen, and CPSO Medical Advisor Keith Hay.
[4] In addition to engagement activities, an extensive review was undertaken in accordance with the usual policy review process, including a literature review; jurisdictional scan; a review of decisions from ICRC; and common inquiries received in Physician Advisory Services and the Patient Help Centre.
[5] The Virtual Care Task Force was created by the Canadian Medical Association, the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada to identify and report on the actions required to promote excellence in virtual care in Canada.

Virtual care is the practice of medicine (Provision #1)

- The draft policy retains the existing requirement that physicians providing virtual care continue to meet the standard of care and the existing legal and professional obligations that apply to care that is provided in person.

- A new expectation, consistent with CPSO's *Walk-in Clinics* policy, specifies that meeting the standard includes conducting any assessments, tests, or investigations required in order to appropriately provide treatment, and providing or arranging for appropriate follow-up care.

    - With the increase in virtual care during the COVID-19 pandemic, the reluctance on the part of some physicians to see patients in person, and concerns about sub-standard virtual care (e.g., referrals or prescriptions without appropriate tests/assessments, etc.), the Working Group felt the need to stress the importance of continuing to conduct necessary tests and ensure appropriate follow-up care when providing virtual care.

Ensuring competence (Provision #2)

- The draft policy includes a new expectation requiring physicians to ensure they have the competence necessary to provide care virtually, including to effectively use the technology.

    - This new provision recognizes that virtual care may involve a modified approach to care and aligns with expectations of other Canadian medical regulators.

Virtual care and patients' best interests (Provision #3)

- The draft policy continues to require physicians only provide virtual care if it is in the patient's best interest to do so, and now defines best interest as when the patient's quality of care will not be compromised by the virtual modality *or* when the potential benefits of virtual care outweigh the risks.

    - This revision acknowledges that in some instances (e.g., during a pandemic) the benefits of patient or public safety override the potential risk to quality of care but that the risk-benefit calculation must always be in the best interest of the patient.

Considerations for determining when virtual care is appropriate (Provision #4)

- In response to requests for guidance on when it is appropriate to provide virtual care, the draft policy includes additional considerations to help physicians make this determination.

    - The draft policy retains the existing considerations, such as the patient's specific circumstances and health care needs, while also now requiring consideration of the need for a physical examination, patient preference, and the technology available to the patient as well as their ability to effectively utilize the technology.

- For additional assistance determining when virtual care is appropriate, the draft *Advice* directs physicians to the *Virtual Care Playbook*.
    - There are a variety of factors that can impact the appropriateness of virtual care and the draft policy now includes clinical and socio-economic factors for consideration.
    - The inclusion of patient preference as a consideration reflects feedback received throughout all engagement activities about the importance of patient input when making these decisions.
    - While aiming to provide clarity on when virtual care is appropriate, the draft retains flexibility and allows physician judgment to drive decisions about appropriateness.

When follow-up is required (Provisions #5—6)

- Over the course of the pandemic, there has been an increase in the number of physicians who practice, or would like to practice, completely virtually. In response, the draft policy sets out a new expectation that physicians must be mindful of the limitations of virtual care and take appropriate action if, during the course of a virtual encounter, it is determined that a patient requires in-person care (e.g., informing patients of the need for in-person care, and arranging a timely in-person assessment or assisting patients in seeking appropriate care).
    - The new draft expectation aligns with CMPA guidance, the expectations of other Canadian medical regulators, and existing guidance in the current *Telemedicine Advice* that addresses virtual walk-in clinics.
- The draft policy also now requires physicians to take appropriate action if the quality of the virtual encounter becomes compromised and no longer serves the patient's best interests (e.g., failed technology or compromised security). Appropriate action is listed as including timely follow-up and/or rescheduling of the appointment.
    - These new expectations are meant to reinforce that physicians must take appropriate action if they are unable to appropriately assess or treat patients during a virtual encounter.

Maintaining privacy and security (Provisions #9—10)

- The draft policy retains the general requirement for physicians to protect the privacy and confidentiality of patients' personal health information (PHI), while updates have been made to clarify the reasonable steps that must be taken to do so in a virtual setting (e.g., conducting the encounter in a private setting and confirming the patient is comfortable discussing or sharing their PHI during the appointment).
- In response to requests for greater clarity on which technology (e.g., platforms, etc.) can be used to provide virtual care, the draft requires using secure technology (e.g., platforms that

are protected by encryption), unless it is in the patient's best interest to do otherwise. The draft requires express patient consent if less secure technology is used.

  - Privacy legislation is complex and feedback from engagement activities cited the importance of simple and clear rules around privacy that do not inhibit access for patients or physicians.

  - The Working Group felt it was important to set clear and reasonable rules around privacy that offer some flexibility depending on the circumstances (e.g., the nature and purpose of the encounter and the availability of secure technology).

  - The draft *Advice* directs physicians to the IPC's guidance for additional information on how to comply with privacy and security obligations when delivering virtual care.

Obtaining informed consent for virtual care (Provision #11)

- The draft policy includes a new expectation that physicians must obtain informed consent from patients for the provision of virtual care and specifies that this includes informing patients of the risks, limitations, and benefits of virtual care (i.e., those related to privacy and clinical limitations). The draft *Advice* provides additional guidance regarding consent (e.g., documenting consent, obtaining express versus implied consent, and the frequency of reviewing the benefits, risks, and limitations of virtual care with patients).

  - Consultation feedback requested clarification on meeting consent requirements.

  - In line with the recommendation of the Federation of Medical Regulatory Authorities of Canada (FMRAC), most Canadian medical regulators have expectations about obtaining informed consent for telemedicine.

Providing virtual care to patients located outside of Ontario (Provision #12)

- The draft policy retains the existing expectation that physicians providing virtual care to patients located in another jurisdiction comply with the licensing requirements of that jurisdiction and includes a new expectation requiring physicians to disclose their identity, location, and licensure status to patients located in other jurisdictions.

  - Physician disclosure regarding their identities, location, and licensure status is a general expectation amongst many Canadian medical regulators. The Working Group was of the view that requiring this type of disclosure in every instance would be unnecessary (e.g., when treating existing patients), while disclosing this information to patients located in other jurisdictions would be reasonable.

Licensing requirements when providing virtual care to Ontario patients (Provision #13)

- CPSO's current *Telemedicine* policy does not address requirements for licensure when providing virtual care to Ontario patients. As a result, rules around licensure have been a common source of confusion with many requests for clarity.

- The draft policy clarifies that physicians who provide virtual care to Ontario patients must hold an active certificate of registration in Ontario to do so, while it does permit some exceptions where virtual care by a physician licensed elsewhere would be in the patient's best interest (e.g., emergency care or care that is not readily available in Ontario).
    - Given the recent increase in virtual care, the Working Group felt it was important to put parameters around when virtual care can be provided without a CPSO license.
    - However, in practice, there are instances where care from physicians licensed elsewhere may be needed to facilitate patient safety (e.g., cross-border paramedic services), access and/or continuity of care. The exception is intended to allow limited virtual care in exceptional circumstances.
- The draft *Advice* clarifies that the CPSO permits physicians licensed in Ontario to provide virtual care to Ontario patients when the patient or physician is temporarily outside of Ontario (where the jurisdiction allows[6]), and that physicians licensed elsewhere can provide virtual care to patients from their jurisdictions who are *temporarily* in Ontario (e.g., on vacation in Ontario).

Consulting with or referring patients to out-of-province physicians for virtual care (removed)

- The current expectations around consulting with or referring patients to out-of-province physicians for virtual care have not been retained in the draft policy. The expectations that have been removed include requirements to:
    - take reasonable steps to ensure these consultations or referrals are appropriate;
    - have reasonable grounds to believe that the out-of-province physician is appropriately licensed; and
    - inform patients that the physician is not physically located or licensed in Ontario.
- The Working Group was of the view that these requirements are outdated, prescriptive, and not aligned with CPSO's "Right Touch" approach to regulation.

Next Steps

- Pending Council's approval, the draft policy and *Advice* will be released for external consultation and engagement. Feedback received as part of these activities will be shared with Council at a future meeting and used to further refine the draft.

Questions for Council

1. Does Council approve the draft *Virtual Care* policy for external consultation and engagement?

[6] Licensing requirements vary between provinces. Some colleges permit physicians licensed anywhere in Canada to deliver telemedicine services to patients in their provinces while other colleges require special registration. Some colleges have taken a similar approach to the draft policy and permit limited virtual encounters from physicians licensed in other jurisdictions.

Virtual Care

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

Virtual Care: Any interaction between patients and/or members of their circle of care[1] that occurs remotely[2], using any form of communication or information technology, including telephone, video conferencing, and digital messaging (e.g., secure messaging, emails, and text messaging) with the aim of facilitating or providing patient care.

Policy

Virtual care is the practice of medicine

1. When providing virtual care, physicians **must** continue to meet the standard of care and the existing legal and professional obligations that apply to care that is provided in person, including those pertaining to prescribing drugs, medical recording-keeping, protecting personal health information, consent to treatment, and continuity of care.[3]

    a. For example, physicians providing virtual care **must** conduct any assessments, tests, or investigations that are required in order for them to

[1] For more information about who is included in the circle of care, please see CPSO's *Protecting Personal Health Information* policy.
[2] Remotely means without physical contact and does not necessarily involve long distances. Patients, patient information and/or physicians may be separated by space (e.g. not in the same physical location) and/or time (e.g. not in real time).
[3] Relevant legal obligations include privacy and confidentiality requirements as set out in the *Personal Health Information Protection Act, 2004*, S.O. 2004, c. 3, Sched. A (hereinafter *PHIPA*), and General, Ontario Regulation 329/04, enacted under *PHIPA*, consent requirements in the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A, and mandatory liability coverage in s. 50.2 of the General By-Law. Professional obligations are set out in CPSO's *Practice Guide* and policies.

appropriately provide treatment and **must** provide or arrange for appropriate follow-up care.

2. Due to the distinct skillset required to provide safe and effective virtual care, physicians **must** ensure they have the competence to provide care virtually, including effectively using the technology.

Virtual Care and Patients' Best Interests

Virtual care is not appropriate in every instance as not all conditions can be effectively treated virtually and not every patient has access to or will be comfortable using virtual care technology.

3. Physicians **must:**

    a. use their professional judgment to determine whether virtual care is appropriate in each instance its use is contemplated; and
    b. only provide virtual care if it is in the patient's best interest to do so. This means only providing virtual care when:

        i. the quality of care will not be compromised; or
        ii. the potential benefits of providing virtual care outweigh the risks to the patient (e.g., during contagious disease outbreaks, or for a patient who has limited mobility or lack of transportation and whose access might be otherwise limited to the point of risking patient harm).[4]

4. When considering whether virtual care is in the patient's best interest, physicians **must** ensure their decisions reflect the following factors:

    a. the nature of the presenting complaint and care required, including whether a physical examination is required in order to meet the standard of care;
    b. the patient's existing health status and specific health-care needs;
    c. the patient's specific circumstances and preferences (e.g., distance required to travel to an in-person appointment or ability to take time off from work); and
    d. the technology available to the patient and their ability to effectively utilize the technology available to them.

[4] In some exceptional circumstances it may be appropriate to provide virtual care even when the quality of care may be compromised by the virtual mode of delivery. These circumstances are generally limited to instances where the virtual care promotes patient or public safety. In these circumstances the potential benefits of patient or public safety override the potential risk to quality of care.

5. Physicians **must:**

    a. be mindful of the limitations of virtual care; and
    b. take appropriate action if, during the course of a virtual encounter it is determined that a patient requires in-person care, including:
        i. informing patients of the need for in-person care; and
        ii. arranging a timely in-person assessment or assisting patients in seeking appropriate care, where possible and necessary.

6. Physicians **must** take appropriate action if, during the course of a virtual encounter the quality of the encounter becomes compromised (e.g., technology fails or security is compromised) and the patient's best interests will no longer be served by continuing with the virtual encounter, including:

    a. ensuring the patient is followed-up with in a timely manner; and/or
    b. rescheduling the appointment, where necessary.

Appropriate Setting and Technology

7. Where the virtual encounter is synchronous (i.e., involves real-time interaction with the patient), physicians **must** confirm the physical setting where the patient is receiving virtual care is appropriate and safe.

8. Physicians providing virtual care **must** use technology that is fit for purpose, can facilitate a quality encounter, and enables the standard of care to be met, including technology that:

    a. supports the sharing of high quality and reliable patient health information (e.g., diagnostic or other images that are of sufficient quality); and
    b. allows physicians to gather the information needed to provide the care.

Maintaining Privacy and Security

The legal obligations to protect the privacy and confidentiality of patients' personal health information (PHI) also exist when delivering virtual care.

9. All physicians **must** take reasonable steps to protect PHI, including protection against theft, loss, and unauthorized access, use, and disclosure of PHI.[5] When providing virtual care, physicians **must**:

[5] *PHIPA*, s. 12 (1).

a. take reasonable steps to accurately identify the patient (e.g., verify their name and date of birth);[6]
b. conduct the encounter in a private setting, where applicable;
c. confirm that the patient is in a reasonably private setting and is comfortable discussing or sharing their PHI during the appointment; and
d. use secure information and communication technology (e.g., platforms that are protected by encryption), unless it is in the patient's best interest to do otherwise, taking into account:

- the nature and purpose of the encounter, including the degree of sensitivity of the personal health information being shared;
- the availability (or lack thereof) of alternative technology;
- the volume of information and frequency of use;
- patient expectations; and
- any emergency or other urgent circumstances.

10. If using less secure technology (e.g., unencrypted platforms), physicians **must** obtain and document the patient's express consent to do so.

Obtaining Informed Consent for Virtual Care

11. Physicians **must** ensure informed consent is obtained from the patient or their substitute decision maker (SDM) for the provision of virtual care, which will require informing patients or their SDM of the benefits, limitations, and potential risks of a virtual encounter, including:

a. those related to privacy (e.g., potential for privacy breaches); and
b. any clinical limitations to providing virtual care and the potential requirement for in-person follow-up.[7]

Providing Virtual Care to Patients located Outside of Ontario[8]

12. When providing or assisting in the provision of virtual care to a patient in another province, territory, or country, physicians **must:**

a. comply with the licensing requirements of that jurisdiction; and

[6] What is reasonable will differ if the encounter takes place within the context of an existing physician-patient relationship compared with a new patient.
[7] For more information about obtaining informed consent see the *Advice to the Profession: Virtual Care* document.
[8] CPSO maintains jurisdiction over its members regardless of where (i.e. physical location) or how (i.e. in-person or virtually) they practise medicine, and will investigate any complaints made about a member, regardless of whether the member or patient is physically located in Ontario.

b. ensure their identity, location, and licensure status (i.e., where they hold a medical licence) are disclosed to the patient.[9]

Licensing Requirements when Providing Virtual Care to Ontario Patients

13. Physicians providing virtual care to Ontario patients located in Ontario **must** hold a valid and active certificate of registration with the CPSO, unless the provision of virtual care from an unregistered physician is in the patient's best interest;[10] for example, the care sought is:

    a. not readily available in Ontario (e.g., specialty care);
    b. provided within an existing physician-patient relationship and intended to bridge a gap in care; or
    c. for urgent or emergency assessment or treatment of a patient.[11]

[9] The medical regulatory authority of the jurisdiction where the physician and/or patient are physically located may also require that physicians hold an appropriate medical licence in that jurisdiction.
[10] This provision does not permit physicians licensed in other jurisdictions to circumvent Ontario licensing requirements and primarily practise in Ontario. It is intended to allow the provision of limited virtual care by physicians licensed in other jurisdictions in circumstances where it may serve a patient's best interests.
[11] CPSO reserves the right to take action against physicians who are providing virtual care to Ontario patients in accordance with Provision #13 if they are not meeting the standard of practice. If CPSO becomes aware of concerns about virtual care provided to an Ontario patient by a physician who is not licensed in Ontario it may share that information with the regulatory authority that has jurisdiction over the member, so that appropriate action can be taken by that regulatory authority.

Advice to the Profession: Virtual Care

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.

Virtual care plays an important role in the health-care system by improving access to care and increasing efficiencies in the way it is delivered. As technology continues to evolve, it will bring new opportunities and advancements in the delivery of virtual care. At the same time, virtual care may not be appropriate in every instance. Not all conditions can be treated virtually and not everyone has equal access to or is comfortable using technology.

CPSO's *Virtual Care* policy sets expectations for physicians about the appropriate use of virtual care. This companion *Advice* document is intended to help physicians interpret their obligations as set out in the policy and provide guidance around how these expectations may be effectively discharged.

Virtual Care is the Practice of Medicine

Does the policy apply to areas of medicine that do not involve patient care?

Yes. Virtual care is the practice of medicine and the principles set out in the policy are applicable to all areas of medicine, including those that do not involve patient care. For example, the same standards apply to Independent Medical Examinations (IMEs) conducted virtually as to those performed in-person. Where a physician is performing an IME, professional judgment will be required to determine if a virtual assessment is appropriate in the circumstances and can meet the standard of practice.

If I have the competence to provide in-person care, do I have the competence to provide the same type of care virtually?

Not necessarily. The provision of virtual care may require the use of new technology, as well as a modified approach to care that is distinct from in-person care and there may be a learning curve when you first begin to provide care virtually. For example, in the absence of seeing a patient in person, assessments done over the telephone or via video conferencing might require you to ask additional or different questions than you would in person. To ensure patient safety, the policy recognizes this unique skillset and requires that before providing virtual care, physicians ensure they have the competence to do so, including to effectively use the technology.

The policy requires the standard of care to be maintained when providing virtual care. How can I meet the standard of care in a virtual environment?

The standard of care is always context-specific with a number of factors determining what the standard is in each instance and whether it can be met with a virtual encounter. The patient's presenting complaint and health care needs, their specific circumstances (e.g., access to in-person care), the technology used to facilitate the encounter and the ability to obtain the information needed to appropriately diagnose and treat the patient, and the risks associated with in-person care are all factors that impact the standard of care in a specific circumstance and whether it is appropriate to provide care virtually.

A risk-benefit analysis can help physicians determine whether the standard of care can be met with a virtual encounter.

Can I delegate controlled acts remotely?

When practising virtually, you must continue to meet the same legal and professional obligations that apply to care that is provided in person, including the expectations set out in CPSO policies such as the *Delegation of Controlled Acts* policy.

The *Delegation of Controlled Acts* policy outlines expectations for physicians about when and how they may delegate controlled acts. These include ensuring that:

- delegation only occurs when it is in the patient's best interest and that controlled acts are not delegated primarily for monetary or convenience reasons;
- delegation occurs in the context of a physician-patient relationship, unless patient best interests dictate otherwise; and
- the delegate has the appropriate knowledge, skill, and judgment to perform the delegated act and is able to accept the delegation.

In addition, you must ensure that any adverse event that occurs will be managed appropriately, which may involve specific considerations if the delegation has taken place remotely.

Can I prescribe medication via virtual care?

It depends. Before authorizing a prescription, you will need to consider whether you are able to meet your legal and professional obligations and the standard of care in relation to the specific patient and the specific care being provided, in the absence of physical interaction with the patient.

You will also need to take into account the expectations contained in CPSO's *Prescribing Drugs* policy which generally requires that the physician undertake an appropriate clinical assessment of the patient prior to prescribing.

What do I need to know when considering opioid prescriptions or treatment via virtual care?

In addition to the general expectations regarding prescribing, CPSO's *Prescribing Drugs* policy also contains expectations specific to prescriptions for narcotic and other controlled substances which must be complied with.

Opioids have a unique risk profile, including potential misuse, abuse, and diversion. When determining whether it is appropriate to prescribe opioids virtually, you need to consider whether you can appropriately assess and mitigate those risks.

Virtual Care and Patient Best Interest

Can I exclusively provide virtual care to patients?

It depends. Every practice is unique and the right balance of virtual to in-person care will require judgment on the part of the physician to determine how to best serve their patients' needs and to meet the standard of care.

Generally, virtual care is not meant to replace but to complement in-person care as there are limits to what can be done virtually and there are some patients that cannot be appropriately treated virtually. Depending on the nature of the practice, meeting the standard of care will likely require physicians to practise in a manner that includes a mix of both in-person and virtual care or having coverage arrangements that allow patients to have timely access to in-person care, when necessary. A fully virtual practice would likely be very limited in scope regarding the type of care that can be provided.

Why doesn't the policy specify the circumstances where virtual care would or would not be appropriate?

Every patient's needs are unique, technology is continuously evolving, and a number of considerations will play into the type of care that is appropriate in each instance. As a result, the policy is flexible and enables physicians to use their professional judgment to make these determinations based on the patient's needs and circumstances, and the technology that is available to them.

Where can I find additional resources that can assist me in determining when virtual care is appropriate?

The *Virtual Care Playbook* is a resource developed by the Canadian Medical Association, the Royal College of Physicians and Surgeons of Canada, and the College of Family Physicians of Canada that sets out key considerations for providing safe, effective, and efficient virtual care and can assist physicians in determining when virtual care is appropriate.

My patient and I disagree about whether virtual care or in-person care is warranted. How can disagreements be addressed?

At times there may be disagreements about the preferred approach to care (in-person or virtual). Not all patients are comfortable with technology or are able to receive care virtually. At the same time, not all patients have equal ability to make themselves available for in-person care. As always, you will need to consider what is in your patient's best interest and work together to find a solution that satisfies the need for patient access, safety, and quality care, while recognizing the patient's specific circumstances, limitations, and preferences (e.g., distance required to travel to an in-person appointment or ability to take time off from work). Effective and sensitive communication in these instances can go a long way towards resolving disagreements, including explaining why the preferred modality is in the patient's best interest (e.g., the limits or benefits of virtual care).

Privacy, Security, and Informed Consent

Where can I find more information about how to comply with privacy and security obligations in a virtual environment?

The Information and Privacy Commissioner of Ontario has released comprehensive guidelines regarding *Privacy and security considerations for virtual health care visits* to assist health care providers in complying with their privacy and security obligations in a virtual environment.

When providing virtual care, am I allowed to use technology (e.g., platforms) that cannot guarantee privacy and security?

The policy recognizes that in some limited situations patients' best interests might be served by using technology that is less secure (e.g., unencrypted) and sets out considerations to help physicians determine when using less secure technology might be appropriate. It also requires that if doing so, physicians obtain express patient consent. Ultimately, less secure technology may be best suited for minor tasks, such as scheduling appointments and appointment reminders, or for exceptional situations in

which the patient is unable to receive virtual care using secure (i.e., encrypted) technologies and consents to proceed with the technology available.

Where can I find more information about virtual care platforms (i.e., videoconferencing and secure messaging solutions) that are appropriate for clinical use?

To assist health care providers in the selection of virtual care solutions appropriate for clinical use, Ontario Health has established a provincial standard and launched a verification process for virtual care solutions. For a list of verified virtual visit solutions (i.e., videoconferencing and secure messaging solutions that comply with provincial requirements), see Ontario Telemedicine Network's (OTN) website.

Do I need to review the benefits, risks, and limitations of virtual care prior to each virtual encounter with the patient?

If you have obtained informed consent for the use of virtual care during an initial virtual encounter you may not need to review the same benefits, risks, and limitations prior to each subsequent virtual encounter with the patient. However, if the benefits, risks, and limitations change between encounters, for example if the technology or platform being used changes, or the risks change, then you will be required to review these new considerations with the patient and obtain informed consent once again.

Do I need to obtain express patient consent each time I provide virtual care to a patient?

The nature of the interaction and degree of sensitivity of the personal health information being shared during the virtual encounter are key considerations when determining whether express or implied consent would be required in each instance. The higher the degree of sensitivity, the more likely express consent will be necessary.

Am I required to document informed consent for the provision of virtual care?

The policy does not require documenting consent for the use of virtual care; however, it is in the physician's best interest to do so, particularly where patients express concern or raise questions about the virtual encounter.

Physicians are reminded that obtaining informed consent involves a discussion with the patient about the benefits, limitations, and risks of a virtual encounter and not just a signed consent form.

Practice Issues

I work in a walk-in clinic where virtual care is available to patients who self-identify with specific complaints and presentations. What do I need to keep in mind in these situations?

As in all cases, you need to keep in mind that the specific interaction may be inappropriate for virtual care. Where a clinic permits patients to choose a virtual care option based on a self-identified concern, new or additional considerations could arise in the course of the patient interaction that change the nature of the investigation, potentially making virtual care inappropriate. There may also be situations in which the self-identified complaint presents issues or complications that cannot be completely assessed through virtual care technology.

Where you feel that virtual care is inappropriate for the specific patient interaction, or has become inappropriate in the course of the interaction, the policy requires physicians to take appropriate action. Appropriate action includes informing patients of the need for in-person care and arranging a timely in-person assessment or assisting patients in seeking appropriate care, where possible.

For additional expectations pertaining to walk-in clinics, physicians can consult CPSO's *Walk-in Clinics* policy.

Providing Virtual Care Across Borders

Am I allowed to virtually treat Ontario patients who are (temporarily) out of the province or country?

If the policy expectations can be met, CPSO permits Ontario physicians to treat Ontario patients who are temporarily out of the province or country as this supports continuity of care and is in the patient's best interest. However, many jurisdictions consider the care to occur where the patient is located, and physicians will also need to be aware of and comply with the licensing requirements of the jurisdiction where the patient receiving virtual care is located.

Physicians with questions about the liability coverage and billing in these circumstances can contact the Canadian Medical Protective Association (CMPA) and the Ministry of Health for more information.

Is it permissible for physicians licensed in Ontario to treat Ontario patients when the physician is (temporarily) out of the province or country?

It depends. Licensing requirements vary between jurisdictions. Treating existing patients while the physician is temporarily out of the province is permissible from the CPSO's

perspective when this is allowed by the jurisdiction where the physician is located at the time and the standard of care is met. Physicians with questions about the liability coverage and billing in these circumstances can contact the CMPA and the Ministry of Health for more information.

If I am licensed in another jurisdiction, am I required to hold a certificate of registration in Ontario when providing virtual care to a patient who is temporarily located in Ontario?

No. Physicians licensed in other jurisdictions are not required to hold a certificate of registration in Ontario when providing virtual care to patients who ordinarily reside in their jurisdiction but are temporarily located in Ontario (e.g., who are on vacation in Ontario).

Council Motion

Motion Title	*Virtual Care* – Draft Policy for Consultation
Date of Meeting	September 13, 2021

It is moved by_____, and seconded by_____, that:

The College engage in the consultation process in respect of the draft policy, “Virtual Care,” (a copy of which forms Appendix “ ” to the minutes of this meeting).

Council Motion

Motion Title	Motion to Go In-Camera
Date of Meeting	September 13, 2021

It is moved by_____, and seconded by_____, that:

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

Council Briefing Note

September 2021

Topic:	Election of 2021-2022 Academic Representatives on Council
Purpose:	For Decision
Relevance to Strategic Plan:	Meaningful Engagement
Public Interest Rationale:	Ensuring the voting academic representatives permit the proper functioning of Council and committees.
Main Contacts:	Dr. Brenda Copps, Chair, Governance Committee Laura Rinke-Vanderwoude, Jr. Governance Analyst Suzanne Mascarenhas, Governance Analyst
Attachments:	N/A

Issue

- The Academic Advisory Committee has recommended three academic representatives to be selected as voting members of Council for 2021-2022. Those recommendations are now before Council for decision.

Background

- The Deans of the six Ontario medical schools appoint an academic representative that attends and participates in the College's Council meetings under section 25 of the General By-Law.
    - Dr. Roy Kirkpatrick (NOSM) and Dr. Karen Saperson (McMaster University) were not up for reappointment in 2021.
    - Dr. Janet van Vlymen (Queen's University), Dr. Mary Jane Bell (University of Toronto), and Dr. Paul Hendry (University of Ottawa) were all reappointed by their Deans.
    - Dr. Terri Paul was replaced by Dr. Andrea Lum as the representative from Western University.

- Every year, three of the six academic representatives are elected as voting members of Council to fulfill the requirements of the *Regulated Health Professions Act*.

- The three that are selected are entitled to voting rights on Council decisions, and function as a Council member for the purposes of committee panel requirements and eligibility to serve as an executive member of Council.

- The remaining three are entitled to participate in discussions of Council, but do not have Council voting rights or eligibility to serve as an executive member of Council, and count as a non-Council committee member in their other work on College committees.

Current Status and Analysis

- Historically, the meeting of the Academic Advisory Committee occurred at lunch during the first day of the September Council meeting. This year, the Academic Advisory Committee's meeting was scheduled in advance to support the Executive Committee election and committee appointment processes.

- At the end of the meeting, the Academic Advisory Committee recommended Dr. Janet van Vlymen, Dr. Roy Kirkpatrick, and Dr. Paul Hendry as the voting members for 2021-2022.

- Council may accept this slate of candidates for the 2021-2022 year. If Council chooses not to accept the proposed slate, a vote will be held in which all members of the Academic Advisory Committee are placed on a ballot.

- The three voting representatives for the 2021-2022 Council term will commence their role following the induction of new Council members at the annual meeting of Council in December 2021.

Decision for Council

1. Does Council accept the recommended slate of 2021-2022 voting academic representatives?

Council Briefing Note

September 2021

Topic:	Executive Committee Elections
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation Continuous Improvement
Public Interest Rationale:	Accountability: Ensuring appropriate governance of the CPSO through elections of the Executive Committee.
Main Contacts:	Dr. Brenda Copps, Chair, Governance Committee Laura Rinke-Vanderwoude, Jr. Governance Analyst Suzanne Mascarenhas, Governance Analyst
Attachments:	Appendix A: Nomination Statements

Issue

- There are upcoming vacancies for the President, Vice President, and Executive Member Representative positions on the Executive Committee for 2021. A vote will take place at the September 13-14 Council to fill these upcoming vacancies.

Background

- The Executive Committee's current composition includes:
    - Dr. Judith Plante, President
    - Dr. Janet van Vlymen, Vice President
    - Mr. Peter Pielsticker, Executive Member Representative
    - Dr. Rob Gratton, Executive Member Representative
    - Ms. Joan Fisk, Executive Member Representative
    - Dr. Brenda Copps, Past President

Current Status and Analysis

- Nomination statements for the vacant positions have been received from:
    - Dr. Janet van Vlymen, for President
    - Dr. Rob Gratton, for Vice President or, alternatively, Executive Member Representative

  - Mr. Peter Pielsticker, for Executive Member Representative
  - Ms. Joan Fisk, for Executive Member Representative
  - Dr. Ian Preyra, for Executive Member Representative.

- Nominations from the floor are permitted.

- All nominees will be given the opportunity to address Council prior to the election.

- Where there is only one candidate for a position, the candidates will be acclaimed. Where there is more than one candidate for a position, an election will be held using an electronic voting software that facilitates secret ballot voting (ElectionBuddy). All Council members must have access to their CPSO email during the voting period to access the voting link.

- As per the General By-Law, the term for Executive Committee members is one year. Dr. Judith Plante will serve as Past President for the 2021 Executive Committee.

Question for Council

1. Who does Council elect as the 2021-2022 Executive Committee President, Vice President, and three Executive Member Representative positions?

APPENDIX A: NOMINATION STATEMENTS
NOMINATION STATEMENT
CANDIDATE FOR 2021 - 2022 EXECUTIVE COMMITTEE
PRESIDENT

DR. JANET van VLYMEN

Queen's University Academic Representative
Kingston, Ontario

Principal Area of Practice: Anesthesiologist

Appointed Council Terms:
December 2, 2016 – December 3, 2021

CPSO Committees and Other CPSO Work:

Education Committee:	2016 - 2019
Education Advisory Group:	2020 – Present (Chair)
Executive Committee:	2020 - Present
Governance Committee:	2020 – Present
Finance & Audit Committee:	2020 - Present
Quality Assurance Committee:	2016 – Present (Chair)
Policy Working Group: *Prescribing Drugs*	March 2018 – December 2019
Policy Review Working Group: *(formerly Policy Redesign Working Group)*	2019 - Present

STATEMENT:

Thank you for considering me for President in 2022. I am thrilled for the opportunity to help lead Council through an exciting year as we emerge from the pandemic and return to in-person meetings. The new year will see us embracing new technology with the latest launch of Solis, the potential for ongoing modernization of our governance structure, and a provincial election. There is never a dull moment at the College and I am eager to see what other changes 2022 will bring.

I feel I am well prepared to take on the role of President. I have considerable experience in leadership in my roles as Deputy Chief of my Anesthesia Department and as Program Medical Director for Perioperative Services at Kingston Health Science Centre. I have also been fortunate to be involved in a variety CPSO committees and have Chaired both the Quality Assurance Committee and Education Advisory Group for the past year. As a strong advocate for high-quality patient care, I am grateful for the opportunity to work with the diverse group of physician and public members on Council to serve the people of Ontario.

NOMINATION STATEMENT
CANDIDATE FOR 2021 - 2022 EXECUTIVE COMMITTEE
VICE PRESIDENT

DR. ROBERT (ROB) GRATTON

District 2 Representative
London, Ontario

Principal Area of Practice: Obstetrics/Gynecology

Elected Council Terms:
December 2, 2016 – December 6, 2019
December 6, 2019 – December 2, 2022

CPSO Committees and Other CPSO Work:

Finance and Audit Committee:	2018 – Present, Vice Chair, 2020 - Present
Inquiries, Complaints and Reports Committee:	2015 – Present Specialty Panel Chair, Obstetrics, 2019 - Present
Policy Working Groups: *Medical Records*	2018 - Present
Executive Committee	2020 - Present

STATEMENT:

Thank you for considering my candidacy for Vice President. I have served on the Executive Committee over the last year and have been a member of Council since 2016.

My involvement in the CPSO began on the Inquiry, Complaints and Reports Committee. I have 6 years of experience on the complaints/investigation side of the college, including 2 years as Specialty Panel Chair for Obstetrics/Gynecology. I have gained a much broader understanding of the college and its many functions while serving on the Finance Committee (Vice Chair over the last year) and the Executive Committee.

The next year will be an exciting time. Governance reform will be prominent as the government proposes consultation on modernization, including opening/changing the *RHPA.* The development of the framework for regulation of PAs will progress rapidly. As well, operationalization of the OPSDT including the new CPSO adjudicators will also occur. The expanded platform of the enterprise system will touch all areas of the college. Finally, re-evaluation of models of work and infrastructure requirements will be necessary.

I believe that my experience on Executive, Council, Finance and Audit and the ICR Committees has positioned me well to support the President, contribute to the Executive Committee and serve the Council.

NOMINATION STATEMENT
CANDIDATE FOR 2021 - 2022 EXECUTIVE COMMITTEE
EXECUTIVE MEMBER REPRESENTATIVE

MS. JOAN FISK

Public Member of Council
Cambridge, Ontario

Occupation: Chief Executive Officer

Appointed Council Terms:
November 1, 2017 – October 31, 2020
November 20, 2020 – November 19, 2023

CPSO Committees and Other CPSO Work:

ICR Committee:	2017 – Present *General Panel Chair* 2020 - Present
Executive Committee:	2020 - Present

STATEMENT:

I am seeking support to re-join the Executive Committee of CPSO. I have been on the committee for a year, and greatly enjoy the experience. I have learned a great deal during my 4 years serving the ICRC. I would like to be able to help with the modernization of the College.

My background is varied, with experience as a CEO in a Textile and Apparel Manufacturing Company (Tiger Brand Knitting Company, 30 years), CEO of the Greater Kitchener Waterloo Chamber of Commerce, Chair of the Waterloo Wellington Local Health Integration Network, and currently as CEO of the United Way Waterloo Region Communities. I have served on 13 boards, including Hospital, University, College, Insurance, Symphony, and other Community and Federal Task Force groups.

I have a Governance designation from Queens University. In addition, I have taken 5 Rotman School of Management courses related to Governance and Finance. I am an enthusiastic participant in my commitments and would welcome this opportunity to guide the College as it moves forward.

Thank you for considering my application.

Joan

NOMINATION STATEMENT
CANDIDATE FOR 2021 - 2022 EXECUTIVE COMMITTEE
EXECUTIVE MEMBER REPRESENTATIVE

DR. ROBERT (ROB) GRATTON

District 2 Representative
London, Ontario

Principal Area of Practice: Obstetrics/Gynecology

Elected Council Terms:
December 2, 2016 – December 6, 2019
December 6, 2019 – December 2, 2022

CPSO Committees and Other CPSO Work:

Finance and Audit Committee:	2018 – Present, Vice Chair, 2020 - Present
Inquiries, Complaints and Reports Committee:	2015 – Present Specialty Panel Chair, Obstetrics, 2019 - Present
Policy Working Groups: *Medical Records*	2018 - Present
Executive Committee	2020 - Present

STATEMENT:

Thank you for considering my candidacy for the Executive Committee. I have served on the Executive Committee over the last year and have been a member of Council since 2016.

My involvement in the CPSO began on the Inquiry, Complaints and Reports Committee. I have 6 years of experience on the complaints/investigation side of the college, including 2 years as Specialty Panel Chair for Obstetrics/Gynecology. I have gained a much broader understanding of the college and its many functions while serving on the Finance Committee (Vice Chair over the last year) and the Executive Committee.

The next year will be an exciting time. Governance reform will be prominent as the government proposes consultation on modernization including opening/changing the *RHPA.* The development of the framework for regulation of PAs will progress rapidly. As well, operationalization of the OPSDT, including the new CPSO adjudicators, will occur. The expanded platform of the enterprise system will touch all areas of the college. Finally, re-evaluation of models of work and infrastructure requirements will be necessary.

I believe that my experience on Executive, Council, Finance and Audit and the ICR Committees has positioned me well to contribute to the Executive Committee.

NOMINATION STATEMENT
CANDIDATE FOR 2021 - 2022 EXECUTIVE COMMITTEE
EXECUTIVE MEMBER REPRESENTATIVE

MR. PETER PIELSTICKER, CA, CPA

Public Member of Council
Tehkummah, Ontario

Occupation: Financial Consulting

Appointed Council Terms:
March 18, 2015 – March 17, 2018
March 18, 2018 – December 31, 2018
January 1, 2019 – June 30, 2019
July 1, 2019 – June 30, 2022

CPSO Committees and Other CPSO Work:

Discipline Committee:	2015 - 2022
Executive Committee:	2019 - 2021
Finance and Audit Committee:	Chair: 2017 - 2020, Member: 2015 - 2017 and 2021 - 2022
Staff Pension Committee:	2017 - 2020
Premises Inspection Committee:	2015 - 2022
Quality Assurance Committee:	2015 - 2022
Policy Working Group:	2020 - 2022

STATEMENT:

Since I was appointed to the CPSO council in 2015 I have been very active on a variety of committees. This has provided me with insight into CPSO operations and assisted me greatly in my decision making on the executive committee.

My background as a professional accountant brings a unique perspective to my CPSO role. Prior to retirement, I had experience in executive management and C suite conditions with sizeable organizations.

COVID19 has changed how we do business. Under the direction of the President and CEO/Registrar this organization has accomplished an enviable reputation in the regulatory milieu and as an executive committee member I would like to continue assisting in the progress and development of this new world environment. My compliments to the President and CEO/Registrar for their outstanding performance this past year.

I have been part of the executive committee for the past 3 years and am honoured to have assisted us through the many changes with the new strategic plan and right touch approach to doing regulatory business. Enhancement to governance and council structure will be a vital part of the coming year activity and my professional business experience can contribute greatly to effective decision making.

The past 6 years on Council and committees has afforded me an in-depth understanding of the medical profession and the issues facing physicians in the future. I am excited about the future and ask for your support in the upcoming election.

NOMINATION STATEMENT
CANDIDATE FOR 2021 - 2022 EXECUTIVE COMMITTEE
EXECUTIVE MEMBER REPRESENTATIVE

Dr. IAN PREYRA

District 4 Representative
Burlington, ON

Principal Area of Practice: Emergency Medicine

Appointed Council Terms:
2019 – 2022

CPSO Committees and Other CPSO Work:

Governance Committee:	2020 - Present
Discipline Committee:	2020 - Present
Fitness to Practise Committee:	2020 - Present

STATEMENT:

The privilege of self-governance afforded to physicians in Ontario carries with it a commitment to the public to effectively regulate the province`s doctors in a transparent, accountable manner. It also requires that the CPSO communicate with our members and with the public as we fulfill our regulatory responsibilities, and pursue our Mission with compassion and sensitivity.

The CPSO's commitment to renewing our governance structures in the face of evolving government policy offers an unprecedented opportunity to redefine the RHPA framework within which we deliver on our promise of Trusted Doctors Providing Great Care.

I bring to the Executive Committee deep experience in corporate governance, having served on both public and private boards. I am a member of the Institute of Corporate Directors, and I am certified as a Chartered Director. I received my MBA from the Schulich School of Business, with a focus on finance and organizational behaviour.

In my current roles, I am Chief of Staff at Joseph Brant Hospital, a Coroner and team emergency physician for the Toronto Maple Leafs.

If elected, I will serve with integrity, thoughtfulness and industry, and advance our Mission as part of an Executive committee that supports Council in effectively serving the public and the profession.

Council Motion

Motion Title	Executive Committee Election
Date of Meeting	September 13, 2021

It is moved by_____, and seconded by_____, that:

The Council appoints _____ (as President),

_____ (as Vice President),

_____ (as Executive Member Representative),

_____ (as Executive Member Representative),

_____ (as Executive Member Representative),

And Dr. Judith Plante (as Past President), to the Executive Committee for the year that commences with the adjournment of the Annual General Meeting of Council in December 2021.

Council Briefing Note

September 2021

Topic:	Request 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 Contacts:	Dr. Brenda Copps, Chair, Governance Committee Suzanne Mascarenhas, Governance Analyst Laura Rinke-Vanderwoude, Jr. Governance Analyst
Attachment:	Appendix A: Request for Exceptional Circumstances

Issue

- The Executive Committee reviewed and approved a request for application of the Exceptional Circumstances provision (General By-law subsection 37(8)), as recommended by the Governance Committee, and is forwarding the recommendation to Council for approval.

Background

- At its meeting in June, Council approved five requests for application of the Exceptional Circumstances by-law provision to enable the extension of the terms of five Committee members for another year, ending December 2022, who would otherwise exceed the term limits in the General By-law.

- The Governance Committee continues to encourage Committees to revisit succession plans in order to have the right mix of members on a Committee, whose skills together, could effectively discharge the responsibilities of the Committee.

- The Exceptional Circumstances provision in the General By-Law ensures that Committees are not destabilized by member turnover and allows a member's appointment to exceed applicable term limits for reasons that include but are not limited to:

- a member is very experienced compared to other Committee member and is critical to maintaining stability and promoting effective functioning of the Committee;
- a member's expertise is providing difficult to replace; and
- a member requires leave for a sudden illness or very unexpected personal reasons.

Current Status and Analysis

- The Chair and Vice-Chair of the Inquiries, Complaints & Reports Committee (ICRC) have issued a second request for application of the exceptional circumstances provision pertaining to Dr. Jerry Rosenblum.
  - Although Dr. Rosenblum was approved by the Governance Committee to transition off ICRC in December 2021, the Chair and Vice-Chair of ICRC have determined that his continued service is necessary (Appendix A) and so have put forward a subsequent request.

Committee Member	Years on Committee	Reason for Extension
Dr. Jerry Rosenblum *(Anesthesiologist)*	11	○ Second request. ○ Provides overall continued chair experience for Surgical and General panels and mentorship to newer Surgical Panel candidates. ○ Extension will also allow for the ability to maintain frequent functioning panels so not to delay timelines. ○ Specific anesthesiology sub-specialty is also necessary for panels for conflicts since there is only one newer Anesthesiologist (Dr. Wayne Nates) that was just onboarded this year.

Decision for Council

1. Does Council approve the request to apply the Exceptional Circumstances by-law provision with respect to Dr. Jerry Rosenblum?

Exceptional Circumstances Request Form

Name of Committee	Inquiries Complaints and Reports Committee		
Committee Member	**Dr. Jerry Rosenblum**		
# of Years on Committee	End of 2021 = 11 years	**Total Years of Service**	11 years
Number of submissions for Committee Member/Year Requested	Second submission for a one-year extension until December 2022. Date: June 11, 2021	**The Governance Committee will approve requests for one year at a time**	
Committee Member's Specific Knowledge, Skills or Experience	- Surgical (Anesthesiology) - Chairs Panels (Surgical, General, Teleconference, Prescribing and Hybrids) - Mentors new Surgical Panel Members - Assigned to 15 panels in 2020 - Assigned to 24 panels up to end of Sept 2021. He has chaired 5 of these and was the assigned mentor for a new Surgical Anesthesiologist on 6 of these panel meetings. Dr. Rosenblum is an anesthesiologist with 10+ years of experience on the committee. He also possesses strong chair, leadership, mentorship and decision writing skills. It is a requirement to have this knowledge and expertise on the ICR committee in order to chair, mentor and manage serious or complex matters that are streamed to either the surgical or general panels. You will note that Dr. Rosenblum is currently scheduled for 24 panel assignments to date this year, 2021. With the loss of several seasoned member due to term limits, the remaining members do not yet possess the necessary Chair or mentoring skills that are required. Dr. Rosenblum's skillset along with his flexible availability has allowed committee support to maintain our current scheduling of the necessary surgical and general panels to accommodate our caseloads. Furthermore, Dr. Rosenblum's specific anesthesiology sub-specialty is also necessary for panels for conflicts since we have only one other newer anesthesiologist that was just onboarded this year. Dr. Rosenblum has been mentoring this year's new surgical candidate and even attended and assisted for 6 such meetings as noted above. It would be ideal if his terms were extended to allow him to mentor new surgical candidate recruits for next year.		

Approaches used to find a suitable replacement for this Committee member	The governance team is actively recruiting for a couple more surgeons. This recruitment may not occur until later this year and the successful candidates will require appropriate mentor assignment. Dr. Rosenblum as mentioned, would be able to assist with this. Currently, ICRC holds 24 Surgical panels, 36 General Panels and 48 Hybrid panels and various other types of meetings. In 2022, the committee will be down to 8 Surgeons to rotate on this same number of panels compared to the current 11 Surgeons we currently have now. With the recruitment of 2 new surgeons outstanding and if we extend Dr. Rosenblum's term, this will keep our numbers at the usual 11 Surgeons. Furthermore, 3/8 (37%) of our current surgical members just started this year and have less than 1 year of experience while 4/8 (50%) have 3 years of experience and only 1/8 (13%) has 4 years of ICRC experience. This shortage of experienced surgeons to participate can have an impact on decision making. Also, Dr. Rosenblum as mentioned has chair experience which is an asset that lends to us being able to continue with the current frequency of ICRC panel meetings. Frequency of panels is required so that matters can be considered and deliberated once the investigation is complete. Having a larger pool of members allows for frequent panels which then lends to faster decision release times.
Requested Length of Extension	The ICRC is requesting that Dr. Rosenblum be extended another year into 2022 in order to provide overall continued chair experience for Surgical and General panels and mentorship to newer Surgical Panel candidates. This extension will also allow for the ability to maintain frequent functioning panels so not to delay timelines.
Description of Recruitment Strategy and/or Succession Plan	2022 Plan: Dr. Rosenblum, with his experience can assist newer members with mentorship and provide guidance when they are assigned to the same panels. He will specifically be able to assist to mentor the new surgical candidates that are recruited. He can also assist as a chair for panels. He will specifically be able to cover conflicts for anesthesiology cases if the other anesthesiologist on committee is conflicted. Dr. Rosenblum is very experienced compared to other Committee members given his understanding of legal processes, College policies and the governing legislation which is critical to maintaining stability and promoting effective functioning of the Committee as it relates to chairing panels, approving decisions and mentoring.

Council Motion

Motion Title	Request for Exceptional Circumstances
Date of Meeting	September 13, 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 to Dr. Jerry Rosenblum for an additional one-year term on the Inquiries, Complaints & Reports Committee, when the term of his current appointment expires at close of the 2021 Annual General Meeting.

Council Briefing Note

September 2021

Topic:	New Committee Appointment Nominations and Reappointments for 2022 Committees
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation System Collaboration
Public Interest Rationale:	Ensures qualified and competent Committee members are appointed to maintain the quality of governance at the College.
Main Contacts:	Dr. Brenda Copps, Chair, Governance Committee Laura Rinke-Vanderwoude, Jr. Governance Analyst Suzanne Mascarenhas, Governance Analyst
Attachments:	Appendix A: Committee 2022 Full Membership List for: • Ontario Physicians and Surgeons Discipline Tribunal (OPSDT) • Fitness to Practise Committee • Finance and Audit Committee • Inquiries, Complaints and Reports Committee (ICRC) • Patient Relations Committee • Premises Inspection Committee • Quality Assurance Committee • Registration Committee

Issue

- The Governance and Executive Committees are making recommendations for Committee reappointments and appointments and terms for existing and new Committee members. Specifically, Council is asked to perform two tasks regarding these vacancies:

    - Consider approving recommendations for reappointment for Council and non-Council Committee members whose terms are expiring, where appropriate, with such appointments taking effect at the Annual General Meeting of Council in December 2021; and,

    - Consider approving recommendations for new appointments for newly recruited non-Council physician members, with such appointments taking effect at the Annual General Meeting of Council in December 2021.

Background

- The Governance Committee is responsible for recruiting Committee members and for making nomination recommendations for Committee positions. These recommendations are in line with Committee and Council term limits, except where Exceptional Circumstances have been granted by Council.

- Most appointments are for three years. However, the General By-Law provides flexibility for appointing Committee members for less than three years where appropriate.

Current Status

- Several members across Committees have appointment terms expiring in December 2021. These individuals require reappointment to continue serving on Committees. These individuals are laid out in *Part 1: Reappointments* below.

- To fill a number of vacancies across various Committees, a recruitment process was undertaken to identify new non-Council Committee members. Recruitment interviews have been completed with feedback from the Chair of the Governance Committee, current Committee Chairs and Vice-Chairs, and other support staff.

    - As a result of these interviews, a total of 15 non-Council physicians were recruited to fill vacancies on the Quality Assurance Committee (QAC), Inquiries, Complaints, and Reports Committee (ICRC), and the Premises Inspection Committee (PIC). These individuals are laid out in *Part 2: Non-Council New Appointments*

- Four vacancies are outstanding, for which staff will continue recruitment efforts. ICRC has a vacancy for a psychiatrist. PIC has two vacancies for plastic surgeons. QAC has one outstanding vacancy for a family physician.

- The Governance Committee's nominations as approved by the Executive Committee for reappointments and new appointments for Council's consideration are summarized for each Committee in tables organized by Committee. In addition, a complete proposed membership list for each Committee is attached in Appendix A.

Part 1: Reappointments

- Some Council and non-Council Committee members require a reappointment to continue serving on Committees. These individuals are as follows:

Discipline Tribunal and Fitness to Practise Committee

- The Chair of the Discipline Tribunal and the Fitness to Practise Committee, Mr. David Wright, recommends cross-appointments for all members of these Committees. As such, the suggested appointments are the same for both.

- At June 2021 Council meeting, Mr. Pierre Giroux was approved for application of the Exceptional Circumstances by-law to extend his term on these Committees for one year. He will need to be reappointed by Council for the 2021-2022 Committee year.

Name of Member	Type	Committee Term
Mr. Jose Cordeiro	Public Member	3 years
Mr. Paul Malette	Public Member	3 years
Mr. Rob Payne	Public Member	3 years
Ms. Linda Robbins	Public Member	3 years
Ms. Shannon Weber	Public Member	3 years
Mr. Pierre Giroux	Public Member	1 year (Exceptional circumstances)

Finance and Audit Committee

- The Vice President elected during the Executive Committee elections for 2022 is expected to participate as a member of the Finance and Audit Committee, as is the usual convention.

Name of Member	Type	Committee Term
Mr. Rob Payne	Public Member	3 years

ICRC

- Mr. Sherman's public member appointment expires in January 2022. In Fall 2021, the Governance Committee will be asked whether they wish to provide a letter of endorsement for Mr. Sherman's reappointment.

- In addition, a request for use of the Exceptional Circumstances by-law for Dr. Jerry Rosenblum to extend his term for one additional year will be taken to Council in September upon approval by the Executive Committee (to be discussed as part of the Governance Committee Report). He will need to be reappointed by Council for the 2021-2022 Committee year.

Name of Member	Type	Committee Term
Mr. Murthy Ghandikota	Public Member	3 years
Mr. Fred Sherman	Public Member	3 years
Dr. Jerry Rosenblum	Physician Member	1 year (Exceptional Circumstances)

Patient Relations Committee

- No reappointments are required.

Premises Inspection Committee

- At the June meeting of Council, Dr. Gillian Oliver was approved for application of the Exceptional Circumstances by-law to extend her term on PIC for one year. She will need reappointment by Council for the 2021-2022 Committee year. No additional appointments are required.

Name of Member	Type	Committee Term
Dr. Gillian Oliver	Physician Member	1 year (Exceptional Circumstances)

Quality Assurance Committee

- At the June meeting of Council, Dr. Patrick Safieh was approved for application of the Exceptional Circumstances by-law to extend his term on the Quality Assurance Committee for one year. He will also need reappointment by Council for the 2021-2022 Committee year.

Name of Member	Type	Committee Term
Dr. Camille Lemieux	Physician Member	3 years
Dr. Sarah Reid	Physician Member	3 years
Mr. Paul Malette	Public Member	3 years
Mr. Peter Pielsticker	Public Member	3 years
Dr. Jacques Dostaler	Physician Member	3 years
Dr. Ken Lee	Physician Member	3 years
Dr. Ashraf Sefin	Physician Member	3 years
Dr. Robert Smith	Physician Member	3 years
Dr. Tina Tao	Physician Member	3 years
Dr. Patrick Safieh	Physician Member	1 year (Exceptional Circumstances)

Registration Committee

- At the June meeting of Council, Dr. Bob Byrick and Dr. Barbara Lent were approved for application of the Exceptional Circumstances by-law to extend their term on the Registration Committee for one year. They will also need reappointment by Council for the 2021-2022 Committee year.

Name of Member	Type	Committee Term
Mr. Paul Malette	Public Member	3 years
Dr. Judith Plante	Physician Member	3 years
Dr. Bob Byrick	Physician Member	1 year (Exceptional Circumstances)
Dr. Barbara Lent	Physician Member	1 year (Exceptional Circumstances)

Part 2: Non-Council New Appointments

- At the time of submission, recommendations had not been made for a late-August public member appointed to Council. Once recommendations are made for this individual, they shall be sent to Council for review.

- The following individuals were recruited this spring for Committee vacancies and require Governance Committee recommendation to Council for appointment. These are the suggested Committee appointments:

Discipline Tribunal and Fitness to Practise Committee

- At the June 2021 Council meeting, several adjudicators were appointed to the Discipline Tribunal and Fitness to Practise Committee. Further non-Council member appointments are not required.

Finance and Audit Committee

- No new appointments have been suggested at this time. Prior to the December Council meeting, additional appointment nominations for the Finance and Audit Committee may be made to adhere to the composition requirements laid out in its Terms of Reference.

ICRC

- One recruitment vacancy remains on ICRC. This leaves a position for a Toronto-based psychiatrist, and future recruitments will focus on finding a suitable candidate for this position.

Name of Recommended Candidate	Vacancy/ Specialty	ICRC Panel	Committee Term	Chairs Who Recommended
Dr. Andrew Stratford	General Surgery	Surgical	3 years	Hamilton, A / Duncan, M
Dr. Olufemi Ajani	Neurosurgery	Surgical	3 years	Hamilton, A / Duncan, M
Dr. Prema Samy	Otolaryngology	Surgical	3 years	Hamilton, A / Duncan, M
Dr. Jude Obomighie	Family Medicine	Family Medicine	3 years	T. Faulds / V. Rachlis
Dr. Amie Cullimore	OBS GYN	Obstetrical	3 years	R. Gratton / E. Herer
Dr. Samantha Kelleher	Psychiatry	Mental Health	3 years	L. Wiesenfeld

Patient Relations Committee

- No new appointments required.

Premises Inspection Committee

- Two vacancies remain on PIC. This leaves vacancies for two Plastic Surgeons, for which recruitment efforts will be made to secure suitable candidates.

- Of note, PIC has requested Dr. Catherine Smyth begin her term immediately. Her term is proposed to run until the end of the Annual General Meeting in 2023.

Name of Recommended Candidate	Vacancy/Specialty	Committee Term	Chairs Who Recommended
Dr. Colin McCartney	Anesthesiology	3 years	G. Oliver / J. Watson
Dr. Catherine Smyth*	Anesthesiology	2+ years (immediate appointment)	G. Oliver / J. Watson
Dr. Suraj Sharma	Gastroenterology	3 years	G. Oliver / J. Watson
Dr. Edsel Ing	Ophthalmology	3 years	G. Oliver / J. Watson
Dr. Wusun Paek	OBS/GYN	3 years	G. Oliver / J. Watson
Dr. Winnie Leung	General Surgery	3 years	G. Oliver / J. Watson
Dr. Haemi Lee	Plastic Surgery	3 years	G. Oliver / J. Watson

Quality Assurance Committee

- One outstanding vacancy remains on the Quality Assurance Committee as the result of a conflict of interest. Additional recruiting will be undertaken to fill that vacancy.

Name of Recommended Candidate	Vacancy/Specialty	Committee Term	Chairs Who Recommended
Dr. Charles Knapp	Anesthesiology	3 years	J. van Vlymen / S. Reid

Registration Committee

- No new appointments required.

Decision for Council

1. Does Council recommend the appointment and reappointment of nominated Committee members to Committees as set out above?

Appendix A: All Committees 2021-2022 Full Membership

(including reappointments and new appointments, excluding Executive and Governance Committees)

Ontario Physicians and Surgeons Discipline Tribunal and Fitness to Practise Committee

Name	Type	Committee Start Date	Appointment End Date	Current Chair Role	Notes
Dr. Glen Bandiera	Physician Council Member	2020-12-04	2023/12/XX		
Dr. Deborah Hellyer	Physician Council Member	2016-12-02	2023/12/XX		
Dr. Paul Hendry	Voting Academic Council Rep	2017-12-01	2023/12/XX		
Dr. Roy Kirkpatrick	Voting Academic Council Rep	2020-12-04	2023/12/XX		
Dr. Ian Preyra	Physician Council Member	2019-12-06	2023/12/XX		
Dr. Deborah Robertson	Physician Council Member	2020-12-04	2023/12/XX		
Dr. Andrew Turner	Physician Council Member	2015-12-04	2023/12/XX		
Mr. Jose Cordeiro	Public Council Member	2020-03-06	2024/12/XX		
Mr. Pierre Giroux	Public Council Member	2013-01-22	2022/12/XX		
Mr. Paul Malette	Public Council Member	2018-01-18	2024/12/XX		
Mr. Rob Payne	Public Council Member	2020-12-04	2024/12/XX		
Mr. Peter Pielsticker	Public Council Member	2015-04-29	2022/12/XX		
Ms. Linda Robbins	Public Council Member	2020-03-06	2024/12/XX		
Ms. Shannon Weber	Public Council Member	2020-12-04	2024/12/XX		
Dr. Ida Ackerman	Non-Council Member	2017-12-01	2023/12/XX		
Dr. Heather-Ann Badalato	Non-Council Member	2019-12-06	2022/12/XX		
Dr. Philip Berger	Non-Council Member	2017-12-01	2023/12/XX		
Dr. Catherine Grenier	Non-Council Member	2021-06-08	2023/12/XX		
Dr. Kristen Hallett	Non-Council Member	2017-12-01	2023/12/XX		
Dr. Stephen Hucker	Non-Council Member	2018-12-07	2023/12/XX		
Dr. Allan Kaplan	Non-Council Member	2019-12-05	2022/12/XX		
Dr. Veronica Mohr	Non-Council Member	2016-12-02	2023/12/XX		
Dr. Joanne Nicholson	Non-Council Member	2017-12-01	2023/12/XX		
Dr. Peeter Poldre	Non-Council Member	2012-12-04*	2022/12/XX		minus one Presidential year
Dr. James Watters	Non-Council Member	2015-12-04	2023/12/XX	Vice Chair	
Mr. David Wright	Non-Council Public Member	2020-12-04	2023/12/XX	Chair	
Dr. Susanna Yanivker	Non-Council Member	2018-12-07	2023/12/XX		
Mr. Raj Anand	Non-Council Public Member	2021-06-18	2023/12/XX		
Ms. Shayne Kert	Non-Council Public Member	2021-06-18	2023/12/XX		
Ms. Sherry Liang	Non-Council Public Member	2021-06-18	2023/12/XX		
Ms. Sophie Martel	Non-Council Public Member	2021-06-18	2023/12/XX		
Ms. Jennifer Scott	Non-Council Public Member	2021-06-18	2023/12/XX		

Inquiries, Complaints and Reports Committee

Name	Type	Committee Start Date	Appointment End Date	Current Chair Role	Notes
Dr. Rob Gratton	Physician Council Member	2015-12-04	2023/12/XX	SP Chair, Obstetrical	
Dr. Brenda Copps	Physician Council Member	2018/12/07*	2023/12/XX		Minus one presidential year
Dr. Kashif Pirzada	Physician Council Member	2020-12-04	2023/12/XX		
Dr. Jerry Rosenblum	Physician Council Member	2010-12-10	2022/12/XX		
Dr. Anne Walsh	Physician Council Member	2018-04-24	2023/12/XX		
Mr. Shahid Chaudhry	Public Council Member	2019-05-24	2023/12/XX		
Ms. Joan Fisk	Public Council Member	2017-12-01	2023/12/XX	SP Chair, General	
Mr. Murthy Ghandikota	Public Council Member	2020-04-28	2024/12/XX		
Dr. Lydia Miljan, PhD	Public Council Member	2020-03-06	2022/12/XX	SP Vice Chair, General	
Mr. Fred Sherman	Public Council Member	2021-02-16	2024/12/XX		
Dr. Trevor Bardell	Non-Council Member	2019-12-06	2022/12/XX		
Dr. Mary Bell	Non-Voting Academic Council Rep	2016-02-26	2023/12/XX	SP Vice Chair, Internal Medicine	
Dr. George Beiko	Non-Council Member	2018-12-07	2023/12/XX		
Dr. Thomas Bertoia	Non-Council Member	2020-02-04	2022/12/XX		
Dr. Brian Burke	Non-Council Member	2014-12-05	2023/12/XX	ICRC Chair & SP Chair, Settlement	
Dr. Paul Cleiman	Non-Council Member	2019-12-06	2022/12/XX		
Dr. Mary Jean Duncan	Non-Council Member	2018-12-07	2023/12/XX	SP Vice Chair, Surgical	
Dr. Gil Faclier	Non-Council Member	2018-04-24	2023/12/XX		
Dr. Thomas Faulds	Non-Council Member	2017-12-01	2023/12/XX	ICRC Vice Chair, SP Chair, Family Practise	
Dr. Daniel Greben	Non-Council Member	2017-12-01	2023/12/XX	SP Vice Chair, Mental Health & HIP	
Dr. Andrew Hamilton	Non-Council Member	2016-12-01	2023/12/XX	SP Chair, Surgical	
Dr. Elaine Herer	Non-Council Member	2015-12-04	2023/12/XX	SP Vice Chair, Obstetrical	
Dr. Christopher Hillis	Non-Council Member	2020-12-04	2023/12/XX		
Dr. John Jeffrey	Non-Council Member	2015-12-04	2023/12/XX		
Dr. Asif Kazmi	Non-Council Member	2020-12-04	2023/12/XX		
Dr. Lara Kent	Non-Council Member	2020-02-04	2022/12/XX		
Dr. Jane Lougheed	Non-Council Member	2019-04-23	2023/12/XX		
Dr. Haidar Mahmoud	Non-Council Member	2014-12-05	2023/12/XX		
Dr. Robert Myers	Non-Council Member	2018-12-07	2023/12/XX		
Dr. Wayne Nates	Non-Council Member	2020-12-04	2023/12/XX		
Dr. Anita Rachlis	Non-Council Member	2016-01-26	2023/12/XX	SP Chair, Internal Medicine	
Dr. Val Rachlis	Non-Council Member	2018-04-24	2023/12/XX	SP Vice Chair, Family Practise	
Dr. Michael Rogelstad	Non-Council Member	2018-12-07	2023/12/XX		
Dr. Karen Saperson	Non-Voting Academic Council Rep	2019-12-06	2022/12/XX		
Dr. Dori Seccareccia	Non-Council Member	2018-04-24	2023/12/XX	SP Vice Chair, Settlement	
Dr. David Tam	Non-Council Member	2020-12-04	2023/12/XX		
Dr. Brian Watada	Non-Council Member	2020-02-04	2022/12/XX		

Name	Type	Committee Start Date	Appointment End Date	Current Chair Role	Notes
Dr. Lesley Wiesenfeld	Non-Council Member	2014-12-05	2023/12/XX	SP Chair, Mental Health & HIP	
Dr. Samantha Kelleher	Non-Council Member	2021-12-10	2024/12/XX		
Dr. Amie Cullimore	Non-Council Member	2021-12-10	2024/12/XX		
Dr. Jude Obomighie	Non-Council Member	2021-12-10	2024/12/XX		
Dr. Andrew Stratford	Non-Council Member	2021-12-10	2024/12/XX		
Dr. Olufemi Ajani	Non-Council Member	2021-12-10	2024/12/XX		
Dr. Prema Samy	Non-Council Member	2021-12-10	2024/12/XX		

Premises Inspection Committee

Name	Type	Committee Start Date	Appointment End Date	Current Chair Role
Dr. Kashif Pirzada	Physician Council Member	2020-12-04	2023/12/XX	
Dr. Jerry Rosenblum	Physician Council Member	2017-12-01	2023/12/XX	
Dr. Andrew Turner	Physician Council Member	2015-12-04	2023/12/XX	
Mr. Peter Pielsticker	Public Council Member	2015-12-04	2022/12/XX	
Dr. Timea Belej-Rak	Non-Council Member	2019-12-06	2022/12/XX	
Dr. Andrew Browning	Non-Council Member	2018-06-19	2023/12/XX	
Dr. Patrick Davison	Non-Council Member	2019-05-24	2023/12/XX	
Dr. Marjorie Dixon	Non-Council Member	2016-12-02	2023/12/XX	
Dr. William (Bill) Dixon	Non-Council Member	2015-03-15	2023/12/XX	
Dr. Mark Mensour	Non-Council Member	2018-04-24	2023/12/XX	
Dr. Gillian Oliver	Non-Council Member	2013-04-18	2022/12/XX	Chair
Dr. Holli-Ellen Schlosser	Non-Council Member	2019-05-24	2023/12/XX	
Dr. Robert Smyth	Non-Council Member	2019-12-06	2022/12/XX	
Dr. James Watson	Non-Council Member	2013-12-06	2022/12/XX	Vice Chair
Dr. Ted Xenodemetropoulos	Non-Council Member	2019-06-19	2023/12/XX	
Dr. Colin McCartney	Non-Council Member	2021-12-10	2024/12/XX	
Dr. Catherine Smyth	Non-Council Member	2021-09-13	2023/12/XX	
Dr. Suraj Sharma	Non-Council Member	2021-12-10	2024/12/XX	
Dr. Edsel Ing	Non-Council Member	2021-12-10	2024/12/XX	
Dr. Wusun Paek	Non-Council Member	2021-12-10	2024/12/XX	
Dr. Winnie Leung	Non-Council Member	2021-12-10	2024/12/XX	
Dr. Haemi Lee	Non-Council Member	2021-12-10	2024/12/XX	

Quality Assurance Committee

Name	Type	Committee Start Date	Appointment End Date	Current Chair Role
Dr. Camille Lemieux	Physician Council Member	2020-12-04	2024/12/XX	
Dr. Sarah Reid	Physician Council Member	2019-12-06	2024/12/XX	Chair
Dr. Patrick Safieh	Physician Council Member	2008-02-08	2022/12/XX	
Mr. Paul Malette	Public Council Member	2019-12-06	2024/12/XX	
Mr. Peter Pielsticker	Public Council Member	2015-04-29	2024/12/XX	
Dr. Jacques Dostaler	Non-Council Member	2016-12-02	2024/12/XX	
Dr. Ken Lee	Non-Council Member	2019-01-15	2024/12/XX	
Dr. Ashraf Sefin	Non-Council Member	2018-12-07	2024/12/XX	Vice Chair
Dr. Robert Smith	Non-Council Member	2015-12-04	2024/12/XX	
Dr. Tina Tao	Non-Council Member	2016-07-26	2024/12/XX	
Dr. Charles Knapp	Non-Council Member	2020-12-10	2024/12/XX	

Registration Committee

Name	Type	Committee Start Date	Appointment End Date	Current Chair Role
Mr. Shahid Chaudhry	Public Council Member	2020-12-04	2023/12/XX	
Mr. Pierre Giroux	Public Council Member	2018-12-07	2022/12/XX	
Mr. Paul Malette	Public Council Member	2019-12-06	2024/12/XX	
Dr. Bob Byrick	Non-Council Member	2006-11-24	2022/12/XX	
Dr. Barbara Lent	Non-Council Member	2011-11-29	2022/12/XX	
Dr. Lynn Mikula	Non-Council Member	2020-12-04	2023/12/XX	
Dr. Damien Redfearn	Non-Council Member	2020-12-04	2023/12/XX	
Dr. Kim Turner	Non-Council Member	2018-12-07	2023/12/XX	Vice Chair
Dr. Judith Plante	Physician Council Member	2021-12-10	2024/12/XX	Chair

Finance and Audit Committee

Name	Type	Committee Start Date	Appointment End Date	Current Chair Role
Dr. Rob Gratton	Physician Council Member	2020-12-04	2023/12/XX	Vice Chair
Dr. Janet van Vlymen	Physician Council Member	2020-12-04	2022/12/XX	
Mr. Rob Payne	Public Council Member	2020-12-04	2024/12/XX	
Mr. Peter Pielsticker	Public Council Member	2020-12-04	2022/12/XX	
Dr. Thomas Bertoia	Non-Council Member	2020-12-04	2023/12/XX	Chair
New Vice President		2021-12-10	2023/12/XX	

Patient Relations Committee

Name	Type	Committee Start Date	Appointment End Date	Current Chair Role
Ms. Nadia Bello	Non-Council Public Member	2020-12-04	2023/12/XX	
Ms. Sharon Rogers	Non-Council Public Member	2019-12-06	2022/12/XX	Chair
Dr. Rajiv Bhatia	Non-Council Member	2020-12-04	2023/12/XX	
Dr. Heather Sylvester	Non-Council Member	2020-12-04	2023/12/XX	
Dr. Angela Wang	Non-Council Member	2020-12-04	2023/12/XX	
Dr. Diane Whitney	Non-Council Member	2019-12-06	2022/12/XX	

Council Motion

Motion Title	Committee Nominations 2021-2022
Date of Meeting	September 13, 2021

It is moved by_____, and seconded by_____, that:

1. The Council appoints Dr. Catherine Smyth to the Premises Inspection Committee, effective immediately, with the term expiring at the close of the Annual General Meeting of Council in December 2023; and,

2. The Council appoints the following individuals to the following Committees for the terms indicated below as of the close of the Annual General Meeting of Council in December 2021:

Ontario Physicians and Surgeons Discipline Tribunal:

Name of Member	Type	Committee Term
Mr. Jose Cordeiro	Public Member	3 years
Mr. Paul Malette	Public Member	3 years
Mr. Rob Payne	Public Member	3 years
Ms. Linda Robbins	Public Member	3 years
Ms. Shannon Weber	Public Member	3 years
Mr. Pierre Giroux	Public Member	1 year

Fitness to Practise Committee:

Name of Member	Type	Committee Term
Mr. Jose Cordeiro	Public Member	3 years
Mr. Paul Malette	Public Member	3 years
Mr. Rob Payne	Public Member	3 years
Ms. Linda Robbins	Public Member	3 years
Ms. Shannon Weber	Public Member	3 years
Mr. Pierre Giroux	Public Member	1 year

Finance and Audit Committee:

Name of Member	Type	Committee Term
Mr. Rob Payne	Public Member	3 years

Inquiries, Complaints and Reports Committee:

Name of Member	Type	Committee Term
Mr. Murthy Ghandikota	Public Member	3 years
Mr. Fred Sherman	Public Member	3 years
Dr. Jerry Rosenblum	Physician Member	1 year
Dr. Andrew Stratford	Non-Council Physician Member	3 years
Dr. Olufemi Ajani	Non-Council Physician Member	3 years
Dr. Prema Samy	Non-Council Physician Member	3 years
Dr. Jude Obomighie	Non-Council Physician Member	3 years
Dr. Amie Cullimore	Non-Council Physician Member	3 years
Dr. Samantha Kelleher	Non-Council Physician Member	3 years

Premises Inspection Committee:

Name of Member		Committee Term
Dr. Gillian Oliver	Non-Council Physician Member	1 year
Dr. Colin McCartney	Non-Council Physician Member	3 years
Dr. Suraj Sharma	Non-Council Physician Member	3 years
Dr. Edsel Ing	Non-Council Physician Member	3 years
Dr. Wusun Paek	Non-Council Physician Member	3 years

Dr. Winnie Leung	Non-Council Physician Member	3 years
Dr. Haemi Lee	Non-Council Physician Member	3 years

Quality Assurance Committee:

Name of Member	Type	Committee Term
Dr. Camille Lemieux	Physician Member	3 years
Dr. Sarah Reid	Physician Member	3 years
Mr. Paul Malette	Public Member	3 years
Mr. Peter Pielsticker	Public Member	3 years
Dr. Jacques Dostaler	Non-Council Physician Member	3 years
Dr. Ken Lee	Non-Council Physician Member	3 years
Dr. Ashraf Sefin	Non-Council Physician Member	3 years
Dr. Robert Smith	Non-Council Physician Member	3 years
Dr. Tina Tao	Non-Council Physician Member	3 years
Dr. Patrick Safieh	Physician Member	1 year
Dr. Charles Knapp	Non-Council Physician Member	3 years

Registration Committee:

Name of Member	Type	Committee Term
Mr. Paul Malette	Public Member	3 years
Dr. Judith Plante	Physician Member	3 years
Dr. Bob Byrick	Non-Council Physician Member	1 year
Dr. Barbara Lent	Non-Council Physician Member	1 year

Council Briefing Note

September 2021

Topic:	Committee Chair and Vice-Chair Nominations
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation System Collaboration
Public Interest Rationale:	Ensures qualified and competent committee Chairs are appointed to maintain the quality of governance at the College.
Main Contacts:	Dr. Brenda Copps, Chair, Governance Committee Laura Rinke-Vanderwoude, Jr. Governance Analyst Suzanne Mascarenhas, Governance Analyst
Attachments:	Appendix A: Full List of Chairs and Vice-Chairs (Including Nominations) Appendix B: Chair and Vice-Chair Role Descriptions

Issue

- The proposed 2022 roster of Chair and Vice-Chair nominations is before Council to make appointments that commence following the December Annual General Meeting.

Background

- To facilitate a smooth appointment process, Committee Chairs and Vice-Chairs appointments are being determined together at the September Council meeting. These appointments will take effect following the December Annual General Meeting. Chair and Vice-Chair recommendations are made by the Governance Committee, but require Council approval.

- Chair and Vice-Chair appointments are for a period of one to two years. Descriptions of the Chair and Vice-Chair roles are available in Appendix B.

- Chairs and Vice-Chairs undergo semi-annual training sessions, typically in March and November.

Current Status

- Several Chair and Vice-Chair roles require a new or renewed appointment. Senior Committee Support staff and current Chairs made recommendations for appointments. A full list of Chairs and Vice-Chairs is available in Appendix A; below is a list of new nominations for appointment or reappointment:

Fitness to Practise (FTP)

- Chair appointment: **Mr. David Wright** is standing for nomination for a **two year term**. He is also the Chair of the Ontario Physicians and Surgeons Discipline Tribunal.

Inquiries, Complaints and Reports Committee (ICRC)

- ICRC Chair appointment: **Dr. Brian Burke** is standing for nomination for a **two year term**, and was previously the ICRC Vice-Chair and is the Settlement Specialty Chair.

- ICRC Vice-Chair appointment: **Dr. Thomas Faulds** is standing for nomination for a **two year term**. He has been on the committee for approximately four years, and is also the Family Practice Specialty Chair.

Premises Inspection Committee (PIC)

- Chair appointment: **Dr. Gillian Oliver**'s appointment term is set to expire at the end of 2021. Exceptional Circumstances were granted in June to maintain the expertise she represents, and her reappointment is now before Council **for one year** as Chair for 2021-2022.

- Vice-Chair Appointment: **Dr. James Watson** is standing for nomination for a Vice-Chair appointment from 2021-2022 for a **one year** term. At the end of 2022, Dr. Watson will reach his 9-year term limit.

- The Premises Inspection Committee is currently restructuring and actively planning for future succession.

Quality Assurance Committee (QAC)

- Chair appointment: **Dr. Sarah Reid** is standing for nomination for a **two year term**, and was previously the Vice-Chair of the QAC. The current Chair, Dr. Janet van Vlymen, will be President of Council during the 2021-2022 term (pending election) and will not be able to serve as Chair of QAC at that time.

- Vice-Chair Appointment: **Dr. Ashraf Sefin** is standing for nomination for a **two year term**. His appointment term should match that of Dr. Sarah Reid for appropriate succession planning.

Registration Committee

- Chair appointment: **Dr. Judith Plante** is standing for nomination for **one year** to resume her role as Chair following her 2021 term as President of Council.

- Vice-Chair Appointment: **Dr. Kim Turner** is standing for nomination for a **one year term**.

Decision for Council

1. Does Council approve the recommended slate of 2021-2022 Chairs and Vice-Chairs?

Appendix A: Full List of Chairs and Vice-Chairs (Including Nominations)

N/C = Non-Council
OPSDT = Ontario Physicians and Surgeons Discipline Tribunal (Formerly Discipline Committee)

COMMITTEE	PROPOSED CHAIR(S)	VICE-CHAIR
OPSDT	Mr. David Wright *(N/C)*	Dr. James Watters (*N/C)*
Executive	Dr. Janet Van Vlymen *(Pending Election)*	*TBD*
Finance & Audit	Dr. Thomas Bertoia *(N/C)*	Dr. Rob Gratton
Fitness to Practise	Mr. David Wright *(N/C)*	Dr. James Watters (*N/C)*
Governance	Dr. Judith Plante	Dr. Janet Van Vlymen *(Pending Election)*
Inquiries, Complaints and Reports	Dr. Brian Burke *(N/C)* **SPECIALTY CHAIRS** Ms. Joan Fisk, General Dr. Brian Burke, Settlement (*N/C)* Dr. Rob Gratton, Obstetrical Dr. Andrew Hamilton, *(N/C)* Surgical Dr. Thomas Faulds, *(N/C)* Family Practice Dr. Anita Rachlis, *(N/C)* Internal Medicine Dr. Lesley Wiesenfeld, *(N/C)* Mental Health & HIP	Dr. Thomas Faulds *(N/C)* **SPECIALTY DESIGNATE CHAIRS** Dr. Lydia Miljan, PhD, General Dr. Dori Seccareccia, Settlement (*N/C)* Dr. Elaine Herer, Obstetrical (*N/C)* Dr. Mary Jean Duncan, Surgical (*N/C)* Dr. Val Rachlis, Family Practice (*N/C)* Dr. Mary Bell, Internal Medicine (*N/C)* Dr. Daniel Greben, Mental Health & HIP (*N/C)*
Patient Relations	Ms. Sharon Rogers, *(N/C)*	*N/A*
Premises Inspection	Dr. Gillian Oliver, *(N/C) (Exceptional circumstances for one year appointment)*	Dr. James Watson, (*N/C) (One year appointment; reaches 9-year term limit at end of 2022)**
Quality Assurance	Dr. Sarah Reid *(Two year appointment, to replace Dr. Janet van Vlymen that is expected to serve as President of Council)*	Dr. Ashraf Sefin (*N/C) (Two year appointment)*
Registration	Dr. Judith Plante *(one year)*	Dr. Kim Turner (*N/C) (one year)*

***The Premises Inspection Committee is undergoing extensive changes in its composition and structure, which will include a review of a future Chair and Vice-Chair.*

Appendix B: Chair and Vice-Chair Roles and Responsibilities

Chair Role:

The role of a Chair on a Committee, Working Group or Advisory Group is to provide leadership and direction to members of the Committee, Working Group or Advisory Group so that they can successfully achieve the objectives set out in their respective Terms of Reference.

Chair Selection:

Chairs are appointed by Council, based on a recommendation from the Governance Committee and informed by current Committee leadership and staff.

Potential Chairs should be identified based on a variety of considerations, including but not limited to:

- eligibility with respect to applicable term limits
- demonstration of core leadership competencies (Appendix A)
- leadership experience
- subject matter expertise necessary to fulfill the mandate of the Committee, Working Group or Advisory Group
- knowledge and support of the regulatory and/or statutory obligations of the Committee, Working Group or Advisory Group (if applicable)
- interest and availability

Chair Responsibilities:

In addition to providing leadership and guidance in support of the objectives and mandate of the Committee, Working Group or Advisory Group are met as outlined in the Terms of Reference and legislation where applicable, Chairs are also responsible for leading and managing activities which include but are not limited to:

- Acting as the principal spokesperson for the Committee in reporting to Council and interfacing with other Committees
- Striving to ensure adherence of group members to CPSO expectations outlined in the Declaration of Adherence
- Working with staff to plan, organize and chair meetings and panels (where applicable)
- Facilitating meaningful discussion among group members and encouraging all members to share ideas and views
- Gaining consensus during the decision-making process in a respectful way
- Introducing strategies to resolve conflicts that may arise
- Collaborating with staff to provide orientation to new members
- Overseeing the development of reports to Council
- Identifying learning needs of the group or individual members as appropriate
- Monitoring performance of individual members and providing feedback to enhance performance

- Liaising with the Governance Committee on issues such as recruitment, mentoring and succession planning of members
- Participating in a self-assessment with the Chair of Governance Committee to obtain feedback and identify opportunities to enhance performance

For Discipline, Fitness to Practice and Inquiries, Complaints and Reports Committees, key duties also include:

- Working with staff to select members to lead and participate in panels
- Providing advice and support to members participating in panels, drawing where appropriate on staff support and other legal advice
- Monitoring panel activities and decisions to ensure alignment with legislative requirements and CPSO policies/procedures

The Chair plays a key role in identifying members who demonstrate strong leadership skills and who may be suitable for a Vice-Chair role as part of succession planning.

Chair Core 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 effectively. 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 Committee/Working Group/Advisory-related goals in support of CPSO's mandate.

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 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 setbacks and change own immediate behaviour or approach to suit the situation. Is candid about opinions and raises justified concerns.

Vice-Chair Role and Responsibilities:

The role of a Vice-Chair on a Committee, Working Group or Advisory Group is to support the Chair in providing leadership and direction to members of the Committee, Working Group or Advisory Group so that they can successfully achieve the objectives set out in their respective Terms of Reference.

Vice-Chair Selection:

Vice-Chairs are appointed by Council, based on a recommendation from the Governance Committee and informed by current Committee leadership and staff.

Potential Vice-Chairs should be identified based on a variety of considerations, including but not limited to:

- eligibility with respect to applicable term limits
- demonstration of core leadership competencies (Appendix A)
- leadership experience or potential
- subject matter expertise necessary to fulfill the mandate of the Committee, Working Group or Advisory Group
- knowledge and support of the regulatory and/or statutory obligations of the Committee, Working Group or Advisory Group (if applicable)
- interest and availability

Vice-Chair Responsibilities:

In addition to supporting the Chair in leading the Committee to achieve the objectives and mandate of the Committee, Working Group or Advisory Group are met as outlined in the Terms of Reference and legislation where applicable, Vice-Chairs are also responsible for activities which include but are not limited to:

- Acting as the delegate for the Chair (where necessary) in reporting to Council and interfacing with other Committees where necessary
- Modeling CPSO expectations outlined in the Declaration of Adherence
- Working with staff and the Chair to plan, organize meetings and panels (where applicable)
- Assisting the Chair with resolving conflicts that may arise
- Supporting orientation for new members
- Participating in the development of reports to Council
- Identifying learning needs of the group or individual members as appropriate
- Informing the Chair regarding the performance of individual members
- Participating in a self-assessment with the Chair of Governance Committee to obtain feedback and identify opportunities to enhance performance

Vice-Chair Core 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 effectively. 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 Committee/Working Group/Advisory-related goals in support of CPSO's mandate.

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 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 setbacks and change own immediate behaviour or approach to suit the situation. Is candid about opinions and raises justified concerns.

Council Motion

Motion Title	2021-2022 Chair and Vice-Chair Appointments
Date of Meeting	September 13, 2021

It is moved by_____, and seconded by_____, that:

The Council appoints the following Committee Members as Chairs and Vice-Chairs, as noted below, to the following Committees as of the close of the Annual General Meeting of Council in December, 2021:

Committee	Chair	Term
Fitness to Practise	Mr. David Wright	2 years
Inquiries, Complaints and Reports	Dr. Brian Burke	2 years
Premises Inspection	Dr. Gillian Oliver	1 year
Quality Assurance	Dr. Sarah Reid	2 years
Registration	Dr. Judith Plante	1year

Committee	Vice-Chair	Term
Inquiries, Complaints and Reports	Dr. Thomas Faulds	2 years
Premises Inspection	Dr. James Watson	1 year
Quality Assurance	Dr. Ashraf Sefin	2 years
Registration	Dr. Kim Turner	1 year

Council Briefing Note

September 2021

Topic:	Licentiate of the Medical Council of Canada (LMCC) Policy
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation
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 **Protection:** Ensuring the protection of the public from harm in the delivery of health care services
Main Contact(s):	Samantha Tulipano, Director, Registration & Membership Services Carolyn Silver, General Counsel, Legal Office Lisa Brownstone, Chief Legal Officer, Legal Office
Attachment(s):	Appendix A: *Requirement for Successful Completion of Part 2 of the MCCQE – Pandemic Exemption* Appendix B: *MCC Announcement* Appendix C: *Statement on the MCC website* Appendix D: *Proposed Policy*

Issue

- The Medical Council of Canada (MCC) has ceased delivery of the MCCQE 2, one of the requirements for issuance of an independent practice certificate.

Background

- Standards and qualifications for issuance of an Independent Practice (IP) certificate set out in Ontario Regulation 856/93 (the "Registration Regulation") include:
    - Successful completion of Parts 1 & 2 of the Medical Council of Canada Qualifying Examination (MCCQE);
    - Certification by examination by the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College of Family Physicians of Canada (CFPC);

- One year of Postgraduate Medical Education or Active Medical Practice in Canada, and
- Canadian Citizenship or Permanent Resident Status.

- Across most of Canada, the Licentiate of the Medical Council of Canada (LMCC) is a fundamental requirement for a Full licence. Specifically, a candidate for a Full licence must have:

    - A recognized Medical Degree;
    - The Licentiate of the Medical Council of Canada (LMCC); and
    - Certification with the College of Family Physicians of Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada (RCPSC).

- Since March 2020, the MCCQE 2 had been postponed numerous times.

- The postponement of the examination and lack of alternate means to complete the exam (the MCC continues to plan for an in-person examination) created a significant backlog of candidates.

- In March 2021, in absence of a formalized plan to address the backlog of candidates Council approved the *Requirement for Successful Completion of Part 2 of the MCCQE – Pandemic Exemption* Policy (Attached as Appendix A)

- The 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.

    1. The applicant demonstrates that they were eligible to challenge the MCCQE2 at the May 2020, October 2020, and/or February 2021 sittings*;
    2. 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;
    3. 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;
    4. The applicant otherwise meets the prescribed requirements for an Independent Practice Certificate of Registration and,
    5. 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.

Current Status and Analysis

- On June 10, 2021, the Medical Council of Canada (MCC) announced that it will cease to deliver the MCCQE 2. Additionally, the MCC stated that successful completion of the MCCQE Part II is no longer required to become a licentiate of the Medical Council of Canada (LMCC) (Attached as Appendix B).

- The MCC announcement directly affects the licensure of both physicians practicing in the province and those physicians seeking initial licensure in Ontario as they are unable to satisfy the prescribed requirement to successfully complete Part 2 of the MCCQE.

- At MCC's Council meeting on June 9, on the recommendation of Federation of Medical Regulatory Authorities of Canada (FMRAC), the MCC affirmed updated criteria informing policy on the granting of the **Licentiate of the Medical Council of Canada (LMCC)** to candidates meeting all the following requirements**:**

  1. Are a graduate from:
     a) a medical school accredited by the Committee on Accreditation of Canadian Medical Schools or the Liaison Committee on Medical Education; or
     b) a medical school listed in one or more directories of medical schools approved from time to time by resolution and be a medical school listed in the World Directory of Medical Schools which includes a sponsor note indicating it is an acceptable medical school in Canada; or
     c) a United States School of Osteopathic Medicine accredited by the American Osteopathic Association.

  2. Have successfully completed the MCCQE Part I (PASS)

  3. Have successfully completed:
     a) at least 12 months of acceptable clinical post graduate medical training as determined by the Executive Director; or
     b) at least 12 months of acceptable osteopathic post graduate clinical training in a program accredited by the Accreditation Council for Graduate Medical Education (ACGME) as determined by the Executive Director; and

  4. Have the required medical credentials including verification of postgraduate training successfully source verified through MCC or, in exceptional circumstances, have

provided evidence of the required medical credentials acceptable to the Executive Director.

- Where an individual otherwise meets all of the above criteria but is subject to a prohibition order barring him or her from writing the MCCQE Part II examination, the Executive Director may award that individual the LMCC only after the expiration of the barring order. A copy of which is enclosed as Appendix C.

Proposal

- Given that MCCQE 2 is no longer available, it will be impossible for any applicant to satisfy the prescribed registration requirements.

- In order to address this, Registration Committee is asking Council to pass a policy in which it would accept the LMCC qualification as an alternative to the MCCQE 2 for the issuance of an independent practice certificate. A copy of the draft Policy is attached as Appendix D

Considerations

- The proposed policy would be applicable to anyone who meets the outlined criteria. Basically, it provides for an exemption for MCCQE 2 for anyone who is granted LMCC by MCC.

- The proposed policy is broader than those eligible under the *Requirement for Successful Completion of Part 2 of the MCCQE – Pandemic Exemption* Policy. It would provide a route for licensure for the following groups who are presently ineligible under the Pandemic Exemption Policy.

    - Individuals with previous unsuccessful attempts at the MCCQE 2
    - New applicants to Ontario;
    - Applicants from another Canadian jurisdiction;

    The FMRAC Canadian standard for full registration requires that the applicant be a Licentiate of the Medical Council of Canada. Notwithstanding that the MCCQE 2 is no longer being offered, qualifying applicants will still be awarded LMCC, accordingly no change is required to the FMRAC Canadian Standard. As noted above the MCC's decision to issue the LMCC and the acceptable criteria were made in consultation with FMRAC.

- Applicants with Section 2 concerns will continue to require Registration Committee review.

Other impacts of the MCC's decision to Discontinue the MCCQE 2

- Given that the CPSO can no longer require MCCQE 2, a number of registration policies are undergoing review for impact and potential revisions as they refer to the MCCQE 2 qualification.

- These policies will be brought to the Registration Committee at its business meeting in October.

Next Steps

- Should Council approve the proposed policy, next steps are as follows:

  Following Council's approval, the policy will be circulated for notice in accordance with Section 22.21 of the Health Professions Procedural Code (HPPC) which provides that if the College wishes to amend the standards and qualifications for a certificate of registration, it shall,

  (a) give notice of the proposed new or amended standards to,
  (i) the Minister of Health
  (ii) the co-ordinating Minister under the *Ontario Labour Mobility Act, 2009*
  (iii) the medical regulatory authorities in Canada

  (b) afford the medical regulatory authorities' opportunity to comment.

- Following the consultation process, the policy will be presented to Council at a subsequent meeting for final approval.

Questions for Council

1. Does Council agree that addressing this issue supports the strategic plan and our role in serving the public interest?

2. What feedback does Council have regarding next steps (if any)?

3. Does Council approve the policy for notice in accordance with Section 22.21 of the Health Professions Procedural Code (HPPC)?

Appendix A: Requirement for Successful Completion of Part 2 of the MCCQE – Pandemic Exemption

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

Update Regarding MCCQE Part II

The Medical Council of Canada (MCC) announced on June 10, 2021 they are stepping away from the delivery of the Medical Council of Canada Qualifying Examination (MCCEQ) Part II going forward.

CPSO is immediately examining the implications of this announcement on all affected physicians and is in the process of developing a policy that will be finalized on a future date. Please continue to monitor the website for updates from the College.

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:

1. The applicant demonstrates that they were eligible to challenge the MCCQE2 at the May 2020, October 2020, and/or February 2021 sittings*;
2. 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;
3. 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;
4. The applicant otherwise meets the prescribed requirements for an Independent Practice Certificate of Registration and,
5. 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: MCC Announcement

From: Medical Council of Canada / Le Conseil médical du Canada <communications@mcc.ca>
Sent: Thursday, June 10, 2021 3:17 PM
To: Samantha Tulipano
Subject: The MCC ceases delivery of the MCCQE Part II / Le CMC met un terme à la prestation de l'EACMC, partie II

MEDICAL COUNCIL OF CANADA | LE CONSEIL MÉDICAL DU CANADA

The MCC ceases delivery of the MCCQE Part II

La version française suit.

Dear Samantha Tulipano,

Following our May 31 communication, the Medical Council of Canada (MCC) confirms that it is stepping away from the delivery of the Medical Council of Canada Qualifying Examination (MCCQE) Part II going forward.

Recognising the impact of the pandemic, and the unprecedented challenges associated with delivering a MCCQE Part II examination, the MCC Council, at a meeting on June 9, affirmed updated criteria informing policy on the granting of the **Licentiate of the Medical Council of Canada (LMCC)** to candidates meeting all the following requirements**:**

1. Are a graduate from:
a) a medical school accredited by the Committee on Accreditation of Canadian Medical Schools or the Liaison Committee on Medical Education; or
b) a medical school listed in one or more directories of medical schools approved from time to time by resolution and be a medical school listed in the World Directory of Medical Schools which includes a sponsor note indicating it is an acceptable medical school in Canada; or

c) a United States School of Osteopathic Medicine accredited by the American Osteopathic Association.

2. Have successfully completed the MCCQE Part I (PASS)

3. Have successfully completed:
a) at least 12 months of acceptable clinical post graduate medical training as determined by the Executive Director; or
b) at least 12 months of acceptable osteopathic post graduate clinical training in a program accredited by the Accreditation Council for Graduate Medical Education (ACGME) as determined by the Executive Director; and

4. Have the required medical credentials including verification of postgraduate training successfully source verified through MCC or, in exceptional circumstances, have provided evidence of the required medical credentials acceptable to the Executive Director.

Where an individual otherwise meets all of the above criteria but is subject to a prohibition order barring him or her from writing the MCCQE Part II examination, the Executive Director may award that individual the LMCC only after the expiration of the barring order.

The LMCC is not a licence to practise medicine. The authority to issue licences is reserved to the provincial and territorial Medical Regulatory Authorities (MRAs).

Independent standardized assessments remain a key component of medical licensure and are critical in ensuring patient safety in Canada. We will continue to work with the Assessment Innovation Task Force (AITF), the medical community and partner organizations, to reflect on how clinical skills and emerging competencies required of physicians will be assessed in the future. Criteria for the award of the LMCC may be reviewed at a future date as standardised assessment requirements for physicians evolve.

We recognize that the exam fees are substantial and are expediting the refund of the MCCQE Part II exam fee within the next 30 days to the credit card that was used for payment. Processing and the award of the LMCC for candidates who were registered for the latest exam session is expected to take up to two months. For other eligible candidates, this process will require coordination with third parties and may take longer. A separate fee for processing the LMCC is expected

to be applied following the meeting of the MCC Finance Committee in late June as this cost was previously included in the exam fee.

For questions about the MCCQE Part II, please contact the MCC service desk.

Sincerely,

Maureen Topps, MB ChB, FCFP, MBA, FRCPC (Hon)
Executive Director and CEO
Medical Council of Canada

MEDICAL COUNCIL OF CANADA
communications@mcc.ca | mcc.ca

Le CMC met un terme à la prestation de l'EACMC, partie II

Bonjour Samantha Tulipano,

Pour donner suite à notre communication du 31 mai, le Conseil médical du Canada (CMC) confirme l'arrêt définitif de la prestation de l'examen d'aptitude du Conseil médical du Canada (EACMC), partie II.

En raison de l'impact de la pandémie et des difficultés éprouvées par le CMC dans l'administration de l'examen d'aptitude du Conseil médical du Canada (EACMC), partie II, le Conseil du CMC, lors d'une séance le 9 juin, a confirmé les critères qui établissent la politique pour l'octroi du titre de **Licencié du Conseil médical du Canada (LCMC)** aux candidats qui répondent à toutes les exigences suivantes :

1. être un diplomé :
a) d'une école de médecine reconnue par le Comité d'agrément des facultés de médecine du Canada ou par le Liaison Committee on Medical Education; ou
b) d'une école de médecine recensée dans le World Directory of Medical Schools avec annotation par une organisation participante

(sponsors), à l’effet que cette école de médecine est acceptable au Canada; ou
c) de la United States School of Osteopathic Medicine accréditée par l’American Osteopathic Association.

2. avoir réussi l’EACMC, partie I.

3. avoir réussi:
a) au moins 12 mois de formation médicale clinique postdoctorale acceptable tel que déterminé par la Directrice générale, ou
b) au moins 12 mois de formation clinique postdoctorale acceptable en ostéopathie dans un programme accrédité par l’Accreditation Council on Graduate Medical Education tel que déterminé par la Directrice générale

4. détenir les attestations des titres de compétence en médecine, incluant confirmation de formation postdoctorale vérifiées à la source par le CMC, ou, exceptionnellement, avoir présenté des attestations des titres de compétence en médecine et de formation postdoctorale que la Directrice générale juge acceptables.

Lorsqu’ une personne qui répond aux critères énoncés ci-dessus fait l’objet d’une ordonnance lui interdisant l’admissibilité à l’EACMC, partie II, la Directrice générale ne sera autorisée à l’inscrire au Registre médical canadien qu’une fois ladite période d’inadmissibilité expirée.

L’inscription à titre de LCMC ne constitue pas un permis pour exercer la médecine. La délivrance de ces permis relève des ordres des médecins provinciaux et territoriaux.

Les évaluations indépendantes standardisées demeurent un élément clé du permis d'exercice médical et sont essentielles pour assurer la sécurité des patients au Canada. Nous continuerons à travailler en collaboration avec le Groupe de travail sur l’innovation en matière d’évaluation (GTIÉ), la communauté médicale et nos organismes partenaires, afin de réfléchir à la meilleure façon d'évaluer les compétences cliniques et les nouvelles compétences clés exigées des médecins à l’avenir. Les critères d'attribution du LCMC pourraient être révisés à une date ultérieure à mesure que les exigences d'évaluation standardisées pour les médecins évoluent.

Nous reconnaissons que les droits d’inscription à l’examen sont élevés et nous accélérons le remboursement des frais d’inscription de

l'EACMC, partie II, dans les 30 prochains jours à la carte de crédit qui a été utilisée pour le paiement. Le traitement et l'attribution du LCMC pour les candidats inscrits à la dernière session d'examen devraient prendre jusqu'à deux mois. Pour les autres candidats admissibles, ce processus nécessitera une coordination avec des tiers et pourrait prendre plus de temps. Des frais distincts pour le traitement du LCMC devraient être appliqués suite à la réunion du Comité des finances du CMC à la fin juin. Il est à noter que ces frais étaient auparavant inclus dans les droits d'inscription.

Pour toute question concernant l'EACMC, partie II, veuillez communiquer avec le bureau de service du CMC.

Cordialement,

Maureen Topps, MB ChB, FCFP, MBA, FRCPC (Hon)
Directrice générale et chef de la direction
Le Conseil médical du Canada

Appendix C: Statement on the MCC website

The MCC ceases delivery of the MCCQE Part II

Assessment / Changes / Exam change / MCCQE Part II / Medical licensure

JUNE 10, 2021

Following our May 31 communication, the Medical Council of Canada (MCC) confirms that it is stepping away from the delivery of the Medical Council of Canada Qualifying Examination (MCCQE) Part II going forward.

Recognising the impact of the pandemic, and the unprecedented challenges associated with delivering a MCCQE Part II examination, the MCC Council, at a meeting on June 9, affirmed updated criteria informing policy on the granting of the **Licentiate of the Medical Council of Canada (LMCC)** to candidates meeting all the following requirements:

1. Are a graduate from:
   a) a medical school accredited by the Committee on Accreditation of Canadian Medical Schools or the Liaison Committee on Medical Education; or
   b) a medical school listed in one or more directories of medical schools approved from time to time by resolution and be a medical school listed in the World Directory of Medical Schools which includes a sponsor note indicating it is an acceptable medical school in Canada; or
   c) a United States School of Osteopathic Medicine accredited by the American Osteopathic Association.
2. Have successfully completed the MCCQE Part I (PASS)
3. Have successfully completed:
   a) at least 12 months of acceptable clinical post graduate medical training as determined by the Executive Director; or
   b) at least 12 months of acceptable osteopathic post graduate clinical training in a program accredited by the Accreditation Council for Graduate Medical Education (ACGME) as determined by the Executive Director; and
4. Have the required medical credentials including verification of postgraduate training successfully source verified through MCC or, in exceptional circumstances, have provided evidence of the required medical credentials acceptable to the Executive Director.

Where an individual otherwise meets all of the above criteria but is subject to a prohibition order barring him or her from writing the MCCQE Part II examination, the Executive Director may award that individual the LMCC only after the expiration of the barring order.

The LMCC is not a licence to practise medicine. The authority to issue licences is reserved to the provincial and territorial Medical Regulatory Authorities (MRAs).
Independent standardized assessments remain a key component of medical licensure and are

critical in ensuring patient safety in Canada. We will continue to work with the Assessment Innovation Task Force (AITF), the medical community and partner organizations, to reflect on how clinical skills and emerging competencies required of physicians will be assessed in the future. Criteria for the award of the LMCC may be reviewed at a future date as standardised assessment requirements for physicians evolve.

We recognize that the exam fees are substantial and are expediting the refund of the MCCQE Part II exam fee within the next 30 days to the credit card that was used for payment. Processing and the award of the LMCC for candidates who were registered for the latest exam session is expected to take up to two months. For other eligible candidates, this process will require coordination with third parties and may take longer. A separate fee for processing the LMCC is expected to be applied following the meeting of the MCC Finance Committee in late June as this cost was previously included in the exam fee.

For questions about the MCCQE Part II, please contact the MCC service desk.

Website: https://www.mcc.ca/news/mcc-ceases-delivery-of-the-mccqe-part-ii/?cn-reloaded=1

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Appendix D: Proposed Policy

Licentiate of the Medical Council of Canada (LMCC) Policy

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 for a certificate of registration.

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

Licentiate of the Medical Council of Canada (LMCC) Policy

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

Until June 2021, the Medical Council of Canada (MCC) awarded individuals who had successfully completed MCCQE Parts 1 &2 with the Licentiate of the Medical Council of Canada (the “LMCC”).
However, on June 10, 2021, the MCC announced that it cancelled the MCCQE 2, and effective June 29, 20211 will award the LMCC to individuals who meet specified criteria, in absence of MCCQE Part 2.

This Policy provides an alternative to the requirement for the successful completion of Part 2 of the MCCQE for physicians who hold the Licentiate of the Medical Council of Canada (LMCC) Qualification.

The Registration Committee may direct the Registrar to issue a certificate of registration authorizing **independent practice** to applicants who hold the LMCC and are otherwise qualified for an Independent Practice Certificate of Registration and satisfy the non-exemptible requirements set out in *Section 2(1) of Ontario Regulation 865/93*.

Council Motion

Motion Title	Licentiate of the Medical Council of Canada (LMCC) Policy
Date of Meeting	September 14, 2021

It is moved by_____, and seconded by_____, that:

The College engage in the notice and consultation process in accordance with section 22.21 of the Health Professions Procedural Code, in respect of the draft policy “Licentiate of the Medical Council of Canada (LMCC) Policy” (a copy of which forms Appendix “ ” to the minutes of this meeting).

Council Briefing Note

September 2021

Topic:	Physician Assistant Regulation Update
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 Contact(s):	Miriam Barna, Senior Government Relations Advisor Craig Roxborough, Director, Policy Danna Aranda, Government Relations Coordinator Atif Mahmood, Project Manager
Attachment(s):	N/A

Issue

- Council is provided with an update on the regulation of physician assistants (PAs), the development of an implementation plan for enacting this regulation, and an overview of the activities currently underway.

Background

- On June 3, 2021, legislation that would regulate PAs under CPSO received Royal Assent. However, the legislation and CPSO's oversight of PAs will not be enacted until a later, currently unknown, date.

- Over the course of the summer, staff have initiated work on the implementation of PA regulation.

    - A core implementation team comprised of staff from Governance, Policy, the Project Management Office, and Legal has been leading the work.

- However, all areas of the College will be involved at some point over the course of implementing PA regulation.

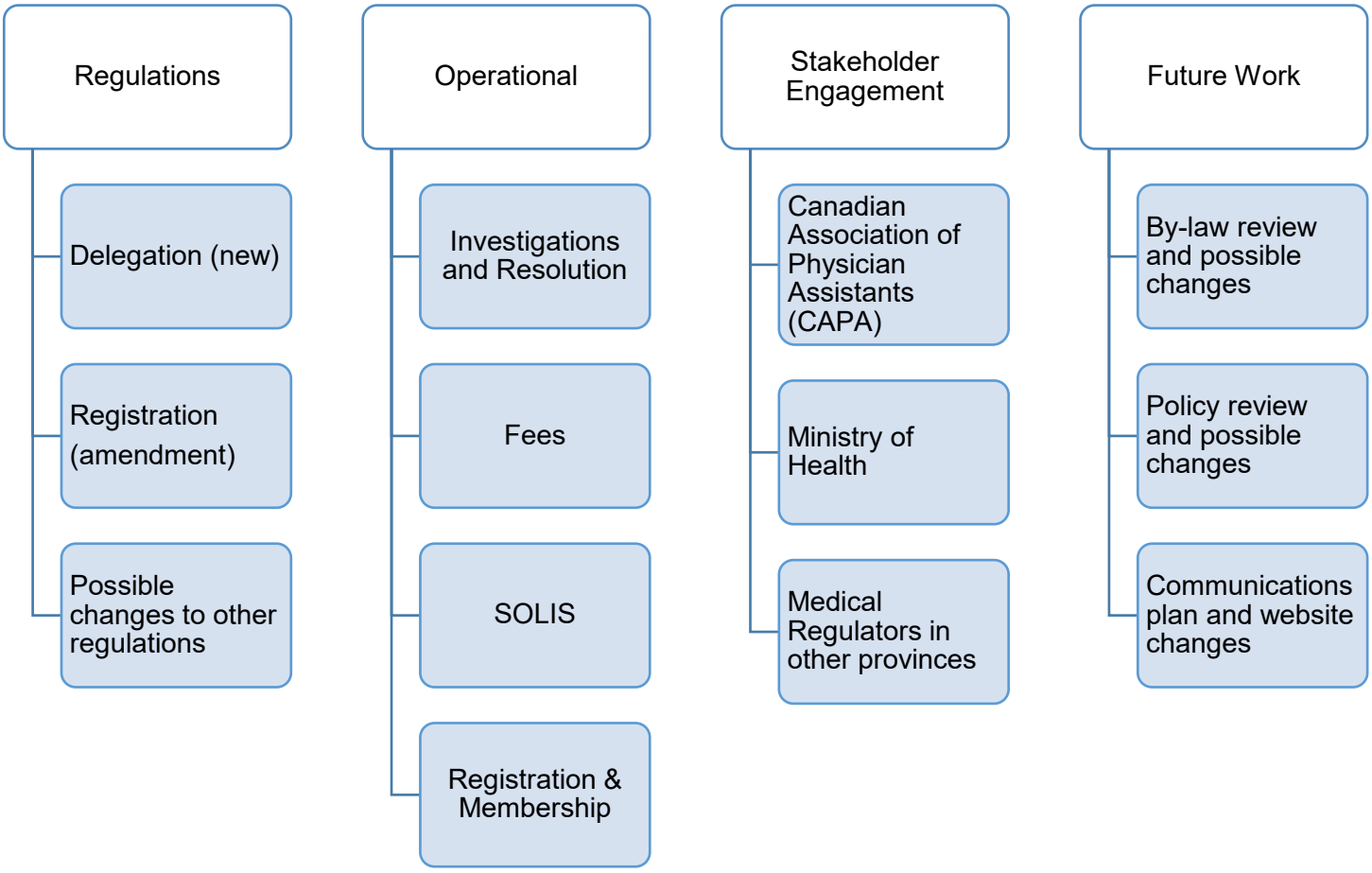
- This briefing note provides Council with an overview of the implementation process for PA regulation and some key considerations as this work moves forward.

Current Status and Analysis

- A chart outlining current implementation activities is provided below. Council should note that this is not a definitive list of all tasks required to implement PA regulation but rather an overview of the necessary foundational work.

- Underscoring all of this work is the commitment to expedite the implementation process while also seeking any possible alignment with the provinces that currently regulate PAs (Manitoba, New Brunswick, and Alberta).

- All of this work is guided by the philosophy and tenets of right-touch regulation.



Regulations

- While the legislation to regulate PAs under CPSO was passed last spring, regulations that set out the specific requirements under which PAs practice – or which require differentiation from the regulations governing physicians – must be developed and enacted prior to PAs coming under CPSO's oversight.

- As set out in Bill 283, a regulation must be developed to allow PAs to perform a controlled act under the authority of a physician. This regulation will set out the delegation requirements and align with the current framework of delegation set out in CPSO's *Delegation of Controlled Acts* policy.

- Amendments to the existing O.Reg 865/93 *Registration* regulation will also be required to define the entry to practice requirements for PAs.

- When this briefing note was written, a full review of all existing regulations under the *Medicine Act, 1991* and *Regulated Health Professions Act, 1991* was being undertaken to evaluate what other amendments may be required.

- All regulations will need to be approved by Council, circulated for consultation by both CPSO and government, and ultimately approved and enacted by government.

- Staff are working to bring a package of draft regulations to Council in December 2021 for approval to consult. Council should note that this work is contingent on discussions with stakeholders, and a variety of external factors and therefore may be subject to change.

Operational

- While the development of regulations is the first step of implementation, and is tied to operational processes and considerations, staff have also initiated a comprehensive review of the operational implications associate with regulating PAs.

- At this early stage, initial work is underway to understand both the implications and needs of program areas such as Investigations and Resolutions as well as Registration and Membership services.

- While not yet initiated, close consideration of operational considerations will be required to integrate PAs into the new SOLIS system, determine the fees charged to PAs, and ensure the seamless integration of PAs into CPSO.

- Additional information will be shared with Council as implementation activities progress.

Stakeholder Engagement

- CPSO has committed to working collaboratively with the PA profession and has initiated regular meetings with the Canadian Association of Physician Assistants (CAPA).
    - These meetings have facilitated open communication, knowledge sharing, and the identification of best practices across the provinces that regulate PAs.
- CPSO has also committed to working closely with Ministry of Health officials as implementation progresses. Staff will be meeting with Ministry of Health representatives this fall in order to streamline the work related to regulations.
- In addition to the jurisdictional research staff have undertaken to evaluate the practices of provinces that currently regulate PAs, CPSO staff have spoken with staff in other medical regulatory colleges in Alberta and Manitoba to learn more about their practices and processes. We anticipate these conversations will continue throughout the implementation process.

Other Work

- Although not yet initiated, the implementation of PA regulation will require an evaluation of existing CPSO by-laws and policies and possible amendments. This work will occur once the initial regulations related work is approved by Council.
- Also, at a later stage of implementation, a communications plan for both physicians and physician assistants will need to be developed as well as changes to CPSO's website.
- Further activities will continue to be identified throughout the implementation process.

Considerations

- CPSO has committed to expeditiously moving forward with PA regulation implementation. However, there are aspects of this implementation that are outside of CPSO's control including the enactment of regulations.
    - Given the upcoming provincial election in June 2022, there is uncertainty regarding the timing of this work.
- Notwithstanding these unknowns, staff will continue to move this work forward quickly and efficiently.

Next Steps

- Staff will continue the work of drafting the required regulations. A package of regulations will be brought to the December 2021 Council meeting for approval to consult.
- Council will be kept apprised of any significant changes to the implementation process or government timelines.

Council Briefing Note

September 2021

Topic:	*Complementary and Alternative Medicine* – Revised Draft Policy for Final Approval
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation Meaningful Engagement System Collaboration
Public Interest Rationale:	Ensures an appropriate balance is struck between protecting the public, and allowing for patient autonomy, professional judgement and innovation.
Main Contact(s):	Courtney Brown, Policy Analyst
Attachment(s):	Appendix A: *Complementary and Alternative Medicine* Revised Draft Policy Appendix B: Revised Draft *Advice to the Profession: Complementary and Alternative Medicine*

Issue

- The College's *Complementary/Alternative Medicine* (CAM) policy is currently under review. A draft policy was released for external consultation in December 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 *Complementary/Alternative Medicine* policy was first approved by Council in 1997 and was last reviewed and updated in November 2011.

- Following extensive research[1], public polling, consultation with the Citizen Advisory Group, and a preliminary consultation[2], a new draft *Complementary and Alternative Medicine* policy was developed with direction from the standing Policy Review Working Group[3]. Additional support was provided by Amy Block (Legal Counsel).

- The draft policy was approved for external consultation by Council in December 2020. The accompanying draft *Advice* was also released at this time.

- A total of 3,032 responses were received as part of this external consultation.[4]

    - Members of the Policy department also met with a number of relevant stakeholders, including representatives of both physicians who provide CAM and patients who receive it.

    - This consultation attracted a significant amount of feedback and was the subject of a substantial letter writing campaign from patients who use complementary and alternative medicine, requesting specific changes to the draft policy.[5]

    - The concerns expressed in the feedback largely centred around the idea that the draft policy would require a standard of evidence that would be difficult to meet and therefore effectively prevent physicians from providing complementary and alternative medicine to patients. Respondents also expressed concerns that certain language in the draft policy, particularly around exploitation, gave the perception that CPSO was biased against complementary and alternative medicine and the physicians who provide it.

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[1] 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).

[2] The consultation was held March - May 2019 and garnered a total of 891 responses: 97 through written feedback and 794 via the online consultation survey. A high-level summary of the feedback received can be found in the May 2019 Council materials.

[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] 1,331 responses were received through written feedback and 1,701 through the online survey. Organizational responses included: Academic Consortium for Integrative Medicine & Health; American Board of Integrative Medicine; Canadian Lyme Disease Foundation; Canadian On Paper Society for Immigrant Physicians Equality, Foundation for International Medical Graduates, College of Physicians and Surgeons of Alberta (CPSA); Environmental Sensitivities Coalition of Canada; Ontario Association of Naturopathic Doctors; Ontario Chiropractic Association; Ontario Lyme Alliance; Ontario Medical Association (OMA) Section on Addiction; and Professional Association of Residents of Ontario (PARO).

[5] 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.

Current Status and Analysis

- Revisions have been made to both the draft *Complementary and Alternative Medicine* policy (**Appendix A**) and *Advice* (**Appendix B**), predominantly in response to feedback obtained during the external consultation.

- The revisions were developed based on feedback and direction from members of the new Policy Review Working Group.[6] Legal Counsel, Amy Block has continued to support this review.

- While many of the revised draft policy expectations are largely consistent with those of the draft policy that was released for consultation, updates have been made to address the concerns raised by consultation respondents and ensure the policy expectations are clear and easily understandable.

- An overview of the key issues considered by the Working Group, along with any corresponding revisions, are set out below.

Definitions

- The definition of "complementary and alternative medicine" in the draft policy has been revised to remove language that was perceived as biased and unnecessary, without substantively changing the definition or what is captured by it. A definition of "conventional medicine" has also been added to the draft policy.

    - The Working Group agreed to these revisions in response to consultation feedback suggesting that there was language used throughout the draft policy that was perceived as indicating that CPSO was biased against CAM practitioners.

    - The Working Group felt that a definition of "conventional medicine" was needed, as CAM is often described as treatments that are not considered conventional medicine. The current policy has a definition of "conventional medicine" and the definition in the revised draft policy aligns with this definition, with updates made to the language to ensure clarity and ease of understanding.

Introductory Preamble

- An introductory preamble was added to the draft policy to clearly articulate that the purpose of this policy is to effectively regulate the provision of CAM by physicians, but not to outright prohibit or prevent its use.

    - This addition was drafted to address the clearly articulated perception in the feedback that CPSO was attempting to shut down the use of CAM, despite this not

[6] Feedback and direction were provided by Brenda Copps, Janet van Vlymen, Lydia Miljan, Sarah Reid, Karen Saperson, and Keith Hay.

being our intention. While our current drafting convention is to minimize or avoid including these kinds of preambles, the Working Group agreed that in this case it was necessary to clearly state the intent of the policy.

- Specific reference the *Medicine Act, 1991* was also added which states that physicians cannot be found guilty of professional misconduct solely on the basis that they provide treatments that could be considered outside of conventional medicine. The *Medicine Act* provision is included in the current policy and a large number of respondents to the consultation specifically requested that this reference be included in the revised draft policy.

Evidentiary Requirements

- The draft policy contained a requirement that physicians only provide CAM treatments that are "*supported* by evidence and scientific reasoning" – an adjustment in wording from the current policy language of "*informed* by evidence and science". The Working Group had initially felt that this change in language may be clearer for physicians. In response to feedback, the revised draft policy has been amended to revert back to the original policy language of "informed".

    - The change in language in the draft policy– while not intended to be a meaningful strengthening of the standard – was read as significantly altering the expectation and setting a bar which would be higher than that for conventional evidence-based medicine.

    - Feedback from respondents expressed significant concern that the language of "supported" that was previously in the draft policy could have the unintended consequence of stifling CAM practitioner's ability to provide appropriate treatments to patients.

    - The Working Group felt strongly that any CAM treatment a physician provides needs to be grounded in evidence, but that the level of evidence that would be required would depend on the level of risk to the patient. They felt that the language of "informed" was appropriate to capture this and should be maintained.

Preventing Exploitation

- The draft policy previously had a section titled "Preventing Exploitation" with two expectations – one requiring that physicians not exploit patients when providing CAM, and one requiring physicians to be aware of and consider a patient's potential vulnerability. This content provoked a significant and critical reaction as part of the consultation process.

    - Many respondents felt that including a section on exploitation implies that physicians who provide CAM are more likely to exploit their patients than other physicians.

- In response to this feedback, the section title and the first provision have been removed. The Working Group agreed that the inclusion of this section title and provision was unnecessary as all physicians are prohibited from exploiting patients, no matter what type of medicine they practice or provide.

- The second provision has been retained but within another section of the policy.

Documentation

- The draft policy requirement for physicians to document the full risk-benefit analysis they undertook to determine whether it is appropriate to provide a CAM treatment to a patient has been removed. General guidance is provided as part of a footnote indicating that the greater the potential risks to the patient are, or the further outside of conventional medicine a treatment is, the greater the need may be to document the full risk-benefit analysis undertaken.

    - There was a significant amount of feedback in the consultation that indicated this requirement would be onerous, and in many cases, heavy handed. While there are some CAM treatments that are high risk, there are many treatments that are low risk and being provided routinely. The requirement to document a full risk-benefit analysis for every treatment would therefore not be proportionate to the risk in each instance.

    - The Working Group agreed that specific additional requirements on top of what is required of all physicians by the *Medical Records Documentation* policy was unnecessary, and there should be room for physicians to use their professional judgement in determining where additional documentation may be necessary, as any physician would.

Application of the policy to "traditional" or culturally important therapies

- New content has been added to the draft *Advice* to address the fact that some CAM therapies or treatments may be of importance to specific cultural groups (for example, traditional Indigenous healing or traditional Chinese medicine). This new content also reminds physicians of the importance of providing culturally competent care.

    - CPSO staff met with representatives of the Nishnawbe Aski Nation to discuss the draft CAM policy and hear their feedback. They expressed concern that it appeared CPSO was attempting to regulate traditional Indigenous healing practitioners, and that the policy did not acknowledge the importance that many such practices hold to particular cultures.

    - The Working Group considered this feedback and agreed that additional content should be added to the *Advice* to clarify that this policy only applies to physicians, that physicians can provide such treatments provided that they do so in line with the policy, and that physicians are welcome to work with other practitioners should

patients so wish. The Working Group also felt it was valuable to remind physicians of the importance of respecting their patient's culture and beliefs.

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 *Complementary and Alternative Medicine* policy as a policy of the College?

Complementary and Alternative Medicine

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

Conventional Medicine: refers to therapeutic concepts, diagnoses, treatments, practices, and products that are considered mainstream medicine. This type of medicine is commonly provided in hospitals and specialty or primary care practices and taught in medical schools.

Complementary and Alternative Medicine: refers to a broad and diverse range of therapeutic concepts, diagnoses, treatments, practices, and products that are not commonly accepted as part of conventional medicine.[1]

For the purposes of this policy, it also includes:

- conventional treatments, practices, and products being used in non-conventional ways, and
- new or emerging treatments, practices, and products that are based on conventional medical understanding and scientific reasoning[2].

Integrative medicine: a commonly used term within the complementary and alternative medicine environment, referring to an approach to patient care that integrates conventional and complementary medicine.

[1] For additional information and clarification on what is considered to be complementary and alternative medicine, please see the College's *Advice to the Profession: Complementary and Alternative Medicine* document.

[2] This policy applies to new medical treatments, including devices, that are not otherwise subject to regulation by other bodies such as Health Canada. Health Canada requires that some treatments or therapies be registered with them as part of a clinical trial. For example, currently stem cell therapies must be authorized by Health Canada to ensure that they are safe and effective before they can be offered to patients. For more information please see Health Canada's website.

Professional affiliation: For the purposes of this policy a professional affiliation is where a physician associates themselves with a clinic, treatment, product, or device. For example, where a physician invests in or owns a clinic, sells a product in their practice, or speaks publicly in support of a treatment or device.

Policy

The aim of this policy is to support and regulate the safe and appropriate provision of complementary and alternative medicine, not to prohibit or prevent its use.

The *Medicine Act, 1991* provides that physicians shall not be found guilty of professional misconduct or incompetence solely on the basis that they practice "a therapy that is non-traditional or that departs from the prevailing medical practice unless there is evidence that proves that the therapy poses a greater risk to a patient's health than the traditional or prevailing practice".

1. As in all other areas of clinical practice, physicians who provide complementary or alternative medicine **must** practice:

    a) in their patient's best interests;
    b) in a manner that is in keeping with their professional, ethical, and legal obligations;
    c) in a manner that is informed by evidence[3] and scientific reasoning; and
    d) within their conventional scope of practice and the limits of their knowledge, skill, and judgment[4].

2. Physicians **must** comply with the expectations of this policy whenever providing complementary or alternative medicine, regardless of whether they are doing so:

    a) in addition to a conventional treatment,
    b) as an alternative to a conventional treatment, or
    c) in the absence of an available conventional treatment.

3. Physicians **must** practice in a manner that is respectful of patient's treatment decisions and their ability to set health care goals in accordance with their own wishes, values and beliefs. This includes the decision to pursue or refuse treatment, whether that treatment is conventional, complementary or alternative.

[3] For more information on use of evidence, please see the *Advice to the Profession* document.
[4] In compliance with Sections 2(1)(c), 2(5), O.Reg. 865/93, Registration, enacted under the Medicine Act, 1991, S.O. 1991, c.30, the College's *Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice* policy, and the Practice Guide. Please see the *Advice to the Profession* document for more information about scope of practice.

Before Providing Complementary or Alternative Medicine

Conducting an Assessment

4. Physicians **must** conduct a conventional clinical assessment in accordance with the standard of practice, including:

    a) conducting a comprehensive patient history;
    b) obtaining information regarding any relevant treatments the patient may already be receiving;
    c) conducting any necessary assessments, examinations, tests, or investigations and considering those already undertaken by other health care professionals, to understand the patient's symptoms, complaints, or condition, or to reach a diagnosis; and
    d) taking any other reasonable steps that may be necessary to obtain relevant and comprehensive information about the patient's symptoms, complaints, or condition.

Reaching and Communicating a Diagnosis

5. Prior to offering complementary or alternative medicine, physicians **must** make a conventional diagnosis or differential diagnosis[5] on the basis of the conventional assessment, communicate it to the patient, and inform the patient of any conventional treatment options that are available to treat their symptoms, complaints or condition.

6. Physicians **must** only offer an additional diagnosis that is not generally accepted as part of conventional medicine, what is sometimes referred to as a 'complementary or alternative diagnosis', where:

    a) the diagnosis is informed by the conventional assessment and conventional diagnosis or differential diagnosis;
    b) any additional assessments conducted to reach the complementary or alternative diagnosis are informed by evidence and scientific reasoning; and
    c) the complementary or alternative diagnosis itself is informed by evidence and scientific reasoning.

Providing Complementary or Alternative Medicine

7. Physicians **must not** provide complementary or alternative treatments that have been demonstrated to be ineffective.

[5] This could include determining that there is no conventional diagnosis that can be made or that the patient is "not yet diagnosed".

8. Physicians **must** only provide complementary or alternative treatments:

    a) to diagnose or treat symptoms, complaints or conditions that are within their scope of practice to treat using conventional medicine;
    b) that they have the knowledge, skill, and judgment to provide;
    c) that are supported by sound clinical judgment; and
    d) that are informed by evidence and scientific reasoning to a degree that is proportionate to the risks to the patient associated with the treatment.[6]

9. In addition to the requirements in provision 8, physicians **must** only provide a complementary or alternative treatment to a patient where the potential benefits outweigh the risks taking into account:

    a) The health status and needs of the patient;
    b) The strength of evidence and scientific reasoning regarding the efficacy of the complementary or alternative treatment for the patient's symptoms, complaints, or condition; and
    c) The potential for harm to the patient due to factors including:
        i. the nature of the proposed complementary or alternative treatment itself,
        ii. the potential interaction between the proposed option and any other treatments the patient is undergoing,
        iii. the conventional options available to treat that patient and their respective efficacy, and
        iv. whether the treatment will be provided alongside conventional treatment or as an alternative to it.

10. Physicians **must** be aware of, consider, and take reasonable steps to address the patient's potential vulnerability[7]. A patient's potential vulnerability will depend on a number of factors including:
    - any potential financial hardship the patient may be experiencing;
    - the probability of the treatment producing a meaningful benefit; and
    - the patient's individual circumstances (for example, the patient suffers from a serious, life-threatening, or terminal illness).

Obtaining Informed Consent

11. Physicians **must** obtain informed consent as required by applicable legislation[8], the College's *Consent to Treatment* policy, and as set out in this policy.

[6] Treatments that are low risk will require less evidence to support their provision to a patient, while treatments that may be high risk will require stronger evidence to support their use. For more information on appropriate evidence please see the *Advice to the Profession* document.
[7] For more information see the *Advice to the Profession* document.
[8] Applicable legislation includes the *Health Care Consent Act, 1996* (HCCA).

12. As part of obtaining informed consent physicians **must** communicate the following information to the patient or their substitute decision-maker before providing complementary or alternative medicine:

    a) the extent to which the complementary or alternative diagnosis reached (if applicable) is supported by the conventional medical community;
    b) the rationale for recommending the treatment;
    c) any benefit, financial or otherwise, that the physician will receive for providing the treatment[9];
    d) an accurate representation of the strength of evidence (e.g., quality and quantity) and scientific reasoning that supports the decision to offer the treatment;
    e) reasonable expectations for the efficacy of the treatment; and
    f) a clear and impartial description of how the treatment compares to:
        i. any conventional treatment that could be offered to treat the patient (including a comparison of risks, side effects, expectations for therapeutic efficacy, cost to the patient, and any other relevant considerations); and
        ii. the option of receiving no treatment.

Documentation

13. Physicians providing complementary or alternative treatment **must** comply with the College's *Medical Records Documentation* policy which, among other expectations, includes the expectation that the medical record contain documentation that supports the treatment or procedure provided (i.e., the rationale for the treatment or procedure is evident in the record).[10]

14. Physicians providing complementary or alternative treatment **must** document that consent to the treatment was obtained and that information was communicated to the patient in accordance with Provision 13 of this policy.

Conflicts of interest and professional affiliations

15. As in all areas of clinical practice, physicians **must:**

[9] Physicians are expected to comply with the O. Reg. 114/94: GENERAL under Medicine Act, 1991, S.O. 1991, c. 30 (the Conflicts of Interest Regulation) which states that it is a conflict of interest for a member where "they or a member of their family, or a corporation wholly, substantially, or actually owned or controlled by them or their family… sells or otherwise supplies any drug, medical appliance, medical product or biological preparation to a patient at a profit, except, a drug sold or supplied by a member to his or her patient that is necessary, (A) for an immediate treatment of the patient, (B) in an emergency, or (C) where the services of a pharmacist are not reasonably readily available…".

[10] The greater the potential risks to the patient are, or the further outside of conventional medicine a treatment is, the greater the need may be to document the full analysis undertaken to determine the appropriateness of providing the treatment.

a) avoid or recognize and appropriately manage conflicts of interest,[11] and
b) **not** charge an excessive fee for the services provided.[12]

16. Physicians who wish to form professional affiliations with complementary or alternative clinics, therapies, products, or devices **must:**

a) critically assess the efficacy and safety of the treatments offered by the clinic and/or the therapeutic benefit to be obtained from the therapy or device and only form a professional affiliation if they are satisfied that they comply with the expectations in this policy;
b) comply with the Advertising provisions in the General Regulation under the *Medicine Act, 1991* including that they**:**
    i. **not** associate themselves with any advertising for a commercial product or service other than their own medical services, or for any facility where medical services are not provided by the physician[13]; and
    ii. ensure any published materials[14] relating to that professional affiliation are accurate, factual, and based on evidence and scientific reasoning.[15]

[11] See O.Reg. 114/94 General, Part IV, Conflicts of Interest, and O.Reg. 856/93 Professional Misconduct, enacted under the Medicine Act, 1991, S.O. 1991, c.30. For example, the Conflict of Interest Regulation requires a physician who or whose family has a proprietary interest in a facility where diagnostic or therapeutic services are performed to inform the College of the details of the interest. The College's Conflict of Interest Declaration Form can be found here.
[12] Section 1(1), paragraph 21, O.Reg. 856/93 Professional Misconduct, enacted under the Medicine Act, 1991 S.O. 1991, c.30. See also the Uninsured Services: Billing and Block Fees policy.
[13] As prohibited by the College's *Advertising* policy and O. Reg. 114/94: GENERAL under *Medicine Act, 1991*, S.O. 1991, c. 30.
[14] For example, presentation materials for conferences, published research or patient materials.
[15] O. Reg. 114/94: GENERAL under *Medicine Act, 1991*, S.O. 1991, c. 30.

Advice to the Profession:
Complementary and Alternative Medicine

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.

This document is intended to provide guidance for how the obligations set out in the *Complementary and Alternative Medicine* policy can be effectively discharged. This document also seeks to provide physicians with practical advice for addressing common issues that arise in practice.

Much of this document is intended to assist physicians who provide complementary or alternative treatments to patients. However, even physicians who do not provide complementary or alternative medicine may be asked questions or have discussions with patients regarding these kinds of treatments. More information on what physicians who do not provide complementary or alternative medicine need to know, can be found towards the end of this document.

What is complementary and alternative medicine?

Complementary and alternative medicine can be described as any treatment that is not part of the conventional medicine that is commonly provided in hospitals and specialty or primary care practices and taught in medical schools, and encompasses a range of therapeutic concepts, practices, and products. This can range from low risk lifestyle change and natural product suggestions, through to medical interventions or procedures that may pose a greater risk of harm to a patient.

Generally, practices like naturopathy, acupuncture, meditation, yoga, reiki, non-contact therapeutic touch, and homeopathy are associated with complementary and alternative medicine.[1]

However, as the policy states, also included in the definition of complementary and alternative medicine are both:

- non-conventional uses of an existing conventional treatment, and
- new or emerging treatments, practices, and products that are based on conventional medical understanding and scientific reasoning.

[1] While many different concepts, practices and products fall within the term "complementary and alternative medicine" this does not mean that all these concepts, practices or products would be permissible under the *Complementary and Alternative Medicine* policy. Only those which comply with the provisions of the policy may be acceptable for physicians to provide.

What is or is not considered complementary and alternative medicine can change over time, as concepts, practices, and products that are proven to be effective are incorporated into conventional medicine.

Some new medical treatments may be subject to other regulatory limits. For example, Health Canada requires that some treatments or therapies be registered with them as part of a clinical trial. Physicians providing this kind of medicine will need to be aware of any other regulatory limits that may apply and comply with them.

Why does the CPSO set out expectations for physicians who provide complementary or alternative medicine?

As the medical regulator in the province of Ontario, the CPSO sets out expectations for physicians who provide care to patients, whether that care is conventional, complementary, alternative, or integrative.

In order to ensure the provision of quality care, the CPSO aims to strike a balance between protecting patients from harm, while respecting patient choice and autonomy, and not impeding innovation and professional judgment.

At their core, CPSO expectations aim to ensure that:

- physicians act with their patients' best interests in mind (for instance, by not exposing the patient to unnecessary risk, by being transparent with patients about the risks and benefits of treatments, etc.);
- physicians respect patient choice or autonomy regarding their health care goals and treatment decisions (for instance, by conveying information to and discussing treatments with patients in a non-judgemental way, providing impartial information, etc.); and
- physicians are aware of and take reasonable steps to address patient's potential vulnerability (for instance, by considering the patient's individual circumstances or any financial hardship a patient may be experiencing, etc.).

What are the health risks associated with complementary and alternative medicine?

On the basis of the available evidence, some complementary or alternative treatments appear to pose little risk in themselves, however, some can present significant, even life-threatening health risks. This may be, for example, because the treatment itself is inherently risky, or because it is interfering with or replacing the administration of a more effective conventional medical treatment, especially for a serious illness. There are cases where the administration of a treatment as an alternative to a more effective medical treatment has contributed to a patient's death. These risks are serious and need to be considered carefully in line with the values and principles of medical professionalism and the expectations set out in the policy.

What is the evidence for complementary and alternative medicine?

For both conventional and complementary or alternative medicine, clinical research can help to identify a treatment's risks and benefits and confirm the extent to which a treatment is effective.

Many complementary or alternative treatments have either not been the subject of randomized controlled clinical trials, or the results of the available research do not convincingly demonstrate any positive effect. There may be very little evidence to support the use of some proposed complementary or alternative treatments. As a result, the full risks and benefits of many such treatments are not always well understood.

The policy requires physicians to only provide complementary or alternative treatments that are informed by evidence and scientific reasoning regarding the efficacy of the treatment. Physicians will need to exercise careful judgment of the evidence to ensure they meet this standard.

What should I consider in evaluating the strength of evidence?

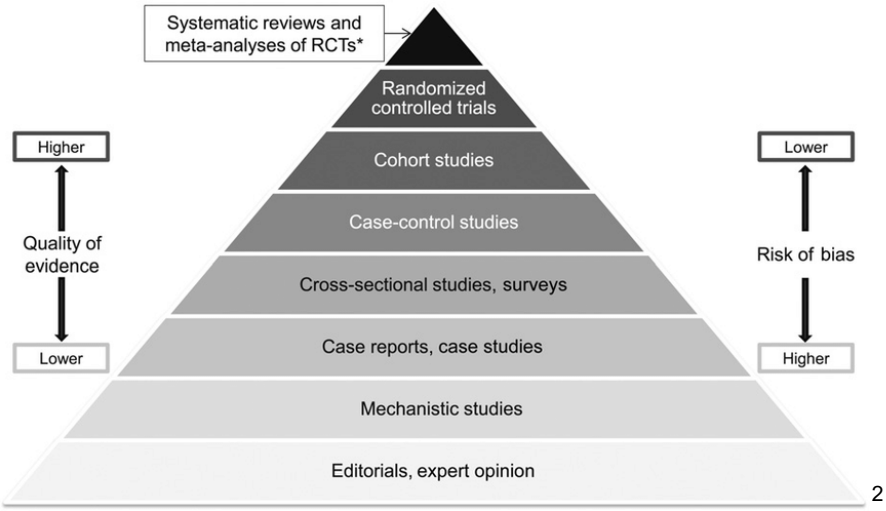
The policy requires that complementary or alternative treatments be informed by evidence and scientific reasoning in order to mitigate the risks associated with providing these treatments.

Recommending a treatment to patients without strong scientific evidence raises several risks, including that:

- it will not be effective,
- it will be less effective than another available treatment (for example, a conventional medical treatment), and/or
- it will have unexpected negative consequences (e.g., side-effects).

Before providing such treatments, physicians must think carefully about the strength of evidence there is for a treatments efficacy and how providing a particular treatment could impact a patient and their health care decisions. For example, where the evidence for a treatment is modest, but the risk of harm to the patient is low and it would be undertaken alongside conventional treatment, it may be appropriate for a physician to provide such treatment. However, where the evidence for the treatment is modest, the risks to the patient are potentially high and it would be provided instead of a conventional treatment, the treatment may be inappropriate. **Generally speaking, the higher the potential risk to the patient, the higher the level of evidence required.**

The strength of evidence can be broadly assessed using the hierarchy of evidence below:



[2]

While the above diagram shows a generally accepted hierarchy of evidence, the list is not exhaustive, and other types of evidence may be considered.

It will also be important to consider other factors that enhance the strength of evidence, such as:

- objectivity, and based on accepted principles of good research;
- coming from reputable sources (for example, peer-reviewed journals);
- clear demonstration of the therapeutic claims made;
- findings that have been replicated and are consistent across multiple studies; and
- consistency with higher quality studies.

Evidence that would be considered less strong and may not be appropriate to rely on could include:

- studies involving no human subjects;
- before and after studies with little or no control or reference group (e.g. case studies);
- self-assessment studies;
- anecdotal evidence based on observations in practice; and
- patient self reporting.

Less strong evidence may not support offering a treatment at all or may not support offering it to a particular patient after engaging in the risk benefit analysis as set out in the policy.

[2] Yetley, Elizabeth et al., (2016). Options for basing Dietary Reference Intakes (DRIs) on chronic disease endpoints: report from a joint US-/Canadian-sponsored working group. American Journal of Clinical Nutrition. 105. 10.3945/ajcn.116.139097.

While these types of evidence may have value in helping to inform a physician's decision-making, they are less reliable than the evidence produced by the kinds of research outlined in the pyramid above.

The evidence base for many areas of complementary and alternative medicine is constantly evolving so it is important that physicians keep current in terms of the evidence they rely on.

What will the College look at in determining whether it was appropriate for a physician to provide complementary or alternative medicine to a patient?

When the College receives a complaint or a report about a physician providing complementary or alternative medicine, there are a number of factors that will determine the appropriateness of the treatment being provided.

The policy requires physicians to only provide a complementary or alternative treatment to a patient where the benefits of providing the particular treatment outweigh the risks. Physicians need to determine this by weighing a number of factors, including:

- the health status and needs of the patient;
- the strength (e.g. quantity and quality) of evidence and scientific reasoning regarding the effectiveness of the treatment provided for the patient's symptoms, complaints or condition;
- the potential for harm to the patient;
- any potential interactions between the proposed treatment and any other treatments the patient is currently undertaking; and
- whether the treatment was provided alongside conventional treatment or as an alternative to it.

These factors exist on a spectrum and need to be considered in relation to each other. As outlined above the strength of evidence required to justify providing a particular treatment to a patient will vary depending on the other factors, such as the potential risks to the patient. Where the risks to a patient are low, there will likely be less concern about the treatment being provided, as long as there is compliance with the other provisions in the policy.

Physicians need to be aware that gaining patient consent is not enough on its own to negate the risk benefit analysis. While patients have autonomy to make personal healthcare decisions, there are limits to the kind of treatments it would be appropriate for physicians to provide, regardless of whether the patient consents. Patient consent does not absolve physicians of their responsibility to use professional judgement and only offer treatments that are in the patient's best interest.

What steps do I need to take to address patient vulnerability when providing complementary or alternative medicine?

Patient vulnerability can vary depending on a variety of factors including the patient's individual circumstances (such as suffering from a life threatening or terminal illness), or where the cost of treatment may cause financial hardship for the patient.

If your patient is particularly vulnerable or at heightened risk of vulnerability additional steps may be needed to avoid (inadvertently) exploiting them. This could include taking extra care to ensure the patient understands the risks of treatment, providing them with additional resources and information, or giving them additional time to consider their options.

What are the limits for complementary or alternative treatments I as a physician can provide?

Physicians can only provide complementary or alternative treatments to address symptoms, complaints, or conditions that are within their conventional scope of practice to treat, and that they have the knowledge, skills, and judgement to provide. Physicians cannot offer treatments for conditions they would not be able to manage within their conventional scope of practice.

For example, a physician practising orthopedics may use complementary or alternative treatments that could assist with musculoskeletal injuries but would not be able to provide complementary or alternative treatments relating to, for example, pancreatic cancer. Such cancer treatment would not be within that physician's conventional scope of practice.

Family physicians generally have a wide scope of practice and may help co-manage conditions with specialists. Generally, if the symptom, condition or complaint is something they would ordinarily treat within their conventional scope of practice then, provided they comply with the other provisions of the policy, they can provide complementary or alternative treatments for those same symptoms, conditions or complaints.

Complementary or alternative medicine is not a scope of practice for physicians. The College's focus is on the practice of medicine, and the role complementary or alternative medicine can play within a physician's conventional scope of practice. Physicians wishing to practice complementary or alternative medicine more broadly and across traditionally defined scopes of practice, will need to train and credential as a complementary or alternative medicine practitioner.

How does the policy apply to therapies that may be of cultural importance to a specific group (for example, Indigenous traditional healing, traditional Chinese medicine or Ayurvedic medicine) and those who practice such therapies?

This policy applies only to physicians and the services they provide. Nothing in this policy prevents patients from accessing care from other practitioners, including those who provide culturally important healing practices and patients are free to seek care from other practitioners of their choosing.

Additionally, nothing in the policy prevents physicians from incorporating such therapies into their practice, as long as in doing so they meet the provisions set out in the policy. Physicians may also work with other practitioners who provide such therapies.

When providing care, it is important for physicians to recognize that some therapies may be practised within a specific cultural context and have particular importance to certain cultural groups. Providing care in a manner that is culturally competent and respects a patient's culture, beliefs, lifestyle, healthcare goals and treatment decisions is an important part of medical professionalism.

I am a physician who doesn't provide complementary or alternative medicine but have patients who use it – what do I need to know?

Complementary and alternative medicine is continually developing. Many physicians may have patients exploring its use and patients are entitled to make treatment decisions and set health care goals in accordance with their own wishes, values, and beliefs. This includes the decision to pursue complementary or alternative medicine.

Some awareness of complementary and alternative medicine would be beneficial and help physicians answer questions patients may have. However, physicians are not required to know about treatment options that are not part of conventional medicine.

Physicians will need to determine what information they feel they are able to provide to a patient based on their knowledge of, and experience with, complementary or alternative medicine.

It is important that physicians inquire about their patients use of complementary or alternative medicine when assessing a patient in order to understand how these treatments may interact with any course of action the physician is recommending. It will also be important for physicians to consider whether they need more information about any treatments a patient says they are undertaking before recommending conventional treatment that may interact with those complementary or alternative treatments.

As stated in the policy, physicians must respect a patient's choice to pursue complementary or alternative medicine. Patients have the right to make their own healthcare decisions and to pursue treatments outside of those provided by their physician.

What should I do if a patient asks me to refer them to another health care provider based on advice they have received from a complementary or alternative medicine practitioner? Or if I'm asked to order a test for a patient that a complementary or alternative medicine practitioner has told them they need?

Physicians are sometimes approached by patients seeking a referral either on the basis of advice the patient has received from a complementary or alternative medicine practitioner, or to investigate questions or concerns related to complementary or alternative medicine.

Physicians may also be approached by patients seeking diagnostic tests or other clinical investigations related to complementary or alternative medicine. Sometimes a complementary or alternative medicine practitioner may recommend some tests which only a physician can order, or where they would be covered by insurance if ordered by a physician.

It is important that physicians always consider whether such a referral or the ordering of a test or investigation would be in the patient's best interest, and whether there is a clinical basis for it. However, it is not appropriate for physicians to provide referrals, or order tests or investigations that are not clinically indicated. Physicians who make a referral or order a specific test or investigation are responsible for them and any follow-up that is required (see the *Managing Tests* policy for more information).

Council Motion

Motion Title	*Complementary and Alternative Medicine* – Revised Draft Policy for Final Approval
Date of Meeting	September 14, 2021

It is moved by_____, and seconded by_____, that:

The Council approves the revised policy "Complementary and Alternative Medicine", formerly the "Complementary/Alternative Medicine" policy, (a copy of which forms Appendix " " to the minutes of this meeting).

Council Briefing Note

September 2021

Topic:	Declared Emergency
Purpose:	For Decision and Discussion
Relevance to Strategic Plan:	Continuous Improvement
Public Interest Rationale:	Ensuring CPSO is agile and able to operate effectively during an emergency situation. 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 Contact(s):	Lisa Brownstone, Chief Legal Officer Marcia Cooper, Senior Corporate Counsel and Privacy Officer
Attachment(s):	Appendix A: Summary of Declared Emergency By-law Appendix B: CPSO Declared Emergency By-law (By-law No. 42)

Issue

- Council is asked to consider ending the emergency declaration made by the Executive Committee in March 2020.

Background

- The Executive Committee declared an emergency under the CPSO Declared Emergency By-law (By-law No. 42) on March 24, 2020, at a time when a state of emergency had been declared by the Province of Ontario due to the pandemic.
- Overall, the By-law provides some flexibility and processes to ensure Council, the Executive Committee and the Registration Committee can continue to function during an emergency situation. A summary of the Declared Emergency By-law is provided in Appendix A.

Current Status and Analysis

State of the Declared Emergency

- While the pandemic is not fully resolved, as of August 3, 2021 Ontario was in Step Three of the Roadmap to Reopen (under O. Reg. 541/21).
    - Certain Orders made under the *Emergency Management and Civil Protection Act* have been extended to August 11, 2021 (for example, the Order relating to scope of practice of regulated health professionals (O. Reg. 305/21)).
    - Several orders under this Act have been revoked (for example work redeployment for LHINS and Ontario Health, and the Stay-at-Home Order).
- Senior management is now discussing return to work policies, with a view to transitioning to a hybrid work model commencing in October, 2021.
- The By-law does not specify criteria for when a declared emergency should be declared over.
- CPSO invoked the powers under the By-law once during the CPSO emergency declaration to postpone the 2020 Council district elections to September.
- For good governance, a declared emergency should not continue indefinitely and should be declared over when there is no longer a basis or rationale for keeping it in place.
- Under the By-law either the Executive Committee or Council may declare (by resolution)[1] the emergency is over.
- At its August meeting, the Executive Committee discussed whether the emergency declaration should be ended and decided to forward the question to Council for its consideration.

Questions for Council

1. Does Council wish to declare the emergency over?

[1] A motion satisfies the requirement for the resolution.

Appendix A

Summary of Declared Emergency By-law

Background

- Passed in June 2007, after SARS and hurricane Katrina, and in case of potential pandemic influenza
- Goal was to ensure Council, Executive Committee and Registration Committee can continue to function during an emergency situation.

Relevant Points of By-law

Where the Executive Committee has declared an emergency:

Notice to Council

- Executive Committee must give immediate notice of the declared emergency to every member of Council.

Vacancies on Executive Committee

- A position on Executive Committee may be declared vacant by the other committee members if they consider the person to be unable to participate in committee meetings due to circumstances connected to the declared emergency.
- There is a process for filling vacancies on the Executive Committee during the declared emergency. Council is to approve a list of Council members in the order in which they are to fulfill vacancies. The Committee should consider whether to do this at May Council, out of an abundance of caution.

Registration Committee

- All members of Council shall be ex-officio members of the Registration Committee.
    - Note: If the Registration Committee is functioning well, it would not be necessary to have Council members who were not already on the Registration Committee participate.

Council Elections

- If a Council election cannot be held, the elected Council members for those districts would continue to be Council members until the first regular Council meeting after the election is ultimately held.

Council Meetings

- Council meetings may be called on shorter notice than usually required. Council meetings may be called by the President or Registrar with sufficient notice to get a quorum.
- Council may consider any matter at a meeting called during an emergency if the majority vote to consider it. This provides more flexibility than in the normal course.

End of Emergency

- The declared emergency ceases when the Executive Committee or Council declares it is over.

Appendix B

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

By-law No. 42

1. The provisions of this By-law shall only take effect during a declared emergency.

2. A declared emergency shall occur in any of the following circumstances:

   (a) the Executive Committee has, by majority resolution, declared there to be an emergency;

   (b) the Registrar has declared there to be an emergency provided that the Registrar may only do so if there has been a declared emergency under the Emergency Management and Civil Protection Act anywhere in the Province of Ontario and the Executive Committee is unable to meet within twenty-four (24) hours of such declaration.

3. In the event of a declared emergency the following provisions shall apply to the governance of Council:

   (a) the Registrar or the Executive Committee, as the case may be, shall give immediate notice to every member of Council that a declared emergency exists;

   (b) in the event that during the declared emergency there shall be a vacancy or vacancies on the Executive Committee, such vacancy or vacancies shall be deemed to be filled by a member of Council in the order in which such member's name appears on a list prepared and approved form time to time by Council by resolution and appended to this By-law;

   (c) a position on the Executive Committee may be declared vacant by the other members of the Executive Committee if the Council member holding that position on the Executive Committee is considered by the other members of the Executive Committee to be unable to participate in Executive Committee meetings due to a circumstance connected to the declared emergency;

   (d) all members of Council shall be ex-officio members of the Registration Committee;

   (e) in the event that an election of Members to Council is not able to be held, the term of office of the elected Council Members shall continue notwithstanding Section 11 of the General By-law until the first regular meeting of Council held after the election;

   (f) Despite Subsections 29 (3) and 29 (4) of the General By-law, a Council meeting may be called by the President or Registrar at any time on such notice as is sufficient for a quorum to be present in person or by teleconference and such meeting may consider and deal with any matter that the Council agrees to consider by a majority vote of those in attendance and voting.

4. In the event of a conflict between this By-law and any other By-law of the College, the provisions of this By-law shall prevail.

5. A declared emergency shall cease when the Executive Committee or Council declares, by resolution, the emergency is over.

Council Motion

Motion Title	Declared Emergency
Date of Meeting	September 14, 2021

It is moved by_____, and seconded by_____, that:

The Council declares that the emergency declared by the Executive Committee on March 24, 2020 under CPSO By-law No. 42 (the Declared Emergency By-law) is over, effective immediately.

Council Briefing Note

September 2021

Topic:	Housekeeping By-law Amendments re Terms of Academic Representatives
Purpose:	For Decision
Relevance to Strategic Plan:	Continuous Improvement
Public Interest Rationale:	Accountability: Holding regulated health professionals accountable to their patients/clients, the College and the public
Main Contact(s):	Marcia Cooper, Senior Corporate Counsel and Privacy Officer
Attachment(s):	Appendix A: Proposed By-law Amendments

Issue

- Housekeeping by-law amendments are proposed to clarify the terms of academic representatives on Council and the Academic Advisory Committee.

Background

- Three academic representatives are selected each year to serve as voting members of Council. The three academic representatives who are not selected as voting members also attend and participate (other than voting) at Council meetings, although they are not Council members by law.

- Physician Council members are subject to a nine year term limit on Council (General By-law s. 11(2)).

- All academic representatives sit on the Academic Advisory Committee. The term limit for service on the Academic Advisory Committee is nine years.

- In considering the eligibility of former academic representatives to stand for election to Council, the Governance Committee has determined that an academic representative's participation at Council in a non-voting capacity should count towards the nine year term limit on Council membership, consistent with the intent of the term limits to capture service to CPSO.

- The Executive Committee agreed with this position.

Current Status and Analysis

- It is recommended that the by-law provisions be amended to clarify that participation by academic representatives at Council, whether as a voting member or in a non-voting capacity, count towards the nine year term limit on Council membership.

- This means that the total of the number of years a physician serves as an elected member of Council plus the number of years the physician serves as an academic representative cannot exceed nine years.

- The proposed by-law amendments are set out in Appendix A. The revisions are underlined in red.

- These by-law amendments are for clarification and are “housekeeping” in nature.

Next Steps

- These by-law amendments do not require circulation to the profession.

Questions for Council

1. Does Council approve the proposed amendments to the General By-law?

Appendix A

ACADEMIC SELECTION

** The red or blue, underlined text are the proposed changes. The other sections are already enacted provisions of the General By-law.*

Academic Advisory Committee

24. …

(3) A member is eligible for appointment to the academic advisory committee if, on the date of the appointment, …

(i) the total of (A) the number of years of the proposed appointment, (B) the number of years the member was an elected member of the council (if any), and (C) the number of years the member was a member of the academic advisory committee (regardless of whether such member was selected as a councillor pursuant to Section 26 for all or part of that time) does not exceed nine years;

~~(i)~~(j) 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);

~~(j)~~(k) council has not disqualified the member from council or from one or more committees during the five years before the election date;

~~(k)~~(l) the member has not resigned from council or from one or more committees during the five years before the election date where there are reasonable grounds to believe that the resignation is related to a proposed disqualification of the member from council or one or more committees; and

~~(l)~~(m) the member has completed the orientation program specified by the College relating to the business and governance of the College and the duties, obligations and expectations of council and committee members.

Selection of Councillors

26. (1) Three members of the academic advisory committee shall be selected as councillors in accordance with this section. …

(5) For purposes of subsection 11(2), the period of time a member was appointed to the academic advisory committee shall be counted as part of the calculation of the nine year total, regardless of whether the member was selected as a councillor pursuant to Section 26 for all or part of that time. [1]

[1] Subsection 11(2) of the By-law sets out the nine-year term limit on physicians as council members.

Council Motion

Motion Title	By-law Amendments – Term of Academic Representatives
Date of Meeting	September 13 or 14, 2021

It is moved by_____, and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 142:

By-law No. 142

(1) Subsection 24(3) of the General By-law is amended by deleting clauses (i) to (l) and replacing them with clauses (i) to (m) below:

(3) A member is eligible for appointment to the academic advisory committee if, on the date of the appointment, …

(i) the total of (A) the number of years of the proposed appointment, (B) the number of years the member was an elected member of the council (if any), and (C) the number of years the member was a member of the academic advisory committee (regardless of whether such member was selected as a councillor pursuant to Section 26 for all or part of that time) does not exceed nine years;

(j) 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);

(k) council has not disqualified the member from council or from one or more committees during the five years before the election date;

(l) the member has not resigned from council or from one or more committees during the five years before the election date where there are reasonable grounds to believe that the resignation is related

to a proposed disqualification of the member from council or one or more committees; and

(m) the member has completed the orientation program specified by the College relating to the business and governance of the College and the duties, obligations and expectations of council and committee members.

(2) Section 26 of the General By-law is amended by adding the following as subsection 26(5):

Selection of Councillors

26. …

(5) For purposes of subsection 11(2), the period of time a member was appointed to the academic advisory committee shall be counted as part of the calculation of the nine year total, regardless of whether the member was selected as a councillor pursuant to Section 26 for all or part of that time.