CPSO

Meeting of Council

Annual General Meeting

December 8 & 9, 2022

NOTICE

OF

MEETING OF COUNCIL

A meeting of the Council of the College of Physicians and Surgeons of Ontario (CPSO) will take place in-person on December 8 and 9, 2022 in the Council Chamber of the College, at 80 College Street, Toronto, Ontario. This is the annual general meeting of Council.

The Council meeting will be open to staff and members of the public who wish to attend in-person. The meeting will also be live streamed. Members of the public who wish to observe the meeting in-person or view the live stream will be required to register online at least 48 hours prior to the meeting. Details on this process are available on the CPSO's website.

The meeting will convene at 10:45 am on Thursday, December 8, 2022.

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

November 16, 2022

Council Meeting Agenda
Annual General Meeting
December 8-9, 2022

CPSO

THURSDAY, DECEMBER 8, 2022

Item	Time	Topic and Objective(s)	Purpose	Page No.
1	**10:45 am** (10 mins)	**Call to Order and Welcoming Remarks** (J. van Vlymen) • Participate in roll call and declare any conflicts of interest • Review meeting norms for in-person meetings	Discussion	N/A
2	**10:55 am** (5 mins)	**Consent Agenda** (J. van Vlymen) 2.1 Approve Council meeting agenda 2.2 Approve minutes from Council meeting held September 22, 2022 and September 23, 2022	Approval (with motion)	1-108
3		**Items for information:** 3.1 Executive Committee Report – No Report 3.2 Ontario Physicians and Surgeons Discipline Tribunal Cases 3.3 Government Relations Report 3.4 Annual Committee Reports 3.5 Policy Report 3.6 Medical Learners Report 3.7 Update on Council Action Items	Information	 -- 109-114 115-116 117-154 155-159 160-162 163-173
4	**11:00 am** (60 mins)	**CEO/Registrar's Report** (N. Whitmore)	Discussion	N/A
*	**12:00 pm** (60 mins)	**LUNCH (Lunch available in the Dining Room)**		
5	**1:00 pm** (45 mins)	**Key Performance Indicators for 2023** (N. Whitmore) • Council is asked to consider approving the Key Performance Indicators for 2023	Decision (with motion)	Presentation at time of meeting
6	**1:45 pm** (10 mins)	**President's Report and Emerging Issues** (J. van Vlymen)	Discussion	N/A
7	**1:55 pm** (15 mins)	**Ontario Physicians and Surgeons Discipline Tribunal's Mission Statement and Core Values** (D. Wright) • Council receives for information the OPSDT's Mission Statement and Core Values	Information	174-176

Item	Time	Topic and Objective(s)	Purpose	Page No.
8	**2:10 pm** (30 mins)	**Equity, Diversity & Inclusion Presentation** (S. Sharda / F. Hill-Hinrichs) • Presentation of EDI work completed in 2022 and EDI plan for 2023	Information	Presentation at time of meeting
*	**2:40 pm** (30 mins)	**NUTRITION BREAK**		
9	**3:10 pm** (10 mins)	**Amendments to the Fees and Remuneration By-law regarding Temporary Independent Practice Certificate of Registration (**M. Cooper / S. Tulipano) • Council is asked to consider approving the By-law amendments (already circulated to the profession) that provide for a fee for the new Temporary Independent Practice Certificate of Registration	Decision (with motion)	177-180
10	**3:20 pm** (30 mins)	**Acceptable Qualifying Examinations** (S. Tulipano) • Council is asked whether the proposed policy amendments can be circulated for notice in accordance with Section 22.21 of the Code	Decision (with motion)	181-188
11	**3:50 pm**	**Adjournment Day 1** (J. van Vlymen)	N/A	N/A

FRIDAY, DECEMBER 9, 2022

Item	Time	Topic and Objective(s)	Purpose	Page No.
*	**8:30 am**	**INFORMAL NETWORKING (Breakfast available in the Dining Room)**		
12	**9:00 am** (5 mins)	**Call to Order** (J. van Vlymen) • Participate in roll call and declare any conflicts of interest	Discussion	N/A
13	**9:05 am** (45 mins)	**Conflicts of Interest and Industry Relationships – Draft Policy for Consultation** (A. Wong) • Council is asked to consider approving the draft Conflicts of Interest and Industry Relationships policy for external consultation	Decision (with motion)	189-206
14	**9:50 am** (5 mins)	**By-law Amendment: Update signing authority title** (M. Cooper) • Council is asked to consider approving the housekeeping by-law amendments to update the title of one of the signing authorities	Decision (with motion)	207-209
15	**9:55 am** (10 mins)	**District Elections for 2023 and By-law Amendment** (C. Allan, C. Ferguson, M. Cooper) • Council is asked to consider approving the proposed dates for the 2023 district elections and the By-law amendments to reflect the update to election timing	Decision (with motion)	210-213
*	**10:05 am** (30 mins)	**NUTRITION BREAK**		
16	**10:35 am** (30 mins)	**Governance Committee Report** (J. Plante) • An update is provided on the September 20 and November 1 Governance Committee meetings 16.1 Governance Committee Elections 16.2 Chair and Vice-Chair Appointments / Reappointments 16.3 Committee Appointments	Decision (with motion)	 214-222 223-226 227-231
17	**11:05 am** (25 mins)	**Dispensing Drugs Policy – Final Approval** (A. Wong) • Council is asked to consider the revised draft Dispensing Drugs policy for final approval	Decision (with motion)	232-239
18	**11:30 am** (15 mins)	**Academic Advisory Committee Update and By-law Amendment** (L. Rinke-Vanderwoude, M. Cooper) • Council is asked to consider approving the proposed by-law amendment to move the mandate of selecting the three voting members from the Academic Advisory Committee to the Governance Committee	Decision (with motion)	240-249
19	**11:45 am** (15 mins)	**Council Award Presentation** (Dr. Rupa Patel) Celebrate the achievements of Dr. Christopher Smith, Kingston, Ontario		
*	**12:00 pm** (60 mins)	**LUNCH (Lunch available in the Dining Room)**		

Item	Time	Topic and Objective(s)	Purpose	Page No.
20	**1:00 pm** (20 mins)	**2023 Budget** (T. Bertoia) • Council is asked to consider the 2023 Budget for approval	Decision (with motion)	251-259
21	**1:20 pm**	**Motion to Go in Camera** (J. van Vlymen)	Decision (with motion)	260
22	**1:20 pm** (85 mins)	**In-Camera Session**		In-Camera package provided under separate cover
*	**2:45 pm** (30 mins)	**NUTRITION BREAK**		
23	**3:15 pm** (25 mins)	**President's Items** (J. van Vlymen) 1. Acknowledge Outgoing Council Members 2. Presidential Address 3. Induction of New President 4. Welcome Incoming Council Members	Information	N/A
24	**3:40 pm** (5 mins)	**Adjournment Day 2** (J. van Vlymen) • Reminder that the next meeting is scheduled on March 2 and 3, 2023	N/A	N/A
*	**3:45 pm**	**Meeting Reflection Session** (J. van Vlymen) • Share observations about the effectiveness of the meeting and engagement of Council members	Discussion	N/A

DRAFT PROCEEDINGS OF THE MEETING OF COUNCIL
September 22 and 23, 2022

Location: Council Chamber, 80 College Street, Toronto, Ontario

September 22, 2022

Attendees

Dr. Madhu Azad
Dr. Glen Bandiera
Ms. Lucy Becker
Mr. Jose Cordeiro
Ms. Joan Fisk
Mr. Murthy Ghandikota
Ms. Julia Goyal
Dr. Robert Gratton (Vice-President)
Dr. Paul Hendry
Mr. Shahab Khan
Dr. Camille Lemieux
Mr. Paul Malette
Dr. Lionel Marks de Chabris
Dr. Lydia Miljan
Dr. Rupa Patel
Mr. Rob Payne
Mr. Peter Pielsticker
Dr. Judith Plante
Dr. Ian Preyra
Ms. Linda Robbins
Dr. Deborah Robertson
Dr. Jerry Rosenblum
Dr. Patrick Safieh
Mr. Fred Sherman
Dr. Janet van Vlymen (Chair and President)
Dr. Anne Walsh

Non-Voting Academic Representatives on Council Present:

Dr. Mary Bell
Dr. Andrea Lum
Dr. Karen Saperson

Regrets:

Mr. Shahid Chaudhry
Dr. Brenda Copps
Dr. Deborah Hellyer

Dr. Roy Kirkpatrick
Dr. Sarah Reid
Ms. Shannon Weber

1. Call to Order and Welcoming Remarks

J. van Vlymen, President of Council and Chair, called the meeting to order at 10:30 am. J. van Vlymen welcomed members of the public, Council Members, staff and those tuning in to the livestream to the Council meeting.

L. Miljan provided the land acknowledgement as a demonstration of recognition and respect for Indigenous peoples of Canada.

J. van Vlymen conducted a roll call and noted regrets. No conflicts of interest were declared on day one of Council.

2. Consent Agenda

J. van Vlymen provided an overview of the items listed on the Consent Agenda for approval. She noted that a new agenda item is being added to the agenda, "Regulatory Proposal – Temporary Class of Licensure".

01-C-09-2022

The following motion was moved by G. Bandiera, seconded by P. Pielsticker and carried, that:

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

- The Council meeting agenda for September 22 and 23, 2022, as amended; and
- The minutes from the Council meeting held on June 16 and 17, 2022, as distributed.

CARRIED

3. For Information

The following information items were included in the Council package:

3.1 Executive Committee Report
3.2 Ontario Physicians and Surgeons Discipline Tribunal Cases
3.3 Government Relations Report
3.4 Policy Report
3.5 Medical Learners Reports – Ontario Medical Students Association (OMSA) and Professional Association of Residents of Ontario (PARO)
3.6 Update on Council Action Items
3.7 2023 Council Meeting Dates

The Chair provided highlights from the OMSA and PARO Reports.

Council Members were requested to note the upcoming 2023 Council meeting dates in their calendars.

4. Chief Executive Officer / Registrar's Report

N. Whitmore, Chief Executive Officer and Registrar presented her report to Council highlighting the mission, vision, and values of the College. She provided an overview on the targets for the Key Performance Indicators.

An overview was provided on the following departments and programs:

- Registration and Membership Services;
- Quality Improvement Program / Quality Assessment Program;
- Out of Hospital Premises Inspection Program;
- Independent Health Facilities;
- Patient & Public Help Centre;
- Legal;
- Ontario Physicians and Surgeons Discipline Tribunal (OPSDT).

Council discussed the number of family physicians involved in active practice and it was noted that there appears to be more family physicians working part-time and taking on a decreased volume of patients contributing to the challenges with availability of family physicians.

It was noted that the OPSDT has thirty-one active cases and is currently in the process of redrafting its Rules of Procedure.

An update was provided on government relations, noting that a recent meeting has taken place with the new Ontario Health Minister, Silvia Jones to discuss priorities and red tape reduction.

On August 19th, a message was sent to the profession addressing system challenges and physician shortage which garnered lots of feedback and had a 69 percent open rate. Approximately 150 physicians replied to our invitation to return to practice to help alleviate system strain.

Updates were provided on the September issue of Dialogue which features an article on unhoused individuals and challenges with access to care. The next In Dialogue podcast will focus on burnout and the Physician Health Program.

The following updates were provided on engagement, collaboration, and operations:

- Outreach engagements in the Equity, Diversity, and Inclusion space
- N. Whitmore's participation on virtual care panel at the CMPA conference
- College moved to hybrid work environment with at least one day per week onsite
- Launch of in-house Lean sessions
- Completion of budget process in the new Finance & Operations system

An overview was provided on the Staff Engagement results from the May 2022 survey with a number of improvements across the College. It was noted that 90 percent of employees responded to the survey demonstrating engaged employees.

There was discussion on the topic of national physician licensure. Challenges and barriers were identified regarding a move toward national licensure including changing the constitution and funding challenges among other factors.

5. President's Report

J. van Vlymen, President, presented her report to Council highlighting feedback received from the June Council meeting. She highlighted common themes and noted that Council is being provided with an overview of the College's department specific functions. The work of the Policy Department and how Policy Analysts research their issues was highlighted for Council as a future topic of discussion.

Other issues were identified, including the need to have Council Members present during meetings and the use of microphones to facilitate with audio for the livestream. Enhanced norms for in-person meetings were updated and presented to Council.

Updates were provided on various meetings attended by the Chair including one to one weekly meetings with the Registrar / CEO, meetings with Council Members, correspondence with new and returning MPPs and upcoming meetings with the Ontario Medical Association, among others.

The Chair and CEO will be attending at the International Society for Quality in Health Care (ISQua) in Brisbane in October.

Planning for the Annual President's Dinner is underway, an invitation will be sent out next week to Council Members.

Change to order of items

It was noted that the Premises Inspection Committee Public Member Update will be moving to the end of day today and the added item, Regulatory Proposal – Temporary Class of Licensure will be moved to day two of Council.

6. Human Rights in the Provision of Health Services – Draft Policy for Consultation

S. Sharda, EDI Lead and Medical Advisor, R. Patel, Member of Council and the Policy Working Group and M. Cabrero Gauley, Senior Policy Analyst provided an overview of the draft Human Rights in the Provision of Health Services policy, formerly, Professional Obligations and Human Rights policy, which sets out expectations and guidance for physicians regarding the provision of health services in a safe, inclusive, and accessible environment. A companion Advice to the Profession document has also been developed. It was noted that efforts are being made to review policies from an anti-racism, anti-oppression, and EDI lens. An overview of the changes and enhancements were provided. Council discussed elements of the policy as well as different case examples.

Following questions and discussion, approval was sought from Council to release the draft policy for external consultation.

02-C-09-2022

The following motion was moved by P. Safieh, seconded by J. Goyal and carried, that:

The Council of the College of Physicians and Surgeons of Ontario engage in the consultation process in respect of the draft policy "Human Rights in the Provision of Health Services," (a copy of which forms Appendix "A" to the minutes of this meeting).

CARRIED

7. Amendments to Declaration of Adherence and Council Code of Conduct (regarding Social Media)

L. Rinke-Vanderwoude, Governance Analyst provided an overview of the proposed amendments to the Declaration of Adherence and Council Code of Conduct regarding social media for Council's consideration and approval. Should Council approve the amendments, the changes will be reflected in the 2023 package. Council discussed and sought clarification on the proposed amendments regarding social media engagement. It was noted that non-compliance with the expectations could result in consequences ranging from education to disqualification.

03-C-09-2022

The following motion was moved by L. Becker, seconded by J. Fisk and carried, that:

The Council of the College of Physicians and Surgeons of Ontario approves the amendments to the Declaration of Adherence, (a copy of which forms Appendix "B" to the minutes of this meeting) and to the Council and Committee Code of Conduct, (a copy of which forms Appendix "C" to the minutes of this meeting).

CARRIED

8. Medical Assistance in Dying – Draft Policy for Consultation

C. Lemieux, Member of Council and the Policy Working Group and M. Cabrero Gauley, Senior Policy Analyst presented the revised draft Medical Assistance in Dying (MAID) policy to Council. The draft policy seeks to set out clear expectations and guidance to assist physicians as they seek to provide MAID in compliance with the federal legislation and is being brought forward to Council for approval to release for external consultation. Additionally, there are two companion resources accompanying the policy, (i) MAID: Legal Requirements and (ii) MAID: Advice to the Profession.

A case example was shared to help Council in understanding the MAID process as well as key legal and professional obligations. Council was engaged in an interactive polling session to assess eligibility requirements and safeguards for MAID requests.

Council expressed their support to approve the release of the revised MAID policy for external consultation and engagement.

04-C-09-2022

The following motion was moved by L. Marks de Chabris, seconded by P. Hendry and carried, that:

The Council of the College of Physicians and Surgeons of Ontario engage in the consultation process in respect of the draft policy, "Medical Assistance in Dying," (a copy of which forms Appendix "D" to the minutes of this meeting).

CARRIED

9. Council Self-Assessment

C. Allan, Manager of Governance provided an overview of the proposed changes to the Council Self-Assessment process. Following feedback and approval from the Governance Committee, this item is being presented to Council for consideration and approval. An overview of each of the enhanced components was provided which includes an opportunity for Council Members to participate in a voluntary one-to-one interview with either the President or Chair of Governance. It was noted that the Governance Office will be reaching out to Council Members to solicit interest regarding one-to-one interviews. Results from the interview will be used to inform next year's planning and determine areas of focus. At the December Council meeting, Council will engage in a small group exercise to discuss and rate domains. The two lowest scoring domains will be the areas of focus for the subsequent year of Council.

Council provided input into the process and discussed whether there will be an opportunity to provide anonymous feedback. There was discussion on providing peer feedback on Council member performance. It was noted that Committee Chairs currently provide feedback to Council Members that sit on Committees. Discussion ensued on the enhanced process.

05-C-09-2022

The following motion was moved by F. Sherman, seconded by S. Khan and carried, that:

The Council of the College of Physicians and Surgeons of Ontario approves the revised Council Self-Assessment process, (a copy of which forms Appendix "E" to the minutes of this meeting).

CARRIED

Item moved from Day 2: Premises Inspection Committee Public Member Update

L. Reid, Director, Investigations and Accreditation provided an overview of the Premises Inspection Committee (PIC) Public Member Update noting that the PIC is undergoing governance modernization. As the College has control and authority over PIC, staff is recommending the removal of the requirement for public members to sit on the Committee's panels for quorum to be met. Given the technical nature of the reports being considered by panels of the committee, it has been determined that the presence of a Public Member is not a necessary condition for the panel to effectively discharge its responsibilities. Following discussion, Council expressed its support to remove the public member requirement to establish meeting quorum.

06-C-09-2022

The following motion was moved by C. Lemieux, seconded by L. Miljan and carried, that:

The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 151:

By-law No. 151

Section 47.2 of the General By-law is revoked and substituted with the following:

47.2 A panel of three members of the Premises Inspection Committee appointed by the chair of the Premises Inspection Committee is a quorum, and may discharge the duties and exercise the authority of the Premises Inspection Committee.

CARRIED

10. Adjournment Day 1

J. van Vlymen adjourned day 1 of the Council meeting at 4:15 pm.

DRAFT PROCEEDINGS OF THE MEETING OF COUNCIL

September 23, 2022

Attendees

Dr. Madhu Azad
Dr. Glen Bandiera
Ms. Lucy Becker
Mr. Jose Cordeiro
Ms. Joan Fisk
Mr. Murthy Ghandikota
Ms. Julia Goyal
Dr. Robert Gratton (Vice-President)
Dr. Camille Lemieux
Mr. Paul Malette
Dr. Lionel Marks de Chabris
Dr. Lydia Miljan
Dr. Rupa Patel
Mr. Rob Payne
Mr. Peter Pielsticker
Dr. Judith Plante
Dr. Ian Preyra
Ms. Linda Robbins
Dr. Deborah Robertson
Dr. Jerry Rosenblum
Dr. Patrick Safieh
Mr. Fred Sherman
Dr. Janet van Vlymen (Chair and President)
Dr. Anne Walsh

Non-Voting Academic Representatives on Council Present:

Dr. Mary Bell
Dr. Andrea Lum
Dr. Karen Saperson

Regrets:
Mr. Shahid Chaudhry
Dr. Brenda Copps
Dr. Deborah Hellyer
Dr. Paul Hendry
Mr. Shahab Khan
Dr. Roy Kirkpatrick
Dr. Sarah Reid
Ms. Shannon Weber

11. Call to Order

J. van Vlymen, Chair and President, called the meeting to order at 9:00 am and welcomed everyone back to the meeting. A roll call was conducted, and regrets were noted.

The Chair declared a conflict of interest regarding item 12.3 regarding her appointment to the Ontario Physicians and Surgeons Discipline Tribunal and Fitness to Practise Committee.

12. Governance Committee Report

J. Plante, Chair of the Governance Committee provided the Governance Committee Report, providing an overview for each of the following items:

12.1 Executive Committee Elections;

12.2 Governance Committee Elections (item deferred to December Council);

12.3 Committee Appointments and Re-appointments.

12.1 Executive Committee Elections

J. Plante provided an overview of the process for the Executive Committee Elections noting that the appointments will be effective as of the end of December 2022 Council meeting. Nomination statements have been received from the following individuals:

Dr. Robert Gratton, for President
Dr. Ian Preyra, for Vice President or, alternatively, Executive Member Representative
Ms. Joan Fisk, for Executive Member Representative
Dr. Lydia Miljan (PhD), for Executive Member Representative
Mr. Peter Pielsticker, for Executive Member Representative
Dr. Sarah Reid, for Executive Member Representative

J. Plante called for nominations from the floor. As there were no nominations from the floor, each of the nominees for the three Executive Member Representative positions addressed Council prior to the election. A video nomination statement received from Dr. Sarah Reid was played. An election for the Executive Member Representatives was held using an electronic voting software (ElectionBuddy). The President and Vice-President positions were acclaimed. J. Plante announced the 2023 Executive Committee Members.

07-C-09-2022

The following motion was moved by R. Payne, seconded by J. Rosenblum and carried, that:

The Council of the College of Physicians and Surgeons of Ontario appoints:

Dr. Robert Gratton (as President),

Dr. Ian Preyra (as Vice President),

Dr. Sarah Reid (as Executive Member Representative),

Ms. Joan Fisk (as Executive Member Representative),

Dr. Lydia Miljan (as Executive Member Representative),

And Dr. Janet van Vlymen (as Past President),

to the Executive Committee for the year that commences with the adjournment of the Annual General Meeting of Council in December 2022.

CARRIED

12.2 Governance Committee Elections – Postponed to December Council

J. Plante advised that the Governance Committee Elections are being postponed to December Council due to insufficient nominees to fill the requirement for two public members on the Committee. A revised Council package has been distributed to remove the item. Background information was provided noting that a call for nominations was sent out in August. One nomination statement was received. It was noted that a Governance Committee nomination statement was inadvertently included in the package for L. Miljan. L. Miljan submitted a nomination statement to run for a seat on the Executive Committee only.

J. Plante appealed to Public Members on Council to consider this important role and she provided an overview of the work of the Governance Committee highlighting the composition, time commitment and duties required. In response to a question raised, it was noted that although one nomination statement was received, the Governance Committee elections need to occur together.

12.3 2022-2023 Committee Appointments and Re-appointments

J. Plante provided an overview of the 2022-2023 Committee Appointments and Re-appointments as noted in the briefing materials. A conflict of interest was declared by J. van Vlymen on her recommended appointment to the Ontario Physicians and Surgeons Discipline Tribunal (OPSDT) and Fitness to Practise (FTP) Committee.

It was noted that there were significant changes to Committee recruitment this year resulting in an unprecedented amount of applications received.

An overview was provided on two urgent cross appointments to take effect immediately as well as the appointment of J. van Vlymen to the OPSDT and FTP Committee. Background was provided on the terms for each of the recommended appointments. It was noted that under normal circumstances appointments are usually three-year appointments. As J. van Vlymen is an Academic Representative on Council, she is appointed yearly by the University Dean. As such, her appointment to the OPSDT and FTP Committee for a one-year term.

08-C-09-2022

The following motion was moved by P. Safieh, seconded by R. Gratton and carried, that:

1. The Council of the College of Physicians and Surgeons of Ontario appoints Dr. George Beiko 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 of the College of Physicians and Surgeons of Ontario appoints Dr. Michael Wan to the Inquiries, Complaints and Reports Committee and to the Premises Inspection Committee, effective immediately, with the term expiring at the close of the Annual General Meeting of Council in December 2024.

CARRIED

09-C-09-2022

The following motion was moved by J. Fisk, seconded by G. Bandiera (with J. van Vlymen abstaining) and carried, that:

3. The Council of the College of Physicians and Surgeons of Ontario appoints Dr. Janet van Vlymen to the Ontario Physicians and Surgeons Discipline Tribunal and the Fitness to Practise Committee, for a term beginning at the close of the Annual General Meeting of Council in December 2022, and expiring at the close of the Annual General Meeting of Council in December 2023.

CARRIED

10-C-09-2022

The following motion was moved by L. Marks de Chabris, seconded by L. Becker and carried, that:

4. The Council of the College of Physicians and Surgeons of Ontario re-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 2022:

Committee	Member Name	Term Length	End Date
Finance and Audit	Dr. Ian Preyra	3 years	December 2025
	Mr. Peter Pielsticker	1 year	December 2023
Fitness to Practice	Dr. Heather-Ann Badalato	3 years	December 2025
	Dr. Allan Kaplan		
	Mr. Peter Pielsticker	1 year, 3 months, 21 days	March 30, 2024
Inquiries, Complaints, and Reports	Dr. Lydia Miljan (PhD)	3 years	December 2025
	Dr. Trevor Bardell		
	Dr. Paula Cleiman		
	Dr. Karen Saperson		
Ontario Physicians and Surgeons Discipline Tribunal	Dr. Heather-Ann Badalato	3 years	December 2025
	Dr. Allan Kaplan		
	Mr. Peter Pielsticker	1 year, 3 months, 21 days	March 30, 2024
Patient Relations	Ms. Sharon Rogers	3 years	December 2025
	Dr. Diane Whitney		
Premises Inspection	Dr. Robert Smyth	3 years	December 2025

CARRIED

13. Education Advisory Group Dissolution

L. Rinke-Vanderwoude, Governance Analyst provided an overview of the proposal to dissolve the Education Advisory Group (EAG) for efficiencies and to help achieve CPSO's strategic objectives. It was noted that much of EAG's work is duplicative of work performed elsewhere in the College and work uniquely performed by EAG would fit within the mandate of other committees.

A draft of the Academic Representative Roles and Responsibilities has been prepared to better define the role of Academic Representatives within CPSO. Concerns were raised about diluting the liaison role regarding education. In response to concerns raised, Academic Representatives will be provided with the opportunity to meet informally to share learnings and information. Academic Representatives will maintain outreach in their own communities and their voice will be maintained at the Council table. In addition, E-Dialogue is provided to the Deans of Medical Schools for distribution to medical students to maintain communication with learners.

11-C-09-2022

The following motion was moved by J. Fisk, seconded by I. Preyra and carried, that:

The Council of the College of Physicians and Surgeons of Ontario approves the dissolution of the Education Advisory Group, effective as of the adjournment of the Annual General Meeting of Council in December 2022.

CARRIED

14. Specialist Recognition Criteria in Ontario

S. Tulipano, Director, Registration and Membership Services, provided an overview of the proposed amendments to the Specialist Recognition Criteria in Ontario policy. The revised policy provides increased clarity on the criteria that a physician must meet in order to be recognized as a specialist by the College. A detailed overview was provided on each of the pathways to be recognized as a specialist.

12-C-09-2022

The following motion was moved by D. Robertson, seconded by C. Lemieux and carried, that:

The Council of the College of Physicians and Surgeons of Ontario approves the revised policy, "Specialist Recognition Criteria in Ontario", (a copy of which forms Appendix "F" to the minutes of this meeting).

CARRIED

15. Regulatory Proposal – Temporary Class of Licensure

C. Roxborough, Director, Policy and S. Tulipano, Director, Registration and Membership Services provided an overview of the item, Regulatory Proposal to create a new temporary class of registration designed to support mobility within Canada. Council is asked whether the proposed regulation amendment can be approved for submission to Government and whether related by-

law amendments can be circulated for consultation. An overview was provided on the voting and approval process noting that a full record of each Council vote on the proposed regulation must be recorded and provided as part of the Ministry submission. The proposed regulation included in the package to Council has been amended based on feedback from Government, and the motion regarding the regulation consequently requires amendment.

The new regulatory proposal introduces a new temporary class of registration. Context and background were provided as well as the minister's letter and CPSO's response. Specific direction was received from the Government to direct that the College make every effort to register out of province and internationally educated physicians to the College as expeditiously as possible. Council was provided with an overview of the regulatory proposal and given the opportunity to ask questions.

The consultation period for the regulation has been waived by the Ministry given the urgent need, and the proposed regulatory changes have been circulated to the Medical Regulatory Authorities. Should Council approve the regulatory proposal, the College will need to submit the proposal to the Government.

The College is also seeking approval from Council to enact a by-law to set out the fees for the new temporary class of registration. An overview of necessary by-law changes was provided, and it was noted that there is a requirement to circulate the by-law to the profession prior to making the by-law. The proposed by-law and motion included in the package to Council also need to be amended due to the Government feedback on the regulation.

Original Motion: 13A-C-09-2022 – Regulatory Proposal for Temporary Class of Licensure

The following motion was moved by L. Marks de Chabris and seconded by P. Malette that:

The Council of the College of Physicians and Surgeons of Ontario approves:

making an amendment to Ontario Regulation 856/93: Registration, regarding a certificate of registration authorizing practice for the provision of temporary services (a copy of which amendment forms Appendix "G" to the minutes of this meeting) and submitting it to the Minister of Health for review and the approval of the Lieutenant Governor in Council; and

exempting the regulatory amendment from the requirement under subsection 95(1.4) of the Health Professions Procedural Code to circulate it to the profession, if such exemption is approved by the Minister.

Motion to Amend: 13B-C-09-2022 – Regulatory Proposal – Temporary Class – Amended Regulation

The following motion to amend Motion 13A-C-09-2022 was moved by R. Payne, seconded by J. Goyal and carried, that:

The Council of the College of Physicians and Surgeons of Ontario approves amending the motion titled, "Regulatory Proposal for Temporary Class of Licensure" by replacing the words "practice for the provision of temporary services" with "temporary independent practice".

Motion: 13B-C-09-2022 CARRIED

Record of each Council vote set out below on Original Motion: 13A-C-09-2022 – Regulatory Proposal for Temporary Class of Licensure, as amended:

Number	Name	Vote
1.	Madhu Azad	In favour
2.	Glen Bandiera	In favour
3.	Lucy Becker	In favour
4.	Jose Cordeiro	In favour
5.	Joan Fisk	In favour
6.	Murthy Ghandikota	In favour
7.	Julia Goyal	In favour
8.	Rob Gratton	In favour
9.	Camille Lemieux	In favour
10.	Paul Malette	In favour
11.	Lionel Marks de Chabris	In favour
12.	Lydia Miljan	In favour
13.	Rupa Patel	In favour
14.	Rob Payne	In favour
15.	Peter Pielsticker	In favour
16.	Judith Plante	In favour
17.	Ian Preyra	In favour
18.	Linda Robbins	In favour
19.	Deborah Robertson	In favour
20.	Jerry Rosenblum	In favour
21.	Patrick Safieh	In favour
22.	Fred Sherman	In favour
23.	Janet van Vlymen	In favour
24.	Anne Walsh	In favour

Motion: 13A-C-09-2022, as amended CARRIED

Original Motion: 14A-C-09-2022 – By-law Amendments for Fees for Temporary Services Certificate of Registration

The motion set out in Appendix "H" to the minutes of this meeting was moved by J. Rosenblum, seconded by L. Becker.

Motion to Amend: 14B-C-09-2022 – By-law Amendments for Fees for Temporary Independent Practice Certificate of Registration

The following motion to amend Motion 14A-C-09-2022 was moved by L. Miljan, seconded by A. Walsh, and carried, that:

The Council of the College of Physicians and Surgeons of Ontario amends the motion titled By-law Amendments for Fees for Temporary Services Certificate of Registration by replacing the proposed By-law No. 153 with the following:

By-law No. 153

1. Section 1 of the Fees and Remuneration By-law (By-law No. 2) is revoked and substituted with the following:

Application Fees

1. A person who submits an application for a certificate of registration or authorization shall pay an application fee. The application fees are as follows:

(a) For a certificate of registration authorizing postgraduate education, 25% of the annual fee specified in section 4(a);

(b) For a certificate of registration authorizing supervised practice of a short duration, 20% of the annual fee specified in Section 4(a);

(b.1) For a certificate of registration authorizing temporary independent practice, 25% of the annual fee specified in section 4(a);

(c) For an application for reinstatement of a certificate of registration, 60% of the annual fee specified in s. 4(a);

(d) For any other certificate of registration, 60% of the annual fee specified in Section 4(a);

(e) *[repealed]: May 31, 2019]*

(f) For a certificate of authorization, $400.00;

(g) For an application to the Registration Committee for an order directing the Registrar to modify or remove terms, conditions or limitations imposed on the member's certificate of registration by the Registration Committee, 25% of the annual fee specified in section 4(a);

(h) If the person:

(i) meets the registration requirements applicable to the class of certificate of registration applied for, as prescribed in the Registration Regulation, Ontario Regulation 865/93 under the *Medicine Act, 1991*; and

(ii) requests the College to conduct the initial assessment of the application within three weeks after receipt by the College of the application,

an additional fee equal to 50% of the application fee applicable to such person under subsection 1(a), (b), (b.1) or (d).

2. Section 3 of the Fees and Remuneration By-law (By-law No. 2) is revoked and substituted with the following:

Annual Fees

3. Every holder of a certificate of authorization, other than a holder of a certificate of registration authorizing supervised practice of a short duration or authorizing postgraduate education for an elective appointment or authorizing temporary independent practice, shall pay an annual fee.

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

(a) $1725 for holders of a certificate of registration other than a certificate of registration authorizing postgraduate education, a certificate of registration authorizing supervised practice of a short duration, or a certificate of registration authorizing temporary independent practice;

Explanatory Note: This proposed by-law must be circulated to the profession.

Motion: 14B-C-09-2022 CARRIED

Motion: 14A-C-09-2022, as amended CARRIED

16. Council Award Presentation

Dr. Anne Walsh, Council Member presented the Council Award to Dr. Georgina Wilcock of Scarborough for her dedication to continuous improvement to increase patient safety and for championing numerous initiatives that embrace patient and community centred care. Dr. Wilcock was recognized for her leadership at Scarborough Heath Network in obstetrics and gynecology. Dr. Wilcock recognized her team for their support. Dr. Wilcock expressed appreciation to the CPSO for recognition of her outstanding contributions to the profession.

17. Motion to Go in Camera

15-C-09-2022

The following motion was moved by J. Fisk, seconded by P. Pielsticker and carried, that:

The Council of the College of Physicians and Surgeons of Ontario exclude the public from the part of the meeting immediately after this motion is passed, under clauses 7(2)(b), (d) and (e) of the Health Professions Procedural Code (set out below).

Exclusion of public

7(2) Despite subsection (1), the Council may exclude the public from any meeting or part of a meeting if it is satisfied that,

(b) financial or personal or other matters may be disclosed of such a nature that the harm created by the disclosure would outweigh the desirability of adhering to the principle that meetings be open to the public;

(d) personnel matters or property acquisitions will be discussed; and

(e) instructions will be given to or opinions received from the solicitors for the College.

CARRIED

18. In-Camera Session

The Council of the College of Physicians and Surgeons of Ontario entered an in-camera session at 1:00 pm and returned to the open session at 1:50 pm.

19. Filling Vacancies on Council – By-law Amendment

M. Cooper, Senior Corporate Counsel and Privacy Officer provided an overview of the proposed by-law amendments for filling Council vacancies and the options available to Council regarding the vacant seat for District 5.

16-C-09-2022 – By-law Amendments re: Filling Council Vacancies (By-law No. 152)

The following motion was moved by L. Marks de Chabris, seconded by J. Plante and carried, that:

The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 152:

By-law No. 152

Section 23 of the General By-law is revoked and substituted with the following:

Filling of Vacancies

23. (1) If the seat of an elected councillor becomes vacant, the council may,

(a) leave the seat vacant, subject to subsection (2);

(b) appoint as an elected member the candidate if any who had the most votes of all the unsuccessful candidates in the last election of councillors for that electoral district; or

(c) direct the registrar to hold a by-election for that electoral district in accordance with this by-law.

(2) If the number of remaining elected councillors is less than the minimum number required by law, the council shall take action under clause (1)(b) or clause (1)(c) to fill the number of vacant seats needed so that the number of elected councillors is not less than the minimum number required by law.

(3) The term of office of a member appointed under clause (1)(b) or elected in a by-election expires when the former councillor's term would have expired.

CARRIED

17-C-09-2022 – Current Council Vacancy

WHEREAS there is currently a vacant Council seat for an elected physician Council member in District 5 (the "Vacant Seat"),

The following motion was moved by J. Fisk, seconded by I. Preyra and carried, that:

The Council of the College of Physicians and Surgeons of Ontario approves leaving the Vacant Seat vacant until the 2023 Annual General Meeting of Council in accordance with the General By-law.

CARRIED

20. Out-of-Hospital Premises Inspection Program (OHPIP) – Draft Standards for Consultation

L. Reid, Director of Investigations and Accreditation and C. Roxborough, Director, Policy provided an overview of the Out-of-Hospital Premises Inspection Program (OHPIP) – Draft Standards for Consultation. C. Brown, T. Terzis and the working group were recognized for their work in developing the draft standards. The Out-of-Hospital Premises Program Standards are being redesigned and revised to enhance their utility and to align with the CPSO's Strategic Plan. Background was provided on the OHPIP and its purpose to ensure that out-of-hospitals (OHPs) are operating safely and effectively. A detailed overview was provided on the ten new draft standards including leveraging the role of the Medical Director.

Dr. Ted Xenodemetropoulos, Vice Chair of the Premises Inspection Committee, via video, expressed his support for engaging in the consultation process in respect of the draft OHPIP standards.

18-C-09-2022

The following motion was moved by P. Pielsticker, seconded by F. Sherman and carried, that:

The Council of the College of Physicians and Surgeons of Ontario engage in the consultation process in respect of the draft "Out-of-Hospital Premises Standards", (a copy of which forms Appendix "I" to the minutes of this meeting).

CARRIED

21. Adjournment Day 2

19-C-09-2022

It was moved by P. Safieh, seconded by P. Pielsticker and carried, that the Council meeting adjourn at 2:45 pm.

The next Council meeting is scheduled on December 8 and 9, 2022.

Chair

Recording Secretary

HUMAN RIGHTS IN THE PROVISION OF HEALTH SERVICES

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

Discrimination: an act, communication, or decision that results in the unfair treatment of an individual or group by either imposing a burden on them, or denying them a right, privilege, benefit, or opportunity enjoyed by others. Discrimination may be direct and intentional; it may also be indirect and unintentional, where rules, practices, or procedures appear neutral but have the effect of disadvantaging certain groups of people. Discrimination is best identified by those who experience it given that there is a difference between intent and impact.

Effective referral: taking positive action to ensure the patient is connected to a non-objecting, available, and accessible[1] physician, other health-care professional, or agency.

For more definitions of key terms/concepts related to this policy, see the College's Equity, Diversity, and Inclusion Glossary.

Policy

Providing Health Services

1. Physicians **must** take reasonable steps to create and foster a safe, inclusive, and accessible environment in which the rights, autonomy, dignity, and diversity of all patients are respected, and where patients' needs are met, by:

    a. complying with the relevant legal requirements under the *Accessibility for Ontarians with Disabilities Act, 2005*[2] and the *Human Rights Code* (the Code)[3]; and

[1] 'Available and accessible' means that the health-care professional must be operating and/or accepting patients at the time the effective referral is made, and in a physical location the patient can reasonably access, or where appropriate, accessible via virtual care.
[2] *Accessibility for Ontarians with Disabilities Act, 2005*, S.O. 2005, c. 11.
[3] *Human Rights Code*, R.S.O. 1990, c. H.19. See 'The Duty to Accommodate' and 'The Duty to Provide Services Free from Discrimination' sections of this policy for more information.

b. incorporating cultural humility, cultural safety, anti-racism, and anti-oppression into their practices.

2. In discharging provision 1, physicians **must not:**

   a. express personal moral judgments about patients' beliefs, lifestyle, identity, or characteristics or the health services that patients are considering;

   b. refuse or delay the provision of health services because the physician believes the patient's own actions have contributed to their condition;[4] or

   c. promote their own spiritual, secular, or religious beliefs when interacting with patients or impose these beliefs on patients.

The Duty to Accommodate

3. Physicians **must** comply with their duty to accommodate patients' needs arising from a protected ground under the *Code*[5] (e.g., disability[6], gender identity) and make accommodations in a manner that is respectful of the dignity, autonomy, and privacy and confidentiality of the patient, unless the accommodation would:

   a. subject the physician to undue hardship (i.e., excessive cost, lack of outside sources of funding to help offset the cost, or health or safety concerns); or

   b. significantly interfere with the legal rights of others.[7]

4. Where a patient requests to receive care from a physician with a particular social identity (e.g., race, ethnicity, culture, sexual orientation and/or gender identity, spiritual/secular/religious beliefs, etc.), physicians **must:**

   a. with appropriate consent[8], provide any emergent or urgent medical care the patient requires; and

   b. where non-emergent or non-urgent care is required, take reasonable steps to accommodate the patient's request if the physician believes that the request is

[4] See the College's *Ending the Physician-Patient Relationship* policy for circumstances where physicians must not end the physician-patient relationship.
[5] The *Code* articulates the right of every Ontario resident to receive equal treatment with respect to services, goods and facilities – including health services – without discrimination on the grounds of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.
[6] "Disability" is defined in s. 10 of the *Code* and includes any degree of physical disability, infirmity, malformation, or disfigurement; a condition of mental impairment or a developmental disability; a learning disability, or a dysfunction in one or more of the processes involved in understanding or using symbols or spoken language; a mental disorder; or an injury or disability for which benefits were claimed or received under the insurance plan established under the *Workplace Safety and Insurance Act, 1997*, S.O. 1997, c. 16, Sched. A.
[7] See the Ontario Human Rights Commission's Policy on ableism and discrimination based on disability for more information on "undue hardship" and other limits on the duty to accommodate (e.g., legal rights of others).
[8] See the College's *Consent to Treatment* policy for expectations on obtaining consent during emergencies.

ethically or clinically appropriate (e.g., patient would like to receive care from a physician who speaks the same language to facilitate communication); or

c. tell the patient that their request will not be accommodated if the physician believes that the request is discriminatory (e.g., racist, sexist, ageist, heterosexist, etc.) and determine whether it is safe and in both parties' best interest to provide any non-emergent or non-urgent care required.[9]

The Duty to Provide Services Free from Discrimination

5. Physicians **must not** discriminate, either directly or indirectly, based on a protected ground under the *Code* when making decisions relating to the provision of health services. This includes when:

   a. accepting or refusing individuals as patients;

   b. providing information to patients;

   c. providing or limiting health services;

   d. providing clinical referrals and effective referrals; and/or

   e. ending the physician-patient relationship.

Limiting Health Services for Clinical Competence/Scope of Practice Reasons

6. Physicians **must** make any decisions to limit the provision of health services for reasons of clinical competence and/or scope of practice in good faith, and in accordance with the *Code*[10] and College expectations.[11]

   a. In making this decision, physicians **must** consider the risks and benefits of limiting the provision of health services and the impact it would have on patients (e.g., if they would have difficulties accessing the services elsewhere in a timely manner due to a lack of resources).

   b. Physicians **must** communicate any decisions to limit the provision of health services for reasons of competence and/or scope of practice to patients in a clear and straightforward manner.

Health Services that Conflict with Physicians' Conscience or Religious Beliefs

7. Where certain health services conflict with physicians' conscience or religious beliefs in a manner that would impact patient access to those health services, physicians **must** fulfill

[9] See the College's *Ending the Physician-Patient Relationship* policy for expectations when ending the physician-patient relationship.
[10] The duty to provide services free from discrimination does not prevent physicians from limiting the health services they provide for legitimate clinical competence and/or scope of practice reasons.
[11] Also see the relevant expectations set out in the College's *Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice*, *Accepting New Patients,* and *Ending the Physician-Patient Relationship* policies.

their professional obligations and fiduciary duty to their patients by putting patients' interests first.[12]

8. Physicians **must** provide patients with enough information about all available or appropriate clinical options to meet their clinical needs or concerns so that patients are able to make an informed decision[13] about exploring a particular option.

9. When a particular service, treatment, or procedure might be a relevant clinical option for a patient and it conflicts with a physician's conscience or religious beliefs in a manner that would impact patient access, physicians **must:**

    a. make any decisions to limit the provision of health services in accordance with the *Code*[14] and inform the patient that they do not provide that service, treatment, or procedure; and

    b. provide the patient with an effective referral.

        i. Physicians **must** provide the effective referral in a timely manner to allow patients to access care.

        ii. Physicians **must** take reasonable steps to confirm that a patient was connected, unless the patient has indicated that they prefer otherwise.

        iii. If physicians learn that the patient was not connected, they **must** take further action to provide an effective referral.

        iv. Physicians **must** have a plan in place on how they will connect patients to the services that would typically be requested in their type of practice, but that conflict with their conscience or religious beliefs.

10. In discharging provisions 8 and 9, physicians **must:**

    a. communicate the necessary information in a clear, straightforward, and neutral manner;

[12] Physicians' freedom of conscience and religion must be balanced against patients' right to access care. The Court of Appeal for Ontario has confirmed that where an irreconcilable conflict arises between a physician's interest and a patient's interest, physicians' professional obligations and fiduciary duty require that the interest of the patient prevails (para. 187 *Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario*, 2019 ONCA 393).

[13] In accordance with the College's *Consent to Treatment* policy and the *Health Care Consent Act, 1996*, S.O. 1996, c.2, Sched. A, physicians need to obtain valid consent in order to proceed with a particular treatment option. In order for consent to be valid, it must be related to the treatment, informed, given voluntarily, and not obtained through misrepresentation or fraud.

[14] Limiting health services on the basis of conscience or religion does not permit physicians to discriminate on the basis of a protected ground under the *Code* and limit to whom they provide services they otherwise offer.

b. comply with the documentation expectations set out in the College's *Medical Records Documentation* policy and where relevant, the College's *Medical Assistance in Dying* policy[15]; and

c. where clinical referrals are provided, comply with the relevant expectations set out in the College's *Transitions in Care* policy.

11. Physicians **must not:**

a. withhold information about the existence of any service, treatment, or procedure because it conflicts with their conscience or religious beliefs;

b. provide false, misleading, confusing, coercive, or incomplete information about available or appropriate clinical options;

c. impede access to information and/or care; or

d. expose patients to adverse clinical outcomes due to a delay in providing the patient with an effective referral.

12. Physicians **must** provide any necessary care in an emergency, even where that care conflicts with their conscience or religious beliefs.[16]

Addressing Violence, Harassment, and Discrimination

13. If physicians see acts of violence, harassment (including intimidation), and discrimination occurring against patients, health-care professionals and/or staff, they **must** take reasonable steps[17] to stop these acts in a manner that does not compromise the safety of the physician.[18]

14. Physicians **must** take any other necessary steps to comply with applicable legislation[19], policies, institutional codes of conduct or by-laws.

[15] Physicians are required to capture, where applicable, all oral and written requests for medical assistance in dying (MAID), the dates they were made, and a copy of the patient's written request in the patient's medical record. This requirement applies to all physicians, including physicians who choose not to assess patients for or provide MAID for reasons of conscience or religion.

[16] For clarity, MAID would never be a treatment option in an emergency and physicians are not required to assess patients for or provide MAID under any circumstances.

[17] There may be times where a patient or individual lacks capacity due to a health condition (e.g., severe mental illness, neurocognitive or neurodevelopmental disorder, etc.) and/or their current health status (e.g., substance intoxication, delirium, etc.) and this will need to be taken into consideration when determining what steps to take to stop the patient or individual.

[18] See the College's *Professional Responsibilities in Medical Education* policy and *Advice to the Profession* document for expectations and guidance in the medical education context, including taking reasonable steps to stop violence, harassment, or discrimination against medical students and/or postgraduate trainees and providing them with support and direction.

[19] For example, the obligations set out in the *Occupational Health and Safety Act*, R.S.O. 1990, c.0.1 and the *Code*.

CPSO

Declaration of Adherence Package 2022

CPSO Council and Committee
Declaration of Adherence Package

This package contains the Declaration of Adherence and Council and Committee Code of Conduct. For convenience of reference, it also includes links and access to policies and other documents referred to in the Declaration of Adherence and Council and Committee Code of Conduct.

Table of Contents

Declaration of Adherence and Council and Committee Code of Conduct

Members of CPSO Council and Committees

As a member of Council and/or a committee of the College of Physicians and Surgeons of Ontario (CPSO), I acknowledge that:

- the CPSO's duty under the *Regulated Health Professions Act, 1991* (RHPA) and the Health Professions Procedural Code (the Code) (relevant excerpts of which are attached to this document) is to serve and protect the public interest.

- I stand in a fiduciary relationship to the CPSO. This means that I must act in the best interests of the CPSO. As a fiduciary, I must act honestly, in good faith and in the best interests of the CPSO, and must support the interests of the CPSO over the interests of others, including my own interests and the interests of physicians.

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

- I am aware of the confidentiality obligations imposed upon me by Section 36 (1) of the RHPA, a copy of which is attached to this Declaration. All information that I become aware of in the course of or through my CPSO duties is confidential and I am prohibited, both during and after the time I am a Council member or a CPSO committee member, from communicating this information in any form and by any means, except in the limited circumstances set out in Sections 36(1)(a) through 36(1)(k) of the RHPA.

- I have read Section 40 (2) of the RHPA, and understand that it is an offence to contravene subsection 36 (1) of the RHPA. I understand that this means in

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addition to any action the CPSO or others may take against me, I could be convicted of an offence if I communicate confidential information in contravention of Section 36 (1) of the RHPA, and if convicted, I may be required to pay a fine of up to $25,000.00 (for a first offence), and a fine of not more than $50,000 for a second or subsequent offence.

- I have read and agree to abide by the Council and Committee Code of Conduct (a copy of which is attached to this Declaration of Adherence).

- I understand that I am subject to the CPSO By-Laws, including the provisions setting out the circumstances in which ~~in~~ I may be disqualified from sitting on Council or on a committee.

- I have read and am familiar with the CPSO's By-laws and governance policies. I am bound to adhere to and respect the CPSO's By-laws and the policies applicable to the Council, including without limitation, the following:

    - Council and Committee Code of Conduct
    - Conflict of Interest Policy
    - Impartiality in Decision Making Policy
    - Confidentiality Policy
    - Use of CPSO Technology Policy
    - Information Breach Protocol
    - E-mail Management Policy
    - Protocol for Access to CPSO Information
    - Safe Disclosure Policy
    - Role Description of a CPSO Council/Committee Member (as applicable)

- I must conduct CPSO work using a CPSO-issued computer or laptop, and that I am not permitted to use a personal computer or laptop for CPSO work.

- I must use **only** my CPSO-provided email address (eg., cpso.on.ca) for any and all communications relating to CPSO work.

- I have completed the attached Conflict of Interest Disclosure Form to the best of my ability, and will notify the CPSO of any changes or additions to the disclosed

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information at the earliest opportunity, in accordance with the Conflict of Interest Policy.

☐ I confirm I have read, considered and understand the Declaration of Adherence including associated documents, and agree to abide by its provisions.

☐ I understand that any breach of this Declaration of Adherence may result in remedial action, censure or removal from office.

Printed Name:	
Signature:	
Date:	

CPSO Council and Committee
Conflict of Interest Declaration Form

As part of your Council or committee work, you are expected to declare any actual or potential conflicts of interest. A conflict of interest is defined in the CPSO General By-law as:

> *A conflict of interest exists where a reasonable person would conclude that a Council or committee member's personal or financial interest may affect his or her judgment or the discharge of his or her duties to the College. A conflict of interest may be real or perceived, actual or potential, direct or indirect.*

Please indicate any financial or personal interests that are or may be perceived to be a conflict of interest with your duties at CPSO, including any positions you hold as an officer or director of any other entity whose interests or mandate could reasonably appear to be in conflict or inconsistent with the CPSO. Please review the *Conflict of Interest* policy for more details and examples of what may constitute a conflict of interest.

Potential conflicts will be investigated by the CPSO to confirm whether a conflict exists, and the extent of the impact of any conflicts on your involvement in work. If you are unsure if something is a conflict, please disclose it below.

I have no conflicts of interest to report ☐

I have the following potential or actual conflicts of interest ☐

1.
2.
3.

Printed Name:

Signature:

Date:

CPSO Council and Committee
Conflict of Interest Declaration Form

Purpose

This Code of Conduct sets out expectations for the conduct of Council and committee members to assist them in:

- carrying out the CPSO's duties under the *Regulated Health Professions Act, 1991* (RHPA) to serve and protect the public interest; and,
- ensuring that in all aspects of its affairs, Council and committees maintain the highest standards of public trust and integrity.

Application

This Code of Conduct applies to all members of Council and to all CPSO committee members, including non-Council committee members.

Fiduciary Duty and Serving and Protecting the Public Interest

Fiduciary Duty

Council members and committee members are fiduciaries of the CPSO and owe a fiduciary duty to the CPSO. This means they are obligated to act honestly, in good faith and in the best interests of the CPSO, putting the interests of the CPSO ahead of all other interests, including their own interests and the interests of physicians.

As set out in the Declaration of Adherence, members must avoid situations where their personal interests will conflict with their duties to the CPSO. See the CPSO's Conflict of Interest Policy for further information.

Members who are appointed or elected by a particular group must act in the best interests of the CPSO even if this conflicts with the interests of their appointing or electing group. In particular:

- Professional members who are elected to Council do not represent their electoral districts or constituents.

- Academic professional members who are appointed to Council by their academic institutions do not represent the interests of their institutions.
- Public members of Council who are appointed by the Lieutenant Governor in Council do not represent the government's interests.

Serving and Protecting the Public Interest

The CPSO is the self-regulating body for the province's medical profession. In carrying out its role as a regulator governed by the RHPA, the CPSO has a duty to "serve and protect the public interest". This duty takes priority over advancing any other interest. For greater clarity, advancing other interests must only occur when those interests are not inconsistent with protecting and serving the public interest. As Council and committee members have a fiduciary duty to the CPSO, they must keep in mind that in performing their duties they are expected to work together to support the CPSO in fulfilling this mandate.

Advancing the Profession's Interests

It is possible that while serving and protecting the public, Council and committee members can also collectively advance the interests of the profession. However, there may be times when serving and protecting the public may not align with the interests of the profession. When this occurs, Council and committee members must protect and serve the public interest over the interests of the profession.

Conduct and Behaviour

Respectful Conduct

Members bring to the Council and its committees diverse backgrounds, skills and experiences. While members may not always agree on all issues, discussions shall take place in an atmosphere of mutual respect and courtesy and should be limited to formal meetings as much as possible.

For greater clarity, discussing Council or committee matters outside of formal meetings is strongly discouraged.

The authority of the President of Council must be respected by all members.

Council and Committee Solidarity

Members acknowledge that they must support and abide by authorized Council and committee decisions, even if they did not support those decisions. The Council and CPSO committees speak with one voice. Those Council or committee members who have abstained or voted against a motion must adhere to and support the decision of a majority of the members.

Media Contact, Social Media, and Public Discussion

Council and CPSO Spokespersons

The President is the official spokesperson for the Council. The President represents the voice of Council to all stakeholders. The Registrar/CEO is the official spokesperson for the CPSO.

Media Contact and Public Discussion

News media contact and responses and public discussion of the CPSO's affairs should only be made through the authorized spokespersons. Authorized spokespersons may include the President, the Registrar/CEO, or specified delegate(s).

No member of Council or a CPSO committee shall speak or make representations (including in social media or in private communications) on behalf of the Council or the CPSO unless authorized by the President (or, in the President's absence, the Vice-President) and the Registrar/CEO. When so authorized, the member's representations must be consistent with accepted positions and policies of the CPSO and Council and must comply with the confidentiality obligations under the RHPA.

Social Media Use

Members of Council or a CPSO Committee are held to a very high standard that moves beyond the Social Media policy that applies to physicians generally. In addition, Council and Committee members must recognize that effective advocacy is generally difficult to balance with their role at the CPSO.

Council and Committee members must always consider the potential impact of all their communications, social media use and online conduct on the reputation of, or public trust in, the CPSO, the profession, medical self-regulation or a CPSO stakeholder (including the

Ontario Medical Association, the government, medical schools and others). This applies to all manner of communications and social media use, whether private or public, and whether the member has or has not explicitly stated that their views do not reflect the views of the CPSO. For example, members mustshould:

- Speak on behalf of the CPSO only when authorized by the President or CEO/Registrar;
- Not engage on social media in any way that could be interpreted to represent or establish the position of the CPSO, reflect bias in the CPSO's decision-making, or compromise the reputation of the CPSO, its Council, or its Committees, even if the views expressed are noted to be a member's individual views and not representative of the CPSO;
- Not respond to any negative or confrontational content that is or could be seen to be related to the CPSO, and notify CPSO staff should they discover or receive any negative/confrontational content on social media; and,
- Be professional and respectful on social media, including but not limited to not engaging in harassing, discriminatory or otherwise abusive behaviour.

In particular, while using social media, members must not engage with matters (including posting, commenting, or reacting to them) when:

- The member's comments may be inconsistent with a stated CPSO position;
- The matters discussed relate to or touch upon specific cases or general themes with regards to cases that may ~~or~~ have come before a CPSO Committee. This may create a possible apprehension of bias on the part of the committee member for future cases. For example, strong statements about a specific physician or group of physicians, or an area of medical practice, that could give rise to the appearance of bias when deciding cases related to them.

Council and Committee members are permitted (and encouraged) to share, comment on, and positively comment on or interact with social media postings that have been approved by the CPSO, for example, sharing CPSO job postings, eDialogue, or other posts from CPSO official channels. Doing so is consistent with speaking with one voice when representing the CPSO.

All Council and Committee members are expected to respond to and cooperate with the CPSO if the CPSO raises concerns about the member's social media engagement. This may include but is not limited to complying with requests to remove or edit previous posts, comments, or reactions, or to cease further posts that cause similar or related concerns.

Council and Committee members are encouraged to obtain guidance from the CPSO prior to engaging with social media to assist with compliance with this Code of Conduct.

Representation on Behalf of the CPSO

Council and committee members may be asked to present to groups on behalf of the CPSO, or may be invited to represent the CPSO at events or within the community. Council and committee members are expected to first obtain authorization to do so, as noted above, and to coordinate with CPSO staff to develop appropriate messaging and materials for such presentations.

Every Council and committee member of the CPSO shall respect the confidentiality of information about the CPSO whether that information is received in a Council or committee meeting or is otherwise provided to or obtained by the member. The duty of confidentiality owed by Council and committee members is set out in greater detail in the CPSO's Confidentiality Policy.

Diversity, Equity, and Inclusion

Diversity, equity, and inclusion is important to the CPSO in order to fulfil our mandate to protect and serve the public interest. Council and committee members are expected to support the CPSO's work towards providing a more diverse, equitable, and inclusive environment at the CPSO, within the profession, and for our patients across the province. This includes Council and committee members approaching all work at the CPSO with a diversity, equity, and inclusion lens.

Email and CPSO Technology

More information on email and CPSO technology use can be found in the:

- Use of CPSO Technology Policy

- Information Breach Protocol
- E-mail Management Policy
- Protocol for Access to CPSO Information

CPSO Email Address

Council and committee members must use **only** their CPSO-provided email address (eg., cpso.on.ca) for all communications relating to their CPSO work. CPSO emails (including virtual meeting invitations) must not be forwarded or sent to a personal email address under any circumstances. This is very important to maintain the confidentiality of CPSO-related communications. The use of the CPSO email system by Council and committee members for personal matters should be incidental and kept to a minimum.

Members are expected to check their CPSO email account regularly. Council and committee members should not expect to receive notifications that CPSO email has been sent to them via a personal email, text or phone number, and should not ask CPSO staff to send these notifications. Council and committee members may contact IT for assistance with accessing or using their CPSO email, including having IT download the CPSO Outlook app on their personal mobile phones.

CPSO Technology

Council and committee members should have no expectation of privacy in their use of CPSO Technology or in CPSO Information. The CPSO may monitor and review the use of CPSO Technology by Council and committee members, and may open and review e-mail messages, instant messaging, internet activity and other CPSO Information (including those of a personal nature), at any time without notice for the purposes of verifying compliance with CPSO policies, to protect CPSO Information and other CPSO property and for other lawful purposes.

The CPSO Policy on Use of CPSO Technology applies to Council and committee members. As provided in that policy, all information and data (including e-mail and instant messaging) (referred to as CPSO Information) generated or stored on CPSO systems, devices and associated computer storage media (referred to as CPSO Technology) are the exclusive and confidential property of the CPSO.

Council and committee members must conduct CPSO work using CPSO-issued computers or laptops, not personal computers or laptops. Use of CPSO-issued computers or laptops

by CPSO Council and committee members for personal or non-CPSO matters should be kept to a minimum.

Additionally, the Information Technology department must approve any software downloads to CPSO Technology or systems.

CPSO information must be saved in CPSO systems, and Council and committee members should not download, save or store CPSO information on CPSO Technology (e.g. on C drive or desktop) or on personal devices.

Council and committee members should be aware that they leave a CPSO "footprint" on the internet when accessing it from the CPSO's wireless network or while using CPSO Technology or their CPSO email address. Members are reminded that when they use CPSO networks, they are representing the CPSO at all times during their Internet travels.

Other Council and Committee Member Commitments

In addition to any other obligation listed in this Code of Conduct or in the Declaration of Adherence, each Council member and committee member commits to:

- uphold strict standards of honesty, integrity and loyalty;
- adhere to all applicable CPSO by-laws and policies, in addition to those listed or referred to in this Code of Conduct;
- attend Council and committee meetings, as applicable to the member, be on time and engage constructively in discussions undertaken at these meetings;
- prepare prior to each Council and committee meeting, as applicable to the member, so that they are well-informed and able to participate effectively in the discussion of issues and policies;
- state their ideas, beliefs and contributions to fellow Council and committee members and CPSO staff in a clear and respectful manner;
- where the views of the Council or committee member differ from the views of the majority of Council or committee members, work together with Council or the committee, as applicable, toward an outcome in service of the highest good for the public, the profession and the CPSO;

- uphold the decisions and policies of the Council and committees;
- behave in an ethical, exemplary manner, including respecting others in the course of a member's duties and not engaging in verbal, physical or sexually harassing or abusive behaviour;
- participate fully in evaluation processes requested by CPSO that endeavor to address developmental needs in the performance of the Council, Committee and/or individual member;
- willingly participate in committee responsibilities;
- promote the objectives of the CPSO through authorized outreach activities consistent with CPSO's mandate and strategic plan and in accordance with this Code of Conduct;
- respect the boundaries of CPSO staff whose role is neither to report to nor work for individual Council or committee members; and,
- if a member becomes the subject of a hearing by the Ontario Physicians and Surgeons Discipline Tribunal[1] or the Fitness to Practice Committee of the CPSO, withdraw from the activities of Council or any committee on which the member serves until those proceedings are formally concluded.

Any member of Council or a CPSO committee who is unable to comply with this Code of Conduct or the Declaration of Adherence, including any policies referenced in them, shall withdraw from the Council and/or such committees.

Amendment

This Code of Conduct may be amended by Council.

Updated and approved by Council: ~~December, 9, 2021~~

[1] The Ontario Physicians and Surgeons Discipline Tribunal is the Discipline Committee established under the Health Professions Procedural Code. For convenience, it is referred to as the OPSDT in other instances in this package.

MEDICAL ASSISTANCE IN DYING

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

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

Additional information, general advice, and/or best practices can be found in companion resources, such as *Advice to the Profession* documents.

Definition

Medical Assistance in Dying (MAID): Under the federal legislation, MAID refers to circumstances where a physician[1] or nurse practitioner[2], at a patient's request: (a) administers medications that cause a patient's death; or (b) prescribes or provides medications for a patient to self-administer to cause their own death, in accordance with the legal requirements.

Policy

1. Physicians who assess patients for and/or provide MAID **must** comply with the relevant legal requirements for MAID, including those pertaining to the eligibility criteria, safeguards, and reporting (an overview of which is provided in the College's *MAID: Legal Requirements* companion resource).[3,4]

[1] A physician who is entitled to practise medicine in Ontario, including postgraduate medical trainees.
[2] A nurse who is entitled to practise in Ontario as a nurse practitioner by holding an extended class of certificate of registration.
[3] This includes: Sections 241.1-241.4 of the *Criminal Code*, R.S.C. 1985, c. C-46 (hereinafter, "*Criminal Code*"); *Regulation for the Monitoring of Medical Assistance in Dying*, SOR/2018-166, enacted under the *Criminal Code*; and Section 10.1 of the *Coroners Act*, R.S.O. 1990, c. C.37.
[4] Physicians may want to seek independent legal advice if they have questions about meeting the legal requirements.

2. Physicians **must** comply with the expectations set out in this policy and other relevant College policies[5], and the terms and conditions of their certificate of registration.
    a. Physicians who choose not to assess patients for or provide MAID for reasons of conscience or religion **must** comply with the expectations set out in the College's *Human Rights in the Provision of Health Services* policy.
    b. When assessing patients for and/or providing MAID, postgraduate medical trainees **must** comply with the terms and conditions of their certificate of registration.[6]
    c. Physicians **must** only assess patients for and/or provide MAID if they have the requisite knowledge, skill, and judgment to do so.

Capacity and Consent

3. Consistent with the College's *Consent to Treatment* policy, physicians **must** ensure the patient is capable[7] and provides valid consent[8] to receive MAID.
    a. Physicians **must** ensure the patient has the capacity to consent at these specific points in the MAID process:
        i. when the eligibility assessments are conducted; and
        ii. when MAID is provided; or
        iii. when entering into a written arrangement that waives the requirement for final express consent.[9]
    b. Where the patient's capacity or voluntariness is in question, physicians **must** conduct and/or refer the patient for a specialized capacity assessment[10].

4. As part of obtaining informed consent, physicians **must** discuss the following with patients who are indicating a preference for self-administered MAID:
    a. The location of the self-administration, including whether the patient is able to store the medications in a safe and secure manner so that it cannot be accessed by others;

[5] This includes the College's *Consent to Treatment*, *Decision-Making for End-of-Life Care*, *Human Rights in the Provision of Health Services,* *Medical Records Documentation*, and *Medical Records Management* policies.
[6] See Section 11(8) of Ontario Regulation 865/93, made under the *Medicine Act, 1991*, S.O. 1991, c. 30.
[7] Meaning the patient is able to understand and appreciate the history and prognosis of their medical condition, treatment options, the risks and benefits of their treatment options, and the certainty of death upon self-administering or having a physician administer the medications.
[8] In order for consent to be valid, it must be related to the treatment, informed, given voluntarily, and not obtained through misrepresentation or fraud.
[9] See Sections 241.2 (3.2)-(3.5) of the *Criminal Code* for more information. These written arrangements are also described in the College's *MAID: Legal Requirements* companion resource.
[10] See the Ministry of the Attorney General's website for a list of capacity assessors.

b. The potential complications associated with self-administration, including the possibility that death may not be achieved;
c. That should the patient's death be prolonged or not achieved, it will not be possible for the physician to intervene and administer medications to cause their death unless the patient is capable and can provide consent immediately prior to administering, or the patient has entered into a written arrangement providing advance consent for physician-administered MAID;[11] and
d. How patients and their family, friends and/or caregivers can prepare for the death if the physician is not present, including what to do when the patient is about to die or has just died (e.g., whom to contact at the time of death).[12]

Medications

5. Physicians **must** use their professional judgment in determining the appropriate medication protocol to achieve MAID,[13] and the goals of the protocol **must** include controlling the patient's pain and anxiety.

6. To allow a pharmacist sufficient time to obtain and/or prepare the medications required, physicians **must** notify the dispensing pharmacist as early as possible that medications for MAID will be required.

7. Before administering the medications for MAID, physicians **must** have a contingency plan in place to address potential complications.[14]

Medical Records Documentation and Management

8. Consistent with principles set out in the College's *Medical Records Documentation* policy, physicians **must** capture, where applicable, the following in the patient's medical record:

[11] See Section 241.2 (3.5) of the *Criminal Code* for advance consent for self-administration requirements. These written arrangements are also described in the College's *MAID: Legal Requirements* companion resource.
[12] For more information, see the College's *Advice to the Profession: End-of-Life Care*.
[13] Physicians may wish to consult the Canadian Association of MAID Assessors and Providers' resources on medication protocols or examples of medication protocols used in other jurisdictions.
[14] For more information, see the Canadian Association of MAID Assessors and Providers' Complication with MAID in the Community in Canada: Review and Recommendations resource.

a. all oral and written requests for MAID, the dates they were made, and a copy of the patient's written request;[15, 16]
b. each element of the patient's assessment in accordance with the eligibility criteria for MAID and a copy of the relevant Clinician Aid[17] with their written opinion;
c. the analysis undertaken to determine whether the patient's natural death was or was not reasonably foreseeable;
d. the steps taken to confirm that the relevant procedural safeguards were met and a copy of any Clinician Aid(s) and written opinion(s) or assessment(s) they received;
e. a copy of any written arrangement that waives the requirement for final express consent;[18]
f. the medication protocol used (i.e., drug[s] and dosage[s]); and
g. the time and date of the patient's death, if known.

9. Consistent with the College's *Medical Records Management* policy, physicians **must** provide patients and authorized parties[19] with access to, or copies of, all the medical records in their custody or control upon request, unless an exception applies.[20, 21]

Medical Certificates of Death

10. Physicians who provide MAID **must** complete the medical certificate of death.[22, 23]

11. When completing the medical certificate of death, physicians:

[15] This documentation requirement applies to all physicians who receive requests for MAID, including physicians who choose not to assess patients for or provide MAID for reasons of conscience or religion.
[16] The Ministry of Health has developed Clinician Aid A to assist patients who request MAID.
[17] The Ministry of Health has developed Clinician Aid B for physicians who provide MAID and Clinician Aid C for physicians who conduct an eligibility assessment.
[18] The Ministry of Health has developed Clinician Aids D-1 and D-2 for MAID providers and patients to use as templates for written arrangements.
[19] Authorized parties include substitute decision-makers and estate trustees/executors of the estate where applicable, and third parties where consent has been obtained.
[20] See Section 52 of the *Personal Health Information Protection Act, 2004, S.O. 2004, c.3, Sched A* for a comprehensive list of the exceptions.
[21] See the College's *Advice to the Profession: Protecting Personal Health Information* document for more information about requests for access to the patient's medical information.
[22] Section 21 of the *Vital Statistics Act*, R.S.O. 1990, c. V.4. For general information on certifying a patient's death, see the College's *Advice to the Profession: End-of-Life Care*.
[23] Sections 10 and 10.1 of the *Coroners Act* require physicians to report deaths to the Office of the Chief Coroner for Ontario (OCC) when the person's death is due to a non-natural cause (e.g., accident, homicide, etc.) or due to MAID. In circumstances where the OCC has discretion as to whether the death ought to be investigated, the OCC will make that determination and will complete the medical certificate of death (or a replacement medical certificate of death) for the deaths that they investigate.

a. **must** list the illness, disease, or disability leading to the request for MAID as the cause of death; and
b. **must not** make any reference to MAID or the medications administered on the certificate.[24]

[24] These requirements were jointly developed by the Ministry of Health, the Ministry of Government and Consumer Services, and the OCC.

Revised Council Self-Assessment

Optional Pre-Council Interviews

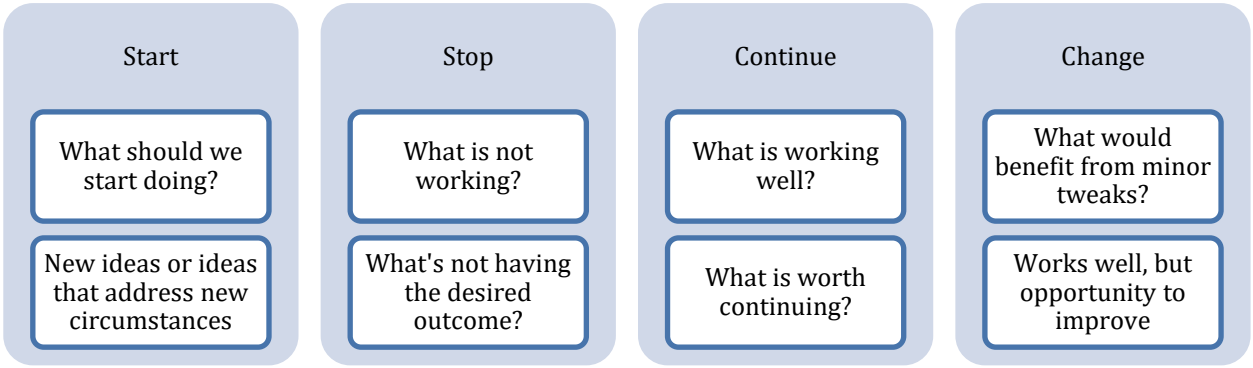
Prior to December Council evaluation, in the latter half of the calendar year, the Council President and Chair of Governance will undertake optional 1:1 meetings with all Council members to collect feedback. These discussions will be guided by a standard interview guide with two or three pre-determined questions to improve the reliability of the qualitative data collection. The focus of these interviews will be on getting feedback on how the Council is operating and where there might be areas of improvement. The results of the interviews will be aggregated and used to identify areas of improvement.

Council Self-Assessment Components

The proposed evaluation will take place in three parts during the in-camera portion of the December meeting of Council. The format and questions will be shared in advance of the meeting to ensure members of Council have adequate time to prepare and contribute to the discussion.

Part 1: Start, Stop, Continue, Change

- Independent feedback exercise, written feedback collected.
- Council members asked to answer each 'Start, Stop, Continue, Change' and submit their feedback around how Council has operated in the past year.
- Results will be used to inform subsequent year Council planning.



Part 2: Break Out Groups

- Break out into six groups of five or six and one group of four (based on the number of Council members present at the meeting)
- The groups will be pre-determined to ensure a mix of both physician and public members
- Each breakout group will be assigned one of the evaluation domains to discuss and rate using the domains and the 5-point scale (strongly agree – strongly disagree) from the 2021 Council Self-Assessment Survey:
    - Performing Board Roles
    - Board Role & Management Relationship
    - Board Quality
    - Board Structure
    - Meeting Processes
    - Overall Board Functioning
    - Individual Director's Functioning
- Each group will assign a speaker to present their rating and rationale to the rest of Council

Part 3: Clicker Exercise

- After the group has presented their rating of the assigned domain, all members of Council will be asked to indicate their agreement or disagreement with the group's evaluation.
    - E.g. Do you agree with the group's assessment of domain 1.1
- Results of the clicker exercise will be displayed using a polling tool and discussion amongst Council will be facilitated in cases where there is a misalignment with a group's rating
- The two lowest performing domains will be the areas of focus for the subsequent year of Council

Specialist Recognition Criteria in Ontario

Purpose

In order to practice medicine in Ontario, an individual must hold a valid certificate of registration issued by the College. Specialty recognition is distinct from registration.

The Ontario Regulation 114/94 provides that no member shall use a term, title or designation relating to a specialty or subspecialty of the profession in respect of their practice of the profession unless the member has been,

1. certified by the Royal College of Physicians and Surgeons of Canada in a specialty or subspecialty of the profession to which the term, title or designation relates;
2. certified by the College of Family Physicians of Canada in a specialty or subspecialty of the profession to which the term, title or designation relates; or
3. formally recognized in writing by the College as specialist in the specialty or subspecialty of the profession to which the term, title or designation relates.

This policy sets out the criteria that a physician must meet in order to be recognized as a specialist by the College of Physicians and Surgeons of Ontario.

Scope

This policy applies to individuals who have met the criteria for registration and have been issued a certificate of registration to practice medicine in Ontario.

Under this policy, the College will recognize specialty titles only in areas for which specialties and sub-specialties are granted by the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada.

This policy does not apply to physicians who hold certification by Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada who are requesting sub-specialist recognition at a time when the sub-specialty examination is available.

Specialist recognition granted under paragraph 3 above is tied to the physician’s practice in Ontario and will automatically expire upon expiry of the physician’s certificate of registration.

The determination as to which specialists should be paid as specialists under the Ontario Health Insurance Plan will be made by the Ministry of Health and Long-Term Care of Ontario.

Policy

A physician who meets any of the requirements below will be recognized by the College as a **specialist**:

1. holds certification by the Royal College of Physicians and Surgeons of Canada; or
2. holds certification in family medicine by the College of Family Physicians of Canada; or
3. holds specialist certification, obtained by examination, by the Collège des médecins du Québec; or
4. holds certification by a specialty member board of the American Board of Medical Specialties (ABMS), and:
    a. ABMS certification was obtained by examination, and
    b. ABMS certification was obtained following successful completion of postgraduate specialty training in a program accredited by the Accreditation Council for Graduate Medical Education (ACGME), and
    c. undertakes to participate in a practice assessment organized by the College one year after having been granted specialist recognition; or
5. holds a restricted certificate of registration authorizing academic practice in Ontario, and:
    a. has successfully completed specialty training and obtained certification as a specialist by the certifying body in the country where the individual completed their training, by an organization outside of North America that recognizes medical specialties, and
    b. the organization which recognized the applicant as a medical specialist did so using standards that are substantially similar to the standards of the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada, and
    c. holds a full-time academic appointment at a medical school in Ontario at the rank of assistant professor, associate professor or full professor; or
6. has completed a minimum of one year of independent or supervised practice in Ontario, and:
    a. has successfully completed specialty training and obtained certification as a specialist by the certifying body in the country where the individual completed their training by an organization outside of North America that recognizes medical specialties, and
    b. the organization which recognized the applicant as a medical specialist did so using standards that are substantially similar to the standards of the Royal

College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada, and

c. has successfully completed a practice assessment that has been directed by the Registration Committee; or

7. hold a restricted certificate of registration in Ontario that has been issued under the College's Restricted Certificates of Registration for Exam Eligible Candidates policy, and:
    a. have received written confirmation from the Royal College of Physicians and Surgeons of Canada of current eligibility, with no pre-conditions, to take the certification examination on the basis of satisfactory completion of a Royal College-accredited residency program in Canada or a Royal College recognized program outside of Canada; or
8. hold a restricted certificate of registration in Ontario that has been issued under the College's Restricted Certificates of Registration for Exam Eligible Candidates policy, and:
    a. have received written confirmation from the College of Family Physicians of Canada of current eligibility, with no pre-conditions, to take the certification on the basis of satisfactory completion of a College of Family Physicians of Canada-accredited residency program in Canada or a College of Family Physicians of Canada recognized program outside of Canada.

Endnotes

[1.] The physician shall be solely responsible for payment of all fees, costs, charges, expenses, etc. arising from request for specialist recognition.

Regulatory Proposal – Temporary Class
Amended Regulation

TEMPORARY INDEPENDENT PRACTICE

(1) The standards and qualifications for a certificate of registration authorizing temporary independent practice are as follows:

1. The applicant must hold a full, unrestricted license or certificate of practice for independent practice in another Province or Territory in Canada, which may include an indication of the specific area of medical practice in which the physician is licensed to practise independently, based on education, qualifications and experience; and

2. The applicant must have an offer from, agreement with, or appointment by a sponsor satisfactory to the Registrar. The offer, agreement, or appointment must be solely for the purposes of providing medical services on a temporary basis.

3. The sponsor referred to in paragraph 2 may be one of the following:
i. A hospital.
ii. An organization, other than a hospital referred to in subparagraph i, that facilitates the provision of medical services.
iii. A member of the College.

(2) The terms, conditions, and limitations of a certificate of registration authorizing temporary independent practice are that,

(a) the holder practise medicine only to the extent,
(i) required by the holder's offer, agreement or appointment with the holder's sponsor, and
(ii) authorized by the holder's license or certificate of practice referred to in paragraph 1 of subsection (1); and

(b) the certificate expires on the earlier of:
(i) the ninetieth day after the certificate is issued; or
(ii) the day after the holder's offer, agreement, or appointment by or with the holder's sponsor expires.

Council Motion

Motion Title	By-law Amendments for Fees for Temporary Services Certificate of Registration
Date of Meeting	September 22, 2022

It is moved by_____, and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario proposes to make the following By-law No. 153, after circulation to stakeholders:

By-law No. 153

1. Section 1 of the Fees and Remuneration By-law (By-law No. 2) is revoked and substituted with the following:

Application Fees

1. A person who submits an application for a certificate of registration or authorization shall pay an application fee. The application fees are as follows:

(a) For a certificate of registration authorizing postgraduate education, 25% of the annual fee specified in section 4(a);

(b) For a certificate of registration authorizing supervised practice of a short duration, 20% of the annual fee specified in Section 4(a);

(b.1) For a certificate of registration authorizing practice for the provision of temporary services, 25% of the annual fee specified in section 4(a);

(c) For an application for reinstatement of a certificate of registration, 60% of the annual fee specified in s. 4(a);

(d) For any other certificate of registration, 60% of the annual fee specified in Section 4(a);

(e) *[repealed]: May 31, 2019]*

(f) For a certificate of authorization, $400.00;

(g) For an application to the Registration Committee for an order directing the Registrar to modify or remove terms, conditions or limitations imposed on the member's certificate of registration by the Registration Committee, 25% of the annual fee specified in section 4(a);

(h) If the person:

(i) meets the registration requirements applicable to the class of certificate of registration applied for, as prescribed in the Registration Regulation, Ontario Regulation 865/93 under the *Medicine Act, 1991*; and

(ii) requests the College to conduct the initial assessment of the application within three weeks after receipt by the College of the application,

an additional fee equal to 50% of the application fee applicable to such person under subsection 1(a), (b), (b.1) or (d).

2. Section 3 of the Fees and Remuneration By-law (By-law No. 2) is revoked and substituted with the following:

Application Fees

3. Every holder of a certificate of authorization, other than a holder of a certificate of registration authorizing supervised practice of a short duration or authorizing postgraduate education for an elective appointment or authorizing practice for the provision of temporary services, shall pay an annual fee.

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

(a) $1725 for holders of a certificate of registration other than a certificate of registration authorizing postgraduate education, a certificate of registration authorizing supervised practice of a short duration, or a certificate of registration authorizing practice for the provision of temporary services;

Explanatory Note: This proposed by-law must be circulated to the profession.

Out-of-Hospital Premises Inspection Program Overview

The Out-of-Hospital Premises Inspection Program (OHPIP) supports continuous quality improvement through developing and maintaining standards for the provision of procedures in Ontario out-of-hospital premises (OHPs) and by inspecting premises for safety and quality of care. The OHP Standards are intended to articulate the core requirements for the performance of procedures in certain settings/premises outside a hospital as defined in Ontario Regulation 114/94 under the *Medicine Act, 1991* (hereinafter "the Regulation").

The Standards are used for the inspection of premises and are applicable to all physicians who work in such premises. The standards include information applicable to the range of all procedures performed in OHPs.

The OHPIP is overseen by CPSO's Premises Inspection Committee. Decisions made by the Premises Inspection Committee will be based on the information within these Standards as well as any additional relevant guidelines, protocols, standards and legislation (e.g. the Canadian Anesthesiologists' Society *Guidelines to the Practice of Anesthesia*, the *Food and Drugs Act*, etc.), including requirements set out by other regulatory bodies and provincial guidelines.

What is the purpose of the Regulation?

The Regulation creates the framework for the regulation of OHPs in Ontario and sets out which procedures are captured by the OHPIP, along with CPSO's powers and responsibilities in relation to inspection of OHPs.

The Regulation sets out specific criteria regarding the procedures that are captured by the OHPIP. How do I determine which procedures are captured by the OHPIP, and therefore can only be performed in an OHP that meets the requirements set out in the Standards?

Any procedure performed under general or regional anesthesia or parenteral sedation is captured by the program and is therefore subject to the requirements set out in the Standards, including approval of and inspection by CPSO.

Some procedures that are performed using local anesthesia are also captured by the Program. This includes any procedure performed with local anesthetic that is:

- A procedure using tumescent anesthesia[1]
- A nerve block for chronic pain
- A cosmetic procedure involving the alteration or removal of tissue or
- A cosmetic procedure where a substance or material (including tissues from the patient's own body i.e. autologous tissue) is injected or inserted into a patient.

There are some procedures performed with local anesthetic that **are not** captured by the Program, including:

- A minor dermatological procedure such as the removal of skin tags, benign moles and cysts

[1] The practice of injecting a very dilute solution of local anesthetic combined with epinephrine and sodium bicarbonate into tissue until it becomes firm and tense.

- A procedure involving the alteration or removal of tissue where done for clinical and *not* cosmetic reasons
- Procedures using only an external topical anesthetic (e.g. Lasik eye surgery).

Minor cosmetic procedures that do not require local anesthesia (e.g. Botox, sclerotherapy) are not captured by the Program.

How are the different types of anesthesia defined?

The following definitions have been adapted from "Continuum of Depth of Sedation" and "Statement on Safe Use of Propofol" by the American Society of Anesthesiologists (ASA):

Local Anesthesia refers to the application, either topically, intradermally or subcutaneously, of agents that directly interfere with nerve conduction at the site of the procedure.

Sedation is an altered or depressed state of awareness or perception of pain brought about by pharmacologic agents and which is accompanied by varying degrees of depression of respiration and protective reflexes.

Minimal Sedation ("Anxiolysis") is a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.[2]

Moderate Sedation ("Conscious Sedation") is a drug-induced depression of consciousness during which patients respond purposefully[3] to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

Deep Sedation is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. Note: Due to the potential for rapid and profound changes in sedative/anesthetic depth and the lack of antagonist medications, patients that receive potent intravenous induction agents (including, but not limited to Propofol, Ketamine, Etomidate, and Methohexital) must receive care that is consistent with deep sedation even if moderate sedation is intended. These medications must be administered by a physician qualified to provide deep sedation.

Regional anesthesia: Major nerve blocks include, but are not limited to, spinal, epidural, caudal, retrobulbar, stellate, paravertebral, brachial plexus, transcapular, intravenous regional analgesia, celiac, pudendal, hypogastric, sciatic, femoral, obturator, posterior tibial nerve and cranial nerve block.

[2] For the purpose of the Standards, sole or minimal use of oral anxiolysis for the purpose of pre-medication is not considered sedation.
[3] Reflex withdrawal from painful stimulus is NOT considered a purposeful response.

General anesthesia is regarded as a continuum of depressed central nervous system function from pharmacologic agents resulting in loss of consciousness, recall, and suppression of somatic and autonomic reflexes.

What are CPSO's responsibilities in relation to regulating OHPs?

CPSO is responsible for considering all issues related to the provision of procedures requiring the use of anesthesia and/or sedation that are performed within OHPs.

CPSO's responsibilities include but are not limited to:

1. Developing and maintaining "OHP Program Standards"
2. Approving any new premises
3. Approving OHP Medical Directors
4. Conducting inspection of the premises and in some cases observing procedures to ensure that services for patients are provided according to the standard of the profession
5. Determining the outcome of inspections
6. Maintaining a current public record of inspection outcomes on the CPSO website
7. Issuing notices for payment of OHP fees.

What does the inspection process involve?

New premises or relocating premises will be inspected within 180 days of notification. All OHPs are inspected every 5 years, or more often if CPSO deems it necessary or advisable.

The inspection may involve but is not limited to:

1. completion of the on-line notification form
2. completion of a pre-visit visit questionnaire
3. a site visit by a nurse inspector appointed by CPSO that includes:
    - a review of records and other documentation
    - review of the OHP's compliance with accepted standards
    - review of any other material deemed relevant to the inspection
4. enquiries or observation of procedures where relevant.

Nurse inspectors provide OHP inspection reports to CPSO, and CPSO provides a copy of the report to the Medical Director.

As outlined in the Regulation, the Premises Inspection Committee determines the inspection outcome and an OHP will be given either a "Pass", "Pass with Conditions", or "Fail" outcome.

What does a "Pass" outcome mean?

A "Pass" outcome means the OHP Standards are met for the specific procedures identified by the OHP at the time of the inspection and that no deficiencies were identified.

What does a "Pass with Conditions" outcome mean?

A "Pass with Conditions" outcome means that deficiencies have been identified in the OHP. If

an OHP receives this outcome they may:

1. be restricted to specific procedures
2. be required to make submissions in writing to CPSO within 14 days of receiving the report
3. be subject to a follow-up inspection at CPSO's discretion within 60 days of receiving the OHP's written submission
4. receive a "Pass" outcome when deficiencies have been corrected to CPSO's satisfaction.

What does a "Fail" outcome mean?

A "Fail" outcome means that significant deficiencies have been identified in the OHP. Where a "Fail" outcome is given:

1. All OHP procedures must cease in the OHP;
2. The OHP may make submissions in writing to CPSO within 14 days of receiving the report; and
3. A follow-up inspection may be conducted at CPSO's discretion within 60 days of receiving the OHP's written submission.

The Medical Director is responsible for ensuring compliance with the OHP Standards and providing any information necessary in relation to the premises. Failure to provide the information may result in an outcome of Fail by the Premises Inspection Committee, in accordance with the *Co-operation with the Out-of-Hospital Premises Inspection Program* Standard and may result in the removal of the Medical Director and direction to appoint a new Medical Director.

Co-operation with the Out-of-Hospital Premises Program Standard

Co-operation with the Out-of-Hospital Premises Inspection Program Standard

Those working in OHPs, including Medical Directors, have an obligation to communicate promptly and accurately with CPSO, to foster a respectful relationship and demonstrate co-operation with the Out-of-Hospital Premises Program (OHPIP). Failure to communicate with or provide information to CPSO in the required manner may result in an outcome of Fail by the Premises Inspection Committee, which requires the OHP to cease operation, or may trigger a reinspection or a referral to CPSO's Inquires, Complaints, and Reports Committee.

Standards

1. All physicians practising in OHPs **must**:

    a. provide accurate information to CPSO, in the form and timeframe specified by CPSO;
    b. co-operate with inspections undertaken by CPSO in order to ensure compliance with the OHP Standards.

2. Medical Directors **must** annually confirm, in the form and manner required by CPSO, their understanding of their responsibilities as set out in the Standards and that they are compliant with these responsibilities. This will include agreement to:

    a. perform their duties with due diligence and in good faith;
    b. ensure that the OHP complies with the Standards and meets its responsibilities,
    c. ensure the OHP provides safe and effective care.

3. Medical Directors **must** respond to CPSO requests for documentation and information in the form and timeframe required, as follows:

    a. within 5 business days for information regarding adverse events;
    b. within 14 days for regular CPSO requests, or
    c. any otherwise specified timeframe as identified by CPSO for other CPSO requests.

4. Medical Directors **must** ensure the OHP does not:

    a. operate in contravention of the Standards;
    b. operate in contravention of any conditions or restrictions imposed by the OHPIP and/or the Premises Inspection Committee.

5. Medical Directors **must** cease operation of an OHP if they receive a fail outcome from an inspection.

6. All physicians planning to practise in an OHP **must** complete the online Staff Affiliation form prior to performing procedures in an OHP.

Notification to CPSO

7. Medical Directors who plan to operate a new OHP **must** notify CPSO of their plans to do so.

8. Medical Directors **must** ensure that no procedures are performed in the OHP until they receive approval from the OHPIP to do so and that only approved OHP procedures are performed.

9. Medical Directors **mus**t notify CPSO of any adverse event in the OHP in writing within 5 business days of learning of the event.[1]

10. Medical Directors **must** notify CPSO in writing at least two weeks prior to any of the following changes to the OHP:

    a. ownership of the OHP
    b. name of the OHP
    c. numbers of procedures performed: any significant increase/decrease (>50% of the last reported inspection)
    d. a new arrangement to rent space to other physicians for the performance of any surgical or anesthetic technique covered by the OHP policy and procedures
    e. decision to cease operation of the OHP[2].

11. Medical Directors **must** notify CPSO in writing at least two weeks prior to any of the following intended changes to the OHP and receive approval (and where necessary undergo a re/inspection):

    a. OHP Medical Director (in accordance with the *Medical Director* Standard);
    b. OHP location/address;
    c. structural changes to patient care areas (including equipment);
    d. new types of procedures or practices;
    e. permitting overnight stays.

Inspection Process

12. Medical Directors and physicians practising in the OHP **must** participate fully in the inspection process and comply with CPSO requests in relation to this process, including:

    a. submitting to an inspection of the OHP;
    b. promptly answering any questions or complying with any requirement of the inspector that is relevant to the inspection;
    c. co-operating fully with CPSO and the inspector who is conducting the inspection;
    d. providing the inspector with any requested records;
    e. allowing direct observation of a physician, including direct observation by an inspector of the physician performing a procedure on a patient;

[1] Please see the *Adverse Events* Standard for more information.
[2] For more information on the appropriate steps to follow when ceasing operation, please see CPSO's *Closing a Medical Practice* policy.

i. Where observation will be occurring, Medical Directors **must** inform the patient prior to the scheduled procedure that an observation of the procedure may take place as a component of the inspection process.

13. Medical Directors **must** ensure that complete records are onsite on the date of planned inspections, including all books, accounts, reports, records or similar documents that are relevant to the performance of a procedure done in the OHP.

14. Medical Directors **must** participate in any requested post inspection processes (e.g., an exit interview with the inspector, completion of a post inspection questionnaire, and providing any required follow-up documentation).

Advice to the Profession: Co-Operation with the Out-of-Hospital Premises Inspection Program Standard

As the Medical Director, how do I need to annually confirm my understanding of my responsibilities?

Medical Directors will need to confirm their understanding of their responsibilities through an Annual Attestation. This attestation is made as part of the annual premises renewal process and is done through the Member Portal.

If I am planning to operate a new OHP, what do I need to do?

Before you can perform any procedures at a new OHP you will need to complete and submit a New Premise Application, pay the required fee and pass a premise inspection, which will be conducted within 180 days of receiving your notice. To complete the application:

1. log into the CPSO Member Portal,
2. click on the OHP tile,
3. click on the New Premises Application button.

Where I am required to notify CPSO of specific changes to the OHP, how do I do this?

You will need to complete a New Request or Notification form and include as many details as possible regarding the change to the OHP. CPSO will then decide if your OHP needs to be re-inspected. To complete a New Request or Notification form:

1. log into the CPSO Member Portal,
2. click on the OHP tile,
3. click on the OHP number of the OHP for which you wish to make changes,
4. click on OHP Requests/Notifications on the left-hand navigation,
5. select the appropriate request or notification button.

What information needs to be available for inspections?

The Standard requires that the Medical Director ensures that complete records are onsite on the date of the inspection. In carrying out an inspection of an OHP, the inspector may require any examination and copies of books, accounts, reports, records or similar documents that are, in the opinion of CPSO, relevant to the performance of the OHP.

More information related to inspections can be found in the *Out of Hospital Premises Inspection Program Overview* document.

Medical Director Standard

Medical Director Standard

Definitions

Medical Director: The Medical Director is the CPSO approved physician responsible for the management and oversight of the OHP.

Acting Medical Director: An "Acting Medical Director" refers to a CPSO approved physician who is overseeing the OHP in the absence of the Medical Director.

Standards

1. All OHPs **must** have a Medical Director or an Acting Medical Director who has been approved by CPSO, and who is responsible for oversight of the OHP, including ensuring compliance with all applicable legislation, regulations, by-laws, CPSO policies, and the requirements in the Standards.

2. Medical Directors **must** annually confirm their understanding of their responsibilities in relation to the OHP, in the manner and form required by CPSO (e.g., sign an annual declaration of responsibilities[1]).

Qualifications

3. Physicians acting as a Medical Director in an OHP **must** have the skills and experience necessary to effectively oversee the OHP[2] and **must** at minimum meet the following criteria:

    a. reside in Ontario;
    b. hold a valid and active CPSO certificate of registration;
    c. not be the subject of any disciplinary or incapacity proceeding in any jurisdiction;
    d. not have lost their hospital privileges or been terminated from employment for reasons of professional misconduct, incompetence, or incapacity; and
    e. not have any terms, conditions or limitations on their certificate of registration that would impact their ability to fulfill the role of a Medical Director.[3]

4. Medical Directors **must** inform the CPSO if, during the course of serving as a Medical Director, they become the subject of a disciplinary or incapacity proceeding and may be required to appoint an Acting Medical Director at the discretion of CPSO.

    a. The Medical Director **must** only resume the role upon CPSO approval.

[1] Please see the *Co-operation with the Out-of-Hospital Premises Inspection Program* Standard for more information
[2] For more information about the types of skills and experience necessary to effectively oversee an OHP, please see the *Advice to the Profession* document.
[3] For additional considerations please see the *Advice to the Profession* document.

Appointment of Acting Medical Director

5. Medical Directors **must** ensure that whenever they are unable or unavailable to perform all of their duties, they have designated another physician practising in the OHP to do so.

6. Medical Directors who plan to take an extended leave of absence or who will be unable to fulfill the duties of their role for an extended period of time (i.e., greater than one month) **must** inform CPSO, who will then determine whether an Acting Medical Director needs to be appointed.

7. Where an Acting Medical Director needs to be appointed, Medical Directors **must** ensure the Acting Medical Director who is appointed:

    a. meets the criteria set out in provision 3 above; and
    b. is approved by CPSO.

8. Where an Acting Medical Director is appointed, the Acting Medical Director **must** sign an agreement with the Medical Director that articulates all of their responsibilities.

9. The Medical Director or Acting Medical Director **must** ensure that all staff working in the OHP are notified when an Acting Medical Director is appointed.

Credentialing and Ensuring Competence

Ensuring competence is a key component of the role of the Medical Director and Medical Directors are ultimately accountable and responsible for all the care provided in the OHP (i.e., for the care provided by the staff practising in the OHP).

10. Medical Directors **must** ensure that all staff practising within the OHP have the requisite knowledge, skill, and judgment to do so competently and safely and that they are practising within their scope of practice and any limitations of their certificate of registration.

11. Medical Directors **must** ensure all staff practising in the OHP have the appropriate qualifications[4] and competence prior to working in the OHP, by at minimum, ensuring the following:

    a. the training and credentials of all staff who wish to practise in the OHP have been reviewed and verified;
    b. all staff are in good standing with their regulatory body, where applicable (i.e., a Certificate of Professional Conduct has been reviewed) including that they:

        i. have a valid and active certificate of registration with their regulatory body;
        ii. are not the subject of any disciplinary or incapacity proceeding in any jurisdiction;
        iii. have not lost their hospital privileges or been terminated from employment for reasons of professional misconduct, incompetence, or incapacity;

[4] For additional information on appropriate qualifications please see Appendix A.

iv. do not have any terms, conditions or limitations on their certificate of registration that would impact their ability to practise in an OHP.

12. Medical Directors **must** ensure that all staff:

    a. read the Policies and Procedures (P&P) manual upon being hired and annually, or where there is a change, and confirm this action (e.g., with a signature and date);
    b. read their individual job descriptions of duties and responsibilities, indicating they have been read and understood (e.g., with a signature and date); and
    c. have professional liability protection as required by their regulatory body, where applicable.

Appropriate Supervision

13. Medical Directors **must** provide a level of supervision and support that ensures safe and effective care within the OHP.

14. Medical Directors **must:**

    a. be on site as needed, to oversee the premises and ensure the OHP is operating safely and effectively, at least one day per month; and
    b. be readily available to provide appropriate oversight and assistance, when necessary.

15. Medical Directors **must** be satisfied that all staff practising within the OHP:

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

16. Medical Directors **must:**

    a. take reasonable steps to ensure that all staff are practising in accordance with the standard of care; and
    b. take appropriate action where there are concerns about the conduct or care of any staff practising in the OHP (e.g., concerns about the number of adverse events), including:

        i. Addressing and documenting the issue with the individual;
        ii. Ensuring appropriate remediation;
        iii. Suspending or terminating the individual, where appropriate;
        iv. Reporting to the professional's regulatory body, where necessary.

Appendix A: Staff Qualifications

Appropriate qualifications generally include the following:

If pediatric care is provided to children 12 and under, staff will:

a. be trained to handle pediatric emergencies; and
b. maintain a current PALS certification.

If administering or recovering pediatric patients from general or regional anesthesia or sedation, staff will need to have recent clinical experience doing so (i.e., within 2 years).

Qualifications for Physicians Performing Procedures

Physicians who perform procedures using local anesthesia in OHPs will hold one of the following:

a. Royal College of Physicians and Surgeons of Canada (RCPSC) or College of Family Physicians of Canada certification that confirms training and specialty designation pertinent to the procedures performed;
b. CPSO recognition as a specialist that would include, by training and experience, the procedures performed (as confirmed by the CPSO's *Specialist Recognition Criteria in Ontario* policy);
c. Satisfactory completion of all CPSO requirements for a physician requesting a change in their scope of practice (based on the CPSO policy, *Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice*). This may include physicians who are currently engaged in a CPSO approved change in scope of practice process.

Qualifications for Physicians Administering Anesthesia

Physicians Administering General or Regional Anesthesia or Deep Sedation

Physicians administering general or regional anesthesia or deep sedation will hold:

a. RCPSC designation[5] as a specialist in anesthesia or one of the following:
    i. Completion of a program accredited by the College of Family Physicians of Canada under the category of "Family Practice Anesthesia";
    ii. CPSO recognition as a specialist in anesthesia, or other specialty pertinent to the regional anesthesia performed, as confirmed by CPSO's *Specialist Recognition Criteria in Ontario* policy.

[5] Physicians who are trained in general or regional anesthesia or deep sedation but who have not been practising in this area for two years or more would be subject to CPSO's *Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice* policy, if they wished to return to this area of practice.

Physicians Administering Minimal to Moderate Sedation

Where a physician is not qualified to administer general anesthesia or deep sedation, but is administering minimal-to-moderate sedation, the physician will hold:

- Education and experience to manage the potential medical complications of sedation/anesthesia, including ability to:
    i. identify and manage the airway and cardiovascular changes which occur in a patient who enters a state of general anesthesia,
    ii. assist in the management of complications, and
    iii. understand the pharmacology of the drugs used, and
- Current ACLS certification.

Nurse Qualifications

Nurses working in OHPs will have training, certification, and appropriate experience as required for the procedures performed, including holding qualifications in accordance with those set out in the National Association PeriAnesthesia Nurses of Canada's *Standards for Practice*, where applicable, as well as current ACLS if administering sedation to, monitoring or recovering patients (RNs only).

Appendix B: OHP Policies and Procedures

The OHP policies and procedures, which must be regularly reviewed, updated, and implemented include the following:

Administrative issues and responsibilities, including:
a. responsibility for developing and maintaining the policy and procedure manual,
b. scope and limitations of OHP services provided,
c. overnight stays, if applicable,
d. staff qualifications, hospital privileges, and records.

Response to emergencies, including those related to:
a. need to summon additional staff assistance urgently within the OHP,
b. fire,
c. power failure,
d. other emergency evacuation,
e. need to summon help by 911, and coordination of OHP staff with those responders.

Urgent transfer of patients, including:
a. appropriate transportation (e.g., ambulance) and accompaniment (e.g., Most Responsible Physician, OHP staff, etc.), and
b. timely transfer of relevant documentation/medical records.

Job Descriptions, including:
a. OHP staff job descriptions that define scope and limitations of functions and responsibilities for patient care; and
b. Responsibility for supervising staff.

Procedures related to:
a. Adverse events (i.e., monitoring, reporting, reviewing and response)
b. Combustible and Volatile Materials
c. Delegating controlled acts and medical directives
d. Routine maintenance and calibration of equipment
e. Infection control, including staff responsibilities in relation to the *Occupational Health and Safety Act*
f. Medications handling and inventory
g. Patient booking system
h. Detailed and clear patient selection/admission/exclusion criteria for services provided
i. Patient consent in accordance with CPSO's *Consent to Treatment* policy
j. Patient preparation for OHP procedures
k. Response to allergic reactions (e.g., latex)
l. Safety precautions regarding electrical, mechanical, fire, and internal disaster
m. Waste and garbage disposal

Forms used

Inventories/Lists of equipment to be maintained

Advice to the Profession: Medical Director Standard

The role of the Medical Director is central to ensuring safe and quality care within an OHP. The quality of the leadership and oversight of the OHP correlates with the quality of the care provided within the OHP.

Accordingly, many of the expectations set out within the Standards are the responsibility of the Medical Director. This companion *Advice* document is intended to help Medical Directors interpret their obligations as set out in the *Medical Director* Standard and provide guidance around how the expectations may be effectively discharged.

The Medical Director Standard sets out minimum criteria that must be met in order to be a Medical Director. If I meet the minimum criteria, will I automatically be approved to be a Medical Director?

No. Satisfaction of minimum criteria does not guarantee approval to be a Medical Director. CPSO will exercise reasonable discretion in approving Medical Directors. Additional considerations may include, but will not be limited to, whether:

- a physician has active investigation(s) and the nature of the investigation(s) (e.g. whether the complaint has a specific impact on the ability to perform in the role);
- a physician is subject to any other regulatory activity or condition that may be relevant to the role;
- a physician is the subject of a discipline finding;
- a physician has had their certificate of registration revoked or suspended.

The Medical Director Standard requires that Medical Directors have the skills and experience necessary to effectively oversee the OHP. What are the skills and experience necessary to oversee an OHP?

The role of a Medical Director is key to ensuring safe and quality care within an OHP. Relevant skills needed to be effective in the role include strong leadership skills, relevant clinical expertise, and knowledge of relevant clinical practice guidelines, quality improvement, and infection prevention and control standards. There are a variety of ways in which the necessary skills and experience can be acquired. While some Medical Directors may have such knowledge, skills and experience before taking on this role, others may acquire the skills over time. For those seeking additional training to help develop the necessary skills, professional development is available. For example, leadership training is offered through programs such as the Canadian Medical Association's The Physician Leadership Institute.

I'm considering hiring a regulated health professional whose certificate of professional conduct (CPC) indicates they have an active investigation. Am I permitted to hire them?

It depends. The *Medical Director* Standard sets out minimum criteria that must be met for staff practising in an OHP. Given that Medical Directors are responsible for their staff

and all of the care provided in the OHP, even if these criteria are met, Medical Directors will need to use their professional judgement and carefully consider the nature and seriousness of the complaint or investigation and how quickly it will be resolved.

Medical Directors are responsible for ensuring their staff are appropriately qualified and have the competence necessary to practise safely in an OHP. Depending on the nature and seriousness of the complaint or investigation (e.g., whether there are concerns about clinical competence) Medical Directors may wish to hold off on hiring the individual until the outcome of the investigation is known, or to take additional steps to satisfy your obligation to ensure the individual's competence. Medical Directors are ultimately responsible for the care provided in the OHP and for exercising due diligence when hiring.

What happens if CPSO determines that a Medical Director cannot fulfill their duties?

The Medical Director is professionally accountable for fulfilling all of their obligations and duties to the OHP and CPSO. In the event that CPSO determines that the Medical Director is not performing their duties in accordance with the legislation, regulations, and policies, CPSO can require the OHP Medical Director to appoint an Acting Medical Director acceptable to CPSO and/or take such other steps as deemed necessary.

If I go on vacation do I need to appoint an Acting Medical Director to fulfill my duties?

Whenever a Medical Director is unable to fulfill their duties as set out in the Standards, they are required to ensure that another physician practising in the OHP can fulfil these duties. If the Medical Director will be unavailable or unable to fulfill their duties for an extended period of time (i.e., more than a month) they are required to notify the CPSO and where deemed necessary, appoint an Acting Medical Director who meets the criteria set out in the Standard and who is approved by CPSO. Temporary or short term absences (less than a month) do not require undergoing the process of appointing an Acting Medical Director that is approved by CPSO, but do require the Medical Director to appoint a physician within the OHP to perform their role while they are unavailable.

Medical Directors are required to be on site as needed, but at least one day per month, to oversee the premises and ensure the OHP is operating safely and effectively. What kind of things would a Medical Director be doing when they are on site?

There are a number of responsibilities that Medical Directors have with respect to the OHP, including those related to supervision, quality assurance, and infection prevention and control. In order to effectively fulfill these duties, it is important that Medical Directors are on site as needed to oversee the premises, ensure that policies and procedures are being adhered to and to ensure that safe, quality care is being provided. The more present and involved a Medical Director is within the OHP, the better the patient care tends to be.

Physicians Practising in Out-of-Hospital Premises Standard

Physicians Practising in Out-of-Hospital Premises Standard

Standards

1. All physicians practising in an Out-of-Hospital Premises (OHP) **must**:
    a. have completed the online Staff Affiliation form for each OHP they wish to practise in, prior to practising in that OHP;
    b. meet the standard of practice of the profession, which applies regardless of the setting in which care is being provided;
    c. practise within their scope of practice and within the limits of their knowledge, skill and judgement;
    d. comply with all applicable requirements in the Standards, including:
        i. cooperating with and providing information to CPSO in accordance with the *Co-operation with the Out-of-Hospital Premises Inspection Program* Standard;
        ii. being appropriately qualified to perform all procedures they perform in that OHP, in accordance with Appendix A of the *Medical Director* Standard;
        iii. complying with pre-procedure, intra-procedure and post-procedure care requirements when performing procedures in accordance with the *Procedures Standard*;
        iv. complying with all infection prevention and control standards and requirements in accordance with the *Infection Prevention and Control* Standard;
        v. managing and reporting all adverse events in accordance with the requirements in the *Adverse Events* Standard;
        vi. participating in quality assurance processes within the OHP, in accordance with the *Quality Assurance* Standard;
        vii. complying with all applicable policies and procedures of the OHP, as set out in Appendix B of the *Medical Director* Standard;
    e. comply with all applicable CPSO policies[1];
    f. comply with the requirements for the OHP set out by the Medical Director and in the OHP's policies and procedures; and
    g. comply with existing standards or guidelines from applicable specialty societies.

[1] This includes but is not limited to the following: *Availability and Coverage*, *Consent to Treatment*, *Delegation of Controlled Acts*, *Disclosure of Harm*, *Physician Behaviour in the Professional Environment*, *Prescribing Drugs*, *Managing Tests*.

Physical Space Standard

Physical Space Standard

Standards

General

1. Medical Directors **must** ensure that the requirements in Public Health Ontario's *Infection Prevention and Control for Clinical Office Practice* document regarding physical spaces, including the surgical space and reprocessing space, are met.

2. Medical Directors **must** ensure:

    a. The OHP complies with all applicable building codes including fire and safety requirements;
    b. All electrical devices are certified by the Canadian Standards Association (CSA) or are licensed for use in Canada;
    c. There is an emergency power supply that allows for safely completing a procedure that is underway and for recovering the patient;
    d. Access for persons with disabilities complies with provincial legislation[1] and municipal bylaws;
    e. Necessary spaces can be accessed by and accommodate stretchers and wheelchairs;
    f. The size of the OHP is adequate for all the procedures that will be performed within it;
    g. The OHP layout facilitates safe patient care and patient flow; and
    h. The following areas of the OHP are functionally separate:
        i. administration and patient-waiting area
        ii. procedure room and/or operating room
        iii. recovery area
        iv. clean utility area
        v. dirty utility room
        vi. reprocessing room
        vii. endoscope cabinet (where applicable)
        viii. staff change room and staff room.

3. Medical Directors **must** ensure the physical space allows for appropriate movement of patients in an emergency, including:

    a. safely evacuating patients and staff if necessary (i.e. stretchers, wheelchairs, or other adequate methods of transport are available), and
    b. appropriate access to the patient for an ambulance to transfer the patient to a hospital.

[1] *Accessibility for Ontarians with Disabilities Act, 2005*, S.O. 2005, c. 11.

Procedure Room/Operating Room Physical Standards

Physical Requirements

4. Medical Directors **must** ensure the OHP has:

    a. lighting as required for the specific procedure being performed;
    b. floors, walls, and ceilings that can be cleaned to meet infection control requirements;
    c. immediate access to hand-washing facilities and proper towel disposal;
    d. openings to the outside effectively protected against the entrance of insects or animals; and
    e. space sufficient to accommodate equipment and staff required for the procedure, and to move around while sterile, without contamination.

Ventilation

5. Medical Directors **must** ensure:

    a. there is ventilation sufficient to ensure patient and staff comfort, and fulfill occupational health and safety requirements;
    b. there is ventilation and air circulation augmented to meet manufacturer's standards and address procedure-related air-quality issues (e.g., cauterysmoke, endoscopy, disinfecting agents, anesthesia gases), where applicable; and
    c. air exchanges meet infection control standards[2] for the type of procedure being performed;
    d. if using gas sterilization for reprocessing, a positive pressure outbound system is used, vented directly to the outside.

Equipment

6. Medical Directors **must** ensure:

    a. Medical equipment is maintained and inspected yearly by a qualified biomedical technician and has an active service contract;
    b. Equipment necessary for emergency situations (i.e., defibrillators, oxygen supply, suction) is inspected on a weekly basis and documented;
    c. Related documentation for all equipment is available, including:
        i. record of certification of medical equipment by a qualified biomedical technician,
        ii. equipment operating manuals,
        iii. equipment maintenance contracts with an independent and certified biomedicaltechnician,
        iv. log for maintenance of all medical devices, and
    d. The following equipment is available:
        i. cleaning equipment as required for the specific procedure,
        ii. accessible anesthetic drugs and equipment,
        iii. blood pressure and oxygen saturation monitoring equipment,

[2] For more information see Public Health Ontario's *Infection Prevention and Control for Clinical Office Practice.*

iv. sterile supplies and instruments,
v. table/chair that permits patient restraints and Trendelenberg positioning, where applicable,
vi. table/chair/stretcher that accommodates procedures performed and provides for adequate range of movement for anesthetic procedures,
vii. suction equipment and backup suction, for anesthesia provider's exclusive use.

Anesthetic and Ancillary Equipment

7. Where an OHP administers general anesthesia, regional anesthesia or sedation, Medical Directors **must** ensure:

    a. Both anesthetic and ancillary equipment and medical compressed gases and pipelines comply with the Canadian Standards Association (CSA) or are licensed for use in Canada;
    b. A second supply of (full cylinder) oxygen capable of delivering a regulated flow is present;
    c. An anesthetic machine and anesthetic cart with appropriate drugs[3] and equipment is provided, where general anesthesia is being administered.
        i. In accordance with the Canadian Anesthesiologists' Society *Guidelines to the Practice of Anesthesia*, appropriate equipment includes at minimum:
            - Pulse oximeter;
            - Apparatus to measure blood pressure, either directly or noninvasively;
            - Electrocardiography;
            - Apparatus to measure temperature;
            - Neuromuscular blockade monitor when neuromuscular blocking drugs are used;
            - Capnography for general anesthesia and to assess the adequacy of ventilation for moderate or deep procedural sedation; and
            - Agent-specific anesthetic gas monitor, when inhalational anesthetic agents are used.

Recovery Area Physical Standards

8. Medical Directors **must** ensure a sink is available for hand washing.

9. Where an OHP provides general anesthesia, regional anesthesia or sedation, Medical Directors **must** ensure:

    a. The size of the recovery area can accommodate the number of patients for two hours of operating room time (i.e., 1 hour procedure = 2 patients, 0.5 hour procedure = 4 patients);
    b. The recovery area allows for transfer of patients to/from a stretcher and performance

[3] For more information on what drugs are needed, see the *Drugs and Equipment* Standard.

of emergency procedures; and

c. Monitoring, suction, oxygen, bag-valve mask devices, and other emergency airway equipment, intravenous and other medical supplies are immediately available.

Drugs and Equipment Standard

Drugs and Equipment Standard

Standards

General

1. Medical Directors **must** ensure the following practices are undertaken in the OHP:

    a. a general drug inventory record is maintained;
    b. periodic inspection of all drugs is undertaken to ensure drugs are not expired;
    c. single dose vials of drugs are used wherever possible;
    d. if multidose vials of drugs must be used, they are dated on opening, disposed of according to manufacturer's guidelines, and are used in accordance with Public Health Ontario's *Updated Guidance on the Use of Multidose Vials*[1];
    e. drugs are labelled in accordance with the *Food and Drug Act*[2] and the *Controlled Drugs and Substances Act*[3] and any regulations made under those statutes;
    f. drugs are stored securely and in accordance with the manufacturer's recommendations (e.g., refrigeration if required); and
    g. emergency drugs are stored in a common location[4].

Controlled Substances

2. Medical Directors **must** ensure that controlled substances are:

    a. handled, stored, and administered in accordance with *Food and Drug Act* and the *Controlled Drugs and Substances Act* and any regulations made under those statutes;
    b. accessed by a qualified designated staff member[5];
    c. stored securely and appropriately to prevent theft and loss; and
    d. accounted for in a "Log of Controlled Substances".[6]

3. Medical Directors **must** ensure that at the beginning and end of each day that controlled substances are used, a balance of the inventory is calculated by physical count and verified.

4. In the event of a discrepancy, Medical Directors **must** ensure that an investigation is conducted and documented with the action taken.

Drugs and Equipment for Urgent or Emergency Situations

5. Medical Directors **must** ensure that staff are prepared to address urgent or

[1] For more information on appropriate use of multidose vials see Public Health Ontario's *Updated Guidance on the Use of Multidose Vials*.
[2] *Food and Drug Act* R.S.C., 1985, c. F-27, s. 1
[3] *Controlled Drugs and Substances Act* (CDSA)S.C. 1996, c.19
[4] A crash cart may be appropriate in OHPs where procedures are done in multiple procedure rooms.
[5] For example, an RN, RPN with medication skills, or a physician.
[6] For additional information on appropriate practices please see the Canadian Society of Hospital Pharmacist's *Controlled Drugs and Substances in Hospitals and Healthcare Facilities: Guidelines on Secure Management and Diversion Prevention.*

emergency situations or resuscitate a patient using appropriate equipment[7] and current drugs, when necessary.

6. Medical Directors **must** ensure that, at minimum, the OHP has the following drugs immediately available:

    a. Oxygen
    b. H1 antihistamines (e.g., Diphenhydramine)
    c. Epinephrine for injection
    d. Bronchodilators (e.g., Salbutamol)
    e. Atropine
    f. Intralipid if using Lidocaine/Bupivacaine/Ropivacaine.

7. Medical Directors **must** ensure that other appropriate equipment and drugs are immediately available to respond to the following situations, proportionate to the level of anesthesia or sedation being administered[8]:

    a. Hypertension
    b. Hypotension
    c. Anaphylaxis
    d. Cardiac events, including those covered in the ACLS Algorithms
    e. Respiratory Events
    f. Malignant Hyperthermia, if using triggering agents [9]
    g. Benzodiazepine reversal
    h. Opioid reversal
    i. Neuromuscular blockade reversal, if using nondepolarizing muscle relaxants
    j. Acidosis
    k. Relevant potential electrolyte disturbances
    l. Hyper and Hypoglycemia
    m. Emesis.

8. If services are provided to infants and children, the Medical Director **must** ensure that required drugs are available and appropriate for that population.

[7] Please see the *Advice* document for more information on the equipment that would be typically required within an OHP.
[8] The drugs required will depend on the type of anesthesia used at the OHP (i.e., local, IV sedation or general). Please see the *Advice* document for more information on the drugs typically used to respond to the listed conditions.
[9] For more information see Malignant Hyperthermia Association of the United States' *What should be on an MH cart?*

Advice to the Profession: Drugs and Equipment Standard

Where can I find more information on how to appropriately store and handle controlled substances?

Additional information on appropriate practices relating to controlled substances can be found in the Canadian Society of Hospital Pharmacists' document *Controlled Drugs and Substances in Hospitals and Healthcare Facilities: Guidelines on Secure Management and Diversion Prevention.*

The Drugs and Equipment Standard requires drugs to be immediately available to respond to a number of situations – which specific drugs are recommended?

Medical Directors are responsible for ensuring that the OHP has the appropriate drugs needed to address the situations outlined in the Standard. This may be achieved in a number of ways but generally speaking the following drugs will support physicians in managing urgent and emergency situations:

Hypertension

- Antihypertensive IV such as Labetalol, Hydralazine or Nitroglycerine (at least 1 for circumstances where sedation or regional anesthesia is being administered, and at least 2 where general anesthesia is being administered)
- BETA Blocker IV such as Metoprolol, Propranolol, Esmolol
- Lasix IV

Hypotension

- At least 2 of:
    - Epinephrine
    - Ephedrine
    - Vasopressin
    - Phenylephrine

Anaphylaxis

- Diphenhydramine IV
- Hydrocortisone IV

Cardiac Events

- Epinephrine
- Amiodarone IV
- ASA
- IV agent for supraventricular tachycardia such as Adenosine, Esmolol, Verapamil, or Metoprolol (at least 2 for circumstances where sedation or regional anesthesia is being administered, and at least 3 where general anesthesia is being administered)
- Nitroglycerine spray
- Atropine IV
- Benzodiazepine IV such as Midazolam, Diazepam, or Lorazepam
- Calcium IV

- Lidocaine 2% pre-filled syringe

Respiratory Events

- Bronchodilators

Malignant hyperthermia

- An adequate supply of Dantrolene, and other appropriate drugs as per MHAUS guidelines

Benzodiazepine Reversal

- Flumazenil IV

Opioid Reversal

- Naloxone IV - if narcotics are stocked

Electrolyte Disturbances

- Magnesium Sulfate IV

Hypoglycemia

- Dextrose 50% IV

Other

- Neuromuscular blocking reversal agents
- Sodium bicarbonate IV

What kind of equipment is appropriate to have immediately available for urgent or emergency situations?

Medical Directors are responsible for ensuring that the OHP has the appropriate equipment needed to address the situations outlined in the Standard. This may be achieved in a number of ways but generally speaking the following equipment will support physicians in managing urgent and emergency situations:

- AED
- IV setup
- Adequate equipment to manage local anesthetic toxicity
- Appropriately sized equipment for infants and children, if required
- Assortment of disposable syringes, needles, and alcohol wipes
- Laryngeal mask airways
- Means of giving manual positive pressure ventilation (e.g., manual - self-inflating resuscitation device)
- Cardiopulmonary resuscitation equipment with current ACLS/PALS - compatible defibrillator
- Qualitative and quantitative means to verify end-tidal CO2
- ECG monitor

- Intubation tray with a variety of appropriately sized blades, endotracheal tubes, and oral airways
- Oxygen source
- Pulse oximeter
- Suction with rigid suction catheter
- Devices to provide active warming
- Torso backboard
- Cognitive Aids (for example, for difficult airways, ACLS algorithms, Malignant Hyperthermia, etc)

The *Physical Space* Standard contains requirements around maintaining and inspecting equipment. Please see that Standard for more information.

Patient Selection Standard

Patient Selection Standard

Patient selection is a crucial component of ensuring procedures performed in an OHP are safe. The appropriateness of performing a procedure in the OHP setting depends on ensuring that the proposed procedure can be performed safely for that particular patient and their particular circumstances.

Standards

1. Physicians **must** use their professional judgement to determine whether a procedure can be provided to a particular patient safely and effectively in an OHP, on a case by case basis.

2. Physicians **must** only perform a procedure on a patient where they are satisfied that the procedure can be safely and effectively performed in the OHP, and it is in the patient's best interest to do so, taking into account:

    a. the patient's existing health status (e.g., any co-morbidities, frailty, stability of any existing conditions), their specific health-care needs and the specific circumstances;
    b. the potential complications that could arise from that specific procedure, including potential complications in surgical management if more than one procedure is to be performed at a time;
    c. anesthetic or sedation factors that may place the patient at a higher risk;
    d. the resources that may be required to perform a procedure on that particular patient;
    e. the duration of the procedure and the potential for a prolonged recovery period; and
    f. the location of the OHP and its proximity to emergency services or hospitals[1], should complications arise from the procedure.

3. Where a prospective patient would be required to undergo general or regional anesthesia or sedation, the physician administering the anesthesia or sedation **must** assign an ASA classification[2] for that prospective patient.

    a. Generally, only patients with ASA classifications of I and II are appropriate for procedures in an OHP setting. Physicians **must** only perform procedures involving the administration of general or regional anesthesia or sedation on patients classified as ASA III if:
        i. the comorbid condition is unlikely to add significant risk to the anesthetic, sedation or procedure; and
        ii. the comorbid condition could not reasonably be expected to be adversely affected by the anesthetic, sedation, or procedure;
    b. The physician administering the anesthesia or sedation and the physician performing the procedure **must** discuss all potential ASA III cases well in advance of the scheduled procedure, with regard to the:

[1] The *Adverse Events* Standard requires OHPs to have an established protocol to facilitate the urgent transfer of patients to the most appropriate hospital for the management of an urgent adverse patient event.
[2] For more information on ASA classifications see the *Advice to the Profession* document.

i. appropriateness of OHP setting for the safe performance of the procedure (including the factors listed in Provision 2 above),
ii. pre-procedure assessment and care required, and
iii. intra-procedure and post-procedure requirements.

Advice to the Profession: Patient Selection Standard

Why is patient selection so important in an OHP?

Appropriate patient selection is critical to help ensure that patients can receive safe care in OHPs. The Out-of-Hospital Premises Inspection Program has historically seen a number of adverse events that result from inappropriate patient selection. The *Patient Selection* Standard requires physicians to classify patients, prior to a procedure where general or regional anesthesia or sedation will be used, using the American Society of Anesthesiologists' Physical Status Classification System and only perform procedures on patients who are classified as ASA I, ASA II or, in some circumstances, ASA III.

The process of determining suitability of a patient to undergo a procedure in an OHP involves the complex interplay of several factors, and there can be a significant difference in the way physicians classify patients and determine which ASA III patients they consider appropriate to treat in an OHP. This Standard is intended to help physicians appropriately exercise professional judgment in relation to these patients.

How do I determine which ASA classification a patient should have?

In determining the appropriate ASA classification for a patient there are a number of factors that need to be considered. The table below[1] outlines some examples of conditions or diseases that would influence the determination of a patient's ASA classification.

ASA Classification	**Definition**	**Adult Examples**
I	A normal healthy patient	Healthy, non-smoking, no or minimal alcohol use
II	A patient with mild systemic disease	Mild diseases only without substantive functional limitations. Examples include (but not limited to): • current smoker, • well-controlled diabetes mellitus or hypertension, • mild lung disease
III	A patient with severe systemic disease	Substantive functional limitations; 1 or more moderate to severe diseases. Examples include (but not limited to): • poorly controlled diabetes mellitus or hypertension, • chronic obstructive pulmonary disease, • transient ischemic attack, • coronary artery disease/stents

[1] Modified from Rajan, N, Rosero E, and Joshi, G 2021, 'Patient Selection for Adult Ambulatory Surgery: A Narrative Review', *International Anesthesia Research Society*, vol. 133, no. 6, pp 1415-1430. Please see this article for more information.

What kind of comorbidities may make a patient inappropriate to perform a procedure on in an OHP?

Several comorbid conditions have been demonstrated to have an effect on patient outcomes after procedures in an OHP type setting and therefore need to play a major role in patient selection. Independent factors identified by a majority of studies include:

- advanced age
- obesity
- obstructive sleep apnea
- cardiac disease,
- chronic obstructive pulmonary disease
- diabetes mellitus
- end-stage renal disease
- transient ischemic attack/stroke,
- chronic opioid use or opioid use disorder, and
- malignant hyperthermia.[2]

Generally, patients would be unsuitable for a procedure in an OHP where they:

- have unstable or poorly managed chronic illnesses such as diabetes, hypertension, hepatitis, etc.;
- have unmanaged alcohol or substance use disorders; or
- are undergoing active immunosuppressant cancer treatment.

Physicians are required to exercise their professional judgement when determining the appropriateness of performing procedures on patients in an OHP, and where they are unsure or where the patient is classified as ASA III, are required to consult with the physician administering the anesthesia or sedation well in advance of the procedure.

Why do physicians need to discuss ASA III cases well in advance?

The *Patient Selection* Standard does allow room for professional judgement when it comes to determining which ASA III patients may be appropriate to have a procedure in an OHP. However, it is important that professional judgment in these circumstances be exercised in a considered way. Requiring that discussions take place between the physician who will be performing the procedure and the physician administering the anesthesia or sedation will help to ensure that both physicians have thought through the potential complicating factors of performing a procedure on the patient in the OHP setting, and both agree that it is appropriate to do so in the circumstances. It is important for discussions to take place in advance in order to manage patient expectations and avoid any pressure to perform a procedure that has been scheduled where it might not be appropriate.

[2] Rajan, N, Rosero E, and Joshi, G 2021, 'Patient Selection for Adult Ambulatory Surgery: A Narrative Review', *International Anesthesia Research Society*, vol. 133, no. 6, pp 1415-1430.

Procedures Standard

Procedures Standard

Standards[1]

1. Physicians **must** meet the standard of practice of the profession, which applies regardless of the setting in which care is being provided.

2. Physicians administering anesthesia or sedation **must** do so in accordance with the Canadian Anesthesiologists' Society *Guidelines to the Practice of Anesthesia,* including requirements for patient assessment, pre-procedural testing, fasting guidelines, patient monitoring, documentation of care in the patient record, and anesthesia support personnel.

    a. Where a physician is administering anesthesia or sedation to a pediatric patient they **must** do so in accordance with the Canadian Pediatric Society's *Recommendations for procedural sedation in infants, children, and adolescents*.

3. Physicians **must** use the Surgical Safety Checklist for all surgical procedures.

4. The Medical Director **must** ensure that nursing staff comply with National Association of PeriAnesthesia Nurses of Canada *Standards for Practice*, including requirements for appropriate staffing, discharge of patients from recovery phases, documentation of care in the patient record and appropriate discharge instructions.

5. Prior to procedure acceptance, physicians **must** have assessed the suitability of the patient to undergo the procedure in the OHP setting in accordance with the *Patient Selection* Standard.

    a. For patients with significant co-morbidities, physicians **must** undertake appropriate consultation (for example, with an anesthesiologist or other specialists) as required, prior to making a decision to proceed with the procedure in the OHP setting.

6. Physicians **must** ensure all elements of patient care are appropriately documented in accordance with CPSO's *Medical Records Documentation* policy. For more information on appropriate documentation, please see the *Advice to the Profession* document.

Pre-Procedure Requirements

7. Physicians **must** provide appropriate pre-procedure instructions to patients including any fasting instructions, and whether they will require adult accompaniment upon discharge from the OHP.

8. The physician performing the procedure **must** undertake an appropriate pre-procedure assessment and ensure a baseline history and physical has been taken.

9. Where anesthesia or sedation will be administered, the physician administering the anesthesia or sedation **must**, on the day of the procedure, undertake a pre-anesthetic

[1] Where this standard uses the term "physician" the expectation can be fulfilled by either the physician performing the procedure, or the physician administering the anesthesia or sedation. Expectations that must be fulfilled by a specific physician state this explicitly.

assessment.

10. Physicians **must** ensure informed consent has been obtained for the procedure, including the use of anesthesia or sedation where applicable, in accordance with CPSO's *Consent to Treatment* policy.

Intra-Procedure Care for Sedation, Regional Anesthesia, or General Anesthesia

11. If the physician administering the regional anesthesia or sedation is also performing the procedure, the physician **must** ensure the patient is attended by a second individual[2] who is not assisting in the procedure, and is appropriately qualified, in accordance with Appendix A of the *Medical Director* Standard, to monitor patients undergoing regional anesthesia or sedation.

Post-Procedure Patient Care

12. A physician **must** remain on site until the patient has met discharge criteria for the most acute phase of recovery, in accordance with the National Association of PeriAnesthesia Nurses of Canada *Standards for Practice*.

13. Medical Directors **must** ensure that where there is an overnight stay at an OHP, all of the following conditions are met:

    a. A physician, appropriately qualified in accordance with Appendix A of the *Medical Director* Standard, is immediately available by telephone and can be available onsite at the premises within thirty minutes for urgent medical matters; and
    b. A minimum of two nurses appropriately qualified to monitor and recover patients from anesthesia or sedation are on premises.

Patient Discharge After General or Regional Anesthesia or Sedation

14. When a patient is being discharged, a physician **must:**

    a. write the discharge order for a patient, and
    b. direct that the discharge summary be distributed to the patient's primary care provider, if there is one and, the patient has provided consent.

15. Recovery area staff **must** ensure that patients are:

    a. Provided with appropriate written discharge instructions[3];
    b. accompanied by an adult when leaving the OHP, and are advised to have an adult stay with the patient during the postoperative period (most commonly 24 hours);
    c. informed that they need to notify the OHP of any unexpected admission to a hospital within 10 days of the procedure.

[2] Such as a physician, respiratory therapist, RN or anesthesia assistant.
[3] For example, no driving for 24 hours, who to contact for routine and emergency follow-up, and instructions for pain management, wound care, and activity.

Advice to the Profession: Procedures Standard

What kind of pre-procedure assessments are appropriate to undertake before performing a procedure on a patient in an OHP?

The *Procedures* Standard requires that an appropriate pre-procedure assessment is undertaken including a baseline history and physical examination.

Where anesthesia or sedation will be administered, the Standard also requires the physician administering the anesthesia or sedation to complete a pre-anesthetic assessment. Such an assessment would typically include the following:

- American Society of Anesthesiologists' (ASA) physical status classification of the patient
- a review of the patient's clinical record (including pre-procedure assessment)
- an interview with the patient
- a physical examination relative to anesthetic aspects of care
- a review and ordering of tests as indicated
- a review or request for medical consultations as necessary for patient assessment and planning of care
- a review of pre-procedure preparation such as fasting, medication, or other instructions that were given to the patient.

When determining which tests are indicated or appropriate for a particular patient, physicians may wish to consult Choosing Wisely Canada's recommendations in relation to anesthesia.

What elements of patient care need to be documented when administering anesthesia or sedation in an OHP?

As the *Procedures* Standard states, physicians must comply with *Medical Records Documentation* policy.

When anesthesia or sedation is administered, an Anesthesia/Sedation Record is required to be completed. A typical Anesthesia/Sedation record includes the following information:

a. pre-procedure anesthetic/sedation assessment
b. all drugs administered including dose, time, and route of administration
c. type and volume of fluids administered, and time of administration
d. fluids lost (e.g., blood, urine) where it can be measured or estimated
e. measurements made by the required monitors:
    - Oxygen saturation must be continuously monitored and documented at frequent intervals. In addition, if the trachea is intubated, a supraglottic airway is used, or moderate to deep sedation is being administered, end-tidal carbon dioxide concentration must be continuously monitored and documented at frequent intervals
    - Pulse and blood pressure documented at least every 5 minutes until patient is recovered from sedation
    - Temperature and neuromuscular blockade monitors
f. complications and incidents (if applicable)
g. name of the physician responsible (and the name of the person monitoring the patient, if applicable)

h. start and stop time for anesthesia/sedation care.[1]

What elements of care need to be documented during the recovery period?

In relation to care provided during the recovery period appropriate documentation would typically include:

a. patient identification
b. date and time of transfer to recovery area
c. initial and routine monitoring of: blood pressure, pulse, respirations, oxygen saturation, temperature, level of consciousness, pain score, procedure site and general status
d. continuous monitoring of vital signs until the patient has met requirements of discharge criteria using an objective scoring system from time of transfer to recovery area until discharge
e. medication administered: time, dose, route, reason, and effect
f. treatments given and effects of such treatment
g. status of drains, dressings, and catheters including amount and description of drainage
h. summary of fluid balance
i. discharge score using a verified discharge scoring system.

What other documents or notes would typically be included in the patient record?

The *Medical Records Documentation* policy states that the goal of the medical record is to "tell the story" of the patient's health care journey. In order to ensure that a full picture of the patient's health care journey is reflected in their record, the following documents or notes would typically be included:

- Documentation of the consent process in accordance with CPSO's *Consent to Treatment* policy, including a record of any forms that were used
- Pre-procedure assessment
- A copy of the completed Surgical Safety Checklist
- The Anesthetic/Sedation Record
- Discharge summary, where applicable
- Any adverse event reports, as required by CPSO.

[1] For more information see the Canadian Anesthesiologists' Society *Guidelines to the Practice of Anesthesia*.

Infection Prevention and Control Standard

Infection Prevention and Control (IPAC) Standard

All OHP staff are responsible for complying with appropriate IPAC practices and for taking action where inappropriate practices are occurring (i.e., those that are out of line with infection prevention and control standards). Everyone has a responsibility to monitor their own practice as well as the practice of the other health care providers working in the OHP to ensure patient safety.

Standards

1. Medical Directors **must** ensure appropriate infection prevention and control practices are occurring within the OHP, including compliance with all applicable legislation and regulations[1], as well as with Public Health Ontario's *Infection Prevention and Control for Clinical Office Practice*[2].[3]

2. In particular, Medical Directors **must** ensure that the following is occurring within the OHP:

    a. Adherence to Routine Practices[4] and Additional Precautions[5];
    b. Compliance with safe medication practices;[6]
    c. Maintenance of a clean and safe health care environment with environmental cleaning and disinfection appropriate to the clinical setting performed on a routine and consistent basis;
        i. Areas where surgery and invasive procedures are performed are cleaned and disinfected according to standards set by the Operating Room Nurses Association of Canada (ORNAC);[7]
    d. Reprocessing of medical equipment is done in accordance with the manufacturer's instructions and/or accepted standards and reflects the intended use of the

[1] This includes, for example, the *Occupational Health and Safety Act* (hereinafter OHSA), as well as the *Needle Safety Regulation (O. Reg 474/07)* under the *OHSA,* and the Workplace Hazardous Materials Information System (WHMIS).
[2] Ontario Agency for Health Protection and Promotion (Public Health Ontario), Provincial Infectious Diseases Advisory Committee. *Infection Prevention and Control for Clinical Office Practice*. 1st Revision. Toronto, ON: Queen's Printer for Ontario; April 2015.
[3] A summary of mandatory practices and best practice recommendations for clinical office practice is set out on page 72 of *Infection Prevention and Control for Clinical Office Practice*.
[4] Routine Practices are based on the premise that all patients are potentially infectious, even when asymptomatic, and that the same standards of practice must be used routinely with all patients to prevent exposure to blood, body fluids, secretions, excretions, mucous membranes, non-intact skin or soiled items and to prevent the spread of microorganisms.
[5] "Additional Precautions" refer to IPAC interventions (e.g., barrier equipment, accommodation, additional environmental controls) to be used in addition to Routine Practices to protect staff and patients and interrupt transmission of certain infectious agents that are suspected or identified in a patient.
[6] For additional information see *Appendix H: Checklist for Safe Medication Practices* set out in *Infection Prevention and Control for Clinical Office Practice*.
[7] For more information about environmental cleaning in surgical areas refer to the Operating Room Nurses Association of Canada (ORNAC) standards, which are now under the auspices of the Canadian Standards Association.

equipment or device and the potential risk of infection involved in the use of the equipment or device[8];

e. Accepted standards of handling regulated waste are adhered to[9].

3. Medical Directors **must** ensure the following is in place to support appropriate IPAC practices:

    a. well documented policies and procedures which are periodically reviewed by staff;
    b. all staff are properly trained and are provided with regular education and support to assist with consistent implementation of appropriate IPAC practices;
    c. responsibility for specific obligations are clearly defined in writing and understood by all staff; and
    d. mechanisms are in place for ensuring a healthy workplace, appropriate staff immunizations and written protocols for exposure to infectious diseases, including a blood-borne pathogen exposure protocol.[10]

4. Where substandard IPAC practices are occurring, all staff **must** take appropriate action, including advising the Medical Director, addressing the issue with the individual responsible for the infraction, and/or reporting to Public Health, where required.

[8] For additional information see *Appendix I: Recommended Minimum Cleaning and Disinfection Level and Frequency for Medical Equipment* set out in *Infection Prevention and Control for Clinical Office Practice*.
[9] "Regulated Waste" means: a) liquid or semi-liquid or other potential infectious material; b) contaminated items that would release blood or other potential infectious materials in a liquid or semi-liquid state are compressed; c) items that contain dried blood or other potential infectious materials and are capable of releasing these materials during handling; d) contaminated sharps; e) pathological and microbiological wastes containing blood or other potentially infectious materials.
[10] For additional information see *Appendix J: Checklist for Office Infection Prevention and Control* set out in *Infection Prevention and Control for Clinical Office Practice*.

Advice to the Profession: Infection Prevention and Control (IPAC) Standard

Why is it important to ensure OHPs are complying with IPAC standards?

IPAC is an important element of care in any health care institution. Given the nature of the procedures done in OHPs, for example the level of invasiveness, it is important to ensure that appropriate IPAC practices are in place and that standards are met. Failure to do so can have serious consequences for both patients and staff.

What are common IPAC infractions observed during inspections?

Many OHPs that fail their inspections do so from a failure to comply with IPAC standards. Common IPAC deficiencies seen during inspections include the following:

- Sinks with no backsplash
- Items stored underneath sinks
- Aerosol or spray trigger cleaning chemicals
- Cloth furniture that is porous
- Biomedical waste that is stored with other supplies
- Refrigerator used for medications with no temperature log
- Multi-use gel or cleaning solutions not dated upon opening
- Multi-use medications not dated upon opening
- Housekeeping supplies not stored in a designated space
- Reprocessing issues (e.g. technician not appropriately trained, reprocessing done incorrectly, missing items essential to reprocessing, reprocessing brushes that are not designed for re-use being used multiple times).

Medical Directors are responsible for compliance with the requirements set out in Public Health Ontario's *Infection Prevention and Control for Clinical Office Practice*[1] and for ensuring the practices within the OHP are current and reflect any changes in requirements relating to IPAC.

What are some actions that minimize risk of infection in the operating room?

Actions that minimize risk of infection in the operating room include adherence to proper use of disinfectants, proper maintenance of medical equipment that uses water (e.g., automated endoscope reprocessors), proper ventilation standards for specialized care environments (i.e., airborne infection isolation, protective environment, and operating rooms), and prompt management of water intrusion into OHP structural elements.

[1] Ontario Agency for Health Protection and Promotion (Public Health Ontario), Provincial Infectious Diseases Advisory Committee. *Infection Prevention and Control for Clinical Office Practice*. 1st Revision. Toronto, ON: Queen's Printer for Ontario; April 2015.

Adverse Events Standard

Adverse Events Standard

Definitions

Adverse Event: An incident that has resulted in harm to the patient as a result of the care provided in the OHP (also known as a "harmful incident"). For specific examples, please see the *Advice to the Profession* document.

Standards

Preparing for Adverse Events

1. Medical Directors **must:**

    a. ensure there are written protocols in place to support the recognition and reporting of adverse events and to appropriately manage any adverse events that occur;
    b. ensure there is an established protocol to facilitate the urgent transfer of patients to the most appropriate hospital for the management of an urgent adverse patient event;
    c. ensure there is a formalized transfer agreement with a local hospital;
    d. be available to provide assistance in managing any adverse events, if necessary;
    e. be satisfied that staff practising within the OHP are capable of managing any adverse events themselves, if necessary; and
    f. have a communication plan in place to keep informed of any adverse events that take place and any actions taken to manage them.

Managing Adverse Events

2. When an adverse event occurs, physicians involved in the adverse event **must** take appropriate and timely action, including:

    a. managing any urgent adverse events appropriately by:
        i. providing any necessary care to address the patient's immediate needs;
        ii. ensuring timely initiation of emergency care or services, where necessary (i.e., where the patient is experiencing severe suffering or is at risk of sustaining serious bodily harm if treatment is not administered promptly);
        iii. initiating a timely transfer to hospital, where necessary;
        iv. accompanying the patient to hospital, where necessary;
        v. communicating with the receiving physician or premises to notify them of the transfer, where the patient is unaccompanied;
        vi. ensuring essential medical information and the referring physician's contact information is sent with the patient to support continuity of care;
    b. caring for, supporting, and following-up with patients, family, and caregivers as necessary.

Documenting and Reporting Adverse Events

3. When an adverse event occurs, physicians involved in the adverse event **must**:

    a. document the details of the adverse event in the patient's medical record;

b. provide a written report to the Medical Director within 24 hours of learning of the event which includes the following information:
    - name, age, and gender of the person(s) involved in the incident, including staff and patients
    - name of witness(es) to the event (if applicable)
    - time, date, and location of event
    - description of the incident and treatment rendered
    - date and type of procedure (if applicable)
    - analysis of reasons for the incident
    - outcome;
c. report the incident, including the details captured in provision 3b, to CPSO in writing within 5 business days of learning of the event;
d. provide CPSO with any relevant medical records and additional information as requested;
e. ensure appropriate disclosure to the patient, in accordance with CPSO's *Disclosure of Harm* policy; and
f. where a death occurs, make a report to the Coroner.

4. Where an adverse event occurs, Medical Directors **must** ensure the reporting obligations set out above are complied with (e.g., that the adverse event has been reported to the CPSO within 5 business days).[1]

Incident Analysis

5. Once the adverse event has been appropriately managed, Medical Directors **must** initiate a process to analyze and learn from the event, including:

    a. undertaking an investigation to understand how and/or why the incident occurred;
    b. developing recommendations to help prevent similar incidents from occurring;
    c. sharing the learnings and recommendations with other staff in the OHP.

6. Medical Directors **must** ensure that recommendations are implemented within the OHP and are monitored over time to assess their effectiveness.

Analyzing and Learning from Adverse Events

7. Medical Directors **must**:

    a. critically review all adverse events that have occurred over a 12 month period and evaluate the effectiveness of the OHP's practices and procedures to improve patient safety;
    b. document the review and any relevant corrective actions and quality improvement initiatives taken; and
    c. provide feedback to all staff regarding identified patterns of adverse events.

[1] Failure to report an adverse event may result in an outcome of Fail by the Premises Inspection Committee.

Advice to the Profession: Adverse Events Standard

An adverse event is defined as an incident that has resulted in harm to the patient as a result of care provided in the OHP. What are some specific examples of adverse events that must be reported to CPSO?

A key component of the definition is that the adverse event must be related to the procedure performed in the OHP. Indicators of adverse events generally include complications related to the use of sedation/anesthesia or to the procedure itself. This includes both serious complications, such as:

- Death within the premises;
- Death within 10 days of a procedure performed at the premises;
- Any procedure performed on the wrong patient, site, or side; or
- Transfer of a patient from the premises directly to a hospital for care.

It also includes other quality assurance incidents which are deemed less critical for immediate action, such as:

- Unscheduled treatment of a patient in a hospital within 10 days of a procedure performed at a premises in relation to the procedure;
- Complications such as infection, bleeding, or injury to other body structures;
- Cardiac or respiratory problems during the patient's stay at the OHP;
- Allergic reactions; or
- Medication-related adverse events.

Patient harm that occurs as a result of an unrelated activity is not considered an adverse event as defined by the Standard and does not need to be reported to CPSO. For example, if a patient has an injury that results in a hospital stay within 10 days of the procedure performed in the OHP but is unrelated to the OHP procedure, this would not be considered an adverse event.

Why is it important for Medical Directors to track adverse events?

Adverse events can serve as a good indicator of where quality improvement can occur in an OHP, both with respect to policies and procedures in the OHP, and with respect to an individual physician's practices. Keeping track of this information is intended to assist OHPs with learning from and improving patient safety within the premises. Reviews of adverse events (and near misses) are considered an effective approach to improving patient safety.

What is the purpose of reporting adverse events to CPSO? What will you do with this information?

CPSO is responsible for the effective oversight of OHPs. Reviewing the severity and frequency of adverse events within each OHP helps CPSO to fulfill this duty by helping to identify any concerning trends. In order to fulfill CPSO's obligation to monitor for higher risk events, and to fulfill their own obligations, Medical Directors are accountable to CPSO for reporting this information and for taking any appropriate corrective action.

CPSO recognizes that adverse events can result from a variety of factors, including risks inherent in the procedure, system failures, or even performance issues with individual

physicians, however they offer opportunity for learning and improvement and can offer insight into areas which might benefit from practice improvement or additional safety measures. Depending on the nature and frequency of adverse events, they are not necessarily an indication of poor practice. However, lack of reporting of adverse events may serve as indication that OHPs are failing to comply with their obligations as set out in the *Adverse Events* Standard.

CPSO is committed to assisting OHPs with improving their practices and collecting information regarding adverse events helps us to do so.

How can I report adverse events and what information needs to be submitted to CPSO?

Adverse events can be reported through the Member Portal on CPSO's website. Physicians involved in the adverse event are required to submit a report with the following information:

- name, age, and gender of the person(s) involved, including staff and patients;
- name of witness(es) to the event (if applicable);
- time, date, and location of event;
- description of the incident and treatment rendered;
- date and type of procedure (if applicable);
- analysis of reasons for the incident;
- outcome;
- any additional information as requested by CPSO.

Physicians will also be asked to submit relevant medical records, including any referral letters, pre- and post-operative notes and tests, surgical notes, the anesthesia record, and an updated memo of the patient's outcome.

Why has CPSO moved away from distinguishing between Tier 1 and Tier 2 adverse events?

With the implementation of CPSO's new Member Portal, you are now required to report all adverse events as they occur, so the distinction between Tier 1 and Tier 2 adverse events no longer serves a purpose. CPSO will continue to review all adverse events that occur within OHPs and respond accordingly.

Where can I learn more about adverse events?

The CMPA's Good Practices Guide and *Learning from adverse events: Fostering a just culture of safety in Canadian hospitals and health care institutions* have additional guidance related to adverse events, including the best approach for reviewing these events.

Quality Assurance Standard

Quality Assurance Standard

Standards

Creating a Culture of Safety and Quality

1. Medical Directors **must** foster a culture of safety and quality within the OHP.

2. Medical Directors **must** ensure that the OHP maintains a Quality Assurance program and that it undertakes initiatives to improve the quality of care within the premises.

3. Medical Directors **must** ensure the OHP has a Quality Assurance (QA) committee for the purpose of creating processes to establish standards, monitor activity, and improve performance to ensure appropriate volume and scope of services provided.

4. Medical Directors **must:**

    a. hold, at a minimum, two QA committee meetings at each OHP site per year, that address quality issues (e.g., infection control, adverse events, etc.);
    b. ensure meetings are attended by all staff providing patient care where possible, and that all staff who are unable to attend are updated on the meeting discussions and outcomes;
    c. ensure all meetings, including the staff who were in attendance, are documented and that the documentation is available to CPSO upon request.

5. Medical Directors **must** hold periodic staff meetings to review policies and procedures, challenging cases, near misses[1], adverse events, and protocols as appropriate to minimize adverse events.

6. Medical Directors **must** ensure that members of staff undertake continuing education relevant to their practice in the OHP, in accordance with applicable regulatory requirements, to maintain clinical competency and knowledge of best practices.

Monitoring Quality of Care

7. Medical Directors **must** ensure there is a documented process in place to regularly monitor the quality of care provided to patients through activities, including the following:

    a. review of all staff performance (i.e., both medical and non-medical staff);
    b. review of individual physician care to assess:
        - patient and procedure selection are appropriate
        - patient outcomes are appropriate
        - adverse events;
    c. review a selection of individual patient records to assess completeness and accuracy of entries by all staff;

[1] Near miss incident is defined in CPSO's *Disclosure of Harm* policy as an incident with the potential for harm that did not reach the patient due to timely intervention or good fortune (also known as a "close call"). For specific examples, please see the *Advice to the Profession: Disclosure of Harm*.

d. review of activity related to cleaning, sterilization, maintenance, and storage of equipment;
e. documentation of the numbers of procedures performed (i.e., any significant increase/decrease (>50% of the last reported assessment)).

Advice to the Profession: Quality Assurance Standard

What is "Quality Assurance" and what does it mean to foster a culture of safety and quality within the OHP?

The term "Quality Assurance" generally refers to the identification, assessment, correction, and monitoring of important aspects of patient care. The *Quality Assurance* Standard sets out a number of quality assurance activities that must be undertaken in an OHP which, when undertaken effectively, can help to foster a culture of safety and quality within the OHP.

The CMPA's *Learning from adverse events: Fostering a just culture of safety in Canadian hospitals and health care institutions*[1] also has guidance around fostering a just culture of safety within an institution.

The Quality Assurance Standard requires that Medical Directors hold periodic staff meetings to review policies and procedures, challenging cases, near misses, adverse events, and protocols as appropriate to minimize adverse events. How often should staff meetings be held?

Medical Directors can determine the frequency of staff meetings based on the needs of the OHP and its staff, any updates or changes in polices and procedures, or any adverse events, near misses, or challenging cases that may need to be reviewed.

Medical Directors are required to regularly monitor the quality of care provided to patients through activities such as reviewing a selection of patient records. What are best practices with respect to this quality assurance activity?

An annual review of a random selection of medical records (e.g., 5-10 records) can help to monitor the quality of care within an OHP, including review of the following:

- record completion[2] and documentation of informed consent
- percentage and type of procedures
- appropriate patient selection[3]
- appropriate patient procedure
- where required, reporting results in a timely fashion
- evaluation of complications
- assessment of transfer to hospital, where required
- follow up of abnormal pathology and laboratory results.

[1] *Learning from adverse events: Fostering a just culture of safety in Canadian hospitals and health care institutions*. Ottawa, ON: Canadian Medical Protective Association; 2009.
[2] For more information see the *Advice to the Profession: Procedures Standard* document.
[3] For more information see the *Patient Selection* Standard.

Council Motion

Motion Title	Council Meeting Consent Agenda
Date of Meeting	December 8, 2022

It is moved by_____, and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario approves the items outlined in the consent agenda, which include in their entirety:

- The Council meeting agenda for December 8 and 9, 2022; and
- The minutes from the meeting of Council held September 22 and 23, 2022

Council Briefing Note

December 2022

Topic:	**Ontario Physicians and Surgeons Discipline Tribunal Report of Completed Cases | September 3, 2022 – November 23, 2022**
Purpose:	For Information
Relevance to Strategic Plan:	Right-Touch Regulation
Public Interest Rationale:	**Accountability:** Holding physicians accountable to their patients/clients, the public, and their regulatory body. **Protection:** Fulfilling the College's mandate to ensure public protection.
Main Contacts:	Dionne Woodward, Tribunal Counsel
Attachments:	None

Issue

- This report summarizes reasons for decision released between September 3, 2022 and November 23, 2022 by the Ontario Physicians and Surgeons Discipline Tribunal.
- It includes reasons on discipline hearings (liability and/or penalty), motions, case management and jurisdictional issues brought before the Tribunal.
- This report is for information.

Current Status and Analysis

In the period reported, the Tribunal released 12 reasons for decision:

- 3 reasons on findings (liability) and penalty
- 2 reasons on liability only
- 1 set of reasons on penalty only
- 5 reasons on motions/case management
- 1 set of reasons on jurisdiction

Findings

Liability findings included:

- 5 findings of disgraceful, dishonorable or unprofessional conduct
- 2 findings of sexual abuse
- 2 findings of failure to maintain the standard of practice of the profession
- 1 finding of contravening a term, condition or limitation on a certificate of registration
- 1 finding of guilty of an offence relevant to suitability to practice
- 1 finding of incompetence

Penalty

Penalty orders included:

- 4 reprimands
- 2 suspensions
- 2 revocations
- 2 imposition 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 were $64,480 and the minimum costs ordered were $6000.

Motions and case management decisions

For the period reported, the Tribunal released three orders and reasons for decisions on motions, two case management decisions and one set of reasons on jurisdiction.

TABLE 1: TRIBUNAL DECISIONS – FINDINGS (September 3, 2022 to November 23, 2022)

Citation and hyperlink to published reasons	Physician	Date of Reasons	Sexual Abuse	Disgraceful, Dishonourable, Unprofessional	Failed to maintain standard of practice	Incompetence	Other
2022 ONPSDT 32	Aboujamra	Sept. 20, 2022	X	X			
2022 ONPSDT 35	Mortada	Oct. 11, 2022		X			Guilty of offence relevant to suitability to practice.
2022 ONPSDT 36	Al-Khafaji	Oct. 26, 2022	X	X			
2022 ONPSDT 39	Khan	Nov. 9, 2022		X	X	X	
2022 ONPSDT 41	Alexander	Nov. 10 2022		X	X		Contravened a term, condition or limitation on certificate of registration

TABLE 2: TRIBUNAL DECISIONS - PENALTIES (September 3, 2022 to November 23, 2022)

Citation and hyperlink to published reasons	Physician	Date of reasons	Penalty (TCL = Term, Condition or Limitation)	Length of suspension in months	Costs
2022 ONPSDT 35	Mortada	Oct. 11, 2022	Reprimand; Suspension; TCL	8 months	$6000
2022 ONPSDT 36	Al-Khafaji	Oct. 26, 2022	Revocation; Reprimand; $16,060 to reimburse College for funding provided for patient's therapy and counselling		$6000
2022 ONPSDT 41	Alexander	Nov. 10, 2022	Reprimand; Suspension; TCL	6 months	$6000
2022 ONPSDT 43	Aboujamra	Nov. 21, 2022	Revocation; Reprimand; $16,060 to reimburse College for funding provided for patient's therapy and counselling		$64,480

TABLE 3: TRIBUNAL DECISIONS - MOTIONS AND CASE MANAGEMENT (September 3, 2022 to November 23, 2022)

Citation and hyperlink to published reasons	Physician(s)	Date of reasons	Motion/Case management outcome	Nature of motion/case management issue
2022 ONPSDT 33	Phillips/Trozzi/Luchkiw	Sept. 21, 2022	Physicians' motion to halt discipline allegations against them denied.	The three physicians asked the Tribunal to halt the discipline allegations against them until the Superior Court of Justice had decided their application against the College, including any appeals.
2022 ONPSDT 34	Gerber	Sept. 28, 2022	Case Management – Order made to restrict communication between witnesses.	In order to promote the integrity of the complainants' evidence, the panel made an order: - prohibiting anyone on either party's witness list from communicating directly with each other about the proceeding; and - prohibiting communication about documents or information either party's witnesses had obtained or learned about through their participation in the proceeding, unless the information was public.
2022 ONPSDT 37	Khan	Oct. 25, 2022	Reasons on Jurisdiction – The panel dismissed the Dr. Khan's application to "cancel" the Tribunal's prior penalty order.	Dr. Khan's position was that the penalty order was of no force and effect due to an inaccurate characterization in the panel's reasons. The panel held that it did not have jurisdiction to hear the application, nor to make the order requested.
2022 ONPSDT 40	Gerber	Nov. 9, 2022	Member's motion for communications exchanged between ten complainants and for records from the Canadian Broadcasting Company (CBC) allowed in part.	The Tribunal directed four of the complainants to produce documents to the Tribunal for review having found they were likely relevant. The CBC was also directed to provide the Tribunal with one record in its possession.

2022 ONPSDT 42	Gerber	Nov. 14, 2022	The panel denied the moving party's request to participate in the hearing.	The moving party asked to participate in the hearing by making oral and written submissions, leading evidence, cross-examining witnesses and participating in case management conferences. The panel dismissed the motion as granting it would delay the upcoming hearing and inappropriately expand its scope.

Council Briefing Note

December 2022

Topic:	Government Relations Report
Purpose:	For Information
Relevance to Strategic Plan:	Right-Touch Regulation System Collaboration
Public Interest Rationale:	Government relations supports CPSO to regulate in a more effective, efficient, and coordinated manner.
Main Contact(s):	Miriam Barna, Senior Government Relations Program Lead Craig Roxborough, Director, Policy Danna Aranda, Government Relations Coordinator

Update on the Ontario Legislature

- The fall legislative session is scheduled to last until December 8th, when the House will rise for a winter break lasting until February 21st.

- The session has been dominated by on-going crises across the health care system, issues of affordability, and labour unrest with educational workers.

- On November 14th, government released its fall economic statement, reflecting greater economic uncertainty than projected in the PC's spring 2022 Budget and promising a number of new affordability and tax measures.

Issues of Interest

a) Registration Regulations

- There continues to be significant developments and interest in registration matters, and more broadly speaking, health human resource challenges.

- At the September meeting of Council, a proposal for a new temporary independent class of registration, providing increased flexibility for those who wish to assist with system needs on a temporary basis, was approved and forwarded to government for their consideration.

- On October 27th, government filed this regulation, and it came into force.

- On the same day that the temporary independent class of registration came into force, government announced the implementation of regulations they released for consultation in June. Council may recall CPSO's response to this consultation.

- These regulations implement legislative changes passed in the previous parliament that are intended to reduce barriers to registration at health regulatory colleges. They will:

    - Establish timelines for some elements of the registration process, including a 30 day time limit for the Registrar to make a decision or refer to the Registration Committee following receipt of a complete application;
    - Identify narrow exceptions to the prohibition of Canadian work experience;
    - Standardize language proficiency requirements; and
    - Require colleges to have a one year, renewable emergency class of registration.

- The first three changes are expected to come into effect on January 1, 2023, with the new emergency class coming into force on August 21, 2023. Staff are continuing to analyze these changes and the work required to implement them.

b) Physician Assistant Regulation

- Council will also recall that CPSO's work on implementing physician assistant (PA) regulation has been on pause since fall 2021.

- Since the late summer, work has resumed on the file and staff have been developing draft regulations over the course of the fall.

- Once draft regulations have been completed, they will be brought to Council for consideration and approval to consult with the public and profession.

Interactions with Government

- Staff continue to engage with Ministry of Health officials on the implementation of physician assistant regulation, registration regulations, and public member issues.

- A set of MPP meetings is scheduled between CPSO's President and select newly elected MPPs. These meetings aim to introduce MPPs to CPSO and facilitate ongoing communication and relationship-building.

- Finally, as of September, a reorganization in the Ministry of Health meant that CPSO, and all the health colleges, had a new Assistant Deputy Minister, Dr. Karima Velji (PhD). CPSO has been able to quickly establish a relationship with Dr. Velji, having had positive and constructive interactions on key files.

Annual Committee Reports 2022

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Executive Committee Annual Report

Committee Mandate

The Executive Committee has the powers and duties of Council (except to make, amend or revoke a regulation or by-law) with respect to matters that, in the Committee's opinion, require immediate attention between meetings of Council. The Executive Committee reports to Council on any powers it exercises [General By-law, s. 30; HPPC[1], s. 12(1)].

The Executive Committee's additional duties set out in Section 39 of the General By-law include:

- review the Registrar's performance and set the Registrar's compensation, which includes:
  - consulting with Council about the Registrar's performance and setting performance objectives in accordance with a process approved by Council;
  - ensuring the Registrar's appointment and re-appointment are approved by Council; and
  - approving a written agreement setting out the Registrar's terms of employment [General By-law, s. 39(3(a) and (4)].
- oversee and assist CPSO staff with the development and delivery of major communications, government relations, and outreach initiatives to the profession, public and other stakeholders, consistent with CPSO's strategic plan [General By-law, s. 39(3(b))]; and
- make recommendations to Council, where appropriate.

The Executive Committee may make appointments to fill any vacancies in another committee's membership, if it is necessary for a committee to achieve its quorum [General By-law, s. 37(4)].

Section 35.1 of the General By-law states that the Executive Committee may rescind a committee member's appointment prior to its expiry, if in the opinion of the committee chair or vice-chair and with the approval of the Governance Committee, the committee member fails to advance the work of the committee, is having significant difficulties with the work of the committee, is disruptive to or negatively affecting the work or functioning of the committee, or is otherwise not performing well on the committee. Section 35.1 does not apply to members of the Governance Committee or Executive Committee. [General By-law, s. 35.1 (1)]

[1] *Health Professions Procedural Code* ("HPPC"), Schedule 2 to the *Regulated Health Professions Act, 1991* ("RHPA")

Committee Members

Ms. Joan Fisk – Executive Member Representative, 2021-2022
Dr. Robert Gratton – Vice-President, 2021-2022
Mr. Peter Pielsticker – Executive Member Representative, 2021-2022
Dr. Judith Plante – Past President, 2021-2022
Dr. Ian Preyra – Executive Member Representative, 2021-2022
Dr. Janet van Vlymen –President, 2021-2022

We wish to thank Dr. Plante and Mr. Pielsticker for their dedication, commitment and contributions to the Executive Committee.

Key Accomplishments

The Executive Committee continues to monitor the key performance indicators (KPIs), as well as monitor progress on the 2020-2025 Strategic Plan. KPIs are reported on at Executive Committee and Council meetings.

Beginning in 2022, the Executive Committee will be responsible for the Council Award selection process and selecting the 2023 winners.

The Executive Committee reviewed and discussed several initiatives this year, including:

- Out-of-Hospital Premises Draft Standards;
- Changes to the presidential compensation;
- Regulatory Proposal — Temporary Class to create a new temporary class of registration designed to support mobility within Canada.

In addition, several By-law Amendments were vetted by the Executive Committee prior to being presented to Council, including:

- Housekeeping updates regarding Tribunal references;
- Update to Council District Election Dates;
- Temporary Independent Practice Certificate of Registration;
- Amendments to the Fees and Remuneration regarding Reduced Membership Fees for Parental Leaves;
- Update to signing authority title;
- Filling Council Vacancies;
- Premises Inspection Committee quorum amendments;
- Amendments to the Register; and
- Fees and Remuneration to reflect changes to Council and Committee Remuneration as it relates to Presidential Compensation.

The Executive Committee reviewed and discussed several policies prior to them being brought to Council for approval, including:

- Social Media policy;
- Virtual Care policy;
- Specialist Recognition Criteria in Ontario;
- Medical Records Management policy;
- Rescinding and revising Registration policies — Post-MCCQE2 changes; and
- Dispensing Drugs policy.

The following draft policies were reviewed and then distributed to key stakeholders for consultation:

- Decision Making for End-of-Life Care;
- Medical Assistance in Dying;
- Human Rights in the Provision of Health Services; and
- Conflicts of Interest and Relationships with Industry.

Find additional information about the Committee's activities in CPSO's 2021 College Performance Measurement Framework Report.

Looking Ahead to 2023

The Executive Committee will continue to build on this year's successes and bring this momentum into 2023. The following activities will be areas of focus for next year:

- Reviewing and providing feedback on By-law modernization initiatives;
- Monitoring KPIs including new response times to public/membership through portal and advisory lines of communication; and
- Governance Modernization and Red-Tape Reduction.

Respectfully submitted,

Dr. Janet van Vlymen
Chair

Dr. Robert Gratton
Vice-Chair

Finance and Audit Committee Annual Report

Committee Mandate

The Finance and Audit Committee shall review and report to the Council regarding the financial affairs and position of the College. In order to fulfill its duty, the Finance and Audit Committee shall:

- meet with the auditor each year,
  - before the audit to review the timing and extent of the audit and to bring to the attention of the auditor any matters to which it considers the auditor should pay attention; and
  - as shortly before the annual financial meeting as practical in order to review and discuss with the auditor the financial statements, the auditor's report and the management letter and any recommendations;
- review the draft budget before it is presented to the Executive Committee, and report to the Executive committee and the Council arising from its review of,
  - the assumptions in the draft budget;
  - the steps taken to maximize efficiency and minimize cost in relation to the quality of goods and level of service; and
  - any other issue which the committee considers may affect the financial affairs and position of the College; and
- review from time to time,
  - the expenditures of the College in relation to the budget;
  - the performance and administration of the College's pension plans;
  - the investment strategies and performance of the College's non-pension investments; and
  - the security of the College's assets generally.

The Finance and Audit Committee reviews and considers implications of proposed significant unbudgeted expenditures and may provide the Executive Committee with a revised budget, except where Council or the Executive Committee directs otherwise by resolution. [General By-law, ss. 43(1)-(3)]

Committee Members

2021-2022:

Dr. Glen Bandeira
Dr. Thomas Bertoia (Chair)
Mr. Murthy Ghandikota
Dr. Robert Gratton (Vice-Chair)
Mr. Rob Payne
Mr. Peter Pielsticker
Dr. Ian Preyra
Dr. Janet van Vlymen (leaving the Committee De December 2022)

An additional member will be added for 2022-2023.

Key Accomplishments

In addition, the Committee reviewed the following topics:

January 27, 2022 (Orientation)

- HIROC insurance coverage overview
- GIC investment update
- Space – Reviewed space options

April 7, 2022 (Audit)

- Auditor's Report and Year-end Financial Statement – The Auditors commented that the College's books were in "top-notch shape"
- Internal Controls – No recommendations for improvement
- FMRAC Integrated Risk Management System (FIRMS) update
- Budget Objectives for 2023 – No anticipation of a increase in fees
- Space – Update was given

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

September 27, 2022 (Budget Review)

- 2023 Draft Budget – Reviewed the draft budget

October 13, 2022 (Budget)

- Tinkham LLP the College's external auditor presented and reviewed the Engagement and Audit Planning Letters for the 2023
- 2023 Budget – No fee increase for the fifth year was recommended
- The College's Compensation Plan – Was presented
- General By-Law Change – Updated to reflect change in title for the Chief Transformation Officer to Chief Operating Officer for purposes of the signing authorities
- Space update – Was presented

Further details on some of these items follow.

2023 Budget

The College is accountable for $80M budget, and regularly demonstrates – through detailed reports to the Finance and Audit Committee and Council, fiscal accountability, optimal resource use and delivery of effective and efficient programs. The transformation that the College embarked on several years ago has allowed the College to provide better service and support to all our stakeholders.

Management is pleased to be able to deliver a budget for 2023 that includes revenue of $80,313,785 and expenses of $80,148,281 resulting in a small surplus of $165,504 – basically a balanced budget. Management is also recommending that the independent practice membership fee of $1,725 be maintained for 2023.

The Finance and Audit Committee approved the following motions:

It was moved by Mr. Pielsticker, seconded by Dr. Bandiera and CARRIED. That the Finance & Audit Committee recommends to Council that the budget for 2023 be approved as presented.

It was moved by Mr. Pielsticker, seconded by Dr. Gratton and CARRIED. That the Finance & Audit Committee recommends to Council that per diems rates be increased by 3% effective January 1, 2023.

It was moved by Dr. Gratton, seconded by Dr. Preyra, and CARRIED. That the Finance and Audit Committee is recommends to Council that the membership fee for 2023 remain at $1,725.

Over the last five years there has been no increase to the Independent Practice Membership fee.

Looking Ahead to 2023

Looking at bringing in a balanced budget and keeping any fee increase minimal if required. By doing this we will able to provide our mandate to protect the public.

Respectfully submitted,

Dr. Thomas Bertoia
Chair

Tribunal Mandate

The Ontario Physicians and Surgeons Discipline Tribunal[2] is a neutral, independent, administrative tribunal that adjudicates allegations of professional misconduct or incompetence of Ontario physicians referred to it by the College of Physicians and Surgeons of Ontario's Inquiries, Complaints and Reports Committee (ICRC). The Tribunal also hears applications brought by former members of the College for reinstatement of their certificate of registration.

The Tribunal is governed by the Health Professions Procedural Code (the Code) and other applicable law, including administrative law. The Tribunal is made up of physicians, non-physician members of the public and experienced adjudicators. The Tribunal manages cases from the point of ICRC referral or a member's reinstatement application forward. This involves conducting case management conferences; deciding motions; holding trial-like hearings on whether allegations are proven and on penalty; and writing reasons for decisions.

The Code sets out that the Tribunal may determine whether a member has committed an act of professional misconduct and, if so, may make an order:

- directing the Registrar to revoke the member's certificate of registration
- directing the Registrar to suspend the member's certificate
- directing the Registrar to impose specified terms, conditions or limitations on the member's certificate
- requiring the member to appear before the panel to be reprimanded
- requiring the member to pay a fine to the Ministry of Finance
- requiring a member found to have committed sexual abuse to contribute to funding for therapy and counselling provided to the patient under the program required under section 85.7 of the Code

[2] The Ontario Physicians and Surgeons Discipline Tribunal is the College of Physicians and Surgeons of Ontario's Discipline Committee established under the Health Professions Procedural Code.

The Code also provides that the Tribunal may determine whether a member is incompetent and impose a penalty.

Further, the Code gives the Tribunal the power to impose costs orders.

Tribunal Members

2021 – 2022 Members

Dr. Ida Ackerman
Mr. Raj Anand
Dr. Madhu Azad (appointed December 2021)
Dr. Heather-Ann Badalato
Dr. Glen Bandiera
Ms. Lucy Becker
Dr. Philip Berger
Mr. Jose Cordeiro
Dr. Michael Franklyn
Mr. Pierre Giroux
Ms. Julia Goyal (appointed December 2021)
Dr. Catherine Grenier
Dr. Kristen Hallett
Dr. Deborah Hellyer
Dr. Paul Hendry
Dr. Stephen Hucker
Dr. Allan Kaplan
Ms. Shayne Kert
Mr. Shahab Khan (appointed February 2022)
Dr. Roy Kirkpatrick
Ms. Sherry Liang
Mr. Paul Malette
Ms. Sophie Martel
Dr. Veronica Mohr
Dr. Joanne Nicholson
Dr. Rupa Patel (appointed December 2021)
Mr. Rob Payne
Mr. Peter Pielsticker
Dr. Peeter Poldre
Dr. Ian Preyra
Dr. John Rapin
Ms. Linda Robbins
Dr. Deborah Robertson
Ms. Jennifer Scott
Dr. James Watters – Vice-Chair
Ms. Shannon Weber
Mr. David Wright – Chair
Dr. Susanna Yanivker

Departing Members

Mr. Pierre Giroux (resigned August 2022)
Dr. Kristen Hallett (resigned April 2022)
Dr. John Rapin (resigned August 2022)
Dr. Peeter Poldre (term ends December 2022)

Key Accomplishments

It has been just over a year since the Tribunal's launch in September 2021. As successor to its predecessor Discipline Committee, the Tribunal has undergone a number of fundamental changes. These changes have enhanced the Tribunal's independence; modernized processes in accordance with best practices; distinguished the Tribunal's public identity from that of the College through a separate website and unique branding; and enhanced the quality, transparency and timeliness of the Tribunal's decisions and processes. Throughout 2022, the Tribunal continued its work towards achieving these goals. The Tribunal remains committed to continuous

improvement and growth, both in its hearings and internal processes, to better serve participants and the public.

Leveraging Technology

The Tribunal is now fully electronic, and we expect that proceedings, including hearings, motions and case management conferences, will largely remain virtual. The Tribunal's transition to a virtual hearing environment has yielded numerous benefits. It has enabled more timely and efficient proceedings, improved public access to hearings and contributed to significant cost savings. The College's IT department has provided support for witnesses and members who require assistance and/or equipment to access electronic hearings.

In a virtual environment, hearings can be scheduled sooner as adjudicator travel is no longer a consideration. Further, scheduling longer hearings on non-consecutive days is a more workable option. Virtual hearings have also enhanced hearing accessibility and openness. The public can view a live stream of the hearing from any location by requesting a YouTube link from the Tribunal Office.

In 2022, the Tribunal joined the College's move to new case management and document management systems (Solis and Vault) and implemented Adobe Sign to manage adjudicator signatures on reasons and orders. The Tribunal continues to seek ways to streamline processes and reduce unnecessary paperwork.

Experienced Adjudicator Model Showing Benefits

In September 2021, coinciding with the Tribunal's launch, College Council approved the appointment of five experienced lawyer adjudicators to the Tribunal. This year marked their first full year as Tribunal members. Experienced adjudicators chair hearing panels, conduct pre-hearing conferences and express the panel's views by preparing the first draft of written reasons for decision.

In 2022, the Tribunal's experienced adjudicators chaired and drafted written reasons for about 40 decisions, including case management decisions, hearings on the merits and/or penalty and motions to address issues arising before or during a hearing. Due to their decision-writing expertise, written reasons are drafted sooner with fewer needed edits. In all cases chaired by an experienced adjudicator, written reasons have been released within the 84-day benchmark, and often well in advance.

A More Intensive Case Management Approach

The Tribunal's transition to the new model has also allowed it to adopt a more intensive case management approach. Case management conferences are chaired by an experienced adjudicator and held several times leading up to a hearing. To date, Tribunal Chair David Wright has been case management chair in most cases referred to the Tribunal.

Case management conferences promote early identification and resolution of issues, set clear timelines for submitting materials and promote settlement. This active case management style has led to fewer late cancellations and hearing adjournments; earlier access to hearing materials by the panel; a smoother process once the hearing is underway; and fostered earlier more frequent settlements.

It has also benefited self-represented parties and representatives appearing before the Tribunal who are not as familiar with the professional discipline process. Through case management, resource imbalances can be mitigated by providing the parties with thorough information on the Tribunal's processes and more extensive pre-hearing directions.

Incorporating Equity, Diversity and Inclusion

In order to be seen as a fair and effective decision-making body by the public, the Tribunal recognizes its duty to be inclusive and respectful of all Ontarians. While there is more work to be done, since its launch the Tribunal has taken several steps to further embrace equity, diversity and inclusiveness. These include:

- increasing racialized representation among Tribunal members;
- implementing non-religious affirmations for witnesses;
- having Tribunal members, parties and witnesses provide pronouns and name pronunciation before every hearing;
- publishing a land acknowledgement on the Tribunal website;
- ensuring Tribunal templates and website content are available in English and French.

In 2022, the Tribunal achieved a significant milestone by holding its first ever French discipline hearing and releasing reasons written in French. This became possible through the appointment by the Ontario government of a second bilingual public member, thus allowing a bilingual panel to be formed that meets legislative requirements. It is worth noting, however, that should either of our bilingual public members leave the Tribunal, French hearings will not be possible until another is appointed by government. The Code requires that panels include two public members.

Modernizing the Tribunal's Rules of Procedure

In 2022, the Tribunal undertook a complete redrafting of its Rules of Procedure, updated corresponding forms, and prepared new practice directions. The Tribunal's Rules set out the general practices and procedures for parties appearing before the Tribunal.

In re-drafting the Rules, the Tribunal aimed to use plain and understandable language; enable flexible processes that could better adapt to a particular case; and to base the Rules on a set of adjudicative values including transparency, fairness, and simplicity.

The Tribunal invited feedback on the draft Rules from the public, Tribunal members and the Practice Advisory Group, comprised of individuals who regularly appear before the Tribunal. The Rules were approved at the Tribunal Business Meeting on October 18, 2022 and take effect on January 1, 2023.

Significant changes to the Tribunal's Rules include the following:

- There is no requirement for a member of the public to file a motion for access to documents that are part of the public record, enabling more timely access for media and public.
- There is an automatic publication ban on patient names or information that would identify patients unless the patient asks otherwise. This protects patient privacy while promoting open hearings.
- We have adapted rules on use of prior sexual history from s. 276 of the *Criminal Code* to prevent a complainant from having evidence of their prior sexual history improperly used to discredit them.
- We have added a rule allowing for costs orders where a party's conduct has been unreasonable, frivolous or vexatious or a party has acted in bad faith.

Mission and Core Values Statements

At its October Business Meeting, Tribunal members and staff gathered for a hands-on workshop to help develop the Tribunal's inaugural mission and values statements. The session, which was facilitated by external consultants, encouraged those in attendance to cultivate a shared understanding of the Tribunal's role and its underlying values.

Based on this session, a draft mission statement describing the Tribunal's role and core values to guide its work were developed. The draft statements were circulated to Tribunal staff and members for feedback, discussed by the Executive Committee and will be presented at the

December Council meeting. Once finalized, the Tribunal's mission and values statements will be posted on the Tribunal's website.

Tribunal Member Orientation and Continuing Education

The Tribunal continues to maintain a robust education program for its members, both when they are first appointed to the Tribunal and as an ongoing initiative. In 2022, Tribunal members were provided formal training and education sessions as follows:

- The new member orientation included an introduction to discipline principles and processes followed by a deeper dive into jurisdiction and procedural fairness, a session on evidence in adjudication, a presentation on myths and stereotypes in sexual violence cases and an introduction to inclusive and accessible adjudication.

- In February 2022, Tribunal members attended a virtual half-day education session on "Quality Decision-Making." The session, which was led by educator Pamela Chapman, covered such concepts as: intuitive versus deliberative thinking; best practices to encourage deliberation; implicit bias; and strategies to facilitate fair and consistent decision-making.

- In May 2022, Tribunal members attended an education and training session delivered by Tribunal Office staff. The presentations focused on applying the *Canadian Charter of Rights and Freedoms* and Ontario *Human Rights Code* to professional discipline (led by Tribunal Chair, David Wright); the appropriate (and inappropriate) use of a member's professional expertise when sitting on a hearing panel (led by Tribunal Counsel, Margaret Leighton); and the role of College policies in discipline hearings (led by Tribunal Counsel, Dionne Woodward).

- October 2022's Tribunal Business and Education Meeting was the first to be held in person. This full-day session included education on the Tribunal's duty to accommodate under the Ontario *Human Rights Code*, from Grace Vaccarelli of Ethical Associates. Further, Margaret Leighton, Tribunal Counsel, highlighted upcoming changes to the Tribunal's Rules of Procedure that have particular relevance for the adjudicator audience.

The Tribunal Office continues to publish a bi-weekly member newsletter titled "Tribunal Roundup" that keeps members up to date on Tribunal cases and important developments in the law that affect its proceedings. In 2022, 20 issues of the newsletter were published and distributed to Tribunal members.

Looking Ahead to 2023

The Tribunal's focus for the end of 2022 and into 2023 will include:

- finalizing the Tribunal's Mission and Core Values Statements and posting on the website;
- enhancing education program for incoming Tribunal members in accordance with adult education best practices;
- implementing and developing jurisprudence under the new Rules of Procedure
- developing a job description and Code of Conduct for Tribunal Members; and
- enhancing the content available on the Tribunal's website to include additional information about current cases.

We are confident that these activities, combined with the Tribunal's core work, will continue to serve the public interest.

Respectfully Submitted,

Mr. David Wright
Chair

Dr. James Watters
Vice-Chair

Patient Relations Committee Annual Report

Committee Mandate

The Patient Relations Committee (PRC) is responsible for advising Council on the College's patient relations program. The College is required under the Health Professions Procedural Code[1] (HPPC) to have a patient relations program comprised of measures for preventing and dealing with sexual abuse of patients, including:

- educational requirements for members;
- guidelines for members' conduct with their patients;
- training for the College's staff; and
- provision of information to the public. [HPPC, s. 84]

The PRC also administers the College's program for funding therapy and counselling for persons alleging sexual abuse by a College member in accordance with the HPPC. [HPPC, s. 85.7]

Committee Members

2021-2022:

Ms. Nadia Bello
Dr. Rajiv Bhatla
Ms. Sharon Rogers - Chair
Dr. Heather Sylvester
Dr. Angela Wang
Dr. Diane Whitney

Key Accomplishments

Continuous Improvement

In 2022, the PRC focused primarily on reviewing funding for therapy/counselling applications as well as requests for specific types of therapy from eligible applicants. The PRC also continued to update the application forms to make them easier to use.

One critical area of improvement for the PRC has included taking a trauma-informed approach as much as possible when updating the application process. This year, we made numerous revisions to clarify some of the forms' key provisions. Most notably, we added a new attestation stating that therapy must address the harm that an eligible applicant experienced as a result of being sexually

abused by their physician. To address issues of confidentiality (some applicants, for example, do not want to receive mail at their homes as they have not told their families about the sexual abuse), applicants can now indicate their preferred mode of communication.

System Collaboration

This year, the PRC also undertook a jurisdictional scan of six other Ontario health regulatory colleges' activities related to the HPPC-mandated Patient Relations Program and/or the Patient Relations Committee. This review led to discussions on whether there were additional activities that our PRC could do to further prevent sexual abuse. The PRC concluded that CPSO compares well relative to other colleges in terms of fulfilling the mandate of the Patient Relations Program.

Meaningful Engagement

The March 2022 issue of *Dialogue* contained an article on best practices for physicians on conducting intimate examinations with sensitivity and respect. *Dialogue* published this article at the request of the PRC after it received numerous funding applications where there was inadequate and problematic communication before and during these examinations. The PRC believes that providing this type of guidance can help ensure quality care in accordance with CPSO's mandate.

The PRC participated in several educational sessions throughout the year, including a presentation on the Ontario Physicians and Surgeons Discipline Tribunal and a presentation by a PRC member about their experiences practising in a diverse city and how physicians can implement equity, diversity, and inclusion (EDI) in their own practices. PRC members, including the chair, participated in additional training sessions provided by CPSO on the importance of EDI.

Looking Ahead to 2023

2023 will be a year of transition for the PRC as we will have a new chair in place by 2024. The Committee will undertake this succession planning in accordance with governance best practices.

The PRC will also look to modernize data tracking to gather relevant benchmark information about its activities. It will continue to develop process improvements and build on the efficiencies that have been recently implemented.

Respectfully submitted,

Sharon Rogers
Chair

Governance Committee Annual Report

Committee Mandate

The Governance Committee shall:

- monitor the governance processes adopted by CPSO Council and report annually to the Council on how we will follow these processes;
- recommend to Council changes to various governance processes;
- ensure nominations for the office of President and Vice-President;
- make recommendations to Council regarding members and Chairs of CPSO committees; and
- make recommendations to the Council regarding any additional officers, officials or other people acting on behalf of the College. [General By-law, s. 44(3)]

Effective December 2022, the Governance Committee will also absorb the former mandate of the Academic Advisory Committee to select the voting Academic Representatives appointed annually to Council.

Committee Members

Dr. Judith Plante – Past President & Chair
Dr. Janet van Vlymen – President & Vice-Chair (Chair in 2022-2023)
Dr. Robert Gratton
Dr. Lydia Miljan (PhD)
Dr. Sarah Reid
Ms. Shannon Weber

We sincerely thank those members whose terms are ending in 2022. We greatly value and appreciate your dedication, commitment, and contribution to the Governance Committee.

Key Accomplishments

In 2022, the Governance Committee continued building on successes from previous years and addressed opportunities for improvement. Areas of focus included legislative and regulatory reform, internal governance modernization, governance education, and implementation of good governance practices.

Right-Touch Regulation

Modernizing and strengthening internal governance structures and processes that are outside the scope of legislation and regulation remains a key priority for CPSO. The Governance Committee continues to support cross-divisional efforts to seek legislative reform consistent with governance best practices.

It was another busy year for committee recruitment activities. The application process underwent modernization, including the creation of an online application form (to replace emailed resume submissions) and revised interview questions. In these new processes, we highlighted the importance of equity, diversity and inclusion (EDI) and skills-based competencies.

We also revised our approach to recruitment, including advertising through social media and emails sent to the profession. This resulted in 282 completed applications, (including in some hard-to-recruit specialties like Plastic Surgery and Psychiatry), which far exceeded the volume of applications of any previous year. As a result, we needed to extend the recruitment timeline to allow proper vetting of candidates. The Committee will keep all applications in a database to allow easier recruitment for other roles, including urgent appointments and new vacancies.

Additional information about the Committee's activities can be found in CPSO's 2021 College Performance Measurement Framework Report.

Continuous Improvement

The Governance Committee plays an instrumental role in designing education for Council and Committee members. Each year, we make enhancements as needed.

With Chairs and Vice Chairs now having two-year terms, the Governance Committee worked with the Governance Office to host two workshops for Committee Chairs, Vice-Chairs and relevant staff. We held the first session virtually in April and educated participants on the importance of EDI and providing feedback to committee members.

The second session was an orientation for Committee leaders and an opportunity for all Chairs and Vice-Chairs to hone their skills. This was a full-day session focused on the practical application of in-meeting management and providing individual feedback. It utilized EDI and unpreparedness case studies in mock-interactions with actors to help participants apply the knowledge they had learned in their training. The feedback for this session was overwhelmingly positive.

In addition, virtual education sessions were developed in collaboration with CPSO's EDI Lead and included sessions on LGBTQ2S+ health and anti-Black racism. The sessions held this year included:

- Rainbow Health Ontario online modules and Education Session (Silvana Hernando)
- Foundational Aspects of Anti-Black Racism in Health Care (Dr. Natasha Johnson)

- Building on Foundational Knowledge of Anti-Black Racism (Dr. Natasha Johnson)

Overall, feedback from the sessions was very positive and Council and Committee member engagement was high. We received requests to continue providing education on equity, diversity, and inclusion issues.

The Governance Office continues to explore opportunities to accredit educational sessions with the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada.

Meaningful Engagement

The Governance Committee continued to strengthen the Council elections process and promote the need for physicians with diverse and broad perspectives on Council. In 2022, that included revisions to the timelines for Council elections through by-law amendments. In collaboration with the EDI Lead and Communications team, the Governance Committee continued to look at EDI education opportunities. The full 2022 EDI Report can be found on the CPSO's website.

The Governance Committee continues to develop and refine tools, resources, and processes to support Council and Committees with implementing good governance practices. Examples of initiatives that the Governance Committee has led this year include but are not limited to:

- Supporting the dissolution of the Education Advisory Group and the creation of a robust Terms of Reference for the Academic Advisory Committee to better define the role and contributions of academic representatives;

- Revising the timelines of the Executive and Governance Committee elections to help provide adequate time for prospective members to indicate their interest in those Committees;

- Overhauling the Council assessment process to reduce the number of surveys and feedback mechanisms and provide more useful and valuable feedback; and,

- Supporting amendments to the composition of the Premises Inspection Committee to enable better functioning by removing the requirement for a Public Member on every panel.

Looking Ahead to 2023

2022 was a busy year for the Governance Committee as it played a critical role in various internal process changes and the ongoing work of governance modernization.

Building on the success of 2022, the Governance Committee will continue advocating for legislative and regulatory changes to our governance structures and processes, review the

internal mechanisms for ensuring good governance and feedback processes for committees, and seek to modernize processes that would benefit from an updated, Lean approach.

The Governance Committee will continue to expand governance education and the importance of applying what we learned in 2022 to our governance processes and structures.

Respectfully submitted,

Dr. Judith Plante
Chair

Inquiries, Complaints and Reports Committee Annual Report

Committee Mandate

The Inquiries, Complaints and Reports Committee has jurisdiction over all CPSO investigations, of which there are three kinds: complaints investigations, Registrar's investigations and incapacity investigations. The Inquiries, Complaints and Reports Committee carries out its mandate, duties and powers in accordance with the HPPC and other applicable law (including administrative law).

The powers of the Inquiries, Complaints and Reports Committee with respect to investigations of complaints and Registrar's investigations include:

- approving the appointments of investigators [HPPC, s. 75(1)(a)];
- conducting investigations, including through staff to whom it may provide investigative direction;
- making interim orders directing the Registrar to suspend or impose terms, conditions or limitations on a member's certificate of registration pursuant to s. 25.4(1) of the HPPC1;
- reviewing and disposing of investigations, including as follows:
- referring a specified allegation of a member's misconduct or incompetence to the Discipline Committee if the allegation is related to the complaint or the report [HPPC, s. 26(1)];
- referring a member to a panel of the Inquiries, Complaints and Reports Committee under s. 58 of the HPPC for incapacity proceedings [HPPC, s. 26(1)];
- requiring a member to appear before a panel of the Inquiries, Complaints and Reports Committee to be cautioned [HPPC, s. 26(1);
- requiring a member to complete a specified continuing education or remediation program [HPPC, s. 26(3)];
- taking action it considers appropriate that is not inconsistent with the RHPA, the HPPC, the regulations or by-laws (for example, directing undertakings). [HPPC, s. 26(1)]; and
- taking no further action; and
- providing reasons when required in support of its decisions [HPPC, s. 27].

With respect to incapacity investigations, the powers of the Inquiries, Complaints and Reports Committee include:

- making inquiries it considers appropriate [HPPC, s. 59(1)];
- requiring the member to submit to physical or mental examinations [HPPC, s. 59(2)];
- referring a matter to the Fitness to Practise Committee [HPPC, s. 61]; and
- making interim orders directing the Registrar to suspend or impose terms, conditions or limitations on a member's certificate of registration pursuant to s. 62(1) of the HPPC2.

Committee Members

2021-2022:

Dr. Olufemi Ajani
Dr. Trevor Bardell
Dr. George Beiko
Dr. Mary Bell
Dr. Thomas Bertoia
Dr. Brian Burke - Chair
Dr. Paula Cleiman
Dr. Brenda Copps
Dr. Amie Cullimore
Dr. Mary Jean Duncan
Dr. Gil Faclier
Dr. Thomas Faulds – Vice Chair
Ms. Joan Fisk
Mr. Murthy Ghandikota
Dr. Robert Gratton
Dr. Daniel Greben
Dr. Andrew Hamilton
Dr Elaine Herer
Dr. Christopher Hillis
Dr. John Jeffrey
Dr. Asif Kazmi
Dr. Samantha Kelleher
Dr. Lara Kent
Dr. Jane Lougheed
Dr. Haidar Mahmoud
Dr. Lydia Miljan
Dr. Robert Myers
Dr. Wayne Nates
Dr. Jude Obomighie
Dr. Anita Rachlis
Dr. Jerry Rosenblum
Dr. Prema Samy
Dr. Karen Saperson
Dr. Dori Seccareccia
Mr. Fred Sherman
Dr. Andrew Stratford
Dr. David Tam
Dr. Anne Walsh
Dr. Brian Watada
Dr. Lesley Wiesenfeld

Key Accomplishments

This year the ICRC welcomed a new chair, Dr. Brian Burke and a new vice chair, Dr. Tom Faulds. The chair and vice chair took many opportunities over the year to collaboratively find ways to increase the knowledge of committee members, while focusing on a year of stability.

The Leadership team of the ICRC, which consists of the committee chair and vice chair, and all specialty panel chairs, and vice chairs, met four times in 2022 to discuss emerging trends, identify potential and real problems and to receive education and training. The trends and issues identified by the leadership team are brought to the larger committee at the Business Meetings, along with training and education opportunities.

In 2022 the committee members received the following training and education sessions:
ICR Committee Training at Business Meetings:

- Right Touch for Calibrating Dispositions – Dr. Anil Chopra, Medical Advisor
- Planning for and Providing Quality End of Life Care Policy - Craig Roxborough, Director Policy
- What's New on U of T's Medical Record Keeping Course – Dr. Eva Knifed, Lecturer, Department of Family and Community Medicine at University of Toronto Ethics and Professionalism Lead
- Social Media Policy New Provisions – Alex Wong, Policy Analyst

- Virtual Care Policy New Provisions – Tanya Terzis, Senior Policy Analyst
- Refresher on ICRC Dispositions – Amy Block, Senior Legal Counsel
- Twice a year Judicial Review, Admin Law/Appeal Updates – CPSO Legal Counsel

ICRC Leadership Training at Leadership Team Meetings:

- What to do when ICRC does not agree with an Independent Opinion/Assessor Report – Amy Block, Senior Legal Counsel
- Guidelines for Section 75(c) and Section 75(a) - Amy Block Senior Legal Counsel
- Just Culture in HealthCare Workshop Saegis Training (Scheduled end of Nov 22)

Other Training - Specific to Settlement Panel Members

- Refresher on Settlement Panels – Morgana Kellythorne, Senior Legal Counsel

ICRC New Member Orientation and Training

- ICRC Responsibilities and Introduction to Investigations and Resolutions
- ICRC Meeting Logistics
- Introduction to RHPA Admin Law
- Role of ICRC
- Focus of Analysis when making decisions
- Deliberative Privilege
- Procedural Fairness
- Deliberative Privilege
- Understand the role of legal counsel/advice
- Understand basic legal framework for sexual abuse matters
- Understand the ICRC's relationship with Discipline Tribunal
- Decision Template and Applying Outcomes and Writing Members Notes

Looking Ahead to 2023

As some of the leadership for the specialty panels change for next year, the committee will continue to focus on leadership training and development. Learning opportunities will be considered for the committee as a whole, with specific attention to a Just Culture workshop and further development in the EDI space.

The leadership team will turn their attention to the evaluation process of individual committee members, how evaluations are being completed and used. The committee will consider revisions and improvements that may be made to the evaluation forms, their purpose and use.

The committee will turn their minds to investigation packages with a focus on improvement. Using right touch regulation principles, and through a lean perspective, the committee will consider what information is required in an adequate investigation versus an exhaustive investigation.

Respectfully submitted,

Dr. Brian Burke
Chair

Dr. Tom Faulds
Vice Chair

Premises Inspection Committee Annual Report

Committee Mandate

The Premises Inspection Committee is responsible for administering and governing the College's premises inspection program, referred to as the Out-of-Hospital Premises Inspection Program, in accordance with Part XI of Ontario Regulation 114/94 (the "Regulation"). The purpose of the Out-of-Hospital Premises Inspection Program is to ensure that out-of-hospital premises (as defined in the Regulation) comply with its Standards.

The Premises Inspection Committee is required to:

- ensure adequate inspections and re-inspections are conducted as authorized under the Regulation;
- review premises inspection reports and other material referred to in the Regulation and determining whether premises pass, pass with conditions or fail an inspection;
- specify the conditions that shall attach to each "pass with conditions" rating and where applicable, "fail" rating;
- deliver written reports as required under the Regulation; and
- establish or approve costs of inspections and re-inspections and ensure the member or members performing the procedures on the premises are invoiced for those costs. [General By-law, s. 47.1]

The Premises Inspection Committee informs Council on policy and program implementation issues including recommending or reviewing periodic changes to the Out-of-Hospital Premises Inspection Program Standards.

Committee Members

2021-2022:

Dr. El-Tantawy Attia
Dr. Olubimpe Ayeni
Dr. George Beiko
Dr. Andrew Browning
Dr. Patrick Davison
Dr. Marjorie Dixon
Dr. Hae Mi Lee
Dr. Winnie Leung
Dr. Colin McCartney
Dr. Mark Mensour
Dr. Gillian Oliver – Chair
Dr. Wusun Paek
Mr. Peter Pielsticker
Dr. Kashif Pirzada
Mr. Ron Pratt
Dr. Jerry Rosenblum

Dr. Holli-Ellen Schlosser
Dr. Suraj Sharma
Dr. Catherine Smyth
Dr. Robert Smyth
Dr. Ted Xenodemetropoulos – Vice Chair

We thank those members whose terms are ending in 2021. Your dedication, commitment and contribution to the Premises Inspection Committee, over the years of your service, has been valued and greatly appreciated.

Key Accomplishments

The Premises Inspection Committee has had a busy year with a number of ongoing changes to the Out of Hospital Premises Inspection Program with some key changes to note.

In September, Council approved the motion to revise the by-law requiring public members to be appointed to each panel of PIC for quorum to be met. The by-law change has given the committee the flexibility to appoint a physician member in place of a public member as required. The committee will be able to review more cases at each panel, with a greater array of specialties.

At the same Council meeting, a motion to approve the draft Program Standards for consultation was passed. The draft Standards are out for consultation until January 2023.

The committee went live in the Solis system in early 2022 which required system training and support for the first few months. The committee is now operational in the Solis system, with all meetings uploaded and completed with the system.

This committee has also spent time focusing on education and training; the following sessions were provided in 2022:

- Refresher training for all members focused on:
  - PIC submissions,
  - The inspection process and changes
- New Member Training and Orientation
- OHPIP Statutory Framework,
- Committee overview, roles and responsibilities
- Review of Consent to treatment policy
- Conflict of interest policy
- How to enter and use members notes in Solis
- Delegation Policy

Looking Ahead to 2023

As the committee moves into 2023, the draft program standards will be finalized and approved by Council by the end of the second quarter. The roll-out of these standards will be a key priority for next year.

As the new chair and vice chair move into their roles, there will be a focus on leadership training and governance principles. There will also be a continued focus on training and education for the committee as a whole throughout the year, using feedback provided by committee members to help steer the learning agenda.

The committee will also spend time focusing on the optimal number of panel meetings per month, along with scheduling logistics. Historically, the committee has only met on Tuesdays and Thursdays, however, as the workload increases the committee will explore holding panel meetings on other days of the week to accommodate members' busy schedules.

Respectfully submitted,

Dr. Gillian Oliver
Chair

Dr. Ted Xenodemetropoulos
Vice Chair

Quality Assurance Committee Annual Report

Committee Mandate

The Quality Assurance Committee (QAC) administers CPSO's quality assurance program in accordance with the *HPPC* and the QA Reg[1]. [QA Reg s. 27(1)]

Accordingly, the QAC has the power to:

- appoint assessors for the quality assurance program [*HPPC* s. 81];
- require a member to undergo a peer and practice assessment [QA Reg. s. 28(1)]; and
- approve how members maintain required records of their participation in a continuing professional development program [QA Reg. s. 29(3)].

The QAC reviews peer and practice assessment reports, and can make one or more of the following decisions regarding assessed members:

- confirm the physician's peer assessment was successful and no further action is required;
- require individual members participate in specified continuing education or remediation programs if their knowledge, skill and/or judgment are found to be unsatisfactory;
- direct the Registrar to impose terms, conditions or limitations for a specified period determined by the Committee on the certificate of registration of a member,
    - whose knowledge, skill and/or judgment have been assessed or reassessed under s. 82 of the *HPPC* and found to be unsatisfactory, or
    - who was directed by the Committee to participate in specified continuing education or remediation programs and has not completed those programs successfully;
- direct the Registrar to remove terms, conditions or limitations before the end of the specified period, if the Committee is satisfied the member's knowledge, skill and/or judgment are now satisfactory; or
- disclose the name of and allegations against a member to the Inquiries, Complaints and Reports Committee, if the QAC believes the member may have committed an act of professional misconduct, or may be incompetent or incapacitated [*HPPC* s. 80.2(1)].

CPSO's operational programs and any other aspect of quality assurance that is not expressly stated under the Mandate, Duties and Powers section above, fall within Council's accountability and are not within the QAC's scope of authority.

Council Oversight of Quality Improvement Program

The Quality Improvement (QI) Program falls within Council's accountability and not within the QAC's scope of authority. From time to time, the QAC may be provided with information and education related to the QI Program as it relates to the Committee's authority to require members undergo peer and practice assessments. Accordingly, the QAC may assess members who do not want to participate in the QI program or do not complete it successfully.

Committee Members

2021-2022:

Dr. Jacques Dostaler
Dr. Mohammad Keshoofy
Dr. Charles Knapp
Dr. Ken Lee
Dr. Camille Lemieux
Mr. Paul Malette
Mr. Peter Pielsticker
Dr. Sarah Reid - Chair
Dr. Patrick Safieh
Dr. Ashraf Sefin -Vice-Chair
Dr. Astrid Sjodin
Dr. Tina Tao

We would like to thank Dr. Patrick Safieh, whose term is ending in 2022. Dr. Safieh's dedication, commitment and contributions over his many years with the QAC have been tremendously valued and appreciated.

Key Accomplishments

The QAC successfully onboarded a new, smaller cohort of assessors following the sunsetting of the Assessor Network Group in 2021. In addition, we implemented nimbler generic assessment tools that address both procedural and office-based practices and established regular monthly virtual and twice-yearly in-person assessor meetings to increase consistency in how peer assessment work is conducted. As a result , the QAC noted improved inter-rater reliability and quality of assessment reports, furthering the Committee's ability to render decisions efficiently and effectively.

In 2021, the QAC launched a pilot project to reframe one of the Opportunity to Address options regarding the Opportunity of the Member to meet the Committee in-person (OTA-i). In 2022, the QAC opted to restructure the interview process by providing an option for physicians to meet with Medical Advisor Dr. Edward Everson to develop their response (OTA-ma). The OTA-

ma option proved effective in reducing the need for OTA-i and supports more meaningful engagement among those involved. The QAC would particularly like to acknowledge the work of Dr. Everson to support this new OTA option, and will continue to evaluate its efficacy and impact throughout 2023.

In collaboration with the QI Program, the QAC was involved in the launch of the QI Enhanced pilot. In line with right-touch regulation principles, the QI Enhanced pilot offers an alternative path for select physicians 70 years of age and older to fulfill their CPSO quality requirements by taking part in a QI program rather than the traditional peer assessment. To-date, 21 physicians opted to take part in this pilot option with increasing numbers of eligible physicians indicating interest in exercising this modernized option in 2023.

Looking Ahead to 2023

Leveraging the momentum of its successful innovations in 2022, the QAC intends to further evaluate the impact of the QI Enhanced pilot, explore means to further engage assessors in Member Specific Information dialogue and restructure how age-related assessments are launched for the calendar year.

New for 2023, physicians can choose in which quarter they would like their age-related assessment to occur and be assigned accordingly, where reasonable. Further embodying Lean methodology, this new approach to how assessments are cohorted and facilitated aims to enhance an agile, consistent and effective method to executing the Committee's aims and objectives.

The QAC looks forward to expanding upon the accomplishments of the past year, and continuing to support CPSO's mandate to protect and serve in the public's interest.

Respectfully submitted,

Dr. Sarah Reid
Chair

Dr. Ashraf Sefin
Vice-Chair

Registration Committee Annual Report

Committee Mandate

The Registration Committee considers applications for a certificate of registration referred to it by the Registrar [HPPC, s. 15(1)]. The Registrar refers these applications when he or she:

- Has doubts on reasonable grounds as to whether the applicant fulfils the registration requirements;
- Believes that the College should impose terms, conditions and limitations on a certificate of registration if the applicant does not consent to the imposition or the applicant already holds an out-of-province certificate that is equivalent to the certificate being applied for;
- Proposes to refuse the application [HPPC, s. 15(2)]; or,
- Believes that the College should issue a certificate to an applicant with terms, conditions and limitations imposed and the applicant consents to the imposition [HPPC, s. 15(4)]

In reviewing applications, the Registration Committee considers any written submissions from an applicant.

The powers of the Registration Committee with respect to the above mandate include:

- Making orders directing the Registrar to:
    - Issue a certificate of registration to an applicant [HPPC, s. 18(2)];
    - Issue a certificate of registration to an applicant subject to the completion of examinations or additional training [HPPC, s. 18(2)];
    - Issue, with the applicant's consent, a certificate of registration with the terms, conditions and limitations specified and imposed by a panel of the Registration Committee [HPPC, s. 18(4)];
    - Impose specified terms, conditions and limitations on a certificate of registration of an applicant and specify a limitation on the applicant's right to apply to remove or modify the term, condition or limitation under s. 19 of the HPPC [HPPC, s. 18(2)]; and
    - Refuse to issue a certificate of registration. [HPPC, s. 18(2)]

- Developing and implementing registration policies passed by Council, including reviewing and updating policies based on information provided to the Committee.

Committee Members

2020-2021

Dr. Judith Plante - Chair
Dr. Salvatore Spadafora (until April 2022)
Dr. Bob Byrick
Mr. Shahid Chaudry
Mr. Pierre Giroux (until March 2022)
Dr. Barbara Lent
Mr. Paul Malette
Dr. Lynn Mikula
Dr. Damien Redfearn
Mr. Murthy Ghandikota
Dr. Kim Turner
Dr. Bruce Fage
Dr. Edith Linkenheil

2022 New Members

In 2021-2022, the following new members were appointed to the Registration Committee: Dr. Salvatore Spadafora, Dr. Edith Linkenheil, Dr. Bruce Fage, and Mr. Murthy Ghandikota.

Key Accomplishments

Right-Touch Regulation

Throughout the pandemic, the Registration Committee has been committed to ensuring that there are minimal to no impacts on health care human resources while ensuring safe care for the public.

This reflects the Committee's core objective to remove barriers to registration for qualified individuals. This has meant creating and maintaining ways to register individuals who may not fulfill the requirements outlined in the Regulation but who can still practise at the standard expected of an Ontario physician.

The Registration Committee continues to regularly review the registration policies to determine if they are still relevant or need further changes.

The following policies were revised and approved by Council in 2022:

Rescinding and Revising Registration Policies – Post MCCQE 2 Changes:

In late 2021, the Medical Council of Canada (MCC) discontinued the MCCQE2 examination and is now granting the Licentiate of the Medical Council of Canada (LMCC) to physicians who have passed the MCCQE1 along with certain other criteria.

As a result, some Registration policies and directives were no longer required, and others needed revisions to provide transparency and expeditious review.

With the MCC now granting a full LMCC, provided that individuals successfully completed MCCQE1 along with other criteria, we no longer required two existing Registration policies and needed to update references to the MCCQE2 in existing Registration Policies and Directives. At the Registration Committee's request, Council approved the following:

Policies revised, without any substantive changes:

- Restricted Certificate of Registration for Exam Eligible Candidates
- Recognition of Certification Without Examination Issued by CFPC

Directives revised without substantive changes:

- Approval of the Imposition of Terms, Conditions and Limitations Proposed by the Registrar for "Residents Working Additional Hours for Pay" (Moonlighting Policy)
- Approval of the Imposition of Terms, Conditions and Limitations Proposed by the Registrar for "Camp Doctors"

In addition, the following policies were rescinded as the new LMCC policy has made them redundant:

- Requirement for the Successful Completion of the MCCQE 2 Pandemic Exemption
- Alternative to the MCCQE2 Examination

Council also approved the Registration Committee's Directive to the Registrar for the LMCC policy to enable staff to register applicants who satisfy the Directive without referral to the Registration Committee.

Specialist Recognition Criteria in Ontario (Specialty Recognition)

The Specialist Recognition policy sets out the criteria that a physician must meet in order to be recognized as a specialist by the College. The policy applies to individuals who have met the established criteria for registration and have been issued a certificate of registration to practice medicine in Ontario. Specialist Recognition by the College permits physicians to hold

themselves out as a specialist. Additionally, external agencies such as OHIP, hospitals, WSIB etc. rely on the College to confirm whether an individual is considered a specialist.

Council approved the following changes to the policy:

A. Clarifying Requirements

- There were ongoing concerns that the language and spirit of the policy were open to misinterpretation, as physicians were applying for recognition in instances when they did not qualify.
- A preamble explaining the purpose of the policy was approved as was language reflecting the expansion on the criteria necessary to qualify under each of the existing routes to Specialty Recognition,
- Additionally, clarifying that specialists trained outside of North America must have training comparable in duration to a RCPSC/CFPC program and adding increased clarity around the conditions leading to expiry of the CPSO specialist recognition were approved

B. Combining “Family Medicine Specialist” and “Non-Family Medicine Specialist” Sections

- The Specialist Recognition policy currently distinguishes between “Specialists in Family Medicine” (i.e., certified by the CFPC) and “Specialists in Specialties Other than Family Medicine”. However, the routes to certification are the same for both.
- The language of the policy is revised to no longer separate family medicine as a specialty.

C. Language Redesign

- The language of the policy has been revised for conciseness and clarity.

Temporary Independent Practice Class – Regulation Amendment

In early August, the Minister of Health issued a letter to the CPSO, directing us to “make every effort to register out of province and internationally educated physicians to the College as expeditiously as possible”. CPSO’s Response to the Minister’s Letter touched on a wide variety of current and potential initiatives and emphasized our diligent work throughout the pandemic to support the health care system such as the timely processing of all applications (including IEPs) and utilizing the short duration class of registration.

The letter emphasized that CPSO is but one part of the broader solution and put forward a range of options to address the current crisis and underlying issues , including a call-out to

recently retired physicians to re-enter practice in order to inject immediate resources into the system (this has subsequently been done); implementing a Practice Ready Assessment program for Ontario; increasing the number of residency positions for IEPS and considering potential policy changes at CPSO that would streamline licensure for IEPs; exploring coordinated systems-based solutions including the expansion of accreditation and assessment processes to identify more equivalent jurisdictions, better alignment of physician training with system needs, the re-introduction of a limited class of registration for general practitioners; and the introduction of regulatory amendments that would create a temporary independent class of license to help support inter-provincial mobility.

Government was particularly interested in pursuing the development of a new class of license to allow for greater inter-provincial/territorial mobility.

The purpose of the regulation amendment is to provide a more flexible option for potential applicants who wish to assist with system needs on a temporary basis, enabling them to practice at full scope, and reducing the administrative burden for all involved. Specifically, it offers benefits over the Short Duration certificate in important ways: Not requiring supervision, enabling physicians to practice independently; Extending the duration of a license (3 months), enabling greater flexibility; Allowing a broader range of system sponsors, including community-based settings; Reducing administrative burden on the sponsor, the physician, and CPSO.

The proposal was forwarded to Government by Council in September and was enacted by the Government towards the end of October. The Registration Committee was pleased to support the regulation amendment proposal, and looks forward to continue its work evaluating alternative qualifications and streamlining licensure as outlined in CPSO's response to the Minister.

System Collaboration

The Registration Committee continues to work closely with several stakeholders, including medical schools, certifying bodies and resident organizations, to ensure we are proactively regulating the profession.

Based on the challenges and increased need of some rural/underserviced and Northern communities, the Registration Committee supported an interactive information session on supervised routes to registration. We also created infographics along with FAQs to support recruitment to these communities and dispel myths around supervised practice.

Education Initiatives

This year, in addition to circulating relevant articles of interest and discussing decision review and outcomes, the Committee participated in educational sessions with stakeholders including the RCPSC, CFPC and MCC.

The Committee also participated in a session on Narrative Medicine facilitated by our Equity, Diversity and Inclusion (EDI) lead, Dr. Saroo Sharda.

The Committee and staff continue to examine ways to increase efficiency without compromising quality. With changes to the administrative processes and procedures, we have been successful in managing increasing caseloads without increasing the Committee in-person meeting days.

Additional information about the Committee's activities can be found in CPSO's College Performance Measurement Framework Report.

Continuous Improvement

In September 2021 the Registration Committee was on-boarded to the College's new Solis enterprise system, which allows for a centralized electronic Committee portal that will increase efficiency.

Looking Ahead to 2023

A guiding principle of Right-Touch Regulation is that we should be proportionate, consistent, targeted, transparent, accountable, and agile in everything we do. Throughout the pandemic, the Committee has diligently supported the health care system by adopting flexible interpretations of policy in light of unprecedented challenges and working with system partners to create solutions to pressing concerns.

Looking to address problems caused by the pandemic, the Committee has identified opportunities to license physicians more flexibly and nimbly by leveraging every licensing mechanism available to us. The COVID-19 pandemic has highlighted Ontario's health human resource challenges, of which registration is one part of a broader solution. The Registration Committee is committed to looking at the College's existing routes to Registration and exploring alternative qualifications.

We will also continue to focus on succession planning throughout the year ahead. In 2023, the Committee will welcome Dr. Lynn Mikula as Vice-Chair, and we look forward to her contributions. The Committee will also continue to foster a core group of experienced members who understand legal processes, College policies, and legislation to provide robust mentorship and training to new members.

The Registration Committee would like to thank our two outgoing members of the Committee, Dr. Bob Byrick and Dr. Barbara Lent, for their guidance, leadership, mentorship, and service in their years on the Committee.

The Registration Committee remains committed to continuous improvement and will continue to improve the efficiency of our processes while ensuring a process that is fair, transparent, impartial, and objective.

Respectfully submitted,

Dr. Judith Plante, MDCM CCFP, FCFP
Chair, Registration Committee

Council Briefing Note

December 2022

Topic:	Policy Report
Purpose:	For Information
Relevance to Strategic Plan:	Right-Touch Regulation Meaningful Engagement
Public Interest Rationale:	Keeping Council apprised of ongoing policy-related issues and activities for monitoring and transparency purposes.
Main Contact(s):	Craig Roxborough, Director, Policy
Attachment(s):	Appendix A: Policy Status Report

Issue

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

Current Status

1. Consultation Update

- Three consultations launched following September 2022 Council. Notice of the consultation was sent to the membership and external stakeholders and was promoted through CPSO's website and social media platforms.
- An overview of the key themes that have emerged in the feedback to date is provided below. Further updates will be provided at future meetings after the consultations close.

General Consultation: *Human Rights in the Provision of Health Services (Human Rights)*

- Council approved the draft *Human Rights* policy in September 2022.

- As of the Council submission deadline, this consultation has received 148 responses: 49 through written feedback and 99 via the online survey.[1]
- Quantitative feedback was supportive of the requirement for physicians to take reasonable steps to create and foster ideal environments where patients' needs could be met, with the majority of survey respondents agreeing that it is important and reasonable for physicians to take reasonable steps to incorporate cultural humility, cultural safety, anti-racism, and anti-oppression into their practices, but the written feedback was varied and conflicting:
    - While some indicated that incorporating these concepts into the draft policy is "encouraging," "a step forward," and "much-needed," others felt it is unreasonable and/or unnecessary to focus on equity, diversity, and inclusion (EDI) initiatives.
- Quantitative and qualitative feedback on effective referrals was mixed: some appreciated the changes made while others still believed that these expectations are unreasonable.
- Constructive feedback from respondents to improve the draft policy included providing further guidance on how to deal with requests that are perceived as discriminatory and to define the EDI concepts and add examples explaining how to incorporate them.

General Consultation: *Medical Assistance in Dying (MAID)*

- Council approved the draft *MAID* policy for public consultation in September 2022.
- As of the Council submission deadline, this consultation has received 188 responses: 84 through written feedback and 104 via the online survey.[2]
- Many respondents expressed concerns regarding the legality of MAID, the eligibility criteria and safeguards set out in the legal framework, and the provincial requirement[3] that prohibits referencing MAID or the drugs administered on medical certificate of deaths.
- Respondents were generally supportive of the structural updates (i.e., moving the legal requirements into the companion and referencing the expectations for physicians who do

[1] Organizational respondents included: Association for Reformed Political Action (ARPA) Canada; Council of Canadians with Disabilities (CCD); Canadian Medical Protective Association (CMPA); Canadian on Paper Society for Immigrant Physicians, Foundation of International Medical Graduates, Alliance for Doctors Denied by Degree, and Society for Canadians Studying Medicine Abroad; Christian Medical Fellowship (CMF) UK; Indigenous Disability Canada; Ontario Association for ACT and FACT (OAAF); Physicians Together with Vulnerable Canadians; Professional Association of Residents of Ontario (PARO); and Toujours Vivant-Not Dead Yet (TVNDY).

[2] Organizational respondents included: ARPA Canada; CCD; CMPA; CMF UK; Indigenous Disability Canada; OAAF; Physicians Together with Vulnerable Canadians; PARO; Protection of Conscience Project; and TVNDY.

[3] See the Ministry of Government and Consumer Services' *Handbook on Medical Certification of Death & Stillbirth* (December 2019) via Publications Ontario. These requirements were jointly developed by the Ministry of Health, the Ministry of Government and Consumer Services, and the Office of the Chief Coroner for Ontario.

not assess or provide MAID due to religion or conscience in the draft *Human Rights* policy) and the new expectations (i.e., related to notifying pharmacists and contingency planning).

- Constructive suggestions to improve the draft policy and companion documents included:
    - Outline what is required for a contingency plan when administering medications;
    - Clarify in the *Advice* whether the 90-day assessment period can start before the request is made; and
    - Provide more detailed guidance concerning waivers of final consent in the *Advice*.

General Consultation: *Out-of-Hospital Premises Inspection Program (OHPIP) Standards*

- Council approved the draft *OHP Standards* for consultation in September 2022. Given the nature of this project and the number of draft *Standards*, the consultation period is extended and is set to close in early January 2023.
- As of the Council submission deadline, this consultation has received 45 responses: eight through written feedback and 37 via the online survey.[4]
- Feedback on some of the key changes made to modernize the draft documents include:
    - *Medical Director*: broad support for the draft *Standard*, including feedback that the proposed requirements (i.e., criteria or qualifications) and responsibilities (i.e., credentialing, ensuring staff competency, and supervision) for OHP medical directors are reasonable and clear.
    - *Drugs and Equipment*: support for moving from a prescriptive list of drugs to events and circumstances that need to be prepared for and managed appropriately.
    - *Patient Selection*: broad support for the enhancements made and that it identifies the right considerations, along with some requests for additional clarity on which patients can be appropriately treated in an OHP.
- Survey respondents agreed it is generally clear which procedures are captured by the program and when changes, new procedures, and adverse events must be reported to CPSO.

2. Policy Status Table

- The status of ongoing policy development and reviews, as well as target dates for completion, is presented for Council's information for each meeting as **Appendix A**.

[4] Organizational respondents included: PARO and Windsor Surgical Centre, Laser Vision London, Clear Vision Surgical, Burlington Laser Eye Centre, Barrie Lasik Centre.

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		
Practice Guide	Dec-22	✓						**2024**	
Blood Borne Viruses	Jun-22		✓					**2024**	
Mandatory and Permissive Reporting	Jun-22		✓					**2024**	
Physicians' Relationships with Industry: Practice, Education and Research	Dec-21			✓				**2023**	The draft policy has been retitled to *Conflicts of Interest and Industry Relationships*.
Dispensing Drugs	Sep-21						✓	**2022**	
Professional Obligations and Human Rights	Dec-20					✓		**2023**	The draft policy has been retitled to *Human Rights in the Provision of Health Services*.
Medical Assistance in Dying	Dec-20					✓		**2023**	
Planning for and Providing Quality End-of-Life Care	Dec-20					✓		**2023**	The draft policy has been retitled to *Decision-Making for End-of-Life Care*.

Table 2: Policy Review Schedule

Policy	Target Review	Policy	Target Review
Providing Physician Services During Job Actions	2018/19	*Walk-in Clinics*	2024/25
Cannabis for Medical Purposes	2020/21	*Disclosure of Harm*	2024/25
Consent to Treatment	2020/21	*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	*Protecting 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
Availability and Coverage	2024/25	*Complementary and Alternative Medicine*	2026
Managing Tests	2024/25	*Virtual Care*	2027
Transitions in Care	2024/25	*Social Media*	2027

Ontario Medical Students' Association
CPSO Council Update
December 8-9, 2022

Presented by:
Angie Salomon, President
Jeeventh Kaur, President-Elect

OMSA AÉMO
Ontario Medical Students Association
Association des étudiant·e·s de médecine de l'Ontario

Thank you once again to the CPSO for inviting representatives from the Ontario Medical Students Association (OMSA) to observe and participate in your Council meeting. OMSA represents the interests and concerns of Ontario's 4000+ medical students, and is entrusted with advocating for changes in education, health policy, and care delivery that will benefit the future physicians of Canada and the communities that we serve.

It's hard to believe that this year's first term is already drawing to a close. Over the last few months, OMSA has been hard at work to engage with and serve Ontario's medical students. **Specific highlights of the last quarter include:**

1. **Passing position papers** penned by Ontario medical students, including 1) Combatting Sexual Assault: Addressing Gaps in Medical School Curricula, and 2) Reducing barriers in Canadian medical school admissions for students with disabilities
2. Attending the Ontario Medical Associations' General Assembly and **representing student voices on the OMA's Priority and Leadership Group**
3. **Launching a new Facebook Page titled, "Ontario Medical Student Opportunities",** for the streamlined dissemination of education, research, advocacy, and service opportunities
4. **Selecting our Day of Action Topic of Housing and Homelessness**, to be discussed with members of Provincial Parliament in Spring 2023
5. **Completing hiring for all 22 committees under OMSA's various portfolios**, on which over 100 students will serve this year.

Looking ahead, we are excited to continue to support medical students with mentorship and social opportunities, including our annual Wellness Weekend in March 2023. We are also working to improve our organizational efficacy through detailed review of our internal policies, work that will continue into the new year.

We look forward to attending, contributing to, and learning from CPSO meetings to help achieve these goals. Thank you as always for welcoming medical students to the table.

Sincerely,

Angie Salomon
President, OMSA
president@omsa.ca

Jeeventh Kaur
President-Elect, OMSA
president_elect@omsa.ca

PARO

Inspired by our love of medicine

CPSO Council November 2022

PARO champions the issues that create the conditions for residents to be their best and ensure optimal patient care. We have determined that to fulfill this mission we must achieve three key goals.

Optimal training - so that residents feel confident to succeed and competent to achieve excellence in patient care.

Optimal working conditions - where residents enjoy working and learning in a safe, respectful, and healthy environment.

Optimal transitions – into residency, through residency, and into practice – so that residents are able to make informed career choices, have equitable access to practice opportunities, and acquire practice management skills for residency and beyond.

We are pleased to submit this update on some organizational projects, info related to COVID-19 as well as some strategic initiatives at PARO.

Burnout and Morale Mitigation
A cornerstone of work has always been to provide opportunities for residents to socialize and make connections outside of the workplace. Many of our members move to new cities, provinces, and indeed for some, to a new country for residency, taking them away from their existing social and family networks. As a result, and on top of the reasons all people are experiencing social-isolation during COVID 19, our members continue to experience high levels of burnout.

Last year, we created a resource guide for members, which helps identify specific signs of burn out and provides specific tips and resources to manage each sign. That guide is available on PARO's website.

Our work this year continues with our PARO Site Teams continuing to host social events for our members ensuring we have in-person and virtual event planning with in-person options occurring in line with local Public Health guidance and attention to PARO's in-person gathering COVID safety measures. We are proud of the significant work of our PARO GC reps to ensure that our members have these opportunities.

Resident Enhancement Fund (REF)
In 2000, PARO's General Council approved the establishment of a fund to be used to support projects that provide a long-term benefit to both existing and future residents. Projects that are approved demonstrate that they augment the well-being of residents at a particular teaching site or throughout the province.

We have two deadlines for applications each year and any PARO member is eligible to submit an application. In evaluating a project proposal, the Resident Enhancement Fund

(REF) Team will consider the amount of any previously funded projects at the same hospital and/or site and endeavor to distribute funds in a fair manner across the province.

Last year, PARO received 26 applications. The applications included a wide variation of requests, which included items such as kettles, coffee machines, device chargers, general lounge updates such as sofa, TV, and fridge.

Our November application process for the current year has just closed and we received 25 applications, with at least one application from each site. We look forward to reviewing the proposals that have been submitted for consideration by this year's team.

PARO Teaching to Teach Program
We continue to deliver the teaching to teach workshop via Zoom to training programs at their academic half day session. Since the program was operationalized in 2017, 38 workshops have been delivered to 752 resident participants.
An important requirement to ensure the success of the teaching to teach program is a comprehensive training component for resident facilitators. To-date, 82 residents have been trained as facilitators and we are planning to host one more training session this academic year.

Residents on *Long* - Long-term Disability
PARO manages a Long-term Disability Program to ensure all our members are protected should they become ill longer than the paid medical time off provided under our Collective Agreement with the Employer. PARO and the Universities have been in discussion to optimally support the small number of residents who are on *long* Long-term Disability to reduce administrative burden on them when a return to work and training is unlikely but still ensuring that there is no negative impact on their return to training should it become possible medically.

Decreasing Applicant Stress for the PGY1 Residency Match
Recognizing residents are uniquely placed understand the stress medical students feel when entering the Match and to help mitigate the stress they experience, PARO created two resources:

- A Best Practices guide for residents who are involved their Program's CaRMS Interview Committees. This guide is provided to PARO members in January to ensure they are well-prepared to participate in their program's interview process and encourage our members across the province to be advocates for consistent best practices in their own programs.

- We developed "survival stories" from our members who have gone through the Match process with a variety of outcomes (i.e. matching through the second iteration, transferring programs after a match, going unmatched, choosing a non-residency post MD career). The goal is to help normalize and de-mystify different potential outcomes. Last year we partnered with OMSA to distribute this resource to their members on Match Day; we hope to continue this partnership with the coming Match.

Kind Regards,

Zainab Mohamed, MD
PARO Board of Directors

Ariel Gershon, MD
PARO Board of Directors

Council Briefing Note

December 2022

Topic:	Update on Council Action Items
Purpose:	For Information
Relevance to Strategic Plan:	Right Touch Regulation, Quality Care, Meaningful Engagement, System Collaboration, Continuous Improvement
Public Interest Rationale:	Accountability: Holding Council and the College accountable for the decisions made during the Council meetings
Main Contacts:	Carolyn Silver, Chief Legal Officer Cameo Allan, Manager of Governance Adrianna Bogris, Council Administrator

Issue

- To promote accountability and ensure that Council is informed about the status of the decisions it makes, an update on the implementation of Council decisions is provided below.

Current Status

- Council held a meeting on September 22 and 23, 2022. The motions carried and the implementation status of those decisions are outlined in Table 1.

Table 1: Council Decisions from September Meeting

Reference	Motions Carried	Status
01-C-09-2022	**Consent Agenda** The Council approves the items outlined in the consent agenda, which include in their entirety: • The Council meeting agenda for September 22 and 23, 2022, as amended; and • The minutes from Council held June 16 and 17, 2022	Completed.

Reference	Motions Carried	Status
02-C-09-2022	**Human Rights in the Provision of Health Services – Draft Policy for Consultation** The Council of the College of Physicians and Surgeons of Ontario engage in the consultation process in respect of the draft policy "Human Rights in the Provision of Health Services," (a copy of which forms Appendix "A" to the minutes of this meeting).	Consultation completed. Revising draft policy is underway.
03-C-09-2022	**Amendments to Declaration of Adherence and Council Code of Conduct (regarding Social Media)** The Council of the College of Physicians and Surgeons of Ontario approves the amendments to the Declaration of Adherence, (a copy of which forms Appendix "B" to the minutes of this meeting) and to the Council and Committee Code of Conduct, (a copy of which forms Appendix "C" to the minutes of this meeting).	Completed.
04-C-09-2022	**Medical Assistance in Dying – Draft Policy for Consultation** The Council of the College of Physicians and Surgeons of Ontario engage in the consultation process in respect of the draft policy, "Medical Assistance in Dying," (a copy of which forms Appendix "D" to the minutes of this meeting).	Consultation completed. Revising draft policy is underway.
05-C-09-2022	**Council Self-Assessment** The Council of the College of Physicians and Surgeons of Ontario approves the revised Council Self-Assessment process, (a copy of which forms Appendix "E" to the minutes of this meeting).	Council Self-Assessment process will take place during the Education Session at Dec. Council

Reference	Motions Carried	Status
06-C-09-2022	**Premises Inspection Committee Public Member Update** The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 151: **By-law No. 151** Section 47.2 of the General By-law is revoked and substituted with the following: 47.2 A panel of three members of the Premises Inspection Committee appointed by the chair of the Premises Inspection Committee is a quorum, and may discharge the duties and exercise the authority of the Premises Inspection Committee.	Completed.
07-C-09-2022	**Executive Committee Elections** The Council of the College of Physicians and Surgeons of Ontario appoints: Dr. Robert Gratton (as President), Dr. Ian Preyra (as Vice President), Dr. Sarah Reid (as Executive Member Representative), Ms. Joan Fisk (as Executive Member Representative), Dr. Lydia Miljan (as Executive Member Representative), And Dr. Janet van Vlymen (as Past President), to the Executive Committee for the year that commences with the adjournment of the Annual General Meeting of Council in December 2022.	Completed.
	Governance Committee Elections	Postponed to December Council

<table>
<tr><th>Reference</th><th>Motions Carried</th><th>Status</th></tr>
<tr><td><u>08-C-09-2022</u></td><td><u>2022-2023 Committee Appointments and Re-appointments</u>

1. The Council of the College of Physicians and Surgeons of Ontario appoints Dr. George Beiko 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 of the College of Physicians and Surgeons of Ontario appoints Dr. Michael Wan to the Inquiries, Complaints and Reports Committee and to the Premises Inspection Committee, effective immediately, with the term expiring at the close of the Annual General Meeting of Council in December 2024.</td><td>Completed.</td></tr>
<tr><td><u>09-C-09-2022</u></td><td>3. The Council of the College of Physicians and Surgeons of Ontario appoints Dr. Janet van Vlymen to the Ontario Physicians and Surgeons Discipline Tribunal and the Fitness to Practise Committee, for a term beginning at the close of the Annual General Meeting of Council in December 2022, and expiring at the close of the Annual General Meeting of Council in December 2023.</td><td>Completed.</td></tr>
<tr><td><u>10-C-09-2022</u></td><td>4. The Council of the College of Physicians and Surgeons of Ontario re-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 2022:</td><td>Completed.</td></tr>
</table>

Committee	Member Name	Term Length	End Date
Finance and Audit	Dr. Ian Preyra	3 years	December 2025
	Mr. Peter Pielsticker	1 year	December 2023
Fitness to Practice	Dr. Heather-Ann Badalato	3 years	December 2025
	Dr. Allan Kaplan		
	Mr. Peter Pielsticker	1 year, 3 months, 21 days	March 30, 2024
Inquiries, Complaints, and Reports	Dr. Lydia Miljan (PhD)	3 years	December 2025
	Dr. Trevor Bardell		
	Dr. Paula Cleiman		
	Dr. Karen Saperson		

Ontario Physicians and Surgeons Discipline Tribunal	Dr. Heather-Ann Badalato	3 years	December 2025
	Dr. Allan Kaplan		
	Mr. Peter Pielsticker	1 year, 3 months, 21 days	March 30, 2024
Patient Relations	Ms. Sharon Rogers	3 years	December 2025
	Dr. Diane Whitney		
Premises Inspection	Dr. Robert Smyth	3 years	December 2025

11-C-09-2022	**Education Advisory Group Dissolution** The Council of the College of Physicians and Surgeons of Ontario approves the dissolution of the Education Advisory Group, effective as of the adjournment of the Annual General Meeting of Council in December 2022.	Completed.
12-C-09-2022	**Specialist Recognition Criteria in Ontario** The Council of the College of Physicians and Surgeons of Ontario approves the revised policy, "Specialist Recognition Criteria in Ontario", (a copy of which forms Appendix "F" to the minutes of this meeting).	Completed.
Original Motion: 13A-C-09-2022	**Regulatory Proposal – Temporary Class of Licensure** The Council of the College of Physicians and Surgeons of Ontario approves: making an amendment to Ontario Regulation 856/93: Registration, regarding a certificate of registration authorizing practice for the provision of temporary services (a copy of which amendment forms Appendix "G" to the minutes of this meeting) and submitting it to the Minister of Health for review and the approval of the Lieutenant Governor in Council; and exempting the regulatory amendment from the requirement under subsection 95(1.4) of the Health Professions Procedural Code to circulate it to the profession, if such exemption is approved by the Minister.	Completed (as revised by motion to amend below).
Motion to Amend: 13B-C-09-2022	**Regulatory Proposal – Temporary Class – Amended Regulation** The Council of the College of Physicians and Surgeons of Ontario approves amending the motion titled, "Regulatory Proposal for Temporary Class of Licensure" by replacing the	Completed

<table>
<tr><td></td><td>words “practice for the provision of temporary services” with “temporary independent practice”.

<u>Motion: 13B-C-09-2022 CARRIED</u></td><td></td></tr>
<tr><td><u>Original Motion: 13A-C-09-2022</u></td><td><u>Record of each Council vote set out below on Original Motion: 13A-C-09-2022 – Regulatory Proposal for Temporary Class of Licensure, as amended:</u>

<table>
<tr><th>Number</th><th>Name</th><th>Vote</th></tr>
<tr><td>1.</td><td>Madhu Azad</td><td>In favour</td></tr>
<tr><td>2.</td><td>Glen Bandiera</td><td>In favour</td></tr>
<tr><td>3.</td><td>Lucy Becker</td><td>In favour</td></tr>
<tr><td>4.</td><td>Jose Cordeiro</td><td>In favour</td></tr>
<tr><td>5.</td><td>Joan Fisk</td><td>In favour</td></tr>
<tr><td>6.</td><td>Murthy Ghandikota</td><td>In favour</td></tr>
<tr><td>7.</td><td>Julia Goyal</td><td>In favour</td></tr>
<tr><td>8.</td><td>Rob Gratton</td><td>In favour</td></tr>
<tr><td>9.</td><td>Camille Lemieux</td><td>In favour</td></tr>
<tr><td>10.</td><td>Paul Malette</td><td>In favour</td></tr>
<tr><td>11.</td><td>Lionel Marks de Chabris</td><td>In favour</td></tr>
<tr><td>12.</td><td>Lydia Miljan</td><td>In favour</td></tr>
<tr><td>13.</td><td>Rupa Patel</td><td>In favour</td></tr>
<tr><td>14.</td><td>Rob Payne</td><td>In favour</td></tr>
<tr><td>15.</td><td>Peter Pielsticker</td><td>In favour</td></tr>
<tr><td>16.</td><td>Judith Plante</td><td>In favour</td></tr>
<tr><td>17.</td><td>Ian Preyra</td><td>In favour</td></tr>
<tr><td>18.</td><td>Linda Robbins</td><td>In favour</td></tr>
<tr><td>19.</td><td>Deborah Robertson</td><td>In favour</td></tr>
<tr><td>20.</td><td>Jerry Rosenblum</td><td>In favour</td></tr>
<tr><td>21.</td><td>Patrick Safieh</td><td>In favour</td></tr>
<tr><td>22.</td><td>Fred Sherman</td><td>In favour</td></tr>
<tr><td>23.</td><td>Janet van Vlymen</td><td>In favour</td></tr>
<tr><td>24.</td><td>Anne Walsh</td><td>In favour</td></tr>
</table>
Motion: 13A-C-09-2022, as amended CARRIED</td><td>Completed</td></tr>
</table>

Original Motion: 14A-C-09-2022	**By-law Amendments for Fees for Temporary Services Certificate of Registration** Refer to Appendix "H" to the minutes of this meeting.	
Motion to Amend: 14B-C-09-2022	**By-law Amendments for Fees for Temporary Independent Practice Certificate of Registration** The Council of the College of Physicians and Surgeons of Ontario amends the motion titled By-law Amendments for Fees for Temporary Services Certificate of Registration by replacing the proposed By-law No. 153 with the following: **By-law No. 153** 1. Section 1 of the Fees and Remuneration By-law (By-law No. 2) is revoked and substituted with the following: **Application Fees** **1.** A person who submits an application for a certificate of registration or authorization shall pay an application fee. The application fees are as follows: (a) For a certificate of registration authorizing postgraduate education, 25% of the annual fee specified in section 4(a); (b) For a certificate of registration authorizing supervised practice of a short duration, 20% of the annual fee specified in Section 4(a); (b.1) For a certificate of registration authorizing temporary independent practice, 25% of the annual fee specified in section 4(a); (c) For an application for reinstatement of a certificate of registration, 60% of the annual fee specified in s. 4(a);	Circulation period completed. This By-law amendment is being brought forward to Council for final approval.

	(d) For any other certificate of registration, 60% of the annual fee specified in Section 4(a); (e) *[repealed]: May 31, 2019]* (f) For a certificate of authorization, $400.00; (g) For an application to the Registration Committee for an order directing the Registrar to modify or remove terms, conditions or limitations imposed on the member's certificate of registration by the Registration Committee, 25% of the annual fee specified in section 4(a); (h) If the person: (i) meets the registration requirements applicable to the class of certificate of registration applied for, as prescribed in the Registration Regulation, Ontario Regulation 865/93 under the *Medicine Act, 1991*; and (ii) requests the College to conduct the initial assessment of the application within three weeks after receipt by the College of the application, an additional fee equal to 50% of the application fee applicable to such person under subsection 1(a), (b), (b.1) or (d). 2. Section 3 of the Fees and Remuneration By-law (By-law No. 2) is revoked and substituted with the following: **Annual Fees** **3.** Every holder of a certificate of authorization, other than a holder of a certificate of registration authorizing supervised practice of a short duration or authorizing postgraduate education for an elective appointment or authorizing temporary independent practice, shall pay an annual fee.	

	3. Subsection 4(a) of the Fees and Remuneration By-law (By-law No. 2) is revoked and substituted with the following: (a) $1725 for holders of a certificate of registration other than a certificate of registration authorizing postgraduate education, a certificate of registration authorizing supervised practice of a short duration, or a certificate of registration authorizing temporary independent practice; Explanatory Note: This proposed by-law must be circulated to the profession. **Motion: 14B-C-09-2022 CARRIED** **Motion: 14A-C-09-2022, as amended CARRIED**	
15-C-09-2022	**Motion to go In-Camera** The Council of the College of Physicians and Surgeons of Ontario exclude the public from the part of the meeting immediately after this motion is passed, under clauses 7(2)(b), (d) and (e) of the Health Professions Procedural Code (set out below). **Exclusion of public** 7(2) Despite subsection (1), the Council may exclude the public from any meeting or part of a meeting if it is satisfied that, (b) financial or personal or other matters may be disclosed of such a nature that the harm created by the disclosure would outweigh the desirability of adhering to the principle that meetings be open to the public; (d) personnel matters or property acquisitions will be discussed; and (e) instructions will be given to or opinions received from the solicitors for the College.	Completed

16-C-09-2022	**Filling Vacancies on Council – By-law Amendment** The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 152: **By-law No. 152** Section 23 of the General By-law is revoked and substituted with the following: **Filling of Vacancies** 23. (1) If the seat of an elected councillor becomes vacant, the council may, (a) leave the seat vacant, subject to subsection (2); (b) appoint as an elected member the candidate if any who had the most votes of all the unsuccessful candidates in the last election of councillors for that electoral district; or (c) direct the registrar to hold a by-election for that electoral district in accordance with this by-law. (2) If the number of remaining elected councillors is less than the minimum number required by law, the council shall take action under clause (1)(b) or clause (1)(c) to fill the number of vacant seats needed so that the number of elected councillors is not less than the minimum number required by law.	Completed
17-C-09-2022	**Current Council Vacancy** **WHEREAS** there is currently a vacant Council seat for an elected physician Council member in District 5 (the "Vacant Seat"), The following motion was moved by J. Fisk, seconded by I. Preyra and carried, that: The Council of the College of Physicians and Surgeons of Ontario approves leaving the Vacant Seat vacant until the	Completed

	2023 Annual General Meeting of Council in accordance with the General By-law.	
18-C-09-2022	**OHPIP – Draft Standards for Consultation** The Council of the College of Physicians and Surgeons of Ontario engage in the consultation process in respect of the draft "Out-of-Hospital Premises Standards", (a copy of which forms Appendix "I" to the minutes of this meeting).	Out for consultation

Council Briefing Note

December 2022

Topic:	Ontario Physicians and Surgeons Discipline Tribunal (OPSDT): Mission and Core Values
Purpose:	For Information
Relevance to Strategic Plan:	- Right-Touch Regulation - Meaningful Engagement - Continuous Improvement
Public Interest Rationale:	The Tribunal's mission and core values support the Tribunal's work in the public interest by: - ensuring that adjudicators and staff have a common understanding of what we do; - making a commitment to participants and the public that we will act in accordance with certain underlying principles; and - helping the public to understand what we do.
Main Contact(s):	David Wright, Tribunal Chair Dionne Woodward, Tribunal Counsel
Attachment(s):	None

Issue

- Tribunal members and staff have developed draft mission and values statements to articulate the Tribunal's role and underlying core values.

- Council is provided with a draft of these statements for discussion.

Background

- At its October Business Meeting, Tribunal members and staff gathered for a hands-on workshop to help develop the Tribunal's inaugural mission and values statements.

- The session, which was facilitated by external consultants, encouraged those in attendance to cultivate a shared understanding of the Tribunal's role and its underlying values.

- Based on this session, a draft mission statement describing the Tribunal's role and core values to guide its work were developed.

- The statements incorporate key abiding principles including fairness, independence, neutrality, equity, accessibility and timeliness.

- The draft statements were circulated to Tribunal staff and members for comment and feedback.

Current Status and Analysis

Consultation Results

- Overall, the feedback received from Tribunal members on the draft mission and values statements was positive.

- Respondents were of the view that the draft statements reflected their discussion at the mission and values workshop.

- Broadly speaking, the suggested edits centered around ensuring that the statements:

    - were written in plain language;
    - appropriately reflected the scope of the Tribunal's work;
    - ensured that all groups that interact with the Tribunal (e.g. parties, witnesses, the public) were captured.

Executive Committee Discussion

- The draft mission and values statements were presented to Executive Committee at its November meeting where certain enhancements were proposed to ensure completeness, accuracy and clarity.

Revised Draft Statements

- In light of feedback received from Tribunal members, Tribunal staff and the Executive Committee, revisions to the draft mission and values statements were made. The updated statements read as follows:

    - **Mission**
        - To hear and decide allegations of physician misconduct and incompetence with independence and fairness, making just decisions in the public interest.

- **Values**
  - Fairness: We are neutral and ensure all parties are heard. Our decisions and processes are accessible and clearly explained.
  - Excellence: We aim for high quality decision making and service.
  - Respect: We actively listen with humility and empathy. We strive to understand the diverse identities and experiences of parties, witnesses and those affected by our decisions.
  - Openness: Our decisions, hearings and processes are transparent, balancing openness and privacy.
  - Timeliness: We recognize the importance to participants and the public of promptly resolving cases. We act and require parties to act in a responsive and timely way.

Next Steps

- Once finalized, the Tribunal's Mission and Values statements will be posted on the Tribunal's website and used in other communications.

Council Briefing Note

December 2022

Topic:	Amendments to the Fees and Remuneration By-law regarding Temporary Independent Practice Certificate of Registration
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation System Collaboration
Public Interest Rationale:	Ensuring transparency and consultation on by-law amendments and appropriateness of fees.
Main Contact(s):	Marcia Cooper, Senior Legal Counsel and Privacy Officer Samantha Tulipano, Director, Registration & Membership Services
Attachment:	Proposed amendments to the Fees and Remuneration By-Law (Appendix A)

Issue

- Amendments to the Fees and Remuneration By-Law were proposed to set fees for the new temporary independent practice license.

Background

- A proposal to amend CPSO By-law to support implementation of the new temporary independent class of license was approved by Council for consultation in September.
    - Given the three month term of the new class, the proposed fee was set at 25% of the annual fee.

Current Status

- Government enacted the regulation for the new temporary independent class of registration as of October 27th.
- No feedback was received during the consultation period, which ended on November 22nd.
- The proposed By-law Amendment in Appendix A highlights the changes to the existing text of the Fees and Remuneration By-law.

Question for Council

1. Does Council approve the proposed by-law amendments set out in Appendix A?

APPENDIX A
BY—LAW AMENDMENTS

Application Fees

1. A person who submits an application for a certificate of registration or authorization shall pay an application fee. The application fees are as follows: …

(b.1) For a certificate of registration authorizing temporary independent practice, 25% of the annual fee specified in section 4(a); …

(h) If the person:

(i) meets the registration requirements applicable to the class of certificate of registration applied for, as prescribed in the Registration Regulation, Ontario Regulation 865/93 under the *Medicine Act, 1991*; and

(ii) requests the College to conduct the initial assessment of the application within three weeks after receipt by the College of the application,

an additional fee equal to 50% of the application fee applicable to such person under subsection 1(a), (b), (b.1) or (d).

Annual Fees

3. Every holder of a certificate of registration or authorization, other than a holder of a certificate of registration authorizing supervised practice of a short duration or authorizing postgraduate education for an elective appointment or authorizing temporary independent practice, shall pay an annual fee.

4. Annual fees as of June 1, 2018, are as follows:

(a) $1725 for holders of a certificate of registration other than a certificate of registration authorizing postgraduate education, a certificate of registration authorizing supervised practice of a short duration, or a certificate of registration authorizing temporary independent practice;

Council Motion

Motion Title	By-law Amendment for Fees for Temporary Independent Practice Certificate of Registration
Date of Meeting	December 8, 2022

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.153:

By-law No. 153

1. Section 1 of the Fees and Remuneration By-law (By-law No. 2) is revoked and substituted with the following:

Application Fees

1. A person who submits an application for a certificate of registration or authorization shall pay an application fee. The application fees are as follows:

(a) For a certificate of registration authorizing postgraduate education, 25% of the annual fee specified in section 4(a);

(b) For a certificate of registration authorizing supervised practice of a short duration, 20% of the annual fee specified in Section 4(a);

(b.1) For a certificate of registration authorizing temporary independent practice, 25% of the annual fee specified in section 4(a);

(c) For an application for reinstatement of a certificate of registration, 60% of the annual fee specified in s. 4(a);

(d) For any other certificate of registration, 60% of the annual fee specified in Section 4(a);

(e) *[repealed]: May 31, 2019]*

(f) For a certificate of authorization, $400.00;

(g) For an application to the Registration Committee for an order directing the Registrar to modify or remove terms, conditions or limitations imposed on the member's certificate of registration by the Registration Committee, 25% of the annual fee specified in section 4(a);

(h) If the person:

(i) meets the registration requirements applicable to the class of certificate of registration applied for, as prescribed in the Registration Regulation, Ontario Regulation 865/93 under the *Medicine Act, 1991*; and

(ii) requests the College to conduct the initial assessment of the application within three weeks after receipt by the College of the application,

an additional fee equal to 50% of the application fee applicable to such person under subsection 1(a), (b), (b.1) or (d).

2. Section 3 of the Fees and Remuneration By-law (By-law No. 2) is revoked and substituted with the following:

Annual Fees

3. Every holder of a certificate of registration or authorization, other than a holder of a certificate of registration authorizing supervised practice of a short duration or authorizing postgraduate education for an elective appointment or authorizing temporary independent practice, shall pay an annual fee.

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

(a) $1725 for holders of a certificate of registration other than a certificate of registration authorizing postgraduate education, a certificate of registration authorizing supervised practice of a short duration, or a certificate of registration authorizing temporary independent practice;

Council Briefing Note

December 2022

Topic:	Acceptable Qualifying Examinations
Purpose:	For Decision
Relevance to Strategic Plan:	• Right-Touch Regulation • Continuous Improvement
Public Interest Rationale:	**Accessibility:** Ensuring individuals have access to services provided by the health profession of their choice and individuals have access to the regulatory system as a whole
Main Contact(s):	Samantha Tulipano, Director, Registration and Membership Services
Attachment(s):	List relevant attachment(s) **Appendix A**: *Current Acceptable Qualifying Examinations Policy* **Appendix B:** *Statement from the FSMB and NBME regarding the discontinuation of the USMLE Step 2 CSA* **Appendix C**: *Proposed Acceptable Qualifying Examinations Policy*

Issue

- Council is being asked to consider proposing changes to the *Acceptable Qualifying Examinations* policy which would result in independent practice certificates being issued to individuals who meet the requirements set out in that policy.

Background

- In February 2005, Council agreed to accept certain alternative examinations as acceptable alternatives to Parts 1 & 2 of the Medical Council of Canada Qualifying Examination (MCCQE). The policy *Acceptable Qualifying Examinations* permitted issuance of an independent practice certificate where an applicant completed one of the alternate examinations and satisfied the requirements for issuance of an Independent Practice certificate.

- In February 2010, Council agreed to support the Federation of Medical Regulatory Authorities of Canada (FMRAC) recommendation for the "Canadian Standard" for a full unrestricted licence and agreed that in order to obtain a full unrestricted licence in Ontario, an individual would be required to hold an acceptable Medical Degree, Licentiate of the Medical Council of Canada (LMCC) and certification from the College of Family Physicians Canada (CFPC) or Royal College of Physicians and Surgeons of Canada (RCPSC).

- At the time Council was advised that the FMRAC agreement does not recognize examinations other than the MCCQE and was asked to modify the Acceptable Qualifying Examination policy.

- Accordingly, Council agreed to modify the Acceptable Qualifying Examination policy to indicate that applicants who completed examinations and obtained a qualification other than the LMCC would be subject to certain restrictions that included:

    - the physician must practise with a mentor and/or supervisor until they have successfully completed an assessment.

- A copy of the current policy is attached as *Appendix A*.

- While the College implemented the requirement to practise under supervision and undergo a practice assessment to ensure consistency with FMRAC standards for independent practice and the FMRAC agreement, other Colleges such as the College of Physicians and Surgeons of British Columbia (CPSBC), College of Physicians and Surgeons of Alberta (CPSA), College of Physicians and Surgeons of Saskatchewan (CPSS) College of Physicians & Surgeons of Nova Scotia (CPSNS), College of Physicians and Surgeons of Prince Edward Island (CPSPEI) and the College of Physicians and Surgeons of Newfoundland and Labrador (CPSNL) have continued to accept the identified alternate qualifications as equivalent without the additional requirements for supervision and assessment.

- In the aforementioned jurisdictions, these individuals are issued full/independent practice certificates.

Proposal:

- Council is being asked whether it approves amendments to the current policy removing the requirement for supervision and a practice assessment, and issuing individuals who have completed an acceptable alternate examination while meeting all other requirements set out in *Section 2(1) of Ontario Regulation 865/93, a certificate of registration authorizing* ***Independent Practice***.

- Additionally, as the Federation of State Medical Boards (FSMB) and the National Board of Medical Examiners (NBME) announced the discontinuation of the Step 2 Clinical Skills (CS) of the United States Medical Licensing Examination (USMLE), (Appendix B) the Committee is asked to remove this requirement from the list of alternative qualifications.

- This is in line with the policies on alternative qualifying examinations that exist in British Columbia and Nova Scotia.

Process for 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.

- Additionally, we are seeking Council's approval to permit the Executive Committee to approve the final policy (subject to feedback received) pursuant to its authority under Section 12 of the Code and Section 30 of the *General By-Law*.

Questions for Council

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

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

Appendix A: Current Acceptable Qualifying Examinations Policy

ACCEPTABLE QUALIFYING EXAMINATIONS

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.

Appendix B: Statement from the FSMB and NBME regarding the discontinuation of the USMLE Step 2 CSA

United States Medical Licensing Examination®

Work to relaunch USMLE Step 2 CS discontinued

Posted January 26, 2021

The Federation of State Medical Boards (FSMB) and NBME, co-sponsors of the United States Medical Licensing Examination® (USMLE®), are today announcing the discontinuation of work to relaunch a modified Step 2 Clinical Skills examination (Step 2 CS).

Following the May 2020 suspension of Step 2 CS due to the COVID-19 pandemic, we announced our intention to take 12-18 months to bring back a modified Step 2 CS exam that was appreciably better than the prior assessment. After reviewing current and anticipated progress with the exam and in consideration of the rapidly evolving medical education, practice and technology landscapes, we have decided to discontinue Step 2 CS. We have no plans to bring back Step 2 CS, but we intend to take this opportunity to focus on working with our colleagues in medical education and at the state medical boards to determine innovative ways to assess clinical skills.

Independent standardized assessments of medical knowledge and clinical skills are important inputs for state medical licensure decisions. In the absence of Step 2 CS, elements of clinical reasoning and communication will continue to be assessed on other exams (Steps) in the USMLE sequence. Computer-based case simulations in Step 3 and communication content recently bolstered in Step 1 are examples of these efforts that will continue. While not a replacement for Step 2 CS, these formats continue to contribute positively, e.g., measuring critical knowledge of medical communication.

Our change in direction will allow us to take additional time to partner with the medical education and medical board community to better develop innovative ways to assess the breadth of clinical skills in medicine.

For questions about the Step 2 CS discontinuation and any other USMLE-related inquiries please contact the USMLE support team: https://www.usmle.org/contact/

"The FSMB is committed to supporting state medical boards in their principal mission to protect the public," said Humayun J. Chaudhry, DO, MACP, President and CEO of the FSMB. "As co-sponsors of the USMLE program, we will continue to seek innovative and sensible ways to assess medical licensing eligibility."

"NBME's commitment to performance-based assessment and clinical skills has accelerated. Our newest area of focus around competency -based assessment, and our exploration of novel assessments, will allow us to work with the medical education and regulatory communities to develop assessments of these essential skills and the optimal way to integrate these assessments into the education and licensure space," said Peter J. Katsufrakis, MD, MBA, President and CEO, NBME.

ECFMG will continue to oversee requirements for its certification of International Medical Graduates (IMGs) and has announced an expansion of its pathways that will allow qualified IMGs to meet the requirements for ECFMG Certification and to continue to pursue U.S. graduate medical education.

Our Sponsors

NBME.org

FSMB.org

Resources

Bulletin of Information

Announcements

Common Questions

Appendix C: Proposed Acceptable Qualifying Examinations Policy

ACCEPTABLE QUALIFYING EXAMINATIONS

This Policy provides an alternative to the requirement for the successful completion of the Licentiate of the Medical Council of Canada (LMCC) Qualification.

Even if you are not a licentiate of the Medical Council of Canada, you may be eligible for a certificate of registration if you have successfully completed one of the following exams:

1. **USMLE Steps 1, 2 and 3**.
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.

The Registration Committee may direct the Registrar to issue a certificate of registration authorizing **independent practice** to applicants who have successfully completed one of the alternate examinations above 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	Acceptable Qualifying Examinations
Date of Meeting	December 8, 2022

It is moved by_____, and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario engage in the notice and consultation process in accordance with Section 22.21 of the Health Professions Procedural Code in respect of the draft revised Acceptable Qualifying Examinations policy (a copy of which forms Appendix " " to the minutes of this meeting).

Council Briefing Note

December 2022

Topic:	*Conflicts of Interest and Industry Relationships* – Draft Policy for Consultation
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation Meaningful Engagement
Public Interest Rationale:	Streamlining and setting expectations for physicians interacting with industry in clinical practice, CME/CPD, and research to support protection of patient's best interest and public trust in the profession.
Main Contact:	Alex Wong, Policy Analyst
Attachments:	Appendix A: *Conflicts of Interest and Industry Relationships* – Draft Policy Appendix B: *Conflicts of Interest and Industry Relationships* – Draft *Advice to the Profession*

Issue

- The College's *Physicians Relationships with Industry: Practice, Education and Research* ("*Industry*") policy is currently under review. A newly titled draft *Conflicts of Interest and Industry Relationships* policy has been developed and the companion *Advice to the Profession* ("*Advice*") document updated.

- Council is asked whether the draft policy can be released for external consultation and engagement.

Background

- The *Industry* policy was approved and last reviewed in 2014. A preliminary consultation on the policy took place from December 2021 to March 2022, receiving a total of 94 responses, including from four organizational respondents.[1] A majority of respondents were physicians. Council received an overview of feedback in the March 2022 and June 2022 Policy Report.

[1] The Ontario Medical Association (OMA), the Professional Association of Residents of Ontario (PARO), and the Information and Privacy Commissioner of Ontario (IPC) responded with written feedback; the Canadian Association of Radiologists provided a survey response.

- The draft policy was developed based on direction from the Policy Working Group[2] and was informed by the consultation feedback and research.

Current Status and Analysis

- The draft policy title has been revised to *Conflicts of Interest and Industry Relationships* for greater brevity and to signal the inclusion of content related to conflicts of interest that are specifically set out under Ontario Regulation 114/94 (the *General* regulation) under the *Medicine Act, 1991*.

    - The draft policy's structure and scope are largely retained from the current policy, with expectations set in the context of clinical practice, continuing medical education/continuing professional development (CME/CPD), consultation and advisory boards, and industry-sponsored research.

    - In response to consultation feedback indicating that most physicians were unaware of the *General* regulation's content and sought guidance in the situations described in the regulation (e.g., referrals or renting premises where the physician may receive a benefit), the draft policy includes a new section directing physicians to the relevant section of the regulation and setting out an additional expectation in this regard.

- The draft policy was revised to significantly streamline policy expectations, including by referring to established standards where they exist (including the *National standard for support of CPD activities*, the *Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans* (TCPS-2), and the International Committee of Medical Journal Editors' recommendations on authorship).

- The definition of "conflict of interest" was amended to incorporate the idea of primary and secondary interests.[3] Additional guidance on different types of interests is outlined in the *Advice to the Profession*.

- The draft policy reintroduces general expectations to guide all physician interactions with industry. Specifically, it requires transparency and proactive disclosure of conflicts of interest and the fulfilment of physicians' fiduciary duties by resolving conflicts in the patient's best interest.

- The draft policy expectations were strengthened with respect to the distribution of samples of drugs and devices, with the addition of a provision requiring physicians to consider the

[2] The Working Group is currently composed of Council Members Sarah Reid, Karen Saperson, Camille Lemieux, Rupa Patel, Fred Sherman, and Lydia Miljan, and CPSO Medical Advisor Keith Hay. Additional assistance was provided by Legal Counsel Alice Cranker.

[3] This definition aligns with usage in other guidance (including Canadian Medical Association's *Guidelines for physicians in interactions with industry* and the Institute of Medicine report *Conflict of Interest in Medical Research, Education, and Practice*.)

influence of industry on their prescribing choices and to use clinical evidence to choose the appropriate drug or device. Additional guidance is included in the *Advice to the Profession* regarding considerations for physicians distributing samples, including cost to patients.

Next Steps

- Subject to Council's approval, the draft policy will be released for external consultation and engagement.

- Feedback received as part of these activities will be shared with the Executive Committee and Council at a future meeting and used to further refine the draft.

Question for Council

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

Conflicts of Interest and Industry Relationships

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

Conflict of interest: A conflict of interest is created any time a reasonable person could perceive that a physician's judgments or decisions about a primary interest (e.g., the patient's best interests, unbiased medical research) are compromised by a secondary interest (e.g., direct financial gain, professional advancement). A conflict of interest can exist even if the physician is confident that their professional judgment is not actually being influenced by the conflicting interest or relationship.

Industry: The full range of commercial enterprises associated with health care. These include, but are not limited to, the pharmaceutical industry, the biotechnology industry, the medical device industry, and commercial providers of services related to clinical practice, research, and/or education.

Policy

General

Interactions between physicians and industry have the potential to benefit both physicians and patients by advancing medical knowledge and improving patient care. While industry has a valuable and legitimate role to play in the practice of medicine, sometimes the goals and interests of industry may be at odds with a physician's professional and legal obligations. This policy sets out expectations to help physicians navigate their interactions with industry and manage conflicts of interest which impact patient and public trust in physicians and the medical profession.

1. Physicians **must** maintain their clinical objectivity and professional independence when interacting with industry.

2. Physicians **must** identify situations or circumstances that are, may reasonably be perceived to be, or may lead to, a conflict of interest and avoid or appropriately manage them.

3. Physicians **must** fulfil their fiduciary duties to their patients by acting in good faith and in the patient's best interest when resolving conflicts of interest.[1]

4. Physicians **must** be transparent and proactively disclose conflicts of interest and details of their interactions with industry to the relevant parties (e.g., patients, research participants, institutions) where they may be reasonably perceived to influence the physician's judgment.

Conflicts of Interest under the *Medicine Act, 1991*

5. Physicians **must** avoid and appropriately manage conflicts of interests as set out in Part IV (ss. 15-17) of Ontario Regulation 114/94 ("the General regulation") under the *Medicine Act, 1991*.[2]

6. In addition to complying with the requirements set out in the General regulation when physicians are when ordering a diagnostic or therapeutic service to be performed by a facility in which the physician or a member of their family[3] has a proprietary interest, they **must** communicate to the patient that:
    a. the patient has the option to obtain the diagnostic or therapeutic service elsewhere; and
    b. the patient's choice will not affect the physician-patient relationship, or the quality of health services provided by the physician.

[1] The physician-patient relationship is a fiduciary relationship from which fiduciary duties arise. In this relationship, the balance of knowledge and information favours the physician, so that patients are reliant on their physicians and may be vulnerable. Patients rely on and must be confident that the physician has put the needs of the patient first.

[2] O. Reg. 114/94: GENERAL under Medicine Act, 1991, S.O. 1991, c. 30. The General regulation sets out when it is a conflict of interest for physicians to receive benefits from a supplier for patient referrals or of medical goods or services to patients; to rent premises; to sell or otherwise supply drugs, medical appliances, medical products, or biological preparations to patients at a profit; and to order a diagnostic or therapeutic service to be performed by a facility in which the physician or a member of their family has a proprietary interest. A physician is required to disclose the details of the proprietary interest to the College. The College's Conflict of Interest Declaration Form is available online.

[3] A "member of his or her family" is defined under s. 15 of the *General* regulation.

Industry Relationships in Clinical Practice

7. Physicians **must not** request or accept fees or equivalent compensation, personal gifts, or inducements of any value from industry in exchange for seeing industry representatives in a promotional or similar capacity.
    a. Where industry representatives are providing information about products or services, physicians are permitted to accept meals for themselves and appropriate staff but **must** only accept meals that are of modest value.

8. Physicians **must** critically evaluate any information provided by industry representatives and **must not** solely rely on this information when making clinical decisions regarding patient care.

9. Physicians **must** only distribute patient teaching aids provided by industry that:
    a. primarily entail a benefit to patients (i.e., have more educational than promotional value);[4,5]
    b. they are satisfied are accurate, balanced, and complete; and
    c. do not have value to the physician outside of their professional responsibilities.

Samples

10. Physicians who accept samples of drugs or devices from industry **must** comply with the expectations set out in relevant College policies.[6]

11. Physicians **must** consider the potential influence of samples on their prescribing choices and use clinical evidence to determine the appropriate choice of drug or device in alignment with the patient's best interests.

12. Physicians **must not** obtain any form of material gain for themselves or for the practice with which they are associated (including from selling or trading) when distributing samples.

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[4] It is preferable that patient teaching aids include at most the logo of the donor company and not refer to specific therapeutic agents, services, or other products.
[5] Section 33 of the *Personal Health Information Protection Act, 2004* (*PHIPA*) prohibits the collection, use, or disclosure of personal health information (PHI) for the purpose of marketing or market research unless the patient expressly consents. For example, physicians would not be permitted to use the PHI of their patients to determine which patients would benefit from receiving marketing information in respect of particular goods, service, products, equipment and devices without their express consent.
[6] Including the *Prescribing Drugs*, *Physician Treatment of Self, Family Members, or Others Close to Them*, and *Medical Records Documentation* policies.

Continuing medical education/Continuing professional development (CME/CPD)

Accredited CME/CPD

13. Physicians participating in industry-sponsored accredited CME/CPD activities and events **must** comply with guidelines outlined by relevant accrediting bodies, including the *National standard for support of accredited CPD activities*.

Unaccredited CME/CPD

14. Physicians who organize and/or present at industry-sponsored unaccredited CPD/CME activities and events **must** only accept reasonable honoraria and reimbursement for hospitality (i.e., travel, lodging, and/or meal expenses).

15. Physicians who attend industry-sponsored unaccredited CPD/CME activities and events **must not** accept reimbursement or subsidies for hospitality, outside of modest meals or social events that are held as part of the activity or event.

Consultation or advisory boards

16. Physicians who sit on advisory or consultation boards or who serve as individual advisors or consultants to industry organizations **must**:
    a. enter into a written agreement setting out the details of the arrangement;
    b. only agree to impart specialized medical knowledge that could not otherwise be acquired by the organization;
    c. not engage in promotional activities on behalf of the organization while in this position;
    d. ensure that all information presented is accurate, balanced, and complete where relevant in the course of their practice, research, or teaching, and when providing educational activities on behalf of the company; and
    e. only accept compensation that is reasonable and commensurate with the services provided.[7]

[7] Reasonable compensation can be at fair market value. Parameters such as time, expenditure, and complexity of the work required may be relevant considerations in determining compensation amount.

Industry-sponsored research

17. Physicians **must** only participate in industry-sponsored research that is ethically defensible, scientifically valid, and that complies with relevant national guidelines, including the *Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans* (TCPS-2), regardless of the source of funding.
    a. Physicians **must** have the approval of a research ethics board when participating in research involving human participants, including post-marketing surveillance studies (phase IV clinical research) and research that only involves the use of personal health information.

18. Physicians **must** ensure that patients are provided full disclosure of all information necessary to make an informed and voluntary decision to consent to participate in a research project,[8] including, but not limited to:
    a. the relative probability of harms and benefits of participating and all risks, including those which are rare or remote, especially if they entail serious consequences;[9]
    b. the nature of the benefit (i.e., the type of benefit and amount of any compensation) the physician will receive for recruiting the patient for participation in the research study; and
    c. that they have the right to decline to participate or to withdraw from the study at any time, without prejudice to their ongoing care.

19. Physicians **must** comply with their legal obligations under the *Personal Health Information Protection Act, 2004* (*PHIPA*) when collecting, using, or disclosing personal health information in relation to all research initiatives.[10]

Compensation

20. Physicians **must** only accept compensation for participation in industry-sponsored research, including attending Investigator Meetings, that is reasonable and commensurate with services provided.

21. Physicians **must** only accept compensation for recruiting patients into a research study if the physician was required to undertake activities beyond their normal

[8] For more on the consent process and information generally required for informed consent see Chapter 3 of the TCPS-2 and the *Advice to the Profession*.
[9] *Halushka v. University of Saskatchewan* (1965), 53 D.L.R. (2d) 436 (Sask. C.A.); *Weiss v. Solomon* (1989), 48 C.C.L.T. 280 (Qc. Sup. Ct.).
[10] For the definition of "personal health information", see section 4 of *PHIPA*. For more information about the legislative and regulatory requirements under *PHIPA*, see the *Advice to the Profession*.

practice (e.g., meeting with patients, discussing the study, and obtaining knowledgeable consent for the disclosure of personal health information).[11]

a. Physicians **must not** accept finder's fees (i.e., payments for identifying or recruiting a patient into a trial, whereby the sole activity performed by the physician is to disclose the names of potential research participants).

Dissemination of research results

22. Physicians **must** only be included as an author of a published article reporting the results of industry-sponsored research if they meet the authorship criteria set out by the International Committee of Medical Journal Editors (ICMJE).[12]

    a. Physicians **must** only agree to be published as author if all contributors are identified as authors, if applicable, or acknowledged as contributors.

23. Physicians **must** make reasonable efforts to disseminate the analysis of data and interpretation of research results in the spirit of good science and in the interest of contributing to the existing body of knowledge, including by **not** knowingly being involved in concealing research results or presenting them in a misleading fashion.[13]

[11] Consent is considered knowledgeable if it is reasonable to believe that the individual knows the purpose of the disclosure and knows that they can give or withhold consent.

[12] Specifically, the criteria found in the ICMJE Recommendation *Defining the Role of Authors and Contributors*.

[13] For more on dissemination of research results, see Article 4.8 of the TCPS-2.

Advice to the Profession: Conflicts of Interest and Industry Relationships

Advice to the Profession companion documents are intended to provide physicians with additional information and general advice in order to support their understanding and implementation of the expectations set out in policies. They may also identify some additional best practices regarding specific practice issues.

The practice of medicine can often involve interaction between physicians and industry. These interactions have the potential to benefit both physicians and patients by advancing medical knowledge and improving patient care. While industry has a valuable and legitimate role to play in the practice of medicine, sometimes the goals and interests of industry may be at odds with a physician's professional and legal obligations, and physicians may find themselves facing ethical dilemmas or conflicts of interest stemming from their relationships with industry. This can have the potential to adversely affect the physician-patient relationship and public trust in the profession.

The *Conflicts of Interest and Industry Relationships* policy does not discourage appropriate physician-industry interactions, but instead aims to assist physicians in managing their relationships with industry appropriately. This companion *Advice* document is intended to provide guidance on how to interpret and effectively discharge the obligations set out in the policy.

General

What circumstances are considered conflicts of interest under the Medicine Act, 1991*?*

In summary, under Part IV of Ontario Regulation 114/94 under the *Medicine Act, 1991*, it is a conflict of interest for physicians to:

- receive any benefit,[1] directly or indirectly, from a supplier (to whom the physician refers patients/specimens or who supplies medical goods or services to the physician's patients);
- rent premises to or from a supplier, except where the rent is normal for the area and the amount of rent is not related to the referral of patients to the landlord;
- sell or otherwise supply any drug, medical appliance, medical product, or biological preparation to a patient at a profit, except:

[1] S. 15 of O. Reg. 114//94 under the *Medicine Act, 1991* defines "benefit."

    - a drug that is necessary
        - for immediate treatment of the patient;
        - in an emergency; or
        - where the services of a pharmacist are not reasonably readily available;
    - an allergy preparation sold or supplied for a price subject to limits;[2]
- order a diagnostic or therapeutic service to be performed at a facility in which they or their family have a proprietary interest, unless the interest is disclosed in advance to the patient, or the facility is a publicly-traded corporation and not owned or controlled by the physician or a member of their family.

When disclosing to a patient the fact that you or a family member has a proprietary interest in a facility where a diagnostic or therapeutic service will be performed, it is important that, at a minimum, the notice is clearly written (e.g., a sign or a form).

How can I appropriately manage conflicts of interest?

In general, it is best practice to avoid conflicts of interest altogether (e.g., by withdrawing or removing oneself from the situation); however, this may not always be possible depending on the circumstances. In addition to disclosing conflicts to patients, making patients aware of alternatives, and offering reassurance that the patient's choice of an alternative will not affect the quality of care, you can also:

- Where applicable, after disclosing the conflict of interest, obtain consent from the patient prior to providing any medical advice or treatment and ensure that the conflict does not affect your decisions about the patient's care.
- Document the details of disclosure and relevant outcomes in the patient's medical record.

In other contexts, such as when participating in continuing medical education or continuing professional development (CME/CPD) activities or conducting research, there are relevant guidelines and/or standards to follow to determine when and how best to disclose and manage conflicts of interest.

It is important to remember that any conflict must be resolved in the best interests of the patient and that you are able to demonstrate that the patient's best interests have been maintained at all times.

[2] S. 16(d)(ii) of O. Reg. 114/94 under the *Medicine Act, 1991.*

The policy defines "conflict of interest" as involving primary and secondary interests. What are examples of these types of interests?

The primary interests of physicians can vary according to the activity they are engaged in. For instance, a primary interest can be providing care in the patient's best interests, conducting unbiased medical research, or fostering high-quality medical education. Patients, the public, research participants, and medical learners need to trust physicians to act in ways that are consistent with these primary interests.[3] Secondary interests can often be in the form of financial gain; however, they can also include the desire for professional advancement or recognition of personal achievement.

Frequently, interests may be described in terms of being direct or indirect, financial or non-financial, and personal or professional. For example:[4]

- **Direct financial interest:** when a physician receives a direct benefit or payment such as industry-sponsored speaking engagements.
- **Indirect financial interest**: when a physician receives an indirect benefit such as industry funding for research.
- **Non-financial interest:** where physicians receive a secondary benefit not related to a payment such as recognition of professional achievement.
- **Personal interest:** where a physician's relative receives a secondary benefit such as referring patients to businesses or facilities in which the relative holds a material financial interest, including diagnostic and/or treatment facilities.

How can I determine whether a primary interest is compromised by a secondary interest?

Whether a primary interest is compromised by a secondary interest is a matter of judgment and depends on the context. Relevant factors to consider in assessing the likelihood and seriousness of a conflict of interest can include:[5]

- **Monetary value:** the greater the value of the secondary interest, the more likely its actual or perceived influence.
- **Scope (duration and depth) of a relationship:** longer and closer associations can increase the risk.
- **Authority and discretion in a role:** certain roles (e.g., Principal Investigator) may afford more discretion and influence in making important decisions.

[3] Lo, Bernard and Field, Marilyn J. *Conflict of Interest in Medical Research, Education, and Practice.* (2009) Institute of Medicine (US) Committee on Conflict of Interest in Medical Research, Education, and Practice.
[4] *Professional Standards Regarding Conflict of Interest*, College of Physicians and Surgeons of Nova Scotia.
[5] Lo, Bernard and Field, Marilyn J. *Conflict of Interest in Medical Research, Education, and Practice.* (2009)

- **Scope of consequences:** conflicts that can impact many patient care decisions (e.g., developing clinical practice guidelines) may have more potential for harm.
- **Extent of accountability:** the availability of accountability measures can reduce the likelihood or severity of harm.

How can I support medical students and postgraduate trainees in avoiding and managing conflicts of interest and interacting with industry appropriately?

Physicians are responsible for modelling professional and ethical behaviour for medical students and postgraduate trainees by acting in accordance with this policy. It is important that students and trainees do not feel pressured to interact with industry where they are uncomfortable doing so and that there be a safe and supportive environment for reporting any concerns around the interpretation of CPSO's policy with physician supervisors/educators.

Industry Relationships in Clinical Practice

Why does the policy prohibit accepting gifts or inducements from industry?

A large body of empirical evidence demonstrates that accepting gifts or inducements of *any* value can influence and undermine a physician's independent clinical judgment, even without the physician's awareness.[6] The expectations contained in this policy are rooted in this research and align with expectations of other stakeholders.

In general, it is important to exercise caution and critically evaluate any information provided by industry representatives. Physicians may sometimes find it helpful to meet with industry representatives to learn about a drug or medical device. However, there is a lack of evidence demonstrating that interactions with industry representatives produce educational benefits. Research indicates that industry representatives may be less likely to discuss a drug's risks and adverse effects than its benefits and has found an association with costlier and lower quality prescribing.[7]

[6] For examples, please see the following articles:
- Katz, Dana, Caplan, Arthur, & Merz, Jon. (2003, June 1). All Gifts Large and Small: Toward an Understanding of Pharmaceutical Gift Giving. *University of Pennsylvania Scholarly Commons – Center for Bioethics Papers*.
- Spurling, GK, et al. Information from Pharmaceutical Companies and the Quality, Quantity, and Cost of Physicians' Prescribing: A Systematic Review. (2010). *PLoS Med*. 7(10), e1000352.
- Brax H, et al. Association between physicians' interaction with pharmaceutical companies and their clinical practices: A systematic review and meta-analysis. (2017) *PLoS One*. 12(4):e0175493.

[7] Spurling, GK, et al.

What is considered a meal of "modest" value?

While CPSO is unable to provide a specific dollar value, physicians can exercise individual judgments and take into consideration the reasonable expectations of their patients in assessing whether a meal is of "modest" value.

What do I need to consider when distributing drug samples to patients?

Samples are primarily used by companies for marketing and promotional purposes, which can raise concerns about their influence on physician prescribing. While samples can be beneficial for patients in certain circumstances (e.g., by allowing physicians to initiate therapy immediately, evaluate clinical performance of medication for a patient, and/or offset costs), they can also lead to the use of medications that are not a physician's first choice and which are costlier than other medications, potentially leading to higher out-of-pocket costs for patients when samples run out.

You must consider the influence of samples on your prescribing and use clinical evidence for therapeutic decisions. This includes taking into account whether the sample is your first choice of treatment and any impact that using samples may have on the patient's current and future costs. If the sample is of a medication which the patient may use on a long-term basis, you may wish to consider discussing with the patient other options for obtaining medications if they are available, for example, through the Ontario Drug Benefit Program or other patient assistance programs.

Continuing Medical Education/Continuing Professional Development (CME/CPD)

Can students/trainees receive funds from industry to attend CME/CPD events?

Scholarships or other funds from industry to permit undergraduate medical students or post-graduate trainees (including fellows) to attend CME/CPD events can be dispensed as long as their academic institution selects the participants for these funds.

Are there expectations I need to know related to unaccredited CME/CPD events?

The *National standard for support of accredited CPD activities* Element 7 sets out responsibilities for organizers of CME/CPD events, specifying that unaccredited CME/CPD events cannot take place at times and locations that interfere or compete with accredited CME/CPD activities and cannot be listed or included within activity agendas, programs or calendars of events (preliminary and final).

Physicians attending informal or non-accredited learning activities with industry involvement will need to approach these activities with caution due to a higher likelihood that such events are promotional in nature. Physicians may wish to follow the guidance set out in the Canadian Medical Association's (CMA) *Guidelines for physicians in interactions with industry*.

Consultation or Advisory Boards

What do I need to be aware of when serving in a consultant or advisory role for industry?

In these roles, it is important to be attentive to the perception of bias when attending meetings and when receiving remuneration. It is generally preferable to attend meetings in your geographic locale or those which form part of a meeting that you would normally attend; however, factors such as the remoteness of your location and the availability of virtual meetings can be taken into consideration. When these arrangements are not feasible, reasonable travel and accommodation expenses may be reimbursed.

What do I need to be aware of if I am developing clinical practice guidelines (CPG)?

The Guidelines International Network's (GIN) *Principles for disclosure of interests and management of conflicts in guidelines*, formulates core principles for disclosing and managing conflicts of interest for physicians involved in CPG development.

Industry-Sponsored Research

What do I need to know when participating in industry-sponsored research?

Physicians participating in industry-sponsored research must continue to meet expectations of all physicians participating in research generally. The principles and responsibilities articulated in the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (TCPS-2) are broadly applicable to physicians conducting research involving human participants.[8] When conducting research with First Nations, Inuit, and Métis peoples, physicians may refer to Chapter 9 of the TCPS-2 and consider the application of the First Nations Principles of OCAP.

While research involving human participants can result in benefits that positively affect society, often there is little to no direct benefit to individual participants. Research can pose various risks to individuals and impact vulnerable populations. When conducting industry-sponsored research, it is important that the primary objective of research be the advancement of the health of the public rather than the private good of either

[8] *Stirrett v Cheema,* 2018 ONSC 2595, at para. 5; *Barker v. Barker,* 2020 ONSC 3746, at para. 1171.

physicians or industry. Seeking approval from a research ethics board (REB) can minimize the risk to patients. It is also important that the REB operate by appropriate governance and procedures.

What information needs to be disclosed to patients for consent to be informed?

A physician's duty towards research participants can be greater than their duty towards a patient because of the experimental nature of the research and the lack of corresponding therapeutic benefit to the research participant that there would be for a patient. Therefore, obtaining consent for participation in research can require a higher level of disclosure than what is typically required when obtaining consent to treatment.

The TCPS-2 requires researchers to provide prospective participants full disclosure of all information necessary for making an informed decision to participate in a research project. Chapter 3 outlines information that may be required, including:

- the identities of the researcher and the funder or sponsor; and
- information concerning any real, potential or perceived conflicts of interest on the part of the researchers, their institutions, or the research sponsors.

Can I participate in post-marketing surveillance studies?

Physicians must only participate in industry-sponsored research that is ethically defensible and scientifically valid. Post-marketing surveillance studies that are scientifically appropriate for drugs or devices relevant to their area of practice and where the study may contribute to medical knowledge about the drug or device may meet these criteria. However, post-marketing surveillance studies that are clearly intended for marketing or other purposes are not.

What are the authorship criteria for publishing articles reporting research results?

The policy refers to the International Committee of Medical Journal Editors (ICMJE) which has developed Recommendations of best practice and ethical standards in the conduct and reporting of research and other material published in medical journals. The ICMJE recommends that authorship be based on meeting four criteria, related to making substantial contributions to the work, drafting or revising the work, final approval of the version to be published, and agreeing to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

What do I need to know about collecting, using, and/or disclosing personal health information when participating in industry-sponsored research?

Physicians must comply with the *Personal Health Information Protection Act, 2004 (PHIPA)* when collecting, using, or disclosing personal health information (PHI). In general, physicians must only collect, use, or disclose PHI if they have the patient's consent, or if the provisions under *PHIPA* which permit the collection, use, or disclosure of PHI for research purposes without consent have been satisfied. Physicians can seek a patient's consent even if an exception to the consent requirements applies and may wish to make reasonable efforts to obtain a patient's consent before disclosing their information whenever possible.

Relevant resources from the Canadian Medical Protective Association (CMPA) and the Information and Privacy Commissioner of Ontario (IPC) can be found below. Further guidance can also be found in Chapter 5 of the TCPS-2.

Can I respond to industry requests to contact patients directly?

Where third party researchers received PHI from a physician about the physician's patients under s. 44(1) of *PHIPA,* they are prohibited from contacting those patients, either directly or indirectly, unless the physician has obtained the patient's consent to be contacted by the researcher (s. 44(6)(e)). If the researcher obtained information by other means, *PHIPA* does not prohibit the researcher from contacting the individuals.

Resources

Canadian Medical Association

Guidelines for physicians in interactions with industry / Recommendations for physician innovators

Canadian Medical Protective Association

Clinical research
Medical-legal issues to consider with clinical research contracts
Physicians and research: Understanding the legal, ethical, and professional obligations

Information and Privacy Commissioner of Ontario

Consent and your personal health information
Use and Disclosure of Personal Health Information for Broader Public Health Purposes

Council Motion

Motion Title	*Conflicts of Interest and Industry Relationships* – Draft Policy for Consultation
Date of Meeting	December 9, 2022

It is moved by_____, and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario engage in the consultation process in respect of the draft policy, "Conflicts of Interest and Industry Relationships," (a copy of which forms Appendix " " to the minutes of this meeting).

Council Briefing Note

December 2022

Topic:	Update of General By-Laws – Signing Officer Title
Purpose:	For Decision
Relevance to Strategic Plan:	Continuous Improvement
Main Contact(s):	Marcia Cooper – Senior Corporate Counsel & Privacy Officer Douglas Anderson – Corporate Services Officer Leslee Frampton – Manager, Finance Department
Attachment(s):	Appendix A: General By-Laws Part 1. Business Practices

Issue

The General By-Law Part 1. Business Practices needs to be updated to reflect the change in title for the Chief Transformation Officer to Chief Operating Officer for purposes of the signing authorities.

Background

The General By-Law Part 1. Business Practices sets out the titles of those at the College who are signing officers or have signing authority in certain circumstances. Currently, it includes the Chief Transformation Officer. This title has recently changed to Chief Operating Officer. This needs to be updated to reflect the current structure of the College.

Current Status and Analysis

This is a "housekeeping item" but necessary to ensure there is no future ambiguity around the validity of signed documents.

These amendments do not need to be circulated to the profession prior to final approval.

Question for Council

1. Does Council approve the proposed by-law amendments set out in Appendix A?

APPENDIX A

General By-law
Part 1. Business Practices

1a. Except as provided otherwise in section 4 of this By-Law, contracts, agreements, instructions and other documents shall be signed on behalf of the College by the registrar/chief executive officer, a deputy registrar or chief ~~transformation~~operating officer.

Expenses

4. (1) Goods may be purchased or leased, and services may be obtained, for the benefit of the College if the purchase, lease or obtaining of services is authorized by, and except as provided in subsection 4(2)(b),any contract or agreement for or relating to such purchase, lease or services shall be signed by,

…

c. two of the registrar, a deputy registrar, chief ~~transformation~~operating officer or corporate services officer if the resulting obligation exceeds $100,000 but does not exceed $250,000 and the expenditure is not authorized by the College budget;

d. after conferring with the chair of the finance and audit committee, one of the registrar, a deputy registrar, chief ~~transformation~~operating officer or corporate services officer and one of the president or vice-president, if the resulting obligation exceeds $250,000 and the expenditure is not authorized by the College budget; or

…

(6) Despite subsection 4(2), an offer of employment or an agreement for employment with the College, which employment position is authorized by the College budget, shall be signed by the director or associate director of the department in which the employee is to be working, the manager responsible for hiring the employee, the associate director of Human Resources, the chief ~~transformation~~operating officer, the registrar or a deputy registrar.

(7) For purposes of Part 1 of the General By-law, the term “signing officer” means any of the following: the registrar, a deputy registrar, the chief ~~transformation~~operating officer, the corporate services officer, the manager of finance and the corporate accountant. A person listed as a signing officer in subsection 4(7) may not sign a cheque or authorize an electronic transfer of funds payable to such person.

Council Motion

Motion Title	By-law Amendment re Change of Signing Authority Title
Date of Meeting	December 9, 2022

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. 154:

By-law No. 154

Section 1a, subsections 4(1)(c) and (d), subsection 4(6) and subsection 4(7) of the General By-law are amended by deleting the reference in each to “chief transformation officer” and substituting it with “chief operating officer”.

Council Briefing Note

December 2022

Topic:	District Elections for 2023 and By-law Amendment
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation, Meaningful Engagement, Continuous Improvement
Public Interest Rationale:	Ensuring that Council elections are appropriately governed.
Main Contacts:	Caitlin Ferguson, Governance Coordinator Laura Rinke-Vanderwoude, Governance Analyst Marcia Cooper, Sr. Legal Counsel and Privacy Officer
Attachment:	Appendix A: By-law Amendments to Change Timing for District Elections

Issue

- Council is asked to approve the 2023 District Election dates and accompanying proposed by-law amendment.

Background

- The Governance Committee previously provided feedback on and approved a revised approach to Council District, Executive Committee, and Governance Committee Elections to ensure adequate time for the elections, avoid overlaps and minimize administrative issues.

Current Status and Analysis

- Based on this approach, the Governance Committee proposed the following 2023 District Election dates, with minor adjustments to the Notice of Election date by the Executive Committee:

Month	Key Activity
January 27	Notice of Election Distributed
February 24	Election Nominations Due
March 21	Governance Committee to review Nomination statements

March 29	Voting begins
April 19	Election Day
April 24	Recount Deadline
April 26	Results released
December	Successful candidates begin their Council term at close of December Council meeting

- In order to implement these dates, a by-law amendment is required to modify the timelines required for Council District elections. The proposed amendment is attached as Appendix A. The change does not require circulation prior to enactment.

Question for Council

1. Does Council approve the proposed by-law amendments and 2023 District Election dates?

Election Date

12. (1) A regular election shall be held in,

(a) April, May or June 2020, and in every third year after that for Districts 5 and 10;

(b) April, May or June 2021, and in every third year after that for Districts 6, 7, 8 and 9; and

(c) April, May or June 2022, and in every third year after that for Districts 1, 2, 3 and 4.

(2) Subject to subsection (1), the council shall set the date for each election of members to the council.

Council Motion

Motion Title	By-law Amendments re Election Dates
Date of Meeting	December 9, 2022

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. 155:

By-law No. 155

Subsection 12(1) General By-law is revoked and substituted with the following:

12. (1) A regular election shall be held in,

(a) April, May or June 2020, and in every third year after that for Districts 5 and 10;

(b) April, May or June 2021, and in every third year after that for Districts 6, 7, 8 and 9; and

(c) April, May or June 2022, and in every third year after that for Districts 1, 2, 3 and 4.

Council Briefing Note

December 2022

Topic:	Governance 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 Governance Committee.
Main Contacts:	Cameo Allan, Manager of Governance Laura Rinke-Vanderwoude, Governance Analyst
Attachment:	Appendix A: Nomination Statements

Issue

- There are three upcoming vacancies for the Governance Committee for 2022. The General By-Law sets out Governance Committee composition requirements and the convention has been to hold an election to fill these vacancies.

Background

- Section 44 of the College's General By-law states that the Governance Committee shall be comprised of the President, Vice-President, and a Past-President of Council, as well as one physician Council member and two public Council members who are not members of the Executive Committee. The term for all Governance Committee members is one year.

- An election is required for the purpose of selecting the two public and one physician Council members. If the number of nominations matches the number of open positions in the Governance Committee, they may be acclaimed rather than elected.

- All Governance Committee members are expected to demonstrate the key behavioural competencies set out in the Council Profile.

Current Status and Analysis

- Dr. Janet van Vlymen (2022-2023 Past President) is slated for appointment by Council to the Governance Committee in her upcoming capacity as Past President. As such, Dr. van Vlymen will serve as the Governance Committee Chair for 2022-2023.
- Dr. Robert Gratton (2022-2023 President) and Dr. Ian Preyra (2022-2023 Vice-President) will also be appointed to the Governance Committee by Council.
- Out of the remaining three vacancies, one must be filled by a physician member of Council and two must be filled by public members of Council.
- At the date of this Briefing Note, nominations for the physician vacancy have been received from Dr. Rupa Patel, Dr. Anne Walsh, and Dr. Patrick Safieh.
- In addition, nominations for the public member vacancies have been received from Ms. Julia Goyal, Ms. Shannon Weber, and Mr. Rob Payne.
- Nominations from the floor will also be accepted on the day of the election.
- As per the General By-Law, the term for Governance Committee members is one year.

Next Steps

- All nominees will be given the opportunity to address Council prior to the election.
- Elections for the physician and public member positions 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.
- Results will then be tabulated, and Council will have the opportunity to appoint members for the 2022-2023 Governance Committee.

Question for Council

1. Who does Council appoint to fill the three vacancies on the Governance Committee for 2022-2023?

Governance Committee Elections

Nomination Statement & Form: Julia Goyal

Ms. Julia Goyal, Public Member of Council (Waterloo)

Occupation: PhD Student

Nominated For:

Member, Governance Committee

Appointed Council Terms:

2021-2024

CPSO Involvement:

Ontario Physicians and Surgeons Discipline Tribunal	2021-Present
Fitness to Practice Committee	2021-Present

Nomination Statement:

As a member of the Board and/or Governance Committee of various organisations in the arts and health sectors, I have been directly involved in their transition to Ontario's Not-for-Profit Corporations Act, and have seen first-hand just how important strong governing structures and policies are to the governance and operations of any organisation. These organisations include the Canadian Association for Research on Work and Health, Canadian Mental Health Association (CMHA) Waterloo-Wellington (Canada's largest CMHA chapter), and Kitchener-Waterloo Symphony, among others. In the past, I have served as Chair of the Graduate Studies Endowment Fund, Senator and Governor at the University of Waterloo (UW).

I am pursuing my joint-doctorate in Public Health Sciences and Mechanical and Mechatronics Engineering at UW. I have completed the Ontario Hospital Association's Governance Essentials for New Directors and the ICD-Rotman Governance Essentials Program. I intend to bring my learnings from my past and present roles in governance, in addition to my governance education, to further advance the College's important work in governance modernization. I have thoroughly enjoyed my work as a member of Council and the Discipline Tribunal the past year, and would like to continue to support the College as a member of the Governance Committee.

Governance Committee Elections

Nomination Statement & Form: Rupa Patel

Dr. Rupa Patel, District 6 Representative (Kingston)

Principal area of practice: Family Medicine

Nominated For:

Member, Governance Committee

Appointed Council Terms:

2021-2024

CPSO Involvement:

Ontario Physicians and Surgeons Discipline Tribunal	2021-Present
Fitness to Practice Committee	2021-Present
Policy Working Group	2021-Present

Nomination Statement:

I am pleased to put my name forward for membership on the CPSO governance committee. The governance committee plays a large role in the College activities and I would like to learn more about the processes and policies that define the CPSO.

I am hoping that the diversity of my personal and professional experience will be an asset to the committee. I have worked extensively in many practice settings over the past 27 years including remote and rural Northern Ontario as well as hospitalist, GP-oncology work and family medicine obstetrics. My current work as a family physician in a Community Health Center allows me to work in a team based practice with multiple health care professionals. I have also been part of numerous community boards and health care organizations. This work has given me an ability to collaborate respectfully with others and participate productively on committees.

I am deeply committed to primary care and public service. I am passionate about providing care to the most vulnerable in our communities. I believe I have a systems based or “big picture” perspective when identifying priorities. I am adaptable, respectful and accountable in my work.

Thank you for your consideration.

MS. SHANNON WEBER

Public Member of Council
Waterloo, Ontario

Occupation:
Faculty Lead – Conestoga College School of Business
Leadership & Governance Consultant

Appointed Council Terms:
2020-2021
2021-2024

CPSO Committees and Other CPSO Work:

Discipline Tribunal	2020-Present

STATEMENT:
(200 words or less)

I am honoured to be nominated for re-election to the CPSO Governance Committee. I have served on this Committee over the past year and offer my service and opportunity for some continuity on the committee.

With your support, I will bring many years of governance and leadership experience working with numerous public and not-for-profit Boards and leadership teams. In addition, I have served as a governance coach and consultant both independently and as an Executive-in-Residence with Capacity Canada. One of the many effective governance tools that I have used is a generative form of stakeholder engagement. I would like to explore this approach with CPSO to further engagement of Council members with our mission and governance activities.

I have additional experience in both external relations and human resource management. I currently teach in a graduate business program at Conestoga College and have recently served in a variety of community organizations, including as: Coach for Girls on Boards program at Fora Network & Startup Laurier; as Strategic Planning Advisor for the KW4 Ontario Health Team; and as an advisor with Wellbeing Waterloo Region.

I appreciate your consideration of my interest in serving the CPSO in this capacity.

Governance Committee Elections

Nomination Statement & Form: Rob Payne

Mr. Rob Payne, Public Member of Council (King City)

Occupation: Financial Advisor

Nominated For:

Member, Governance Committee

Appointed Council Terms:

2020-2021
2021-2024

CPSO Involvement:

OPSDT & FTP Committee	2020-Present
Finance & Audit Committee	2020-Present

Nomination Statement:

Rob is currently a Financial Advisor at Edward Jones Investments and public board member of the College of Physicians & Surgeons of Ontario. In addition, he is a member of the OPSDT, FTP and Finance & Audit Committee. He is a strategic, active listener and active member of his local community. Rob has a solid track record for implementing processes for effective decision making, accountability and inspiring strategic thinking and communicating a clear and compelling vision. Finally, Rob has successfully managed large cross-functional teams to deliver exceptional performance through contagious energy, drive and passion.

Governance Committee Elections

Nomination Statement & Form: Patrick Safieh

Dr. Patrick Safieh, District 10 Representative (Toronto)

Principal area of practice: Family and Emergency Medicine

Nominated For:

Member, Governance Committee

Appointed Council Terms:

2017-2020
2020-2023

CPSO Involvement:

Quality Assurance Committee	2008-Present

Nomination Statement:

Thank you for considering me for a position on the Governance Committee. I have a long history with the CPSO as well as multiple hospital leadership roles which enables me to be an effective, experienced and knowledgeable member of the Governance Committee.

I have been involved with the CPSO as a Peer Assessor (2000-2008), a non-Council member (2008-2017, three of which as co-chair), and as a Council Member (since 2017), as well as being Chief of Family Medicine (St. Joseph's Health Centre, Humber River Hospital), Chief of Emergency Medicine and Chief of Staff. Currently I am involved in working on a new Family Medicine Teaching Unit at Humber River Hospital, while also continuing active clinical practice (both in my busy and diverse family practice & in Emergency). In addition to my formal leadership positions, I have acted as a mentor and provided encouragement to my colleagues, including during the challenges of the pandemic.

Personally, I am married to a family physician for 31 years and have four adult children. I enjoy travelling, cycling and spending time with my family and friends. I consider myself to be well balanced (although maybe work a bit too much according to my wife!).

Governance Committee Elections

Nomination Statement & Form: Anne Walsh

CPSO

Dr. Anne Walsh, District 5 Representative (Newmarket)

Principal area of practice: Obstetrics and Gynecology

Nominated For:

Member, Governance Committee

Appointed Council Terms:

2020-2023

CPSO Involvement:

Inquiries, Complaints and Reports Committee	2018-Present

Nomination Statement:

I have had the privilege of completing two years as a member of CPSO Council and this, in combination with an increasing variety of roles and responsibility on ICRC, leads me to believe I have the experience and knowledge required to allow me to further serve the College in a Governance role.

My previous experience, sitting on my hospital's Medical Advisory Council, taught me the detailed administrative requirements of a medical institution which translate well to the workings of a Regulatory Body.

As Chief of Obstetrics, I spearheaded the creation of a Policy Review process which continues in our institution today. From the public/patient perspective, an external poll ranked us first place for provision of Maternity Service in Ontario.

I have received a recognition award for my multidisciplinary and inclusive approach, and I thrive working in a collaborative setting.

The education provided to me on Council, including knowledge of EDI and Right Touch Regulation, will be applied to Committee work. I plan to promote education through quality improvement whilst being mindful of our CPSO vision.

With these abilities in my toolbox, I would appreciate the opportunity to fulfill my fiduciary commitment and serve further on the Governance Committee of CPSO.

Council Motion

Motion Title	Governance Committee Elections
Date of Meeting	December 9, 2022

It is moved by_____, and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario appoints the following individuals to the 2022-2023 Governance Committee each for a one-year term commencing upon the adjournment of the Annual General Meeting of Council in December 2022:

Dr. Janet van Vlymen, Chair
Dr. Robert Gratton, Vice-Chair
Dr. Ian Preyra – Vice President
X – Physician Member of Council
X – Public Member of Council
X – Public Member of Council

Council Briefing Note

December 2022

Topic:	Chair and Vice-Chair Appointments and Re-appointments
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation System Collaboration
Public Interest Rationale:	Accountability: Ensuring that CPSO committees have qualified and diverse members will enable the College to carry out its strategic objectives and fulfill its mandate to serve in the public interest.
Main Contact(s):	Caitlin Ferguson, Governance Coordinator Cameo Allan, Manager of Governance

Issue

- The Executive Committee is making recommendations to Council for the appointment of Chairs and Vice-Chairs of several committees and specialty panels.

Background

- The Governance and Executive Committees have recommended individuals for appointment to fill multiple Chair, Vice-Chair, Specialty Panel Chair, and Specialty Panel Vice-Chair vacancies.

Current Status and Analysis

- The Committees and ICRC Specialty Panels listed in the table below have Chairs and/or Vice-Chairs whose leadership term expires at the conclusion of the Annual General Meeting of Council in 2022.

- Committee leadership and Committee Support have been canvassed regarding succession planning for these leadership positions.

- Candidates for leadership positions have been approached by either the current Chair, current Vice-Chair, Committee Support, or a member of the Governance Office to confirm that they are willing and able to take on a leadership position.

- Governance staff have verified that the members are eligible to serve the term(s) suggested without reaching their term limit for the individual committee or their overall term limit for service on Council and committees.

- As those appointed to a Vice-Chair role typically serve a subsequent 2-year term as Chair, Governance staff have also verified that all candidates nominated for a Vice-Chair or Specialty Vice-Chair appointment have at least 4 years remaining before reaching their term limit for the committee in question.

- Several committees have requested to have their Chairs re-appointed for a one-year term, instead of having the current Vice-Chair move into the Chair position as per convention. This was requested either to allow for adequate training and mentorship for a new Vice-Chair who will commence their term in December 2022, or to give Chairs and Vice-Chairs adequate time to mentor and select new committee leadership.

- The Executive Committee recommends the following members for Chair, Vice-Chair, Specialty Chair, or Specialty Vice-Chair appointments that would begin at the conclusion of the 2022 Annual General Meeting of Council, for terms as specified in the table:

Committee	Role	Member Name	Term Length	End Date	Term Limit Date
Finance and Audit	Chair	Dr. Thomas Bertoia	1 year	December 2023	December 2025
	Vice-Chair	Mr. Rob Payne	1 year	December 2023	December 2029
ICRC Family Practice	Specialty Chair	Dr. Paula Cleiman	2 years	December 2024	December 2028
	Specialty Vice-Chair	Dr. Lara Kent	2 years	December 2024	December 2029
ICRC General	Specialty Chair	Ms. Joan Fisk	1 year	December 2023	December 2026
	Specialty Vice-Chair	Dr. Lydia Miljan (PhD)	1 year	December 2023	March 2029
ICRC Internal Medicine	Specialty Chair	Dr. Mary Bell	2 years	December 2024	February 2025
	Specialty Vice-Chair	Dr. Jane Lougheed	2 years	December 2024	April 2028
ICRC Mental Health & HIP	Specialty Chair	Dr. Lesley Wiesenfeld	1 year	December 2023	December 2025

	Specialty Vice-Chair	Dr. Daniel Greben	1 year	December 2023	December 2026
ICRC Obstetrics & Gynecology	Specialty Chair	Dr. Elaine Herer	2 years	December 2024	December 2024
	Specialty Vice-Chair	Dr. Anne Walsh	2 years	December 2024	April 2027
ICRC Settlement	Specialty Chair	Dr. Dori Seccareccia	2 years	December 2024	April 2027
	Specialty Vice-Chair	Dr. Thomas Faulds	2 years	December 2024	December 2026
ICRC Surgical	Specialty Chair	Dr. Mary Jean Duncan	2 years	December 2024	December 2027
	Specialty Vice-Chair	Dr. Thomas Bertoia	2 years	December 2024	February 2029
OPSDT & FTP	Vice-Chair	Dr. James Watters	1 year	December 2023	December 2024
Premises Inspection	Chair	Dr. Ted Xenodemetropoulos	2 years	December 2024	June 2028
	Vice-Chair	Dr. Patrick Davison	2 years	December 2024	May 2028
Patient Relations	Chair	Ms. Sharon Rogers	1 year	December 2023	December 2028
Registration	Chair	Dr. Judith Plante	1 year	December 2023	December 2025
	Vice-Chair	Dr. Lynn Mikula	1 year	December 2023	December 2029

Next Steps

- If Council chooses to appoint the nominees laid out in this briefing note, the Governance Office will communicate with the individuals accordingly and proceed with the onboarding and training process for new Committee leaders.

Question for Council

1. Does Council appoint the nominees to the Committee leadership positions as laid out in this briefing note?

Council Motion

Motion Title	2022-2023 Chair and Vice-Chair Appointments and Reappointments
Date of Meeting	December 9, 2022

It is moved by_____, and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario appoints the following Committee Members as Chairs and Vice-Chairs, as noted below, to the following Committees, for the terms indicated below, as of the close of the Annual General Meeting of Council in December 2022:

Committee	Role	Member Name	Term Length
Finance and Audit	Chair	Dr. Thomas Bertoia	1 year
	Vice-Chair	Mr. Rob Payne	1 year
ICRC Family Practice	Specialty Chair	Dr. Paula Cleiman	2 years
	Specialty Vice-Chair	Dr. Lara Kent	2 years
ICRC General	Specialty Chair	Ms. Joan Fisk	1 year
	Specialty Vice-Chair	Dr. Lydia Miljan (PhD)	1 year
ICRC Internal Medicine	Specialty Chair	Dr. Mary Bell	2 years
	Specialty Vice-Chair	Dr. Jane Lougheed	2 years
ICRC Mental Health & HIP	Specialty Chair	Dr. Lesley Wiesenfeld	1 year
	Specialty Vice-Chair	Dr. Daniel Greben	1 year
ICRC Obstetrics & Gynecology	Specialty Chair	Dr. Elaine Herer	2 years
	Specialty Vice-Chair	Dr. Anne Walsh	2 years
ICRC Settlement	Specialty Chair	Dr. Dori Seccareccia	2 years
	Specialty Vice-Chair	Dr. Thomas Faulds	2 years
ICRC Surgical	Specialty Chair	Dr. Mary Jean Duncan	2 years
	Specialty Vice-Chair	Dr. Thomas Bertoia	2 years
OPSDT & FTP	Vice-Chair	Dr. James Watters	1 year
Premises Inspection	Chair	Dr. Ted Xenodemetropoulos	2 years
	Vice-Chair	Dr. Patrick Davison	2 years
Patient Relations	Chair	Ms. Sharon Rogers	1 year
Registration	Chair	Dr. Judith Plante	1 year
	Vice-Chair	Dr. Lynn Mikula	1 year

Council Briefing Note

December 2022

Topic:	2022-2023 Committee Appointments
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation System Collaboration
Public Interest Rationale:	Accountability: Ensuring that CPSO committees have qualified and diverse members will enable the College to carry out its strategic objectives and fulfill its mandate to serve in the public interest.
Main Contacts:	Caitlin Ferguson, Governance Coordinator Cameo Allan, Manager of Governance

Issue

- The Executive Committee is making recommendations to Council for approval of the remaining Committee appointments for the 2022-2023 Committee year.

Background

- The table below provides the status of the recruitment needs that were indicated to the Governance Office for 2022-2023:

Committee	Specialty Requested	Status
Finance and Audit Committee	One physician Council member needed	Pending
Inquiries, Complaints, and Reports Committee (ICRC)	One anesthesiologist	Appointment pending
	One ophthalmologist	Filled
	One gynecologist	Appointment pending
	Two psychiatrists	Appointments pending
	Two to three family physicians	Appointments pending
Patient Relations Committee	No recruitment needs identified	N/A

Premises Inspection Committee (PIC)	One ophthalmologist	Filled
	One plastic surgeon	Appointment pending
Quality Assurance Committee (QAC)	No recruitment needs identified	N/A
Registration Committee	No recruitment needs identified	N/A

Current Status and Analysis

Re-Appointment to Premises Inspection Committee

- Mr. Peter Pielsticker's re-appointment to the Premises Inspection Committee (PIC) was held back earlier in the year, pending potential changes to the composition of PIC.
- Now that Council has decided that public members may still be appointed to PIC, the Executive Committee is recommending a re-appointment for Mr. Pielsticker.
- Mr. Pielsticker's appointment as a public member will end on March 30, 2024. Therefore, the Executive Committee is proposing a one-year re-appointment, beginning at the conclusion of the 2022 Annual General Meeting of Council and ending with the Annual General Meeting of Council in December 2023.

New Appointment – Premises Inspection Committee

- An interview has been completed to fill a vacancy for a plastic surgeon on the PIC. Interview feedback has been received from the Chair of the Governance Committee, the current Committee Chair and Vice-Chair, and other support staff.
- The Executive Committee recommends appointing Dr. Bryan Chung for a term beginning at the conclusion of the 2022 Annual General Meeting of Council and ending with the Annual General Meeting of Council in December 2025.

New Appointments – OPSDT & FTP

- Dr. Marie-Pierre Carpentier has been appointed as the new Academic Representative for the University of Ottawa.
- At the August 11, 2022 meeting of the Academic Advisory Committee, Dr. Carpentier was nominated to be a voting member of Council for the 2022-2023 year.
- Mr. Normand Allaire has been appointed as a new Public Member of Council.
- The Ontario Physicians and Surgeons Discipline Tribunal (OPSDT) continues to have challenges with ensuring there are enough Council Members who are willing and able to sit

on panels. It also continues to have challenges constituting a panel of members who speak French at a level required to hear cases entirely in French.

- Dr. Carpentier and Mr. Allaire have both confirmed that they speak French at the level the OPSDT requires, and that they are willing and able to commit adequate time for participation on the OPSDT.

- It is convention that members of the OPSDT are also cross-appointed to the Fitness to Practise Committee (FTP).

- Mr. David Wright, the Chair of the OPSDT and FTP, has spoken with Dr. Carpentier , and Ms. Cameo Allan, Manager of Governance with Mr. Allaire, and he has confirmed his interest in having them join both the OPSDT and FTP.

- The Executive Committee recommends the appointment of Dr. Marie-Pierre Carpentier to the OPSDT and FTP for a one-year term beginning immediately after the Annual General Meeting of Council in 2022 and ending at the Annual General Meeting of Council in December 2023. Re-appointments will be considered based on vote allocation for Academic Representatives going forward.

- The Executive Committee recommends the appointment of Mr. Normand Allaire to the OPSDT and FTP for a one-year term beginning immediately after the Annual General Meeting of Council in 2022 and ending at the Annual General Meeting of Council in December 2023. Re-appointments will be considered if Mr. Allaire's term as a public member is extended beyond one year.

New Appointments – Inquiries Complaints and Reports Committee (ICRC)

- Interviews have been completed to fill the vacancies for an anesthesiologist, an obstetrician gynecologist, two psychiatrists, and two family physicians on the ICRC. Interview feedback has been received from the Chair of the Governance Committee, the current Committee Chair and Vice-Chair, and other support staff.

- The Executive Committee recommends appointing the following physicians for a term beginning at the conclusion of the 2022 Annual General Meeting of Council and ending with the Annual General Meeting of Council in December 2025.

Specialty	Name
Obstetrics and gynecology	Dr. P. Gareth Seaward
Anesthesiology	Dr. Anna Rozenberg
Psychiatry	Dr. Diane Meschino
Psychiatry	Dr. Susan Lieff
Family Medicine	Dr. Paul Miron

Next Steps

- If Council chooses to appoint the nominees laid out in this briefing note, the Governance Office will communicate with the individuals accordingly and complete the onboarding process for new Committee members.

Question for Council

1. Does Council appoint the nominees as laid out in this briefing note?

Council Motion

Motion Title	2022-2023 Committee Appointments
Date of Meeting	December 9, 2022

It is moved by_____, and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario 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 2022:

Premises Inspection Committee

Mr. Peter Pielsticker, public Council member – 1 year
Dr. Bryan Chung, non-Council physician – 3 years

Ontario Physicians and Surgeons Discipline Tribunal

Dr. Marie-Pierre Carpentier, physician Council member – 1 year
Mr. Normand Allaire, public Council member – 1 year

Fitness to Practice Committee

Dr. Marie-Pierre Carpentier, physician Council member – 1 year
Mr. Normand Allaire, public Council member – 1 year

Inquiries Complaints and Reports Committee

Dr. P. Gareth Seaward, non-Council physician – 3 years
Dr. Anna Rozenberg, non-Council physician – 3 years
Dr. Diane Meschino, non-Council physician – 3 years
Dr. Susan Lieff, non-Council physician – 3 years
Dr. Paul Miron, non-Council physician – 3 years

Council Briefing Note

December 2022

Topic:	*Dispensing Drugs* – Revised Policy for Final Approval
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation Meaningful Engagement
Public Interest Rationale:	Setting out up-to-date and clear expectations and guidance for physicians who dispense drugs
Main Contact:	Alex Wong, Policy Analyst
Attachments:	Appendix A: Revised Draft *Dispensing Drugs* Policy Appendix B: Revised Draft *Advice to the Profession: Dispensing Drugs*

Issue

- The College's *Dispensing Drugs* policy is currently under review. A revised draft policy and new companion *Advice to the Profession* ("*Advice*") document have been developed.

- Council is asked whether the draft policy can be approved as a policy of the College.

Background

- The *Dispensing Drugs* policy previously underwent minor housekeeping amendments in 2018 and was part of a batch of redesigned policies in 2019. However, it has not undergone a formal policy review since Council approved the policy in 2010.

- Given the recent housekeeping updates and niche nature of the policy, it was selected for a streamlined policy review process, shortening the consultation period and foregoing review by the Policy Working Group. Preliminary research was undertaken in accordance with the usual process with additional consultation undertaken with the Ontario College of Pharmacists. Council received an overview of the preliminary consultation feedback at June 2022 Council and approved the draft policy for external consultation.

- The draft *Dispensing Drugs* policy and *Advice* underwent consultation from June to August 2022. A total of 33 responses were received, mostly from physicians.[1] Council received an overview of the consultation feedback in the Policy Report at the September 2022 Council meeting. Written feedback can be found on a dedicated page of the College's website.

[1] Organizational responses included the Canadian Ophthalmological Society, the Ontario Medical Association (OMA), and the OMA Section on Plastic Surgery.

Current Status and Analysis

- Consultation feedback was broadly supportive of the draft policy, with most respondents agreeing that the draft is clearly written, easy to understand, and reasonable. As such, the revised policy retains the same core expectations, with minor revisions as described below.

- The draft policy includes a definition of "dispensing" and two new policy expectations related to patient counselling and monitoring of recalled drugs.

- The proposed draft expectation that physicians inform patients of the option to purchase the drug being dispensed at another location, if available, was removed. The provision was felt to be generally inapplicable given the limited circumstances where physicians may be dispensing, and feedback indicated that this expectation could be impractical and/or interfere with care in some instances.

- The companion *Advice to the Profession* document was newly developed to provide additional guidance on various dispensing issues, including labelling, procurement, and storage and security. Following the consultation, new content was added to the *Advice* to guide physicians around their obligations when charging a dispensing fee, including references to existing expectations in the *Uninsured Services* policy and relevant sections of the General regulation (O. Reg. 114/94) under the *Medicine Act, 1991*.

- Feedback generally indicated that application of the policy to distribution of samples could have a negative impact and lead to increased burden for physicians. However, the draft policy was also seen as helpful to apply to drug samples.

    - In line with this feedback, the revised policy continues to retain its original scope and exclude drug samples, with a focus on dispensing where the physician is acting similar to a pharmacist, and the draft *Advice* indicates that the policy expectations may be informative when distributing samples.

Next Steps

- Should Council approve the revised draft policy, it will be announced in *Dialogue* and added to the College's website.

Question for Council

1. Does Council approve the revised draft *Dispensing Drugs* policy as a policy of the College?

Dispensing Drugs

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

Dispensing: refers to the process of preparing and providing a prescription drug to a patient for subsequent administration or use. Dispensing involves both technical and cognitive components.[1] For the purposes of this policy, dispensing does not include the distribution of drug samples.[2]

Policy

1. Physicians who dispense drugs **must** meet the same dispensing standards as pharmacists[3] and comply with the requirements set out in this policy, in any other relevant College policies,[4] and provincial and federal legislation.[5]

2. Physicians **must** dispense drugs only for their own patients.

[1] Technical components may include drug selection, verification, and quantity determination, applying appropriate labelling, and documentation. Cognitive components may include assessing the appropriateness of drug therapy, considering drug interactions and contraindications, providing patient communication and counselling, and offering follow-up advice. For more information see the *Advice to the Profession.*

[2] Relevant expectations relating to drug samples can be found in other College policies, including *Medical Records Documentation*, *Prescribing Drugs*, and *Physicians Relationships' with Industry: Practice, Education and Research*. For more information, see the *Advice to the Profession.*

[3] For example, see the Ontario College of Pharmacists' (OCP) Standards of Practice.

[4] Including, but not limited to, the *Prescribing Drugs* policy and the *Medical Records Documentation* policy.

[5] Including, but not limited to, the *Controlled Drugs and Substances Act*, *Narcotics Safety and Awareness Act, 2010*, *Drug and Pharmacies Regulation Act* (*DPRA*), *Drug Interchangeability and Dispensing Fee Act*, and *Food and Drugs Act*. These acts and their regulations set out requirements for the sale and dispensing of drugs, including labelling, record keeping, and record retention.

3. Physicians **must:**
    a. provide appropriate packaging and labelling for the drugs dispensed;[6] and
    b. provide patient counselling, including discussing instructions for proper drug use.

4. Physicians **must not** sell drugs to a patient at a profit, except when permitted by legislation.[7]

5. Physicians **must not** charge fees associated with dispensing that are excessive.[8]

6. Physicians **must not** dispense drugs that are past their expiry date or that will expire before the patient completes their normal course of therapy.[9]

7. Physicians **must**:
    a. use proper methods of procurement in order to confirm the origin and chain of custody of drugs being dispensed;
    b. have an audit system in place in order to identify possible drug loss;
    c. store drugs securely;
    d. store drugs appropriately to prevent spoilage (for example, temperature control where necessary);
    e. monitor recalled drugs[10] and have a process for contacting patients whose dispensed drugs are affected; and
    f. dispose of drugs that are unfit to be dispensed (for example, expired, damaged, or recalled) safely and securely and in accordance with any environmental requirements.[11]

8. Physicians **must** keep records:
    a. of the purchase and sale of drugs; and
    b. which allow for the retrieval and/or inspection of prescriptions.

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[6] Subsection 156(3) of the *DPRA* sets out the information to be recorded on the container of a dispensed drug. The *Food and Drug Regulations* sets out specific requirements for physicians dispensing Class A opioids. For more information, see the *Advice to the Profession*.

[7] Under O. Reg. 114/94 of the *Medicine Act, 1991*, it is a conflict of interest to sell or otherwise supply a drug to a patient at a profit except where the drug is necessary for the immediate treatment of the patient, in an emergency, or where the services of a pharmacist are not reasonably readily available (s. 16 (d)).

[8] Under O. Reg. 856/93 of the *Medicine Act, 1991*, it is an act of professional misconduct to charge a fee that is excessive in relation to the services provided (ss. 1(1) 21.), and to charge a fee for a service that exceeds the fee set out in the then current schedule of fees published by the Ontario Medical Association without informing the patient, before the service is performed, of the excess amount that will be charged. (ss. 1(1) 22.) For more information on charging a dispensing fee, see the *Advice to the Profession.*

[9] This requirement does not apply to *pro re nata* (PRN) medications when physicians may not know whether patients will finish the medication before their expiry date.

[10] For instance, through Health Canada's Recalls and Safety Alerts Database or subscribing to MedEffect Canada notices of recalls.

[11] For more information about the safe disposal of drugs, please see the College's *Advice to the Profession: Prescribing Drugs*.

Appendix B

Advice to the Profession: Dispensing Drugs

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.

CPSO, in consultation with the Ontario College of Pharmacists (OCP), has developed the *Dispensing Drugs* policy for those physicians who dispense drugs. The aim of the policy is to help physicians meet the same standards as pharmacists when dispensing drugs. This companion Advice document is intended to provide guidance to physicians on how to interpret and effectively discharge their obligations as set out in the policy.

What is dispensing?

The OCP's *Dispensing Components Included in the Usual and Customary Fee* guideline describes dispensing as involving both technical and cognitive components. Technical components may include drug selection, verification, and quantity determination, applying appropriate labelling, and documentation. Cognitive components (which may overlap with a physician's responsibilities when prescribing) may include assessing the appropriateness of drug therapy, considering drug interactions and contraindications, providing patient communication and counselling, and offering follow-up advice.

Does this policy apply if I am distributing drug samples?

The policy is intended to set expectations for physicians dispensing in limited circumstances in a role that is comparable to a pharmacist. It does not apply to the distribution of drug samples. However, relevant expectations for drug samples can be found in the *Medical Records Documentation*, *Prescribing Drugs*, and *Physicians Relationships' with Industry: Practice, Education and Research* policies, such as keeping relevant documentation of the drug name, dose, directions for use, quantity, and lot number in the patient's medical record

Some of the expectations articulated in the *Dispensing Drugs* policy are also informative and may help guide appropriate conduct when it comes to distributing samples. This includes not distributing expired medications. Further guidance around samples can be found in the OCP's *Distribution of Medication Samples* policy.

How can I determine what dispensing fee to charge?

A dispensing fee may incorporate the cost of the drug and reasonable handling costs, such as shipping and secure storage for the drug. Further guidance on charging for uninsured services more generally can be found in the *Uninsured Services: Billing and Block Fees* policy. In line with this policy, you must consider the patient's ability to pay when charging for uninsured services. The Ontario Medical Association also publishes an annual *Physician's Guide to Uninsured Services* which provides recommendations to help physicians set their fees.

What information do I need to provide to a patient when dispensing a drug?

Many aspects of patient counselling may overlap with the responsibility to obtain informed consent from a patient or substitute decision-maker for treatment and before prescribing a drug. Information to provide a patient can include directions for using the drug, the expected therapeutic effect, potential side effects, drug contraindications and precautions, and information about the drug therapy as it relates to the patient's condition. You can also communicate with patients to evaluate their ability to comply with the therapeutic regimen. You can exercise judgment as to what is discussed when dispensing repeats or refills.

What information do I need to include on labels for dispensed drugs?

Subsection 156(3) of the *Drug and Pharmacies Regulation Act* sets out the information which must be recorded on the container of the dispensed drug, including, not limited to, the identification number on the prescription; drug name, strength, and manufacturer; the date the prescription is dispensed; the name of the prescriber; the name of the person for whom it is prescribed; and the directions for use as prescribed.

Under the *Food and Drug Regulations*, physicians who dispense Class A opioids are required to apply a warning sticker to the prescription bottle, container, or package, and provide a patient information handout to accompany the drug. A sticker or handout is not required if the drug is being administered under the supervision of a practitioner (for example, a physician or nurse practitioner). For more information about these requirements, see Health Canada's FAQ.

What do I need to know about procuring drugs?

Physicians must use proper methods of procurement and keep documentation of each sale or product transaction (e.g., with a packing slip from the manufacturer or wholesaler). Physicians can meet this expectation by procuring drugs from reliable

sources and in accordance with federal legislation, such as from manufacturers or wholesalers who have been issued drug establishment licences by Health Canada.

For controlled substances, physicians must keep purchase/receiving records that contains information about the name and quantity of the substance received; the date the substance was received; and the name and address of the person from whom the substance was received.

Additional guidance can be found in the OCP's policy on medication procurement and inventory management and fact sheet on federal purchase and sales record requirements, and Health Canada's *Recommended guidance in the areas of security, inventory, reconciliation and record-keeping for community pharmacists*.

What do I need to do to store drugs securely and appropriately?

Physicians need to implement practices that enable storing drugs in a clean and organized area, with appropriate temperature, light, humidity, ventilation, regulation, security, and safety controls. It is important to store drugs in areas appropriate to their classification and which are accessed only by designated and appropriately trained personnel.

With respect to controlled substances, the regulations do not define what is considered reasonable or necessary to ensure security nor do they establish specific storage requirements. A combination of methods can be used, such as physical security measures (e.g., alarm system, locks, video surveillance, restricted access), inventory management (e.g., physical counts, accurate record-keeping), operational processes, audits, and inventory reconciliation.

Additional guidance can be found in the OCP's policy on medication procurement and inventory management and fact sheet on security and reconciliation of controlled substances, and Health Canada's *Recommended guidance in the areas of security, inventory, reconciliation and record-keeping for community pharmacists*.

How can I minimize dispensing errors?

Dispensing errors can include providing the wrong drug, strength, quantity, or dosing regimen; not identifying potential drug interactions; or mislabelling drugs. You can minimize errors by instituting standardized dispensing procedures (including labelling, instructions, and documentation), using a checklist or other mechanisms to ensure the dispensing process is accurately completed and the correct drug dispensed, and using technology to assist with workflow. The *Advice to the Profession: Prescribing Drugs* outlines what to do in the case of a medication incident.

Council Motion

Motion Title	*Dispensing Drugs* - Revised Policy for Final Approval
Date of Meeting	December 9, 2022

It is moved by_____, and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario approves the revised policy "Dispensing Drugs", as a policy of the College (a copy of which forms Appendix " " to the minutes of this meeting).

Council Briefing Note

December 2022

Topic:	Academic Advisory Committee Update and By-Law Amendment
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation System Collaboration
Public Interest Rationale:	Accountability: Ensuring appropriate governance structures that adhere to legislation designed to serve the public interest.
Main Contacts:	Laura Rinke-Vanderwoude, Governance Analyst Marcia Cooper, Sr. Corporate Counsel and Privacy Officer
Attachments:	Appendix A: Proposed by-law amendment Appendix B: Proposed Academic Advisory Committee Terms of Reference

Issue

- The Executive Committee previously recommended examining having the Governance Committee select those academic representatives who will be voting members of Council and whether to dissolve the Academic Advisory Committee, an entity set out in by-law.

Background

- The *Medicine Act* requires three representatives from Ontario medical school faculty to sit on Council, and says they are to be *selected* in accordance with by-laws.
- General By-law section 24 provides for each of the six medical schools in Ontario to appoint an Academic Representative to the Academic Advisory Committee.
- As set out in s. 26 of the General By-law, the six members appointed to the Academic Advisory Committee select the three voting academic members of Council annually, and their selection is then brought to Council for acceptance.
- As per section 25 of the General By-Law, Academic Representatives are typically appointed for a three-year term.

- The Academic Advisory Committee does not currently have a Terms of Reference or any additional mandate. Their sole required meeting is for the purposes of recommending which three academic representatives should become voting members of Council the following year.

- In the process of considering whether to dissolve the Education Advisory Group, the Executive Committee expressed that the mandate of proposing voting members of Council is consistent with the Governance Committee's mandate of recommending appointments for the CPSO's other committees.

- In addition, the assignment of voting rights by the Academic Advisory Committee is largely constrained by the need for membership on the Ontario Physicians and Surgeons Discipline Tribunal (OPSDT) or on the Executive Committee. The needs and/or requirements of these two committees necessitate that an individual must be a voting member of Council. Generally, the Governance Committee is more aware of these recruitment needs, making that committee a more appropriate body for nominating voting members annually.

- As a result, it was suggested to examine whether the Academic Advisory Committee could also be dissolved and its mandate incorporated into the Governance Committee's mandate, and a Roles and Responsibilities document drafted for all academic representatives.

- The Academic Advisory Committee was made aware of the proposal for their mandate to be moved under the Governance Committee. They are generally supportive of this direction, but expressed that they desire the role of academic representatives to be sufficiently formalized moving forward.

Current Status and Analysis

- A by-law amendment has been proposed to move the mandate of selecting voting members from the Academic Advisory Committee to the Governance Committee without affecting the continuity of the Academic Advisory Committee.

- Even with the task of selecting the voting academic members of Council transferred to the Governance Committee, there are some reasons for maintaining the Academic Advisory Committee. Namely:

    - The Deans of the medical faculties would continue to appoint their academic representatives to the Academic Advisory Committee, rather than a general appointment as a representative, which may create some ambiguity around the appointment.

  - By being appointed to a CPSO committee, it helps ensure that non-voting Academic Representatives continue to be subject to the Declaration of Adherence and Council and Committee Code of Conduct[1], which maintains the position that they hold a fiduciary duty to the CPSO.[2]

- Given these considerations, it is not recommended to dissolve the Academic Advisory Committee.

- An opportunity has been identified to utilize the Academic Advisory Committee to formalize the role of Academic Representatives by transitioning the proposed Roles and Responsibilities document into a formal Terms of Reference for the committee. The Terms of Reference would be limited to establishing the roles and responsibilities of the academic representatives, but would not assign any additional mandate to this Committee. This would help address the need to establish a continuing fiduciary duty, and maintain the current mechanism for Dean appointments, which provide the pool of potential candidates for voting Academic Representative Council members.

- The Academic Representatives have reviewed and made suggestions regarding a draft Roles and Responsibilities document. This document was also reviewed by Council, but does not require Council approval. The Roles and Responsibilities document has been transformed into the base for a Terms of Reference for the Academic Advisory Committee. The proposed Terms of Reference, which will be reviewed by members of the Academic Advisory Committee and approved by the Governance Committee if the by-law amendment is adopted, is attached.

Next Steps

- If Council approves the proposed by-law amendment and approach, the Governance Committee will need to approve the Terms of Reference for the Academic Advisory Committee, which will be re-circulated to Academic Advisory Committee members and then finalized at the January Governance Committee meeting.

[2] Ensuring there is a fiduciary duty is particularly important for non-voting Academic Representatives to continue being able to attend in-camera sessions.

Questions for Council

1. Does the Council have any feedback on the proposed approach to have the Governance Committee select the voting academic representatives on Council, and to establish Terms of Reference for the Academic Advisory Committee?

2. Does Council approve the by-law amendment set out in Appendix A?

ACADEMIC SELECTION

Academic Advisory Committee

24. (1) An Academic Advisory Committee shall be established and shall be composed of members appointed under this section.

(2) ~~Between one and two months before~~ Before the meeting of the council when the term of office of newly elected councillors starts, the dean of each faculty of medicine of a university in Ontario may appoint one member to the academic advisory committee.

...

Selection of Councillors

26. (1) Three members of the academic advisory committee shall be selected as councillors in accordance with this section.

(2) At ~~the last~~a meeting of the council before the meeting when the term of office of newly elected councillors starts, the council shall ~~a~~ vote by a show of hands ~~shall be held by Council~~ to select as councillors three members of the academic advisory committee for the following council year, starting upon the adjournment of the next annual general meeting until the following annual general meeting. ~~. The academic advisory committee shall recommend three of its members to Council and Council shall vote by a show of hands as to whether to accept the three proposed members as councillors.~~

~~(3) Should the majority of those present at Council eligible to vote accept the three members proposed by the academic advisory committee as members of Council, those members shall be councillors for the following year.~~

~~(4) Should the academic advisory committee not propose three members to be selected as councillors, or should Council not select, by the method outlined in paragraph 2 above, the three members proposed by the academic advisory committee, a vote shall be held at Council in which all members of the academic advisory committee are placed on a ballot. Each councillor may vote for up to three members of the academic advisory committee. The three members of the academic advisory committee for whom the most ballots are cast will be selected as councillors for the following year.~~

(3~~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.

Governance Committee

44. ...

(3) The Governance Committee shall,

(a) monitor the governance process adopted by the Council and report annually to the Council on the extent to which the governance process is being followed;

(b) consider and, if considered advisable, recommend to the Council changes to the governance process;

(c) ensure nominations for the office of president and vice-president;

(d) make recommendations to the Council regarding the members and chairs of committees, and the selection of members of the academic advisory committee to serve as councillors; and

(e) make recommendations to the Council regarding any other officers, officials or other people acting on behalf of the College.

Academic Advisory Committee
Terms of Reference

Mandate and Academic Representative's Role

In addition to the individual's role on Council and on any other Committees they are appointed to, the mandate of the Academic Advisory Committee and the role of its members ("Academic Representatives") is to create a link between the CPSO and their academic institution, and to help inform the Governance Committee's selection of voting Academic Representatives for Council.

Academic Representative Responsibilities

In addition to work related to Council and any Committees the individual may serve on, the responsibilities of Academic Representatives include:

- Advising the Governance Committee regarding interest in sitting as a voting member of Council for a given year;
- Exploring opportunities within their faculty and institution for the CPSO to perform outreach or make presentations;
- Disseminating and marketing eDialogue to medical students, residents, and other learners at their institution;
- Providing input when requested by Council, CPSO staff, and other committees; and,
- Soliciting involvement from colleagues, medical students, residents and other learners, and administrators at their institutions for policy, communications, or quality consultations and initiatives.
- Attending and participating on Council matters.

Academic Representatives should not assume the role of representing the CPSO at their institution unless authorized by the CPSO, including but not limited to speaking or presenting on behalf of the CPSO.

Academic Representatives are expected to liaise with CPSO staff to obtain the resources and support needed to meet their responsibilities

Composition and Academic Representative Selection

The Academic Advisory Committee is composed of Academic Representatives each appointed by their Dean to the Committee. In addition to the eligibility criteria set out in the by-laws (which are mandatory for appointment), criteria Deans can use to appoint their Academic Representative include:

- Eligibility with respect to applicable term limits (a total of 9 years on the Academic Advisory Committee, regardless of whether the Academic Representative was selected as a voting member of Council for all or part of that time)
- Demonstrated leadership experience

- Knowledge and support of the regulatory and/or statutory obligations of the CPSO
- Interest and availability
- Skills and competencies identified as needs by the CPSO.

Reporting

If required, the Academic Advisory Committee reports to the Governance Committee.

Term of Appointment

Academic Representatives are appointed for a 3-year term or such shorter period as may be specified, renewable until the member has served nine years cumulatively.

Chair

The Academic Advisory Committee does not have a Chair or Vice-Chair.

Meetings and Communications

The Academic Advisory Committee is not required to meet virtually or in person and may obtain instruction and communicate via email using their CPSO address. Members may request support from the Governance Office to arrange a meeting or discussion if required.

Quorum

A majority of the members of the Academic Advisory Committee constitutes a quorum.

Compensation

Members of the Academic Advisory Committee will be compensated by the CPSO for travel expenses, preparing for and attending meetings on the same basis as committee members in accordance with section 20 of CPSO By- Law No. 2 (Fees and Remuneration By-Law).

Declaration of Adherence

Each member of the Academic Advisory Committee must sign a Declaration of Adherence and Council and Committee Code of Conduct annually in the form provided by CPSO, which requires members to comply with, among other things, conflict of interest, confidentiality obligations and CPSO policies.

Fiduciary Duty

Academic Representatives, whether or not they are voting members of Council, have a fiduciary duty to the CPSO, as do other Council and Committee members, and are similarly accountable to all policies and requirements laid out in the Declaration of Adherence, the Council and Committee Code of Conduct, and its associated policies.

Amendments to the Terms of Reference

A Quorum of the Academic Advisory Committee may make recommendations to the Governance Committee for amendments to the Terms of Reference, which may be approved at the discretion of the Governance Committee.

Council Motion

Motion Title	By-law Amendments re Selection of Voting Academic Council Members
Date of Meeting	December 9, 2022

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. 156:

By-law No. 156

1. Subsection 24(2) of the General By-law is revoked and substituted with the following:

Academic Advisory Committee

24. …
(2) Before the meeting of the council when the term of office of newly elected councillors starts, the dean of each faculty of medicine of a university in Ontario may appoint one member to the academic advisory committee.

2. Subsection 26(2) of the General By-law is revoked and substituted with the following:

Selection of Councillors

26. …
(2) At a meeting of the council before the meeting when the term of office of newly elected councillors starts, the council shall vote by a show of hands to select as councillors three members of the academic advisory committee for the following council year, starting upon the adjournment of the next annual general meeting until the following annual general meeting.

3. Subsections 26(3) and (4) of the General By-law are revoked.

4. Subsection 44(3)(d) of the General By-law is revoked and substituted with the following:

Governance Committee

44. …

(3) The Governance Committee shall, …

(d) make recommendations to the Council regarding the members and chairs of committees, and the selection of members of the academic advisory committee to serve as councillors; and

Council Briefing Note

December 2022

Topic:	Finance and Audit Committee Recommendations – Budget 2023
Purpose:	For Decision
Main Contact(s):	Dr. Thomas Bertoia (Chair, Finance and Audit Committee) Ms. Nathalie Novak, Chief Operating Officer Mr. Douglas Anderson, Corporate Services Officer Ms. Leslee Frampton, Manager, Finance
Attachment(s):	Appendix A: SOO 2023 Budget Appendix B: Budget 2023 Expenditures by Department Appendix C: Budget 2023 Expenditures by Account

Issue

The Finance and Audit Committee met on October 13, 2022 and is recommending the following item to Council for approval:

- 2023 Budget

Background

2023 Budget

The College is accountable for $80M budget, and regularly demonstrates – through detailed reports to the Finance and Audit Committee and Council, fiscal accountability, optimal resource use and delivery of effective and efficient programs. The transformation that the College embarked on several years ago has allowed the College to provide better service and support for all our stakeholders.

Management is pleased to be able to deliver a budget for 2023 that includes revenue of $80,313,785 and expenses of $80,148,281 resulting in a projected small surplus of $165,504 – basically a balanced budget. Management is also recommending that the independent practice membership fee of $1,725 be maintained for 2023. There fee has remained the same since 2018.

The Finance and Audit Committee approved the following motions:

It was moved by Mr. Pielsticker, seconded by Dr. Bandiera and CARRIED. That the Finance & Audit Committee recommends to Council that the budget for 2023 be approved as presented.

It was moved by Mr. Pielsticker, seconded by Dr. Gratton and CARRIED. That the Finance & Audit Committee recommends to Council that per diem rates be increased by 3% effective January 1, 2023.

It was moved by Dr. Gratton, seconded by Dr. Preyra, and CARRIED. That the Finance and Audit Committee is recommends to Council that the membership fee for 2023 remain at $1,725.

Over the last five years there has been no increase to the Independent Practice Membership fee.

Questions for Council

1. Does Council approve the budget for 2023 as presented?

2. Does Council approve that per diem rates be increased by 3% effective January 1, 2023?

3. Does Council approve that the membership fee for 2023 remain at $1,725?

Statement of Operations

College of Physicians and Surgeons of Ontario

	ACTUALS			BUDGET			
	ACTUALS 2019	ACTUALS 2020	ACTUALS 2021	BUDGET 2022	BUDGET 2023	% CHANGE OVER 2022 BUDGET	
REVENUE							
MEMBERSHIP FEES							
Independent Practice	63,368,956	64,354,783	65,029,592	64,998,000	68,430,750	5.28%	
Post Graduate	2,326,220	2,322,055	2,413,734	2,415,000	2,365,000	-2.07%	
Penalty Fees	178,723	1,026	563,126	404,478	431,250	6.62%	
Credit Card Service Charges	(1,521,195)	(1,540,401)	(1,628,051)	(1,519,241)	(1,668,196)	9.80%	
TOTAL MEMBERSHIP FEES	**64,352,704**	**65,137,462**	**66,378,401**	**66,298,237**	**69,558,804**	**4.92%**	
APPLICATION FEES							
New Independent Practice	2,353,910	2,458,901	2,827,847	2,742,750	2,797,220	1.99%	
New Post Graduate Educational	1,382,384	1,254,861	1,318,240	1,326,094	1,422,815	7.29%	
IP & SD - Expedited Review Fees	125,408	79,824	135,240	-	164,333	100.00%	In 2022, all IP Application fees were budgetted on the IP line.
PG - Expedited Review Fee	123,224	67,452	108,828	-	121,497	100.00%	In 2022, all IP Application fees were budgetted on the IP line.
Certificates of Professional Conduct	662,175	146,740	-	-	-	0.00%	
Certificates of Incorporation	4,052,675	3,925,495	4,447,325	4,075,750	4,377,050	7.39%	
TOTAL APPLICATION FEES	**8,699,775**	**7,933,273**	**8,837,479**	**8,144,594**	**8,882,915**	**9.07%**	
OTHER							
Investment Income	4,016,920	2,740,013	895,820	825,000	1,407,500	70.61%	Increase in interest rates.
Miscellaneous Services	70,992	19,763	(4,927)	(15,000)	(857)	94.29%	
OPSDT Costs Recovered	610,458	367,616	674,015	500,000	430,403	-13.92%	
Court Costs Awarded	32,500	15,000	19,000	15,000	35,020	133.47%	
Prior Year Items	145,266	53,111	104,549	-	-	0.00%	
TOTAL OTHER	**4,876,136**	**3,195,503**	**1,688,457**	**1,325,000**	**1,872,066**	**41.29%**	
TOTAL REVENUE	**77,928,615**	**76,266,237**	**76,904,337**	**75,767,830**	**80,313,785**	**6.00%**	
EXPENDITURES							
REGISTRAR	(2,908,039)	(1,380,461)	(1,699,156)	(1,882,863)	(2,923,710)	-55.28%	Approved salary adjustments and New Position - Lean Sensei.
CHIEF MEDICAL ADVISOR	(2,757,832)	(3,349,480)	-	-	-	0.00%	
QUALITY MANAGEMENT	(6,582,175)	(4,252,194)	(5,799,834)	(7,123,064)	(6,681,071)	6.21%	
REGISTRATION & MEMBERSHIP SERVICES	(4,816,222)	(5,078,722)	(5,487,375)	(4,343,387)	(6,363,292)	-46.51%	12 Positions were excluded from the 2022 Budget.
COMMUNICATIONS & MEDIA	(1,921,124)	(1,526,751)	(1,916,526)	(2,204,870)	(2,512,415)	-13.95%	1 position moved into the department (Engagement Specialist) and 2 new contracts.
TRANSFORMATION OFFICE	(20,053,911)	(19,471,645)	(26,770,749)	(27,047,322)	(26,868,765)	0.66%	
LEGAL OFFICE	(4,909,346)	(5,450,469)	(5,793,840)	(6,192,546)	(6,503,928)	-5.03%	
COMPLAINTS	(19,943,676)	(17,230,316)	(17,493,263)	(20,414,057)	(21,358,909)	-4.63%	
OPSDT	(3,134,584)	(2,797,033)	(3,118,188)	(3,387,246)	(2,351,192)	30.59%	Expected continued reduced volume and time for hearings and writing under new Tribunal model.
GOVERNANCE	(1,421,270)	(2,051,854)	(2,399,790)	(3,200,816)	(2,666,424)	16.70%	Budget for PA regulation moved to Policy.
POLICY	(1,947,412)	(1,377,120)	(1,689,532)	(1,658,026)	(1,918,574)	-15.71%	Gov't Relations Advisor moved from Governance to Policy in 2023.
TOTAL EXPENDITURES	**(70,395,591)**	**(63,966,045)**	**(72,168,253)**	**(77,454,197)**	**(80,148,281)**	**-3.48%**	
EXCESS REVENUE OVER EXPENDITURES	**$7,533,024**	**$12,300,192**	**$4,736,083**	**($1,686,367)**	**$165,504**		

EXPENDITURES BY DEPARTMENT

College of Physicians and Surgeons of Ontario
Cost Centre

	ACTUALS			BUDGET					
	ACTUALS 2019	ACTUALS 2020	ACTUALS 2021	BUDGET 2022	BUDGET 2023	FORECAST FOR 2022	DIFFERENCE TO FORECAST	CHANGE FROM PY BUDGET $	CHANGE FROM PY BUDGET %
REGISTRAR DIVISION									
Executive Department	($2,908,039)	($1,380,461)	($1,699,156)	($1,882,863)	($2,923,710)	($2,800,798)	($122,913)	($1,040,847)	-55.28%
TOTAL REGISTRAR DIVISION	**($2,908,039)**	**($1,380,461)**	**($1,699,156)**	**($1,882,863)**	**($2,923,710)**	**($2,800,798)**	**($122,913)**	**($1,040,847)**	**-55.28%**
CHIEF MEDICAL ADVISOR DIVISION									
CHIEF MEDICAL ADVISOR	($2,757,832)	($3,349,480)	$0	$0	$0	$0	$0	$0	0.00%
TOTAL MEDICAL ADVISOR DIVISION	**($2,757,832)**	**($3,349,480)**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**0.00%**
QUALITY MANAGEMENT DIVISION									
Assessor Bi-Annual Meeting	($35)	($36,573)	$0	$0	$0	$0	$0	$0	0.00%
Assessor Networks	($30,093)	($5,317)	($3,181)	$0	$0	$0	$0	$0	0.00%
Changing Scope Working Group	($3,081)	$0	$0	$0	$0	$0	$0	$0	0.00%
Education Advisory Group	($15,621)	($10,669)	($24,628)	($26,160)	$0	($32,932)	$32,932	$26,160	100.00%
Peer Assessment Program	($752,669)	($394,098)	($1,042,952)	($1,330,207)	($1,346,249)	($1,224,016)	($122,233)	($16,042)	-1.21%
QA/QI Department	($3,012,173)	($2,593,904)	($3,845,580)	($3,881,548)	($3,817,937)	($3,221,492)	($596,445)	$63,612	1.64%
Quality Assurance Committee	($598,769)	($170,555)	($173,159)	($376,615)	($346,165)	($238,516)	($107,649)	$30,450	8.09%
Quality Improvement Program	($1,179,592)	($436,554)	($692,507)	($1,493,858)	($1,125,457)	($1,467,649)	$342,192	$368,401	24.66%
Quality Management Department	($857,556)	($569,595)	$0	$0	$0	$0	$0	$0	0.00%
Assessor Training	($47,933)	($34,928)	($17,827)	($14,676)	($45,263)	($127,872)	$82,609	($30,587)	-208.41%
Registration Pathways Evaluation	($84,652)	$0	$0	$0	$0	$0	$0	$0	0.00%
TOTAL QUALITY MANAGEMENT DIVISION	**($6,582,175)**	**($4,252,194)**	**($5,799,834)**	**($7,123,064)**	**($6,681,071)**	**($6,312,477)**	**($368,593)**	**$441,994**	**6.21%**
REGISTRATION & MEMBERSHIP SERVICES DIVISION									
Annual Membership Survey	($11,330)	($207)	$0	$0	$0	$0	$0	$0	0.00%
Applications and Credentials	($2,958,205)	($3,366,171)	($5,222,113)	($4,090,086)	($5,364,700)	($5,198,482)	($166,217)	($1,274,614)	-31.16%
Change of Scope/Re-Entry	$0	$0	$0	$0	($675,730)	($105,396)	($570,334)	($675,730)	-100.00%
Corporations Department	($928,961)	($680,133)	$0	$0	$0	$0	$0	$0	0.00%
Membership Department	($762,744)	($905,235)	$0	$0	$0	$0	$0	$0	0.00%
Registration Committee	($154,981)	($126,975)	($265,261)	($253,301)	($322,862)	($344,948)	$22,086	($69,561)	-27.46%
TOTAL REGISTRATION & MEMBERSHIP SERVICES DIVISION	**($4,816,222)**	**($5,078,722)**	**($5,487,375)**	**($4,343,387)**	**($6,363,292)**	**($5,648,827)**	**($714,466)**	**($2,019,905)**	**-46.51%**
COMMUNICATIONS & MEDIA DIVISION									
Communications Department	($1,909,833)	($1,524,609)	($1,913,568)	($2,063,033)	($2,425,415)	($2,401,824)	($23,591)	($362,382)	-17.57%
Outreach Program	($11,291)	($2,142)	($2,958)	($19,837)	($17,000)	($17,190)	$190	$2,837	14.30%
Equity, Diversity, and Inclusion	$0	$0	$0	($122,000)	($70,000)	($122,000)	$52,000	$52,000	42.62%
TOTAL COMMUNICATIONS AND MEDIA DIVISION	**($1,921,124)**	**($1,526,751)**	**($1,916,526)**	**($2,204,870)**	**($2,512,415)**	**($2,541,013)**	**$28,599**	**($307,545)**	**-13.95%**
TRANSFORMATION DIVISION									
Enterprise Systems	$0	($432,566)	($3,492,186)	($4,195,946)	($3,056,811)	($4,912,824)	$1,856,013	$1,139,135	27.15%
Infrastructure	($4,069,669)	($2,756,544)	($3,826,370)	($3,475,859)	($5,688,185)	($4,410,133)	($1,278,052)	($2,212,326)	-63.65%
IT Support	($4,539,285)	($3,373,973)	($3,678,410)	($3,179,537)	($5,018,767)	($4,405,516)	($613,251)	($1,839,231)	-57.85%
800 Bay Street	($717,978)	($641,952)	($754,114)	($750,000)	($750,000)	($750,000)	$0	$0	0.00%
Facility Services	($1,039,424)	($980,169)	($928,491)	($995,419)	($1,033,653)	($1,158,099)	$124,446	($38,235)	-3.84%
Finance Committee	($77,593)	($68,849)	($94,575)	($74,537)	($85,101)	($67,374)	($17,727)	($10,564)	-14.17%
Finance Department	($2,583,762)	($2,071,084)	($2,401,642)	($1,916,487)	($1,991,052)	($2,165,856)	$174,804	($74,565)	-3.89%
Occupancy	($2,603,259)	($2,292,704)	($2,454,060)	($2,767,213)	($2,603,798)	($2,800,345)	$196,547	$163,415	5.91%
Continuous Improvement	$0	($2,045,465)	($2,892,033)	($3,377,637)	($1,039,580)	($1,826,685)	$787,106	$2,338,058	69.22%
Human Resources Department	($1,417,604)	($1,545,880)	($1,599,977)	($1,873,992)	($1,457,881)	($1,495,035)	$37,154	$416,111	22.20%
Training & Documentation	$0	($504,751)	($1,421,326)	($1,544,880)	($1,148,947)	($1,598,529)	$449,582	$395,933	25.63%
AD&D Support Department	($1,853,906)	($1,179,880)	($1,688,881)	($1,343,646)	($1,559,003)	($1,518,609)	($40,394)	($215,357)	-16.03%
AD&D Support Projects	($67,628)	($11,265)	$0	$0	$0	$0	$0	$0	0.00%
Education Program Development	($950)	($11,741)	($5,049)	($17,100)	($25,916)	($7,768)	($18,148)	($8,816)	-51.56%
Business Services	($199,696)	($101,947)	$0	$0	$0	$0	$0	$0	0.00%
Records Management	($883,158)	($1,452,875)	($1,533,634)	($1,535,070)	($1,410,072)	($1,437,598)	$27,526	$124,999	8.14%
TOTAL TRANSFORMATION DIVISION	**($20,053,911)**	**($19,471,645)**	**($26,770,749)**	**($27,047,322)**	**($26,868,765)**	**($28,554,371)**	**$1,685,605**	**$178,557**	**0.66%**
LEGAL OFFICE DIVISION									
Legal Services	($4,909,346)	($5,450,469)	($5,793,840)	($6,192,546)	($6,503,928)	($5,362,006)	($1,141,922)	($311,382)	-5.03%

	ACTUALS			BUDGET					
	ACTUALS 2019	ACTUALS 2020	ACTUALS 2021	BUDGET 2022	BUDGET 2023	FORECAST FOR 2022	DIFFERENCE TO FORECAST	CHANGE FROM PY BUDGET $	CHANGE FROM PY BUDGET %
TOTAL LEGAL OFFICE DIVISION	**($4,909,346)**	**($5,450,469)**	**($5,793,840)**	**($6,192,546)**	**($6,503,928)**	**($5,362,006)**	**($1,141,922)**	**($311,382)**	**-5.03%**
COMPLAINTS DIVISION									
I&R Administration	($592,266)	($775,676)	($1,784,262)	($1,846,491)	($1,167,020)	($1,414,405)	$247,386	$679,471	36.80%
OHPIP Assessors	$0	$0	$0	($75,000)	$0	($75,000)	$75,000	$75,000	100.00%
Health Assessments	($128,747)	($73,047)	($27,433)	($151,716)	$0	($91,183)	$91,183	$151,716	100.00%
Incapacity Investigations	($426,689)	($6,117)	$0	$0	$0	$0	$0	$0	0.00%
Medical Assessors (MIs)	($690,739)	($401,529)	($250,853)	($586,063)	($818,471)	($130,105)	($688,366)	($232,408)	-39.66%
PC Investigations	($3,641,255)	($75,729)	$0	$0	$0	$0	$0	$0	0.00%
PC Resolutions	($2,994,558)	($8,599,546)	($8,417,441)	($9,623,393)	($11,216,375)	($9,013,194)	($2,203,181)	($1,592,981)	-16.55%
Peer Opinions (IOs)	($231,893)	($122,444)	($199,126)	($275,855)	$0	($185,706)	$185,706	$275,855	100.00%
Registrar's Investigations	($1,924,565)	($102,704)	$0	$0	$0	$0	$0	$0	0.00%
Sexual Impropriety Investigation	($1,035,826)	($96,708)	$0	$0	$0	$0	$0	$0	0.00%
Spec Panel - Family Practice	$0	$0	($112,944)	($361,473)	$0	($358,340)	$358,340	$361,473	100.00%
Spec Panel - Internal Medicine	$0	$0	($45,258)	($148,695)	$0	($134,591)	$134,591	$148,695	100.00%
Spec Panel - Obstetrics	$0	$0	($30,305)	($143,517)	$0	($143,517)	$143,517	$143,517	100.00%
Spec Panel - Mental Health	$0	$0	($93,760)	($148,695)	$0	($148,468)	$148,468	$148,695	100.00%
Business, Leadership, Training	($228,022)	($110,426)	($97,722)	($189,483)	($180,806)	($121,360)	($59,447)	$8,677	4.58%
Caution Panels	($95,473)	($42,793)	($32,425)	($86,876)	$0	($7,025)	$7,025	$86,876	100.00%
Gen,Hybrid,Teleconfs,Ad-Hocs	($1,172,348)	($758,346)	($804,734)	($1,011,603)	($2,220,286)	($884,368)	($1,335,917)	($1,208,683)	-119.48%
Spec Panel - Surgical	$0	$0	($137,159)	($322,354)	$0	($318,771)	$318,771	$322,354	100.00%
ICR Committee Support	($2,287,726)	($1,968,114)	($1,906,123)	($2,257,933)	($1,110,388)	($1,994,206)	$883,818	$1,147,545	50.82%
ICRC - Health Inquiry Panels	($21,839)	($30,125)	($22,522)	($46,406)	$0	($30,565)	$30,565	$46,406	100.00%
ICRC - Specialty Panels	($911,923)	($825,539)	($553,030)	($45,543)	$0	($27,162)	$27,162	$45,543	100.00%
Compliance Monitoring	($2,082,242)	($1,965,871)	($1,867,512)	($1,886,722)	($3,282,575)	($1,954,218)	($1,328,357)	($1,395,853)	-73.98%
Training - Non-Staff	($29,241)	($2,632)	($11,452)	($42,000)	($42,090)	($42,000)	($90)	($90)	-0.21%
Advisory Services Department	($1,448,322)	($1,272,969)	($1,099,203)	($1,164,237)	($1,320,899)	($1,150,118)	($170,781)	($156,662)	-13.46%
TOTAL COMPLAINTS DIVISION	**($19,943,676)**	**($17,230,316)**	**($17,493,263)**	**($20,414,057)**	**($21,358,909)**	**($18,224,302)**	**($3,134,606)**	**($944,852)**	**-4.63%**
OPSDT									
Fitness to Practice Committee	($856)	($204)	$0	$0	$0	$0	$0	$0	0.00%
OPSDT - Case Management	($200,047)	($190,591)	($28,384)	($70,612)	($80,487)	($20,938)	($59,549)	($9,874)	-13.98%
OPSDT - Hearings	($1,727,728)	($1,851,850)	($1,830,238)	($1,506,322)	($1,116,074)	($666,750)	($449,324)	$390,248	25.91%
OPSDT - Policy/Training	($300,575)	($184,111)	($132,523)	($324,172)	($163,963)	($191,730)	$27,767	$160,209	49.42%
Tribunal Office	($905,379)	($570,276)	($1,127,043)	($1,486,139)	($990,668)	($1,047,458)	$56,789	$495,471	33.34%
TOTAL OPSDT DIVISION	**($3,134,584)**	**($2,797,033)**	**($3,118,188)**	**($3,387,246)**	**($2,351,192)**	**($1,926,876)**	**($424,316)**	**$1,036,054**	**30.59%**
GOVERNANCE									
Committee Education	$0	$0	($82,092)	($445,071)	($314,620)	($453,659)	$139,039	$130,451	29.31%
Council	($487,344)	($379,781)	($406,467)	($575,228)	($508,938)	($577,557)	$68,620	$66,290	11.52%
Council Elections	($4,508)	($5,600)	($3,340)	($5,000)	($13,000)	($3,850)	($9,150)	($8,000)	-160.00%
Executive Committee	($81,084)	($51,032)	($47,364)	($103,127)	($131,190)	($93,901)	($37,289)	($28,062)	-27.21%
FMRAC	($445,616)	($454,528)	($454,528)	($465,000)	($465,000)	($454,528)	($10,472)	$0	0.00%
GOVERNANCE	$0	($977,214)	($1,281,466)	($1,082,255)	($871,871)	($744,349)	($127,522)	$210,384	19.44%
Governance Committee	($42,472)	($91,493)	($71,248)	($82,423)	($64,656)	($91,866)	$27,210	$17,768	21.56%
Government Relations	$0	$0	($100)	($270,932)	$0	($10,732)	$10,732	$270,932	100.00%
President's Expenses	($89,803)	($87,197)	($53,186)	($171,779)	($297,150)	($172,503)	($124,647)	($125,371)	-72.98%
Strategic Planning Project	($270,443)	($5,009)	$0	$0	$0	$0	$0	$0	0.00%
TOTAL GOVERNANCE DIVISION	**($1,421,270)**	**($2,051,854)**	**($2,399,790)**	**($3,200,816)**	**($2,666,424)**	**($2,602,945)**	**($63,479)**	**$534,392**	**16.70%**
POLICY									
Patient Relations Program	($424,110)	($327,629)	($285,976)	($118,655)	($113,218)	($113,630)	$412	$5,438	4.58%
POLICY	($1,443,285)	($979,751)	($1,343,492)	($1,434,369)	($1,682,537)	($1,613,103)	($69,434)	($248,168)	-17.30%
Policy Working Group	($80,017)	($69,740)	($60,064)	($105,002)	($122,820)	($341,867)	$219,047	($17,818)	-16.97%
TOTAL POLICY DIVISION	**($1,947,412)**	**($1,377,120)**	**($1,689,532)**	**($1,658,026)**	**($1,918,574)**	**($2,068,600)**	**$150,025**	**($260,549)**	**-15.71%**
TOTAL EXPENDITURES	**($70,395,591)**	**($63,966,045)**	**($72,168,253)**	**($77,454,197)**	**($80,148,281)**	**($76,042,214)**	**($4,106,067)**	**($2,694,084)**	**-3.48%**

EXPENDITURES BY ACCOUNT

College of Physicians and Surgeons of Ontario
Cost Centre

	ACTUALS			BUDGET					
	ACTUALS 2019	ACTUALS 2020	ACTUALS 2021	BUDGET 2022	BUDGET 2023	FORECAST FOR 2022	DIFFERENCE TO FORECAST	CHANGE FROM PY BUDGET $	CHANGE FROM PY BUDGET %
PER DIEMS									
Attendance	($2,273,658)	($1,884,096)	($2,208,584)	($3,950,595)	($3,563,783)	($3,769,601)	$205,818	$386,812	9.79%
Preparation Time	($2,299,417)	($2,021,977)	($2,323,597)	($2,963,342)	($2,801,187)	($2,282,127)	($519,060)	$162,155	5.47%
Decision Writing	($611,481)	($601,551)	($804,586)	($1,289,027)	($832,512)	($833,153)	$641	$456,515	35.42%
HST on Per Diems	($426,810)	($278,115)	($335,456)	($391,534)	($373,687)	($350,538)	($23,150)	$17,846	4.56%
Travel Time	($871,275)	($254,163)	($247,730)	($525,094)	($548,321)	($501,669)	($46,651)	($23,227)	-4.42%
Teleconference	($994)	$0	$0	$0	$0	$0	$0	$0	0.00%
Expert/Peer Opinions	($774,158)	$0	$0	$0	$0	$0	$0	$0	0.00%
TOTAL PER DIEMS	**($7,257,794)**	**($5,039,903)**	**($5,919,954)**	**($9,119,592)**	**($8,119,490)**	**($7,737,087)**	**($382,403)**	**$1,000,102**	**10.97%**
STAFFING COSTS									
Salaries	($38,002,208)	($36,963,166)	($39,732,440)	($39,372,964)	($42,444,768)	($38,220,475)	($4,224,293)	($3,071,804)	-7.80%
Benefits	($5,406,604)	($5,043,510)	($4,529,777)	($5,570,215)	($6,308,651)	($5,346,723)	($961,928)	($738,436)	-13.26%
Pension	($4,044,850)	($3,558,382)	($3,712,062)	($3,922,313)	($4,054,919)	($3,845,837)	($209,082)	($132,606)	-3.38%
Part Time Help	($237,241)	($185,003)	($397,864)	($507,000)	($491,872)	($768,708)	$276,836	$15,128	2.98%
Professional Fees - Staff	($139,656)	($153,466)	($142,105)	($192,085)	($186,270)	($137,244)	($49,026)	$5,815	3.03%
Employee Engagement	($285,935)	($223,957)	($239,754)	($315,426)	($270,800)	($399,950)	$129,150	$44,626	14.15%
Training and Conferences	($572,149)	($246,379)	($1,050,240)	($982,312)	($851,998)	($1,048,764)	$196,766	$130,314	13.27%
Vacation Accrual	$4,172	$0	$0	$0	$0	$0	$0	$0	0.00%
TOTAL STAFFING COSTS	**($48,684,470)**	**($46,373,862)**	**($49,804,241)**	**($50,862,315)**	**($54,609,278)**	**($49,767,700)**	**($4,841,578)**	**($3,746,963)**	**-7.37%**
PROFESSIONAL/CONSULTING FEES									
Audit Fees	($62,498)	($53,901)	($77,061)	($50,000)	($50,000)	($50,000)	$0	$0	0.00%
Recruiting	($24,380)	($14,780)	($169,530)	($55,000)	($55,000)	($55,000)	$0	($0)	-0.00%
Consulting Fees	($4,193,348)	($2,103,068)	($3,719,762)	($4,598,954)	($3,346,578)	($4,491,710)	$1,145,132	$1,252,376	27.23%
Legal Fees	($981,253)	($1,471,356)	($916,475)	($410,000)	($485,000)	($373,955)	($111,045)	($75,000)	-18.29%
TOTAL PROFESSIONAL/CONSULTING COSTS	**($5,261,479)**	**($3,643,106)**	**($4,882,827)**	**($5,113,954)**	**($3,936,578)**	**($4,970,666)**	**$1,034,088**	**$1,177,376**	**23.02%**
OTHER COSTS									
Grants	($140,297)	($38,244)	($74,000)	($50,000)	($50,000)	($50,000)	$0	$0	0.00%
Members' Dialogue	($388,540)	($296,598)	($360,445)	($390,000)	($380,000)	($390,000)	$10,000	$10,000	2.56%
Equipment Leasing	($65,674)	($89,030)	($103,780)	($100,960)	($240,000)	($163,923)	($76,077)	($139,040)	-137.72%
Printing	($8,537)	($2,962)	($6,641)	($1,000)	($1,300)	($500)	($800)	($300)	-29.99%
Equipment Maintenance	($15,089)	($5,378)	($33,104)	($100,210)	($39,570)	($183,078)	$143,508	$60,640	60.51%
Software Costs	($875,862)	($1,445,372)	($2,382,005)	($2,193,300)	($3,308,680)	($2,578,273)	($730,407)	($1,115,380)	-50.85%
Internal Charges	$570,480	$454,432	$618,652	$1,265,492	$1,193,704	$1,265,484	($71,780)	($71,788)	5.67%
Kilometer Expense	($1,352)	$0	$0	$0	$0	$0	$0	$0	0.00%
Telephone	($271,337)	($256,965)	($403,943)	($311,805)	($373,126)	($390,193)	$17,066	($61,321)	-19.67%
Teleconference	($10,890)	$0	$0	$0	$0	$0	$0	$0	0.00%
Bad Debt Expense	($280,206)	($106,655)	($459,164)	$0	($2,500)	$647	($3,147)	($2,500)	-100.00%
Postage	($201,715)	($96,248)	($85,806)	($103,350)	($53,181)	($153,779)	$100,598	$50,169	48.54%
Photocopying	($279,907)	($218,532)	($158,609)	($217,459)	($227,450)	($207,321)	($20,129)	($9,991)	-4.59%
Miscellaneous	($90,502)	($201,731)	($58,623)	($245,022)	($154,800)	($239,997)	$85,197	$90,222	36.82%
Office Supplies	($242,016)	($501,879)	($114,175)	($156,690)	($206,040)	($163,821)	($42,219)	($49,350)	-31.50%
Courier	($31,430)	($24,346)	($26,200)	($31,050)	($33,500)	($77,821)	$44,321	($2,450)	-7.89%

EXPENDITURES BY ACCOUNT

College of Physicians and Surgeons of Ontario
Cost Centre

	ACTUALS			BUDGET					
	ACTUALS 2019	ACTUALS 2020	ACTUALS 2021	BUDGET 2022	BUDGET 2023	FORECAST FOR 2022	DIFFERENCE TO FORECAST	CHANGE FROM PY BUDGET $	CHANGE FROM PY BUDGET %
Meals	($461,483)	($237,426)	($134,553)	($335,175)	($407,246)	($311,652)	($95,594)	($72,071)	-21.50%
Accommodations	($255,041)	($76,105)	($22,714)	($217,738)	($235,578)	($220,451)	($15,127)	($17,839)	-8.19%
Travel Expenses	($479,699)	($132,019)	($89,141)	($358,874)	($516,329)	($466,307)	($50,022)	($157,455)	-43.87%
Publications and Subscriptions	($206,111)	($185,454)	($164,497)	($173,917)	($132,097)	($427,918)	$295,821	$41,820	24.05%
Reporting and Transcripts	($311,878)	($263,056)	($461,531)	($747,670)	($641,850)	($471,178)	($170,672)	$105,820	14.15%
Offsite Storage Fees	($205,831)	($180,690)	($192,813)	($202,600)	($210,000)	($200,816)	($9,184)	($7,400)	-3.65%
Witness Expenses	($45,442)	($8,403)	($18,364)	($50,700)	($40,700)	($27,400)	($13,300)	$10,000	19.72%
Therapy Costs	($391,089)	($293,966)	($241,476)	($65,000)	($50,000)	($65,000)	$15,000	$15,000	23.08%
FMRAC Fees	($445,616)	($454,528)	($454,528)	($465,000)	($465,000)	($454,528)	($10,472)	$0	0.00%
TOTAL OTHER COSTS	**($5,135,061)**	**($4,661,154)**	**($5,427,462)**	**($5,252,029)**	**($6,575,243)**	**($5,977,825)**	**($597,418)**	**($1,323,214)**	**-25.19%**
OCCUPANCY COSTS									
Electrical	($235,418)	($260,815)	($47,326)	($31,300)	($60,000)	($75,578)	$15,578	($28,700)	-91.69%
Mechanical	($143,040)	($146,835)	($183,942)	($115,100)	($155,000)	($115,100)	($39,900)	($39,900)	-34.67%
Plumbing	($52,579)	($48,760)	($30,638)	($32,500)	($60,000)	($35,015)	($24,985)	($27,500)	-84.62%
Building Consultants	($486,143)	($48,091)	($59,201)	($335,900)	($200,000)	($335,900)	$135,900	$135,900	40.46%
Building Maintenance	$0	$0	($1,176)	$0	$0	$0	$0	$0	0.00%
Other Building Costs	($94,594)	($144,877)	($324,336)	($87,900)	($100,000)	($87,900)	($12,100)	($12,100)	-13.77%
Housekeeping	($231,790)	($222,194)	($231,745)	($254,750)	($240,000)	($240,918)	$918	$14,750	5.79%
Realty Taxes	($102,593)	($108,101)	($112,793)	($115,000)	($120,000)	($114,920)	($5,080)	($5,000)	-4.35%
Hydro	($180,394)	($134,042)	($141,720)	($141,000)	($150,000)	($145,706)	($4,294)	($9,000)	-6.38%
Natural Gas	($15,093)	($14,799)	($19,215)	($20,000)	($25,000)	($24,316)	($684)	($5,000)	-25.00%
Water and Other Utilities	($18,358)	($11,095)	($6,580)	($12,000)	($12,000)	($3,225)	($8,775)	$0	0.00%
Offsite Leasing	($727,355)	($641,587)	($748,012)	($1,150,000)	($750,000)	($750,000)	$0	$400,000	34.78%
Insurance	($545,263)	($592,234)	($723,127)	($800,000)	($725,000)	($800,000)	$75,000	$75,000	9.38%
TOTAL OCCUPANCY COSTS	**($2,832,618)**	**($2,373,430)**	**($2,629,810)**	**($3,095,450)**	**($2,597,000)**	**($2,728,578)**	**$131,578**	**$498,450**	**16.10%**
DEPRECIATION AND AMORTIZATION									
Depreciation	($1,224,169)	($1,529,317)	($1,496,623)	($1,735,414)	($1,162,548)	($1,868,034)	$705,486	$572,866	33.01%
Depreciation - Non Building	$0	($345,273)	($2,007,336)	($2,275,443)	($3,148,144)	($2,992,324)	($155,820)	($872,701)	-38.35%
TOTAL DEPRECIATION AND AMORTIZATION	**($1,224,169)**	**($1,874,590)**	**($3,503,959)**	**($4,010,857)**	**($4,310,692)**	**($4,860,358)**	**$549,666**	**($299,835)**	**-7.48%**
TOTAL EXPENDITURES	**($70,395,591)**	**($63,966,045)**	**($72,168,253)**	**($77,454,197)**	**($80,148,281)**	**($76,042,214)**	**($4,106,067)**	**($2,694,084)**	**-3.48%**

Council Motion

Motion Title	2023 Budget Approval
Date of Meeting	December 9, 2022

It is moved by_____, and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario approves the Budget for 2023 (a copy of which forms Appendix “ ” to the minutes of this meeting) authorizing expenditures for the benefit of the College during the year 2023.

Council Motion

Motion Title	Fees and Remuneration By-law Amendment – Council and Committee Remuneration
Date of Meeting	December 9, 2022

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. 157:

By-law No. 157

Subsection 20(3) of By-law No. 2 (the Fees and Remuneration By-law) is amended by deleting the reference to "$178" and substituting it with "$184".

Explanatory Note: This proposed by-law does not need to be circulated to the profession.

Council Motion

Motion Title	Motion to Go In-Camera
Date of Meeting	December 9, 2022

It is moved by_____, and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario exclude the public from the part of the meeting immediately after this motion is passed, under clauses 7(2)(b) and (d) of the Health Professions Procedural Code (set out below).

Exclusion of public

7(2) Despite subsection (1), the Council may exclude the public from any meeting or part of a meeting if it is satisfied that,

(b) financial or personal or other matters may be disclosed of such a nature that the harm created by the disclosure would outweigh the desirability of adhering to the principle that meetings be open to the public;

(d) personnel matters or property acquisitions will be discussed.