CPSO

Meeting of Council

Annual Financial Meeting

June 8, 2023

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 June 8th, 2023, in the Council Chamber of the College, at 80 College Street, Toronto, Ontario. This meeting is the Annual Financial Meeting of Council.

Due to an increased number of serious threats and concern for the safety of College staff and Council members, CPSO has made the difficult decision to limit public access to our building, including our quarterly Council meetings. Accordingly, the public will not be able to attend this Council meeting in person.

The meeting will be streamed live on YouTube. Members of the public who wish to observe the meeting can access the YouTube stream that will be posted on the CPSO's website in advance of the meeting.

The meeting will convene at 9:00 a.m. on June 8th, 2023.

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

May 9, 2023

Council Meeting Agenda
Annual Financial Meeting
June 8, 2023

THURSDAY, JUNE 8, 2023

Item	Time	Topic and Objective(s)	Purpose	Page No.
*	**8:30 am** (30 mins)	**INFORMAL NETWORKING** (Breakfast available in the Dining Room)		
1	**9:00 am** (10 mins)	**Call to Order and Welcoming Remarks** (R. Gratton) • Participate in roll call and declare any conflicts of interest	Discussion	N/A
2	**9:10 am** (5 mins)	**Consent Agenda** (R. Gratton) 2.1 Approve Council meeting agenda 2.2 Approve draft minutes from Council meeting held on March 2-3, 2023 and the draft minutes from the Special Council meeting held April 14, 2023	Approval (with motion)	1-49
3	**9:15 am** (5 mins)	**Items for information:** 3.1 Executive Committee Report 3.2 Ontario Physicians and Surgeons Discipline Tribunal Cases 3.3 Government Relations Report 3.4 Finance and Audit Committee Report 3.5 Policy Report 3.6 Medical Learners Report 3.7 Update on Council Action Items	Information	 50-51 52-56 57-62 63 64-67 68-70 71-78
4	**9:20 am** (60 mins)	**CEO/Registrar's Report** (N. Whitmore)	Discussion	N/A
5	**10:20 am** (10 mins)	**President's Report** (R. Gratton)	Discussion	N/A
*	**10:30 am** (20 mins)	**NUTRITION BREAK**		
6	**10:50 am** (30 mins)	**Governance Committee Report** (J. van Vlymen) 6.1 Council Elections Update 6.2 Executive Committee Elections 6.3 Committee Appointments 6.4 2024 Voting Academic Representative Selection	 Information Decision (with Motion) Decision (with Motion) Decision (with Motion)	 79-88 89-91 92-94

Item	Time	Topic and Objective(s)	Purpose	Page No.
7	**11:20 am** (20 mins)	**Final Approval: Revised Draft Out-of-Hospital Premises Standards** (L. Reid, T. Terzis, C. Brown, J. Kitchen) • Council is asked to consider approving the revised standards regarding Out-of-Hospital Premises	Decision (with motion)	95-149
8	**11:40 am** (20 mins)	**Draft Policies for Consultation: Academic Registration and Specialist Recognition Criteria in Ontario** (S. Tulipano) • Council is asked to consider whether the draft policies can be released for consultation	Decision (with motion)	150-159
*	**12:00 pm** (60 mins)	**LUNCH**		
9	**1:00 pm** (20 mins)	**Draft Policy for Consultation: Practice Ready Assessment and potential fees** (S. Tulipano) • Council is asked to consider whether the draft policy can be released for consultation	Decision (with motion)	160-194
10	**1:20 pm** (20 mins)	**Draft Policies for Consultation: Recognition of RCPSC Subspecialist Affiliate Status and Specialist Recognition Criteria in Ontario** (S. Tulipano) • Council is asked to consider whether the draft policies can be released for consultation	Decision (with motion)	195-202
11	**1:40 pm** (5 mins)	**Approval Item: Waiver of Certain Fees Under the Residents Working Additional Hours for Pay ("Moonlighting") Policy** (S. Tulipano) • Council is asked to consider approving waiving the application fees for residents applying under the *Residents Working Additional Hours for Pay* ("Moonlighting") Policy	Decision (with motion)	203-208
12	**1:45 pm** (20 mins)	**Finance and Audit Committee Update** (T. Bertoia, D. Anderson, Tinkham LLP) **12.1 Audited Financial Statements for the 2022 Year**		209-210
		12.2 For Approval: Audited Financial Statements for the fiscal year ended December 31, 2022	Decision (with motion)	211-228
		12.3 For Approval: Appointment of the Auditor for 2023 fiscal year	Decision (with motion)	229
13	**2:05 pm** (30 mins)	**Draft Regulations for Consultation: Physician Assistant Regulation** (T. Terzis) • Council is asked to consider approving the draft regulation for consultation	Decision (with motion)	230-241

Item	Time	Topic and Objective(s)	Purpose	Page No.
14	**2:35 pm**	**Motion to move in-camera**	Decision	242
15	**2:35 pm** (10 mins)	**In-camera items**		Materials provided under separate cover
16	**2:45 pm**	**Adjournment Day 1** (R. Gratton)	N/A	N/A

DRAFT PROCEEDINGS OF THE MEETING OF COUNCIL
March 2 and 3, 2023

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

March 2, 2023

Attendees

Dr. Baraa Achtar
Dr. Madhu Azad
Ms. Lucy Becker
Dr. Marie-Pierre Carpentier
Mr. Jose Cordeiro
Ms. Joan Fisk
Mr. Murthy Ghandikota
Ms. Julia Goyal
Dr. Robert Gratton (Chair and President)
Mr. Shahab Khan
Dr. Roy Kirkpatrick
Dr. Camille Lemieux
Mr. Paul Malette
Dr. Lionel Marks de Chabris
Dr. Carys Massarella
Dr. Lydia Miljan (PhD)
Dr. Rupa Patel
Mr. Peter Pielsticker
Dr. Judith Plante
Dr. Ian Preyra (Vice Chair and Vice President)
Dr. Sarah Reid
Ms. Linda Robbins
Dr. Deborah Robertson
Dr. Patrick Safieh
Mr. Fred Sherman
Dr. Andrea Steen
Dr. Janet van Vlymen
Dr. Anne Walsh
Ms. Shannon Weber

Non-Voting Academic Representatives on Council Present:

Dr. Mary Bell
Dr. Karen Saperson

Regrets:

Dr. Glen Bandiera
Mr. Shahid Chaudhry
Dr. P. Andrea Lum
Mr. Rob Payne

1. Call to Order and Welcoming Remarks

R. Gratton, President and Chair of Council called the meeting to order at 10:30 am and welcomed all Council Members, including new Council Members, B. Achtar, M. Pierre Carpentier, C. Massarella and A. Steen. He also welcomed staff, and members of the public tuning in via YouTube. He reminded the meeting participants of the College's mission, vision and values and noted that R. Kirkpatrick is conflicted from participating and voting on the Registration items covered under item 7: Alternative Pathways to Registration and Specialist Recognition – Draft policies for circulation; item 8: CFPC Certification without Examination – Draft policy for circulation; and item 9: Emergency Class of Registration – Draft regulation for consultation. There were no other conflicts of interest declared.

F. Sherman delivered the land acknowledgement as a demonstration of recognition and respect for Indigenous peoples of Canada.

R. Gratton conducted a roll call and noted regrets.

2. Consent Agenda

R. Gratton provided an overview of the items listed on the Consent Agenda for approval noting that the order of items on day 2 of Council have shifted.

01-C-03-2023

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

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

- The Council meeting agenda for March 2 & 3, 2023, as amended; and
- The minutes from the Council meeting held on December 8 & 9, 2022, as distributed.

CARRIED

3. For Information

The following items were included in Council's package for information:

3.1 Executive Committee Report
3.2 Ontario Physicians and Surgeons Discipline Tribunal Cases
3.3 Government Relations Report
3.5 Policy Report

3.6 Medical Learners Reports – Ontario Medical Students Association (OMSA) and Professional Association of Residents of Ontario (PARO)
3.7 Update on Council Action Items

4. Chief Executive Officer / Registrar's Report

N. Whitmore, Chief Executive Officer and Registrar presented her report to Council. Targets and metrics for the final 2022 key performance indicators were presented.

The College's mission, vision, and values were highlighted.

An overview was provided on the following departments and programs:

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

The Annual Renewal Process is set to launch on April 10th and close on June 1st. An overview was provided on new questions added to the annual renewal , including a request to receive a hard copy of Dialogue. Membership fees will remain at $1725. We have the lowest fees of physician regulators in the country. Three Registration policies are coming forward to Council to address physician supply and remove barriers.

Targets and metrics for the 2023 key performance indicators from January to February 15th were highlighted.

An overview of the 2023 QI Enhanced Pilot was provided.

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

- Government Relations Update
- Message to the Profession in December about CPSO's recommendations to government on physician supply shortages, 2022 EDI Report and the December issue of eDialogue (open rate 71%)
- Media update
- Tackling Misinformation
- CPSO's In Dialogue podcast episodes released in December through to February 2023
- Celebrating Black History Month and addressing Anti-Black Racism in Healthcare in CPSO EDI Lunch and (Un)Learn with Dr. Sharda and Dr. Johnson
- Recognizing and celebrating International Women's Day 2023
- College Outreach activities

- Implementation of a Data Lake
- Implement Information Modernization initiatives and digitizing paper records
- Staff Engagement –
    - January Wellness Challenge
    - Annual Cake Auction - Staff raised $3,000 for Seeds of Hope
    - Upcoming International Women's Day documentary screening
    - Upcoming Oscar contest
    - CPSO Lean Update

5. President's Report and Emerging Issues

R. Gratton, President and Chair presented his report to Council. He noted that he had the opportunity to join the General staff meeting in December and witnessed the high level of staff engagement and celebrating Key Performance Indicators.

Updates on legislation and licensure will be coming forward to Council over the next two days. Communications to Council will be occurring in between meetings to highlight key agenda items, convey important information to keep Council apprised and foster engagement.

Highlights regarding recent MPPs meetings were provided along with reflections on a recent Roundtable on Medical Professionalism that was undertaken to support the Practice Guide review.

Focus for 2023 will continue on the by-law refresh and governance modernization opportunities. Planning for the June Council meeting is underway. A governance speaker with in-depth knowledge in health care regulation will be presenting to Council at the June meeting.

6. Governance Committee Report

J. van Vlymen, Chair of Governance Committee provided the Governance Committee Report from the January 24, 2023 meeting. She reported on the recent work of the Committee led by C. Allan, Manager of Governance and her team. The Committee received a detailed overview of the 2023 Governance Committee workplan. The work underway includes Committee succession planning and recruitment and Council election reform. It was noted that consideration of Governance modernization initiatives is underway within the College's legislative and regulatory framework. An update was provided on the 2023 Council District Elections in Districts 5 and 10. There are two positions in District 5 and four positions in District 10. A number of candidates have submitted nomination statements in both districts. The Committee will review the nomination statements, and voting will close on April 19th.

At the upcoming March meeting, the Committee will decide who will be attending this year's Federation of Medical Regulatory Authorities of Canada conference, one physician and one public member of Council will be selected to attend.

Council was asked to consider the Inquiries, Complaints and Reports Committee appointment of Dr. Shaul Tarek.

02-C-03-2023

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

The Council of the College of Physicians and Surgeons of Ontario appoints Dr. Shaul Tarek to the Inquiries, Complaints and Reports Committee, effective immediately, with the term expiring at the close of the Annual General Meeting of Council in December 2025.

CARRIED

R. Kirkpatrick departed the meeting for items 7, 8 and 9 due to a conflict of interest.

7. Alternative Pathways to Registration for Physicians Trained in the United States and Specialist Recognition Criteria in Ontario – Draft Policies for Circulation

S. Tulipano, Director of Registration and Membership Services, provided an overview of the proposed policy amendments to the "*Alternative Pathways to Registration for Physicians Trained in the United States*" and the "*Specialist Recognition Criteria in Ontario*" policies. The updated policies are being brought forward to Council for approval to circulate for notice in accordance with Section 22.21 of the Code. Following questions and discussion, Council expressed support for the updated policies. To enable the timely implementation of these new routes, the Executive Committee will approve the final policies (subject to feedback received) on behalf of Council.

03-C-03-2023

The following motion was moved by P. Malette, seconded by S. Reid and carried, 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 policy, "*Alternative Pathways to Registration for Physicians Trained in the United States*" (a copy of which forms Appendix "A" to the minutes of this meeting), and the draft revised policy, "*Specialist Recognition Criteria in Ontario*" (a copy of which forms Appendix "B" to the minutes of this meeting).

CARRIED

8. Recognition of Certification without Examination Issued by CFPC – Draft Policy for Circulation

S. Tulipano, Director of Registration and Membership Services, provided an overview of the proposed policy amendments to the "*Recognition of Certification Without Examination Issued by CFPC*" policy. Background was provided on the current policy and an overview was provided on the proposed new pathways to registration under the amended policy. The updated policy is being brought forward to Council for approval to circulate for notice in accordance with Section 22.21 of the Code. Council raised questions on how the restricted certificate classification appears on the public register. Following questions and discussion, Council expressed support

for the updated policy. To enable timely implementation of these new routes, the Executive Committee will approve the final policy (subject to feedback received) on behalf of Council.

04-C-03-2023

The following motion was moved by S. Weber, seconded by R. Patel and carried, 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 policy, "*Recognition of Certification Without Examination Issued by CFPC*" (a copy of which forms Appendix "C" to the minutes of this meeting).

CARRIED

9. Emergency Class of Registration – Draft Regulation for Consultation

C. Roxborough, Director, Policy, provided an overview of the draft regulation, "*Emergency Class of Registration* " for consultation. Amendments were drafted to Ontario Regulation 865/93 (Registration) under the *Medicine Act, 1991*, setting out a new emergency circumstances practice class of registration. Due to government directed timelines, the Executive Committee acted on behalf of Council at its February 7, 2023 meeting to approve the release for circulation in accordance with Section 22.21 of the *Health Professions Procedural Code* and an external public consultation of 60 days, ending April 10, 2023. The draft regulation is being brought forward to Council for feedback. It was noted that all health regulatory colleges are required to introduce an emergency class of registration pursuant to a bill passed in October. Following the consultation period, the draft regulation will return to the Executive Committee and Council for final approval. To comply with the final submission deadline of May 1, 2023, a virtual Council meeting will be held in April to approve the draft regulation.

Council recognized the work of Policy, Registration and Legal departments on their work to draft the regulation in response to the government's request.

R. Kirkpatrick re-joined the meeting.

10. College Performance Measurement Framework

C. Roxborough, Director, Policy, provided an overview of the 2022 College Performance Measurement Framework (CPMF) report, provided for information. The CPMF sets out expectations and reporting requirements for all Ontario health regulatory colleges. The purpose for the CPMF is to strengthen the Ministry's oversight role of the Colleges. It was confirmed that the College has met the requirements set out in the report. The final report will be posted online and submitted to the Ministry in advance of the March 31, 2023 deadline.

11. By-law Refresh Update and Proposed Register By-law Amendments

An overview was provided on the approach for bringing the proposed Register By-law Amendments to Council for consideration. C. Silver, Chief Legal Officer and M. Cooper, Senior Corporate Counsel and Privacy Officer, provided a detailed overview of the recommended changes to the By-laws relating to register content and information to be provided by members

to the College. The proposed by-law amendments are intended to update and streamline the by-laws. Substantive changes were recommended to register content relating to: (i) Hospital Reports, (ii) Charges in other jurisdictions, (iii) Post Graduate Training, (iv) Quality Assurance Committee Specified Continuing Education or Remediation Program (SCERPs), and (v) Out-of-Hospital Premises outcomes. Council asked questions on the proposed changes and provided feedback. There was discussion regarding former names and gender identification on the register. These issues will be taken back and considered further as part of the public register changes.

05-C-03-2023 – By-law Amendments regarding Register Content and Member Information (Omnibus)

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

The Council of the College of Physicians and Surgeons of Ontario proposes to make By-law No. 158, as set out in Appendix "D", after circulation to stakeholders.

CARRIED

06-C-03-2023 – By-law Amendments regarding Register Content (Hospital Reports)

The following motion was moved by R. Patel, seconded by R. Kirkpatrick and carried, that:

The Council of the College of Physicians and Surgeons of Ontario proposes to make the following By-law No. 159 after circulation to stakeholders:

By-law No. 159

Paragraph 11 of subsection 49(1) of the General By-law is revoked and substituted with the following:

Additional Register Content

49. (1) For purposes of paragraph 20 of subsection 23(2) of the Health Professions Procedural Code, the register shall contain the following additional information with respect to each member: …

11. All revocations of the member's hospital privileges at hospitals in Ontario reported to the College by hospitals under section 85.5 of the Health Professions Procedural Code or section 33 of the *Public Hospitals Act*.

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

CARRIED

07-C-03-2023 – By-law Amendments regarding Register Content (Charges)

The following motion was moved by F. Sherman, seconded by J. Fisk and carried, that:

The Council of the College of Physicians and Surgeons of Ontario proposes to make the following By-law No. 160 after circulation to stakeholders:

By-law No. 160

Paragraph 26 of subsection 49(1) of the General By-law is revoked and substituted with the following:

Additional Register Content

49. (1) For purposes of paragraph 20 of subsection 23(2) of the Health Professions Procedural Code, the register shall contain the following additional information with respect to each member: …

26. If a member has been charged with an offence under the *Health Insurance Act* (Ontario), and the charge is outstanding and is known to the College:

    i. the fact and content of the charge; and

    ii. the date and place of the charge.

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

CARRIED

08-C-03-2023 – By-law Amendments regarding Register Content (PG Training)

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

The Council of the College of Physicians and Surgeons of Ontario proposes to make the following By-law No. 161 after circulation to stakeholders:

By-law No. 161

Paragraph 31 of subsection 49(1) of the General By-law is revoked.

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

CARRIED

09-C-03-2023 – By-law Amendments regarding Register Content (QAC SCERPs)

The following motion was moved by C. Massarella, seconded by A. Steen and carried, that:

The Council of the College of Physicians and Surgeons of Ontario proposes to make the following By-law No. 162 after circulation to stakeholders:

By-law No. 162

Paragraphs 32.1, 32.2 and 32.3 of subsection 49(1) of the General By-law are revoked.

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

CARRIED

10-C-03-2023 – By-law Amendments regarding Register Content (OHP Outcomes)

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

The Council of the College of Physicians and Surgeons of Ontario proposes to make the following By-law No. 163 after circulation to stakeholders:

By-law No. 163

Subsection 49(2) of the General By-law is revoked and substituted with the following:

Additional Register Content

49. …

(2) The register shall contain the most current outcome or status of inspections of all premises (including conditions and/or reasons for fail results) carried out since April 2010 under Part XI of Ontario Regulation 114/94, including the relevant date.

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

CARRIED

Item 16 – Blood Borne Viruses – Proposal to Rescind moved up to Day 1

16. Blood Borne Viruses – Proposal to Rescind

C. Roxborough, Director of Policy and A. Chopra, Medical Advisor provided an overview of the Blood Borne Viruses policy and asked Council for approval to rescind. Following the overview, Council expressed support to rescind the policy.

11-C-03-2023

The following motion was moved by C. Lemieux, seconded by R. Patel and carried, that:

The Council of the College of Physicians and Surgeons of Ontario rescinds the College's Blood Borne Viruses policy (a copy of which forms Appendix "E" to the minutes of this meeting).

CARRIED

Item 18 – In-Camera Session moved up to Day 1

18. Motion to Go in Camera

12-C-03-2023

The following motion was moved by L. Becker, seconded by J. Plante 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 clause 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; and

(d) personnel matters or property acquisitions will be discussed.

CARRIED

19. In-Camera Session

The Council of the College of Physicians and Surgeons of Ontario entered into an in-camera session at 4:10 pm and returned to the open session at 4:50 pm.

12. Adjournment Day 1

R. Gratton adjourned day 1 of the Council meeting at 4:50 pm.

Draft Proceedings of Council – March 3, 2023

Attendees

Dr. Baraa Achtar
Dr. Madhu Azad
Ms. Lucy Becker
Dr. Marie-Pierre Carpentier
Mr. Jose Cordeiro
Ms. Joan Fisk
Mr. Murthy Ghandikota
Ms. Julia Goyal
Dr. Robert Gratton
Mr. Shahab Khan
Dr. Roy Kirkpatrick
Dr. Camille Lemieux
Mr. Paul Malette
Dr. Lionel Marks de Chabris
Dr. Carys Massarella
Ms. Lydia Miljan
Dr. Rupa Patel
Mr. Peter Pielsticker
Dr. Judith Plante
Dr. Ian Preyra
Dr. Sarah Reid
Ms. Linda Robbins
Dr. Deborah Robertson
Dr. Patrick Safieh
Mr. Fred Sherman
Dr. Andrea Steen
Dr. Janet van Vlymen
Dr. Anne Walsh
Ms. Shannon Weber

Non-Voting Academic Representatives on Council Present:

Dr. Mary Bell
Dr. Karen Saperson

Regrets:

Dr. Glen Bandiera
Mr. Shahid Chaudhry
Dr. P. Andrea Lum
Mr. Rob Payne

13. Call to Order

R. Gratton, 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. B. Achtar and L. Marks de Chabris declared conflicts of interest with respect to Item 17 Image Guidance when Administering Nerve Blocks for Adult Chronic Pain. B. Achtar also asked if he is in conflict with respect to Item 15 Decision- Making for End-of Life Care, but it was determined that he did not have a conflict of interest regarding that agenda item. No other conflicts of interest were declared.

14. Council Education Presentation – Mr. Imran Ahmed

R. Gratton introduced Council's guest speaker, Mr. Imran Ahmed, Chief Executive Officer of the Center for Countering Digital Hate. Mr. Ahmed presented on health disinformation and countering digital hate.

15. Decision Making for End-of-Life Care – Revised Policy for Final Approval

S. Reid, Council Member and Member of the Policy Working Group presented the revised draft Decision-Making for End-of-Life Care policy for final approval. An overview was provided on the provisions of the current policy outlining challenges faced. A summary was provided on the feedback received from the consultation process and the changes made to address feedback. Discussion ensued on the revised policy. L. Kirshin, Senior Policy Analyst, and R. Bernstein, Policy Analyst responded to questions raised. Following questions and discussion, Council expressed approval of the revised policy.

13-C-03-2023

The following motion was moved by R. Kirkpatrick, seconded by C. Lemieux and carried, that:

The Council of the College of Physicians and Surgeons of Ontario approves the revised policy, "Decision-Making for End-of-Life Care", formerly titled "Planning for and Providing Quality End-of-Life Care", as a policy of the College (a copy of which forms Appendix "F" to the minutes of this meeting).

CARRIED

B. Achtar and L. Marks de Chabris departed the meeting for item 17 – Image Guidance when Administering Nerve Blocks for Adult Chronic Pain due to a conflict of interest.

17. Image Guidance when Administering Nerve Blocks – Revised Standard for Approval

L. Reid, Director of Investigations and Accreditation and C. Roxborough, Director, Policy provided an overview of the revised standard for Image Guidance when Administering Nerve Blocks for Adult Chronic Pain. A summary was provided on the feedback received as part of the extensive consultation and engagement process. In addition to the public consultation, a targeted consultation was undertaken with several specialty groups and physicians practising in the pain space including the Royal College of Physicians and Surgeons of Canada and the Ontario Medical Association Section on Chronic Pain. Revised drafts were circulated to the Premises Inspection Committee. Dr. Catherine Smyth, Premises Inspection Committee member spoke to why the standard is important from a quality and patient safety perspective.

Council weighed in and debated the revised standard. Implications of not using image guidance was shared including an increase in adverse events resulting in patient harm. Following a fulsome discussion and debate, Council expressed its support for the revised standard. The Out-of-Hospital Premises will be given six months to comply with the new standard.

14-C-03-2023

The following motion was moved by R. Patel, seconded by P. Pielsticker and carried, that:

The Council of the College of Physicians and Surgeons of Ontario approves the Out-of-Hospital Premises Standard "Image Guidance When Administering Nerve Blocks for Adult Chronic Pain" (a copy of which forms Appendix "G" to the minutes of this meeting).

CARRIED

B. Achtar and L. Marks de Chabris rejoined the meeting.

20. Close Meeting - Day 2

R. Gratton closed the Council Meeting at 1:30 pm on March 3, 2023. The next Council meeting is scheduled on June 8 and 9, 2023.

Chair

Recording Secretary

Appendix A

ALTERNATIVE PATHWAYS TO REGISTRATION FOR PHYSICIANS TRAINED IN THE UNITED STATES

CPSO offers three alternative pathways for physicians trained in the United States (US) looking to gain licensure in the province of Ontario but who are applying outside of our regular registration requirements.

Pathway A

This pathway is for physicians who are certified by a US Specialty Board.

If you gain licensure under this pathway, you will be issued a restricted certificate of registration to practice independently limited to your scope of practice.

We may issue you a certificate if you have:

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

Pathway B

This pathway is for physicians who are missing RCPSC or CFPC certification and do not currently hold a certificate in a Canadian jurisdiction while having five or more continuous years of practice in Canada or the US.

If you gain licensure under this pathway, you will undergo an assessment after completing a minimum of one year of supervised practice in Ontario. Upon satisfactory completion of the assessment, you will be issued a restricted certificate of registration to practice independently limited to your scope of practice.

Your initial certificate automatically expires 18 months from the date of issuance, but the Registration Committee may renew it with or without terms, conditions and limitations.

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

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

Pathway C

This pathway is for physicians who are missing US Specialty Board certification but are eligible to take the board examinations.

If you gain licensure under this pathway, you will be issued a time-limited, restricted certificate of registration to practice under supervision. Your initial certificate automatically expires within three years from the date of issuance.

We may issue you a certificate if you have:

- One of the following degrees:
    - an acceptable medical degree as defined in Ontario Regulation 865/93 under the *Medicine Act, 1991*; **or**
    - a “doctor of osteopathy” degree granted by an osteopathic medical school in the US that was accredited by the American Osteopathic Association at the time it granted you your degree;
- successfully completed a residency program accredited by the ACGME in the last five years;
- been deemed officially eligible to take a US Specialty Board certification examination; and
- successfully completed the US Medical Licensing Examination or successfully completed an acceptable qualifying exam.

This restricted certificate is subject to the following conditions:

1. You must practice with a supervisor.
2. Your restricted certificate will expire the earlier of:
    a. three years from the date it is issued, if you do not successfully complete all outstanding examinations of a US Specialty Board;
    b. when you have been certified by a US Specialty Board; or
    c. when you are no longer eligible to write a US Specialty Board certification examination.

Only in exceptional circumstances will we consider candidates for a renewal of their restricted certificate of registration after the expiration date.

Once candidates have been certified by a US Specialty Board, they will be eligible for a restricted certificate of registration under Pathway A.

Appendix B

SPECIALIST RECOGNITION CRITERIA IN ONTARIO

Approved by Council: April 2005
Reviewed and Updated: November 2011, September 2022

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 (RCPSC) 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 (CFPC) 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 RCPSC and the CFPC.

This policy does not apply to physicians who hold certification by RCPSC or the CFPC 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 RCPSC; or
2. holds certification in family medicine by the CFPC; 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); 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 RCPSC or the CFPC, 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 RCPSC or the CFPC, and

    c. has successfully completed a practice assessment that has been directed by the Registration Committee; or
7. holds a restricted certificate of registration in Ontario that has been issued under the College's *Alternative Pathways to Registration for Physicians Trained in the United States* policy, and:
    a. has received written confirmation from a US Specialty Board of eligibility to take the certification examination on the basis of satisfactory completion of a residency program accredited by the ACGME within the last five years; or
8. holds 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. has received written confirmation from the RCPSC of current eligibility, with no pre-conditions, to take the certification examination on the basis of satisfactory completion of a RCPSC-accredited residency program in Canada or a RCPSC recognized program outside of Canada; or
9. holds 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. has received written confirmation from the CFPC of current eligibility, with no pre-conditions, to take the certification on the basis of satisfactory completion of a CFPC-accredited residency program in Canada or a CFPC 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.

Appendix C

RECOGNITION OF CERTIFICATION WITHOUT EXAMINATION ISSUED BY CFPC

There are two scenarios in which the CPSO will recognize your certification in lieu of a CFPC examination and issue you a certificate of registration:

1. You may be issued a **restricted certificate** of registration to practice independently limited to your scope of practice if you have a medical degree from an acceptable medical school and have:
    - Successfully obtained certification without examination by the CFPC.

2. You may be issued an **independent practice certificate** of registration if you have a medical degree from an acceptable medical school and have:
    - Successfully obtained certification without examination by the CFPC; and
    - Successfully completed Part 1 of the Medical Council of Canada Qualifying Examination or obtained the LMCC.

Council Motion

Motion Title	By-law Amendments re Register Content and Member Information (Omnibus)
Date of Meeting	March 2, 2023

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. 158 after circulation to stakeholders:

By-law No. 158

Sections 48, 49, 50.1, 50.2, 51 and 51b of the General By-law are revoked and substituted with the following:

Part 4. Registration Matters

Member Names and Addresses

48. (1) A member's name in the register shall be the member's full name and consistent with the name of the member as it appears on the member's degree of medicine, as supported by documentary evidence satisfactory to the College.

(2) The registrar may direct that a member's name, other than as provided in subsection 48(1), be entered in the register if the member satisfies the registrar that the member has validly changed the member's name and that the use of the newer name is not for an improper purpose.

(3) The registrar may give a direction under subsection (2) before or after the initial entry of the member's name in the register.

(4) A member's business address in the register shall be the member's principal place of practice reported by the member to the College.

Additional Register Content

49. (1) For purposes of paragraph 20 of subsection 23(2) of the Health Professions Procedural Code, the register shall contain the following additional information with respect to each member:

1. Any changes in the member's name that have been made in the register since the College first issued a certificate of registration to the member, the date of such change, if known to the College, and each former name of the member that was listed in the register as the member's name.

2. The member's registration number.

3. The member's gender.

4. The facsimile number or the business e-mail address that the member makes available to the public and uses for practice purposes.

5. In addition to the member's business address, other locations at which the member practises medicine reported by the member to the College.

6. If a member is no longer practising in Ontario, contact information regarding the transfer or provisional custody of medical records, if applicable and if that information has been provided to the College.

7. The language(s) in which the member is competent to conduct practice, as reported by the member to the College.

8. The name of the medical school from which the member received the member's degree in medicine and the year in which the member obtained the degree.

9. The date the member received specialty certification or recognition (if any).

10. The name of each hospital in Ontario where the member holds privileges and appointment to the professional staff of the hospital.

11. All revocations, suspensions, restrictions, resignations and relinquishments of the member's privileges or practice, and rejections of appointment or reappointment applications, reported to the College by hospitals under section 85.5 of the Health Professions Procedural Code or section 33 of the *Public Hospitals Act*, but excluding voluntary leaves of absence by members, in each case commencing from the date the relevant portion of this by-law goes into effect.

12. The classes of certificate of registration held by the member and the date on which each certificate was issued.

13. If a member's certificate of registration is revoked or suspended:

i. the effective date of the suspension or revocation of the member's certificate of registration:

ii. the committee that ordered the suspension or revocation of the member's certificate of registration, if applicable; and

iii. the date of removal of a suspension, if applicable.

14. If a member's certificate of registration is expired, the expiration date and the reason for the expiry.

15. In respect of a decision of the Inquiries, Complaints and Reports Committee that includes a disposition of a caution, if the complaint that led to the decision, or, in a case where there is no complaint, the first appointment of investigators in the file, is dated on or after January 1, 2015, a summary of that decision and, if applicable, a notation that the decision has been appealed or reviewed. If that decision is overturned on appeal or review, the summary of that decision shall be removed from the register.

16. In respect of a decision of the Inquiries, Complaints and Reports Committee that includes a disposition of a Specified Continuing Education or Remediation Program ("SCERP"), if the complaint that led to the decision, or, in a case where there is no complaint, the first appointment of investigators in the file is dated on or after January 1, 2015:

    i. a summary of that decision, including the elements of the SCERP;

    ii. if applicable, a notation that the decision has been appealed or reviewed; and

    iii. a notation that all of the elements of the SCERP have been completed, when so done.

    If that decision is overturned on appeal or review, the summary of that decision shall be removed from the register.

17. If terms, conditions and limitations (other than those required by regulation) are imposed on a member's certificate of registration or if terms, conditions and limitations in effect on a member's certificate of registration are amended:

    i. the effective date of the terms, conditions and limitations imposed or of the amendments; and

    ii. a notation as to whether the member or a committee imposed or amended the terms, conditions and limitations on the member's certificate of registration, and if a committee, the name of the committee.

18. If a member's certificate of registration is subject to an interim order of the Inquiries, Complaints and Reports Committee made on or after **[DATE BY-LAW COMES INTO EFFECT]**, a notation of that fact, the nature of that order and the effective date of that order, until such interim order is no longer in effect.

19. If an allegation of professional misconduct or incompetence against the member has been referred to the Ontario Physicians and Surgeons Discipline Tribunal and not yet decided:

    i. a summary of the allegation and/or notice of hearing if it was referred to the Ontario Physicians and Surgeons Discipline Tribunal prior to **[DATE BY-LAW COMES INTO EFFECT];**

    ii. the notice of hearing if it was referred to the Ontario Physicians and Surgeons Discipline Tribunal on or after **[DATE BY-LAW COMES INTO EFFECT]**;

    iii. the anticipated date of the hearing, if the date has been set;

    iv. if the hearing has been adjourned and no future date has been set, the fact of the adjournment; and

    if the decision is under reserve, that fact.

20. If the result of a disciplinary proceeding in which a finding was made by the Ontario Physicians and Surgeons Discipline Tribunal in respect of the member is in the register:

    i. the date on which the Ontario Physicians and Surgeons Discipline Tribunal made the finding;

    ii. the date on which the Ontario Physicians and Surgeons Discipline Tribunal ordered any penalty; and

    iii. if the finding is appealed, the status of the appeal and the disposition of the appeal.

21. If an allegation of the member's incapacity has been referred to the fitness to practise committee and not yet decided, a notation of that fact and the date of the referral.

22. If the result of an incapacity proceeding in which a finding was made by the fitness to practise committee in respect of the member is in the register:

    i. the date on which the fitness to practise committee made the finding;

    ii. the effective date of any order of the fitness to practise committee;

    iii. if the finding is under appeal, a notation to that effect; and

    iv. when an appeal of a finding of incapacity is finally disposed of, the notation added under subparagraph iii of this paragraph shall be removed.

23. If an application for reinstatement has been referred to the Ontario Physicians and Surgeons Discipline Tribunal, that fact and if the application has been decided, the decision of the Ontario Physicians and Surgeons Discipline Tribunal.

24. If an application for reinstatement has been made to the Council or the Executive Committee under s.74 of the Health Professions Procedural Code:

    i. that fact;

    ii. the date on which the Council or the Executive Committee will consider the application;

    iii. in the case of an application with respect to a person whose certificate of registration has been revoked or suspended as a result of disciplinary proceedings, if the application has been decided, the decision of the Council or Executive Committee; and

    iv. in the case of an application with respect to a person whose certificate of registration has been revoked or suspended as a result of incapacity proceedings, if the application has been decided, a summary of the decision of the Council or Executive Committee or if the registrar determines that it is in the public interest that the decision be disclosed, the decision of the Council or Executive Committee.

25. If an application to vary, suspend or cancel an order of the Ontario Physicians and Surgeons Discipline Tribunal has been filed on or after June 16, 2022, that fact and if the application has been decided, the decision of the Ontario Physicians and Surgeons Discipline Tribunal.

26. Where a member has been charged with an offence under the *Health Insurance Act* (Ontario), under any criminal laws of another jurisdiction or under laws of another jurisdiction comparable to the *Health Insurance Act* (Ontario) or the *Controlled Drugs and Substances Act* (Canada), and the charge is outstanding and is known to the College, the fact and content of the charge and, if known to the College, the date and place of the charge.

27. Any currently existing conditions of release following a charge against a member for a *Health Insurance Act* (Ontario) offence, or subsequent to a finding of guilt under the *Health Insurance Act* (Ontario) and pending appeal, or any variations to those conditions, in each case if known to the College.

28. If there has been a finding of guilt made against a member (a) under the *Health Insurance Act* (Ontario), on or after June 1, 2015, (b) under any criminal laws of another jurisdiction, on or after September 20, 2019, or (c) under laws of another jurisdiction comparable to the *Health Insurance* Act (Ontario) or the *Controlled Drugs and Substances Act* (Canada), on or after September 20, 2019, in each case if known to the College:

    i. a brief summary of the finding;

    ii. a brief summary of the sentence;

iii. if the finding is under appeal, a notation that it is under appeal, until the appeal is finally disposed of; and

iv. the dates of the information under subparagraphs i-iii of this paragraph.

29. If a notation of a finding of professional negligence or malpractice in respect of the member is in the register:

i. the date of the finding; and

ii. the name and location of the court that made the finding against the member, if known to the College.

30. The date on which the College issued a certificate of authorization in respect of the member, and the effective date of any revocation or suspension of the member's certificate of authorization.

31. A description of the member's postgraduate training in Ontario.

32.1 In respect of a decision of the QAC that includes a disposition of a SCERP, if the decision is made on or after June 1, 2016, the elements of the SCERP.

32.2 In respect of the elements of a SCERP, referred to in paragraph 32.1 above, a notation that all of the elements have been completed, when so done.

32.3 Where a decision referred to in paragraph 32.1 above is overturned on review, the summary shall be removed from the Register.

(2) The register shall also contain the outcome and/or status of inspections of all premises (including conditions and/or reasons for fail results) carried out since April 2010 under Part XI of Ontario Regulation 114/94, including the relevant date. This paragraph applies to the most current outcome and/or status as of January 31, 2013, and every outcome and/or status thereafter.

Public Information

50.1 (1) All information required by the by-laws to be contained in the register is designated as public, other than:

i. any information that, if made public, would violate a publication ban if known to the College; and

ii. information that the registrar refuses or has refused to post on the College's website pursuant to subsection 23(6), (7), (8), (9) or (11) of the Health Professions Procedural Code.

(2) Notwithstanding subsection 50.1(1), the content of terms, conditions or limitations are no longer public information if:

i. the terms, conditions or limitations were directed to be imposed upon a member's certificate of registration by a committee other than the Ontario Physicians and Surgeons Discipline Tribunal; and
ii. the terms, conditions or limitations have been removed from the register.

(3) The registrar may give any information contained in the register which is designated as public to any person in printed, electronic or oral form.

Liability Protection

50.2 Each member shall obtain and maintain professional liability protection that extends to all areas of the member's practice, through one or more of:

(a) membership in the Canadian Medical Protective Association;

(b) a policy of professional liability insurance issued by a company licensed to carry on business in the province, that provides coverage of at least $10,000,000;

(c) coverage under the Treasury Board Policy on Legal Assistance and Indemnification.

Notification Required by Members

51. (1) A member shall notify the College in writing or electronically as specified by the College of:

(a) the member's preferred mailing address and e-mail address for communications from the College;

(b) the address and telephone number of the member's business address that is the member's principal place of practice;

(c) the identity of each hospital and health facility in Ontario where the member holds privileges and appointment to the professional staff; and

(d) any changes in the member's name that have been made in the register since the College first issued a certificate of registration to the member.

(2) If there is a change in the information provided under subsection (1), the member shall notify the College in writing or electronically, as specified by the College, of the change within thirty days of the effective date of the change.

(3) The College may at any time and from time to time request information from its

members. In response to each such request, each member shall accurately and fully provide the College with the information requested using the Member Portal (as defined in section 51.4), or such other form or method specified by the College, by the due date set by the College. A College request for member information may include (but is not limited to) the following:

(a) the member's home address;

(b) the address of all locations at which the member practises medicine, together with a description or confirmation of the services and clinical activities provided at all locations at which the member practises medicine;

(c) a business e-mail address that the member makes available to the public and uses for practice purposes;

(d) the names, business addresses and telephone numbers of the member's associates and partners;

(e) information required to be maintained on the register of the College;

(f) the member's date of birth;

(g) information respecting the member's participation in continuing professional development and other professional training, including, without limitation, acceptable documentation confirming completion of continuing professional development programs in which the member has participated during a specified period of time;

(h) the types of privileges held at each hospital at which a member holds privileges and appointment to the professional staff of the hospital;

(i) information that relates to the professional characteristics and activities of the member that may assist the College in carrying out its objects, including but not limited to:

i. information that relates to the member's health;

ii. information about actions taken by other regulatory authorities and hospitals in respect of the member;

iii. information related to civil lawsuits involving the member;

iv. information relating to criminal arrest(s) and charge(s); and

v. information relating to offences; and

(j) information for the purposes of compiling statistical information to assist the College in fulfilling its objects.

51.1. (1) In this section “premises” and “procedure” have the definitions that are set out in s.44(1) of Ontario Regulation 114/94 made under the *Medicine Act 1991* (Ontario);

(2) Every member who performs a procedure in a premises subject to inspection under Part XI of Ontario Regulation 114/94 shall report to the College, in writing or electronically as specified by the College, within 24 hours of learning of any of the following events:

(a) Death within the premises;

(b) Death within 10 (ten) days of a procedure performed at the premises;

(c) Any procedure performed on wrong patient, site, or side; or

(d) Transfer of a patient from the premises directly to a hospital for care.

(3) In addition to reporting the event, the member shall provide all information underlying the event to the College in writing or electronically as specified by the College and in an Adverse Events Reporting form approved by the College.

51.2. (1) When applying for a certificate of registration or a renewal of a certificate of registration, an applicant must sign a declaration that the member complies with section 50.2 .

(2) A member must have available at the member’s business address, in written or electronic form, for inspection by the College, evidence that the member complies with section 50.2, or may have the provider of the protection under section 50.2 provide regular updates to the College confirming compliance with section 50.2.

(3) Section 50.2 and subsection 51.2(1) do not apply to:

(a) a member who provides written evidence, satisfactory to the College, that the member is not providing any medical service in Ontario to any person;
(b) a person who holds emeritus status or who is designated as a life member under s. 43 of O. Reg. 577/75; or
(c) a member who provides written evidence, satisfactory to the College, from the member’s employer that:

i. the member is only providing medical service to other employees of the employer, and not to any members of the public; and

ii. any professional liability claim made against the member will be covered by the employer or the employer’s insurer.

51.3. Every health profession corporation that holds a certificate of authorization from the College shall provide the registrar with notice, in writing or electronically as specified by the College, of any change in the shareholders of such corporation, who are members of the College, within fifteen days following the occurrence of such change. The notification shall

include the identity of the shareholder who has ceased to be a shareholder, and the identity of any new shareholder(s), and the date upon which such a change occurred. The notification shall be signed by a director of the health profession corporation. The notification may be sent (i) electronically as specified by the College, or (ii) in printed form by regular mail, courier or personal delivery addressed to the registrar, in care of the Registration Department of the College, re: Notice of Shareholder Change. The registrar may from time to time approve one or more standard forms (printed and/or electronic) for the purposes of providing the notice required by this section and if any such form has been approved, the notice shall be submitted in the applicable approved form.

51.4. If the College specifies, or these by-laws require or permit, that a member or a health profession corporation provide or submit to the College a notice, information, declaration or other documentation electronically, the term "electronically" includes (but is not limited to, unless the College specifies otherwise) the College's electronic member portal system (the **"Member Portal"**).

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

BLOOD BORNE VIRUSES

Approved by Council: November 1998
Reviewed and Updated: September 2005, May 2012, December 2015, September 2020

Companion Resource: Advice to the Profession

Other References:

- Classification of BBP Exposure Risk for Otolaryngology–Head and Neck Surgery
- Results from the most recent consultation

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

Blood Borne Viruses: Blood borne viruses (BBVs) refer to hepatitis B virus (HBV), hepatitis C virus (HCV), and/or human immunodeficiency virus (HIV).

Exposure Prone Procedures: The Centers for Disease Control and Prevention (CDC) defines an exposure prone procedure as one which involves one or more of the following:

1. digital palpation of a needle tip in a body cavity (a hollow space within the body or one of its organs) or the simultaneous presence of the health-care worker's fingers and a needle or other sharp instrument or object in a blind or highly confined anatomic site (e.g., during major abdominal, cardiothoracic, pelvic, vaginal and/or orthopaedic operations); or
2. repair of major traumatic injuries; or
3. manipulation, cutting or removal of any oral or perioral tissue, including tooth structures during which blood from a health-care worker has the potential to expose the patient's open tissue to a blood borne pathogen.[1]

The College has adapted the list of procedures that have been identified in the SHEA Guideline for Management of Healthcare Workers Who Are Infected with Hepatitis B Virus, Hepatitis C Virus, and/or Human Immunodeficiency Virus as those for which there is a definite risk of blood borne virus transmission (Category III Procedures).

Examples of procedures that are classified as 'exposure-prone' are set out in Appendix A.

Routine Practices: Routine Practices refers to a set of practices designed to protect health-care workers and patients from infection caused by a broad range of pathogens including blood borne viruses. These practices must be followed when caring for all patients at all times regardless of the patient's diagnosis. Key elements of Routine Practices include: point of care risk assessment; hand hygiene; use of barriers (e.g., personal protective equipment, such as gloves, mask, eye protection, face shield and/or gowns) as per the risk assessment; safe handling of sharps; and cleaning and disinfection of equipment and environmental surfaces between uses for each patient.

Routine practices are set out in Appendix B.

Treating Physician: For the purposes of this policy, treating physician refers to the physician who is managing the care of the seropositive physician with respect to their infection with a blood borne virus.

Policy

1. Physicians **must** take steps to safeguard their own health and that of their patients, and report their own seropositive status to the College in accordance with the requirements of this policy.

Safeguarding Health

2. Physicians **must** comply with the expectations set out in this section, as well as other precautionary measures, as required and as recommended by their treating physician and relevant public health authorities.[2]

Routine Practices

3. Physicians **must** adhere to Routine Practices in accordance with Appendix B. This expectation applies equally to physicians who are seropositive for blood borne viruses, and physicians who are seronegative.

HBV Vaccination

4. Physicians who are not currently and have not previously been infected with HBV are **strongly advised** to be immunized for HBV and tested to confirm the presence of an effective antibody response[3], unless a contraindication exists, or there is evidence of prior immunity.
5. Physicians who do not respond to the vaccine (do not seroconvert as evidence of immunity) are **advised** to seek expert advice on alternative vaccination protocols in order to confirm the presence of an effective antibody response.

Testing for BBVs

Beginning Exposure Prone Procedures in Ontario

6. Physicians[4] who want to perform or assist in performing exposure prone procedures in Ontario[5] **must** be tested for HCV, HIV and HBV, if they have not been confirmed immune to HBV, before they commence performing or assisting in performing exposure prone procedures in Ontario.

Periodic Testing

7. Physicians who perform or assist in performing exposure prone procedures **must** be tested for HCV and HIV every three years.
8. Physicians who perform or assist in performing exposure prone procedures **must** be tested annually for HBV unless the physician has been confirmed immune to HBV.

Testing Post-Exposure

9. Physicians who have been exposed to bodily fluids of unknown status through a specific incident, such as a needle prick, or splash onto a mucous membrane or non-intact skin **must** seek expert advice regarding the frequency of testing that is required to determine if they have been infected with one or more blood borne viruses and whether any post-exposure prophylaxis is necessary.
10. Physicians are advised to consult the Blood Borne Diseases Surveillance Protocol for Ontario Hospitals[6] and their own hospital's protocols and/or policies for detailed information about post-exposure protocols, including post-exposure prophylaxis.

Reporting Serological Status

11. Physicians who perform or assist in performing exposure prone procedures **must** report if they are seropositive with respect to HBV, HCV (including either HCV antibody or HCV RNA), and/or HIV through the completion of the Annual Renewal Survey.
12. When physicians learn they are seropositive for HBV, HCV (including either HCV antibody or HCV RNA) and/or HIV they **must** report, outside the context of the Annual Renewal Survey. Physicians **must** make a report to the College as soon as is reasonably practical after learning of their status and not wait to report their status on the next Annual Renewal Survey.[7]

Seropositive Physicians

13. Physicians[8] who have tested positive for HBV, HCV (including either HCV antibody or HCV RNA), and/or HIV and who wish to begin performing or assisting in performing exposure prone procedures in Ontario or to continue performing or assisting in performing exposure prone procedures **must** be under the care of a treating physician who has expertise in the management of their infection (e.g., infectious diseases expert, hepatologist).
14. Physicians who have tested positive for HBV, HCV (including either HCV antibody or HCV RNA), and/or HIV **must** undergo such regular testing as is recommended by their treating physician, and approved by the College for the purposes of monitoring their health, including their viral loads.

Appendix A

SHEA Guideline for Management of Healthcare Workers who are Infected with Hepatitis B Virus, Hepatitis C Virus, and/or Human Immunodeficiency Virus

Examples of Procedures Classified as Exposure Prone

The College has adapted the list of procedures that have been identified in the SHEA Guideline as those for which there is a definite risk of blood borne virus transmission (Category III Procedures). The list that follows sets out examples of procedures that are classified as 'exposure prone' for the purposes of the Annual Renewal Survey, and the Blood Borne Viruses policy:

- general surgery, including nephrectomy, small bowel resection, cholecystectomy, subtotal thyroidectomy, other elective open abdominal surgery;
- general oral surgery, including surgical extractions, hard and soft tissue biopsy (if more extensive and/or having difficult access for suturing), apicoectomy, root amputation, gingivectomy, periodontal curettage, mucogingival and osseous surgery, alveoplasty or alveoectomy, and endosseous implant surgery;
- cardiothoracic surgery, including valve replacement, coronary artery bypass grafting, other bypass surgery, heart transplantation, repair of congenital heart defects, thymectomy, and open-lung biopsy;
- open extensive head and neck surgery involving bones, including oncological procedures;
- neurosurgery, including craniotomy, other intracranial procedures, and open-spine surgery;
- nonelective procedures performed in the emergency department, including open resuscitation efforts, deep suturing to arrest hemorrhage, and internal cardiac massage;
- obstetrical/gynecological surgery, including cesarean delivery, hysterectomy, forceps delivery, episiotomy, cone biopsy, and ovarian cyst removal, and other transvaginal obstetrical and gynecological procedures involving hand-guided sharps;
- orthopedic procedures, including total knee arthroplasty, total hip arthroplasty, major joint replacement surgery, open spine surgery, and open pelvic surgery;
- extensive plastic surgery, including extensive cosmetic procedures (e.g., abdominoplasty and thoracoplasty);
- transplantation surgery (except skin and corneal transplantation);
- trauma surgery, including open head injuries, facial and jaw fracture reductions, extensive soft-tissue trauma, and ophthalmic trauma; and
- any open surgical procedure with a duration of more than three hours, probably necessitating glove change.

Appendix B

Routine Practices

The information set out in this appendix consists of information found in Public Health Ontario's documents set out in the references below.

Preamble

The term "Routine Practices" (RP) refers to a set of practices designed to protect health-care workers (HCW) and patients from infection caused by a broad range of pathogens including blood borne viruses. These practices must be followed when caring for all patients at all times regardless of the patient's diagnosis. Although RP are targeted to prevent transmission of microbes from patient to patient and HCW to HCW as well as between HCW and patient, the focus of this discussion is the transmission of microbes from HCW to patient and/or patient to HCW, in particular as related to the blood borne viruses hepatitis B (HBV), hepatitis C (HCV) and human immunodeficiency virus (HIV).

RP begin with a point of care risk assessment to consider the potential for microbial transmission during the upcoming process of care. This risk assessment is routinely followed by hand hygiene and donning of the appropriate barrier equipment (Personal Protective Equipment) prior to examining the patient. RP also include care in the use and disposal of needles and other sharp instruments, documented immunity/immunization against HBV as appropriate, and proper reprocessing of medical equipment. HCWs performing exposure prone procedures* are at an increased risk of infection with blood borne pathogens and must be knowledgeable about and diligently adhere to RP. The key elements of RP are discussed briefly below, and a glossary of terms appropriate to this document follows. For more information please check the appropriate reference(s).

Point of Care Risk Assessment

- The risk of exposure to blood, body fluids* and non-intact skin* must be considered by assessing the nature of the upcoming process of care, the patient, the HCW and the health-care environment.
- Strategies (e.g., choice of barrier precautions) must be identified and implemented to decrease exposure risk and prevent the transmission of microorganisms.

Hand Hygiene

- Hand hygiene is the single most important measure to prevent the spread of infection.
- Hand hygiene refers to both washing with soap and water or the use of alcohol-based hand rubs (ABHR).
- Use of ABHR (70-90% alcohol) is the preferred method of cleaning hands when hands are not visibly soiled. Hand washing with soap and water must be performed when hands are visibly soiled.
- Hand hygiene must be performed:
  - before initial patient/patient environment contact,
  - before performing an aseptic procedure,
  - after body fluid exposure risk and after gloves have been removed, and
  - after patient/patient environment contact.

To prevent cross-contamination of different body sites, it may be necessary to perform hand hygiene between procedures on the same person.

Gloves

- Medical grade gloves (clean, non-sterile gloves are adequate for routine care) must be worn when contact with blood/body fluids, secretions, excretions, mucous membranes*, non-intact skin and/or potentially contaminated items is anticipated.
- Gloves must be changed or removed after touching a patient's contaminated body site and prior to touching the patient's clean body site or the environment.
- Gloves must be removed promptly after use, followed by immediate hand hygiene.

Personal Protective Equipment: Mask, Eye Protection, Face Shield and Gowns

- Masks, eye protection (safety glasses, goggles or face shield) and/or gowns as appropriate to the type of contact anticipated must be worn in order to protect mucous membranes and/or clothing during clinical procedures, care activities or handling used medical equipment if splashes or sprays of blood, body fluids, secretions, or excretions might be generated.

Handling Sharps

- Sharps must be handled as minimally as possible.
- Needles must not be re-capped.
- Used needles and other sharps must be discarded in a specially designed sharps container.
- For specific requirements under Ontario's needle safety legislation see the *Occupational Health and Safety Act*, O. Regulation 474/07, Needle Safety, available at: http://www.e-laws.gov.on.ca/html/regs/english/elaws_regs_070474_e.htm.

Cleaning and Disinfection of Equipment and Environmental Surfaces

- All used medical equipment must be cleaned and then disinfected or sterilized as appropriate prior to use on another patient.
- Equipment that enters sterile tissues, including the vascular system is referred to as a critical device and must be sterilized after cleaning.
- Equipment that comes in contact with non-intact skin or mucous membranes but does not penetrate them is referred to as a semi-critical device and requires high level disinfection after cleaning.
- Equipment that touches only intact skin and not mucous membranes, or does not directly touch the patient is referred to as a non-critical device and requires low level disinfection after cleaning.
- Single-use items must be discarded after use and never be reprocessed.

Glossary

Body fluids: blood, vomit, stool, semen, vaginal fluid, urine, CSF, peritoneal fluids, pleural fluids, droplets from coughing or sneezing, except sweat, regardless of whether or not they contain visible blood.

Mucous membranes: lining of the eyes, nose and mouth.

Non-intact skin: open lesions, and dermatitis.

References

Public Health Ontario. Ministry of Health and Long-Term Care of Ontario. Routine practices and additional precautions in all health care settings. November 2012
http://www.publichealthontario.ca/en/eRepository/RPAP_All_HealthCare_Settings_Eng2012.pdf

Public Health Ontario. Ministry of Health and Long-Term Care of Ontario. Best practices for hand hygiene in all health care settings. April 2014
http://www.publichealthontario.ca/en/eRepository/2010-12%20BP%20Hand%20Hygiene.pdf

Public Health Ontario. Ministry of Health and Long-Term Care of Ontario. Best practices for cleaning, disinfection and sterilization of medical equipment/devices. May 2013.
http://www.publichealthontario.ca/en/eRepository/PIDAC_Cleaning_Disinfection_and_Sterilization_2013.pdf

Endnotes

1. Centers for Disease Control and Prevention, 1998.

2. This includes precautionary measures required by hospitals and other health-care institutions where physicians work.

3. If a physician has received the hepatitis B vaccine and is immune, the physician will have antibody to hepatitis B surface antigen (anti-HBsAg).

4. This includes physicians who perform or assist in performing procedures that may become exposure-prone (for example, a laparoscopic procedure that may convert to an open procedure) and also includes physicians who have the potential to perform or assist in performing exposure prone procedures in the course of providing day-to-day care even though they may not be currently performing them.

5. This applies to new registrants (including physicians who perform or assist in performing exposure prone procedures in other jurisdictions), physicians who will begin performing or assisting in performing exposure prone procedures as part of their educational training, and physicians who are changing their scope of practice or re-entering practice. Physicians may wish to consult *the Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice* policy for more general guidance on these topics.

6. This document is available at: https://www.oha.com/Documents/Blood%20Borne%20Diseases%20Protocol%20(November%202018).pdf

7. Physicians **are advised** to contact the College's Physicians Advisory Service at 416-967-2606; Toll Free: 1-800-268-7096 Ext.606

8. This includes physicians who wish to perform or assist in performing procedures that may become exposure-prone (for example, a laparoscopic procedure that may convert to an open procedure) and also includes physicians who will have the potential to perform or assist in performing exposure prone procedures in the course of providing day-to-day care even though they may not be currently performing them.

Decision-Making for End-of-Life Care

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

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

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

Definitions

Advance care planning discussions: Conversations that take place between health-care providers, patients, and/or substitute decision-makers to help identify the patient's personal, cultural, and religious/spiritual values and beliefs, as well as their wishes, including which treatment(s) they may or may not want at the end of life. The aim of these discussions is to prepare patients and/or substitute decision-makers for future decision-making.

Goals of care discussions: Conversations that take place between health-care providers, patients, and/or substitute decision-makers, in the context of a significant illness or disease when there are treatment or care decisions that need to be made in the foreseeable future. The aim of these discussions is to educate patients and/or substitute decision-makers about available treatment options, and help define obtainable goals of care by identifying the patient's personal, cultural, and religious/spiritual values and beliefs, as well as their wishes, if they can be ascertained.

Life-sustaining treatment: Any medical procedure or intervention which utilizes mechanical or other artificial means to sustain or replace a vital function essential to the life of the patient (e.g., mechanical ventilation, medically assisted nutrition and hydration, vasopressors and/or inotropes).

Resuscitative measures: A suite of medical interventions (e.g., chest compressions, artificial ventilation, intubation and/or defibrillation) that may be provided following cardiac or respiratory arrest in an attempt to restore or maintain cardiac, pulmonary, and circulatory function. Not all interventions in the suite will necessarily be provided or required in all cases.

Substitute decision-maker (SDM): A person, or persons, who may give or refuse consent to a treatment on behalf of an incapable person.[1]

Policy

Advance Care Planning and Goals of Care Discussions

1. When a patient's specific circumstances and health status make it appropriate, physicians who provide care as part of a sustained physician-patient relationship[2] **must**, where possible, initiate a discussion about advance care planning, which includes:
    a. raising end-of-life care issues with the patient; and
    b. encouraging the patient to discuss those issues with their SDM.

2. When patients have a significant illness or disease and are at risk of clinical deterioration (e.g., cardiac or respiratory arrest) in the foreseeable future, physicians **must**, where possible:
    a. initiate a timely goals of care discussion, which includes:
        i. describing the underlying illness or medical condition and prognosis;
        ii. educating the patient and/or SDM about the available treatment options, which may include resuscitative measures, and explaining the outcomes that can and cannot be achieved; and
        iii. defining the patient's goals of care by helping the patient and/or SDM identify the patient's wishes, values and beliefs, or if they cannot be ascertained, identifying what would be in the patient's best interests;
    b. facilitate the goals of care discussion to help build understanding about the treatment decision(s) that need to be made; and
    c. review the goals of care discussion with the patient and/or SDM whenever it is appropriate to do so (e.g., when there is a significant change in the patient's medical condition or when the patient and/or SDM indicate that the patient's wishes, values, and/or beliefs have changed).

End-of-Life Care

3. Physicians **must** seek to balance medical expertise and patient wishes, values, and beliefs when making decisions about end-of-life care.

[1] For more information on SDMs, please see the College's *Consent to Treatment* policy.
[2] A sustained physician-patient relationship is a physician-patient relationship where care is actively managed over multiple encounters.

Withdrawing Life-Sustaining Treatment

4. Physicians **must** obtain consent from patients and/or SDMs before withdrawing life-sustaining treatment.[3] As part of the consent process, physicians **must**:

    a. explain why they are proposing to withdraw life-sustaining treatment; and
    b. provide details regarding clinically appropriate care or treatment(s) they propose to provide.

Managing Disagreements

5. Where consent cannot be obtained and the physician is of the view that life-sustaining treatment should be withdrawn, the physician **must** try to resolve the disagreement with the patient and/or SDM in a timely manner by:
    a. communicating information regarding the patient's diagnosis and/or prognosis, treatment options, and assessments of those options;
    b. identifying the basis for the disagreement, taking reasonable steps to clarify any misunderstandings, and answering questions;
    c. reassuring the patient and/or SDM that the patient will continue to receive clinically appropriate care or treatment(s);
    d. making reasonable efforts to support the patient's physical comfort, as well as their emotional, psychological, and spiritual well-being, by offering supportive services (e.g., social work, spiritual care, palliative care) and consultation with the patient's primary care provider, where appropriate and available;
    e. offering to make a referral to another health-care provider, where appropriate and available;
    f. facilitating an independent second opinion, where appropriate and available; and
    g. offering consultation with an ethicist or ethics committee, where appropriate and available.

6. Physicians **must** determine whether to apply to the Consent and Capacity Board when:[4]
    a. in relation to treatment decisions, disagreements arise with an SDM over an interpretation of a wish, or assessment of the applicability of a wish, or if no wish can be ascertained, what is in the best interests of the patient; or

[3] The Supreme Court of Canada determined in *Cuthbertson v. Rasouli, 2013 SCC 53* (hereinafter *Rasouli*) that consent must be obtained prior to withdrawing life-sustaining treatment.
[4] In *Rasouli,* the Supreme Court of Canada determined that when SDMs refuse to provide consent to withdraw life-support that, in the physician's opinion, is not in the patient's best interests, physicians must apply to the Consent and Capacity Board for a determination of whether the SDM has met the substitute decision-making requirements of the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A (hereinafter *HCCA*) and whether the refused consent is valid. See in particular paragraph 119 of *Rasouli*.

b. they are of the view that an SDM is not acting in accordance with their legislative requirements.[5]

Withholding Resuscitative Measures

A physician's decision to withhold resuscitative measures is not "treatment" and therefore does not require the patient or SDM's consent.[6]

Where the risk of harm associated with resuscitation outweighs the potential benefits, physicians may decide it is appropriate to withhold resuscitative measures and write an order to this effect in the patient's medical record.

7. Before determining that resuscitative measures will not be provided because the risk of harm in providing those interventions would outweigh the potential benefits, the physician **must** consider the patient's wishes, as well as their personal, cultural, and religious/spiritual values and beliefs, if they can be ascertained or the physician is aware of them.

8. When a physician determines that the risk of harm in providing resuscitative measures would outweigh the potential benefits, the physician can write an order to withhold resuscitative measures in the patient's medical record but **must**, before writing the order:
    a. inform the patient and/or SDM that the order will be written;
    b. communicate information regarding the patient's diagnosis and/or prognosis, and explain to the patient and/or SDM why resuscitative measures are not appropriate, including the risk of harm in providing those interventions and the likely clinical outcomes if the patient is resuscitated; and
    c. provide details to the patient and/or SDM regarding clinically appropriate care or treatment(s) they propose to provide.

9. When a patient's condition is deteriorating rapidly and there is an imminent need for an order to be written (e.g., actual or impending cardiac or respiratory arrest), the physician can write an order to withhold resuscitative measures in the patient's medical record but **must** comply with the expectations set out in provision 8 at the earliest opportunity (rather than before writing the order).

[5] Please see footnote 1.

[6] In *Wawrzyniak v. Livingstone*, 2019 ONSC 4900, the Court concluded that the writing of a Do Not Resuscitate (DNR) order and withholding of cardiopulmonary resuscitation (CPR) do not fall within the meaning of "treatment" in the *HCCA*. Accordingly, consent is not required prior to writing a DNR order and withholding resuscitative measures, such as CPR, and physicians are only required to provide resuscitative measures in accordance with the standard of care.

Providing Support if Disagreements Arise

10. If the patient and/or SDM disagree with the writing of an order to withhold resuscitative measures, the physician can write the order, but **must**, at the earliest opportunity after learning of the disagreement, make reasonable efforts to provide support to the patient and/or SDM by:
    a. identifying the basis for the disagreement, taking reasonable steps to clarify any misunderstandings, and answering questions;
    b. reassuring the patient and/or SDM that the patient will continue to receive clinically appropriate care or treatment(s);
    c. making reasonable efforts to support the patient's physical comfort, as well as their emotional, psychological, and spiritual well-being, by offering supportive services (e.g., social work, spiritual care, palliative care) and consultation with the patient's primary care provider, where appropriate and available;
    d. facilitating an independent second opinion, where appropriate and available; and
    e. offering consultation with an ethicist or ethics committee, where appropriate and available.

Out-of-Hospital Premises Standard: Image Guidance When Administering Nerve Blocks for Adult Chronic Pain

The use of image guidance is widely accepted as a critical component of administering nerve blocks in order to reduce the risk of complications, ensure the injection is delivered to the target, and enhance patient safety.

In keeping with our mandate to serve the public interest, this Standard sets out the College of Physicians and Surgeons of Ontario's (CPSO) expectations for physicians administering nerve blocks for adult chronic pain in Out-of-Hospital Premises.

Scope

This Standard only applies to nerve blocks administered for adult chronic pain in Out-of-Hospital Premises.

Standard

1. When administering nerve blocks for adult chronic pain physicians **must** practise in a manner that is consistent with this Standard, relevant practice standards, quality standards, and clinical practice guidelines.
2. Physicians administering neuraxial, paravertebral and plexus nerve blocks for adult chronic pain **must** use image guidance.
3. Physicians administering all other nerve blocks for adult chronic pain **must** use image guidance where indicated in the circumstances, taking into account:
    a. the depth of the nerve being blocked;
    b. proximity to the neuroaxis and/or other vital structures[1];
    c. whether the patient has abnormal or challenging anatomy;
    d. whether the patient has had an injury or undergone previous surgery in the area where the nerve block is to be administered that may affect the anatomy or spread of medications; and
    e. the potential harm to the patient were the block to be administered incorrectly.
4. When using image guidance physicians **must**:
    a. capture an image demonstrating appropriate placement (e.g., an image of needle placement, appropriate contrast spread, or local anesthetic spread) and maintain a copy of the image in the patient's medical record or documentation of how and/or where the image can be accessed;[2]
    b. ensure that the level of imaging used (e.g. ultrasound, computerized tomography (CT) and/or fluoroscopy) is appropriate for the type of nerve block being performed;

[1] For example, major blood vessels and internal organs.
[2] Images must be retained in accordance with CPSO's *Medical Records Management* policy.

   i. For example, it is not appropriate for ultrasound to be used for all nerve blocks. CT and/or fluoroscopy must be used where clinically indicated;[3]

c. be qualified and able to perform the required level of imaging within their premises or have a process in place for the timely referral of patients to a qualified health care professional.[4]

[3] Please see the *Advice to the Profession* document for additional information on practice standards, quality standards, and clinical practice guidelines that indicate where CT and/or fluoroscopy are necessary for proper visualization.

[4] For example, physicians practising in premises with only ultrasound available, need to have procedures in place for the referral of patients in the event that CT and/or fluoroscopy is indicated for proper visualization.

DRAFT PROCEEDINGS OF THE SPECIAL MEETING OF COUNCIL
April 14, 2023

Location: Virtual Meeting via MS Teams

Attendees

Dr. Baraa Achtar
Ms. Lucy Becker
Dr. Marie-Pierre Carpentier
Mr. Jose Cordeiro
Ms. Joan Fisk
Mr. Murthy Ghandikota
Ms. Julia Goyal
Dr. Robert Gratton (Chair and President)
Mr. Paul Malette
Dr. Lionel Marks de Chabris
Dr. Carys Massarella
Dr. Lydia Miljan (Ph.D.)
Mr. Rob Payne
Dr. Judith Plante
Dr. Ian Preyra (Vice Chair and Vice President)
Dr. Sarah Reid
Dr. Deborah Robertson
Dr. Patrick Safieh
Mr. Fred Sherman
Dr. Andrea Steen
Dr. Janet van Vlymen
Dr. Anne Walsh
Ms. Shannon Weber

Non-Voting Academic Representatives on Council Present:

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

Regrets:
Dr. Madhu Azad
Mr. Shahid Chaudhry
Mr. Shahab Khan
Dr. Camille Lemieux
Dr. Rupa Patel
Mr. Peter Pielsticker
Ms. Linda Robbins

Conflicts of Interest:
Dr. Glen Bandiera
Dr. Roy Kirkpatrick

1. Call to Order and Welcoming Remarks

R. Gratton, President and Chair of Council called the Special Council meeting to order at 8:00 am and welcomed all Council Members, staff, and members of the public, tuning in via YouTube.

I. Preyra delivered the land acknowledgment as a demonstration of recognition and respect for the Indigenous peoples of Canada.

R. Gratton conducted a roll call and noted regrets. He noted that G. Bandiera and R. Kirkpatrick are conflicted from participating and voting on the Registration item and, as such, have recused themselves from the meeting. There were no other conflicts of interest declared.

R. Gratton informed Council that the Executive Committee, at its meeting on April 4, 2023, approved the following revised draft policies as final policies on behalf of Council, consistent with Council's direction in order to support the timely implementation of these revised policies:

- Alternative Pathways for Registration and Specialist Recognition
- Recognition of Certification without Examinations Issued by CFPC

2. Revised Draft Regulation for Final Approval: Emergency Circumstances Practice Class of Registration

C. Roxborough, Director of Policy, provided an overview of the revised draft regulation, "*Emergency Circumstances Practice Class of Registration,* " for final approval, including the feedback received from the 60-day consultation period.

Revisions were made to grant Council the ability to specify additional limitations that may be needed when enacting this class of registration in order to align eligibility with the nature of the emergency circumstances themselves. Additional revisions were made to the exemptions granted to those transferring from this class to the independent practice class to ensure alignment with the Federation of Medical Regulatory Authorities of Canada national standard and to remove financial barriers.

Pending Council's approval of the draft regulation, the regulation proposal will be submitted to the Ministry of Health (MoH) in advance of the May 1, 2023 submission deadline. The draft regulation is subject to feedback from the MoH. Following questions and discussion, Council expressed support for the revised draft regulation.

Council recognized the work of the Policy, Registration, and Legal departments to draft the regulation and meet the tight timelines set out by the MoH.

01-C-04-2023

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

The Council of the College of Physicians and Surgeons of Ontario approves making an amendment to Ontario Regulation 856/93: Registration, regarding an Emergency Circumstances Practice class of registration (a copy of which amendment forms Appendix "A" to the minutes of this meeting) and submitting it to the Ontario Minister of Health for review and the approval of the Lieutenant Governor in Council.

Record of each Council vote set out below on Council Motion: 01-C-04-2023 – Emergency Circumstances Practice Class of Registration:

Number	Name	Vote
1.	Baraa Achtar	Abstained
2.	Lucy Becker	In favour
3.	Marie-Pierre Carpentier	In favour
4.	Jose Cordeiro	Abstained
5.	Joan Fisk	In favour
6.	Murthy Ghandikota	In favour
7.	Julia Goyal	In favour
8.	Rob Gratton	Abstained
9.	Paul Malette	In favour
10.	Lionel Marks de Chabris	In favour
11.	Carys Massarella	In favour
12.	Lydia Miljan	In favour
13.	Rob Payne	In favour
14.	Judith Plante	In favour
15.	Ian Preyra	In favour
16.	Sarah Reid	In favour
17.	Deborah Robertson	In favour
18.	Patrick Safieh	In favour
19.	Fred Sherman	In favour
20.	Andrea Steen	In favour
21.	Janet van Vlymen	In favour
22.	Anne Walsh	In favour
23.	Shannon Weber	In favour

CARRIED

3. Close Meeting

R. Gratton closed the Council Meeting at 8:20 am. The next Council meeting is scheduled on June 8 and 9, 2023.

Chair

Recording Secretary

Appendix A

Emergency Circumstances Practice

s. 6.2 (1) The standards and qualifications for a certificate of registration authorizing practice in emergency circumstances are as follows:

1. Council has determineds ~~s~~ that there are emergency circumstances, and that it is in the public interest that the College issue emergency certificates of registration to address the emergency circumstances.
2. The applicant must have a degree in medicine.
3. The applicant must have completed a year of postgraduate medical education at an accredited medical school.
4. A member who is a physician holding a certificate of registration authorizing independent practice must give an undertaking to supervise the applicant and be responsible for providing continuing care for patients attended by the applicant in Ontario.
5. The applicant must have any other standard or qualification that Council has identified as necessary in order for emergency certificates of registration to assist in addressing the determined emergency circumstances.

(2) The requirements of paragraphs 1, 2, 3 ~~and,~~ 4, and 5 of subsection (1) are non-exemptible.

(3) It is a term, condition and limitation of a certificate of registration authorizing practice in emergency circumstances that:

1. The holder practice under the supervision of a member who is a physician;
2. The certificate expires the earlier of:
   (a) one year from the date the certificate was issued or renewed; or
   (b) the ninetieth day after Council declares that the emergency circumstances have ended.
3. The holder must adhere to any other terms, conditions and limitations that Council has identified as necessary in order for emergency certificates of registration to assist in addressing the determined emergency circumstances.

(4) The Registrar may renew a certificate of registration authorizing practice in emergency circumstances for one or more periods, each of which is not to exceed one year, provided that Council has not declared that the emergency circumstances have ended.

Proposed addition to Independent Practice class

3.2 (1) An applicant who has held a certificate of registration authorizing practice in emergency circumstances issued by the College in the year immediately preceding his or her application for a certificate of registration authorizing independent practice is exempt from the standards and qualifications required under paragraphs ~~2,~~ 3 and 4 of subsection 3(1) if the applicant satisfies the following standards and qualifications:

1. The applicant must have certification by the Royal College of Physicians and Surgeons of Canada or by the College of Family Physicians of Canada.

3.2(2) An applicant who has held a certificate of registration authorizing practice in emergency circumstances issued by the College in the year immediately preceding his or her application for a certificate of registration authorizing independent practice is exempt from the standards and qualifications required under paragraph (c) of subsection 2(2), only in respect of payment of the relevant application fee and not, for greater certainty, in respect of payment of the annual membership fee.

Council Motion

Motion Title	Council Meeting Consent Agenda
Date of Meeting	June 8, 2023

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 June 8, 2023; and
- The minutes from the meeting of Council held March 2 and 3, 2023, and the minutes from the Special Council meeting held April 14, 2023.

Council Briefing Note

June 2023

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

Executive Committee Meeting – February 7, 2023

03-EX-Feb-2023 **Acceptable Qualifying Examinations**

On a motion moved by I. Preyra, seconded by S. Reid and carried, that the Executive Committee approves on behalf of Council, the revised draft Acceptable Qualifying Examinations policy as a policy of the College, set out in Appendix "A".

06-EX-Feb-2023 **Emergency Circumstances Practice Class of Registration – Draft Regulation for Consultation**

On a motion moved by J. Fisk, seconded by J. van Vlymen and carried, that the Executive Committee approves engaging in the notice and consultation process in accordance with Section 22.21 of the *Health Professions Procedural Code*, on behalf of Council, in respect of the draft regulation for Emergency Circumstances Practice Class of Registration as set out in Appendix "E".

Executive Committee Meeting – April 4, 2023

03-EX-Apr-2023 **Revised Draft Policy for Final Approval: Recognition of Certification without Examination Issued by the College of Family Physicians of Canada (CFPC)**

On a motion moved by J. Fisk, seconded by S. Reid and carried, that the Executive Committee approves on behalf of Council, the revised draft *"Recognition of Certification without Examination Issued by the College of Family Physicians of Canada (CFPC)"* policy, as set out in Appendix "A".

04-EX-Apr-2023 **Revised Draft Policies for Final Approval: Alternative Pathways to Registration for Physicians Trained in the United States and Specialist Recognition Criteria in Ontario**

On a motion moved by L. Miljan, seconded by S. Reid and carried, that the Executive Committee approves on behalf of Council, the revised draft *"Alternative Pathways to Registration for Physicians Trained in the United States"* and *"Specialist Recognition Criteria in Ontario"* policies, as set out in Appendices "B" and "C".

Executive Committee Meeting – May 16, 2023

04-EX-May-2023 **Vice-Chair Appointment to the Inquiries, Complaints and Reports Committee**

On a motion moved by J. Fisk, seconded by L. Miljan and carried, that the Executive Committee approves on behalf of Council, the appointment of Dr. Thomas Bertoia as Vice-Chair of the Inquiries, Complaints and Reports Committee for a term effective May 16, 2023, and ending with the Annual General Meeting of Council in 2024.

Contact: Robert Gratton, President
Carolyn Silver, Chief Legal Officer

Date: May 24, 2023

Council Briefing Note

June 2023

Topic:	**Ontario Physicians and Surgeons Discipline Tribunal Report of Completed Cases | February 9, 2023 – May 19, 2023**
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 February 9, 2023 and May 19, 2023 by the Ontario Physicians and Surgeons Discipline Tribunal.
- It includes reasons on discipline hearings (liability and/or penalty), costs hearings, motions and case management issues brought before the Tribunal.
- This report is for information.

Current Status and Analysis

In the period reported, the Tribunal released 7 reasons for decision:

- 4 reasons on findings (liability) and penalty
- 1 set of reasons on penalty only
- 1 set of reasons on liability only
- 1 set of reasons on a motion

Findings

Liability findings included:

- 4 findings of disgraceful, dishonorable or unprofessional conduct
- 2 findings of failure to maintain the standard of practice of the profession
- 1 finding of incompetence
- 1 finding of contravening a term, condition or limitation on certificate of registration
- 1 finding that the governing body of another health profession found that the member committed an act of professional misconduct that would, in the opinion of the panel, be an act of professional misconduct under the Code or as defined in the regulations.

Penalty

Penalty orders included:

- 5 reprimands
- 4 suspensions
- 1 revocation
- 3 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 $72,590 and the minimum costs ordered were $6000.

Motions and case management decisions

For the period reported, the Tribunal released one order and reasons for decision on a motion.

TABLE 1: TRIBUNAL DECISIONS – FINDINGS (February 9, 2023 to May 19, 2023)

Citation and hyperlink to published reasons	Physician	Date of Reasons	Sexual Abuse	Disgraceful, Dishonourable, Unprofessional	Failed to maintain standard of practice	Incompetence	Other
2023 ONPSDT 8	Safar Zadeh	February 28, 2023		X			
2023 ONPSDT 9	Ghumman	March 28, 2023			X		
2023 ONPSDT 10	Kadri	April 6, 2023		X	X	X	- Contravened a term, condition or limitation on certificate of registration
2023 ONPSDT 11	Gerber	April 18, 2023		X			
2023 ONPSDT 12	Czilli	April 28, 2023		X			- Another health profession found that the member committed an act of professional misconduct that would, in the opinion of the panel, be an act of professional misconduct under the Code or as defined in the regulations.

TABLE 2: TRIBUNAL DECISIONS - PENALTIES (February 9, 2023 to May 19, 2023)

Citation and hyperlink to published reasons	Physician	Date of reasons	Penalty (TCL = Terms, Conditions or Limitations)	Length of suspension in months	Costs
2023 ONPSDT 6	Khan	February 9, 2023	Revocation, reprimand		$72,590
2023 ONPSDT 8	Safar Zadeh	March 28, 2023	Reprimand, suspension, TCL	5	$6000
2023 ONPSDT 9	Ghumman	March 28, 2023	Reprimand, suspension, TCL	2	$6000
2023 ONPSDT 11	Gerber	April 18, 2023	Reprimand, suspension, TCL	4	$6000
2023 ONPSDT 12	Czilli	April 28, 2023	Reprimand, suspension	12	$6000

TABLE 3: TRIBUNAL DECISIONS - MOTIONS AND CASE MANAGEMENT (February 9, 2023 to May 19, 2023)

Citation and hyperlink to published reasons	Physician(s)	Date of reasons	Motion/Case management outcome	Nature of motion/case management issue
2022 ONPSDT 7	Phillips/Trozzi/Luchkiw	March 23, 2023	The physicians' motion that the Tribunal exclude (with one exception) all evidence produced under the relevant Appointments of Investigator (AOIs) was dismissed.	The physicians argued that the AOIs were not legally valid because the College's statements about COVID-19 conduct and communications were merely guidelines, without binding effect, and could not be the basis for the belief that they had committed acts of professional misconduct or were incompetent. The panel dismissed the members' motion, rejecting the physicians' argument that the AOIs were invalid.

Council Briefing Note

June 2023

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):	Tanya Terzis, Interim Manager, Policy
Attachment(s):	**Appendix A:** CPSO Submission to the Legislative Committee on Bill 60

Update on the Ontario Legislature

- Legislators have been busy since returning to Queen's Park – introducing a slate of bills addressing health, education, and affordability among others. Among the bills introduced, those not impacting but of relevance to CPSO include:
    - Bill 79, Working for Workers Act, 2023, is a government bill that would, if passed, expand the mandate of non-health regulators (e.g., the Law Society, Ontario College of Teachers etc.) to consult with government to ensure that Ontarians "have access to adequate numbers of qualified, skilled and competent regulated professionals." The bill is in Third Reading and is likely to pass.
    - Bill 76, Respecting Workers in Health Care and Related Fields Act, introduced by opposition MPPs, would require minimum protections, compensation, and benefits for health-care workers. The bill carried through First Reading and is unlikely to pass.

- Meanwhile, the Ontario Liberals have signaled they will choose their next leader before the end of the year. Liberal Member of Parliament, Nate Erskine-Smith recently put his name forward as the first official candidate. Others, including MPP Ted Hsu (Kingston and the Islands) and MPP Adil Shamji, a physician-turned-MPP, have been reported as potential candidates.

Issues of Interest

a) Bill 60, Your Health Act Update

- On government's first day back to Queen's Park, Health Minister Sylvia Jones introduced Bill 60, *Your Health Act*, which enacts and amends various other acts. The bill comprises three Schedules, two of which are of importance to CPSO:

- Schedule 1 enacts the *Integrated Community Health Services Centres Act* and replaces the *Independent Health Facilities Act*, paving the way for the government's plans to expand diagnostic and surgical procedures in community-based clinics.
- Schedule 2 of the Bill amends several other Acts to advance the government's "As of Right" rules that would permit out-of-province regulated health professionals (OPRHPs) to practise in Ontario without first having to register with the appropriate regulatory college.

- CPSO made a submission to the Committee, specifically addressing Schedule 2 of the bill (**Appendix A**).

- The Committee submission articulates that CPSO's registration processes are not a barrier to timely mobility within Canada and that there are many practical and regulatory risks associated with the proposal. It also provides a recommendation that OPRHPs only be permitted to practise if engaged in a registration process to minimize risks.

- The bill was sent back to the House with a very minor amendment that does not change the bill's intent and impact. The bill has passed and is expected to receive Royal Assent.

- Regulations will subsequently need to be developed by the government to enact the various provisions of the bill. CPSO staff have been in regular contact with Ministry staff to understand the intended direction of the regulations that will be developed to implement the bill's provisions. That said, as of the submission deadline, there have been no substantive or public developments on this front.

b) Emergency Circumstances Practice Class of Registration

- At its last ad-hoc meeting, Council approved a final draft emergency circumstances practice class of registration for submission to the government. Since Council's approval, staff have prepared a submission package to the government outlining the proposed changes to the registration regulation. The package was submitted to the government on May 1st and any feedback received will be considered by staff. Updates will be given to Council should there be any changes to the draft regulation.

Interactions with Government

- Staff continue to engage with government on Bill 60 and the subsequent regulations that will follow to enact it, physician assistant regulation, registration matters, public members, and other emergent issues.

CPSO

Serving the people of Ontario through effective regulation of medical doctors

College of Physicians and Surgeons of Ontario

Submission on Bill 60: Your Health Act, 2023

Standing Committee on Social Policy

March 23, 2023

Bill 60: Your Health Act, 2023

Response from the College of Physicians and Surgeons of Ontario

Introduction

Thank you for the opportunity to provide input on the legislative amendments related to Bill 60, *Your Health Act, 2023*. The College of Physicians and Surgeons of Ontario (CPSO) has a legislative mandate to serve in the public interest by ensuring physicians have the proper credentials for licensing, setting standards for the profession through policy, and ensuring quality care is provided by physicians. This is in addition to our role in managing and investigating complaints from the public concerning a physician's care, conduct, and capacity to practise and referring cases to discipline, as required.

Bill 60 introduces many significant changes, however, the focus of this submission will be on Schedule 2, which advances government's "As of Right" rules that would permit out-of-province registered health professionals (OPRHPs) to practice in Ontario without first having to register with the appropriate health regulatory college.

CPSO appreciates the significant system pressures the government is seeking to address with this proposal and is committed to finding novel and timely solutions that both respond to these system pressures and strengthen interjurisdictional mobility within Canada. Given the expeditious manner with which CPSO registers labour mobility applicants, it is not clear what benefit will be derived from the proposed framework. In addition, we have identified some key concerns and minimum requirements that government will need to address moving forward.

CPSO's Current Approach to Supporting Labour Mobility

Central to CPSO's regulatory obligations is to ensure that Ontarians are provided care by duly qualified physicians though a robust registration process. Like all regulatory bodies, we discharge this responsibility by exercising the authorities granted to us in legislation as we collect and assess relevant information to determine the suitability of applicants.

While CPSO maintains robust standards and safeguards when registering applicants, our current process is not a barrier to mobility within Canada. CPSO already supports and facilitates timely registration of physicians licensed elsewhere in Canada. For example:

- CPSO registers labour mobility applicants on average, within 2.6 weeks from initial contact and within 5 days of receiving a complete application.
- At the Minister's request, CPSO introduced a new *Temporary Independent Practice* class of licensure precisely to support interjurisdictional mobility within Canada and can issue these licenses very quickly when needed.
- CPSO has also leveraged previously existing regulatory mechanisms to support interprovincial temporary coverage of emergency departments in Northern Ontario, issuing licenses within as little as one day on numerous occasions.

CPSO continues to have discussions with other medical regulators across Canada to find further efficiencies and explore novel approaches to registration, including examining the issue of national licensure.

Concerns with "As of Right" Rules

Bill 60 establishes the legislative framework needed to implement "As of Right" rules with the eventual development of several regulations. The framework being developed contemplates enabling individuals who are not vetted or overseen by the provincial regulator to practice for a period without a license. This introduces both practical and regulatory challenges that need to be addressed.

Vetting of OPRHPs

Prior to issuing a license, CPSO and other regulators exercise significant regulatory authority to access detailed information about applicants in order to ensure the public interest will be served through issuance of a license. For example, and in keeping with our legislative responsibilities, concerns identified by other jurisdictions are always considered as part of CPSO's registration process. Other system partners will not be able to exercise the same degree of rigour that health regulatory colleges do when registering labour mobility applicants.

It is also not clear how other system partners will be equally well positioned to assess or enforce any terms, conditions, and limitations on an OPRHP's license or how scopes of practice will be assessed for those registered in another province. This includes imposing any site or supervision restrictions.

Moreover, regulators can collect and assess all the relevant information in a very timely and effective manner. It is not clear how other system partners will access or analyze this information in a manner that is any more efficient than our registration processes.

Oversight of OPRHPs

Regulatory bodies exercise their authority granted through legislation to regulate all health professionals they license. It would thus not be appropriate to hold health regulatory colleges accountable for the conduct of OPRHPs while they practice in Ontario if they have neither been vetted nor registered by the relevant College. Appropriate oversight will need to be established outside of our regulatory framework as regulatory bodies cannot be responsible for the conduct of OPRHPs. This will include providing clarity on who will be responsible for conducting investigations and managing complaints.

Jurisdictional Limitations

Related to the above, it is unlikely that the government will simply be able to rely on the out-of-province regulatory body to retain oversight of these individuals while they are in Ontario. It is not reasonable to presume that out-of-province regulatory bodies will be willing or able to assume responsibility for this period of practice, particularly given jurisdictional limitations that exist. For example, the legal authority of each regulatory body is relied upon to compel information (e.g., personal health information, summoning of witnesses) and enforce outcomes. The provincial or territorial nature of this authority may preclude these regulators from retaining full responsibility for practice in another jurisdiction.

Additionally, many medical regulatory authorities across the country are concerned with this proposal and any presumption of relying on their oversight.

Going Forward

The issues outlined above will need to be addressed as government pursues the enactment of these "As of Right" rules. At minimum, we urge the government to enact a framework that acts as a bridge between the start of practice and being registered. Rather than enabling individuals to practice in Ontario in a manner that is untethered from our registration processes, there needs to be a requirement that OPRHPs be engaged in their respective college's registration processes prior to commencing practice in the province. This will support the government's intention of being able to immediately deploy OPRHPs without delay and minimize, but not remove, the risks identified above. Should government pursue this approach, CPSO is committed to ensuring that the window of unregulated practice is as minimal as possible so that the public is protected while the system pressures are being addressed.

In closing, CPSO will continue to support the timely registration of labour mobility applicants to ensure that the need for this new framework is minimized and that we are not acting as a barrier to addressing system shortages. We offer the considerations above based on our extensive regulatory experience and understanding of the registration and licensure processes. We are happy to continue to offer our expertise to government as it explores next steps in approval of this legislation and the eventual development of the regulations needed to enact it.

Council Briefing Note

June 2023

Topic:	Finance and Audit Committee Report
Purpose:	For Information
Main Contact(s):	Dr. Thomas Bertoia, Chair, Finance and Audit Committee Nathalie Novak, Chief Operating Officer Douglas Anderson, Corporate Services Officer Leslee Frampton, Manager Finance
Attachment(s):	N/A

Issue

- The Finance and Audit Committee met on April 20, 2023 and has the following summary for the June 2023 Council meeting

Finance and Audit Committee Summary

The Finance and Audit Committee addressed the following agenda items:

- The Committee discussed the 2023 work plan and Terms of Reference
- The Committee reviewed the year end 2022 Financial Statements and Variance Analysis
- Tinkham LLP Chartered Professional Accountants presented the 2022 Audited Financial Statements to the Committee
- The Committee reviewed the Internal Controls
- The Committee held an in-camera meeting with the auditors
- The Committee discussed the budget objectives for 2023
- The Committee took part in Security training hosted by IT and Governance

Council Briefing Note

June 2023

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.
Main Contact(s):	Tanya Terzis, Interim Manager, 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

Preliminary Consultation: *Physician Behaviour in the Professional Environment ("Physician Behaviour")*

- CPSO is reviewing the current *Physician Behaviour* policy that outlines physicians' responsibilities to patients, other health-care professionals, and the profession.
- A 60-day public consultation launched following March 2023 Council via CPSO's regular communication and social media channels inviting external stakeholders and membership.

- This consultation received 282 responses: 32 through written feedback and 250 via the online survey. The vast majority of respondents were Ontario physicians, and feedback was received from five organizations.[1]
- An overview of the key themes that emerged in the feedback is provided below. Further updates regarding the status of this review will be provided to Council at future meetings.
- When asked to describe "disruptive behaviour," survey respondents broadly described unprofessional or inappropriate behaviour by physicians that compromises or interferes with the delivery of quality care or the safety of the health-care team.
    - However, some physician respondents felt that the term "disruptive" is not necessarily harmful and that disruption is sometimes necessary to affect needed change (for example, advocating for patients, "calling in" discriminatory or harmful policies and practices, or raising concerns to or challenging administration).
- Many respondents noted that reporting disruptive behaviour can be difficult, with feedback indicating that physicians believe there can be abuses of power, subversive behaviour, and retaliation from leaders when instances of disruptive behaviour are reported.
    - Key supportive suggestions from physician respondents included normalizing positive feedback and behaviours and empowering staff to report through mechanisms that do not penalize the reporter and protect witnesses.
- The majority of survey respondents agreed that the current policy provides helpful guidance related to physician behaviour in the professional environment. However, much of the feedback focused on suggestions to update the policy, which included:
    - Integrating principles of equity, diversity, and inclusion (EDI), including explicitly referencing prejudiced and discriminatory behaviours as disruptive;
    - Reframing the language and expectations to support a positive working environment, including acknowledging the importance of physician health and wellness and that disruptive behaviour is often the effect (or cause) of burnout and moral injury; and
    - Expanding "professional setting" to include academic environments and social media.
- The vast majority of survey respondents felt that it is appropriate for physicians to advocate for issues related to healthcare institutions and the system in a public forum.

2. Policy Status Table

- The status of ongoing policy development and reviews and target completion dates are presented for Council's information for each meeting as **Appendix A**.

[1] Organizational respondents included: the Canadian Psychiatric Association, College of Nurses of Ontario, FAIR Association of Victims for Accident Insurance Reform, Ontario Medical Association, and the Professional Association of Residents of Ontario.

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		
Physician Behaviour in the Professional Environment	Mar-23		✓					**2025**	
Practice Guide	Dec-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*.
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**	

Table 2: Policy Review Schedule

Policy	Target Review	Policy	Target Review
Providing Physician Services During Job Actions	2018/19	*Prescribing Drugs*	2024/25
Cannabis for Medical Purposes	2020/21	*Boundary Violations*	2024/25
Consent to Treatment	2020/21	*Medical Records Documentation*	2025/26
Physician Treatment of Self, Family Members, or Others Close to Them	2021/22	*Medical Records Management*	2025/26
Accepting New Patients	2022/23	*Protecting Personal Health Information*	2025/26
Ending the Physician-Patient Relationship	2022/23	*Advertising*	2025/26
Uninsured Services: Billing and Block Fees	2022/23	*Delegation of Controlled Acts*	2025/26
Ensuring Competence: Changing Scope of Practice and Re-entering Practice	2023/24	*Professional Responsibilities in Medical Education*	2025/26
Public Health Emergencies	2023/24	*Third Party Medical Reports*	2025/26
Closing a Medical Practice	2024/25	*Complementary and Alternative Medicine*	2026
Availability and Coverage	2024/25	*Virtual Care*	2027
Managing Tests	2024/25	*Social Media*	2027
Transitions in Care	2024/25	*Dispensing Drugs*	2027
Walk-in Clinics	2024/25	*Decision-Making for End-of-Life Care*	2028
Disclosure of Harm	2024/25		

Ontario Medical Students' Association
CPSO Council Update
June 8, 2023

Presented by:
Angie Salomon, President
Jeeventh Kaur, President-Elect

OMSA Ontario Medical Students Association
AÉMO Association des étudiant·e·s de médecine de l'Ontario

Thank you once again to the CPSO for inviting representatives from the Ontario Medical Students Association (OMSA) to observe and participate in your Council meeting.

OMSA represents the interests and concerns of Ontario's 4,000+ 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.

Spring is certainly OMSA's busy period, and since the last CPSO meeting we have successfully implemented a number of significant initiatives and events. We hosted the second **OMSA Equity, Diversity, Inclusion, and Decolonization conference** that brought together students, faculty, and advocates from various schools and communities in Ontario to identify EDID gaps in the curriculum, showcase grassroots efforts for curriculum reform, and discuss systemic solutions. We also carried out our provincial **Day of Action focusing on Housing and Homelessness**, with asks related to increasing the affordability, availability, and accessibility of housing for all. We also held the **Ontario Student Medical Education Research Conference (OSMERC)**, which showcased important student projects pertaining to the reform of medical education curricula in Ontario.

On May 20th and 21st, OMSA hosted its largest-ever **in-person Leadership Summit and Annual General Meeting (AGM)**. Eighty Ontario medical students were selected as delegates to learn about **leading through uncertainty** through workshops, speakers, and a case competition**.** At the AGM, we elected our 2023-2024 OMSA Executive Board. **Angie Salomon** has successfully completed her term as OMSA President & Chair of OMA Section of Medical Students, and **Jeeventh Kaur** will soon be transitioning into this role.

Thank you for welcoming medical students to the table and we look forward to continuing to work together.

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 June 2023

PARO champions the issues that create the conditions for residents to be their best and ensure optimal patient care. We have determined that to fulfill this mission we must achieve three key goals.

Optimal training - so that residents feel confident to succeed and competent to achieve excellence in patient care.

Optimal working conditions - where residents enjoy working and learning in a safe, respectful, and healthy environment.

Optimal transitions – into residency, through residency, and into practice – so that residents are able to make informed career choices, have equitable access to practice opportunities, and acquire practice management skills for residency and beyond.

We are pleased to submit this update on some strategic initiatives at PARO.

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.

PARO Input to the OMA/Ministry of Health Collective Bargaining
As part of the OMA/MOH negotiations preparations, the OMA provides us with the opportunity to identified some priorities for our PARO.

For this round, we have identified three priorities:
- ensuring that new entrants to practice should be treated fairly, equitably, and on the same terms as our colleagues already in practice.
- *to end Mandatory Return of Service Agreement requirements*
- Create a funding mechanism for hospital employers to remunerate residents and supervising physicians who provide service under the Restricted Registration Program.

PARO Site Teams
Our PARO GC Site Teams have delivered incredible groundbreaking work at our sites to help deliver on our strategic plan**.**

- At McMaster the preparation work for the upcoming accreditation has been outstanding. Over 80% of McMaster residents participated in the accreditation workshops hosted by RDOC and PARO – this is the highest participation rate at a Canadian University – ever!

• Team NOSM have been successful in getting a resident lounge back for our members!

• Team Queen's has been working with their PG Dean to improve hospital spaces at Kingston General while they undergo renovations.

• Team Ottawa has put a focus on providing a robust social calendar with events at the Christmas Market and a Dog Park Social. The Ottawa Team is planning a transition to practice event, open to our other sites, which will feature some PARO graduates who can share their experiences and how-to tips.

• Team Toronto's has been working with the hospital committee (of 19 hospitals) to remove duplication of training modules for individual hospital clinical sites so that our members only have to do them once. We can't underscore how much of a change in the daily life of a resident this is. They are also working to ensure all facilities have appropriate lactation and multi-faith prayer facilities.

• Team Western has successfully advocated for the implementation of the two-way ride home program for on-call residents, and for private, safe breastfeeding spaces for lactating residents.

PARO Board of Directors
We are pleased to announce that Dr. Sonja Wakeling, an Emergency Medicine trainee, is our 2023-2024 PARO President and Dr. Ari Cuperfain was elected to a third term as PARO Treasurer. Dr. Brendan Lew moves into the role of Past President on June 2nd.

Dr. Wakeling will be the RDoC Board member for Ontario, and Dr. Cuperfain continues this year in the role of PARO Member at RDOC. The rest of our Board will be elected at our next PARO General Council meeting next week.

Kind Regards,

Zainab Mohamed, MD
PARO Board of Directors

Council Briefing Note

June 2023

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 March 2 and 3, 2023, and a Special Council meeting on April 14, 2023. The motions carried and the implementation status of those decisions are outlined in Table 1.

Table 1: Council Decisions from March and April Meetings

Reference	Motions Carried	Status
01-C-03-2023	**Consent Agenda** 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 March 2 & 3, 2023, as amended; and – The minutes from the Council meeting held on December 8 & 9, 2022, as distributed.	Completed.

Reference	Motions Carried	Status
02-C-03-2023	**Governance Committee Report – Committee Appointment** The Council of the College of Physicians and Surgeons of Ontario appoints Dr. Shaul Tarek to the Inquiries, Complaints and Reports Committee, effective immediately, with the term expiring at the close of the Annual General Meeting of Council in December 2025.	Completed.
03-C-03-2023	**Alternative Pathways to Registration for Physicians Training in the United States and Specialist Recognition Criteria in Ontario – Draft Policies for Circulation** 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 policy, "*Alternative Pathways to Registration for Physicians Trained in the United States*" (a copy of which forms Appendix "A" to the minutes of this meeting), and the draft revised policy, "*Specialist Recognition Criteria in Ontario*" (a copy of which forms Appendix "B" to the minutes of this meeting).	Completed.
04-C-03-2023	**Recognition of Certification without Examination Issued by CFPC – Draft Policy for Circulation** 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 policy, "*Recognition of Certification Without Examination Issued by CFPC*" (a copy of which forms Appendix "C" to the minutes of this meeting).	Completed.
05-C-03-2023	**By-law Amendments regarding Register Content and Member Information (Omnibus)** The Council of the College of Physicians and Surgeons of Ontario proposes to make By-law No. 158, as set out in Appendix "D", after circulation to stakeholders.	By-law circulated to the profession. Proposed amendments to be provided to Council at a future meeting.

Reference	Motions Carried	Status
06-C-03-2023	**By-law Amendments regarding Register Content (Hospital Reports)** The Council of the College of Physicians and Surgeons of Ontario proposes to make the following By-law No. 159 after circulation to stakeholders: **By-law No. 159** Paragraph 11 of subsection 49(1) of the General By-law is revoked and substituted with the following: Additional Register Content 49. (1) For purposes of paragraph 20 of subsection 23(2) of the Health Professions Procedural Code, the register shall contain the following additional information with respect to each member: … 11. All revocations of the member's hospital privileges at hospitals in Ontario reported to the College by hospitals under section 85.5 of the Health Professions Procedural Code or section 33 of the *Public Hospitals Act*. Explanatory Note: This proposed by-law must be circulated to the profession.	By-law circulated to the profession. Proposed amendments to be provided to Council at a future meeting.
07-C-03-2023	**By-law Amendments regarding Register Content (Charges)** The Council of the College of Physicians and Surgeons of Ontario proposes to make the following By-law No. 160 after circulation to stakeholders: **By-law No. 160** Paragraph 26 of subsection 49(1) of the General By-law is revoked and substituted with the following: **Additional Register Content** **49.** (1) For purposes of paragraph 20 of subsection 23(2) of the Health Professions Procedural Code, the register shall	By-law circulated to the profession. Proposed amendments to be provided to Council at a future meeting.

Reference	Motions Carried	Status
	contain the following additional information with respect to each member: … 26. If a member has been charged with an offence under the *Health Insurance Act* (Ontario), and the charge is outstanding and is known to the College: i. the fact and content of the charge; and ii. the date and place of the charge. Explanatory Note: This proposed by-law must be circulated to the profession.	
08-C-03-2023	**By-law Amendments regarding Register Content (PG Training)** The Council of the College of Physicians and Surgeons of Ontario proposes to make the following By-law No. 161 after circulation to stakeholders: **By-law No. 161** Paragraph 31 of subsection 49(1) of the General By-law is revoked. Explanatory Note: This proposed by-law must be circulated to the profession.	By-law circulated to the profession. Proposed amendments to be provided to Council at a future meeting.

Reference	Motions Carried	Status
09-C-03-2023	**By-law Amendments regarding Register Content (QAC SCERPs)** The Council of the College of Physicians and Surgeons of Ontario proposes to make the following By-law No. 162 after circulation to stakeholders: **By-law No. 162** Paragraphs 32.1, 32.2 and 32.3 of subsection 49(1) of the General By-law are revoked. Explanatory Note: This proposed by-law must be circulated to the profession.	By-law circulated to the profession. Proposed amendments to be provided to Council at a future meeting.
10-C-03-2023	**By-law Amendments regarding Register Content (OHP Outcomes)** The Council of the College of Physicians and Surgeons of Ontario proposes to make the following By-law No. 163 after circulation to stakeholders: **By-law No. 163** Subsection 49(2) of the General By-law is revoked and substituted with the following: **Additional Register Content** **49. …** (2) The register shall contain the most current outcome or status of inspections of all premises (including conditions and/or reasons for fail results) carried out since April 2010 under Part XI of Ontario Regulation 114/94, including the relevant date. Explanatory Note: This proposed by-law must be circulated to the profession.	By-law circulated to the profession. Proposed amendments to be provided to Council at a future meeting.

Reference	Motions Carried	Status
11-C-03-2023	**Blood Borne Viruses – Proposal to Rescind** The Council of the College of Physicians and Surgeons of Ontario rescinds the College's Blood Borne Viruses policy (a copy of which forms Appendix "E" to the minutes of this meeting).	Completed.
12-C-03-2023	**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 clause 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; and (d) personnel matters or property acquisitions will be discussed.	Completed.
13-C-03-2023	**Decision Making for End-of-Life Care – Revised Policy for Final Approval** The Council of the College of Physicians and Surgeons of Ontario approves the revised policy, "Decision-Making for End-of-Life Care", formerly titled "Planning for and Providing Quality End-of-Life Care", as a policy of the College (a copy of which forms Appendix "F" to the minutes of this meeting).	Completed.

<table>
<tr><th>Reference</th><th>Motions Carried</th><th>Status</th></tr>
<tr><td><u>14-C-03-2023</u></td><td><u>Image Guidance when Administering Nerve Blocks – Revised Standard for Approval</u>

The Council of the College of Physicians and Surgeons of Ontario approves the Out-of-Hospital Premises Standard “Image Guidance When Administering Nerve Blocks for Adult Chronic Pain” (a copy of which forms Appendix “G“ to the minutes of this meeting).</td><td>Completed.</td></tr>
<tr><td><u>01-C-04-2023</u></td><td><u>Revised Draft Regulation for Final Approval: Emergency Circumstances Practice Class of Registration</u>

The Council of the College of Physicians and Surgeons of Ontario approves making an amendment to Ontario Regulation 856/93: Registration, regarding an Emergency Circumstances Practice class of registration (a copy of which amendment forms Appendix “A“ to the minutes of this meeting) and submitting it to the Ontario Minister of Health for review and the approval of the Lieutenant Governor in Council.

<u>Record of each Council vote set out below on Council Motion: 01-C-04-2023 – Emergency Circumstances Practice Class of Registration:</u>

<table>
<tr><th>Number</th><th>Name</th><th>Vote</th></tr>
<tr><td>1.</td><td>Baraa Achtar</td><td>Abstained</td></tr>
<tr><td>2.</td><td>Lucy Becker</td><td>In favour</td></tr>
<tr><td>3.</td><td>Marie-Pierre Carpentier</td><td>In favour</td></tr>
<tr><td>4.</td><td>Jose Cordeiro</td><td>Abstained</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>Abstained</td></tr>
<tr><td>9.</td><td>Paul Malette</td><td>In favour</td></tr>
<tr><td>10.</td><td>Lionel Marks de Chabris</td><td>In favour</td></tr>
<tr><td>11.</td><td>Carys Massarella</td><td>In favour</td></tr>
<tr><td>12.</td><td>Lydia Miljan</td><td>In favour</td></tr>
<tr><td>13.</td><td>Rob Payne</td><td>In favour</td></tr>
<tr><td>14.</td><td>Judith Plante</td><td>In favour</td></tr>
<tr><td>15.</td><td>Ian Preyra</td><td>In favour</td></tr>
<tr><td>16.</td><td>Sarah Reid</td><td>In favour</td></tr>
<tr><td>17.</td><td>Deborah Robertson</td><td>In favour</td></tr>
<tr><td>18.</td><td>Patrick Safieh</td><td>In favour</td></tr>
<tr><td>19.</td><td>Fred Sherman</td><td>In favour</td></tr>
<tr><td>20.</td><td>Andrea Steen</td><td>In favour</td></tr>
</table></td><td>Draft Regulation Submitted to the Ministry of Health.</td></tr>
</table>

Reference	Motions Carried			Status
	21. 22. 23.	Janet van Vlymen Anne Walsh Shannon Weber	In favour In favour In favour	

Council Briefing Note

June 2023

Topic:	Executive Committee Elections
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation Continuous Improvement
Public Interest Rationale:	Accountability: Ensuring appropriate governance of the CPSO through elections of the Executive Committee.
Main Contacts:	Dr. Janet van Vlymen, Chair, Governance Committee Cameo Allan, Manager of Governance Laura Rinke-Vanderwoude, Governance Analyst
Attachment:	**Appendix A:** Nomination Statements

Issue

- There are upcoming vacancies for the President, Vice President, and Executive Member Representative positions on the Executive Committee for 2024. A vote will take place at the June 8, 2023 meeting of Council to fill these vacancies.

Background

- The Executive Committee's current composition includes:
  - Dr. Janet van Vlymen, Past President
  - Dr. Robert Gratton, President
  - Dr. Ian Preyra, Vice President
  - Dr. Lydia Miljan (PhD), Executive Member Representative
  - Ms. Joan Fisk, Executive Member Representative
  - Dr. Sarah Reid, Executive Member Representative

Current Status and Analysis

- Nomination statements for the vacant positions have been received from:
    - Dr. Ian Preyra, for President
    - Ms. Joan Fisk, for Vice-President, or, alternatively, Executive Member Representative
    - Dr. Sarah Reid, for Vice-President, or, alternatively, Executive Member Representative
    - Dr. Lydia Miljan (PhD), for Executive Member Representative
    - Dr. Patrick Safieh, for Executive Member Representative
- In accordance with the By-laws, the Past President will be appointed to serve on the Executive Committee.
- All nominees for contested positions will be given the opportunity to address Council prior to the election.
- Where there is only one candidate for a position, the candidates will be acclaimed. Where there is more than one candidate for a position, an election will be held using 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. A test vote will be emailed to all Council members prior to the Executive Committee elections.
- As per the General By-Law, the term for Executive Committee members is one year. Dr. Robert Gratton will serve as Past President for the 2024 Executive Committee.

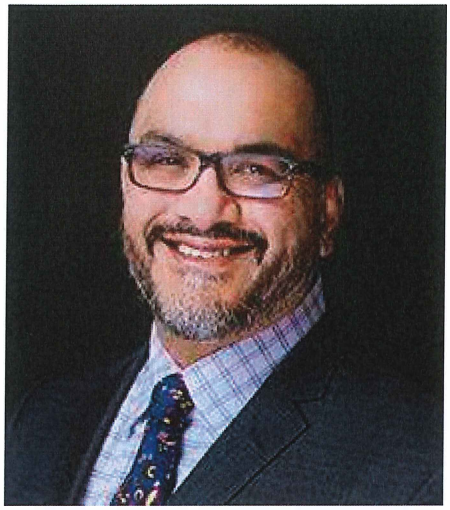
Question for Council

1. Who does Council elect as the 2023-2024 Executive Committee President, Vice President, and three Executive Member Representative positions?

Executive Committee Elections

Nomination Statement & Form: Ian Preyra

CPSO



Dr. Ian Preyra, District 4 Representative (Burlington, ON)

Principal area of practice: Emergency Medicine

Nominated For:

President

Appointed Council Terms:

2019-2022
2022-2025

CPSO Involvement:

Executive Committee	2001 - 2023
Finance & Audit Committee	2021 - 2025
Governance Committee	2020 - 2023
Ontario Physicians and Surgeons Discipline Tribunal & Fitness to Practise Committee	2020 - 2023

Nomination Statement:

I am honored to stand for election as President of the College. I have had the good fortune to serve on Council and participate in many of the CPSO's committees during a time of growth and transition for the organization. Under the leadership of our past Presidents and Registrar/CEO, our College has modernized and reinvented itself, becoming an exemplar of what a professional regulator ought to be.

If elected, I will work tirelessly to advance the Mission of the College with integrity and transparency while collaborating to build sustainable, effective governance structures that will ensure that the organization can succeed in an uncertain future.

I look forward to the opportunity to help lead the ongoing and important work of guiding the profession and protecting the public.

Executive Committee Elections

Nomination Statement & Form: Joan Fisk

Ms. Joan Fisk, Public Member of Council

Chief Executive Officer

Nominated For:

Vice-President
Executive Member Representative

Appointed Council Terms:

Nov 2017 – Oct 2020
Nov 2020 – Nov 2023

CPSO Involvement:

Executive Committee	2020-2023
Inquiries, Reports & Complaints Committee	2017-2023 General Panel Chair 2020-2023

Nomination Statement:

I am asking for your support to be elected to the role of Vice-President of the Council. I have enjoyed my role on the Executive Committee of Council and ICRC, most recently as Chair of the General Panel.

My background includes leadership positions in Business, as CEO in 3 different capacities, as a Public Board member, serving on many Committees for 17 years on Governance as a Board Chair of the WWLHIN, and the Chair of all LHIN's across the Province.

This has provided me an understanding of the health care system in Ontario, and the roles and responsibilities of the Health Sector, and a familiarity of historical and current trends in improvements to health services delivery.

I have taken the Queens Governance program and many courses in Governance at Rotman School of Management.

Executive Committee Elections

Nomination Statement & Form: Joan Fisk

I am asking for your support to be re-elected to the role of Executive Committee Member Representative. I have enjoyed my role on the Executive Committee of Council and ICRC, most recently as Chair of the General Panel.

My background includes leadership positions in Business, as CEO in 3 different capacities, as a Public Board member, serving on many Committees for 17 years on Governance as a Board Chair of the WWLHIN, and the Chair of all LHIN's across the Province.

This has provided me an understanding of the health care system in Ontario, and the roles and responsibilities of the Health Sector, and a familiarity of historical and current trends in improvements to health services delivery.

I have taken the Queens Governance program and many courses in Governance at Rotman School of Management.

Executive Committee Elections

Nomination Statement & Form: Sarah Reid

Dr. Sarah Reid, District 7 Representative (Ottawa, ON)

Principal area of practice: Pediatric Emergency Medicine

Nominated For:

Vice-President
Executive Member Representative

Appointed Council Terms:

2018-2021
2021-2024

CPSO Involvement:

Education Committee	2018 - 2019
Executive Committee	2022 - 2023
Governance Committee	2021 - 2022
Policy Working Group	2020 - 2024
Quality Assurance Committee	2019 - 2024

Nomination Statement:

I am seeking to become Vice-President because I am committed to upholding CPSO's vision of trusted doctors providing great care and have the experience to support and lead our work on Council. In my clinical role as a Pediatric Emergency Physician, I remain dedicated to my patients, their families and my colleagues as we work together within a health care system under tremendous strain.

I was first elected to Council in 2018 and am currently serving my second term representing District 7. In addition to my work on Council, I am Chair of the Quality Assurance Committee and Policy Working Group, and a member of the Executive Committee. These additional responsibilities at CPSO have afforded me a deeper understanding of the College's commitment to continuous improvement, right-touch regulation, and Quality Improvement. I fully appreciate the importance of our role in guiding the profession within our legislative framework, collaborating with stakeholders, and upholding and integrating EDI principles into all our work.

I am an open, optimistic and collaborative leader and I would be honoured to serve as your Vice-President. I sincerely appreciate your consideration.

Executive Committee Elections

Nomination Statement & Form: Sarah Reid

I am seeking to continue my role as a member of the Executive Committee for a second term. I am committed to upholding CPSO's vision of trusted doctors providing great care and have the experience to support and contribute to the work of our Executive and Council. In my clinical role as a Pediatric Emergency Physician, I remain dedicated to my patients, their families and my colleagues as we work together within a health care system under tremendous strain.

I was first elected to Council in 2018 and am currently serving my second term representing District 7. In addition to my work on Council and the Executive Committee, I am Chair of the Quality Assurance Committee and Policy Working Group. These additional responsibilities at CPSO have afforded me a deeper understanding of the College's commitment to continuous improvement, right-touch regulation, and Quality Improvement. I fully appreciate the importance of our role in guiding the profession within our legislative framework, collaborating with stakeholders, and upholding and integrating EDI principles into all our work.

I am an open, optimistic and collaborative leader and I would be honoured to continue to serve on the Executive Committee. I sincerely appreciate your consideration.

Executive Committee Elections

Nomination Statement & Form: Lydia Miljan

Dr. Lydia Miljan, Public Member of Council

Professor

Nominated For:

Executive Member Representative

Appointed Council Terms:

Jan 2020 – Jan 2022
Jan 2022 – Jan 2025

CPSO Involvement:

Executive Committee	2022 - 2023
Governance	2021 - 2022
Inquiries, Reports & Complaints Committee	2020 - 2025
Policy Working Group	2020 - 2022

Nomination Statement:

As researcher and advocate for political engagement, I bring a unique perspective and skill set that makes me an excellent addition to the committee. I have found my experience on Executive to be a rewarding and engaging experience and would like to continue to serve for the next year.

I have skills competencies in most of the areas identified by CPSO. Of the key attributes I believe the ones that align best with my background in public policy are governance, continuous learning, and policy development.

Throughout my career, I have dedicated myself to advancing knowledge and understanding of political systems and the role of citizens within them. I have published extensively on topics ranging from electoral reform to public policy (including health care) and my work has been widely recognized for its contributions to the field. I have a strong grasp of the complex legal and ethical considerations involved in regulatory decision-making.

As a member of Executive Committee, I bring my expertise in research and analysis, and my commitment to the public to the table. I am confident that I can continue to make valuable contributions to the committee's work and help advance the mission of CPSO.

Executive Committee Elections

Nomination Statement & Form: Patrick Safieh

Dr. Patrick Safieh, District 10 Representative (Toronto, ON)

Principal area of practice: Family Medicine

Nominated For:

Executive Member Representative

Appointed Council Terms:

2017-2020
2020-2023

CPSO Involvement:

Governance Committee	2022-2023
Quality Assurance Committee	2008-2022

Nomination Statement:

Thank you for considering me for a position on the Executive 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 Executive 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), member of the Governance Committee, QI Coach, 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. I have introduced and developed 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 am considered to be well balanced with a good a calm demeanour.

Council Motion

Motion Title	Executive Committee Elections
Date of Meeting	June 8, 2023

It is moved by_____, and seconded by_____, that:

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

_____ (as President),

_____ (as Vice President),

_____ (as Executive Member Representative),

_____ (as Executive Member Representative),

_____ (as Executive Member Representative),

and Dr. Robert Gratton (as Past President),

to the Executive Committee for the year that commences with the adjournment of the Annual General Meeting of Council in December 2023.

Council Briefing Note

June 2023

Topic:	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

- Council is asked to consider three candidates for appointment to the Registration Committee
- Council is asked to consider the appointment of Dr. Faiq Bilal (PhD), Public Member, to the Registration Committee and Inquiries, Complaints and Reports Committee

Background

- A need to recruit three new physician members by mid-year was identified by the Registration Committee in January.
- Council is asked to appoint Dr. Diane Hawthorne, Dr. Sachdeep Rehsia, and Dr. Anjali Kundi to the Registration Committee.
- Dr. Faiq Bilal (PhD) was appointed as a new Public Member of Council on May 4, 2023.
- Council is asked to appoint Dr. Bilal to both the Registration Committee and Investigations, Complaints and Reports Committee (ICRC).

Current Status and Analysis

Physician Members - Registration Committee Appointments

- Interviews for the Registration Committee were conducted on March 31 and April 3.
- Interview feedback was received from the Chair of the Governance Committee, the current Registration Committee Chair, the Director of Registration, and other Support staff.
- Dr. Hawthorne and Dr. Kundi, both family physicians, and Dr. Rehsia, an internist, were identified as the preferred candidates.
- The Governance and Executive Committees recommend appointing Dr. Diane Hawthorne, Dr. Sachdeep Rehsia, and Dr. Anjali Kundi for a term effective June 9, 2023, and ending with the Annual General Meeting of Council in December 2025.

Public Member Committee Appointments

- Dr. Bilal's appointments to the Registration Committee, and ICRC were recommended by the Governance and Executive Committee in a joint meeting on May 16. The Governance and Executive Committees recommend appointing Dr. Bilal for a three-year term beginning immediately, and ending with the Annual General Meeting of Council in December 2025.

Next Steps

- Pending Council's decision, the new members of the Registration Committee and ICRC will immediately begin the onboarding process.

Question for Council

1. Does Council appoint to the Registration Committee the individuals as laid out in this briefing note?
2. Does Council appoint Dr. Bilal to the Registration Committee and ICRC as laid out in this briefing note?

Council Motion

Motion Title	Committee Appointments
Date of Meeting	June 8, 2023

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, effective immediately:

Committee	Member Name	Role	Term Length	End Date
Registration Committee	Dr. Diane Hawthorne	Physician Committee Member	2.5 years	AGM 2025
Registration Committee	Dr. Sachdeep Rehsia	Physician Committee Member	2.5 years	AGM 2025
Registration Committee	Dr. Anjali Kundi	Physician Committee Member	2.5 years	AGM 2025
Registration Committee	Dr. Faiq Bilal (PhD)	Public Committee Member	2.5 years	AGM 2025
Inquiries, Complaints and Reports Committee	Dr. Faiq Bilal (PhD)	Public Committee Member	2.5 years	AGM 2025

Council Briefing Note

June 2023

Topic:	Voting Academic Representative Selection
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation Meaningful Engagement
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

- Council is asked to appoint three Academic Representatives to be voting members of Council in 2024.

Background

- In late 2022, the Governance Committee absorbed the former mandate of the Academic Advisory Committee to select the voting Academic Representatives for each year. The General By-Law was amended to reflect this change.
- The Governance Committee selected the voting Academic Representatives for the first time at its April 25, 2023 meeting. These representatives will serve during the 2023-2024 year. These representatives were forwarded to Council for approval by the Executive Committee at its May 16, 2023 meeting.
- The allocation of voting positions has historically considered:
    - If any Academic Representatives wish to be nominated for the Executive Committee;
    - Which Academic Representatives have the interest and availability to serve on the OPSDT, with a strong preference for French-speaking individuals available for longer hearings.

Current Status and Analysis

- The Governance Committee recommends Dr. Roy Kirkpatrick, Dr. Marie-Pierre Carpentier, and Dr. Janet van Vlymen as the voting Academic Representatives for 2023-2024. The Executive Committee supported these recommendations.
- These members were all selected due to their current service on the OPSDT, and their willingness to continue serving. Dr. Kirkpatrick and Dr. Carpentier also speak French.

Next Steps

- If appointed, selected nominees' appointments to the OPSDT will be recommended for renewal, where required.

Question for Council

1. Who does Council appoint as the voting Academic Representatives of Council for 2023-2024?

Council Motion

Motion Title	Voting Academic Representative Selection
Date of Meeting	June 8, 2023

It is moved by_____, and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario selects and appoints the following three members of the Academic Advisory Committee as councillors for the year that commences with the adjournment of the Annual General Meeting of Council in December 2023, in accordance with section 26(2) of the General By-Law:

Dr. Janet van Vlymen,
Dr. Roy Kirkpatrick, and
Dr. Marie-Pierre Carpentier.

Council Briefing Note

June 2023

Topic:	Final Approval – Revised Draft Out-of-Hospital Premises Standards
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation Quality Care
Public Interest Rationale:	The OHP Standards have been redesigned and revised to enhance their utility, to align the OHPIP with the CPSO's Strategic Plan and to ensure the public interest is being effectively served.
Main Contact(s):	Courtney Brown, Senior Policy Analyst Tanya Terzis, Interim Manager, Policy Laurie Reid, Director of Investigations and Accreditation Jennifer Kitchen, Manager of Accreditation
Attachment(s):	**Appendix A:** Draft OHP Standards and Advice documents

Issue

- As part of a commitment to modernize and redesign the Out-of-Hospital Premises Inspection Program (OHPIP) Standards, ten new draft standards were developed and released for external consultation in September 2022.

- Council is provided with an overview of the feedback received during the consultation and the revisions made in response and is asked whether the revised draft standards can be approved as standards of the College.

Background

- To ensure out-of-hospital premises (OHPs) are operating safely and effectively, the OHPIP inspects all facilities performing procedures requiring the use of anesthesia or sedation and through the inspection regime enforces a set of standards (called "Program Standards"), outlining the core requirements that must be met when performing these procedures in OHPs.

- Internal and external feedback has historically indicated that the Standards can be difficult to navigate and understand. This is due in part to their length and format.

- As a result, a commitment was made to modernize and redesign the Program Standards.

- In September 2022 Council was provided with information on the activities undertaken to understand the challenges within the program, potential opportunities for improvement, the

approach taken to redesign and revise the Standards, and an outline of the changes that had been made to the draft Standards as a result.

Updates to the OHP Standards

- The process of updating the Standards resulted in significant structural changes to the layout of the Standards and how the expectations are articulated. There was a move away from one single long, dense and detailed document, to a set of ten separate, succinct, standalone documents that more clearly convey the expectations of OHPs and the members who work within them.

- Substantive changes were also made to make the new Standards more principle-based and to refer to existing external guidelines, where appropriate.

- Companion Advice documents were also developed for many of the draft Standards to answer key questions, along with one general *Program Overview* document that captures details about the Program, the inspection process, and CPSO's role in regulating this space.

- The following schematic outlines each of the new draft Standards along with a brief overview of their function.

Co-operation with the Program	Medical Director	Physicians Practising in OHPs	Physical Space	Drugs and Equipment
• Sets out requirements related to providing accurate/timely information, reporting to CPSO, the inspection process and consequences for failure to comply with the Standards.	• Elevates and leverages the role of Medical Director and their responsibility for all care provided in the OHP while setting out requirements relating to their eligibility and specific responsibilities.	• Captures the range of responsibilities for physicians working in OHPs including compliance with Standards, CPSO policies, external guidelines and the standard of care.	• Sets out requirements for the size and layout of the OHP in order to provide safe care, and requirements relating to inspection and maintenance of equipment.	• Sets out requirements to maintain appropriate drugs and equipment for certain urgent and emergency scenarios/conditions.

Patient Selection	Procedures	IPAC	Adverse Events	Quality Assurance
• Emphasises the importance of appropriate selection, along with jet factors to be considered and additional requirements for ASA III patients.	• Sets out requirements for pre, during, and post procedure, and requires compliance with external guidelines such as CAS Guidelines and Surgical Safety Checklist.	• Sets out requirement to comply with Public Health Ontario's "IPAC for Clinical Office Practice" and to take appropriate action where substandard IPAC practices are occurring.	• Sets out requirements for preparing for, managing, reporting, and analyzing and learning from adverse events.	• Sets out requirements related to creating a culture of safety and quality in the OHP, along with requirements for the Quality Assurance Committee and monitoring of quality care.

- While these draft Standards retained many of the core expectations of the current Program Standards, some significant revisions were made. For example:

- **Medical Director**: This draft Standard significantly elevated and leveraged the role of the Medical Director by more clearly and explicitly articulating existing requirements and setting out new requirements relating to both eligibility and responsibility.

- **Drugs and Equipment:** A shift in approach to articulating the events, conditions, or scenarios that need to be managed was adopted rather than providing a detailed list of required drugs and/or equipment.

- **Patient Selection:** Given the critical importance of patient selection in this practice environment, a new draft standard was developed. The draft set out general selection considerations, aligned with guidelines from the Canadian Anesthesiologists' Society (i.e., ASA I and II patients can be appropriately treated in an OHP, along with some ASA III patients), and sets out additional guidance when evaluating higher risk patients.

- **Procedures:** The historically prescriptive approach was updated by setting out principled expectations that point to existing and well-established clinical practice guidelines.

- **Additional substantive changes:** The remaining draft Standards were revised to more clearly identify and articulate existing expectations, remove explanatory or duplicative content, reference existing external guidelines, emphasize specific areas of importance, and clarify responsibilities.

Current Status and Analysis

- Council approved the draft Standards for external consultation in September 2022. Given the nature of this project and the number of draft Standards, the consultation period was extended and closed in early January 2023.

- The consultation received 516 responses: 415 through written feedback and 101 via the online survey[1]. The majority of responses were from members of the public through a letter writing campaign[2] along with Medical Directors and physicians practising in OHPs[3].

[1] Respondents were given an opportunity to comment on each of the draft standards. The number of comments varied for each draft.
[2] 337 form letters were received expressing concerns about how the draft standards might impact abortion care.
[3] Respondents provided a variety of different medical services including: ophthalmology, endoscopy/colonoscopy; interventional pain management, cosmetic services, abortion services, and fertility services.

- Generally, there was broad support for modernizing the standards and for the re-designed approach.

- In particular, there was broad support for the draft *Medical Director* 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.

- The majority of the critical feedback received focused on the application of the standards to specific settings (e.g., abortion and pain clinics) and the continuation of the historical approach recognizing the unique needs of these settings. Staff confirmed with representatives that the status quo will be maintained and these additional resources will be updated following the approval of the revised Standards.

Key Revisions

- Other key feedback and corresponding updates made include:

    - **Scope of Program:** Requests for clarity were received regarding the scope of the program, particularly as this relates to cosmetic procedures and certain interventional pain procedures. Updates have been made to the *Program Overview* document, to clarify the scope of the Program and to provide additional examples of procedures that are or are not captured by the Program.

    - **OHP Levels:** OHPs are currently classified by levels which are determined by the type of procedures done in the premises and the type of anesthesia used. Instead of setting out expectations based on levels, the draft Standards tied requirements solely to the type of anesthesia being administered. Since the levels are well understood by physicians practising in OHPs and feedback suggested that setting out expectations based solely on anesthesia would not appropriately capture risk, the OHP levels have now been reinstated.

    - **Patient Selection:** A number of comments indicated that the *Patient Selection* Standard was being read as overly restrictive when it came to the type of patients who could be appropriately treated in an OHP. Revisions have been made to clarify what kind of comorbidities may make a patient inappropriate for treatment in an OHP and to signal that one comorbidity on its own might not preclude a patient from being treated in an OHP.

    - **Formal Transfer Agreement with a Hospital:** The requirement to have a formal transfer agreement with a hospital in the case of an adverse event has been removed from the draft standard in response to feedback that this requirement is not practical, feasible, or necessary.

- Key updates that have been made in response to additional research and consideration include the following:

    - Additional expectations related to extended or overnight stays were added to the *Procedures* Standard. An update was also made to the *Adverse Events Advice* to classify unexpected extended or overnight stays as an adverse event that must be reported.

    - A number of equipment related expectations have been moved from the *Physical Space* Standard to the *Drugs and Equipment* Standard, without changing the substance of the expectations.

Next Steps

- Should Council approve the revised draft Standards they will be added to the CPSO website, an article will be published in Dialogue, and a communication will be sent to all OHPs, informing them of the new Standards.

- Upon final approval, the companion documents addressing the specific application of the Standards to OHPs providing abortion services, interventional pain management, and endoscopy will be updated to reflect the new OHP Standards.

Question for Council

1. Does Council approve the revised draft OHP Standards as standards of the College?

CPSO

Out-of-Hospital Premises Standards

Table of Contents

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 OHP Standards are used for the inspection of premises and are applicable to all physicians who work in such premises. The OHP Standards include information applicable to the range of 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 OHP 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 OHP 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 tumescent procedure involving the administration of dilute, local anesthetic
- A nerve block for chronic pain
- A cosmetic procedure involving the surgical alteration or removal of lesions or tissue; or
- A cosmetic procedure involving the injection or insertion of any permanent filler, autologous tissue (i.e., tissue from the patient's own body), synthetic device, materials or substances.

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
- 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 are not captured by the Program include temporary and semi-permanent fillers (e.g., hyaluronic acid fillers), botulinum toxin injections, platelet rich plasma injections, laser skin resurfacing, and sclerotherapy.

Ultimately CPSO makes the final determination over which procedures are captured by the OHP Program, and whether specific procedures can be performed in an OHP.

What are the OHP Levels and how are they determined?

The OHP level has two determinants - anesthesia and procedure - and the level is decided by the higher ranking of the two. For example, if the patient is receiving a minor nerve block (level 1) for limited invasive procedure (level 2), the OHP is considered level 2.

OHP Level	***Anesthesia***	***Procedure***
Level 1	• Local anesthesia • Minor nerve block e.g., occipital • Tumescent anesthesia <500cc of infiltrate solution	Minimally Invasive: • No surgical wound is created • Procedure does not interfere with target organ function or general physiological function. • e.g., permanent fillers
Level 2	• IV Sedation • Regional anesthesia e.g., major nerve blocks, spinal, epidural, or caudal • Tumescent anesthesia >500cc of infiltrate solution	Limited Invasiveness: • Surgical wound is created, but not for the purpose of penetration of a body cavity or viscus • Procedure has minimal impact on target organ or general physiological response • Liposuction 1 to 1000cc of aspirate • A small subcutaneous implant is inserted • e.g., facelift, surgical abortion, endoscopy, cataract extraction, lip or chin implant
Level 3	• General anesthesia	Significantly Invasive: • Surgical wound allows access to a body cavity or viscus • A significant amount of liposuction aspirate is removed (1000 - 5000 cc.) • A large prosthesis is inserted • e.g., augmentation mammoplasty, arthroscopy

How are the different types of anesthesia defined?[1]

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.

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's responsibilities include but are not limited to:

1. Developing and maintaining the OHP Standards
2. Approving any new premises

[1] The definitions of anesthesia have been adapted from the "Continuum of Depth of Sedation" and "Statement on Safe Use of Propofol" by the American Society of Anesthesiologists.
[2] For the purpose of the OHP 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.

3. Approving OHP Medical Directors
4. Approving new OHP procedures
5. 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
6. Determining the outcome of inspections
7. Maintaining a current public record of inspection outcomes on CPSO's website
8. 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 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.

CPSO provides a copy of the inspection 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 Inspection Program Standard

Those working in OHPs, including Medical Directors, have a duty to co-operate with the CPSO, to communicate promptly and accurately with CPSO, to foster a respectful relationship and demonstrate co-operation with the Out-of-Hospital Premises Inspection Program (OHPIP). Failure to co-operate, 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 of all OHP procedures, 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 OHP 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 OHP 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 OHP Standards; and/or
    b. operate in contravention of any conditions or restrictions imposed by the OHPIP and/or the Premises Inspection Committee.

5. Medical Directors **must** ensure OHPs cease performance of all OHP procedures 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 ensure that CPSO is notified in writing of any adverse event in the OHP within 5 business days of learning of the event.[1]

10. Medical Directors **must** notify CPSO in writing at least two weeks prior to making any of the following changes to the OHP or as soon as reasonably possible:

    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 intending to perform OHP procedures
    e. decision to cease operation of the OHP[2]
    f. intention to provide extended or overnight stays[3].

11. Medical Directors **must** notify CPSO in writing at least two weeks or as soon as reasonably possible 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. addition of new OHP procedures.

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;

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[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.
[3] An extended or overnight stay is where a patient has not met discharge criteria and is required to stay in the OHP beyond normal operating hours.

d. providing the inspector with any requested records;
e. allowing direct observation of a physician, including direct observation by an inspector and/or assessor of the physician performing a procedure on a patient;
    i. Where observation will be occurring, Medical Directors **must** ensure that the patient is informed in advance of the scheduled procedure that an observation of the procedure may take place as a component of the inspection process and that written consent to the observation has been obtained.

13. Medical Directors **must** ensure that complete records are onsite and available to the CPSO and inspector 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** be on site during inspections, where requested.

15. 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 CPSO 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

Definitions

Medical Director: The Medical Director is the CPSO approved physician responsible for 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 OHP Standards.

2. Medical Directors **must** annually affirm their compliance with their responsibilities in relation to the OHP, in the manner and form required by CPSO (e.g., complete the Annual Attestation[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 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 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 one month or more, **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:

    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** affirm their compliance with their responsibilities in relation to the OHP, in the manner and form required by CPSO (e.g., complete an Annual Attestation).

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 there are policies and procedures addressing the issues set out in Appendix B, and that they are regularly reviewed, updated, and implemented.

11. Medical Directors **must** ensure that all staff practising in 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.

12. 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

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

employment for reasons of professional misconduct, incompetence, or incapacity;
iv. do not have any terms, conditions or limitations on their certificate of registration that would impact their ability to practise in an OHP.

13. Medical Directors **must** ensure that current records are kept for each staff member practising in the OHP, including qualifications, relevant experience, and any hospital privileges.

14. Medical Directors **must** ensure that all physicians intending to practise in the OHP have notified the CPSO through the Staff Affiliation form.

15. 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

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

17. 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.

18. 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.

19. 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:

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 one of the following:

a. RCPSC designation[5] as a specialist in anesthesia;
b. Completion of a program accredited by the College of Family Physicians of Canada under the category of "Family Practice Anesthesia";
c. 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;
d. 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.

Physicians administering general or regional anesthesia or deep sedation will hold current ACLS certification, unless the physician is an anesthesiologist with active hospital privileges.

[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.

Qualifications for Physicians and Nurses Providing Pediatric Care

If pediatric care is provided to children 12 and under, all physician and nursing 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).

Reprocessing of Medical Equipment

Staff responsible for the sterilization and reprocessing of medical equipment need to be adequately educated and trained.

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. extended and overnight stays, if applicable (including a plan for managing any unplanned extended or overnight stays),
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. Blood borne viruses in relation to exposure prone procedures (to support post exposure testing and ongoing monitoring)
m. Safety precautions regarding electrical, mechanical, fire, and internal disaster
n. 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 essential 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 OHP Standards are the responsibility of the Medical Director. This companion *Advice to the Profession* document *(Advice)* 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 number of OHPs a physician is currently holding the role of a Medical Director for.

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?

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 their 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 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 a Medical Director goes on vacation, will they need to appoint an Acting Medical Director to fulfill their duties?

Whenever a Medical Director is unable to fulfill their duties as set out in the OHP Standards, they are required to ensure that another physician practising in the OHP will fulfill these duties. If the Medical Director will be unavailable or unable to fulfill their duties for one month or more 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 the appointment of an Acting Medical Director that is approved by CPSO but do require the Medical Director to designate 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

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. report any revocation, suspension, or restriction of hospital privileges to the Medical Director within 2 weeks;
    c. meet the standard of practice of the profession, which applies regardless of the setting in which care is being provided;
    d. practise within their scope of practice and within the limits of their knowledge, skill and judgement;
    e. comply with all applicable requirements in the OHP 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 *Adverse Events* Standard;
        vi. participating in quality assurance processes within the OHP, in accordance with the *Quality Assurance* Standard;
    f. comply with all applicable CPSO policies[1];
    g. comply with the requirements for the OHP set out by the Medical Director and all applicable policies and procedures of the OHP, including those set out in Appendix B of the *Medical Director* Standard; and
    h. comply with existing standards or guidelines from applicable speciality societies. [2]

[1] This includes but is not limited to the following: *Availability and Coverage*, *Consent to Treatment*, *Delegation of Controlled Acts*, *Disclosure of Harm*, *Prescribing Drugs*, *Managing Tests.*
[2] For example, the Canadian Anesthesiologists' Society *Guidelines to the Practice of Anesthesia* and the National Association of PeriAnesthesia Nurses of Canada *Standards for Practice.*

Physical Space Standard

Standards

General[1]

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. Any anesthetic or ancillary equipment and any medical compressed gases and pipelines comply with the CSA or be licensed for use in Canada;
    d. There is an emergency power supply that allows for safely completing a procedure that is underway and for recovering the patient (e.g., generator, uninterrupted power supply, etc.);
    e. Access for persons with disabilities complies with provincial legislation[2] and municipal bylaws;
    f. Necessary spaces can be accessed by and accommodate stretchers and wheelchairs;
    g. The size of the OHP is adequate for all the procedures that will be performed within it;
    h. The OHP layout facilitates safe patient care and patient flow; and
    i. At minimum, 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 (where applicable)
        iv. clean utility area
        v. dirty utility room
        vi. reprocessing room (where applicable)
        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 (e.g., stretchers, wheelchairs, or other adequate methods of transport are available), and

[1] The Canadian Standards Association (CSA) and other standards development organizations have published standards and guidance documents for the design, construction, and renovation of healthcare facilities. Please see CSA Standard Z8000 for more information. The Canadian Anesthesiologist's Society also identifies a list of CSA Standards that describe the standards for medical devices and equipment. For more information see here.
[2] *Accessibility for Ontarians with Disabilities Act, 2005*, S.O. 2005, c. 11.

b. appropriate access to the patient for an ambulance to transfer the patient to a hospital.

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., cautery smoke, endoscopy, disinfecting agents, anesthesia gases), where applicable;
    c. air exchanges meet infection control standards[3] for the type of procedure being performed; and
    d. if using gas sterilization for reprocessing, a positive pressure outbound system is used and vented directly to the outside.

Equipment Maintenance and Inspection

6. Medical Directors **must** ensure:

    a. Medical equipment is maintained and inspected at least yearly and as necessary 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:
        a. record of certification of medical equipment by a qualified biomedical technician,
        b. equipment operating manuals,
        c. equipment maintenance contracts with an independent and certified biomedical technician, and
        d. log for maintenance of all medical devices.

[3] For more information see the *Surgical Space* requirements set out in Public Health Ontario's *Infection Prevention and Control for Clinical Office Practice.*

Recovery Area Physical Standards

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

8. For Level 2 and 3 facilities, 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); and
    b. The recovery area allows for transfer of patients to/from a stretcher and performance of emergency procedures.

Drugs and Equipment Standard

Standards

Drugs - 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*;
    e. drugs are labelled in accordance with the *Food and Drug Act*[1] and the *Controlled Drugs and Substances Act*[2] 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[3].

2. In the event of the closure of the OHP, the Medical Director **must** ensure that any drugs are disposed of safely and appropriately.

Controlled Substances

3. 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[4];
    c. stored in a designated fixed and locked cabinet to prevent theft and loss; and
    d. accounted for in a "Log of Controlled Substances".[5]

4. 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.

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

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[1] *Food and Drug Act* R.S.C., 1985, c. F-27, s. 1
[2] *Controlled Drugs and Substances Act* (CDSA)S.C. 1996, c.19
[3] A crash cart may be appropriate in OHPs where procedures are done in multiple procedure rooms.
[4] For example, an RN, RPN with medication skills, or a physician.
[5] 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.*

Equipment – General

6. Medical Directors **must** ensure the following equipment is available in the OHP:

    a. cleaning equipment as required for the specific procedure,
    b. sterile supplies and instruments,
    c. accessible anesthetic drugs and equipment, as required for the specific procedure,
    d. monitoring equipment appropriate for continuous monitoring of vital signs, including but not limited to, heart rate, respiratory rate, blood pressure and oxygen saturation monitoring equipment,
    e. table/chair that permits patient restraints and Trendelenberg positioning, where applicable,
    f. table/chair/stretcher that accommodates procedures performed and provides for adequate range of movement for anesthetic procedures,
    g. suction equipment and backup suction, for anesthesia provider's exclusive use, where applicable.

7. For Level 2 and 3 facilities, Medical Directors **must** ensure appropriate equipment is available for the procedures being performed, in accordance with the Canadian Anesthesiologists' Society *Guidelines to the Practice of Anesthesia*[6] ,including but not limited to:
    - Pulse oximeter;
    - Apparatus to measure blood pressure, either directly or noninvasively;
    - Electrocardiography;
    - Apparatus to measure temperature;
    - A difficult airway kit;
    - 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;
    - Agent-specific anesthetic gas monitor, when inhalational anesthetic agents are used;
    - A second supply of (full cylinder) oxygen capable of delivering a regulated flow; and
    - Monitoring, suction, oxygen, difficult airway equipment and other emergency equipment for airway management, resuscitation and life support are immediately available in the recovery area.

8. For Level 3 facilities, Medical Directors **must** ensure an anesthetic machine and anesthetic cart with appropriate drugs[7] and equipment is available.

Drugs and Equipment for Urgent or Emergency Situations

9. Medical Directors **must** ensure that staff are prepared to address urgent or emergency situations or resuscitate a patient using appropriate equipment[8] and

[6] Please see the *Advice to the Profession* document for more information on the equipment that would be typically required within an OHP.
[7] Please see the *Advice to the Profession* document for more information on appropriate drugs.
[8] Please see the *Advice to the Profession* document for more information on the equipment that would typically be required for urgent and emergency situations.

drugs, when necessary.

10. For Level 1, 2, and 3 facilities Medical Directors **must** ensure that, at minimum, the following drugs are immediately available:

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

11. For Level 2 and 3 facilities Medical Directors **must** ensure that appropriate equipment and drugs are immediately available to respond to the following situations, relevant to the procedures being performed at the OHP [9].

    a. Hypertension
    b. Hypotension
    c. Anaphylaxis
    d. Cardiac events, including those covered in the ACLS Algorithms
    e. Bleeding
    f. Respiratory Events
    g. Malignant Hyperthermia, if using triggering agents[10]
    h. Benzodiazepine excess or overdose
    i. Opioid excess or overdose
    j. Persistent neuromuscular blockade, if using nondepolarizing muscle relaxants
    k. Acidosis
    l. Relevant potential electrolyte disturbances
    m. Hyper and Hypoglycemia
    n. Emesis.

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

[9] The drugs required will depend on the type of procedures and anesthesia used at the OHP. Please see the *Advice* document for more information on the drugs typically used to respond to the listed conditions.
[10] 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 urgent and emergency 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
- Intravenous diuretic such as Furosemide

Hypotension

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

Anaphylaxis

- Diphenhydramine IV
- Hydrocortisone IV
- Epinephrine

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

- Calcium IV
- Lidocaine 2% pre-filled syringe

Bleeding

- Tranexamic acid

Respiratory Events

- Bronchodilators

Malignant hyperthermia

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

Benzodiazepine Excess or Overdose

- Flumazenil IV

Opioid Excess or Overdose

- Naloxone IV - if narcotics are stocked

Electrolyte Disturbances

- Magnesium Sulfate IV
- Calcium IV

Hypoglycemia

- Dextrose 50% IV

Other

- Neuromuscular blocking reversal agents
- Sodium bicarbonate IV
- Benzodiazepine IV such as Midazolam, Diazepam, or Lorazepam

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 relevant urgent or emergency situations outlined in the Standard. This may be achieved in a number of ways but generally speaking, depending on the types of procedures being performed and the level of the facility, the following equipment will support physicians in managing urgent and emergency situations:

- AED (Level 1 facilities) or cardiopulmonary resuscitation equipment with current ACLS/PALS - compatible defibrillator (Level 2 and 3 facilities)
- IV setup
- Difficult Airway Kit
- 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)
- 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 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. Physicians **must** only perform Level 2 or 3 procedures 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[3] **must**, where possible, discuss all potential ASA III cases well in advance of the scheduled procedure where more than mild sedation will be administered, 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 hospital for the management of an urgent adverse patient event.
[2] For more information on ASA classifications see the *Advice to the Profession* document.
[3] In a situation where the same physician is administering the anesthesia or sedation and performing the procedure (e.g., for surgical abortion), the physician will need to consider all ASA III cases in advance, including the considerations in provision 3.b., and consult with a colleague where appropriate.

iii. appropriateness of OHP setting for the safe performance of the procedure (including the factors listed in Provision 2 above),
iv. pre-procedure assessment and care required, and
v. 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. Generally, ASA IV patients are unsuitable to be treated in an OHP.

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. The *Patient Selection* Standard and this Advice are 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 are key considerations when determining whether it's appropriate to perform a procedure on a patient 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 be carefully considered in patient selection. Independent factors identified by a majority of studies include:

- advanced age
- morbid 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]

While any one comorbid condition on its own may not make a patient unsuitable for care in an OHP, physicians will need to carefully consider how any of these co-morbidities could put a patient at higher risk of a poor outcome in an OHP.

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

- have unstable or poorly managed chronic illnesses;
- 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 and will be receiving more than mild sedation, 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

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[2], 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].

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

4. Medical Directors **must** ensure that care provided in the OHP complies with the 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, discussion with an anesthesiologist or other specialists) as required, prior to making a decision to proceed with the procedure in the OHP setting.

Pre-Procedure Requirements

6. 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.

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

8. 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 assessment.

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[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.
[2] For more information on appropriate documentation, please see the *Advice to the Profession* document.
[3] While this resource may refer to hospitals, the expectations will equally apply in an OHP setting.

9. 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 Mild and Moderate Sedation and Regional Anesthesia

10. If the physician administering the regional anesthesia or sedation is also performing the procedure[4], the physician **must** ensure the patient is attended by a second individual[5] who is solely responsible for actively monitoring the patient 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

11. 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*.

Extended and Overnight Stays[6]

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

    a. The extended stay takes place on the premises and patients are not transferred to another location pre-discharge, unless it is necessary to transfer the patient to a hospital;
    b. 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;
    c. A minimum of two nurses appropriately qualified to monitor and recover patients from anesthesia or sedation are on premises;
    d. Necessary monitoring equipment and equipment and drugs to respond to urgent or emergency situations, in accordance with the *Drugs and Equipment* Standard are immediately available;
    e. The patient is continuously and appropriately monitored until they meet discharge criteria;
    f. An appropriate post-operative diet is available for the patient; and
    g. The patient has access to a washroom.

13. Medical Directors **must** ensure that no patient remains in an OHP longer than 24 hours. Should a patient need continued monitoring or be unable to meet discharge criteria after 24 hours in an OHP, the physician who performed the procedure or who administered the anesthesia **must** ensure the patient is transferred to hospital.

[4] This may occur in certain scenarios, such as for surgical abortion or circumcisions.
[5] Such as a physician, respiratory therapist, registered nurse, or anesthesia assistant.
[6] An extended or overnight stay is where a patient has not met discharge criteria and is required to stay in the OHP beyond normal operating hours.

Patient Discharge After 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 a summary of the care provided be distributed to the patient's primary care provider (e.g., an operative or procedural note), 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[7];
    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.

[7] 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 by the physician performing the procedure 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 relevant 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?

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 (at least every 5 minutes). 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 validated discharge scoring system.

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

CPSO's *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 (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] and any directives or guidelines issued by Public Health Ontario or the Ministry of Health, 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 the relevant Medical Officer of Health, where required[11].

[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*.
[11] Please see CPSO's *Mandatory and Permissive Reporting* policy for more information on the specific instances that require reporting to the Medical Officer of Health.

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. 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 appropriate IPAC practices. Common IPAC deficiencies observed during inspections include the following:

- Sinks with no backsplash
- Items are stored underneath sinks
- Aerosol or spray trigger cleaning chemicals
- Cloth furniture is porous
- Biomedical waste is stored inappropriately (e.g., with other supplies)
- No temperature log is kept for refrigerators used to store medications
- Multi-use gel or cleaning solutions are not dated upon opening
- Multi-use medications are not dated upon opening
- Intravenous solution bags are used as a common source of supply for multiple patients
- Housekeeping supplies are not stored in a designated space
- Laundry is not in a dedicated space
- Reprocessing issues (e.g., technicians are not appropriately trained, reprocessing is done incorrectly, there are missing items essential to reprocessing, reprocessing brushes that are not designed for re-use are being used multiple times).

Medical Directors are responsible for ensuring compliance with Public Health Ontario's *Infection Prevention and Control for Clinical Office Practice*[1] and for ensuring the practices within the OHP meet current guidelines.

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.

Where can I find more information about appropriate IPAC practices?

Public Health Ontario has a number of resources to support physicians in complying with appropriate IPAC practices, including the following:

- IPAC Checklist for Clinical Office Practice: Core Elements
- IPAC Checklist for Clinical Office Practice: Reprocessing of Medical Equipment/Devices
- IPAC Checklist for Clinical Office Practice: Endoscopy.

Please see their website for more information and additional resources.

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 written protocol to facilitate the urgent transfer of patients to the hospital for the management of an urgent adverse patient event;
    c. be available to provide assistance in managing any adverse events, if necessary;
    d. be satisfied that staff practising within the OHP are aware of the written protocols and are capable of managing any adverse events themselves; and
    e. 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 (e.g., 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 by appropriate means in light of the patient's condition, 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 all relevant information (e.g., date and type of procedure, description of the incident and treatment rendered, analysis of reasons for the incident, outcome);
c. report the incident, including all relevant details, to CPSO in the form and manner required by CPSO, 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 with the physician(s) and staff involved in the adverse event 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, where appropriate;
    c. sharing the learnings and recommendations with other staff in the OHP, as appropriate.[2]

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.

[2] Investigations and any corresponding actions need to be proportionate to the circumstances and to the adverse event that occurred. More serious adverse events may require a more in-depth investigation and/or more significant corrective actions.

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:

- Unplanned extended or overnight stays[1];
- 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.

What is the purpose of reporting adverse events to CPSO? What will CPSO 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 ensuring that this information is reported 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

[1] An extended or overnight stay is where a patient has not met discharge criteria and is required to stay in the OHP beyond normal operating hours.

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 report all relevant information and submit relevant medical records, including any referral letters, pre- and post-operative notes and tests, surgical notes, the anesthesia record, and an update 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. Medical Directors must also review all adverse events and respond accordingly. Investigations and any corresponding actions need to be proportionate to the circumstances and to the adverse event that occurred. More serious adverse events may require a more in-depth investigation and/or more significant corrective actions.

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

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) and review policies and procedures, challenging cases, near misses[1], adverse events and protocols as appropriate to minimize adverse events;
    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** 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

6. 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[2];

[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*.
[2] In an OHP where the Medical Director is the only practising physician, the process for reviewing records will need to include a review of that physician's patient records by a peer.

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 annual 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 purpose of quality assurance monitoring activity is to identify problems and the frequency with which they occur, assess severity of issues, and develop remedial action as required to prevent or mitigate harm to patients.

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.

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	Revised Out-of-Hospital Premises Standards – Standards for Final Approval
Date of Meeting	June 8, 2023

It is moved by_____, and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario approves the revised "Out-of-Hospital Premises Standards", formerly titled "Out-of-Hospital Premises Inspection Program (OHPIP) Program Standards", (a copy of which forms Appendix " " to the minutes of this meeting).

Council Briefing Note

June 2023

Topic:	Draft Policies for Consultation – *Academic Registration and Specialist Recognition Criteria in Ontario*
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation System Collaboration
Public Interest Rationale:	Accessibility: facilitating the registration of internationally educated physicians to support increased access to health care services in Ontario
Main Contact(s):	Samantha Tulipano, Director, Registration & Membership Services Tanya Terzis, Interim Manager, Policy Alex Wong, Policy Analyst Mike Fontaine, Policy Analyst
Attachment(s):	**Appendix A:** Draft *Academic Registration* Policy **Appendix B:** Draft *Specialist Recognition Criteria in Ontario* Policy

Issue

- Council is provided with an overview of the draft *Academic Registration* policy and draft *Specialist Recognition Criteria in Ontario* policy and is asked to consider whether these draft policies can be approved for consultation.

Background

- In response to the Ontario Minister of Health's direction to determine ways of registering more internationally trained physicians in Ontario, CPSO has been actively reviewing its registration policies to evaluate whether barriers to licensure can be removed and whether additional pathways to registration can be explored through policy.

Current Status and Analysis

Current Academic Registration Policy

- The current *Academic Registration* policy enables CPSO to issue restricted certificates of registration to physicians recruited by an Ontario medical school for an academic position but who may not meet the requirements for an academic practice certificate set out in O.Reg. 865/93: Registration such as certification by the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College of Family Physicians of Canada (CFPC).

- Under the current policy, physicians holding a certificate of registration authorizing academic practice are eligible to transfer to a scope-limited restricted certificate after practising in an academic setting for at least five years and successfully completing a practice assessment.

Proposed Amendments to the Academic Registration Policy

- The draft *Academic Registration* policy (**Appendix A**) removes the requirement for physicians to complete a practice assessment to receive a scope-limited restricted certificate of registration after five years of practice in an academic setting.

- The draft policy additionally specifies that applicants must have maintained an active clinical practice and must provide evidence of satisfactory clinical performance, knowledge, skill, judgement, and professional conduct from the medical school where the applicant holds their academic appointment.

- The draft *Specialist Recognition Criteria in Ontario* policy (**Appendix B**) has been amended to grant specialist recognition to physicians issued the restricted certificate under the draft *Academic Registration* policy. This will permit physicians registered under this policy to call themselves specialists.

Considerations

- The proposed change removes a barrier to independent practice for internationally trained physicians who may not be certified by the RCPSC or the CFPC but who have maintained an active practice in Ontario for at least five years within an academic setting.

- Other Canadian medical regulators allow physicians to transfer from a provisional license to a full license in similar circumstances.

    - For example, Nova Scotia and Saskatchewan allow physicians to transfer after a period of practice from a provisional license to a full license without additional assessment/examination.

- Under the current policy, physicians applying for a restricted certificate after five years of practice have historically had a high rate of success in the practice assessment. Removing the practice assessment is not expected to raise any concerns, as physicians must still provide satisfactory evidence of conduct and performance to the Registration Committee. Like all applicants, these applicants will also need to demonstrate they meet the non-exemptible registration standard prescribed under section 2 of the Registration Regulation.

Next Steps

- Should Council approve the proposed draft policies, they will be circulated in accordance with Section 22.21 of the *Health Professions Procedural Code* (the Code).

- Additionally, pending Council's direction, in order to support the timely implementation of these new routes we will seek the Executive Committee's approval of the final policies (subject to feedback received) pursuant to its authority under s. 12 of the Code and s. 30 of the General By-Law.

Question for Council

1. Does Council recommend that the draft policies be approved for consultation?

ACADEMIC REGISTRATION

This policy is for applicants recruited by an Ontario medical school for an academic position, but who do not meet the usual requirements for an academic practice certificate. (The usual requirements include certification by the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada.) **This policy applies for positions of assistant, associate or full professor**.

Requirements

You may be issued a certificate of registration authorizing academic practice if:

1. you have a degree in medicine as defined in Ontario Regulation 865/93 under the *Medicine Act, 1991*;
2. you:
    i. hold specialist certification by the Royal College of Physicians and Surgeons of Canada ("RCPSC") or the College of Family Physicians of Canada ("CFPC"), **or**
    ii. hold specialist certification by a board in the United States of America that is a regular member of a board of the American Board of Medical Specialties, **or**
    iii. are recognized as a specialist in the jurisdiction where you practise medicine by an organization outside of North America that recognizes medical specialties, and the organization which recognized you as a medical specialist did so using standards that are substantially similar to the standards of the RCPSC or the CFPC;
3. you have been offered a full time clinical academic appointment to the faculty of an accredited medical school in Ontario at the rank of assistant, associate or full professor; and
4. you are recognized in the same discipline you are being recruited for appointment in Ontario.

There are additional requirements for assistant professors:

1. A written job description stating that you will be involved in clinical practice, teaching, research, administration, or clinical development and evaluation or some combination of these; and
2. An agreement from the medical school to assess your clinical and academic performance and to submit annual reports in a form that is satisfactory to the CPSO.

Terms, conditions and limitations

1. The following terms, conditions and limitations will be attached to a certificate of registration authorizing academic practice for all professors: You may practise medicine only in a setting that is approved by the Chair of the department in which you hold an academic appointment at the rank of assistant, associate, or full professor, and in accordance with the requirements of your academic appointment.
2. The certificate automatically expires when you no longer hold the academic appointment.

In addition, for assistant professors:

1. The certificate of registration automatically expires seven years from the date of issuance, or when you no longer hold the academic appointment at the rank of assistant professor.
2. The certificate of registration automatically expires, but may be renewed by the Registration Committee, with or without terms, conditions and limitations, if the Registration Committee:
    i. receives a report indicating that your clinical performance, knowledge, skill, judgment, professional conduct, or academic progress is unsatisfactory, or
    ii. does not receive an annual report, or
    iii. receives a report that is unsatisfactory in form or content.

Application for a restricted certificate of registration

If you are registered under this policy, you may apply for a restricted certificate of registration to practise independently limited to your scope of practice if you:

1. Have practised in an academic setting and maintained an active clinical practice in Ontario for a minimum of five years; and
2. Provide evidence of satisfactory clinical performance, knowledge, skill, judgement, and professional conduct from the medical school where you hold your academic appointment.

End Notes

Full Time Clinical Academic Appointment: an academic appointment that includes a combination of clinical and academic work. In this document, Full Time Clinical

Appendix A

Academic Appointment does not require that the individual must practise a certain number of hours per week. The individual, however, must hold a full time clinical academic appointment and may only practise medicine in an academic setting, under the aegis of the academic head.

Academic Setting: a setting that has an infrastructure in place for reporting clinical and academic performance.

Appendix B

SPECIALIST RECOGNITION CRITERIA IN ONTARIO

Approved by Council: April 2005
Reviewed and Updated: November 2011, September 2022

Purpose

In order to practise 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 (RCPSC) 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 (CFPC) 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 practise 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 RCPSC and the CFPC.

This policy does not apply to physicians who hold certification by RCPSC or the CFPC 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 RCPSC; or
2. holds certification in family medicine by the CFPC; 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); 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 RCPSC or the CFPC, 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. holds a restricted certificate of registration that has been issued under the College's *Academic Registration* policy, and:
    a. has completed a minimum of five years of clinical practice in an academic setting in Ontario, and
    b. has provided evidence of satisfactory clinical performance, knowledge, skill, judgement, and professional conduct from the medical school where the academic appointment was held; or
7. 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 RCPSC or the CFPC, and
    c. has successfully completed a practice assessment that has been directed by the Registration Committee[1]; or
8. holds a restricted certificate of registration in Ontario that has been issued under the College's *Alternative Pathways to Registration for Physicians Trained in the United States* policy, and:
    a. has received written confirmation from a US Specialty Board of eligibility to take the certification examination on the basis of satisfactory completion of a residency program accredited by the ACGME within the last five years; or
9. holds 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. has received written confirmation from the RCPSC of current eligibility, with no pre-conditions, to take the certification examination on the basis of satisfactory completion of a RCPSC-accredited residency program in Canada or a RCPSC recognized program outside of Canada; or
10. holds 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. has received written confirmation from the CFPC of current eligibility, with no pre-conditions, to take the certification on the basis of satisfactory completion of a CFPC-accredited residency program in Canada or a CFPC recognized program outside of Canada.
11. holds a restricted certificate of registration in Ontario that has been issued under the College's *Recognition of RCPSC Subspecialist Affiliate Status* policy.[2]

Endnotes

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

[2.] Physicians who have been granted Subspecialist Affiliate status from RCPSC must only identify themselves as specialists in the subspecialty in which their Subspecialist Affiliate attestation was granted. CPSO does not recognize these physicians in a primary/core specialty.

Council Motion

Motion Title	Draft Revised Policies for Consultation -- *Academic Registration* and *Specialist Recognition Criteria in Ontario*
Date of Meeting	June 8, 2023

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 policy, "*Academic Registration*" (a copy of which forms Appendix " " to the minutes of this meeting) and the draft revised policy, "*Specialist Recognition Criteria in Ontario*" (a copy of which forms Appendix " " to the minutes of this meeting).

Council Briefing Note

June 2023

Topic:	Draft Policy for Consultation: *Practice Ready Assessment Program*
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation System Collaboration
Public Interest Rationale:	Accessibility: facilitating physician registration to support increased access to health care services in underserved communities in Ontario
Main Contact(s):	Samantha Tulipano, Director, Registration & Membership Services Tanya Terzis, Interim Manager, Policy Alex Wong, Policy Analyst Mike Fontaine, Policy Analyst
Attachment(s):	**Appendix A:** Draft *Practice Ready Assessment Program* policy **Appendix B:** Draft PRO Candidate Requirements **Appendix C:** Approved Terms for Practice Assessment **Appendix D:** Approved Terms for Supervised Practice **Appendix E**: Touchstone Institute Presentation

Issue

- The Ministry of Health (MOH) has requested the creation of a practice ready assessment (PRA) program for family medicine to launch as a pilot in 2023-2024. Touchstone Institute will administer this program, known as Practice Ready Ontario (PRO).

- In April 2023, the Registration Committee approved the proposed terms, conditions and limitations for the certificates of registration that would facilitate this initiative. A draft *Practice Ready Assessment Program* policy has been developed based on the PRO Program as we presently understand it, and the approved proposed terms, conditions and limitations.

- Council is asked to consider whether the draft *Practice Ready Assessment Program* policy can be approved for consultation.

Background

- CPSO has long been committed to the development of a PRA program in Ontario and has undertaken considerable work to support its operationalization. Work was previously underway in 2016 to implement an Ontario PRA Program for family medicine, based on the

government's request. In 2017, CPSO completed the operational framework for the program launch, but the government placed the initiative on hold.

- In response to a letter from the Minister in August 2022 directing CPSO to make every effort to register out-of-province and internationally educated physicians as expeditiously as possible, CPSO expressed support for government to take immediate steps to implement a PRA program.

- In February 2023, the Minister of Health committed to launching the PRA Program in Ontario this year to help qualified international medical graduates (IMGs) enter practice.

Current Status and Analysis

Practice Ready Assessment Program in Ontario: Practice Ready Ontario (PRO)

- PRO is designed to assess IMGs over a 12-week period with direct supervision and observation, deploy candidates to high-need communities with a Return of Service (ROS) commitment, and provide a path to independent practice.

- The program administrator, Touchstone Institute, is a non-profit that develops competency-based services for internationally educated health professionals. While Touchstone is responsible for establishing the eligibility and program requirements, they have been consulting with CPSO to promote alignment with the licensure requirements we need to establish.

- The National Assessment Collaboration (NAC) has created a pan-Canadian model with a set of common standards, tools, and materials for PRA programs. Seven provinces (British Columbia, Alberta, Saskatchewan, Manitoba, Quebec, Newfoundland and Labrador, and Nova Scotia) currently offer PRA programs under this framework. PRO has been developed in accordance with these national standards.

Proposed Certificates and Draft *Practice Ready Assessment Program* Policy

- A draft *Practice Ready Assessment Program* policy (**Appendix A**) has been developed setting out the certificates of registration to be issued to candidates participating in PRO.

- The certificates correspond to two stages: Clinical Field Assessment and Supervised Practice (**Appendices C** and **D** set out the approved terms, conditions, and limitations for the certificates).[1] The draft policy also describes how participants in the PRA program may transition to independent practice through the program.

[1] With respect to fees, candidates will be charged a single application fee for both certificates of registration using the existing fees structure in the CPSO's Fees and Remuneration by-law.

A. Clinical Field Assessment (CFA)

- Touchstone selects candidates based on the eligibility requirements they have set out (**Appendix B**) which include the completion of MCCQE Part 1, Part 2/LMCC, or the NAC exam, and a minimum of two years of postgraduate training in family medicine or general practice. Selected candidates must also pass the Therapeutics Decision Making (TDM) examination and an interview assessing non-medical expert competencies.

- The successful candidates will undergo a 12-week CFA and practise with ongoing and close supervision by an assessor who has been designated by the director of PRO. The CFA is not a training period, but rather an assessment that will result in a pass/fail decision. Multiple independent observations will be made across multiple situations by multiple observers.

- CPSO would issue a restricted certificate for the 12-week duration requiring the candidate to practise under supervision to a degree specified by the PRA program director. The candidate will not be the Most Responsible Physician.

B. Supervised Practice

- Touchstone will determine which candidates have successfully completed the CFA. The CFA assessor submits their assessment and recommendation to Touchstone, and final decisions are made by a sub-committee.

- After a candidate is deemed successful, they will apply for a certificate of registration to practise under supervision in accordance with a ROS agreement.

- If approved, the Registration Committee would issue the candidate a restricted certificate similar to the existing certificates for exam eligible candidates to enable them to complete their ROS agreement (made with the MOH) over a period of three years.

- Candidates will practise only in the community designated in their ROS agreement, under usual CPSO supervision arrangements. During this time, they may write the College of Family Physicians of Canada (CFPC) exam.

    - Our understanding is that those who successfully complete the CFA will be deemed eligible to sit the CFPC exam; however, details on timing of eligibility remain unclear.

C. Independent Practice

- If the candidate has successfully obtained CFPC certification, they may apply to remove the supervision requirement while completing the rest of their ROS commitment.

- After completing their ROS agreement, if the candidate has successfully obtained CFPC certification they will be eligible for a certificate of registration authorizing independent practice as they will have completed the requirements set out in the *Registration* regulation (including MCCQE), subject to any issues arising under section 2.

Considerations

- PRO aligns with CPSO's commitment to examining routes to registration to grant increased access and reduce barriers to practise. PRO could more quickly integrate qualified IMGs into the workforce and enhance primary care access to communities in need. The target for the first two years of the program is 50 candidates each year in 2023-24 and 2024-25.

- The policy will be published and come into force at a later date when assessment/assessor details have been finalized by Touchstone and PRO is ready for implementation (currently anticipated for January 2024).

Next Steps

- Should Council approve the proposed policy, it will be circulated for notice in accordance with Section 22.21 of the *Health Professions Procedural Code* (the Code).

- Additionally, pending Council's direction, we will seek the Executive Committee approval of the final policy (subject to feedback received) pursuant to its authority under s. 12 of the Code and s. 30 of the General By-Law.

Question for Council

1. Does Council recommend that the draft policy be approved for consultation?

Practice Ready Assessment Program

The National Assessment Collaboration (NAC) has created a pan-Canadian model with a set of common standards, tools, and materials for practice ready assessment (PRA) programs.

Practice Ready Ontario (PRO) is a PRA program administered by Touchstone Institute. It is available to internationally trained family physicians with the aim of obtaining an independent practice certificate in Ontario. This program aligns with the NAC standards.

The PRA program provides successful candidates with the opportunity to work under supervision and be assessed for clinical competence over a period of 12 weeks. Candidates who successfully complete the assessment will be required to complete a three-year Return of Service (ROS) agreement with the Ministry of Health (MOH) to practise in a community in Ontario as identified by the MOH.

Eligibility and Applicant Screening

Touchstone Institute is responsible for the candidate screening and selection process for PRO. Along with meeting the eligibility criteria, applicants must achieve a passing grade on the Therapeutics Decision-Making (TDM) exam and be assessed through an interview in order to be selected for the program.

Clinical Field Assessment (CFA)

If you have been accepted into the PRA program by Touchstone, you may be issued a restricted certificate during the 12-week assessment period, subject to terms, conditions and limitations, including the following:

1. You may practise only in the PRA program and to the extent required to complete PRA program;
2. You must practise under supervision by a member of the College designated by the director of PRA program at a level of supervision determined by the director;
3. You may not be the Most Responsible Physician (MRP); and
4. You may not charge a fee for medical services.

Your restricted certificate will expire the earlier of either:

1. 12 weeks from the date it is issued; or
2. When you are no longer enrolled in the program.

Supervised Practice

If you have successfully completed the CFA and meet the non-exemptible requirements set out in *Section 2(1) of Ontario Regulation 865/93*, you may be issued a restricted certificate limited to your scope of practice, to fulfil your ROS commitment, subject to terms, conditions and limitations, including the following:

1. You may practise family medicine only in accordance with your ROS agreement;
2. You will work under supervision in the community specified in your ROS agreement.

Your restricted certificate will automatically expire three years from the date it is issued.

Independent Practice

If you successfully obtain College of Family Physicians of Canada (CFPC) certification during the supervised practice period, you may apply to the College to remove the requirement to work under supervision while completing your ROS commitment.

Upon the completion of your ROS commitment and successfully obtaining CFPC certification, if you 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*, you may apply for an independent practice certificate of registration.

Appendix B

Practice Ready Ontario Candidate Requirements

- Proof of Canadian citizenship or permanent resident status (Canadian passport or Permanent Resident Card)
- Valid Medical Identification Number for Canada (MINC)
- Valid physiciansapply.ca candidate code
- Successful completion of a medical degree issued by a school listed in the World Directory of Medical Schools (WDMS).
- Evidence of English Language Proficiency demonstrated through one of the following ways.
    - Successful completion of one of the following language proficiency exams:
        - Academic International English Language Testing System (IELTS Academic) with a minimum score of 7.0 in each of the four components, achieved in the same sitting. IELTS results are valid for a two-year period from the date taken.
        - Occupational English Test - Medicine (OET) with a minimum grade of B in each of the four components, achieved in the same sitting. OET results are valid for a two-year period from the date taken.
        - Canadian English Language Proficiency Index Program General (CELPIP-General) test with a minimum score of 9 in each of the four skills, achieved in the same sitting. CELPIP results are valid for a two- year period from the date taken.
- Completion of an undergraduate or postgraduate medical education in English in one of the countries that have English as a first and native language (see list below); or
- Current practice in a country or jurisdiction where English is the first and native language (see list below)

    List of countries that have English as a first and native language: Australia, Bahamas, Bermuda, British Virgin Islands, Canada, Ireland, New Zealand, Singapore, South Africa, United Kingdom, United States of America, US Virgin Islands; and the Caribbean Islands of Anguilla, Antigua and Barbuda, Barbados, Dominica, Grenada, Grenadines, Jamaica, St. Kitts and Nevis, St. Lucia, St. Vincent, Trinidad and Tobago
- Successfully passed and achieved an accepted score in the following Medical Council of Canada examinations.
    - Medical Council of Canada Qualifying Examination (MCCQE) Part 1 and either the;
    - Medical Council of Canada Qualifying Examination (MCCQE) Part 2 before its discontinuation on June 10, 2021 or the;
    - National Assessment Collaboration (NAC) Examination
        - March 2013 to September 2018: 75%
        - March 2019 to March 2020: 429
        - September 2020: Pass with Superior Performance. A “pass” will not meet minimum eligibility requirements.

    - October 2021 onwards: 1405
    - **Note:** PRO will not accept NAC exam scores for exam sessions prior to March 2013.
- Evidence of a minimum of two years of postgraduate training in family medicine or general practice in another jurisdiction.
- Ability to demonstrate completion of the below seven core rotations.
    - Minimum of 8 weeks postgraduate training in family medicine or general practice.
    - Minimum of 4 weeks postgraduate training in emergency medicine, general surgery, internal medicine, obstetrics/gynecology, pediatrics, and psychiatry.
- A completed Confirmation of Postgraduate Training form, in addition to anything shared with Touchstone Institute via physiciansapply.ca. This form must be completed by the Dean or Postgraduate Training Director at your postgraduate training program. The completed form must be mailed directly to Touchstone Institute.
    - Note that the following details regarding your postgraduate training will be required: clinic/training location (address), start and end dates of training, supervisor's name and title.
- Evidence of having completed a minimum of three consecutive years of independent practice as a general or family physician (patient's Most Responsible Physician) in another jurisdiction.
- Evidence demonstrating 24 weeks (960 hours) of clinical practice as a family physician or general practitioner in the immediately preceding three years (with a minimum of 90% of these hours being in-person care and a maximum 10% being virtual-care).
- No more than two previous practice ready assessment attempts in Canada.
- Ability to provide a current curriculum vitae.
- Ability to provide three completed reference forms
    - References must be completed by the following individuals at the hospital/clinic where you presently practice or where you last practiced as a family physician or general practitioner: Chief of Staff, Department Head and Head Nurse.
    - If your current or previous practice is not hospital, please arrange for the three references from physicians in authority who can comment on your current practice (i.e., Medical Director or most senior physician at the clinic).
    - If you are currently enrolled in a clinical fellowship, one of the three reference forms may be completed by your supervisor.
    - In the event you are unable to arrange for references exactly as specified (i.e., you do not practice with nurses) please upload an explanatory letter outlining the circumstances.
    - Contact information (such as primary telephone number and email address) will be required.

Appendix C

Note: The following qualifications will be required to obtain this certificate:

- **Appointment in Practice Ready Assessment Program (or the CFA)**
- **The CPSO will screen all applicants section 2 in the application process.**

Terms and conditions for physicians entering the Clinical Field Assessment (CFA)of the PRA program:

1. Dr. FULL NAME may practise medicine only:
   (i) In the Practice Ready Assessment Program to which the holder is appointed;
   (ii) to the extent required to complete the Practice Ready Assessment Program to which the holder is appointed; and
   (iii) under supervision by a member of the College of Physicians and Surgeons of Ontario designated by the director of the Practice Ready Assessment Program, at a level of supervision determined by the director of the Practice Ready Assessment Program
2. Dr. FULL NAME may not charge a fee for medical services.
3. Dr. FULL NAME may not be the Most Responsible Physician.
4. This certificate expires the earlier of:
   (i) when Dr. LAST NAME is no longer enrolled in the Practice Ready Assessment Program specified in paragraph (1)
   (ii) twelve weeks from the date of issuance

Note: This certificate is issued on DATE and expires EXPIRY (12 weeks from issuance), or when Dr. LAST NAME's enrolment in the Practice Ready Assessment Program ends, whichever occurs first.

Appendix D

Note: The applicants will be required to demonstrate successful completion of the Clinical Field Assessment and will be screened for section 2 issues

Terms and Conditions for Physicians Entering the Practice Phase of the PRA Program:

1. Dr. FULL NAME may practise family medicine only,
   (i) in accordance with Dr. FULL NAME's Return of Service Agreement with the Crown in Right of the Province of Ontario and the Addendum to the Return of Service Agreement that Dr. FULL NAME signed on DATE, and
   (ii) at LOCATION in CITY, Ontario while under supervision coordinated by supervisor acceptable to the College

Expiry

1. The certificate of resignation automatically expires the earlier of:
   (i) three years from the date of issuance;
   (ii) when Dr. FULL NAME's eligibility to take the College of Family Physicians of Canada's examination expires
2. The Certificate of registration automatically expires if Dr. FULL NAME practises medicine other than in compliance with Dr. FULL NAME's agreement with the Crown in Right of the Province of Ontario and the Addendum.
3. The Certificate of registration automatically expires upon the following events' unless the Registration Committee renews the certificate with or without additional or other terms, conditions and limitations:
   (i) the supervisor notifies the College of any concerns regarding Dr. FULL NAME's knowledge, skill, judgment or attitude, does not provide the required reports to the College by the due date or if the reports are unsatisfactory in for or content, or
   (ii) the supervisor is no longer able or willing to continue to supervise Dr. NAME's practice.

Pre-conditions:

Dr. NAME will agree to the terms, conditions and limitations outlined in the Undertaking document, and which includes but not limited to:

- to practice under the supervision of Dr. SUPERVISOR;
- take the College of Family Physicians of Canada certification examination, each time it is available to them during the term of this certificate, until such time that they are successful in the examination

The supervising physician will agree to the terms, conditions and limitations outlined in the document undertaking of the supervising physician and which includes, but not limited to:

- provide supervision of Dr. NAME's practice;
- submit reports to the College every six months, at minimum.

This certificate is issued in connection with Dr. FULL NAME's participation in the return-of-service stage of the Practice Ready Assessment (PRA) Program.

Practice Ready Ontario

A Practice Ready Assessment Program for Family Medicine

College of Physicians and Surgeons of Ontario - Registration Committee

June 2023

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COMPETENCY EVALUATION EXPERTS

About Touchstone Institute

- We are a non-profit corporation that offers expertise in evaluation and curriculum development to promote public confidence in professional competence in the Canadian health workforce.
- We excel in providing competency-based services in support of successful transitions to training and practice that meet professional and societal needs.
- We are supported by expertise in simulation, innovation in exam technology, and robust research-based quality assurance to meet the diverse needs of our clients, stakeholders, and partners.
- We specialize in creating valid and authentic competency-based experiences for internationally educated health professionals.

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Introduction

- This information was brought forth to the CPSO's Registration Committee for review and subsequently approval for restricted certificates for candidates who participate in the Practice Ready Ontario (PRO) program
- The restricted certificates will enable qualified candidates to participate in a 12-week Clinical Field Assessment and complete a three-year Return of Service

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Introduction to Practice Ready Ontario (PRO)

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Practice Ready Assessment (PRA)

- Provides an alternative route to licensure for internationally trained physicians (ITPs)
- Follows guidelines of the National Assessment Collaboration's (NAC) Pan-Canadian Practice-Ready Assessment (PRA), Medical Council of Canada*
- Utilizes standardized and recommended clinical assessment tools, comprehensive clinical assessor training, and a thorough orientation program for candidates
- Distributes incoming physicians to communities in high need

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* https://www.mcc.ca/assessments/practice-ready-assessment/pan-canadian-pra-assessment-framework/

NAC-PRA Family Medicine Standards

- NAC-PRA guidelines provide standards for consistent and comparable practice ready assessments across provinces and territories
- Several provinces already benefit from successful programs:
  - Practice Ready Assessment – Physicians for BC (PRA-BC)
  - Practice Readiness Assessment Alberta (PRA-AB)
  - Saskatchewan International Physician Practice Assessment (SIPPA)
  - University of Manitoba International Medical Graduate Program (PRA MB – Family Practice & PRA MB – Specialty Practice)
  - Collège des médecins du Québec
  - Practice Ready Assessment – Newfoundland and Labrador (PRA-NL)
  - Nova Scotia Practice Ready Assessment Program (NSPRAP)

PRA in Ontario

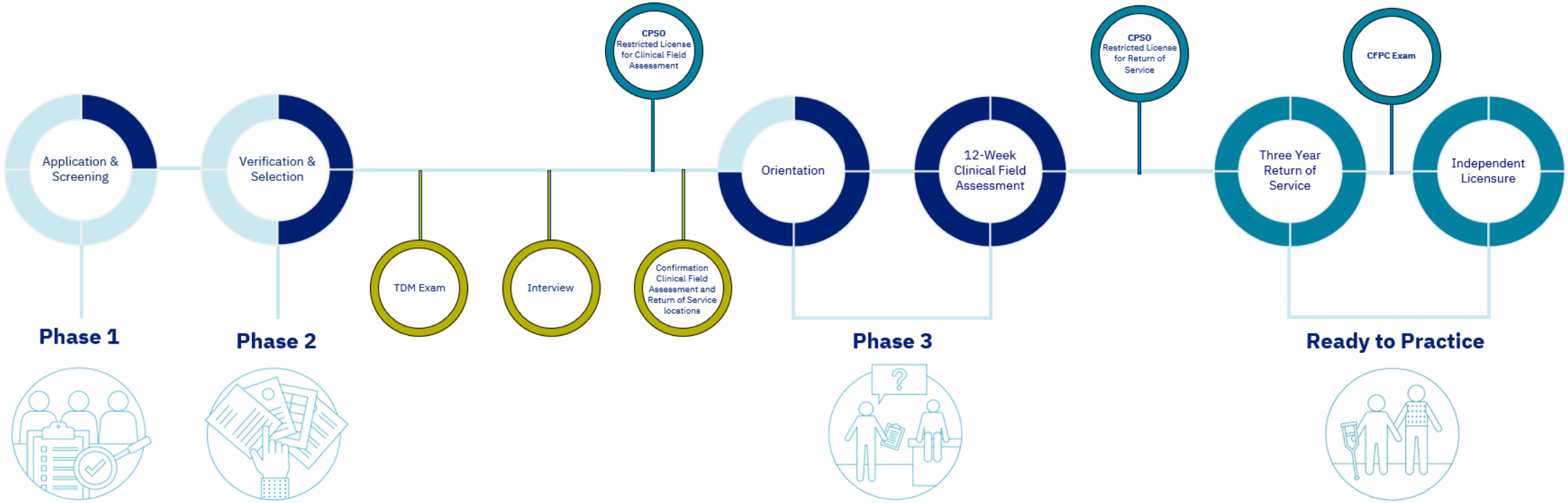
- NAC-PRA framework is adapted to provincial conditions and administered through provincial stakeholders
- Ontario Ministry of Health funding provided to offer PRO to family medicine physicians, following the NAC-PRA FM Standards*
- Target is 50 candidates each year, 2023-24; 2024-25
- The practice ready assessment in Ontario will be called Practice Ready Ontario (PRO)

* https://mcc.ca/media/NAC-PRA-Family-Medicine-standards.pdf

PRO Process Map

Return of Service

Independent Practice Supervision → Independent Practice



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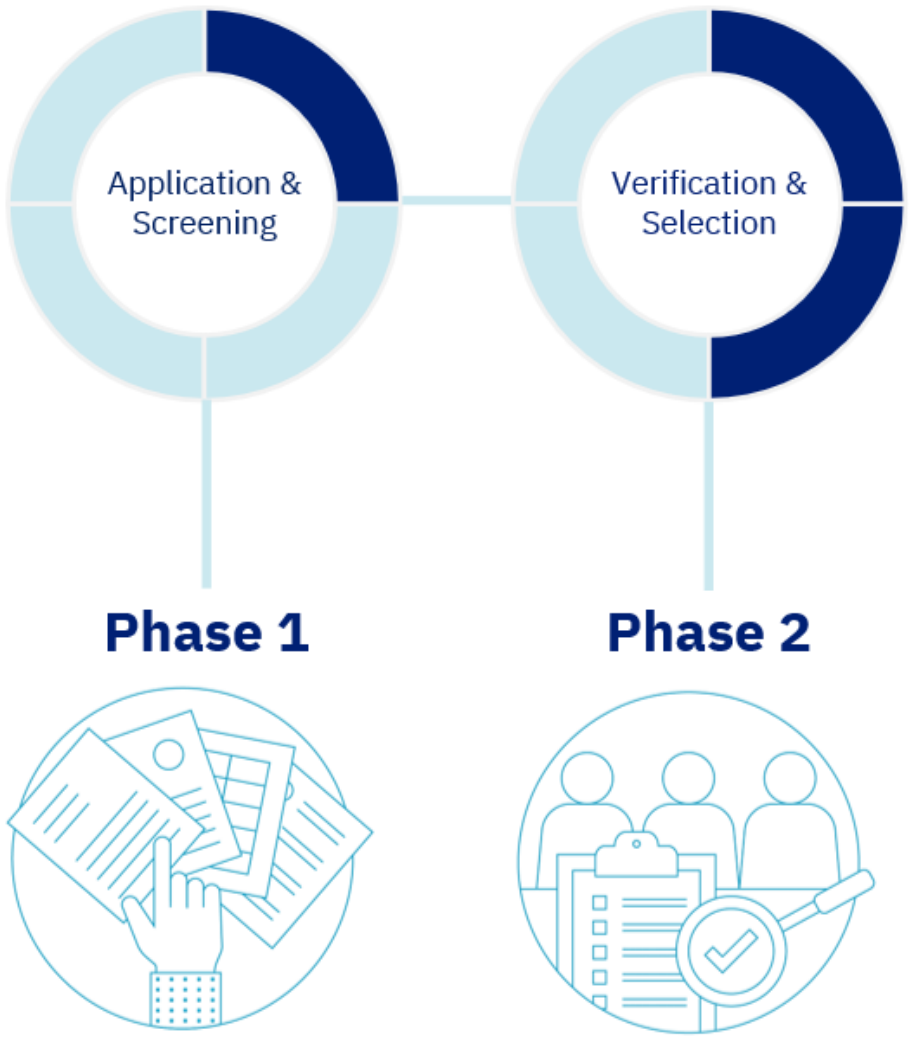

Candidate Eligibility Requirements & Selection

Selected eligible applicants will:

- Meet eligibility requirements
- Write the Therapeutics Decision-Making (TDM) Examination
- Participate in a customized assessment of non-medical expert competencies in the form of an interview

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Candidate Eligibility Requirements

Medical Education	Successful completion of a medical degree issued by a school listed in the World Directory of Medical Schools (WDMS)
Examinations	Medical Council of Canada Qualifying Examination (MCCQE) Part 1 **OR** be a Licentiate of the Medical Council of Canada (LMCC) ; **AND** Medical Council of Canada Qualifying Examination (MCCQE) Part 2 (pre-2021) **OR** National Assessment Collaboration (NAC) Examination
Post-Graduate Training	A minimum of two years of postgraduate training in family medicine or general practice in another jurisdiction including the following rotations: • Minimum of 8 weeks postgraduate training in family medicine or general practice. • Minimum of 4 weeks postgraduate training in emergency medicine, general surgery, internal medicine, obstetrics/gynecology, pediatrics, and psychiatry.
Independent Practice	A minimum of three consecutive years of independent practice as a general or family physician (patient's Most Responsible Physician) in another jurisdiction in the past. Preference to be given to recent independent practice experience and experience with minimal interruptions or gaps.
Currency of Practice	24 weeks (960 hours) of clinical practice as a family physician or general practitioner in the immediately preceding three years (virtual-care will be considered, however a minimum of 850 hours must be in-person care). Preference will be given to applicants with recent clinical practice experience.

Candidate Eligibility Requirements (con't)

Immigration Status	Proof of Canadian citizenship or permanent resident status (Canadian passport or Permanent Resident Card)
English Proficiency	Acceptable minimum language proficiency as per current FMRAC Model Standards*
Other	Academic Credential Verification Proof of Professional Conduct Criminal Record Check Valid Medical Identification Number for Canada (MINC) & MCC Candidate Code No more than one previous practice ready assessment attempt in Canada No existing Return of Service Agreement

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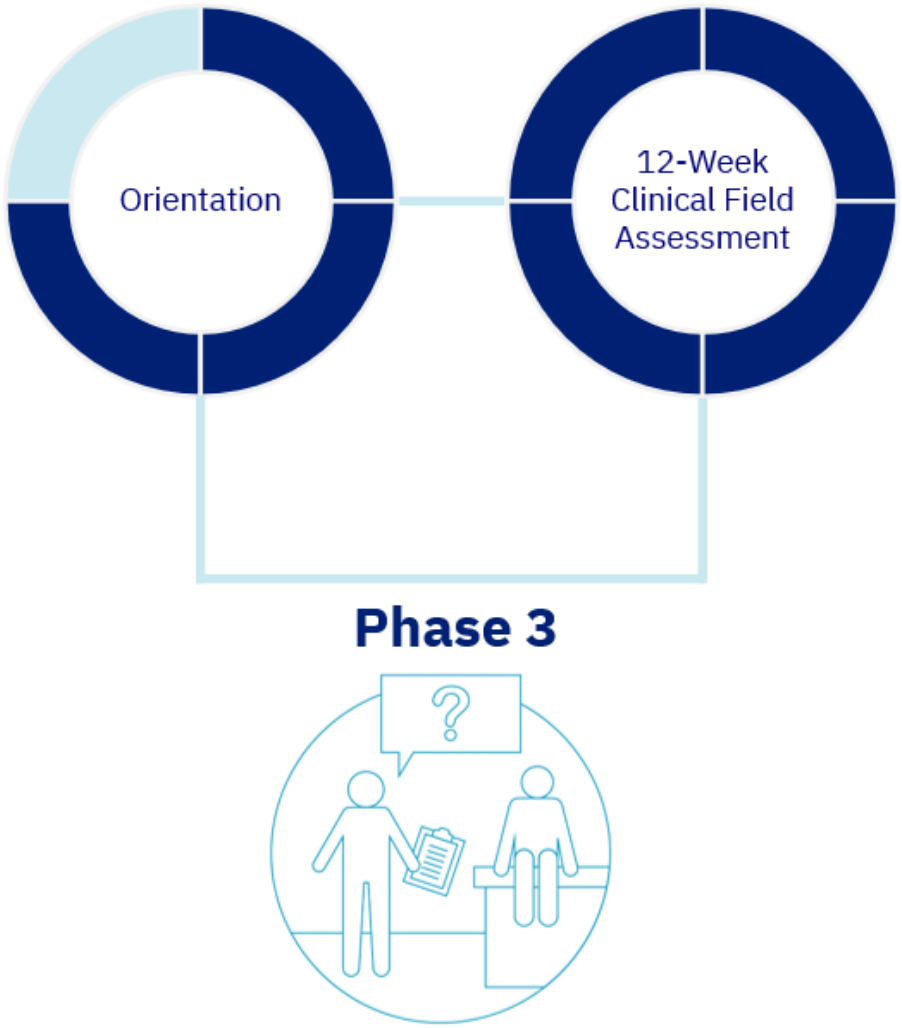
* https://fmrac.ca/wp-content/uploads/2022/11/FMRAC-Model-Standards-December-2021.pdf



Orientation & Clinical Field Assessment

- Candidate orientation
- Sites & Assessors

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Candidate Orientation

- Candidates are required to participate in orientation prior to beginning their clinical field assessment
- Curriculum follows National PRA Standards; some shared curriculum materials available through MCC online, some customized content
- MCC standardized online modules will be supplemented by an Ontario-specific curriculum
- Leverages Touchstone Institute's experience delivering the Pre-Residency Program, an orientation for International Medical Graduates (IMGs)

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12-Week Clinical Field Assessment

- Candidates will be required to participate in a 12-week Clinical Field Assessment (CFA)
- CFA is an assessment, not a training period, resulting in a pass/fail decision
- Upon successfully passing the CFA, and therefore the PRO, candidates will begin a three-year Return of Service with the Ontario Ministry of Health

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12-Week Clinical Field Assessment

- During the CFA candidates are not the Most Responsible Physician (MRP) – It is a supervised practice setting (ongoing & closely supervised with sufficient time and structure)
- PRA model includes multiple independent observations made across multiple situations by multiple observers
- Following recommendations for assessment documentation as per National PRA Standards

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Clinical Field Assessment Evaluation

Comprised of various formats of assessment;

- Multi-source Feedback Questionnaires
  - MD Colleague
  - Co-Worker (such as nurses, pharmacists, psychologists, social workers, etc.)
  - Patient
- Mini-Clinical Evaluation Exercises
- Field Notes
- Chart Simulation Recalls
- Chart Review Reports

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Clinical Field Assessment Sites

- Candidates will be paired with Clinical Field Assessment sites around the province, in like areas to Return of Service locations
  - A candidate's Clinical Field Assessment and Return of Service will **not** be in the same location due to potential conflict of interest
- Each site is required to have physician assessors who are committed to the candidate's competency evaluation
- A physician assessor will be designated as a lead for a predetermined period throughout the 12-week assessment

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Clinical Field Assessor Selection

- Recruitment of assessors and appropriate assessment sites led by Touchstone Institute with support from Ontario Health
- Proposed Assessors criteria:
  - CPSO Certificate of Professional Conduct to ensure Good Standing status with the College
  - Have 3 years in practice with a similar scope of practice to the proposed PRO placement
  - CFPC certification preferred but not mandatory
- Comprehensive assessor training provided and support throughout assessment period
- Compensation provided for the 12-week period

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Clinical Field Assessor Role

- Assess the candidate's fitness for independent practice in family medicine through various observations and recording of assessments
- Ensures patients are informed that the candidate is part of a practice ready assessment allowing patients the options to decline to be seen by the candidate without any penalty
- Coordinates the distribution and collection of multi-source feedback from patients, colleagues and other allied professionals (through standardized forms)
- Identifies any concerns regarding the candidate to the PRO Administrator in a timely manner

*Roles & Responsibilities currently being finalized
*Based on the MCC NAC-PRA Standards and Guidelines

Clinical Field Assessor Supports

- Fully supported by the Touchstone Institute team throughout the 12-week period
- Submits Interim and Final Clinical Field Assessment Report (CFARs) to Touchstone Institute in a timely fashion
- Submits a recommendation for a practice-ready decision to Touchstone Institute (via Final CFAR)
- Final decisions made by a sub-committee

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Return of Service & Beyond

- Three-year Return of Service agreement with the Ministry of Health
- Certification Examination in Family Medicine through CFPC
- Independent Licensure with CPSO

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Return of Service

- Candidates who successfully complete PRO will be required to fulfill a three-year return of service in a specified eligible community established by the Ministry of Health
- Practice locations in communities with a Rurality Index of Ontario (RIO) score of 40 and above and in Northern Urban Referral Centres (i.e., Timmins, North Bay, Sudbury, Sault Ste. Marie, and Thunder Bay) are eligible. RIO is a measure of rurality that is derived from three factors: population (count and density), travel time to a basic referral centre, and travel time to an advanced referral centre. RIO scores are assigned to Statistics Canada census subdivisions. Community RIO scores are available here: https://apps.oma.org/RIO/index

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CFPC Examination & Independent Practice

- Sitting the Certification Examination in Family Medicine with the College of Family Physicians of Canada and subsequently applying for independent licensure with CPSO are the sole responsibility of the candidate and not part of the Practice Ready Ontario program.

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Thank You

Our Vision

Public confidence in professional competence.

Our Mission

To excel in providing competency assessment and education services that meet professional and societal needs.

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Council Motion

Motion Title	Draft Policy for Consultation - *Practice Ready Assessment Program*
Date of Meeting	June 8, 2023

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 policy, "*Practice Ready Assessment Program*" (a copy of which forms Appendix " " to the minutes of this meeting).

Council Briefing Note

June 2023

Topic:	Draft Policies for Consultation – *Recognition of RCPSC Subspecialist Affiliate Status* and *Specialist Recognition Criteria in Ontario*
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation System Collaboration
Public Interest Rationale:	Accessibility: facilitating the registration of internationally educated physicians to support increased access to health care services in Ontario
Main Contact(s):	Samantha Tulipano, Director, Registration & Membership Services Tanya Terzis, Interim Manager, Policy Alex Wong, Policy Analyst Mike Fontaine, Policy Analyst
Attachment(s):	**Appendix A:** Draft *Recognition of RCPSC Subspecialist Affiliate Status* Policy **Appendix B:** Draft *Specialist Recognition Criteria in Ontario* Policy

Issue

- Council is provided with an overview of the new draft *Recognition of RCPSC Subspecialist Affiliate Status* policy and draft *Specialist Recognition Criteria in Ontario* policy and is asked to consider whether these draft policies can be approved for consultation.

Background

- Since the Ontario Minister of Health's 2022 direction to "make every effort to register out of province and internationally educated physicians [IEPs] to the College as expeditiously as possible," CPSO has been actively re-evaluating whether barriers to licensure can be removed and whether new pathways to registration can be explored through policy.

Current Status and Analysis

Royal College of Physicians and Surgeons of Canada (RCPSC) Subspecialist Affiliate Status

- The RCPSC offers assessment programs in the form of the Subspecialty Examination Affiliate Program (SEAP) and Practice Eligibility Route for the Subspecialty Examination Affiliate Program (PER-SEAP) for internationally trained subspecialists who are not certified by the RCPSC in a primary specialty.

  - As part of this process, RCPSC determines whether an applicant is eligible to take the subspeciality exam based on a review of their postgraduate residency training, their practice experience, and a multi-source feedback survey.

  - Physicians who have successfully challenged the RCPSC subspeciality exam have demonstrated the requisite knowledge, skill, and judgment to practise within their subspeciality.

  - Upon successful completion of the RCPSC's subspecialty exam, physicians are invited to become Subspecialist Affiliates and are recognized by the RCPSC in their subspecialty only.

- Subspecialist Affiliate attestation enables physicians to maintain engagement with the RCPSC, but it does not confer certification with the RCPSC. Subspecialist Affiliates are required to participate in the Royal College Maintenance of Certification (MOC) Program.

Recognition of RCPSC Subspecialist Affiliate Status Draft Policy

- A new *Recognition of RCPSC Subspecialist Affiliate Status* draft policy (**Appendix A**) has been developed which creates a new pathway to licensure for internationally trained subspecialists who are not otherwise eligible to practise in Ontario.

- The draft policy enables CPSO to issue restricted certificates of registration to physicians who lack RCPSC certification in a primary specialty but have Subspecialist Affiliate status. This certificate will allow physicians to practise independently in the subspecialty in which they were trained and received their Subspecialist Affiliate attestation.

- Physicians not certified by the RCPSC are not able to use the specialist title unless CPSO grants them the ability to do so. To allow Subspecialist Affiliates registered under this draft policy to use the specialist designation in relation to their subspecialty, draft amendments have been proposed for the *Specialist Recognition Criteria in Ontario* policy (**Appendix B**).

Considerations

- There is currently no pathway for Subspecialist Affiliates to be licensed in Ontario. The draft policy creates a new route for IEPs to practise in Ontario.

  - Generally, Subspecialist Affiliate candidates are training and registered as clinical fellows in RCPSC-accredited subspecialty training programs, but do not have prerequisite RCPSC certification in a primary specialty for RCSPC Fellowship, based on the jurisdiction of their primary specialty training. Accordingly, they do not have a route to licensure outside the postgraduate class. This pathway provides a route for these physicians who have successfully challenged the RCPSC subspecialty exam to practice independently in their scope.

- The qualifications and requirements set out in the draft *Recognition of RCPSC Subspecialist Affiliate Status* policy are aligned with those of other provinces which already offer licences recognizing RCSPC Subspecialist Affiliate status.

    - In Nova Scotia, Subspecialist Affiliates are granted a full license to practise in their subspecialty.

    - In Saskatchewan, Subspecialist Affiliates may be granted provisional licenses but must practise under supervision and for one year and complete an assessment before they can practise independently.

Next Steps

- Should Council approve the proposed draft policies, they will be circulated in accordance with Section 22.21 of the *Health Professions Procedural Code* (the Code).

- Additionally, pending Council's direction, in order to support the timely implementation of these new routes we will seek the Executive Committee's approval of the final policies (subject to feedback received) pursuant to its authority under s. 12 of the Code and s. 30 of the General By-Law.

Question for Council

1. Does Council recommend that the draft policies be approved for consultation?

Appendix A

RECOGNITION OF RCPSC SUBSPECIALIST AFFILIATE STATUS

The Royal College of Physicians and Surgeons of Canada (RCPSC) can grant Subspecialist Affiliate status to internationally trained subspecialists who are not certified in their primary specialty.

CPSO may issue you a restricted certificate of registration to practise independently in your subspecialty if you have:

- A medical degree from an acceptable medical school;
- Successfully completed postgraduate training in the subspecialty in which your Subspecialist Affiliate attestation was granted;
- Obtained the LMCC or completed an acceptable qualifying examination; and
- Obtained Subspecialty Affiliate status from RCPSC.

In addition to the eligibility requirements above, you must satisfy the non-exemptible requirements set out in *Section 2(1)* of *Ontario Regulation 865/93* to be issued a certificate of registration.

Appendix B

SPECIALIST RECOGNITION CRITERIA IN ONTARIO

Approved by Council: April 2005
Reviewed and Updated: November 2011, September 2022

Purpose

In order to practise 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 (RCPSC) 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 (CFPC) 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 practise 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 RCPSC and the CFPC.

This policy does not apply to physicians who hold certification by RCPSC or the CFPC 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 RCPSC; or
2. holds certification in family medicine by the CFPC; 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); 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 RCPSC or the CFPC, 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. holds a restricted certificate of registration that has been issued under the College's *Academic Registration* policy, and:
    a. has completed a minimum of five years of clinical practice in an academic setting in Ontario, and
    b. has provided evidence of satisfactory clinical performance, knowledge, skill, judgement, and professional conduct from the medical school where the academic appointment was held; or
7. 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 RCPSC or the CFPC, and
    c. has successfully completed a practice assessment that has been directed by the Registration Committee[1]; or
8. holds a restricted certificate of registration in Ontario that has been issued under the College's *Alternative Pathways to Registration for Physicians Trained in the United States* policy, and:
    a. has received written confirmation from a US Specialty Board of eligibility to take the certification examination on the basis of satisfactory completion of a residency program accredited by the ACGME within the last five years; or
9. holds 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. has received written confirmation from the RCPSC of current eligibility, with no pre-conditions, to take the certification examination on the basis of satisfactory completion of a RCPSC-accredited residency program in Canada or a RCPSC recognized program outside of Canada; or
10. holds 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. has received written confirmation from the CFPC of current eligibility, with no pre-conditions, to take the certification on the basis of satisfactory completion of a CFPC-accredited residency program in Canada or a CFPC recognized program outside of Canada.
11. holds a restricted certificate of registration in Ontario that has been issued under the College's *Recognition of RCPSC Subspecialist Affiliate Status* policy.[2]

Endnotes

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

[2.] Physicians who have been granted Subspecialist Affiliate status from RCPSC must only identify themselves as specialists in the subspecialty in which their Subspecialist Affiliate attestation was granted. CPSO does not recognize these physicians in a primary/core specialty.

Council Motion

Motion Title	Draft Policies for Consultation -- *Recognition of RCPSC Subspecialist Affiliate Status* and *Specialist Recognition Criteria in Ontario*
Date of Meeting	June 8, 2023

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 policy, "*Recognition of RCPSC Subspecialist Affiliate Status*" (a copy of which forms Appendix " " to the minutes of this meeting) and the draft revised policy, "*Specialist Recognition Criteria in Ontario*" (a copy of which forms Appendix " " to the minutes of this meeting).

Council Briefing Note

June 2023

Topic:	Approval Item: Waiver of Certain Fees Under the Residents Working Additional Hours for Pay ("Moonlighting") Policy
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation
Public Interest Rationale:	**Accessibility:** Ensuring individuals have access to services provided by the health profession of their choice and individuals have access to the regulatory system as a whole
Main Contact:	Samantha Tulipano, Director, Registration & Membership Services
Attachment:	**Appendix A:** *Residents Working Additional Hours for Pay* Policy

Issue

- To consider waiving the application fees for residents applying under the *Residents Working Additional Hours for Pay* ("Moonlighting") Policy.

Background

- In November 2004 Council approved a policy to allow residents, in limited circumstances, to work outside of their training program for pay. This policy, *Residents Working Additional Hours for Pay*, is often referred to as the "Moonlighting" policy. The policy permits residents on a postgraduate education certificate to apply for a Restricted certificate, provided they satisfy specific criteria (see **Appendix A**).

Current Status and Analysis

Existing Application Process

- After obtaining an offer of employment and confirming a Supervising Physician at a healthcare facility, the resident submits an academic application package to the Restricted Registration Program (RRP) Office for approval. Once approved, the academic application package is forwarded to CPSO and the resident must apply for a Restricted certificate.

- The CPSO application fee for this activity is presently $1,035. This is in addition to the $345 annual membership fee.

- Additionally, the RRP Office requires the resident to submit a separate academic application package for **every proposed** healthcare facility. Accordingly, the resident must also apply to the CPSO each time they would like to add a new site to their Restricted certificate, which carries an amendment fee of $431.25.

Ongoing Health Human Resources (HHR) Crisis

- Throughout the pandemic residents played a vital role in alleviating pressures caused by the on-going HHR crisis.

- In April 2021 the Ontario Government launched the *Medical Resident Redeployment* (MRR) *Program* to further support hospital staffing and capacity pressures caused by the third wave of the COVID-19 pandemic. The program allowed residents to provide additional services at hospitals across Ontario for pay, without requiring an independent practice license, a Restricted Registration certificate, or Program Director approval. The program was extended to March 31, 2023.

- As the MRR Program ends and the acute COVID-19 pandemic emergency eases (transitioning to an endemic situation), the strain on the Ontario healthcare system and health human resources remains at a critical level.

- The Residents Working Additional Hours for Pay policy continues to play a vital role in helping hospitals meet clinical demands and staffing needs, and the CPSO is committed to facilitating flexible, expeditious processing for all stakeholders involved.

- Waiving the fees for Moonlighting recognizes the ongoing efforts made by Ontario's residents to provide system coverage, and alleviates some of the gaps the cessation of the MRR program has left.

- As the application fees may be a barrier to registration for this activity, waiving the fees may also result in an increased number of individuals applying to undertake this activity, and further support HHR.

Analysis

- For the 2022/2023 academic year (July 2022-June 2023) we had 218 individuals holding a license under the Moonlighting policy.

  - Based on this data, the estimated annual revenue loss would be 218 * 1,035 for a total of $225,630.

- We are seeking Council's approval to waive the Moonlighting-related fees for the 2023-2024 academic year in an effort to alleviate some of the strain on the health care system and will revisit this decision next year.

Question for Council

1. Does Council support waiving the Moonlighting fees for the 2023-2024 academic year?

Appendix A

RESIDENTS WORKING ADDITIONAL HOURS FOR PAY

Approved by Council: December 2010
To be Reviewed by: December 2016

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

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

Please note if you currently hold a certificate of registration in any Canadian jurisdiction you may be eligible for registration in Ontario under new provisions of the *Health Professions Procedural Code* (the "Code"). Please refer to sections 22.15 to 22.23 of the Code. Please see Legislation and By-Laws for more details.

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

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

All applicants may choose to proceed through any other applicable registration policy. In such instances, the provisions in this policy will not apply.

This policy allows residents, in limited circumstances, to work for additional hours for pay outside of their training requirements.

Principles

- The College affirms that neither patient safety nor the well-being of residents be compromised for the purpose of meeting the administrative/staffing needs of hospitals or the personal financial concerns of residents.
- The College recognizes that Ontario residents are a valuable human resource for providing health care, whose full potential has not yet been realized.
- As residents progress through their education and training, the College accepts that they are able to practice medicine, within their area of training, in an increasingly independent manner.

Policy

A resident holding a postgraduate education certificate of registration may apply for a restricted certificate of registration under certain prescribed conditions.

To apply for a restricted certificate of registration to practice medicine outside of their training program, medical residents are required to:

- complete a minimum of one year of residency training;
- receive approval from the Dean of his/her medical school or his/her designate;
- arrange additional work only in existing rotations already successfully completed as a trainee;
- be in the same supervisory relationship with the Most Responsible Physician taking responsibility for the care of the patient; and
- ensure that the work for pay does not interfere with the work requirements of the residency program and that any additional hours worked not be done in a fashion which would contravene the collective agreement.

Council Motion

Motion Title	*Waiver of Certain Fees Under the Residents Working Additional Hours for Pay ("Moonlighting") Policy*
Date of Meeting	June 8, 2023

It is moved by_____, and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario approves waiving the application fees for residents holding a postgraduate education certificate of registration who apply for a restricted certificate of registration under the *Residents Working Additional Hours for Pay ("Moonlighting")* Policy for the July 2023 to June 2024 academic year.

Council Briefing Note

June 2023

Topic:	Audited Financial Statements for the 2022 Year
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:** Draft Audited Financial Statements for the Year Ended December 31, 2022

Issue

- Audited Financial Statements – Year ended December 31, 2022
- Appointment of the Auditor for the 2023 fiscal year

Background

- Mr. Paul Brocklesby, of Tinkham LLP Chartered Professional Accountants, reviewed the audited financial statements for the year ended December 31, 2022 for the Finance and Audit Committee.

- Mr. Brocklesby reported that the financial statements are represented fairly and in accordance with Canadian accounting standards for not-for-profit organizations. The reports states:

  "In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the College as at December 31, 2022, and the results of its operations and its cash flows for the year then ended in accordance with Canadian accounting standards for not-for-profit organizations."

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

- The Finance and Audit Committee is pleased to inform Council that for the fiscal year ended December 31, 2022, the College is reporting a surplus of $4.1M (5%) which can be attributed to the following:

    - Membership Revenue is higher by $1.9M or 3% as compared to a 1% increase in the prior year.
    - Application Fee Revenue is higher by $.2M or 2% due to an increase in PGE applications in the latter part of the year.
    - Interest Income is up by 1.3 million due to higher interest rates in our current account negotiated with the College's bank.
    - Staffing costs only increased by 1% ($.7M) despite a Cola increase of 2.5%.
    - Software costs are higher by 1.0M related to licensing costs for the new systems (F&O, Solis, and Vault).
    - Savings in Per Diem costs of $1.1M due to more virtual sessions.
    - Savings in Consulting Fees of $.5M.
    - The surplus was distributed to the Restricted Funds as per below:

Invested in Capital Assets (2022 Net)	2,185,041.04
Transfer to Intangible Asset Fund	(6,824,197.18)
Pension Adjustment	559,148.00
Total Surplus	(4,080,008.14)

- The Finance and Audit Committee made the following motions:

    The Finance and Audit Committee recommends to Council that the audited Financial Statements for the year ended December 31, 2022, be accepted as presented by Tinkham LLP Chartered Professional Accountants.

    The Finance and Audit Committee recommends to Council that $6,824,197.18 of the unrestricted net assets as of December 31, 2022 be transferred to the Intangible Asset Fund.

    The Finance and Audit Committee recommends to Council that the firm of Tinkham LLP Chartered Professional Accountants be appointed as the College's auditors for the fiscal year 2023.

Questions for Council

1. Does Council approve the audited financial statements for the year ended December 31, 2022 as presented?
2. Does Council approve the recommendation that the firm of Tinkham LLP Chartered Professional Accountants be reappointed as the College's auditors for the year 2023?

Financial statements of the

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 31, 2022

TINKHAM LLP | CHARTERED PROFESSIONAL ACCOUNTANTS

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INDEPENDENT AUDITOR'S REPORT

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

We have audited the accompanying financial statements of the College of Physicians and Surgeons of Ontario ("College"), which comprise the statement of financial position as at December 31, 2022 and the statements of operations and changes in unrestricted net assets and cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the College as at December 31, 2022, and the results of its operations and its cash flows for the year then ended in accordance with Canadian accounting standards for not-for-profit organizations.

Basis for Opinion

We conducted our audit in accordance with Canadian generally accepted auditing standards. Our responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of our report. We are independent of the College in accordance with the ethical requirements that are relevant to our audit of the financial statements in Canada, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide basis for our opinion.

Responsibilities of Management and Those Charged with Governance for the Financial Statements

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

In preparing the financial statements, management is responsible for assessing the College's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless management either intends to liquidate the College or to cease operations, or has no realistic alternative but to do so.

Those charged with governance are responsible for overseeing the College’s financial reporting process.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Canadian generally accepted auditing standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with Canadian generally accepted auditing standards, we exercise professional judgment and maintain professional skepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the College's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast doubt on the College's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the College to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

TORONTO, Ontario
June 8, 2023

Licensed Public Accountants

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
Statement of Financial Position

As at December 31	**2022**	2021
Assets		
Current		
Cash	**$ 62,375,231**	$ 58,578,305
Accounts receivable	**972,073**	1,903,588
Prepaid expenses	**3,097,552**	1,573,129
	66,444,856	62,055,022
Investments (note 3)	**50,694,192**	50,331,712
Capital assets (note 4)	**14,613,491**	16,828,346
	$131,752,539	$129,215,080
Liabilities		
Current		
Accounts payable and accrued liabilities	**$ 8,101,808**	$ 9,208,460
Current portion of obligations under capital leases (note 7)	**500,341**	689,167
	8,602,149	9,897,627
Deferred revenue (note 5)	**32,989,051**	33,240,949
	41,591,200	43,138,576
Accrued pension cost (note 6)	**4,542,816**	5,256,150
Obligations under capital leases (note 7)	**475,105**	316,093
	46,609,121	48,710,819
Net assets		
Internally restricted (note 8)		
Invested in capital assets	**13,638,045**	15,823,086
Building Fund	**60,700,276**	60,700,276
Intangible Asset Fund	**10,805,097**	3,980,899
Pension remeasurements	**(725,130)**	(1,284,280)
Unrestricted	**725,130**	1,284,280
	85,143,418	80,504,261
	$131,752,539	$129,215,080

Commitments and contingencies (notes 9 and 10, respectively)

Approved on behalf of the Council

_____

_____

See accompanying notes to the financial statements.

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Statement of Operations and Changes in Unrestricted Net Assets

Year ended December 31	**2022**	2021
Revenue		
Membership fees		
General and educational (note 5)	**$ 68,881,162**	$ 67,443,326
Penalty fee	**991,749**	563,126
	69,872,911	68,006,452
Application fees	**9,038,049**	8,837,479
OHPIP annual and assessment fees (note 5)	**1,339,476**	1,440,239
IHF annual and assessment fees (note 5)	**2,269,119**	1,431,792
OHPIP, IHF application fees and penalties	**102,099**	62,525
Cost recoveries and other income	**1,779,428**	2,290,504
Interest income	**1,835,684**	553,628
	86,236,766	82,622,619
Expenses		
Staffing costs (schedule I)	**52,360,938**	51,707,598
Per diems (schedule II)	**9,002,543**	7,869,158
Other costs (schedule III)	**9,825,788**	7,805,729
Professional fees (schedule IV)	**4,353,531**	4,886,444
Amortization of capital assets	**4,541,294**	3,503,959
Occupancy (schedule V)	**2,435,145**	2,629,811
	82,519,239	78,402,699
Excess of revenue over expenses before undernoted items	**3,717,527**	4,219,920
Investment income	**362,480**	342,192
Excess of revenue over expenses for the year	**4,080,007**	4,562,112
Unrestricted net assets, beginning of year	**1,284,280**	1,173,107
Less: Invested in capital assets (net)	**2,185,041**	(2,470,040)
Less: Transfer to Intangible Asset Fund	**(6,824,198)**	(1,980,899)
Unrestricted net assets, end of year	**$ 725,130**	$ 1,284,280

See accompanying notes to the financial statements.

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
Statement of Cash Flows

Year ended December 31	**2022**	2021
Cash flows from operating activities:		
Excess of revenue over expenses for the year	**$ 4,080,007**	$ 4,562,112
Amortization of capital assets	**4,541,294**	3,503,959
	8,621,301	8,066,071
Net change in non-cash working capital items:		
Accounts receivable	**931,515**	(277,581)
Prepaid expenses	**(1,524,423)**	(429,216)
Accrued interest receivable	**(362,480)**	(331,712)
Accounts payable and accrued liabilities	**(1,106,652)**	(14,338)
Deferred revenue	**(251,898)**	(9,491)
Pension cost	**(154,184)**	(174,821)
Cash provided by operating activities	**6,153,179**	6,828,912
Cash flows used by investing activities:		
Purchase of capital assets	**(1,563,448)**	(5,137,442)
Cash flows used by financing activities:		
Payment of capital lease obligations	**(792,805)**	(836,557)
Net increase in cash	**3,796,926**	854,913
Cash, beginning of year	**58,578,305**	57,723,392
Cash, end of year	**$ 62,375,231**	$ 58,578,305

See accompanying notes to the financial statements. 6

1 Organization

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

The College is exempt from income taxes.

2 Significant accounting policies

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

(a) Cash

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

(b) Investments

Guaranteed investment certificates are carried at amortized cost.

(c) Capital assets

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

When conditions indicate a capital asset no longer contributes to the College's ability to provide services or that the value of future economic benefits or service potential associated with the capital asset is less than its net carrying amount, its net carrying amount is written down to its fair value or replacement costs. As at December 31, 2022, no such impairment exists.

(i) Tangible assets

Tangible assets are measured at cost less accumulated amortization and accumulated.

Amortization is provided for, upon the commencement of the utilization of the assets, on a straight-line basis over their estimated lives as follows:

Building	10 - 25 years	Computer and other equipment	3 - 5 years
Furniture and fixtures	10 years	Computer equipment under capital lease	2 - 4 years

(ii) Intangible assets

Intangible assets, consisting of separately acquired computer application software, are measured at cost less accumulated amortization.

Amortization is provided for, upon the commencement of the utilization of the assets, on a straight-line basis over their estimated useful lives of four years.

2 Significant accounting policies (continued)

(d) Pension plans

(i) Healthcare of Ontario Pension Plan

Healthcare of Ontario Pension Plan ("HOOPP") is a multi employer best five consecutive year average pay defined benefit pension plan.

Defined contribution accounting is applied to HOOPP and contributions are expensed when due.

(ii) CPSO Retirement Savings Plan 2019

CPSO Retirement Savings Plan 2019 is a defined contribution plan. Contributions are expensed when due.

(iii) Designated Employees' Retirement Plan for the College of Physicians and Surgeons on Ontario

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

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

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

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

(e) Revenue recognition

(i) Members' fees and application fees

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

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

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

(iii) Cost recoveries

Cost recoveries are recognized at the same rate as the related costs are expensed.

(iv) Other income

Other income is recognized as the services are provided, the amount is known and collection is reasonably assured.

2 Significant accounting policies (continued)

(e) Revenue recognition (continued)

(v) Interest and investment income

Interest income is comprised of interest on cash deposits held in an interest bearing account at a major financial institution. Investment income is comprised of income on guaranteed investment certificates.

Interest and investment income are recognized when earned. Income on guaranteed growth investment certificates is determined at maturity based on the percentage change in price of an equally weighted portfolio of five Canadian bank's shares. Interest is accrued at the minimum guaranteed rates.

(f) Financial instruments

(i) Measurement

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

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

(ii) Impairment

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

(g) Management estimates

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

(h) Internally restricted reserves

Council has established the following internally restricted reserves:

(i) Invested in capital assets which comprises the net book value of capital assets less the related obligations under capital leases;

(ii) Building Fund which comprises assets restricted for future building requirements; and

(iii) Intangible Asset Fund which comprises assets restricted for future information technology infrastructure development and improvements.

3 Investments

As at December 31	**2022**	2021
Guaranteed Investment Certificates (GIC)		
Bank of Montreal (BMO) Extendible GIC	**$ 25,000,000**	$ 25,000,000
National Bank of Canada (NBC) Canadian Banks Portfolio Flex GIC	**25,000,000**	25,000,000
Accrued interest	**694,192**	331,712
	$ 50,694,192	$ 50,331,712

The BMO Extendible GIC earns interest at 1.45% and had an initial maturity date of February 1, 2022. The issuer exercised its option to extend the maturity date on the initial maturity date. The maturity date can continue to be extended by the issuer in six month increments on each extended maturity date thereafter extending to August 1, 2027. The GIC is not redeemable at the option of the College. At maturity the principal amount of $25,000,000, plus accrued interest, is guaranteed. The fair market value, including accrued interest, of the GIC as at December 31, 2022 is $21,632,459 (2021 - $24,139,209).

The NBC Canadian Bank Portfolio Flex GIC matures on January 29, 2026 and earns a return determined at maturity based on the percentage change in price of an equally weighted portfolio of five Canadian bank's shares. At maturity the principal amount of $25,000,000 is guaranteed. The fair market value of the GIC as at December 31, 2022 is $21,832,500 (2021 - $24,212,500).

4 Capital assets

As at December 31	**2022**		2021	
	Cost	**Accumulated Amortization**	Cost	Accumulated Amortization
Tangible assets				
Land	**$ 2,142,903**	**$ -**	$ 2,142,903	$ -
Building and building improvements	**21,282,321**	**17,158,430**	21,101,419	16,639,886
Furniture and fixtures	**4,625,827**	**4,289,074**	4,571,754	4,155,683
Computer and other equipment	**2,960,347**	**2,868,451**	1,984,487	1,951,546
Computer equipment under capital lease	**3,850,304**	**2,874,858**	4,038,383	3,033,123
Intangible assets				
Computer application software	**12,368,526**	**5,425,924**	11,122,247	2,352,609
	47,230,228	**32,616,737**	44,961,193	28,132,847
Net book value		**$ 14,613,491**		$ 16,828,346

5 Deferred revenue

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

	Membership Fees	IHF	OHPIP	2022 Total	2021 Total
Balance, beginning of year	**$ 28,645,293**	**$ 3,392,841**	**$ 1,202,815**	**$ 33,240,949**	$ 33,250,440
Amounts billed during the year	**69,490,715**	**1,398,430**	**1,348,714**	**72,237,859**	70,305,866
Less: Recognized as revenue	**(68,881,162)**	**(2,269,119)**	**(1,339,476)**	**(72,489,757)**	(70,315,357)
Balance, end of year	**$ 29,254,846**	**$ 2,522,152**	**$ 1,212,053**	**$ 32,989,051**	$ 33,240,949

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

6 Employee future benefits

(a) Designated Employees' Retirement Plan and Supplementary Arrangements

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

Defined Benefit Plan	Funded Plan	Unfunded Plan	2022 Total	2021 Total
Plan assets at fair value	**$ 2,053,650**	**$ -**	**$ 2,053,650**	$ 2,698,132
Accrued pension obligations	**(3,084,053)**	**(3,512,413)**	**(6,596,466)**	(7,954,282)
Funded status - deficit	**$ (1,030,403)**	**$ (3,512,413)**	**$ (4,542,816)**	$ (5,256,150)

(ii) Pension plan assets

Defined Benefit Plan	Funded Plan	Unfunded Plan	2022 Total	2021 Total
Fair value, beginning of year	**$ 2,698,132**	**$ -**	**$ 2,698,132**	$ 2,845,069
Interest income	**72,850**	**-**	**72,850**	62,592
Return (loss) on plan assets (excluding interest)	**(382,787)**	**-**	**(382,787)**	112,592
Employer contributions	**-**	**296,102**	**296,102**	291,856
Benefits paid	**(334,545)**	**(296,102)**	**(630,647)**	(613,977)
Fair value, end of year	**$ 2,053,650**	**$ -**	**$ 2,053,650**	$ 2,698,132

6 Employee future benefits (continued)

(a) Designated Employees' Retirement Plan and Supplementary Arrangements (continued)

(iii) Accrued pension obligations

Defined Benefit Plan	**Funded Plan**	**Unfunded Plan**	**2022 Total**	2021 Total
Balance, beginning of year	**$ 3,689,691**	**$ 4,264,591**	**$ 7,954,282**	$ 8,164,867
Interest cost on accrued pension obligations	**99,622**	**115,144**	**214,766**	179,627
Benefits paid	**(334,545)**	**(296,102)**	**(630,647)**	(613,977)
Actuarial (gains) losses	**(370,715)**	**(571,220)**	**(941,935)**	223,765
	$ 3,084,053	**$ 3,512,413**	**$ 6,596,466**	$ 7,954,282

The most recent actuarial valuation of the pension plan for funding purposes was made effective December 31, 2021. The next required actuarial valuation for funding purposes must be as of a date no later than December 31, 2024.

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

	2022	2021
Funded defined benefit plan	**$ 26,772**	$ 20,797
Unfunded supplementary defined benefit plan	**115,144**	96,238
Defined contribution plan	**659,766**	708,993
Healthcare of Ontario Pension Plan	**3,323,141**	3,019,898
	$ 4,124,823	$ 3,845,926

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

Defined Benefit Plan	**Funded Plan**	**Unfunded Plan**	**2022 Total**	2021 Total
Interest cost on accrued pension obligations	**$ 99,622**	**$ 115,144**	**$ 214,766**	$ 179,627
Interest income on pension assets	**(72,850)**	**-**	**(72,850)**	(62,592)
Pension expense recognized	**$ 26,772**	**$ 115,144**	**$ 141,916**	$ 117,035

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

Defined Benefit Plan	**Funded Plan**	**Unfunded Plan**	**2022 Total**	2021 Total
Actuarial (gains) losses	**$ (370,717)**	**$ (571,220)**	**$ (941,937)**	$ 223,765
Return (loss) on plan assets (excluding interest)	**382,787**	**-**	**382,787**	(112,592)
Charge to net assets	**$ 12,070**	**$ (571,220)**	**$ (559,150)**	$ 111,173

6 Employee future benefits (continued)

(a) Designated Employees' Retirement Plan and Supplementary Arrangements (continued)

(vii) Actuarial assumptions

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

	2022	2021
Discount rate	**5.00 %**	2.70 %

(b) Healthcare of Ontario Pension Plan

Employer contributions made to the plan during the year total $3,323,141 (2021 - $3,019,898). These amounts are included in staffing costs in the statement of operations.

Each year an independent actuary determines the funding status of HOOPP by comparing the actuarial value of invested assets to the estimated present value of all pension benefits that members have earned to date. The most recent actuarial valuation of the Plan as at December 31, 2022 indicates the Plan is 112% funded. HOOPP's statement of financial position as at December 31, 2022 disclosed total pension obligations of $92.7 billion with net assets at that date of $103.7 billion indicating a surplus of $11 billion.

(c) Restructuring benefits

The College continues to restructure its affairs during the year for the purpose of achieving long-term savings, which resulted in severance benefits to employees in the amount of $2,721,876 (2021 - $2,006,829), which has been included in staffing costs.

7 Obligations under capital leases

The College has entered into capital leases for computer equipment. The following is a schedule of the future minimum lease payments over the term of the leases:

2023	$	500,341
2024		287,022
2025		188,083
		975,446
Less: current portion		500,341
	$	475,105

8 Internally restricted net assets

2022	Invested in Capital Assets	Intangible Asset Fund	Building Fund	Pension Re-measurement
Balance, January 1	**$ 15,823,086**	**$ 3,980,899**	**$ 60,700,276**	**$ (1,284,280)**
Deficiency of revenue over expenses for the year	**(4,541,294)**	**-**	**-**	**-**
Transfer to Intangible Asset Fund	**-**	**6,824,198**	**-**	**-**
Actuarial remeasurement for pensions	**-**	**-**	**-**	**559,150**
Transfer to Invested in Capital Assets	**2,356,253**	**-**	**-**	**-**
Balance, December 31	**$ 13,638,045**	**$ 10,805,097**	**$ 60,700,276**	**$ (725,130)**

2021	Invested in Capital Assets	Intangible Asset Fund	Building Fund	Pension Re-measurement
Balance, January 1	$ 13,353,046	$ 2,000,000	$ 60,700,276	$ (1,173,107)
Deficiency of revenue over expenses for the year	(3,503,959)	-	-	-
Transfer to Intangible Asset Fund	-	1,980,899	-	-
Actuarial remeasurement for pension	-	-	-	(111,173)
Transfer to Invested in Capital Assets	5,973,999	-	-	-
Balance, December 31	$ 15,823,086	$ 3,980,899	$ 60,700,276	$ (1,284,280)

Net assets invested in capital assets is calculated as follows:

As at December 31	2022	2021
Net book value of capital assets	**$ 14,613,491**	$ 16,828,346
Less: obligations under capital leases	**(975,446)**	(1,005,260)
	$ 13,638,045	$ 15,823,086

9 Commitments

The College has a lease for additional office space which extends to February 28, 2024. Minimum payments for base rent and estimated maintenance, taxes and insurance in aggregate and for each year of the current term are estimated as follows:

2023	$ 782,404
2024	123,117
Total	$ 905,521

10 Contingencies

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

11 Financial instruments

General objectives, policies and processes

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

Credit risk

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

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

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

Liquidity risk

Liquidity risk is the risk that the College will not be able to meet a demand for cash or fund its obligations as they come due. The College meets its liquidity requirements and mitigates this risk by monitoring cash activities and expected outflows by holding cash.

Market risk

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

(i) Currency risk

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

(ii) Interest rate risk

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

(iii) Equity risk

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

Changes in risk

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

Schedule I - Staffing costs

Year ended December 31	**2022**	2021
Salaries	**$ 41,596,600**	$ 41,679,796
Employee benefits	**5,628,852**	4,741,440
Pension (note 6)	**4,124,823**	3,845,926
Training, conferences and employee engagement	**884,860**	1,297,111
Professional association fees	**125,803**	143,325
	$ 52,360,938	$ 51,707,598

Schedule II - Per diem

Year ended December 31	**2022**	2021
Attendance	**$ 3,838,874**	$ 2,929,045
Preparation time	**2,879,945**	2,895,023
Decision writing	**1,093,725**	1,208,111
Travel time	**677,543**	411,359
HST on per diems	**512,456**	425,620
	$ 9,002,543	$ 7,869,158

Schedule III - Other costs

Year ended December 31	**2022**	2021
Software	**$ 3,362,074**	$ 2,382,274
Credit card service charges	**1,688,446**	1,628,051
Meals and accommodations	**618,370**	195,328
Survivors fund	**567,560**	241,476
Travel	**458,983**	169,542
FMRAC membership fee	**454,528**	454,578
Reporting and transcripts	**405,166**	461,481
Telephone	**379,172**	408,998
Members dialogue	**360,649**	360,445
Equipment leasing	**288,845**	104,998
Miscellaneous	**243,248**	560,903
Offsite storage	**213,668**	192,813
Publications and subscriptions	**172,938**	164,444
Photocopying	**171,679**	137,841
Office supplies	**156,185**	115,203
Equipment maintenance	**120,010**	33,104
Grants	**74,000**	74,000
Postage	**64,102**	94,050
Courier	**26,165**	26,200
	$ 9,825,788	$ 7,805,729

Schedule IV - Professional fees

Year ended December 31	**2022**	2021
Consultant	**$ 3,231,121**	$ 3,723,378
Legal	**855,482**	916,475
Recruiting	**200,088**	169,530
Audit	**66,840**	77,061
	$ 4,353,531	$ 4,886,444

Schedule V - Occupancy

Year ended December 31	**2022**	2021
Insurance	**$ 776,044**	$ 723,127
Building maintenance and repairs	**690,516**	878,364
Rent	**666,412**	748,012
Utilities	**185,518**	167,515
Realty taxes	**116,655**	112,793
	$ 2,435,145	$ 2,629,811

Council Motion

Motion Title	Approval of the Audited Financial Statements for fiscal year 2022
Date of Meeting	June 8, 2023

It is moved by_____, and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario approves the audited financial statements for the fiscal year ended December 31, 2022, as presented (a copy of which forms Appendix " " to the minutes of this meeting).

Council Motion

Motion Title	Appointment of the Auditors (for fiscal year 2023)
Date of Meeting	June 8, 2023

It is moved by_____, and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario appoints Tinkham LLP, Chartered Accountants, as auditors to hold office until the next annual financial meeting of Council.

Council Briefing Note

June 2023

Topic:	Draft Regulations for Consultation – Physician Assistant Regulation
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation System Collaboration
Public Interest Rationale:	Bringing physician assistants under the authority of CPSO will ensure the protection of patients and work to fulfill our public interest mandate.
Main Contact(s):	Tanya Terzis, Interim Manager, Policy Alex Wong, Policy Analyst Stephanie Sonawane, Policy Analyst
Attachment(s):	**Appendix A:** Draft Enabling Regulation **Appendix B:** Draft Registration Regulation **Appendix C:** Draft Quality Assurance (CPD) Regulation **Appendix D:** Draft Professional Misconduct Regulation

Issue

- Council is provided with an overview of proposed regulatory changes required to bring physician assistants (PAs) under CPSO's oversight and key considerations moving forward.
- Council is asked for approval to release the draft regulatory amendments for circulation and an external public consultation for 60 days.

Background

- On June 3, 2021, Bill 283, the legislation that would enable CPSO to regulate PAs, received Royal Assent and Council received an update regarding the bill at its June 2021 meeting.
- Following the bill's passage, CPSO moved quickly to initiate work on implementing PA regulation. In the fall of 2021, work was significantly delayed due to uncertainty regarding the core regulatory framework being designed but resumed in earnest in summer of 2022.
- The legislation and CPSO's oversight of PAs will not be enacted until a later date, which the provincial government has signalled will be in 2024, in order to give time for the necessary regulatory amendments to be developed and approved.

Current Status and Analysis

- A full review of all existing regulations under the *Medicine Act, 1991* and the *Regulated Health Professions Act, 1991* (*RHPA*) was undertaken to identify where amendments will be required as PAs become members of the CPSO. This review has led to the development of four regulatory amendments under the *Medicine Act, 1991*.
    - While the regulatory amendments proposed are CPSO's to make, government ultimately must approve and enact these changes.
- In drafting the regulations, staff have aimed to set high-level expectations, align with the principles of right-touch regulation, and be mindful of the need to future-proof this work. Staff have also sought input from both government and the Canadian Association of Physician Assistants to inform the drafting of the regulations.

*Enabling Regulation (amendment to O. Reg. 114/94: General) (**Appendix A**)*

- A key principle in CPSO's presentation to the Legislative Committee and throughout negotiations with government was the importance of maintaining the status quo of the existing relationship between physicians and PAs. This approach relies on maintaining the existing delegation framework as set out in CPSO's *Delegation of Controlled Acts* policy.
- The legislative framework requires that regulations be developed to articulate how PAs will perform controlled acts as they have not been granted independent authorization through the legislation to perform these acts.
- In keeping with well-established principles of delegation while also continuing to provide flexibility for future policy or practice changes, the draft regulation stipulates:
    - That a PA member shall only perform controlled acts if delegated to by a physician, with the exception of psychotherapy, which cannot be delegated;
    - PAs may not sub-delegate a controlled act that has been delegated to them; and
    - The conditions in which a physician may delegate an act and the conditions in which a PA may accept the delegation of this act (e.g., where the act is within the physician's scope of practice and the PA has the competence to perform the act).
- Unlike other Canadian jurisdictions where PAs are regulated (Manitoba, New Brunswick, and Alberta), this approach does not contemplate specifying specific supervisory relationships between a physician and a PA. Rather, and in keeping with the current delegation framework, it enables greater flexibility by allowing PAs to support multiple physicians and practise in multiple settings.

*Registration Regulation (amendment to O. Reg. 865/93: Registration) (**Appendix B**)*

- The existing Registration regulation sets out entry-to-practice requirements for CPSO members. The general non-exemptible standards and qualifications under Section 2 for physician members will also apply to PAs and do not require amendments. These include good character, payment of relevant fees, and acquiring professional liability insurance.

- Amendments are proposed to set out the registration requirements for PAs. Namely, that an applicant must:

    - Be a graduate of an accredited or approved degree-granting program designed to train PAs;

    - Obtain either Canadian certification or the equivalent American certification, or another certification as approved by Council.

- The proposed amendments include giving Council the ongoing power to approve new education programs and accreditation bodies as the PA profession expands and to support the inclusion of internationally educated PAs over time.

- The draft amendment also includes a transitional grandparenting provision to enable two specific cohorts who are duly trained and who are currently practising as PAs but do not meet the standards and qualifications set out in the proposed regulation to register as members. The transitional provision aims to capture:

    - Individuals who have successfully completed the Canadian Armed Forces Physician Assistant Program; and

    - Individuals who have successfully completed the Physician Assistant Integration Program, which is a historical, assessment-based program that enabled internationally educated physicians to become PAs.

- In keeping with a new requirement under the *RHPA* for health regulatory colleges to make regulations creating an emergency class of registration, an Emergency Circumstances Practice Class for Physician Assistants has also been developed. The PA Emergency Circumstances Practice Class aligns with what has been developed for physicians, which was approved by Council in April 2023 and is currently being finalized with government.

*Quality Assurance Regulation (amendment to O. Reg. 114/94: General, Part VII) (**Appendix C**)*

- The *Health Professions Procedural Code* sets out the minimum requirements for a quality assurance program, which will apply equally to PA members of the College as it does to physician members. The core requirements of the quality assurance program, as set out in

the Quality Assurance sections of the regulation, will therefore be the same: peer and practice assessments, continuing professional development (CPD), and self-assessments.

- While much of the quality assurance regulation is broad enough to apply to PAs without amendment, changes are required to the CPD section to distinguish the PA CPD program from the program for physicians and to create a mechanism for tracking PA CPD.

- Specifically, new provisions have been drafted to require that PAs participate in a program of CPD and that PAs shall, each year, provide to the College proof of their participation that is satisfactory to the College. The drafting is purposefully broad to provide CPSO with discretion on the precise obligations relating to tracking and monitoring CPD.

*Professional Misconduct Regulation (amendment to O. Reg. 856/93: Registration) (**Appendix D**)*

- The existing professional misconduct regulation will apply equally to PA members of the College. However, one small amendment is required to add "physician assistant" to the existing "conduct unbecoming a physician."

Regulations not requiring amendments

- It was determined that no changes were needed to the regulations setting out obligations concerning records, the out-of-hospital premises inspection program, advertising, conflicts of interest, or funding for therapy and counselling. In all of these instances, the analysis suggested that there were no grounds to broadly exclude PAs from the existing regimes and the application will depend on each specific scenario/practice environment.

Next Steps

- If approved by Council, the regulations will be released for consultation for a 60-day period per the requirements set out in s. 95(1.4) of the *Health Professions Procedural Code* and circulated for notice in accordance with s. 22.21 of the *Health Professions Procedural Code*.

- Following consultation, the feedback received will be assessed and amendments to the draft regulations will be considered. Council will receive a final package of draft regulatory amendments at a later meeting date to approve for submission to government.

Question for Council

1. Does Council approve the draft regulatory amendments for circulation and consultation?

Enabling Mechanism (Delegation) – General Regulation Amendments

NOTE: The following new sections will need to be added in order to set out the enabling mechanism for PAs.

O. Reg. 114/94: General. Made under the *Medicine Act, 1991*.

PART XII

Physician Assistants

52. (1) A member who is a physician assistant shall only perform an act under the authority of section 4 if the performance of the act has been delegated to the member who is a physician assistant by a member who is a physician.

(2) Despite subsection (1), a member who is a physician shall not delegate to a member who is a physician assistant the authorized act of treating, by means of psychotherapy technique delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgment, insight, behaviour, communication or social functioning.

(3) A member who is a physician assistant shall not delegate the performance of an act that has been delegated to them.

(4) A member who is a physician shall ensure, before delegating an authorized act to a member who is a physician assistant, that,

(a) The member who is a physician has the knowledge, skill and judgment to perform the authorized act safely and competently themselves; and

(b) The member who is a physician is satisfied, after taking reasonable steps, that the member who is a physician assistant has the knowledge, skill and judgment to perform the act safely and competently.

(5) A member who is a physician assistant is entitled to presume that a member who is a physician is permitted to delegate an authorized act to them, unless the member who is a physician assistant has reasonable grounds to believe otherwise.

(6) A member who is a physician assistant shall only perform an authorized act delegated to them by a member who is a physician if, before performing the authorized act, the member who is a physician assistant ensures that they have the knowledge, skill and judgement to perform the authorized act safely and competently.

Registration Regulation Amendments

NOTE: The existing general requirements under this regulation will apply to both physician and PA members of CPSO. Two new sections (see below) will need to be added in order to set out entry-to-practice requirements for PAs and create an emergency class of registration for PAs.

O. Reg 865/93: Registration. Made under the *Medicine Act, 1991*.

Physician Assistant - General

9.1 The standards and qualifications for a certificate of registration authorizing practice as a physician assistant are as follows:

(1) The applicant must have a minimum of a baccalaureate degree evidencing the successful completion of a program designed to educate and train persons to be practising physician assistants which was:

a. accredited by the Canadian Medical Association or Accreditation Canada at the time the applicant graduated;

b. accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) at the time the applicant graduated;

c. another accrediting body as approved by Council; or

d. another program as approved by Council; and

(2) The applicant must hold certification as a physician assistant as follows:

a. Canadian Certified Physician Assistant (CCPA) certification by the Physician Assistant Certification Council of Canada (PACCC);

b. Physician Assistant-Certified (PA-C) by the National Commission on Certification of Physician Assistants NCCPA (US); or

c. another certification as approved by Council.

9.2 (1) Where section 22.18 of the *Health Professions Procedural Code* applies to an applicant for a certificate of registration authorizing practice as a physician assistant, the applicant is deemed to have met the requirements of subsection 9.1.

(2) Where an applicant to whom subsection (1) applies is unable to satisfy the Registrar or a panel of the Registration Committee that the applicant practised the profession of medicine to the extent that would be permitted by a certificate of registration authorizing practice as a physician assistant at any time in the three years immediately preceding the date of that applicant's application, the applicant must meet any further requirement to undertake, obtain or undergo material additional training, experience, examinations or assessments that may be specified by a panel of the Registration Committee.

(3) Despite subsection (1), an applicant is not deemed to have met a requirement if that requirement is described in subsection 22.18 (3) of the *Health Professions Procedural Code*.

Transition

9.3 The following apply for the first 24 months after the day this Regulation comes into force,

Paragraph (1) of subsection 9.1. does not apply in respect of an application for a certificate of registration authorizing practice as a physician assistant where:

(a) the applicant successfully completed the Canadian Armed Forces Health Training Centre Physician Assistant Program or the Ontario Physician Assistant Integration Program by the Centre for the Evaluation of Health Professionals Educated Abroad; and

(b) the applicant is able to satisfy the Registrar or a panel of the Registration Committee that the applicant engaged in practice in Canada within the scope of a physician assistant during the two-year period that immediately preceded the date that the applicant submitted their application.

Physician Assistants - Emergency Circumstances Practice

9.4 (1) The standards and qualifications for a certificate of registration authorizing practice in emergency circumstances for physician assistants are as follows:

1. The Minister has requested the College to initiate registrations under this class based on the Minister's opinion that emergency circumstances call for it, or Council has determined that there are emergency circumstances, and that it is in the public interest that the College issue emergency certificates of registration for physician assistants to address the emergency circumstances.

2. The applicant must have a minimum of a baccalaureate degree evidencing the successful completion of a program designed to educate and train persons to be practising physician assistants which was:

    (a) accredited by the Canadian Medical Association or Accreditation Canada at the time the applicant graduated;

    (b) accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) at the time the applicant graduated;

    (c) accredited by another accrediting body as approved by Council; or

    (d) a program as approved by Council.

3. The applicant must have any other standard or qualification that Council has identified as necessary in order for emergency certificates of registration for physician assistants to assist in addressing the determined emergency circumstances.

(2) The requirements of paragraphs 1, 2, and 3 of subsection (1) are non-exemptible.

(3) It is a term, condition and limitation of a certificate of registration authorizing practice in emergency circumstances for physician assistants that:

1. The certificate expires the earlier of the following:
    (a) one year from the date the certificate was issued or renewed; or
    (b) the 90th day after Council declares that the emergency circumstances have ended; and
2. The holder must adhere to any other terms, conditions and limitations that Council has identified as necessary in order for holders of emergency certificates of registration for physician assistants to assist in addressing the determined emergency circumstances.

(4) The Registrar may renew a certificate of registration authorizing practice in emergency circumstances for one or more periods, each of which is not to exceed one year, if Council has not declared that the emergency circumstances have ended.

9.5 (1) An applicant who in the year immediately preceding their application for a certificate of registration authorizing practice as a physician assistant, has held a certificate of registration issued by the College authorizing practice in emergency circumstances for physician assistants, is exempt from the standards and qualifications required under clause 2(2)(c), only in respect of payment of the relevant application fee but not in respect of payment of the annual membership fee.

Quality Assurance (CPD) – General Regulation Amendments

NOTE: Amendments are required to s. 29 to distinguish the CPD program for physicians. A new s. 29.1 sets out the CPD requirements for PAs.

O. Reg. 114/94: General. Made under the *Medicine Act, 1991*.

Part VII, ss. 26-29 – Quality Assurance and CPD

CONTINUING PROFESSIONAL DEVELOPMENT AND SELF-ASSESSMENT

29. (1) Members who are physicians shall participate in a program of continuing professional development that includes a self-assessment component and that meets the requirements for continuing professional development set by the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada. O. Reg. 346/11, s. 1.

(2) As evidence of a member who is a physician's participation in a program of continuing professional development, members who are physicians shall, each year, provide to the College,

(a) in the case of a program of continuing professional development offered by the Royal College of Physicians and Surgeons of Canada or by the College of Family Physicians of Canada, proof of the member's participation that is satisfactory to the Committee; or

(b) in the case of a program of continuing professional development offered by an organization other than the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada that has been approved by the Council for that purpose, written confirmation, satisfactory to the Committee, that the member has completed a program of continuing professional development that meets the requirements for continuing professional development set by the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada. O. Reg. 346/11, s. 1.

(3) A member who is a physician shall maintain a record of his or her participation in a program of continuing professional development in the form and manner approved by the Committee and shall retain the record for a minimum of 10 years from the date of his or her participation in the program. O. Reg. 346/11, s. 1.

(4) At the request of the Committee, an assessor or an employee of the College, a member who is a physician shall submit his or her record of participation in a program of continuing professional development to the College within the time period specified in the request or, if no time period is specified, within 30 days of the request. O. Reg. 346/11, s. 1.

29.1 (1) Members who are physician assistants shall participate in a program of continuing professional development that meets the requirements for continuing professional development set by the certifying body of the member.

(2) As evidence of a member who is a physician assistant's participation in a program of continuing professional development, members who are physician assistants shall, each year, provide to the College proof of the member's participation that is satisfactory to the Committee.

(3) A member who is a physician assistant shall maintain a record of his or her participation in a program of continuing professional development in the form and manner approved by the Committee and shall retain the record for a minimum of 10 years from the date of his or her participation in the program.

(4) At the request of the Committee, an assessor or an employee of the College, a member who is a physician assistant shall submit his or her record of participation in a program of continuing professional development to the College within the time period specified in the request or, if no time period is specified, within 30 days of the request.

Professional Misconduct Regulation Amendments

NOTE: The following amendment is required in order to capture PAs within this heading of professional misconduct.

O. Reg 856/93: Professional Misconduct. Made under the *Medicine Act, 1991*.

1. (1) The following are acts of professional misconduct for the purposes of clause 51 (1) (c) of the Health Professions Procedural Code:

…

34. Conduct unbecoming a physician or physician assistant.

Council Motion

Motion Title	Draft Regulations for Consultation – Physician Assistant Regulation
Date of Meeting	June 8, 2023

It is moved by_____, and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario release for external consultation and engage in the notice and consultation process in accordance with Section 22.21 of the Health Professions Procedural Code, in respect of the draft physician assistant regulatory amendments to the *Medicine Act, 1991* regulations (a copy of which amendments form Appendices “ “, “ “, “ “, and “ “ to the minutes of this meeting).

Council Motion

Motion Title	Motion to Go In-Camera
Date of Meeting	June 8, 2023

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; and

(d) personnel matters or property acquisitions will be discussed.