

The College of Physicians and Surgeons of Ontario

Meeting of Council



December 1 and 2, 2016



THE
COLLEGE
OF
PHYSICIANS
AND
SURGEONS
OF
ONTARIO

**NOTICE
OF
MEETING OF COUNCIL**

A meeting of The College of Physicians and Surgeons of Ontario will take place on Thursday December 1 and Friday December 2, 2016 in the Council Chamber of the College, at 80 College Street, Toronto, Ontario.

The meeting will convene at 9:00 a.m. on Thursday December 1, 2016.

Rocco Gerace, MD
Registrar

November 10, 2016



THE
COLLEGE
OF
PHYSICIANS
AND
SURGEONS
OF
ONTARIO

MEETING OF COUNCIL
December 1 and 2, 2016
Council Chamber, 3rd Floor, 80 College Street, Toronto

Thursday, December 1, 2016

CALL TO ORDER		
9:00 am	President's Announcements	
Motion	Council Meeting Minutes of September 8 and 9, 2016	1
	Executive Committee's Report to Council - April to June, 2016	17
FOR DECISION		
9:10 am Motion	Accepting New Patients Policy – Draft for Consultation The College's <i>Accepting New Patients</i> policy is currently under review. The Working Group has developed a revised draft policy informed by research and feedback received and public polling results. Council is asked to approve the release of the draft policy for external consultation.	19

<p>9:30 am</p> <p>Motion</p>	<p>Ending the Physician-Patient Relationship Policy – Draft for Consultation</p> <p>The College's <i>Ending the Physician-Patient Relationship</i> policy is currently under review. The Working Group has developed a revised version of the policy reflecting research, discussion, and public consultation on the current policy.</p> <p>Council is asked to approve the release of the draft policy for external consultation.</p>	<p>38</p>
<p>9:55 am</p> <p>Motion</p>	<p>Marijuana for Medical Purposes Policy Update</p> <p>The federal government has updated the regulations governing the medical use of marijuana. As a result, the current policy <i>Marijuana for Medical Purposes</i> no longer addresses all of the relevant issues arising from the legislation.</p> <p>Council is asked whether it supports revisions to the policy which reflect the new regulations.</p>	<p>53</p>
<p>10:15 am</p>	<p>Break</p>	
<p>PRESENTATION</p>		
<p>10:30 am</p>	<p>Cindy Morton, Chief Executive Officer, eHealth Ontario</p> <p>eHealth Update</p> <p>Cynthia Morton is the Chief Executive Officer of eHealth Ontario, responsible for implementing an electronic health record system for the province of Ontario.</p>	<p>64</p>
<p>COUNCIL AWARD PRESENTATION</p>		
<p>11:30 am</p>	<p>Council Award Winner: Dr. Mohit Bhandari of Hamilton, Ontario</p>	<p>65</p>
<p>12:00 noon</p>	<p>Lunch</p>	

FOR DECISION		
1:00 pm Motion	<p>Alternatives to Degrees in Medicine from Schools Listed in the World Directory of Medical Schools Published by the World Health Organization (WHO)</p> <p>The Registration Committee recommends formalizing the existing informal policy to accept alternatives to degrees in medicine from schools that are not listed in the WHO Directory. Council is being asked to approve the policy.</p>	67
1:15 pm Motion	<p>Restricted Certificate of Registration for Exam Eligible Candidates</p> <p>The Registration Committee recommends revising the College's existing <i>Restricted Certificate of Registration for Exam Eligible Candidates</i> Policy to provide increased clarity regarding exam eligibility and subsequent applications. Council is being asked to approve the revised policy.</p>	74
1:30 pm Motion	<p>Consultation Report on Proposed Changes to OHPIP Standards – Accountability of Medical Director, Staff Qualifications, Infection Control and Quality Assurance</p> <p>Council is provided with a report on the draft OHPIP Standards consultation and the proposed revisions made to the Standards in response to the feedback received. Council is asked to approve the revised draft OHPIP Standards.</p>	87
FOR DISCUSSION		
1:45 pm	<p>Opioid Update</p> <p>Council is provided with an overview of recent developments and the current status of on-going opioid work at the CPSO.</p>	110
REGISTRAR'S REPORT		
2:00 pm	Strategic Update - Dashboard	116

Friday, December 2, 2016

CALL TO ORDER		
9:00 am	President's Announcements	
FINANCE COMMITTEE REPORT on the 2017 BUDGET		
9:05 – 9:45 am 5 Motions	<p>The Report of the Finance Committee</p> <p>The Finance Committee recommends Council approve the 2017 Budget, as presented. This includes a fee increase of \$30 and an increase to Per Diems. The Committee is also recommending increases to Certificates of Incorporations, Certificates of Professional Conduct and application fees for both Independent Practice and Postgraduate Education and establishing an Expedited Review fee.</p> <p>Finance Committee Motions:</p> <p>Motion #1: Budget 2017 Motion #2: Fee Increase (by-law change) Motion #3: Per Diems Increase (by-law change) Motion #4: Cost Awards in Discipline Hearings Motion #5: Other by-law changes: Application Fee Increases; expedited review; and Certificate of Professional Conduct.</p>	122
GOVERNANCE COMMITTEE REPORT PART 1		
9:45 am Motion	<p>Discussion: 2016 Council Performance Assessment Results</p> <p>Decision: Motion: Review of Council's Nominations Guidelines</p>	140
10:00 am	Break	
MEMBER TOPICS		

ANNUAL COMMITTEE REPORTS		
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INFORMATION ITEMS		
1.	Policy Report	242
2.	Medical Assistance in Dying Update	262
3.	Government Relations Report	265
4.	Updated: Independent Health Facilities Clinical Practice Parameters and Facility Standards for Sleep Medicine	271
5.	2016 District Council Elections	275
6.	Registration Program Evaluation: Project update	280
7.	Discipline Committee – Report of Completed Cases, December 2016	314

11:30 am	Motion to Go In Camera	
IN CAMERA		
12:00	Lunch	
PRESIDENT'S TOPICS		
1:00 pm	Presidential Address: Dr. Joel Kirsh	
	Induction of New President: Dr. David Rouselle	
GOVERNANCE COMMITTEE REPORT PART II		
1:20 pm 2 Motions	Decision: Motion #1: 2016-17 Governance Committee Election Motion #2: 2016-17 Committee Membership Appointments	377
Closing Remarks		
ADJOURN		

COUNCIL MEETING MINUTES OF SEPTEMBER 8 and 9, 2016

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 1, 2016

It is moved by

....., and

seconded by

....., that :

The Council accepts as correct the minutes of the meeting of the Council held on September 8 and 9, 2016.

- OR -

The Council accepts the minutes of the meeting of the Council held on September 8 and 9, 2016, with the following corrections:

- 1.

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Accepting New Patients: Draft Policy for Consultation

December 1, 2016

It is moved by

and seconded by

that:

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

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Ending the Physician-Patient Relationship: Draft Policy for Consultation

December 1, 2016

It is moved by

and seconded by

that:

The College engage in the consultation process in respect of the draft policy “Ending the Physician-Patient Relationship” (a copy of which forms Appendix “ ” to the minutes of this meeting).

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Marijuana for Medical Purposes Policy Update

December , 2016

It is moved by,

and seconded by,

that:

The Council approves the revised policy “Marijuana for Medical Purposes”, (a copy of which forms Appendix “ ” to the minutes of this meeting) as a policy of the College.

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

**ALTERNATIVES TO DEGREES IN MEDICINE FROM
SCHOOLS LISTED IN THE WORLD DIRECTORY OF
MEDICAL SCHOOLS PUBLISHED BY THE WORLD HEALTH
ORGANIZATION**

December 1, 2016

**It is moved by,
and seconded by,
that:**

**The Council adopt the policy “Alternatives to Degrees in
Medicine from Schools Listed in the World Directory of Medical
Schools published by the World Health Organization”, (a copy
of which forms Appendix “ ” to the minutes of this meeting) as a
policy of the College.**

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

**RESTRICTED CERTIFICATES OF REGISTRATION FOR EXAM
ELIGIBLE CANDIDATES**

December 1, 2016

**It is moved by,
and seconded by,
that:**

**The Council approve the revised policy “Restricted Certificates
of Registration for Exam Eligible Candidates” (a copy of which
form Appendix “ ” to the minutes of this meeting) as a policy of
the College.**

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

**CONSULTATION REPORT ON PROPOSED CHANGES TO OHPIP
STANDARDS – ACCOUNTABILITY OF MEDICAL DIRECTOR,
STAFF QUALIFICATIONS, INFECTION CONTROL AND QUALITY
ASSURANCE**

December 1, 2016

**It is moved by,
and seconded by,
that:**

**The Council approve the revisions to Sections 2, 5, 7 and 8 of
the “Out-of-Hospital Premises Inspection Program (OHPIP)
Standards” as identified in and incorporated into Appendix A to
the briefing note, a copy of which forms Appendix “ ” to the
minutes of this meeting).**

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

APPROVAL OF NOMINATIONS GUIDELINES

December 1, 2016

It is moved by

and seconded by

that:

The Council approve the revised “Nominations Guidelines” (a copy of which forms Appendix “ ” to the minutes of this meeting).

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

IN-CAMERA MOTION

December 2, 2016

It is moved by,
and seconded by.....,

that:

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

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

BUDGET APPROVAL

December 2, 2016

It is moved by

and seconded by

that:

The Council approve the “Budget for 2017” (a copy of which forms Appendix “ ” to the minutes of this meeting) authorizing expenditures for the benefit of the College during the year 2017.

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

2017 ANNUAL FEE

December 2, 2016

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. 111, after circulation to stakeholders:

By-law No. 111

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

Annual Fees

4. Annual fees for the year beginning June 1, 2017, are as follows:

(a) \$1625 for holders of a certificate of registration other than a certificate of registration authorizing postgraduate education and other than a certificate of registration authorizing supervised practice of a short duration;

(c) For a holder of a certificate of authorization, \$175 per year.

Explanatory Note: - This by-law must be circulated to the profession and will return to the Council after the circulation.

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

COUNCIL AND COMMITTEE REMUNERATION FOR 2017

December 2, 2016

It is moved by

and seconded by

that:

The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 112:

By-law No. 112

Paragraphs 20(3)(a)(i),(ii), and (iii) of By-Law No. 2 (the Fees and Remuneration By-Law) are revoked and the following are substituted, effective January 1, 2017:

Council and Committee Remuneration

20.-(3) The amount payable to members of the council and a committee is, subject to subsection (4),

- (a) for attendance at, travel to, and preparation for, meetings to transact College business,**
 - (i) \$621 per half day for the president,**
 - (ii) \$510 per half day for the vice-president, and**
 - (iii) \$480 per half day for the other members, and**

<p>Explanatory Note: - This proposed by-law does not need to be circulated to the profession.</p>
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COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

COST AWARD FOR DISCIPLINE HEARINGS

December 2, 2016

It is moved by

and seconded by

that:

The Council of the College of Physicians and Surgeons of Ontario amends the Discipline Committee's Tariff Rate for Costs and Expenses for the College to Conduct a Day of Hearing, increasing the Tariff Rate to \$5,500, effective January 1, 2017.

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

APPLICATION FEES INCREASE FOR 2017

December 2, 2016

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. 113, after circulation to stakeholders:

By-law No. 113

1. Subsections 1(a), (d) and (f) of By-Law No. 2 (the Fees and Remuneration By-law) are revoked and the following are substituted:

APPLICATION FEES

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

- (a) For a certificate of registration authorizing postgraduate education, 25% of the annual fee specified in section 4(a);**
- (d) For any other certificate of registration, 60% of the annual fee specified in Section 4(a);**
- (f) For a certificate of authorization, \$400.00;**

2. Section 1 of By-Law No. 2 (the Fees and Remuneration By-law) is amended by deleting the “.” at the end of subsection 1(g), substituting it with a “;”, and adding the following as new subsection 1(h):

APPLICATION FEES

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

(h) If the person:

- (i) meets the registration requirements applicable to the class of certificate of registration applied for, as prescribed in the Registration Regulation, Ontario Regulation 865/93 under the *Medicine Act, 1991*; and
- (ii) requests the College to conduct the initial assessment of the application in three weeks after receipt by the College of the application,

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

3. Section 16 of By-Law No. 2 (the Fees and Remuneration By-law) is revoked and the following is substituted:

16. There is a \$75 fee for the College to issue a certificate of professional conduct for a member.

<p>Explanatory Note: - This by-law must be circulated to the profession and will return to the Council after the circulation.</p>
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COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

NOMINATIONS – GOVERNANCE COMMITTEE ELECTION

December 2, 2016

It is moved by

and seconded by

that:

**The Council appoints _____(as physician member),
_____(as public member) and _____
(as public member), to the Governance Committee for 2016-17.**

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

NOMINATIONS – COMMITTEE MEMBERSHIP APPOINTMENTS FOR 2016-17

December 2, 2016

**It is moved by,
and seconded by,**

that the Council appoints the following people to the following committees:

Council Award Selection Committee:

Discipline Committee:

Education Committee:

Finance Committee:

Fitness to Practise Committee:

Governance Committee:

Dr. Steven Bodley

Dr. Joel Kirsh

Dr. David Rouselle

_____ (physician member of Council)

_____ (public member of Council)

_____ (public member of Council)

Inquiries, Complaints and Reports Committee:

Methadone Committee:

Outreach Committee:

Patient Relations Committee:

Premises Inspection Committee:

Quality Assurance Committee:

Registration Committee:

**DRAFT PROCEEDINGS OF THE
MEETING OF COUNCIL
OF
THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
September 8, 2016**

Members:

Dr. Joel Kirsh (President)	Mr. Peter Pielsticker
Dr. El-Tantawy Attia (PhD)	Dr. Judith Plante
Mr. Sudershen Beri	Dr. Dennis Pitt
Dr. Steven Bodley	Dr. Peeter Poldre
Dr. Brenda Copps	Mr. Ron Pratt
Ms. Lynne Cram	Dr. John Rapin
Ms. Diane Doherty	Mr. Arthur Ronald
Mr. Harry Erlichman	Dr. Jerry Rosenblum
Dr. Marc Gabel	Dr. David Rouselle
Ms. Debbie Giampietri	Dr. Eric Stanton
Major Abdul Khalifa	Dr. Peter Tadros
Mr. John Langs	Mr. Emile Therien
Dr. Carol Leet	Dr. Andrew Turner
Dr. Haidar Mahmoud	Dr. James Watters

Non-voting Academic Representatives on Council: Dr. John Jeffrey, Dr. Akbar Panju and Dr. Robert (Bob) Smith

Regrets: Mr. Pierre Giroux, Dr. Barbara Lent, Dr. Richard (Rick) Mackenzie, Ms. Joan Powell, Ms. Peggy Taillon and Dr. Ronald Wexler

CALL TO ORDER

President's Announcements

Dr. Joel Kirsh called the meeting to order at 10:30 a.m., and welcomed members of Council and guests.

Council Meeting Minutes of May 30-31, 2016

01-C-09-2016

It is moved by Mr. Sudershen Beri and seconded by Dr. Marc Gabel that:

The Council accepts the minutes of the meeting of the Council held on May 30-31, 2016.

CARRIED

Executive Committee's Report to Council – April to June 2016

Received with no comments.

02-C-09-2016

It is moved by Dr. Marc Gabel and seconded by Dr. Attia El-Tantaway that:

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

CARRIED

IN CAMERA

Council entered into an in-camera session at 10:35 a.m. and returned to open session at 11:30 a.m.

COUNCIL AWARD WINNER

Dr. Judith Plante presented the Council Award to Dr. Martin White of Carleton Place, Ontario.

PRESENTATION

Quality Management Partnership: Quality Reports

Ms. Laurie Bourne and Mr. Eli Kane from Cancer Care Ontario provided an overview of the development and implementation of the Quality Management Partnership's facility quality reports (a copy of which forms Appendix "A" to the minutes of this meeting).

FOR DECISION

By-law Amendments – Public Register

03-C-09-2016

It is moved by Mr. Peter Pielsticker and seconded by Dr. Attia El-Tantawy that:

The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 110:

By-law No. 110

1. Paragraphs 1, 6, 7, 8, 12, 14, 16, 23, 24, 25 and 27 of subsection 49(1), of By-Law No. 1 (the General By-Law) are revoked and the following are substituted:

1. Any changes in the member's name since his or her undergraduate medical training that is used or to be used in his or her practice, and the date of such change, if known to the College.
6. A description of the member's postgraduate training in Ontario.
7. If the member is certified by the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada,
 - i. that fact,
 - ii. the date of the certification, and
 - iii. the discipline or sub-discipline in which the member is certified.
8. The classes of certificate of registration held by the member and the date on which each certificate was issued and, if applicable, the revocation, suspension or expiration date, or date of removal of a suspension.
12. The identity of each hospital in Ontario where the member has professional privileges, and where known to the College, all revocations, suspensions, restrictions, resignations, relinquishments 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*, in each case commencing from the date the relevant portion of this by-law went into effect.
14. If the result of a disciplinary proceeding in which a finding was made by the discipline committee in respect of the member is in the register,

the date on which the discipline committee made the finding, and

- ii. the date on which the discipline committee ordered any penalty.
16. 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. where 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 16 shall be removed.
23. 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, a summary of that decision, including the elements of the SCERP, and, where applicable, a notation that the decision has been appealed.
24. In respect of the elements of a SCERP referred to in paragraph 23 above, a notation that all of the elements have been completed, when so done.
25. Where a decision referred to in paragraph 23 above is overturned on appeal or review, the summary shall be removed from the register.
27. Where a member is currently registered or licensed to practice medicine in another jurisdiction, and such licence or registration has been made known to the College as of or after September 1, 2015, the fact of that licensure or registration.

2. Subsection 49(1) of By-Law No. 1 (the General By-Law is amended by adding the following subsections:

- 7.1 If the member is formally recognized as a specialist by the College,
- i. that fact,
 - ii. the date of recognition, and
 - iii. the discipline or sub-discipline in which the member is recognized.
29. If the 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 the committee or the member, as applicable, that imposed or amended the terms, conditions and limitations on the member's certificate of registration.
 - 30. Where a member's certificate of registration is revoked or suspended, the committee that ordered the suspension or revocation of the member's certificate of registration, if applicable.
 - 31. Where a member's certificate of registration is expired, the reason for the expiry.
 - 32. Where 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.
 - 33. 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.
 - 34. The language(s) in which the member is competent to conduct practice, as reported by the member to the College.
- 4. Subsection 49(2) of By-Law No. 1 (the General By-Law) is revoked.**
- 5. Subsection 50.1(1) of By-Law No. 1 (the General By-Law) is revoked and the following is substituted:**

Public Information

50.1 (1) All information contained in the register, other than:

- (a) a member's preferred address for communications from the College,
- (b) a member's e-mail address,
- (c) a member's date of birth,
- (d) a member's place of birth,
- (e) any information that, if made public, would violate a publication ban if known to the College, and
- (f) 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,

is designated as public except that,

- (g) if,

- (i) terms, conditions or limitations were directed to be imposed upon a member's certificate of registration by a committee other than the discipline committee, and
- (ii) the terms, conditions or limitations have been removed,

the content of the terms, conditions or limitations are no longer public information.

6. Subsection 50.2 of By-Law No. 1 (the General By-Law) is amended by adding the following as a heading preceding the subsection:

Liability Protection

5. Subsection 51(1) of By-Law No. 1 (the General By-Law) is revoked and the following is substituted:

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 address (both mailing and e-mail) for communications from the College;
- (b) the address and telephone number of the member's principal place of practice;
- (c) the identity of each hospital and health facility in Ontario where the member has professional privileges;
- (d) any currently existing conditions of release (not including any information subject to a publication ban) following a charge for a criminal or provincial offence, or subsequent to a finding of guilt and pending appeal, and any variations to those conditions; and
- (e) any changes in the member's name since his or her undergraduate medical training that is used or will be used in the member's practice.

CARRIED

College Oversight of Fertility Services – Regulation Change Proposal

04-C-09-2016

It is moved by Mr. Emile Therien and seconded by Dr. Haidar Mahmoud that:

The Council approve in principle and circulate to the membership and other interested parties and stakeholders for feedback the following proposed amendments to Ontario Regulation 114/94 ("O.Reg. 114/94") made under the *Medicine Act, 1991*:

1. That Subsection 44(1) of O.Reg. 114/94 be amended by adding 44(1)(b.1), 44(1)(e) and 44(3), as highlighted below:

44. (1) In this Part,

“inspector” means a person designated by the College to carry out an inspection under this Part on behalf of the College;

“premises” means any place where a member performs or may perform a procedure on a patient but does not include a health care facility governed by or funded under any of the following Acts:

1. The *Long-Term Care Homes Act, 2007*.
2. The *Developmental Services Act*.
3. The *Homes for Special Care Act*.
4. Revoked: O. Reg. 134/10, s. 1 (2).
5. Revoked: O. Reg. 192/14, s. 1.
6. The *Ministry of Community and Social Services Act*.
7. The *Ministry of Correctional Services Act*.
8. The *Ministry of Health and Long-Term Care Act*.
9. Revoked: O. Reg. 134/10, s. 1 (2).
10. The *Private Hospitals Act*.
11. The *Public Hospitals Act*;

“procedure” means,

- (a) any act that, when performed in accordance with the accepted standard of practice on a patient, is performed under the administration of,
 - (i) general anaesthesia,
 - (ii) parenteral sedation, or
 - (iii) regional anaesthesia, except for a digital nerve block, and

- (b) any act that, when performed in accordance with the accepted standard of practice on a patient, is performed with the administration of a local anaesthetic agent, including, but without being limited to,
 - (i) any tumescent procedure involving the administration of dilute, local anaesthetic,
 - (ii) surgical alteration or excision of any lesions or tissue performed for cosmetic purposes,
 - (iii) injection or insertion of any permanent filler, autologous tissue, synthetic device, materials or substances for cosmetic purposes,
 - (iv) a nerve block solely for the treatment or management of chronic pain, or
 - (v) any act that, in the opinion of the College, is similar in nature to those set out in subclauses (i) to (iii) and that is performed for a cosmetic purpose,

(b.1) any act that is performed in connection with,

(i) in vitro fertilization,

(ii) intra-uterine insemination, or

(iii) fertility preservation for medical purposes,

but does not include,

- (c) surgical alteration or excision of lesions or tissue for a clinical purpose, including for the purpose of examination, treatment or diagnosis of disease, or
- (d) minor dermatological procedures including without being limited to, the removal of skin tags, benign moles and cysts, nevi, seborrheic keratoses, fibroepithelial polyps, hemangioma and neurofibromata. O. Reg. 134/10, s. 1 (1, 2); O. Reg. 192/14, s. 1.
- (e) the sole act of counseling or referral for the procedures set out in subsection (b.1).

(2) Anything that may be done by the College under this Part may be done by the Council or by a committee established under clause 94 (1) (i) of the Health Professions Procedural Code. O. Reg. 134/10, s. 1 (1).

(3) For the purposes of procedures included in subsection 44(1)(b.1) the definition of "premises" shall include a health care facility governed by or funded under The *Public Hospitals Act*.

2. That Subsection 47(c) of O.Reg. 114/94 be amended by adding the words highlighted below:

47. It is the duty of every member whose premises are subject to an inspection to,
- (a) submit to an inspection of the premises where he or she performs or may perform a procedure on a patient in accordance with this Part;
 - (b) promptly answer a question or comply with a requirement of the inspector that is relevant to an inspection under this Part; and
 - (c) co-operate fully with the College and the inspector who is conducting an inspection of a premises, including collection and provision of information requested, in accordance with this Part. O. Reg. 134/10, s. 1 (1).
3. That Section 49 of O.Reg. 114/94 be amended by adding Subsection 49(6), as highlighted below:

49. (1) No member shall commence using premises for the purposes of performing procedures unless the member has previously given notice in writing to the College in accordance with subsection (5) of the member's intention to do so and the premises pass an inspection or pass an inspection with conditions. O. Reg. 134/10, s. 1 (1).

(2) The College shall ensure that an inspection of the premises of a member referred to in subsection (1) is performed within 180 days from the day the College receives the member's notice. O. Reg. 134/10, s. 1 (1).

(3) A member whose practice includes the performance of a procedure on a patient in any premises on the day this Part comes into force shall give a notice in writing to the College in accordance with subsection (5) within 60 days from the day this Part comes into force. O. Reg. 134/10, s. 1 (1).

(4) The College shall ensure that an inspection of the premises of a member referred to in subsection (3) is performed within 24 months from the day this Part comes into force. O. Reg. 134/10, s. 1 (1).

(5) The notice required in subsections (1) and (3) shall include the following information, submitted in the form and manner required by the College:

1. The full name of the member giving the notice and the full name of the owner or occupier of the premises, if he or she is not the member who is required to give notice under this section.
2. The full name of any other member who is practising or may practise in the premises with the member giving the notice.
3. The name of any health profession corporation that is practising at the premises.

4. The full name of any hospital where the member or other members at the premises have privileges or where arrangements have been made to handle emergency situations involving patients.
5. The full name of any other regulated health professional who is practising or may practise in the premises with a member at the premises, along with the name of the College where the regulated health professional is a member.
6. The full address of the premises.
7. The date when the member first performed a procedure on a patient in the premises or the proposed date when the member or another member intends to perform a procedure on a patient at the premises.
8. A description of all procedures that are or may be performed by a member or other members at the premises and of procedures that may be delegated by the member or other members at the premises.
9. A description of any equipment or materials to be used in the performance of the procedures.
10. The full name of the individual or corporation who is the owner or occupier of the premises, if different from the member giving the notice.
11. Any other information the College requires that is relevant to an inspection conducted at the premises in accordance with this Part. O. Reg. 134/10, s. 1 (1).

[49\(6\)](#) All timelines and notice requirements provided in this section apply to every premises where a member performs or may perform a procedure listed in subsection 44(1)(b.1) with reference to the day that section 44(1)(b.1) comes into force.

CARRIED

Proposed Regulation under the *Safeguarding our Communities Act (Patch for Patch Return Policy), 2015*

05-C-09-2016

It is moved by Dr. Eric Stanton and seconded by Ms. Debbie Giampietri that:

The Council approves the revised "Prescribing Drugs" policy, (a copy of which forms Appendix "B" to the minutes of this meeting).

CARRIED

06-C-09-2016

It is moved by Dr. Carol Leet and seconded by Dr. Jerry Rosenblum that:

The Council approves the College issuing a fact sheet regarding the provincial government's fentanyl return program and, if possible, to do so jointly with the College of Pharmacists (a copy of which forms Appendix "C" to the minutes of this meeting).

CARRIED

Governance Committee Report - Items for Decision

07-C-09-2016

It is moved by Dr. Marc Gabel and seconded by Dr. Steven Bodley that:

The Council consider the motion to appoint members of the Academic Advisory Committee to the Council.

CARRIED

I Election of the 2016/2017 Academic Advisory Committee Members to the Council

08-C-09-2016

It is moved by Mr. Sudershen Beri and seconded by Dr. Eric Stanton, that:

The Council appoints the following members of the Academic Advisory Committee to the Council, as of the close of the annual general meeting of Council in December 2016:

1. Dr. Barbara Lent
2. Dr. Joel Kirsh
3. Dr. James Watters

CARRIED

II 2017 Chair Appointments

09-C-09-2016

It is moved by Mr. John Langs and seconded by Ms. Diane Doherty that:

The Council appoints the following committee members as chairs, co-chairs or vice chairs of the following committees as of the close of the annual general meeting of Council in December 2016:

Council Award Selection Committee:

Dr. Joel Kirsh

Discipline Committee:

Dr. Peeter Poldre

Dr. Carole Clapperton

Education Committee:

Dr. Barbara Lent

Executive Committee:

Dr. David Rouselle

Finance Committee:

Mr. Pierre Giroux

Fitness to Practise Committee:

Dr. Dennis Pitt

Governance Committee:

Dr. Joel Kirsh

Inquiries, Complaints and Reports Committee:

Dr. Carol Leet, Chair, ICRC, Co-Vice Chair, Settlement Panels

Dr. Edith Linkenheil, Co-Vice Chair, Settlement Panels

Ms. Lynne Cram, Co-Vice Chair, General

Mr. Harry Erlichman, Co-Vice Chair, General

Dr. Dale Mercer, Vice Chair, Surgical

Dr. Lawrence Oppenheimer, Vice Chair, Obstetrical

Dr. Akbar Panju, Vice Chair, Internal Medicine

Dr. Brian Burke, Vice Chair, Mental Health and Incapacity

Dr. Steven Whittaker, Vice Chair, Family Practice

Methadone Committee:

Ms. Diane Doherty

Outreach Committee:

Ms. Lynne Cram

Patient Relations Committee:

Ms. Lisa McCool-Philbin

Premises Inspection Committee:
Dr. Dennis Pitt

Quality Assurance Committee:
Dr. Brenda Copps
Dr. Patrick Safieh

Registration Committee:
Dr. Barbara Lent

CARRIED

Information Items

- III Committee Appointments
- IV Public Member Reappointments
- V 2016 District 1, 2, 3 and 4 Election Update
- VI Completion of 2016 Council Performance Assessment (Form)

MEMBER TOPIC

Dr. Dennis Pitt encouraged Council members to consider applying to attend the FMRAC Conference, which he found valuable. Dr. Brenda Copps concurred, stating she would gladly go again. Next year's meeting is in Winnipeg.

ADJOURNMENT

The President adjourned the meeting at 2:45 p.m.

Dr. Joel Kirsh, President

Ms. Franca Mancini, Recording Secretary

**DRAFT PROCEEDINGS OF THE
MEETING OF COUNCIL
OF
THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
September 9, 2016**

Members:

Dr. Joel Kirsh (President)	Dr. Judith Plante
Dr. El-Tantawy Attia (PhD)	Dr. Dennis Pitt
Mr. Sudershen Beri	Dr. Peeter Poldre
Dr. Steven Bodley	Mr. Ron Pratt
Ms. Lynne Cram	Dr. John Rapin
Ms. Diane Doherty	Mr. Arthur Ronald
Mr. Harry Erlichman	Dr. Jerry Rosenblum
Dr. Marc Gabel	Dr. David Rouselle
Ms. Debbie Giampietri	Dr. Eric Stanton
Major Abdul Khalifa	Dr. Peter Tadros
Mr. John Langs	Mr. Emile Therien
Dr. Carol Leet	Dr. Andrew Turner
Dr. Haidar Mahmoud	Dr. James Watters
Mr. Peter Pielsticker	

Non-voting Academic Representatives on Council: Dr. John Jeffrey, Dr. Akbar Panju and Dr. Robert (Bob) Smith

Regrets: Dr. Brenda Copps, Mr. Pierre Giroux, Dr. Barbara Lent, Dr. Richard (Rick) Mackenzie, Ms. Joan Powell, Ms. Peggy Taillon and Dr. Ronald Wexler

CALL TO ORDER

President's Announcements

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

REGISTRAR'S REPORT

Strategic Priorities Report and Dashboard

Dr. Rocco Gerace provided an update on the Strategic Priorities Report and the Dashboard.

PRESENTATION – 'OUR CALL TO ACTION'

Guest Speakers: Ms. Ronnie Gavsie, President and CEO, Trillium Gift of Life and Dr. Andrew Healey, Chief Medical Officer for Donation at Trillium Gift of Life.

Ms. Gavsie and Dr. Healey provided an overview of the *Donation and Transplantation Process in Ontario* and how it works from a physician and patient perspective (a copy of which forms Appendix “D” to the minutes of this meeting).

PRESENTATION

Update on Education Strategic Initiative (ESI)

Dr. Bill McCauley, Medical Advisor, provided Council with an update on the goals, progress and status of the Education Strategic Initiative (a copy of which forms Appendix “E” to the minutes of this meeting).

PRESENTATION

Data and Information Management Strategic Initiative

Ms. Karey Iron, Director of Research and Evaluation, provided an update on the goals, progress and status of the Data and Information Strategic Initiative (a copy of which forms Appendix “F” to the minutes of this meeting).

INFORMATION ITEMS

2017 Council and Executive Committee Meeting Dates

Policy Report

Government Relations Report

Medical Assistance in Dying Update

ADJOURNMENT

The President thanked everyone for their time and adjourned the meeting at 1:45 p.m.

Dr. Joel Kirsh, President

Ms. Franca Mancini, Recording Secretary

EXECUTIVE COMMITTEE'S REPORT TO COUNCIL
April 2016 – June 2016
In Accordance with Section 12 HPPC
The College of Physicians and Surgeons of Ontario

April 26, 2016 EXECUTIVE COMMITTEE MEETING

1. Interventional Pain Management (IPM) Procedures: Working Group Recommendations

An Interventional Pain Management (IPM) Working Group was convened to provide advice to the College regarding concerns raised by physicians specific to IPM procedures being performed in out-of-hospital premises (OHPs), namely the paravertebral nerve block (PVNB).

The Working Group provided definitions for the current list of IPM procedures in College documents and made key recommendations to require assessors to focus assessments on optimal patient outcomes rather than technique.

The Executive Committee accepted the Interventional Pain Management (IPM) Working Group's recommendations, and directed that the proposed nerve block definitions be added to the College document *"Expectations of Physicians Who Have Changed or Plan to Change their Scope of Practice to Include IPM"*.

2. Governance Committee Report - Request to rescind ICR Committee Appointment– Dr. Eugenia Piliotis

The Executive Committee rescinds the ICR Committee appointment for Dr. Eugenia Piliotis.

June 21, 2016 EXECUTIVE COMMITTEE MEETING

1. Expert Advisory Group on Methadone Treatment and Service Report: CPSO Feedback

The Ministry of Health and Long-Term Care formed an Expert Advisory Group to review best practices on methadone treatment and service and make recommendations for opioid use disorder treatment. The CPSO Methadone Committee reviewed the recommendations of the Expert Advisory Group and provided feedback. The Executive Committee reviewed the Methadone Committee's feedback and considered next steps.

The Methadone Committee's response was that the advisory group was unable to do justice to a wide variety of complicated topics in a short period of time. None of the recommendations involving the CPSO were seen to have enough detail to determine if they will have significant organizational impact.

The Executive Committee directed staff to provide to the Expert Advisory Group on Methadone Treatment and Service Report, a letter supporting in principle only those recommendations aligned with existing College positions, such as the need for a better Narcotics Monitoring System and more physician education.

2. Pilot Project for Independent Legal Advice to Complainants/ Witnesses in Discipline Hearings relating to Sexual Misconduct

The Executive Committee supported a 12-month pilot project to provide independent legal advice to complainants/witnesses who are expected to testify in a College discipline hearing relating to sexual misconduct.

The College's goal is to help improve the process of testifying in sexual misconduct hearings for witnesses, and to demonstrate to other potential victims and the public that the College takes these matters seriously and wants to do what it can to make the experience less difficult for witnesses.

3. Supervised Injection Services Request for Support from the Medical Officer of Health

The Medical Officer of Health has asked for the CPSO's support of the introduction of supervised injection services in three clinics in Toronto.

The Executive Committee approves sending a general letter of support to the Medical Office of Health stating that supervised injection services are consistent with the College's public protection mandate, and with the goals of the methadone program, including harm reduction. The College's letter will not address the specific locations of the proposed supervised injection services.

4. Physician-Assisted Death/Medical Assistance in Dying: Update

Now that Bill C-14 has received royal assent, the draft *Medical Assistance in Dying* policy, approved by Council in May 2016, was updated to reflect the final language of the federal law. As contemplated by Council, the Executive Committee reviewed the updated version and approved the policy on its behalf.

The Executive Committee directed that the *Physician-Assisted Death* policy be rescinded.

The Executive Committee approved the *Medical Assistance in Dying* policy.

COUNCIL BRIEFING NOTE

TOPIC: **Accepting New Patients Policy - Draft for Consultation**

FOR DECISION

ISSUE:

- The College's [Accepting New Patients](#) policy is currently under review. The Working Group has developed a revised draft policy (Appendix 1). The draft policy is informed by research undertaken and feedback received during the preliminary consultation period, along with public polling results.
- Council is provided with an overview of the policy review and development process, along with highlights of the draft policy. Council is asked to direct whether the draft policy may be released for external consultation.

BACKGROUND:

- The *Accepting New Patients* policy was first approved by Council in November 2008 and last updated in 2009. The policy is currently under review in accordance with the CPSO's regular policy review cycle.
- The policy sets out physicians' professional and legal obligations when accepting new patients and emphasizes that physicians must accept new patients in a fair and professional manner. This is achieved, in part, by accepting new patients on a first-come, first-served basis.
- A joint Working Group has been struck to lead the review of the *Accepting New Patients* policy, along with the review of the *Ending the Physician-Patient Relationship* policy. This joint working group is chaired by Dr. Michael Franklyn, and comprised of Dr. Brenda Copps, Dr. Lynne Thurling, Mr. Arthur Ronald, and Mr. John Langs. The Working Group is supported by Dr. Angela Carol (Medical Advisor) and Jessica Amey (Legal Counsel).

a. Research

- The policy development process has been informed by an extensive research review, which included the following:
 - **Literature Review:** A comprehensive literature review of Canadian and international scholarly articles, government reports, research papers, and

newspaper publications was performed. The topics considered included, but were not limited to:

- Health human resource availability;
 - Disparities in access to care according to, for instance, socioeconomic status and geographic location (e.g. urban vs. rural); and
 - Patient perceptions of discrimination when seeking a new healthcare provider.
- **Jurisdictional Research:** A jurisdictional review was conducted on guidance provided by medical regulators and medical associations, both within Canada and internationally, with respect to accepting new patients. A summary of this research is included as Appendix 2.
 - **Internal Data Collection:** A review of inquiries received from physicians and the public through the College's Public and Physician Advisory Services was performed. Further, matters considered by the Investigations, Complaints and Resolutions (ICR) Committee, where the *Accepting New Patients* policy was relied upon, were examined.

b. Preliminary Public Consultation

Consultation Process

- An external preliminary consultation¹ on the current policy was held between June 10 and August 7, 2015.
- The College received a total of 105 responses to this consultation. These include 58 comments on the College's online discussion page (33 comments from physicians, 12 from the public, 10 anonymous respondents, and 3 from organizations²), and 47 online surveys³ (34 were submitted by physicians, 9 by members of the public, and 4 by other health care professionals).
- All stakeholder feedback has been posted publicly on the [consultation-specific page](#) of the College's website.

¹ Invitations to participate in the consultation were sent via email to a broad range of stakeholders, including the College's entire membership. In addition, a general notice was posted on the College's website, Facebook page, and announced via Twitter. It was also published in *Dialogue* and *Noteworthy* (the College's public e-newsletter). Stakeholders were given the option of submitting their feedback in writing, via email or regular mail, via a brief online survey, or by posting comments to an online discussion page.

² The organizational respondents were: Information and Privacy Commissioner of Ontario (IPC); Ontario Medical Association (OMA); and Professional Association of Residents of Ontario (PARO).

³ 50 respondents started the survey. Of these, 3 respondents did not complete any of the substantive questions. These respondents were removed from the analysis below, leaving 47 respondents who either fully or partially completed the survey.

Feedback Summary

- Stakeholders provided feedback covering a range of issues pertaining to accepting new patients. A summary of the substantive comments advanced in the feedback is set out below.⁴
 - i. Support for Current Policy*
 - The majority of survey respondents felt that the current policy is clear, easy to understand, and well organized.
 - Many respondents expressed support for the first-come, first-served approach outlined in the policy.
 - ii. Physicians to balance their own practices*
 - Some physician respondents indicated that physicians should have the ability to balance their own practices and should be able choose who they accept into their practice.
 - These respondents indicated that being able to choose who they accept into their practice would assist them in managing their patient load effectively and avoiding “burn out”.
 - iii. Patients wishing to change physicians*
 - Many respondents commented on the appropriateness of declining to accept a patient into a practice when the patient already has a physician.
 - Some physician respondents felt that it is appropriate to decline patients who already have a primary care provider. Other respondents (physicians and members of the public) indicated that patients may have legitimate reasons for wanting to change physicians. These reasons include, but are not limited to, the patient’s proximity to their current physician and/or dissatisfaction with the care being provided.
 - iv. Scope of Practice- a ‘Loophole’*
 - Both physicians and members of the public expressed the view that some physicians are using scope of practice as a reason to unfairly decline patients with complex healthcare needs.

⁴ This summary includes feedback received via the website’s discussion page and the consultation survey.

v. *Family Health Teams and Rostering*

- Some respondents indicated that “cherry-picking” is a particular problem in Family Health Teams where patients are rostered to the practice.
- Specifically, through the rostering system, respondents indicated that physicians are compensated for accepting any patient, regardless of their healthcare needs. This in turn results in a bias towards accepting generally healthy, uncomplicated patients into a practice.

c. Public Polling

- In order to supplement feedback received through the preliminary consultation, a poll of 822 Ontario residents⁵ was conducted between May 19th and May 26th, 2015.
- The primary purpose of this poll was to further our understanding of the experiences of Ontarians in accessing care generally, and in particular, when seeking a new physician. The polling questions addressed, for instance, the nature of the interaction between prospective patients and physicians prior to the establishment of the physician-patient relationship.
- Key highlights from the polling results are as follows:
 - Over a third of Ontarians report that they have experienced difficulty finding a family physician (36%), with several indicating that they have had “a great deal of trouble” finding one (13%).
 - Of the many possible reasons Ontarians might have difficulty finding a family physician, the most common ones respondents noted were a shortage of doctors in their area who were accepting new patients, and a lack of knowledge about which physicians were accepting new patients.
 - Just over a third of respondents indicated that when looking for a new physician, they were asked to attend an appointment with the physician before being accepted as a new patient. Further, 60% of those asked to attend an appointment with the physician before being accepted as a new patient felt as if they were being screened for suitability.
 - Only a small minority of Ontarians, less than one-in-ten, have ever been refused entrance into a physician’s practice. The most common reason offered for being refused entry is that the doctor’s practice is full.

⁵ The online panel was recruited randomly using an Interactive Voice Response system. Results can therefore be generalized to the online population of Ontario, which represents approximately 80% of the adult population. Findings are accurate to +3.5%, at the 95% level of confidence.

CURRENT STATUS:

- Based on research undertaken, feedback received through the preliminary consultation period, and the results of public polling, the Working Group has developed a draft *Accepting New Patients* policy (Appendix 1).
- Overall, the general expectations set out in the current policy have been maintained in the draft policy. These expectations include, but are not limited to, the following:
 - That physicians accept new patients in a manner that is fair, transparent, and respectful of the rights, autonomy, dignity and diversity of all prospective patients;
 - That physicians follow the first-come, first-served approach when accepting new patients; and
 - That clinical competence and/or scope of practice are not used as a means of discriminating against patients with, for instance, complex or chronic health needs.
- The key revisions and additions reflected in the draft policy are highlighted below:
 - i. Policy Principles [Lines 14-29]*
 - In the ‘Principles’ section of the policy, content has been added to emphasize physicians’ professional obligation to respect patient autonomy and a patient’s freedom of choice of healthcare provider.
 - ii. Policy Scope [Lines 31-37]*
 - The scope of the policy has been amended to clarify that the draft policy applies to all physicians, and those acting on their behalf, regardless of practice area or specialty.
 - iii. Use of Introductory Tools [Lines 67-70]*
 - Content has been added to explicitly address the use of introductory tools such as introductory meetings (e.g. ‘meet-and-greet’ appointments), and medical questionnaires.
 - The policy states that it is inappropriate for physicians to use introductory tools to ‘vet’ prospective patients and determine whether to accept those patients into their practice.

- However, these tools may be appropriately used after a patient is accepted into a physician's practice to, for instance, identify a new patient's needs and expectations, disclose to the patient information about the physician's knowledge area, advise of after-hours coverage, and to determine whether the physician's practice approach is acceptable to the patient.

iv. Application of First-Come, First-Served Approach [Lines 85-144]

- Content has been added to the policy to explain the application of the first-come, first-served approach where physicians:
 - Limit their practices due to clinical competence, scope of practice and/or a focused practice area;
 - Provide specialty care; and/or
 - Maintain a waiting list of prospective new patients.

v. Potential Exceptions to First-Come, First-Served Approach [Lines 146-169]

- The draft policy provides two circumstances where physicians are justified in deviating from the first-come, first-served approach when accepting new patients. The listed exceptions include when: (a) Caring for Higher Need and Complex Patients; and (b) Caring for Patients' Family Members.

a) Higher Need and Complex Patients [Lines 148-159]

- The draft provides additional guidance for physicians in assessing whether a patient may be categorized as high-need and/or complex. This includes taking into account the individual patient's healthcare needs, and any social factors, including education, housing, food security, employment and income, that may influence the patient's health outcomes.

b) Caring for Patients' Family Members [Lines 161-169]

- The Working Group felt it important to explicitly state in the policy that it may be acceptable for physicians to prioritize access to care for the family members of current patients. This is to acknowledge that caring for patients and their family members may assist in the provision of quality care.

NEXT STEPS

- In keeping with College policy processes, the next stage in the policy review process is to solicit feedback on the draft policy externally, through a consultation with the profession, the public and other interested stakeholders.

- Pending Council's direction, the draft policy will be released for external consultation following the December Council meeting. The feedback received would inform the development of a revised draft policy, which would then be presented to both Executive Committee and Council in the Spring of 2017.
-

DECISIONS FOR COUNCIL:

1. Does Council have any feedback on the draft *Accepting New Patients* policy?
 2. Does Council recommend that the draft policy be released for external consultation?
-

CONTACT: Dionne Woodward, Ext. 753
Tanya Terzis, Ext. 545

DATE: November 10, 2016

Attachments

Appendix "1": Draft *Accepting New Patients* policy
Appendix "2": Jurisdictional Review Chart

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Accepting New Patients

INTRODUCTION

Physicians must accept new patients in a manner that is fair, transparent, and respectful of the rights, autonomy, dignity and diversity of all prospective patients. Doing so reinforces public trust in the profession, and fosters confidence in the physician-patient relationship.

This policy sets out physicians' professional and legal obligations when accepting new patients. Physicians satisfy these obligations, in part, by accepting new patients on a first-come, first-served basis. Doing so helps to ensure compliance with the Ontario *Human Rights Code*, which entitles every Ontario resident to health services free from discrimination.

PRINCIPLES

The key values of professionalism articulated in the College's *Practice Guide* –compassion, service, altruism and trustworthiness – form the basis of the expectations set out in this policy. Physicians embody these values and uphold the reputation of the profession by, among other things:

1. Acting in the best interests of prospective patients by ensuring that decisions to accept new patients are equitable, transparent and non-discriminatory.
2. Communicating effectively and respectfully with prospective patients in a manner that fosters trust in the profession and supports the establishment of a trusting physician-patient relationship.
3. Respecting patient autonomy and a patient's freedom of choice of health-care provider.
4. Managing conflicts with compassion and sensitivity, especially where the physician's values differ from the values of the prospective patient.
5. Participating in self-regulation of the medical profession by complying with the expectations set out in this policy.

SCOPE

This policy applies to all physicians, and those acting on their behalf¹, regardless of practice area or speciality. Specifically, this policy applies both where physicians, by nature of their practice, would typically establish:

- A longitudinal physician-patient relationship characterized by repeated clinical encounters;² or
- A physician-patient relationship that exists for a defined time period.³

¹For instance, physicians may rely upon clinical managers and/or office staff to accept new patients on their behalf. Organizations may also act as a physician's representative in this context.

²For instance, the relationship typically established between a patient and their primary care provider.

³For instance, a relationship established between a patient and a physician providing speciality care for a specific condition over a finite time period.

40 POLICY

41 Physicians must employ the first-come, first-served approach when accepting new patients into
 42 their practices. This approach, which is set out below, helps to ensure that all patients receive
 43 equal treatment with respect to health services, as required under the Ontario *Human Rights*
 44 *Code*.

45
 46 This policy begins by describing the first-come, first-served approach, and explains its rationale.
 47 The policy details how this approach applies in circumstances where physicians:

- 48 • Limit their practices due to clinical competence , scope of practice and/or a
 49 focused practice area;⁴
- 50 • Provide speciality care; and/or
- 51 • Maintain a waiting list of prospective patients.

52
 53 The College acknowledges that there are circumstances where physicians are justified in
 54 prioritizing access to care for those most in need. These limited exceptions are set out below.

56 **First-Come, First-Served Approach**

57
 58 The College expects physicians, and those acting on their behalf, to follow the first-come, first-
 59 served approach when accepting new patients. This means that physicians must accept all new
 60 patients, on a first-come, first-served basis, when the patient's needs are within:

- 61 • The physician's clinical competence and/or scope of practice;
- 62 • The physician's focused practice area; and/or
- 63 • The terms and conditions of the physician's practice certificate and associated practice
 64 restrictions, if applicable.

65
 66
 67 It is counter to the first-come, first-served approach, and therefore inappropriate, for
 68 physicians to use introductory meetings such as 'meet-and-greet' appointments, or other tools
 69 such as medical questionnaires, to vet prospective patients and determine whether to accept
 70 those patients into the practice.^{5,6} Doing so may be considered discrimination against
 71 prospective patients.⁷

⁴ Physicians with a 'focused practice area' may include those with a commitment to one or more specific clinical practice areas, or who serve a defined target population.

⁵ Medical questionnaires include those administered in person, by phone, or electronically by physicians or those acting on their behalf.

⁶ Introductory tools may be used after a patient is accepted into a physician's practice to, for instance, identify a new patient's needs and expectations, disclose to the patient information about their knowledge area, advise of after-hours coverage, and to determine whether the terms of the physician-patient relationship are acceptable to the patient. Introductory meetings may involve establishing expectations regarding adherence to a prescribed therapy. This may include, for instance, establishing a treatment agreement (e.g. narcotics contract) between the physician and the patient.

⁷ The Human Rights Tribunal of Ontario has primary responsibility for investigating and adjudicating claims of discrimination.

72

73 **Rationale for the First-Come, First-Served Approach**

74

75 The first-come, first-served approach helps to ensure that physicians fulfill their legal
 76 obligations under the Ontario *Human Rights Code* (the 'Code'). The *Code* entitles every Ontario
 77 resident to equal treatment with respect to services, goods and facilities, without regard to
 78 race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation,
 79 gender identity, gender expression, age, marital status, family status or disability.

80

81 Under the *Code*, all those who provide services in Ontario, including physicians providing health
 82 services, must do so free from discrimination on any of the above-listed grounds. In keeping
 83 with this legal obligation, physicians must not refuse prospective patients based on any of the
 84 prohibited grounds of discrimination.⁸

85

86 **Applying the First-Come, First-Served Approach**

87

88 ***i. Clinical Competence, Scope of Practice and Focused Practices***

89

90 Physicians may limit the health services they provide based on their own clinical competence
 91 and/or scope of practice. Further, some physicians have limited or focused practices based on
 92 specific clinical areas such as geriatrics, psychotherapy or adolescent health.

93

94 If a patient's care needs do not align with the physician's clinical competence and/or scope of
 95 practice, this would be permissible grounds for refusing a prospective patient. Similarly, if a
 96 patient's care needs do not align with the physician's focused practice area, this would also be
 97 permissible grounds to refuse to accept a patient into the practice. Such decisions, however,
 98 must be made in good faith.

99

100 Physicians, and those acting on their behalf, must not use clinical competence and/or scope of
 101 practice as a means of discriminating against patients as defined by law, or to refuse patients:

102

- 103 ■ With complex or chronic health needs;
- 104 ■ With a history of prescribed opioids and/or psychotropic medication;⁹
- 105 ■ Requiring more time than another patient with fewer medical needs; or
- 106 ■ With an injury, medical condition, psychiatric condition or disability¹⁰ that may require
 107 the physician to prepare and provide additional documentation or reports.

108

109 Where a physician refuses a patient based on clinical competence scope of practice, and/or a
 110 focused practice area, the reasons for the refusal must be clearly communicated to the patient.

⁸ For more information see the College's *Professional Obligations and Human Rights* policy.

⁹ Physicians are advised to consult the College's *Prescribing Drugs* policy for further information on the College's position on blanket 'no narcotics' prescribing policies.

¹⁰ Physicians should be aware that under the *Code*, the term 'disability' is interpreted broadly and covers a range of conditions. 'Disability' encompasses physical, mental and learning disabilities, mental disorders, hearing or vision disabilities, epilepsy, drug and alcohol dependencies, environmental sensitivities, and other conditions. The *Code* protects individuals from discrimination because of past, present and perceived disabilities.¹⁰

111 This is to ensure that the individual understands that the refusal is not based on discriminatory
 112 bias or prejudice.
 113

114 Physicians in family practice are reminded that given their broad scope of practice, there are
 115 few occasions where scope of practice would be an appropriate ground to refuse a prospective
 116 patient.
 117

118 Where clinical competence and/or scope of practice limit the types of services a physician
 119 provides, patients seeking care must not be abandoned. In such circumstances, the College
 120 requires physicians to provide the patient with a referral to another appropriate health-care
 121 provider for those elements of care the physician is unable to manage directly.
 122

123 *ii. Specialist Care*

124
 125 The expectations set out in this policy apply to all physicians, including those who provide
 126 specialist care. The College recognizes that the process by which a patient is accepted into a
 127 specialist's practice is distinct from that applicable to primary care. This process will typically
 128 involve a referral from another physician or health-care provider.
 129

130 The College expects specialists to employ the first-come, first-served approach by accepting
 131 new patients in the order in which the referral was received. Departing from this practice is
 132 appropriate only to accommodate patients requiring priority access to care.
 133

134 Where a referral is outside of the specialist's clinical competence or scope of practice, the
 135 specialist must promptly communicate this information to the referring health care
 136 practitioner, and/or patient where appropriate, to facilitate timely access to care.
 137

138 *iii. Waiting Lists*

139
 140 Some physicians maintain a waiting list of prospective patients. Where this practice is
 141 employed, the first-come, first-served approach continues to apply in relation to all patients
 142 who have been noted on the list. Wait-listed patients are to be accepted into the physician's
 143 practice in the same order in which they were added to the list. Physicians are advised to use
 144 waitlists cautiously, and to manage patient expectations by clearly communicating the expected
 145 waiting period.
 146

147 **Potential Exceptions to First-Come, First-Served Approach**

148 **i. Accepting Higher-Need and Complex Patients**

149
 150
 151 There are circumstances where it may be appropriate for physicians to prioritize access to care
 152 for higher-need and/or complex patients.¹¹ Any decision to prioritize a patient's access to care
 153 must be made in good faith. Physicians must use their professional judgement to determine

¹¹ Patients who may be categorized as higher-need and/or complex include, but are not limited to, those with chronic conditions, particularly where the chronic condition is unmanaged, an activity-limiting disability and/or mental illness.

154 whether prioritization based on need is appropriate. In doing so, physicians must take into
155 account the individual patient’s health-care needs, and any social factors, including education,
156 housing, food security, employment, and income, that may influence the patient’s health
157 outcomes.
158

159 **ii. Caring for Patients’ Family Members**
160

161 In the context of primary care, there may be times where a physician is asked to accept the
162 family members of current patients. The College acknowledges that caring for patients and
163 their family members may assist in the provision of quality care. Caring for family members, for
164 instance, may help the physician to have a clearer picture of family history, which may in turn
165 contribute to better health outcomes for the patient. Accordingly, where a physician’s practice
166 is otherwise closed, it may be acceptable for the physician to prioritize access to care for the
167 family members of current patients.
168

DRAFT

The chart below highlights guidance provided by medical regulators and medical associations, both within Canada and internationally, with respect to accepting new patients. The guidance has been categorized, where possible, according to the following themes:

- (a) General Guidelines;
- (b) Permissible grounds for limiting patient entry into practice;
- (c) Inappropriate grounds for patient refusal; and
- (d) Meet and Greet/Introductory Appointments

A. MEDICAL REGULATORS - CANADA	
British Columbia	<p>DOCUMENT TYPE: Professional Standards & Guidelines • TITLE: Access to Medical Care • DATE: November 2012</p> <p>(a) General Guidelines</p> <ul style="list-style-type: none"> • All patients have the right to access appropriate medical care. • It is both professional and ethical, and in many situations required by law, that physicians exercise fairness in making decisions about access to medical care. • Decisions to accept (or refuse) new patients must be made in good faith. • While physicians are not obliged to see all patients, they are required to treat those in need of emergent or urgent medical care. <p>(b) Permissible grounds for limiting patient entry into practice</p> <ul style="list-style-type: none"> • Physicians may decline to accept new patients who are not in need of urgent medical care into their medical practice if they are at practice capacity, and legitimately need to manage their own work-life balance. • Family physicians may choose to limit their practice to an area of special interest. <p>(c) Inappropriate grounds for patient refusal</p> <ul style="list-style-type: none"> • A defined scope of practice must not be used as a means of unreasonably refusing patients with complex health needs. <p>(d) Meet and Greet / Introductory Appointments</p> <ul style="list-style-type: none"> • While an introductory meeting is deemed acceptable practice for physicians to get to know a new patient and learn of his/her health concerns and history, it may not be used as a means to select the “easy patients” and screen out those with more difficult health concerns, such as chronic disease.
Alberta	<p>DOCUMENT TYPE: Standards of Practice • TITLE: Establishing the Physician Patient Relationship • DATE: June 11, 2015</p> <p>(a) General Guidelines</p> <ul style="list-style-type: none"> • A regulated member must provide care to the best of his or her ability to a patient in an urgent medical situation where no other regulated member is providing care, regardless of whether a physician-patient relationship has been established. • Inform potential patients of any conditions or restrictions on the regulated member’s practice permit and/or patient selection criteria established by the regulated member. • Accept patients on a “first come, first served basis” within any such selection criteria.

<p>Alberta <i>contd....</i></p>	<p>(b) Permissible grounds for limiting patient entry into practice</p> <ul style="list-style-type: none"> • A regulated member may establish patient selection criteria if such criteria are based on matters relevant to the regulated member’s scope of medical practice, and available to the College on request. <p>(c) Inappropriate grounds for patient refusal</p> <ul style="list-style-type: none"> • A regulated member must not refuse to establish a physician-patient relationship based on: <ul style="list-style-type: none"> a) any prohibited ground of discrimination including, but not limited to age, gender, marital status, medical complexity, national or ethnic origin, physical or mental disability, political affiliation, race, religion, sexual orientation, or socioeconomic status; b) the patient choosing not to pay a block fee or purchase uninsured services; c) the patient’s care requiring more time than another patient with fewer medical needs; or d) the circumstances of the patient’s injury or medical condition that may require the regulated member to prepare and provide additional documentation or reports. <p>(d) Meet and Greet / Introductory Appointments</p> <ul style="list-style-type: none"> • A regulated member who offers introductory appointments must: <ul style="list-style-type: none"> a) advise patients in advance when an introductory appointment is not a medical appointment; b) not bill or charge for such an appointment; c) comply with all relevant privacy legislation and the Patient Records standard of practice with respect to retaining, disclosing and disposing of information collected during an introductory appointment; and d) when deciding not to establish a physician-patient relationship, disclose the reason(s) to the patient unless disclosure of the reasons could reasonably be expected to: <ul style="list-style-type: none"> i. result in immediate and grave harm to the patient’s mental or physical health or safety; ii. threaten the mental health, physical health or safety of another individual; or iii. pose a threat to public safety.
<p>Saskatchewan</p>	<p>DOCUMENT TYPE: Unknown • TITLE: Patient-Physician Relationships • DATE: March 30, 2012</p> <p>(a) General Guidelines</p> <ul style="list-style-type: none"> • In an emergency situation, the physician must provide emergency care if no other suitable physician is available unless there is real and imminent threat of harm or violence to the physician. • In providing medical services, do not discriminate against any patient on such grounds as age, gender, marital status, medical condition, national or ethnic origin, physical or mental disability, political affiliation, race, religion, sexual orientation, or socioeconomic status. This does not abrogate the physician’s right to refuse to accept a patient for legitimate reasons (CPSS Code of Ethics – Section 17). <p>(b) Permissible grounds for limiting patient entry into practice</p> <ul style="list-style-type: none"> • N/A <p>(c) Inappropriate grounds for patient refusal</p> <ul style="list-style-type: none"> • N/A <p>(d) Meet and Greet / Introductory Appointments</p> <ul style="list-style-type: none"> • The physician may use a meet-and-greet to identify the patients’ needs and expectations, disclose to the patient information about their area of knowledge, skills, limitations of practice and mode of after-hours operations, and determine whether the terms of the relationship (partnership) are mutually acceptable.

Manitoba	<p>DOCUMENT TYPE: Statement • TITLE: Discrimination in Access to Physicians • DATE: September 2008</p> <p>(a) General Guidelines</p> <ul style="list-style-type: none"> • Refusing to provide health care to an individual for reasons that are not directly related to the physician’s ability to provide quality health care services or for reasons which unreasonably favour the physician’s interests over the responsibility of the physician as a member of the profession may compromise the public trust and place an undue burden on colleagues. <p>(b) Permissible grounds for limiting patient entry into practice</p> <ul style="list-style-type: none"> • Physicians who are accepting new patients on anything other than a “first come, first served” basis must establish appropriate criteria for patient selection, based on matters relevant to the physician’s practice and the patient’s health care. • Examples of factors that may be relevant to the physician’s practice include but are not limited to: <ul style="list-style-type: none"> a) maintaining a sufficient mix of patients in a practice to maintain competence to provide care to defined categories of patients within a closed practice. b) accepting a new patient on the basis of a specific request based on special circumstances. <p>(c) Inappropriate grounds for patient refusal</p> <ul style="list-style-type: none"> • Physicians must not abuse the right to refuse to accept new patients by applying criteria for acceptance of a patient which discriminates on the basis that: <ul style="list-style-type: none"> a) accepting the patient may lead to the physician being required to complete forms (e.g. for MPI, WCB or an insurance company), or to participate as a witness in legal proceedings; or b) the patient’s care needs are too complex and providing care to the patient would therefore require extra time as compared to the time required by patients with less complex care needs. <p>(d) Meet and Greet / Introductory Appointments</p> <ul style="list-style-type: none"> • Physicians must: <ul style="list-style-type: none"> a) clearly communicate the selection criteria to anyone who inquires about becoming a new patient. b) clearly advise any prospective patient that the first meeting will be an interview appointment, not a medical appointment. c) recognize the vulnerability of patients who are searching for a new physician, and ensure that the process is not overwhelming for or demeaning to the patient. d) when a patient does not meet the criteria, advise the patient why the criteria were not met. e) An appointment for the purpose of determining whether to accept an individual as a patient must not be billed to Manitoba Health or to the patient. It is acceptable to bill for medical care provided during the appointment. • Information collected by physicians for the purposes of deciding whether to accept an individual as a patient must be collected, used, disclosed, retained and destroyed in accordance with the requirements of <i>The Personal Health Information Act</i> and the College requirements respecting medical records.
Quebec	N/A
Nova Scotia	<p>DOCUMENT TYPE: Policy • TITLE: Policy Regarding Accepting New Patients • DATE: October 14, 2011</p> <p>(a) General Guidelines</p> <ul style="list-style-type: none"> • Decisions to accept or refuse patients must be made in good faith. • Physicians who are accepting new patients into their practices should use a first-come, first-served approach. • Caring for patients’ family members is part of the ethos of family practice. Accordingly, physicians who are not otherwise accepting new patients are justified in accepting immediate members of existing patients’ families into their practices.

<p>Nova Scotia contd....</p>	<ul style="list-style-type: none"> • In providing medical service, do not discriminate against any patient on such grounds as age, gender, marital status, medical condition, national or ethnic origin, physical or mental disability, political affiliation, race, religion, sexual orientation, or socioeconomic status. This does not abrogate the physician's right to refuse to accept a patient for legitimate reasons. • Physicians must provide whatever appropriate assistance they can to any persons with an urgent need for medical care. <p>(b) Permissible grounds for limiting patient entry into practice</p> <ul style="list-style-type: none"> • While physicians should accept or refuse new patients on a first-come, first-service basis, clinical competence and scope of practice are permissible grounds for limiting patient entry into a practice. • Where the focus is legitimately based on clinical competence and a clearly defined scope of practice, this would be a generally acceptable reason for refusing to accept a potential patient. In such cases, it is expected that physicians will, to the best of their ability, provide a referral to another physician with the appropriate expertise. <p>(c) Inappropriate grounds for patient refusal</p> <ul style="list-style-type: none"> • Clinical competence and scope of practice must not be used as a means of unfairly refusing patients with complex health care needs or patients who are perceived to be otherwise "difficult". • While it is not acceptable to turn away patients who appear to be seeking controlled drugs for abuse or diversion, you are fully justified in refusing to prescribe controlled drugs to this group of patients. • Denial of care of individuals who request controlled drugs could constitute discrimination under the Nova Scotia <i>Human Rights Act</i>. • If treating addiction or co-morbidities is outside your scope of practice or clinical competence, you should refer these patients accordingly (to addiction services, for example), while caring for other aspects of their health, as appropriate. <p>(d) Meet and Greet / Introductory Appointments</p> <ul style="list-style-type: none"> • While initial appointments and health status questionnaires are acceptable practice for physicians to get to know new patients and to learn of their health concerns and history, these may not be used to select "easy patients" and/or screen out those with more difficult health concerns, such as chronic or terminal disease.
<p>New Brunswick</p>	<p>DOCUMENT TYPE: Guideline • TITLE: Screening of Potential Patients • DATE: November 2013</p> <p>(a) General Guidelines</p> <ul style="list-style-type: none"> • A physician's criteria for selection must not include any prohibited ground of discrimination, including age, gender, marital status, medical condition, national or ethnic origin, physical or mental disability, political affiliation, race, religion, sexual orientation, or socioeconomic status. • Physicians must provide care to a person in an urgent medical situation when no other physician is immediately available. <p>(b) Permissible grounds for restricting patient entry into practice</p> <ul style="list-style-type: none"> • A physician who is accepting patients on anything other than a "first come first served basis" must establish criteria for patient selection based on matters relevant to the physician's scope of medical practice. <p>(c) Inappropriate grounds for patient refusal</p> <ul style="list-style-type: none"> • A physician who treats injuries in the usual course of the physician's medical practice must not refuse to treat a person with injuries sustained under circumstances that may require the physician to prepare and provide additional documentation or reports. • A physician must not refuse to accept a patient into his or her medical practice because that person's care may require more time than other patients with fewer medical needs. • Physicians are reminded of the following form of misconduct:

<p>New Brunswick contd....</p>	<p><i>40. interfering, either directly or indirectly, with the patient's freedom of choice of a physician or a patient's right to consult another physician or other professional:</i></p> <ul style="list-style-type: none"> • As a consequence, it would be considered ethically unacceptable to require the permission of another physician to accept a patient. It would be similarly unacceptable for the original physician to refuse such a request. In addition, it is understood that certain physicians or clinics will contact the original physician for information prior to accepting the patient. This may also be ethically questionable until the patient has been accepted into the new practice. (<i>*Source: Selected Commentaries: Access to Physicians (Interference) , November 2013</i>) • The College has received reports that certain physicians are expressly refusing to accept into their practice patients in certain circumstances. This has generally taken the form of refusing to see patients over a certain age. Physicians are reminded that this is contrary to the Code of Ethics, as well as to Human Rights legislation. Such an approach creates the risk of a complaint on either basis. (<i>*Source: Selected Commentaries: Access to Physicians (Discrimination) , June 2004</i>) <p>(d) Meet and Greet / Introductory Appointments</p> <ul style="list-style-type: none"> • A physician must inform a potential patient of his or her medical practice limitations, restrictions, and selection criteria prior to accepting that person as a patient, preferably before the introductory visit. • A physician must advise a potential patient in advance when an introductory appointment is not a medical appointment. • When a person is not accepted as a patient in a physician's medical practice, the physician must advise the person of the reasons unless disclosure of the reasons could be expected to: <ul style="list-style-type: none"> (a) result in immediate and grave harm to that person's mental or physical health or safety, (b) threaten the mental health and physical health or safety of another individual, or (c) pose a threat to public safety. • Information collected for the purposes of screening prospective patients must be collected, disclosed and retained in accordance with relevant privacy legislation and the College's requirements.
<p>Newfoundland</p>	<p>DOCUMENT TYPE: Practice Advice • TITLE: Screening patients using questionnaires • DATE: February 4, 2008</p> <p>(a) General Guidelines</p> <ul style="list-style-type: none"> • N/A <p>(b) Permissible grounds for limiting patient entry into practice</p> <ul style="list-style-type: none"> • N/A <p>(c) Inappropriate grounds for patient refusal</p> <ul style="list-style-type: none"> • N/A <p>(d) Meet and Greet / Introductory Appointments</p> <ul style="list-style-type: none"> • The College would caution physicians against requiring or asking prospective patients to fill out medical questionnaires until they have been accepted as patients. • The College also advises that the College would seek the physician's response to any allegation from a patient that a physician allegedly used information obtained from a medical questionnaire as a cause to decline accepting a patient into the physician's practice, and that such an allegation may become the subject of an investigation by the Complaints Authorization Committee.

B. MEDICAL ASSOCIATIONS : NORTH AMERICA

Canadian Medical Association	<p>DOCUMENT TYPE: Code of Ethics • TITLE: Code of Ethics - ss. 17 & 18 • DATE: 2004</p> <p>(a) General Guidelines</p> <ul style="list-style-type: none"> • 17. In providing medical service, do not discriminate against any patient on such grounds as age, gender, marital status, medical condition, national or ethnic origin, physical or mental disability, political affiliation, race, religion, sexual orientation, or socioeconomic status. This does not abrogate the physician's right to refuse to accept a patient for legitimate reasons. • 18. Provide whatever appropriate assistance you can to any person with an urgent need for medical care. <p>(b) Permissible grounds for limiting patient entry into practice</p> <ul style="list-style-type: none"> • N/A <p>(c) Inappropriate grounds for patient refusal</p> <ul style="list-style-type: none"> • N/A <p>(d) Meet and Greet / Introductory Appointments</p> <ul style="list-style-type: none"> • Some new physicians have abused the label and their 'meet and greet' has actually been a 'meet and screen' visit—which is absolutely unacceptable. Do not ask prospective patients to complete medical questionnaires before they meet you. If you chose to not accept that patient, he or she could allege that you turned them down due to their medical problems, a practice that is unethical and unprofessional. If you want to use a questionnaire, provide patients with the form after you have accepted them into your practice. (**Source: Practice Management Module, Starting Your Practice on the Rights Foot, October 2012)
American Medical Association	<p>DOCUMENT TYPE: Opinion • TITLE: Potential Patients • DATE: June 2008</p> <p>(a) General Guidelines</p> <ul style="list-style-type: none"> • Physicians cannot refuse to care for patients based on race, gender, sexual orientation, or any other criteria that would constitute invidious discrimination, nor can they discriminate against patients with infectious diseases. • When deciding whether to take on a new patient, physicians should consider the individual's need for medical service along with the needs of their current patients. Greater medical necessity of a service engenders a stronger obligation to treat. <p>(b) Permissible grounds for limiting patient entry into practice</p> <ul style="list-style-type: none"> • N/A <p>(c) Inappropriate grounds for patient refusal</p> <ul style="list-style-type: none"> • N/A <p>(d) Permissible grounds for restricting patient entry into practice</p> <ul style="list-style-type: none"> • It may be ethically permissible for physicians to decline a potential patient when: <ul style="list-style-type: none"> a) The treatment request is beyond the physician's current competence. b) The treatment request is known to be scientifically invalid, has nonmedical indication, and offers no possible benefit to the patient. c) A specific treatment sought by an individual is incompatible with the physician's personal, religious, or moral beliefs.

C. GENERAL MEDICAL COUNCILS : UNITED KINGDOM & AUSTRALIA

<p>General Medical Council – U.K.</p>	<p>DOCUMENT TYPE: Guidance • TITLE: Good Medical Practice • DATE: April 2013</p> <p>(a) General Guidelines</p> <ul style="list-style-type: none"> • 56. You must give priority to patients on the basis of their clinical need if these decisions are within your power. • 59. You must not unfairly discriminate against patients or colleagues by allowing your personal views* to affect your professional relationships or the treatment you provide or arrange. <p>(b) Permissible grounds for limiting patient entry into practice</p> <ul style="list-style-type: none"> • N/A <p>(c) Inappropriate grounds for patient refusal</p> <ul style="list-style-type: none"> • 57....You must not refuse or delay treatment because you believe that a patient’s actions or lifestyle have contributed to their condition. • 58. You must not deny treatment to patients because their medical condition may put you at risk. If a patient poses a risk to your health or safety, you should take all available steps to minimize the risk before providing treatment or making other suitable alternative arrangements for providing treatment. <p>(d) Permissible grounds for restricting patient entry into practice</p> <ul style="list-style-type: none"> • N/A
<p>Australia Medical Council</p>	<p>DOCUMENT TYPE: Code of Conduct • TITLE: Good Medical Practice: Decisions About Access to Medical Care • DATE: N/A</p> <p>(a) General Guidelines</p> <ul style="list-style-type: none"> • Your decisions about patients’ access to medical care need to be free from bias and discrimination. Good medical practice involves: <ul style="list-style-type: none"> ○ 2.4.1 Treating your patients with respect at all times. ○ 2.4.2 Not prejudicing your patient’s care because you believe that a patient’s behaviour has contributed to their condition. ○ 2.4.3 Upholding your duty to your patient and not discriminating on medically irrelevant grounds, including race, religion, sex, disability or other grounds, as described in antidiscrimination legislation. <p>(b) Permissible grounds for limiting patient entry into practice</p> <ul style="list-style-type: none"> • N/A <p>(c) Inappropriate grounds for patient refusal</p> <ul style="list-style-type: none"> • N/A <p>(d) Meet and Greet / Introductory Appointments</p> <ul style="list-style-type: none"> • N/A

37

COUNCIL BRIEFING NOTE

TOPIC: Ending the Physician-Patient Relationship Policy - Draft for Consultation

FOR DECISION

ISSUE:

- The College's Ending the Physician-Patient Relationship policy is currently under review.
- A Working Group has been struck to undertake this review, and has developed a revised version of the policy which reflects extensive research, discussion, and public consultation on the current policy.
- Council is provided with an overview of the policy review process undertaken to-date, as well as a copy of the draft policy. Council is asked whether it approves that the draft policy be released for external consultation.

BACKGROUND:

- The College's [Ending the Physician-Patient Relationship](#) policy is currently under review in accordance with the College's regular policy review cycle.
- The policy, which was originally approved by Council in 2000, and last updated in 2008, sets out key principles and expectations for physicians when ending the physician-patient relationship for any reason other than the physician's retirement, relocation, leave of absence, or as a result of disciplinary action by the College.
- A policy Working Group has been struck to undertake this review. The members of the Working Group are Dr. Michael Franklyn (Chair), Dr. Brenda Copps, Dr. Lynn Thurling, Mr. Arthur Ronald, and Mr. John Langs. Staff support is being provided by Dr. Angela Carol (Medical Advisor) and Jessica Amey (Legal Counsel).
- This Working Group is simultaneously undertaking a review of the College's Accepting New Patients policy, as both policies address inter-related issues of professionalism, patient access, and balancing the best interests of physicians and patients.
- The draft policy produced by the Working Group and presented for Council's consideration has been informed by extensive research, external consultation, and discussions with College staff.

Research

- The development of the draft policy has been informed by extensive research which included the following:
 1. A comprehensive literature review of Canadian and international scholarly articles, research papers, and newspaper publications. The topics explored include, among others:
 - Health human resource availability and access to care;
 - Marginalized and vulnerable populations' access to care;
 - The impact of ending the physician-patient relationship on patients;
 - Appropriate and inappropriate reasons to end a treating relationship; and
 - Actions to take when ending the physician-patient relationship.
 2. An extensive jurisdictional review was also undertaken to evaluate the policy positions of Canadian medical regulators and select international regulatory bodies.

External consultation

- An external preliminary consultation¹ was held on the current policy between June 10 and August 7, 2015.
- During the consultation period, the College received a total of 60 responses. This included 27 written comments and 33 online surveys.
- Approximately 75% of respondents to the consultation identified themselves as physicians, 11% as members of the public, 4% as organizations², and 10% as other.
- All stakeholder feedback has been posted publicly on the [consultation-specific page](#) of the College's website, and a comprehensive report of survey results is available on the [consultation page](#).
- Broadly speaking, stakeholder feedback covered a range of issues pertaining to ending a physician-patient relationship. A summary of the major substantive comments advanced in the feedback is set out below:

¹ Invitations to participate in the consultation were sent via email to a broad range of stakeholders, including the College's entire membership. In addition, a general notice was posted on the College's website, Facebook page, and announced via Twitter. It was also published in Dialogue and Patient Compass (the College's public e-newsletter). Stakeholders were given the option of submitting their feedback in writing, via email or regular mail, via a brief online survey, or by posting comments to an online discussion page.

² The organizational respondents included the Ontario Medical Association (OMA), the OMA Section on Addiction Medicine, the Office of the Information and Privacy Commissioner of Ontario (IPC), and the Professional Association of Residents of Ontario (PARO).

- **General support for the policy:** Many respondents expressed general support for the current version of the policy, including the majority of survey respondents³.
 - **Acting in the patient's best interests:** A few respondents expressed the view that it is not in the patient's best interest to continue receiving care from a physician when the mutual trust and respect between the physician and the patient has broken down. This underscores the importance of allowing physicians to make the decision to end the physician-patient relationship in circumstances where the relationship has deteriorated.
 - **Physicians' interests must also be respected:** A few physician respondents expressed the view that the current policy does not adequately support what they feel is their right to end the physician-patient relationship. The OMA Section on Addiction Medicine suggested that the policy should explicitly state that both physicians and their patients are entitled to be treated with respect and without discrimination during all stages of the physician-patient relationship.
 - **Impacts on physician-wellness:** Some physicians expressed the belief that physicians' fear of patient complaints discouraged them from discontinuing the care of disruptive patients, and that continuing to provide care to these patients contributed to increased physician-stress and other negative health impacts.
 - **Reducing the size of a practice:** A few physician respondents requested clarification on appropriate ways to reduce the size of one's practice when it has become too large to manage.
 - **Rostered practices:** A number of respondents raised questions around the appropriateness of ending the physician-patient relationship when the patient has sought care outside of a rostered practice.
- In addition to the public consultation, a public opinion poll was undertaken between May 19th and May 26th, 2015. The poll, which solicited feedback from a representative sample of 822 Ontario residents, was intended to gain a sense of the circumstances in which the general public felt physicians were justified in ending the physician-patient relationship.
 - Highlights from the polling results include:
 - 15% of respondents reported having had their relationship with a physician discontinued for a variety of reasons (8% due to a conflict or disagreement).

³ A majority of survey respondents viewed the current policy as clear, comprehensive, and were generally supportive of it.

- The majority of those polled indicated that they agreed⁴ that it was appropriate for physicians to end the physician-patient relationship as a result of a threat of harm (93%), patient fraud (91%), other inappropriate behaviour (88%), or a breakdown in mutual trust and respect (81%).
- The public was more divided regarding ending a physician-patient relationship in order to reduce a practice size (55%).

CURRENT STATUS:

- Building upon the research and feedback gathered to-date, the Working Group has developed a revised draft of the Ending the Physician-Patient Relationship policy (**Appendix A**).
- Overall, the draft policy retains the key content and central principles of the current policy, while changes have been made to enhance clarity and flow, to address issues not currently addressed by the policy, and to ensure alignment and consistency with other College policies.
- Importantly, the draft policy now clarifies that it is when circumstances arise that create a conflict between a physician's obligation to provide care to a patient, and their competing duties and obligations owed to other patients, staff, colleagues, and themselves, that the physician may consider ending the physician-patient relationship.
- The key revisions and additions reflected in the draft policy are set out below:

Key revisions and additions

1. General updates to the introduction:

- The introduction has been reframed, and now focuses the policy on circumstances where the physician's ethical and professional obligation to provide care to a patient is in conflict with other important duties or obligations.
- The introduction to the policy has been expanded to address a physician's duty to ensure their own health and well-being, as well as the responsibility they owe to staff, colleagues, and other patients to foster a safe and respectful working environment.

2. New principles have been added:

- A principle has been added to emphasize the importance of respecting patient autonomy with respect to lifestyle, healthcare goals, and treatment

⁴ These include respondents who indicated that they "strongly agree" and "somewhat agree".

decisions, and to help clarify that disagreements related directly to patient autonomy are not appropriate grounds for ending the physician-patient relationship.

- A principle has been added pertaining to appropriately balancing the duties that a physician owes to patients, staff, colleagues, and themselves.
- A principle has been added pertaining to participating in the self-regulation of the medical profession by complying with the expectations set out in this policy.

3. The scope of the policy has been further defined:

- Although not explicitly stated, the College’s position has historically been that the expectations contained in the policy applied equally to specialist physicians and primary care physicians.
- The draft policy has been updated to explicitly clarify that the expectations contained in the policy apply to all physicians, regardless of specialty (Lines 25 – 31).

4. Ending the physician-patient relationship due to a “breakdown in mutual trust and respect”:

- Some stakeholders have expressed the view that it was difficult to define when a relationship had broken down to a degree that justified ending the relationship, and that this rationale was used as a justification for discontinuing the care of patients inappropriately.
- The draft policy now provides more explicit guidance to help physicians determine whether a relationship has broken down to the point that discontinuing the relationship is appropriate, and provides more explicit guidance around the steps a physician must take prior to ending the relationship (for example, taking steps to resolve the issue where possible) (Lines 56 – 67 & 73 - 87).

5. Missed appointments and failure to pay fees:

- The Public and Physician Advisory Service (PPAS) frequently receives inquiries from both physicians and patients as to whether a relationship can be discontinued because a patient repeatedly misses appointments and/or fails to pay outstanding fees for uninsured services (e.g. as the result of missed appointments).
- The draft policy now clarifies that it is inappropriate to end a physician-patient relationship solely because the patient has failed to pay an outstanding fee (Lines 129 – 133), and cites frequently missed appointments as an example of a situation that *may* contribute to a breakdown in the physician-patient relationship (Line81).

6. Where patients have sought care outside of a rostered practice:

- The College is aware of physicians who have threatened or who have proceeded to discontinue their relationship with patients because the patient sought care outside of a rostered practice (in some cases, physicians incur a financial penalty as a result).
- The draft policy now clarifies that it is inappropriate to end a physician-patient relationship *solely* because the patient has sought care outside of a rostered practice (Lines 135 – 143); however, a footnote further clarifies that in some limited cases, where seeking care outside of the rostered practice gives rise to significant conflicts or broader conduct issues, termination may be appropriate (footnote # 10).

7. Ending the physician-patient relationship when a patient has been absent from a practice for a long period of time:

- The College is aware of cases where physicians have discontinued the care of patients who have been absent from the practice for an extended period of time without notification.
- The draft policy now permits physicians to end the relationship with a patient who has been absent for an extended period of time, provided that a letter is first sent to the patient to inquire about their status as a patient (Lines 101 – 109).

8. Reducing the size of a practice:

- The College sometimes receives inquiries from physicians who wish to reduce the size of their practice. In these cases, physicians are often unsure how to select the patients whose care will be discontinued.
- This section of the draft policy has been enhanced in the following ways:
 - A statement has been added to remind physicians of their obligation to not selectively or disproportionately discharge difficult or complex patients (Line 100); and
 - A statement has been added noting that each physician's practice and patient population is unique, and that physicians must exercise their own professional judgment, consistent with the policy, in selecting which patients to remove from their practice (Lines 94 – 95).

9. Communicating the decision to end the physician-patient relationship:

- ***Notification in person:*** The draft policy now emphasizes that when ending the physician-patient relationship, physicians are expected to communicate the decision in person, whenever possible (Lines 148 – 150).

- **Notification in writing:** The OMA Section on Addiction Medicine expressed the view that the requirement for physicians to send notification by registered mail contained in the current policy was unnecessarily narrow and onerous, and that other forms of communication should be sufficient.
- The draft policy has been revised to permit alternative methods for communicating the decision in writing (Lines 151 – 155).

10. Patient access to medical records:

- In their response to the preliminary consultation, the Office of the Information and Privacy Commissioner suggested that the policy be updated to include direction for physicians to proactively inform patients of their right to access / transfer medical records.
- The draft policy now includes additional expectations around proactively communicating a patient's right to access / transfer their medical records when the relationship has been discontinued (Lines 184 – 185).

11. Actions physicians must take prior to ending the physician-patient relationship:

- The draft policy has been updated to include a section that sets out actions physicians must take prior to ending the physician-patient relationship.
- This section sets out a number of best practices for physicians that are meant to facilitate communication between the physician and the patient and attempt to remedy potential conflicts before they occur (Lines 56 – 67).

NEXT STEPS

- In keeping with College policy processes, the next stage in the review process is to solicit feedback on the draft policy externally, through a consultation with the profession, the public, and other interested stakeholders.
- Should Council approve the draft, it will be released for external consultation between December, 2016, and February, 2017.

DECISIONS FOR COUNCIL:

1. Does Council have any feedback on the draft Ending the Physician-Patient Relationship policy?
 2. Does Council recommend that the draft policy be released for external consultation?
-

CONTACT: Cameron Thompson, Ext. 246
Tanya Terzis, Ext. 545

DATE: November 10, 2016

Attachments

Appendix "A": Draft *Ending the Physician-Patient Relationship* policy

Ending the Physician-Patient Relationship

1 Introduction

2 While physicians are expected to act first and foremost in the best interests of their patients, there may
3 be times when physicians' ethical and professional obligation to provide care to a patient is in conflict
4 with other important duties or obligations, such as the duty to ensure their own health and well-being,
5 or the responsibility they owe to staff to foster a safe working environment.

6 When circumstances arise which create a significant and irremediable conflict between a physician's
7 obligation to provide care to a patient, and the physician's additional obligations to their staff, other
8 patients, colleagues, or their own health, the physician may consider ending the physician-patient
9 relationship.

10 While both physicians and patients may choose to end the physician-patient relationship, physicians are
11 expected to do so in a manner that is in-keeping with the fiduciary nature of the physician's role, and
12 which recognizes the vulnerability of patients when faced with the discontinuation of care.

13 Principles

14 The key values of professionalism – compassion, service, altruism and trustworthiness – form the basis
15 for the expectations set out in this policy. Physicians embody these values and uphold the reputation of
16 the profession by:

- 17 1. Acting in the best interests of their patients;
- 18 2. Respecting patient autonomy with respect to lifestyle, healthcare goals, and treatment decisions;
- 19 3. Treating patients with respect and without discrimination during all stages of the physician-patient
20 relationship, even if the relationship faces discontinuation;
- 21 4. Appropriately balancing the duties that are owed to patients, staff, colleagues, and themselves;
- 22 5. Participating in the self-regulation of the medical profession by complying with the expectations set
23 out in this policy.

24 Purpose & Scope

25 This policy articulates the College's expectations of physicians when ending the physician-patient
26 relationship.

27 These expectations apply equally to specialist physicians whenever a specialist chooses to discontinue
28 the care of a patient prior to reaching the normal or expected conclusion of the patient's treatment or
29 assessment. When, in the normal course of providing care, a specialist's involvement with a patient
30 reaches its natural or expected conclusion (for example, because the treatment or assessment have
31 concluded), the specialist physician is not required to formally end the physician-patient relationship.

32 This policy does not apply in situations where a physician ends the physician-patient relationship due to
 33 the physician's retirement, relocation, leave of absence, or as a result of disciplinary action by the
 34 College of Physicians and Surgeons of Ontario.¹

35 Policy

36 Physicians must comply with the expectations set out in this policy when ending the physician-patient
 37 relationship.

38 This policy is organized as follows:

- 39 • The first section of this policy contains general expectations for physicians who are considering
 40 ending the physician-patient relationship;
- 41 • The second section sets out specific examples of situations which may cause a physician to
 42 consider ending the physician-patient relationship, and clarifies when this may be appropriate
 43 or inappropriate; and
- 44 • The third section sets out the actions physicians must undertake whenever ending the
 45 physician-patient relationship.

46 **1. Expectations for physicians who are considering ending the physician-** 47 **patient relationship**

48 When considering whether to end a physician-patient relationship, physicians must apply good clinical
 49 judgment and compassion in each case to determine the most appropriate course of action. In every
 50 case, physicians must bear in mind that ending the physician-patient relationship may have significant
 51 consequences for the patient, for example, by limiting their access to care, or by reducing their level of
 52 trust in the medical profession.

53 For this reason, physicians must undertake reasonable efforts to resolve the situation in the best
 54 interest of the patient, and only consider ending the physician-patient relationship where those efforts
 55 have been unsuccessful.²

56 **Actions physicians must take prior to ending the physician-patient relationship**

57 Physicians who are considering ending the physician-patient relationship for reasons other than
 58 decreasing their practice size are expected to first undertake reasonable efforts to resolve the issues
 59 affecting their ability to provide care. These efforts must include:

¹ Expectations for physicians in instances of retirement, relocation, leave of absence, or disciplinary action are included in the CPSO policy [Practice Management Considerations for Physicians Who Cease to Practice, Take an Extended Leave of Absence or Close their Practice Due to Relocation](#).² In some cases, it may not be possible or safe to attempt to resolve a conflict with a patient. For example, where a patient has threatened to harm a physician, their staff, or other patients, physicians are not expected to undertake efforts to resolve the conflict directly with the patient.

² In some cases, it may not be possible or safe to attempt to resolve a conflict with a patient. For example, where a patient has threatened to harm a physician, their staff, or other patients, physicians are not expected to undertake efforts to resolve the conflict directly with the patient.

- 60 • Proactively communicating expectations for patient conduct to all patients;³
 61 • Considering whether a particular incident or behaviour is an isolated example, or part of a larger
 62 pattern; and
 63 • Having a discussion with the patient regarding the reasons affecting the physician's ability to
 64 continue providing care.

65 Notwithstanding the above, when a physician believes that the patient poses a genuine risk of harm to
 66 themselves, their staff, colleagues, or other patients, the physician has no obligation to interact with
 67 that patient prior to discontinuing the relationship.

68 **2. Situations which may lead a physician to end the physician-patient** 69 **relationship**

70 While the following situations may be appropriate grounds for ending the physician-patient relationship,
 71 each case is ultimately fact-specific. Physicians must always use their own professional judgment, in
 72 keeping with this policy, to determine whether discontinuing the relationship is appropriate.

73 **(i) Where there has been a significant breakdown in the physician-patient relationship**

74 An effective physician-patient relationship is essential for the provision of quality medical care. This
 75 relationship is built upon mutual trust, confidence, and respect between the physician and the patient.
 76 Where these qualities are absent or have been undermined, the provision of quality care may be
 77 compromised.

78 Examples of situations that may lead to a significant breakdown in the physician-patient relationship
 79 include, among others:

- 80 • Prescription-related fraud;
 81 • Where the patient frequently misses appointments without appropriate cause or notice;
 82 • As a result of behaviour which significantly disrupts the practice;
 83 • Other forms of inappropriate behaviour, including abusive or threatening language; and
 84 • Where there is a risk of harm to the physician, staff, colleagues, and/or other patients.

85 In all cases where there has been a significant breakdown in the physician-patient relationship,
 86 physicians must only end the physician-patient relationship where the breakdown cannot reasonably be
 87 resolved, or in response to a genuine risk of harm.

88 **(ii) Where the physician wishes to decrease practice size**

89 Over the course of a physician's career, there may be factors that impact the number of patients a
 90 physician is able to effectively manage in their practice. These factors may include, as examples: the

³ For example, physicians can fulfil this expectation by establishing office policies and posting them in a prominent location.

91 stage of the physician's career, the status of the physician's health or well-being, or the physician's
 92 career goals. In these circumstances it may be necessary for the physician to decrease the number of
 93 patients to whom they provide care.

94 As each practice and patient population is unique, physicians must exercise their own professional
 95 judgment, consistent with this policy, in selecting which patients to remove from their practice.

96 Whatever method a physician uses, it must be fair, transparent, and compassionate, and take into
 97 account the medical needs of each patient. Physicians must also consider any other relevant factors,
 98 including the patient's vulnerability, and their ability to find alternative care in an appropriate
 99 timeframe.

100 Physicians must not selectively or disproportionately discharge difficult or complex patients.

101 **(iii) The patient has been absent from the practice for an extended period of time**

102 When a patient has not been in contact with a practice for an extended period of time (for example,
 103 several years), the physician may assume that the patient has sought care elsewhere, and remove them
 104 from their practice.

105 Before formally ending the physician-patient relationship, physicians must make a good-faith effort to
 106 contact the patient to determine whether they would prefer to maintain the relationship. This effort
 107 must include, at minimum, a letter of inquiry sent to the patient's last known address.

108 Where no response is received, or the patient indicates that they have sought care elsewhere,
 109 physicians may formally remove the patient from their practice.

110 **Situations where it is inappropriate for physicians to end a physician-patient relationship**

111 **(i) Where it is prohibited by legislation**

112 Physicians must ensure that any decision to end the physician-patient relationship is compliant with
 113 relevant legislation. This legislation includes:

- 114 • *The Commitment to the Future of Medicare Act, 2004*, which prohibits physicians from ending
 115 the physician-patient relationship because the patient chooses not to pay a block or annual fee
 116 (CPSO expectations related to block fees are outlined in the College's [Block Fees and Uninsured](#)
 117 [Services](#) policy);
- 118 • The Ontario *Human Rights Code*, which prohibits ending the physician-patient relationship due
 119 to one of the protected grounds set out in the Code;^{4,5}

⁴ Protected grounds include: age; ancestry, colour, race; citizenship; ethnic origin; place of origin; creed; disability; family status; marital status (including single status); gender identity, gender expression; receipt of public assistance (in housing only); record of offences (in employment only); sex (including pregnancy and breastfeeding); and sexual orientation.

⁵ For more information about physician's obligations under the Ontario *Human Rights Code*, please see the College's [Professional Obligations and Human Rights](#) policy.

- 120 • The professional misconduct regulations⁶ under the *Medicine Act, 1991*.
 121 **(ii) Solely because the patient chooses not to follow the physician's advice**

122 Physicians must respect the right of patients to make their own decisions with respect to their
 123 healthcare⁷ and lifestyle, and not end the physician-patient relationship solely because the
 124 patient chooses not to follow their advice.

125 For example, it would be inappropriate for a physician to discontinue their relationship with a
 126 patient solely because the patient did not follow their advice with respect to smoking cessation,
 127 drug or alcohol use, or the patient's decision to refrain from vaccinating themselves or their
 128 children.

- 129 **(iii) Solely because the patient has failed to pay an outstanding fee**

130 While physicians are entitled to receive and pursue payment for any uninsured services
 131 rendered to a patient, or any other outstanding fees (such as those related to missed
 132 appointments), physicians must not end the physician-patient relationship solely because the
 133 patient has failed or refused to pay an outstanding fee.⁸

134 While fees are outstanding, physicians must not withhold any aspect of medical care.

- 135 **(iv) Solely because the patient has sought care outside of a rostered practice**

136 Rostered practices⁹ impose specific commitments on both family physicians and their patients:
 137 physicians commit to provide comprehensive and timely care, and patients commit to seek
 138 treatment from their enrolling physician or group except in specified circumstances. When
 139 patients seek care outside of the practice, except in specific circumstances, the physician may
 140 incur a financial penalty.

141 Physicians must not end the physician-patient relationship solely because the patient has sought
 142 care outside of a rostered practice. Where a patient has sought care outside of the practice,
 143 physicians are advised to remind patients of their commitment to the practice.¹⁰

⁶ Ontario Regulation 856/93, as amended (made under the *Medicine Act, 1991*), s. 1(1)7.

⁷ *Health Care Consent Act, 1996*.

⁸ For further expectations related to fees for uninsured services please see the College's policies on [Block Fees and Uninsured Services](#), [Medical Records](#), and [Third Party Reports](#). Physicians are further reminded that, in accordance with the College's [Third Party Reports](#) policy, they are encouraged to refrain from requiring prepayment for uninsured services on compassionate grounds, when the patient or examinee is responsible for payment directly, and the report relates to basic income and health benefits.

⁹ Patient rostering in family practice is a process by which patients register with a family practice, family physician, or team. Patient rostering facilitates accountability by defining the population for which the primary care organization or provider is responsible, and facilitates an ongoing relationship between the patient and provider.

¹⁰ In some limited cases, a patient's repeated failure to adhere to their commitments within a rostered practice may give rise to significant conflicts or broader conduct issues. In these limited cases, physicians are reminded that any decision to discontinue care must be made in accordance with the relevant expectations of this policy. These include the expectation that reasonable efforts be undertaken to resolve the situation in the best interest of the patient prior to discontinuing care.

144 **3. Actions to be taken when ending the physician-patient relationship**

145 When a physician decides to end the physician-patient relationship, the College expects physicians to
146 undertake the following actions:

147 1. Notify the patient of the decision to discontinue the physician-patient relationship.

148 Physicians are advised to notify each patient of their decision to end the physician-patient
149 relationship in person, to help ensure clear communication, except where the patient poses
150 a genuine risk of harm.

151 In all cases, physicians must provide every patient with written notification that the
152 relationship has been discontinued (See Appendix A for a sample letter). Whichever method
153 a physician uses to transmit the written notification, it must be secure and ensure patient
154 confidentiality (acceptable methods of transmission include, among others: hand delivery to
155 the patient during an appointment, registered mail, and courier).¹¹

156 In most cases, it is appropriate and useful for the patient to be advised of the reasons why
157 the relationship is being discontinued; however, physicians may use their discretion in
158 situations where there is a genuine risk of harm associated with communicating those
159 reasons to the patient.

160 2. Document in the patient's medical record the reasons for the discontinuation of care, and all
161 steps undertaken to resolve the conflict prior to discontinuation.

162 3. Clearly convey to the patient that he or she should seek ongoing care.

163 4. Be as helpful as possible to the patient in finding a new physician or other primary care
164 provider, and provide him or her with a reasonable amount of time for doing so. In
165 determining what a 'reasonable amount of time' is for a particular patient, physicians are
166 advised to take into account the following:

- 167 • What is considered 'a reasonable amount of time' depends on the
168 circumstances of each case, including the patient's specific healthcare needs.
- 169 • This period can usually be defined as the amount of time it would take a person
170 using reasonable effort to find a new physician; however, physicians must also
171 seek to accommodate patients with special needs or disabilities that may make
172 seeking new care challenging.
- 173 • 'A reasonable amount of time' may vary from community to community,
174 depending on the availability of alternative healthcare providers.
- 175 • Sometimes it may be impossible for a patient to find a new physician. In such
176 circumstances, the College would not expect the physician to continue to

¹¹ A copy of the written notification and confirmation of receipt must be retained in the patient's medical record.

- 177 provide care indefinitely, but would expect that he or she would provide care in
 178 an emergency, where it is necessary to prevent imminent harm.
- 179 5. Ensure the provision of necessary medical services in the interim.¹² This may include:
- 180 • Renewing prescriptions, where medically appropriate, for a reasonable length of
 181 time given the needs of the patient, the time required to find a new physician,
 182 and the nature of the medication;¹³ and
- 183 • Ensuring appropriate follow-up on all laboratory and test results ordered.¹⁴
- 184 6. Inform the patient of their right to have their medical records transferred or provided to
 185 them.¹⁵
- 186 7. Ensure the timely transfer of a copy or summary of the patient’s medical records upon the
 187 patient’s request.¹⁶
- 188 8. Notify appropriate staff (e.g., office receptionist) that care is no longer being provided to the
 189 patient.
- 190 9. Notify the patient’s other health care providers that care is no longer being provided to the
 191 patient if such notification is necessary for the purposes of the patient’s care and if the
 192 patient has not expressly restricted you from providing information to other health care
 193 providers.¹⁷

¹² Discontinuing professional services that are needed may constitute professional misconduct unless alternative services are arranged, or the patient is given a reasonable opportunity to arrange alternative services (O. Reg. 856/93 s.1(17)).

¹³ It is not expected that prescriptions will be renewed indefinitely. All prescribing should be done in accordance with the College’s [Prescribing Drugs](#) policy.

¹⁴ For further information on appropriate follow-up, refer to the CPSO policy on [Test Results Management](#).

¹⁵ In accordance with the College’s Medical Records policy, physicians are able to charge a reasonable fee for copying and transferring medical records.

¹⁶ For further information, refer to the CPSO policy on [Medical Records](#).

¹⁷ Under the *Personal Health Information Protection Act, 2004*, a health care provider may provide personal health information about a patient to another health care provider for the purposes of providing health care or assisting in the provision of health care to the patient. Despite this provision, the Act also gives patients the right to expressly restrict his/her physician from providing another health care provider with his/her personal health information, including whether the physician is providing the patient with services. In cases where a physician is asked by another health care provider for information about a patient that is reasonably necessary for the provision of health care or assisting in the provision of health care to the patient, the physician must notify the other health care provider if they have been restricted from disclosing information about the patient and they may wish to advise the other health care provider to direct any inquiry to the patient him/herself for a response.

COUNCIL BRIEFING NOTE

TOPIC: Marijuana for Medical Purposes Policy Update FOR DECISION

ISSUE:

- The College's [Marijuana for Medical Purposes](#) policy was approved by Council in March, 2015.
- Since that date, there have been significant developments in the regulatory landscape, including the introduction of new regulations governing access to marijuana for medical purposes.
- As a result, the current policy is now out-of-date, and no longer addresses all of the relevant issues arising from the regulations.
- This briefing note provides Council with an update on these developments, and proposes that amendments be made to the Marijuana for Medical Purposes policy to reflect the new regulations. Council is asked whether it approves the revised Marijuana for Medical Purposes policy.

BACKGROUND:

- The College's current [Marijuana for Medical Purposes](#) policy was drafted in response to the introduction of the Federal *Marijuana for Medical Purposes Regulations (MMPR)* in 2014.
- These regulations updated the legal framework that enabled patients to access a legal supply of marijuana with the support of their physician.
- The policy was drafted to specifically reflect the framework established by the *MMPR*, and was approved by Council at their March, 2015 meeting.

Legal challenges to the MMPR

- Following the introduction of the *MMPR*, several legal challenges were launched against key components of the regulations. Namely, that they infringed on patients' rights under the *Canadian Charter of Rights and Freedoms* in two ways:

1. By limiting legal possession to dried marijuana only, the regulations effectively forced patients to smoke it, rather than consume it in a manner that was less likely to harm their respiratory health (e.g. by consuming it as an oil); and
 2. By prohibiting patients from growing their own supply of marijuana, or from designating someone to grow it on their behalf, the regulations effectively forced patients to pay a premium to obtain marijuana from a commercial producer. This was thought to represent a barrier to access for lower-income patients.
- Both challenges were ultimately successful, and in February, 2016, the Federal Courts gave Health Canada 6 months to develop a new, Charter-compliant regulatory structure.
 - The Executive Committee and Council received updates with respect to these developments in spring, 2016, at which point they were advised that staff would continue to monitor the Federal response.

Introduction of the new *Access to Cannabis for Medical Purposes Regulations (ACMPR)*

- In response to the Federal Court's decision, the Federal Government formally replaced the *MMPR* with the new [*Access to Cannabis for Medical Purposes Regulations \(ACMPR\)*](#) on August 24th, 2016.
- Under the *ACMPR*, patients are now permitted to:
 1. Access marijuana in forms *other* than dried, including fresh buds and leaves, and cannabis oil, among others; and
 2. Apply to Health Canada for authorization to grow their own supply of marijuana plants, or to designate someone to grow plants for them.
- The new regulations do not change the role of the physician in authorizing patient access to marijuana for medical purposes. As before, physicians are still required to complete a medical document which is effectively equivalent to a prescription.
- As the current Marijuana for Medical Purposes policy reflects the framework established by the former *MMPR*, it does not reflect the new changes introduced by the *ACMPR*.

CURRENT STATUS:

- With the public release of the *ACMPR* in August, College staff have been aware of the issues arising from the new regulations that are not addressed in policy.

- The College's Public and Physician Advisory Service (PPAS) has also received a number of inquiries from physicians and patients who have noted the discrepancies between the College's policy and the new regulations.
- To-date, these inquiries have been resolved informally, in-keeping with the requirements of new the regulations, and in the spirit of the existing policy; however, it is recommended that the current Marijuana for Medical Purposes policy be updated to clearly reflect the College's expectations in relation to the new regulations.

Proposed amendments to the policy

- The following proposed policy amendments have been discussed with Dr. Marc Gabel, Dr. Angela Carol, and Carolyn Silver, all of whom were involved in the original policy development process.
- A draft version of the revised policy is attached as **Appendix A**. The proposed amendments reflect the relevant changes introduced by the *ACMPR*, and include the following:
 - The legislative references have been updated to refer the *Access to Cannabis for Medical Purposes regulations (ACMPR)*;
 - The qualifier "dried" has been removed whenever referring to marijuana for medical purposes, in recognition of the fact that marijuana is now available in other formulations;
 - The lines stating that the policy refers only to dried marijuana have been removed (lines 42 – 43 & lines 45 – 48);
 - The statement that completed medical documents must be submitted directly to licensed producers has been removed to reflect the fact that when patients are applying to grow their own supply of marijuana, the medical document must now be submitted to Health Canada instead (lines 54 – 56);
 - In discussing the potential risks associated with consuming marijuana, it is clarified that the symptoms of chronic bronchitis are associated with smoking only (lines 80 – 81); and
 - Language throughout the section relating to "determining a safe and effective dose" has been modified so as not to focus specifically on "dried" marijuana, while retaining the guiding principles that prescribing should be cautious, and should only be initiated with low-quantity, low-THC formulations (lines 113 – 128).

CONSIDERATIONS:

- As Council may be aware, in the 2015 Speech from the Throne, the Federal Government publicly committed to legalizing, regulating, and restricting access to marijuana for recreational uses by 2017.
- A Federal Task Force has now been struck with a mandate to engage with provincial, territorial, and municipal stakeholders to provide the government with advice on the design of a new Federal framework.
- It is not yet clear what approach the Federal Government intends to take with respect to legalizing the recreational use of marijuana. The timelines for this work are also unclear.
- It is, however, highly likely that any new legislation will have significant implications for medicinal use, even to the extent of eliminating the need for a medical regime altogether. This in turn will have direct implications for the College's policy, and may necessitate the rescission of the policy.
- Staff will continue to monitor developments at the federal level and will keep Council apprised.

NEXT STEPS:

- Should Council approve the policy, as revised, it will be published in *Dialogue* and will replace the current version of the Marijuana for Medical Purposes policy on the CPSO website.

DECISIONS FOR COUNCIL:

1. Does Council approve the revised Marijuana for Medical Purposes policy?
-

CONTACT: Cameron Thompson, ext. 246

DATE: November 10, 2016

Appendix A: Revised Draft Marijuana for Medical Purposes policy



1 Marijuana for Medical Purposes

2 **Policy Number:** #3-06
 3 **Policy Category:** Practice
 4 **Under Review:**
 5 **Approved by Council:**
 6 **Reviewed and Updated:**
 7 **College Contact:** Advisory Services

8 INTRODUCTION

9 The Government of Canada's *Access to Cannabis for Medical Purposes Regulations (ACMPR)*¹
 10 establish the legal framework that enables patients to obtain authorization to possess
 11 marijuana for medical purposes.

12 Under these regulations, physicians have primary responsibility for the decision to authorize
 13 patient use of marijuana for medical purposes.² Physicians enable patients to access a legal
 14 supply of marijuana by completing a medical document that functions like a conventional
 15 prescription.

16 While conclusive evidence regarding the safety and effectiveness of marijuana as a medical
 17 treatment is limited, many patients, physicians, and researchers have voiced support for the
 18 cautious and compassionate use of marijuana, particularly where other therapeutic options
 19 have been exhausted and failed to alleviate the patient's symptoms. Furthermore, court rulings
 20 have required reasonable access to a legal source of marijuana for medical purposes when
 21 authorized by a physician.³

22 In keeping with the College's mandate to serve and protect the public,⁴ this policy sets out
 23 expectations for physicians relating to the prescribing of marijuana for medical purposes.

¹ [Access to Cannabis for Medical Purposes](#), SOR/2016-230.

² The *ACMPR* authorize both physicians and nurse practitioners to prescribe marijuana for medical purposes; however, to date the College of Nurses of Ontario has not permitted their members to prescribe.

³ *R. v. Mernagh*, 2011 ONSC 2121.

⁴ Section 3(2) of the Health Professions Procedural Code, Schedule 2 of the Regulated Health Professions Act, 1991, S.O. 1001, c.18 (hereinafter *HPPC*).



24 These expectations are grounded in the principles of medical professionalism set out in the
25 [Practice Guide](#), and take into account the best available evidence regarding the medical use of
26 marijuana.

27 **PRINCIPLES**

28 The key values of professionalism – compassion, service, altruism and trustworthiness – form
29 the basis for the expectations set out in this policy. Physicians embody these values and uphold
30 the reputation of the profession by:

- 31 1. Acting in the best interests of their patients;
- 32 2. Demonstrating professional competence, which includes maintaining the medical
33 knowledge and clinical skills necessary to prescribe appropriately;
- 34 3. Collaborating effectively and respectfully with patients, physicians and other health-care
35 providers;
- 36 4. Avoiding or appropriately managing conflicts of interest;⁵ and
- 37 5. Participating in the self-regulation of the medical profession by complying with the
38 expectations set out in this policy.

39 **PURPOSE AND SCOPE**

40 This policy sets out the College’s expectations of all physicians who prescribe marijuana for
41 medical purposes.

42 **TERMINOLOGY**

43 **Marijuana:** Throughout this policy, the term “marijuana” and “marijuana for medical purposes”
44 should be understood to mean not only dried marijuana, but also any other form of marijuana
45 that is legally permitted by the current legislation.

46 **Medical document:** The *ACMPR* require that patients obtain a medical document completed by
47 an authorized healthcare practitioner in order to access a legal supply of marijuana for medical
48 purposes. The medical document contains information that would normally be found on a
49 prescription, including the patient’s name, the physician’s name and CPSO number, the daily
50 quantity of marijuana to be used by the patient, and the period of use, among other
51 information.⁶

⁵ For more information on conflicts of interest, please see [Part IV of the General, O. Reg., 114/94](#), enacted under the *Medicine Act, 1991*, S.O. 1991, c. 30 (hereinafter *Medicine Act, General Regulation*).

⁶ Section 8 of the [Access to Cannabis for Medical Purposes Regulations](#).

52 **Prescription:** Throughout this policy, the term “prescription” should be understood to include
53 the completion of a medical document in accordance with the *ACMPR*.

54 **POLICY**

55 It is the College’s position that the medical document required under the *ACMPR* is equivalent
56 to a prescription.

57 Physicians who prescribe marijuana must comply with the expectations set out in this policy as
58 well as the expectations and guidelines for prescribing that are set out in the College’s
59 [Prescribing Drugs](#) policy. Physicians must also ensure compliance with the *ACMPR* and any
60 other relevant College policies, including, but not limited to, the [Dispensing Drugs](#),
61 [Complementary/Alternative Medicine](#), and [Telemedicine](#) policies.

62 **1. Before Prescribing**

63 Physicians must always practise within the limits of their knowledge, skills and judgment⁷, and
64 never provide care that is beyond the scope of their clinical competence.⁸ As with any
65 treatment, physicians are not obligated to prescribe marijuana if they do not believe it is
66 clinically appropriate for their patient.⁹

67 ***Assessing the appropriateness of marijuana for the patient***

68 Before a physician may prescribe marijuana, he/she must carefully consider whether it is the
69 most appropriate treatment for their patient.¹⁰

⁷ [Sections 2\(1\)\(c\), 2\(5\), O. Reg. 865/93, Registration](#), enacted under the Medicine Act, 1991, S.O. 1991, c.30;
[Changing Scope of Practice](#) policy; [The Practice Guide](#).

⁸ This expectation applies to all non-emergent situations. In emergency situations, physicians may be permitted to act outside their scope of expertise in some circumstances. See the [Physicians and Health Emergencies](#) policy for more detail.

⁹ Physicians may sometimes have difficulty addressing patient disagreement with a decision not to prescribe marijuana. Recommendations for communicating with patients about this decision can be found in Kahan, Meldon, et al. (2014). [Prescribing Smoked Cannabis for Chronic Noncancer Pain: Preliminary Recommendations](#). *Canadian Family Physician*, 60, 1083-1090.

¹⁰ While conclusive evidence regarding the safety and effectiveness of marijuana is currently limited, there are a number of resources physicians can consult for more information. These include, among others: Health Canada’s [Information for Health Professionals](#) webpage; the College of Family Physicians of Canada’s [Authorizing Dried Cannabis for Chronic Pain or Anxiety: Preliminary Guidance](#); and Kahan, Meldon, et al. (2014). [Prescribing Smoked Cannabis for Chronic Noncancer Pain: Preliminary Recommendations](#). *Canadian Family Physician*, 60: 1083-1090. Physicians must be mindful that resources may become outdated as further research is undertaken in this field.



70 As part of this process, physicians must weigh the available evidence in support of marijuana
71 against other available treatment options, including the oral and buccal¹¹ pharmaceutical form
72 of cannabinoids.

73 Physicians must also consider the risks associated with the use of marijuana, which may
74 include, among others, a risk of addiction, the onset or exacerbation of mental illness, including
75 schizophrenia, and – when smoked – symptoms of chronic bronchitis.¹²

76 Physicians are expected to comply with the applicable standard of practice when assessing the
77 risk of marijuana to their patients and take such steps as are clinically indicated in the specific
78 circumstances of each case to mitigate those risks. The published literature with respect to
79 marijuana provides some general guidance as to some of the recommended components in
80 such a risk assessment. These include, among others, an assessment of each patient for their
81 risk of addiction and substance diversion,¹³ and an assessment of risk factors for psychotic
82 disorders, mood disorders, and other mental health issues that may be affected by the use of
83 marijuana.

84 ***Prescribing to patients under the age of 25***

85 Current evidence strongly suggests that children, adolescents, and young adults who consume
86 marijuana are at a greater risk than older adults for marijuana-associated harms, including
87 suicidal ideation, illicit drug use, cannabis use disorder, and long-term cognitive impairment.¹⁴
88 Given the potentially severe nature of these risks, physicians must not prescribe marijuana to
89 patients under the age of 25¹⁵ unless all other conventional therapeutic options have been
90 attempted and have failed to alleviate the patient’s symptoms.

¹¹ Buccal pharmaceutical cannabinoids include oromucosal sprays.

¹² For a more complete overview of the adverse health effects associated with the consumption of dried marijuana, please see: Volkow, N.D, et al. (2014). Adverse Health Effects of Marijuana Use. *The New England Journal of Medicine*. 370(23): 2219-2227.

¹³ Physicians who wish to find further guidance with respect to preventing prescription drug abuse and assessing patients for their risk of addiction should refer to the National Opioid Use Guideline Group, [Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain](#) and the Specific Issues in Prescribing: Narcotics and Controlled Substances section of the College’s [Prescribing Drugs](#) policy.

¹⁴ For more information, please see Volkow, N.D, et al. (2014). Adverse Health Effects of Marijuana Use. *The New England Journal of Medicine*. 370(23): 2219-2227, Health Canada’s [Information for Health Professionals](#) webpage, the Centre for Addiction and Mental Health’s [Cannabis Policy Framework](#), and the College of Family Physicians of Canada’s [Authorizing Dried Cannabis for Chronic Pain or Anxiety: Preliminary Guidance](#).

¹⁵ Current evidence suggests that children, adolescents, and young adults are at a higher risk of experiencing the harmful effects of marijuana. This may be because their brains are still undergoing a process of neural development, during which they are more vulnerable to the harmful effects of certain chemical compounds found in marijuana. Until the effects of marijuana on the developing brain are better understood, all patients within the period of neural development – which continues from the prenatal period until the mid 20’s – must be considered higher risk for marijuana-related harm.



91 Even after all other conventional therapeutic options have been exhausted, physicians must still
92 be satisfied that the anticipated benefit of marijuana outweighs its risk of harm.

93 ***Obtaining consent***

94 In order to authorize any therapeutic intervention, physicians must always obtain valid and
95 informed consent in accordance with their legal obligations¹⁶ and the College's [Consent to](#)
96 [Medical Treatment](#) policy.

97 In keeping with these obligations, physicians who prescribe marijuana must advise patients
98 about the material risks¹⁷ and benefits of marijuana, including its effects and interactions,
99 material side effects, contraindications, precautions, and any other information pertinent to its
100 use. As part of this discussion, physicians must caution all patients who engage in activities that
101 require mental alertness that they may become impaired while using marijuana.¹⁸

102 Furthermore, the College recommends that physicians explain to the patient the extent and
103 quality of the evidence that informs their understanding of the appropriateness of marijuana
104 for their clinical condition.

105 **2. When Prescribing**

106 ***Determining a safe and effective dose***

107 Unlike conventional pharmaceutical products, marijuana is available in a variety of strains and
108 formulations that vary significantly in their potency and chemical composition. Furthermore,
109 research suggests that there are significant differences among patient sensitivities to the
110 psychoactive and therapeutic effects of marijuana. For these reasons, determining a safe and
111 effective dose for each patient may be challenging.

112 Absent established clinical guidelines, physicians must proceed cautiously: the College
113 recommends that physicians initiate treatment with a low quantity of marijuana¹⁹ and only

¹⁶ [Health Care Consent Act](#), 1996, S.O. 1996, c. 2, Sched. A.

¹⁷ The material risks that must be disclosed are risks that are common and significant, even though not necessarily grave, and those that are rare, but particularly significant. In determining which risks are material, physicians must consider the specific circumstances of the patient and use their clinical judgment to determine the material risks.

¹⁸ An important consideration is the impact that the consumption of marijuana may have on an individual's ability to safely operate a motor vehicle. The consumption of marijuana has been correlated with an increased risk of traffic accidents based on epidemiological studies. For more information on the impact of marijuana on driving, please see: Neavyn, M, Blohm, E, & Babu, K. (2014). Medical Marijuana and Driving: A Review. *American College of Medical Toxicology*. DOI 10.1007/s13181-014-0393-4.

¹⁹ While there are currently no established clinical guidelines setting out appropriate dosages for dried marijuana, more information on dosing can be found on Health Canada's [Information for Health Professionals](#) webpage and



114 prescribe marijuana that is low in the psychoactive compound tetrahydrocannabinol (THC).²⁰
 115 Where the initial prescription proves ineffective, physicians may incrementally increase the
 116 quantity prescribed and/or substitute marijuana with a higher THC concentration until a dose is
 117 reached that achieves symptom management while causing minimal euphoria or cognitive
 118 impairment.

119 In order to ensure that the above expectations are met, physicians must specify on every
 120 prescription the quantity of marijuana to be dispensed to the patient as well as the percentage
 121 of THC it must contain.

122 ***Managing the risk of abuse, misuse and diversion***

123 Marijuana, like many other conventionally prescribed drugs, carries with it a risk of abuse,
 124 misuse and diversion. As the risks posed by marijuana are not fundamentally different from
 125 those posed by other controlled drugs, physicians are advised to follow the guidelines for
 126 managing the risk of abuse, misuse and diversion of narcotics and controlled substances set out
 127 in the [Prescribing Drugs](#) policy.

128 As with any drug, physicians who prescribe marijuana must monitor patients for any emerging
 129 risks or complications. Prescribing must be discontinued where marijuana fails to meet the
 130 physician's therapeutic goals or the risks outweigh the benefits.

131 The College also recommends that physicians who prescribe marijuana first require patients to
 132 sign a written treatment agreement.²¹ This agreement must contain, at minimum, a statement
 133 from the patient that they: will not seek marijuana from another physician or any other source;
 134 will only use marijuana as prescribed; will store their marijuana in a safe and secure manner;
 135 and will not sell or give away their marijuana. It is recommended that the treatment agreement
 136 contain a statement that if the agreement is breached, the physician may decide not to
 137 continue prescribing marijuana to the patient.

the College of Family Physicians of Canada's [Authorizing Dried Cannabis for Chronic Pain or Anxiety: Preliminary Guidance](#) document.

²⁰ Tetrahydrocannabinol (THC) is the primary psychoactive compound found in marijuana. It is responsible for the "high" that users experience when consuming marijuana, but may also be responsible for some of marijuana's beneficial therapeutic effects. At high levels, THC has been correlated with marijuana-related harm and is more likely to produce undesirable psychoactive effects in patients. While some commercially available strains of marijuana contain THC concentrations as high as 30%, the College of Family Physicians of Canada's [Authorizing Dried Cannabis for Chronic Pain or Anxiety: Preliminary Guidance](#) document suggests that current evidence does not support prescribing marijuana with a THC concentration greater than 9%.

²¹ Treatment agreements are formal and explicit agreements between physicians and patients that delineate key aspects regarding adherence to the treatment. A sample treatment agreement can be found in the College of Family Physicians of Canada's [Authorizing Dried Cannabis for Chronic Pain or Anxiety: Preliminary Guidance](#) document.

138 3. Charging Fees

139 The College considers the medical document authorizing patient access to marijuana to be
140 equivalent to a prescription. Prescriptions, together with activities related to prescriptions, are
141 insured services. Accordingly, physicians must not charge patients or licensed producers of
142 marijuana for completing the medical document, or for any activities associated with
143 completing the medical document, including, but not limited to: assessing the patient;
144 reviewing his/her chart; educating or informing the patient about the risks or benefits of
145 marijuana; or confirming the validity of a prescription in accordance with the *ACMPR*.

146 Physicians who are unsure about what services they may charge for are advised to refer to the
147 College's [Block Fees and Uninsured Services](#) policy and the OHIP Schedule of Benefits for
148 further guidance.

DRAFT



CYNTHIA MORTON, CEO, eHEALTH ONTARIO

Cynthia Morton is the Chief Executive Officer of eHealth Ontario. Hired in September, 2014, Cynthia is responsible for implementing an electronic health record system for the province of Ontario.

Cynthia has an extensive background in the Ontario public service, most recently as the Deputy Minister of Labour. Prior to that, she served as Deputy Minister of the Ministry of Health Promotion. Cynthia also served as Deputy Minister of the ministries of Attorney General, Education and Labour in British Columbia.

A graduate of Osgoode Hall Law School, Cynthia practiced law before joining the public service as Senior-Vice President and General Counsel of the Workplace Safety and Insurance Board.

COUNCIL BRIEFING NOTE

TOPIC: COUNCIL AWARD

BACKGROUND:

The Council Award honours Ontario physicians who have demonstrated excellence based on eight “physician roles”.

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

At the December 1, 2016 meeting of Council, **Dr. Mohit Bhandari** of Hamilton, Ontario will receive the Council Award

DECISION FOR COUNCIL:

No decisions required

CONTACT: Tracey Sobers, ext. 402

DATE: November 14, 2016

Appendices: N/A

COUNCIL BRIEFING NOTE

TOPIC: 2017 COUNCIL AWARD RECIPIENTS
INFORMATION

ISSUE: To inform the Council of the four 2017 Council Award recipients.

BACKGROUND

The Council Award honours four Ontario physicians who have demonstrated excellence based on eight “physician roles”.

1. The physician as medical expert / clinical decision maker
2. The physician as communicator
3. The physician as collaborator
4. The physician as gatekeeper / resource manager
5. The physician as health advocate
6. The physician as learner
7. The physician as scientist / scholar
8. The physician as person and professional

The following Ontario physicians were chosen by the Council Award Committee to receive the 2017 Council Award

- Dr. Shazia Ambreen (Alliston, ON)
- Dr. Kenneth P. Fung (Toronto, ON)
- Dr. Michael Colin Stephenson (Kitchener/Waterloo, ON)
- Dr. William Gary Smith (Orillia, ON)

THERE ARE NO DECISIONS REQUIRED

CONTACTS: Tracey Sobers, extension 402

DATE: November 14, 2016

**BRIEFING NOTE
COUNCIL**

TOPIC: ALTERNATIVES TO DEGREES IN MEDICINE FROM SCHOOLS LISTED IN THE WORLD DIRECTORY OF MEDICAL SCHOOLS PUBLISHED BY THE WORLD HEALTH ORGANIZATION

FOR: DECISION

ISSUE:

The Registration Committee recommends formalizing the existing informal policy to accept alternatives to degrees in medicine from schools that are not listed in the WHO Directory. Council is being asked to approve the recommendation.

BACKGROUND:

- Section 1 of the Registration Regulation defines “Degree in Medicine” to include:
 - (b) an MD or equivalent basic degree in medicine, based on successful completion of a conventional undergraduate program of education in allopathic medicine that:
 - (iii) was, at the time of graduation, listed in the World Directory of Medical Schools published by the World Health Organization.
- Commencing in 1953 and at the time the Registration Regulation was enacted; the World Health Organization (WHO) published the World Directory of Medical Schools.
- The last update of the World Directory of Medical Schools by the WHO was in 2007.
- The Registration Regulation does not provide a means to exempt an applicant from the requirement that they hold a degree in medicine listed in the World Directory of Medical Schools published by the WHO.

- Anyone applying to the College for registration, who are holders of a degree in medicine that does not satisfy the requirements as set forth in Section 1(b)(iii), requires review and approval by the College’s Registration Committee.
- In August 2007, the World Health Organization and the University of Copenhagen signed an agreement which gave the University the responsibility for the development and administration of a new directory called AVICENNA with the assistance of the World Federation for Medical Education.
- In late 2013, AVICENNA and the International Medical Education Directory (IMED) directories merged, forming the World Directory of Medical Schools.
- In 2016, the online *World Directory of Medical Schools* was developed through a partnership between the World Federation for Medical Education (WFME) and the Foundation for Advancement of International Medical Education and Research (FAIMER). The *World Directory of Medical Schools* provides a comprehensive compilation of the information previously contained in the *IMED* and *Avicenna* directories.
- As the Regulation provides no means by which to substitute successor organizations, an applicant with a degree in medicine from a medical school that is not listed in the WHO directory requires an exemption in order to be registered.
- Although the Registration Committee routinely grants exemptions for degrees in medicine as defined in the Regulation, as long as it is listed in the *World Directory of Medical Schools*, to-date there is no formal Registration policy which addresses this issue.

CURRENT STATUS:

- Since 2007 the Registration Committee has reviewed, and granted an exemption, to 177 applications whose qualifications did not satisfy the requirements as set forth in Section 1(b)(iii), but who demonstrate that they have an acceptable alternative, being listed in AVICENNA, FAIMER or the new *World Directory of Medical Schools*.
- Since 2007, candidates from 48 schools have been approved by the Registration Committee using the World Directory of Medical School’s criteria. The full listing of the approved schools is attached (Appendix A).
- The World Directory of Medical Schools is now a joint venture of the World Federation for Medical Education (WFME) and the Foundation for Advancement

of International Medical Education and Research (FAIMER). The World Directory of Medical Schools has been created by merging FAIMER's International Medical Education Directory (*IMED*) and WFME's Avicenna Directory and is published by WDOMS.org.

- The College's application packages were updated to reflect the new directory and inform applicants that the medical school from which they graduated must be listed in this new directory (if not in the WHO prior to 2007) and that such cases require review and approval by the Registration Committee.

CONSIDERATIONS

- The Registration Committee routinely grants an exemption to applicants who do not satisfy the requirements as set forth in Section 1(b)(iii), but who demonstrate that they have an acceptable alternative, however, this is done in the absence of a formal policy.
- Creating a formal policy will provide clarity and increased transparency to the public and prospective applicants.

ANALYSIS

- The policy will reflect that the Registration Committee will accept an M.D. or equivalent basic degree in medicine from a medical school that was, at the time of graduation, listed in the World Directory of Medical Schools published by WDOMS.org as an alternative to the requirement set out in s. 1 (b)(iii) of the Registration Regulation.
- All applications submitted under this Policy require review and approval by the College's Registration Committee.
- A copy of the proposed policy is attached as Appendix B.

Pros

- Creating a Registration Policy for Alternatives to degrees in medicine from schools listed in the World Directory of Medical Schools published by the World Health Organization will increase transparency and reduce ambiguity by including a definition and a means by which an exemption will be granted.
- The proposed policy is consistent with the Registration Committee's current practice.

Cons

- None identified
-

DECISION FOR COUNCIL:

1. Approve the proposed policy.
-

CONTACT: Dr. Barbara Lent, Chair, Registration Committee
Nathalie Novak, ext 432
Wade Hillier, ext 636

DATE: November 8, 2016

APPENDICES:

Appendix A: List of Approved Schools

Appendix B: Proposed Policy on “Alternatives to degrees in medicine from schools listed in the World Directory of Medical Schools Published by the World Health Organization”

APPENDIX A

Name of Medical School	Country
All Saints University	Dominica
Al-Quds University	Israel
American University of Antigua, College of Medicine	Antigua
American University of Caribbean School of Medicine	St. Maartens
Aureus University School of Medicine	Aruba
Australian National University	Australia
Belgorod State University	Russian Federation
Bharathiar University	India
Bond University	Australia
Cadi Ayyad University	Morocco
College of Medicine and Health Sciences	St. Lucia
Gulf Medical College	United Arab Emirates
Hope University School of Medicine	Virginia, USA
Instituto Universitario de Ciencias de la Salud	Argentina
International American University College of Medicine	Saint Lucia
Kaosiung Medical University	Taiwan
King Saud Bin Abdulaziz University for Health Sciences College of Medicine	Riyadh, Saudi Arabia
Medical University of the Americas (Belize)	Belize
National Defense Medical Center	Taiwan
National Yang-Ming University	Taiwan
October 6 th University	Egypt
RCSI – Medical University of Bahrain	Bahrain
Saint James School of Medicine (Anguilla)	Anguilla
Santosh Medical College	India
Silliman University	Phillipines
Southeast University	China

Universita Degli Studi del Piemonte Orientale 'Amedeo Avogadro'	Italy
Univerisita Degli Studi di Udine	Italy
Universidad de Antofagasta	Chile
Universidad Autonoma de Guerrero	Mexico
Universidad Miguel Hernandez (de Elche)	Spain
Universidad Panamericana	Mexico
Universidade Estacio de Sa (UNESA)	Brazil
Universidade Estadual de Montes Claros	Brazil
Universidade Luterana do Brazil	Brazil
Universidade de Marilia	Brazil
Universidade de Regiao de Joinville	Brazil
Universidade de Santiago	Chile
University of Limerick	Ireland
University of Medicine and Health Sciences	Saint Kitts
University of Rajasthan, Government Medical College Kota	India
University of Sharjah	United Arab Emirates
University of Sulaimani	Iraq
University of Wollongong	Australia
Vinayaka Mission's Medical College, Pondicherry University	India
Warwick Medical School (University of Warwick)	Coventry, UK
Weill Cornell Medical College	Qatar
Xavier University	Aruba

Alternatives to Degrees in Medicine from Schools Listed in the World Directory of Medical Schools Published by the World Health Organization

Introduction

It is a regulatory requirement for all applicants for a certificate of registration, regardless of the class of certificate, that the applicant must have a “degree in medicine”. The Registration Regulation (O. Reg. 865/93) defines “degree of medicine” to include an M.D. or an equivalent degree in medicine, that, among other things, was, at the time of graduation, listed in the World Directory of Medical Schools published by the World Health Organization.

The World Directory of Medical Schools is no longer being published by the World Health Organization. The *World Directory of Medical Schools* has been developed through a partnership between the World Federation for Medical Education (WFME) and the Foundation for Advancement of International Medical Education and Research (FAIMER).

This policy reflects that the Registration Committee will accept an M.D. or equivalent degree from the World Directory of Medical School as satisfying the requirement of a medical degree as defined in s.1(b)(iii)the regulation.

Policy

A degree in medicine is defined in section 1 of the Registration Regulation to include the following:

- (b) an M.D. or equivalent basic degree in medicine, based upon successful completion of a conventional undergraduate program of education in allopathic medicine that,
 - i. teaches medical principles, knowledge and skills similar to those taught in undergraduate programs of medical education at accredited medical schools,
 - ii. includes at least 130 weeks of instruction over a minimum of thirty-six months, and
 - iii. was, at the time of graduation, listed in the World Directory of Medical Schools published by the World Health Organization.

The Registration Committee will accept an M.D. or equivalent basic degree in medicine from a medical school that was, at the time of graduation, listed in the World Directory of Medical Schools [online registry](#) as satisfying the requirement set out in s. 1 (b)(iii) of the Registration Regulation.

All applications submitted under this Policy require review and approval by the College’s Registration Committee. All applicants must satisfy all other criteria for registration.

COUNCIL BRIEFING NOTE

TOPIC: RESTRICTED CERTIFICATES OF REGISTRATION FOR EXAM ELIGIBLE CANDIDATES

FOR: DECISION

ISSUE:

The Registration Committee recommends revising the existing Council Policy *Restricted Certificates of Registration for Exam Eligible Candidates* to provide increased clarity regarding exam eligibility and subsequent applications for extension. Council is being asked to approve the revised policy.

BACKGROUND:

- This policy was originally approved by Council, in 2003, and updated in 2011. The current policy is included as “Appendix A”.
- Under this policy, the Registration Committee may grant restricted certificates of registration to physicians who have yet to attempt the exam or successfully complete the qualifying and/or certification examinations for independent practice required under Section 3 of Ontario Regulation 865/93.
- Such physicians are required to practice medicine under supervision, for three years or until the physician’s eligibility to write the RCPSC or CFPC examination expires, whichever comes first. Both RCPSC and CFPC discern the criteria for eligibility. Furthermore, physicians approved under this policy are expected to complete the outstanding examinations during this period.
- The three year time frame was imposed for 2 reasons: it correlated with the time frame during which physicians had access/eligibility to the RCPSC/CFPC exams and it was seen as a reasonable period of time in which to complete the exams.

CURRENT STATUS:

- In recent years, the CFPC and RCPSC have made significant changes to their rules on eligibility for the certification exams. The RCPSC and the CFPC routinely make exceptions to allow physicians to take the examinations beyond the three year period of eligibility.

RCPSC

Since the new eligibility rules were established in 2007, a small number of physicians have been allowed to make more than 3 attempts at the exam.

CFPC

Recent changes to the eligibility requirements mean that candidates who are practice eligible for the exam are provided unlimited attempts at the examination as long as they continue to meet the eligibility criteria. Information pertaining to CFPC exam eligibility is included as Appendix C.

MCC

The Registration Committee has seen physicians who have attempted the MCCQ exams up to 11 times.

- These changes to the limits on eligibility have required the Registration Committee to reconsider the 3 year limit.
- The policy on Restricted Certificates of Registration for Exam Eligible Candidates is due for its regular policy review and updates are sought to respond to the changes in eligibility criteria and clarity of renewal requests.
- Executive Committee is in support of the recommendation to include language which dissuades the applicant from assuming renewal of their certificate will be automatic with an eligibility letter.

CONSIDERATIONS

- The policy was written to provide physicians three years to complete any outstanding examinations, based on an assumption that physicians would only be eligible for 3 years.
 - This would include first time applicants coming from a recognized jurisdiction, as deemed by the RCPSC or CFPC or Canadian graduates who were not successful in completing one or more of the required exams.
- Not considered in 2003 was the possibility that candidates could still be unsuccessful but remain eligible after 3 years/3 attempts.
- On average, the Registration Committee approves 150 applicants under this policy annually. Since its inception in 2003, the Committee has granted an extension beyond three years to a total of 20 candidates, in order for them to complete the outstanding examinations.
- When extension requests are approved by the Committee, the Committee generally requests the candidate undertake to continue practice with a higher level of supervision than that approved with the first restricted certificate and

an enhanced study plan or Individualized Education Plan (IEP) to address any deficiencies identified in the examination performance results.

- The Committee's practice has been to approve extension requests as long as physicians provide a sufficient study plan and evidence that they continue to be eligible to write the outstanding exam(s).
- This creates the potential for physicians remaining under supervised practice for longer than 3 years as they continue their attempts to complete the exam successfully.
- This has created the issue of unsuccessful applicants continuing to ask for license extensions beyond 3 years, while they continue to practice under supervision.
- With these candidates, we are now in a position where we are at risk of inadvertently creating a permanent supervised class of certificate. In addition, the RCPSC and CFPC may now include pre-conditions on a candidate's initial eligibility for an examination, such as successful completion of a *principles of surgery* examination or *PEARLS.ce*, a program of evidence-based practice reflection exercises that facilitate the integration of new clinical knowledge into practice.
- The Registration Committee's practice has been to consider applicants under the Restricted Certificates of Registration for Exam Eligible Candidates policy only when they have access to the certifying examinations without pre-condition. It is recommending a change to the policy that would formalize this approach.

ANALYSIS

- If we don't impose limitations on extensions to exam eligible candidates we could create a permanent supervised class of registration.
- Strictly enforcing the three year maximum duration of a certificate of registration could mean extensions would no longer be considered for physicians with extenuating factors (health problems, family issues, etc.) that have prevented physicians from attempting an examination.
- The Registration Committee is recommending revising the policy so that not all applicants with extension letters of eligibility from the Royal College and CFPC need be considered for renewal.

DECISION FOR COUNCIL:

The following is proposed:

Approve the following revisions to the existing policy:

The Registration Committee may direct the Registrar to issue a restricted certificate of registration, to individuals who have provided the College with proof of:

1. having completed the certification exam of the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada, but who have not yet completed parts 1 and 2 of the MCCQE, and/or
2. being currently eligible ***without pre-condition*** to take the certification exam of the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada. The individual may or may not have yet completed Parts 1 & 2 of the MCCQE.

In addition, revise the following statement from the existing policy:

Candidates will not normally be considered for a renewal of their restricted certificate of registration after the expiration time, but each situation will be considered on its own merits.

With:

Only in exceptional circumstances will candidates be considered for a renewal of their restricted certificate of registration after the expiration time.

A copy of the proposed option is included as Appendix D

CONTACT: Nathalie Novak, Ext 432
Wade Hillier, Ext 636
Barbara Lent - Chair

DATE: December 2016

APPENDICES:

Appendix A: Current Policy “Restricted Registration for Exam Eligible Candidates”

Appendix B: RCPSC Continuing Eligibility Details

Appendix C: CFPC Limits on Eligibility

Appendix D: Copy of Proposed Policy



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Restricted Certificate of Registration for Exam Eligible Candidates

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Policy Category: Registration

Approved by Council: November 2003

Reviewed and Updated: November 2011

College Contact: Registration Inquiries

 Downloadable Version(s): [Guide to Policy for Restricted Certificates](#)

Purpose

The policy permits the issuance of a time-limited, restricted certificate to physicians who are missing Medical Council of Canada Qualifying Examination Parts 1 and 2, and/or Royal College of Physicians and Surgeons of Canada or College of Family Physicians of Canada certification, but are officially eligible to take these examinations.

The Registration Committee may direct the Registrar to issue a restricted certificate of registration, to individuals who have provided the College with proof of:

- i. having completed the certification exam of the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada, but who have not yet completed parts 1 and 2 of the MCCQE, or
- ii. being currently eligible to take the certification exam of the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada. The individual may or may not have yet completed Parts 1 & 2 of the MCCQE.

Candidates who are issued a restricted certificate of registration based on this policy will only practise in prescribed circumstances under monitoring or supervisory arrangements, with accountability to the College for full compliance with the arrangements and for completing all examinations as required.

The issuance of a restricted certificate of registration is subject to the following conditions:

1. The physician must practice with a supervisor until s/he has completed all outstanding examinations.
2. The restricted certificate of registration will expire within a reasonable number of years, not to exceed three years from the date that the restricted certificate of registration is issued; if
 - a. the candidate does not successfully complete all outstanding MCC examinations; and
 - b. the candidate does not receive certification by examination by either the RCPSC or by the CFPC.

Candidates will not normally be considered for a renewal of their restricted certificate of registration after the expiration time, but each situation will be considered on its own merits.

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ROYAL COLLEGE
OF PHYSICIANS AND SURGEONS OF CANADA
COLLÈGE ROYAL
DES MÉDECINS ET CHIRURGIENS DU CANADA

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[Redacted]
Dr. [Redacted]
[Redacted]
[Redacted]

RECEIVED
OCT 29 2014
CPSO Registrations

October 16, 2014

Dear Doctor [Redacted],

Re: Examinations Neurology

This is further to our letter of October 1, 2014 regarding the completion of a study plan in order to regain eligibility to the Royal College examinations in Neurology.

I wish to inform you that the Royal College has accepted the proposed study plan from you and Allan S. Gordon, who will provide mentorship and supervision during the execution of this study plan and will provide the Royal College with a report by March 1, 2015.

The acceptance of this study plan grants you provisional eligibility to the Neurology examinations in 2015. You will receive the examination registration forms with instructions in December 2014, so that you can register by the deadline of February 1, 2015.

When we receive the report from your mentor that you have successfully carried out the study plan and are ready to take the examination, you will be granted full eligibility. If you are unsuccessful, or do not appear at this examination, your file will be referred back to the Credentials Unit for review to determine further eligibility.

Sincerely,

Kenneth Harris, MD FRCSC
Executive Director, Office of Education

jw

NOTE: The Royal College must have your correct mailing address, e-mail and telephone number(s) at all times.

September 30, 2014

Dr. [REDACTED]
[REDACTED]
[REDACTED]

Dear Doctor [REDACTED]:

Re: Examinations in Neurology

This is further to our letter of June 5, 2014 which advised you that you were unsuccessful following the 2014 examination in Neurology.

The Credentials Unit of the Royal College of Physicians and Surgeons of Canada has had the opportunity to review your file. It is the decision of the Credentials Unit that, as of this date, in order to regain eligibility to the certification examination in Neurology you must complete a study plan which involves the assistance of a mentor.

Study plans are a minimum of six months in duration, and must include 6 out of the 8 tools listed below.

- Practice short answer examination questions (SAQ's)
- Practice oral and objective and structured clinical examination (OSCE's)
- Discipline specific preparatory courses for examinations
- Detailed sessions set up with mentors to discuss the history/physical treatment plan for specific patients
- Participation in grand rounds
- Participation in study groups with final year residents in your specialty who are preparing for the examination
- If written communication skills are an issue, participation in a medical writing course
- If oral communication is an issue, completion of a relevant course

Your study plan must include working with a mentor who helps you tailor a study plan particular to your needs. You are responsible for finding a mentor and must provide him/her with the attached letter outlining their responsibilities. Your mentor must be certified by the Royal College and be practicing in a clinical environment in Canada. If you are unable to secure a mentor to execute a study plan you will be required to complete training at a senior level in order to regain eligibility.

Once a study plan has been created by you and your mentor, it must be submitted to the Royal College Credentials Unit for approval. Your mentor must also submit a letter indicating that s/he will assist you in completing your study plan.

If your study plan is approved, you will receive preliminary eligibility to the certification examination. Final eligibility is dependent upon written confirmation from your mentor that you have successfully completed your study plan. Your mentor must submit confirmation of

your success by March 1, 2015 in order for you to receive final eligibility to the 2015 examination.

Your study plan must be submitted for approval no later October 15, 2014. All study plans must be completed prior to the beginning of the spring examination session on April 1, 2015.

I would be pleased to comment in advance as to the acceptability of any proposed training or study plan. If you have any questions, please contact the Credentials Unit directly at 1-800-267-2320 or via email to credentials@royalcollege.ca.

The Royal College would also like to extend the possibility of being considered for the Practice Eligibility Route (PER). PER is a new route to certification for international medical graduates who are *currently practising* specialty medicine in Canada. A guide book which outlines the three step process for certification, the eligibility criteria, and includes the application forms is available on our website:

http://www.royalcollege.ca/portal/page/portal/rc/credentials/start/routes/practice_eligibility_route_specialists

Sincerely,



Kenneth A. Harris, MD, FRCSC
Executive Director, Office of Specialty Education

jw

NOTE: The Royal College must have your correct mailing address, e-mail and telephone number(s) at all times.


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EDUCATION

EXAM INFORMATION

CERTIFICATION EXAMINATION IN FAMILY MEDICINE

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[FAQs for the Certification Examination in Family Medicine](#)

[FAQs for the de-harmonization of the Certification Examination in Family Medicine](#)

ALTERNATIVE PATHWAYS TO CERTIFICATION IN FAMILY MEDICINE

EXAMINATION OF SPECIAL COMPETENCE IN EMERGENCY MEDICINE

CERTIFICATES OF ADDED COMPETENCE IN FAMILY MEDICINE

UNDERGRADUATE EDUCATION

POSTGRADUATE EDUCATION

TRIPLE C COMPETENCY BASED CURRICULUM

FOR RESIDENTS

FOR MEDICAL STUDENTS

FOR TEACHERS

Requirements for Practising Physician Eligibility

Practising physicians may qualify to sit the exam as practise eligible candidates if they meet the criteria listed in either Category A or B. Category A applies to graduates of medical schools accredited by the Liaison Committee on Medical Education (LCME), the Committee on Accreditation of Canadian Medical Schools (CACMS) or Graduates of schools of osteopathic medicine accredited by the Bureau of Professional Education of the American Osteopathic Association (AOA). Category B applies to graduates of medical schools not accredited by the organizations in Category A who are currently in full-time active family practice in Canada.

Category A

Category B

In order to be eligible to challenge the Certification Examination in Family Medicine, graduates of medical schools accredited by the Liaison Committee on Medical Education (LCME), the Committee on Accreditation of Canadian Medical Schools (CACMS) or Graduates of schools of osteopathic medicine accredited by the Bureau of Professional Education of the American Osteopathic Association (AOA) must:

1. Possess a licence in good standing to practice family medicine independently in Canada or elsewhere;
2. Be an active member in good standing with the College of Family Physicians of Canada*
3. Have completed 12 months of relevant postgraduate medical training;
4. Have completed a minimum of five years of full-time active family practice prior to the date of application;**
5. Have been in continuous full-time active family practice for a minimum period of two years immediately preceding the date of application;
6. Remain in continuous full-time active practice and maintain their licensure through the time they sit the examination;

*Please ensure your membership fees are paid and up to date well before the exam application deadline since membership payments can take up to 72 hours to process, you will not have access to the exam application if you have outstanding membership fees. Late exam applications will not be considered.

**Physicians wishing to apply for the Certification Examination in Family Medicine, who have had interruptions in their practice during the five-year period leading up to the date of application may still qualify for the examination as long as the interruption does not occur during the two-year period immediately preceding the date of application. Depending on the chronology and the duration of the interruption and the total number of years in practice, additional time in practice may be required to qualify for the examination.

**Relevant postgraduate training may be counted as equivalent to years in practice.

Credit for training towards practice

Individuals who have successfully completed postgraduate training in Canada or elsewhere in family medicine, emergency medicine, obstetrics and gynecology, pediatrics, surgery, internal medicine or psychiatry which is over and above the 12-month postgraduate training requirement may receive not more than three years of credit for this training towards the five-year, full-time active practice requirement. For purposes of practice eligibility each year of additional training will be accepted as follows:

a. For individuals who have attended a CFPC or an ACGME accredited family medicine residency program, each full year of additional training is equivalent to two years in full-time active practice with no maximum.

b. For individuals who have attended a family medicine residency program not accredited by CFPC or ACGME, each full year of additional training is equivalent to one year in full-time active practice up to a maximum of two years.

Appendix C

c. For individuals with training experience in emergency medicine, obstetrics and gynecology, pediatrics, surgery, internal medicine or psychiatry, each full year of additional training is equivalent to one year of full-time active practice up to a maximum of two years. Individuals who have completed their training in other disciplines or programs may apply to the Board of Examiners for recognition of their training toward meeting this requirement.

No credit will be granted for any additional training that is incomplete, unsuccessful or less than a full year in duration.

As part of the application process, all Category A candidates are required to:

1. Provide references from two colleagues who are licensed and in good standing in the same jurisdiction as the applicant. They should have known the applicant for at least two years. At least one letter of support must be from a member of the CFPC who holds certification in family medicine;
2. Complete a pre-certification program ([Pearls.ce](#)) within two years prior to sitting the examination. This program is a process independent of the application to sit the examination and will include a fee. Further information about [Pearls.ce](#) can be obtained from the Department of Education at the CFPC.
3. Provide verification of registration or licensure for each medical regulatory authority in which they hold a certificate of registration or licence authorizing independent practice.

Limits on Eligibility

Practice eligibility expires after three failed attempts on the full Certification exam or three years after the completion of the pre-certification program ([Pearls.ce](#)), but in no circumstance shall it extend for more than three years.

In order to maintain eligibility, all candidates must maintain a full unrestricted licence to practice family medicine in Canada and they must remain in continuous full-time active family practice, consistent with their category of eligibility.

Candidates must successfully complete both the written (SAMP) and the oral (SOO) components of the exam to be awarded Certification in Family Medicine (CCFP).

All candidates must initially take the entire examination.

If candidates are unsuccessful on both components of the exam, they will be required to repeat the full exam on a subsequent attempt.

If candidates are unsuccessful on one of the two exam components, they may retake that component up to three times before they will be required to repeat the entire examination.

If a candidate's eligibility expires, the candidate will be permitted to re-apply to sit the examination and will be expected to meet the practice eligible criteria in place at the time of application.

Candidates who requalify following expired eligibility, will be required to start a new eligibility cycle by initially taking the entire examination.

Pre-certification Program ([Pearls.ce](#))

The pre-certification program ([Pearls.ce](#)) is a variation on the Pearls program of the College which involves the completion of a series of three literature searches about topics arising out of your own practice experience. The purpose of the [Pearls.ce](#) is to introduce practicing physicians to the basic concept of evidence based family medicine. It is intended as educational and not a pass/fail activity, however, it is a requirement that you complete the program in order to qualify for the exam. You will receive a kit of instructions and background materials to get you started with the program. To assist you in the completion of these exercises, you will have access to a tutor who will work with you and who will assess your completed work. You will be asked to complete three to five exercises involving literature searches related to critical questions arising out of your own practice. Upon reviewing the first three exercises, your tutor will determine whether or not an additional one or two exercises is required for you to attain the objectives of the program. The program provides a unique opportunity for you to work closely with an expert in evidence-based family practice and will give you a chance to reflect critically on your practice as you prepare for the examination.

Apply for Examination

Appendix C

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THE COLLEGE OF
FAMILY PHYSICIANS
OF CANADA



LE COLLÈGE DES
MÉDECINS DE FAMILLE
DU CANADA



We comply with the
HONcode standard
for trustworthy health
information:
verify here.

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Appendix D

The policy permits the issuance of a time-limited, restricted certificate to physicians who are missing Medical Council of Canada Qualifying Examination Parts 1 and 2 , and/or Royal College of Physicians and Surgeons of Canada or College of Family Physicians of Canada certification, but are officially eligible to take these examinations. The Registration Committee may direct the Registrar to issue a restricted certificate of registration, to individuals who have provided the College with proof of:

- i. having completed the certification exam of the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada, but who have not yet completed parts 1 and 2 of the MCCQE, or
- ii. being currently eligible without pre-condition to take the certification exam of the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada. The individual may or may not have yet completed Parts 1 & 2 of the MCCQE.

Candidates who are issued a restricted certificate of registration based on this policy will only practise in prescribed circumstances under monitoring or supervisory arrangements, with accountability to the College for full compliance with the arrangements and for completing all examinations as required.

The issuance of a restricted certificate of registration is subject to the following conditions:

1. The physician must practice with a supervisor until s/he has completed all outstanding examinations.
2. The restricted certificate of registration will expire within a reasonable number of years, not to exceed three years from the date that the restricted certificate of registration is issued; if
 - a. the candidate does not successfully complete all outstanding MCC examinations; and
 - b. the candidate does not receive certification by examination by either the RCPSC or by the CFPC.

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



COUNCIL BRIEFING NOTE

December 2016

TOPIC: CONSULTATION REPORT ON PROPOSED CHANGES TO OHPIP STANDARDS – ACCOUNTABILITY OF MEDICAL DIRECTOR, STAFF QUALIFICATIONS, INFECTION CONTROL, AND QUALITY ASSURANCE

FOR DECISION

ISSUE:

- The proposed changes to the Out of Hospital Premises Inspection Program (OHPIP) Standards were circulated for external consultation between May 31, 2016 and August 12, 2016.
- Council is provided with a report on the external consultation, as well as some additional changes to the final draft Standards.
- The changes focus on increasing the responsibilities and duties of the Medical Director role in Out-of Hospital Premises (OHPs). Additional sections of the OHPIP Standards that reference the role of the Medical Director were also updated.
- Council is asked whether it approves the revised Standards ('Appendix A').

BACKGROUND:

- A Working Group, consisting of Premises Inspection Committee (PIC) members, CPSO staff (OHPIP, Investigations and Resolutions, CPSO legal counsel, and project coordinator), was convened to consider ways to increase the accountability of the Medical Director role in Out-of-Hospital Premises.
- This work was undertaken in response to a number of concerns raised specific to the accountability associated with this role:
 1. *Absenteeism* – a Medical Director may not always be physically present at the OHP with which he or she is affiliated.



2. *Restricted Certificate (not same functional specialty/under supervision)*– a Medical Director may hold a restricted certificate which limits his or her scope of practice to an area of medicine that is not associated with the type/scope of procedures being performed at the OHP.

In other cases, a Medical Director may hold a Restricted certificate of registration that is at odds with the Medical Director role, e.g. a physician who holds a Restricted certificate of registration that requires him or her to be supervised (pathway 4), and yet is a Medical Director.

3. *Authority for Appropriate Patient Selection/Admission* – Does the Medical Director have the medical specialty background to appropriately select/approve patients for procedures being performed?
 4. *Infection Prevention and Control* – Is it practical for the Medical Director to have responsibility for infection control and prevention practices of OHP clinic staff? How does he or she verify that infection prevention and control procedures are being followed?
 5. *Corporate Ownership* – often a corporation will appoint a Medical Director in name only, i.e. there is minimal follow-up/lack of accountability when a lapse or adverse event occurs.
 6. *Different Specialties working in OHP* – How does the Medical Director who is certified in one specialty (e.g. plastic surgeon) ensure that he or she is meeting their responsibilities in relation to another type of procedure being performed in the same OHP, e.g. interventional pain management?
- The Working Group proposed key changes to the OHPIP Standards (refer to shaded text in 'Appendix A') that enhanced the responsibilities and accountability of the Medical Director.
 - The proposed changes were approved by Council for external consultation at their May 2016 meeting.

CURRENT STATUS:

- Council is provided with a report on the consultation.



A. Report on Consultation

Consultation process

- Invitations to participate in the consultation were sent via email to a broad range of stakeholders, including the entire CPSO membership. In addition, a general notice was posted on the CPSO's website, Facebook page, and announced via Twitter. It was also published in *Dialogue* and *Patient Compass* (the CPSO's public e-newsletter, formerly *Noteworthy*).
- A [consultation-specific page](#) was created, giving stakeholders the option of submitting their feedback in writing, via email or regular mail, or by posting comments to an online discussion page.
- The consultation was held between May 31st, 2016 and August, 12th, 2016.

Number of responses

- The CPSO received a total of 15 consultation feedback responses on the consultation specific discussion page. 11 physicians and 4 organizations responded.

Feedback

- All [written feedback](#) received during the consultation was posted on the CPSO website in keeping with regular consultation processes and posting guidelines.
- Stakeholders provided feedback on a variety of issues relating to the proposed changes to the OHPIP Standards. A summary of the key comments received is set out below.

General Comments

Support for the changes

- Generally speaking, stakeholders expressed support for the proposed changes, with some suggestions for change.



General Feedback

- Some physician stakeholders noted that some of the CPSO expectations were either: vague, too burdensome, or unfair.

Requests for Clarification or Additional Detail

- Clarity or additional detail was sought on a number of issues, including notification of Acting Medical Director, “Fail” outcome when not communicating in a timely manner with the CPSO, restricting Medical Directors who are under investigation, and defining high risk patients.

Substantive Comments

Professional Liability Protection

- Stakeholders encouraged an addition to the Standards document to clearly encourage proper liability protection by the Medical Director, the OHP owner and all healthcare professionals working at the OHP. (*Ontario Trial Lawyers Association, Canadian Medical Protective Association*).

Medical Director Subject to Proceedings

- A number of stakeholders expressed that the exclusion criteria for Medical Director was vague, inconsistent and unfair. The CMPA suggested the disqualification criterion and reporting obligation be limited to physicians who have been referred to the College’s Discipline or Fitness to Practice Committee.
- Physician stakeholders suggested that the exclusion criteria should be applied to both existing and future Medical Directors.

B. Revisions in Response to Feedback

- All of the feedback has been carefully reviewed, and was considered in the development of the latest draft OHPIP Standards (‘Appendix A’).
- All revisions reflect input of the Premises Inspection Committee, CPSO staff (OHPIP program staff, Investigations and Resolutions staff, legal, and senior management), and Executive Committee.



Key revisions

- In response to the feedback, minor wording changes were made to improve clarity, including the following additional revisions:
 - Medical Director Responsibilities
 - Removed the provision that prevents Quality Assurance responsibilities from being delegated. If a Medical Director has delegated all other responsibilities to an Acting Medical Director, there is no reason why he or she should not delegate the Quality Assurance responsibilities as well.
 - Inspection-Assessment Process
 - Wording was revised to provide the CPSO with flexibility on how it enforces OHP submission deadlines.
 - Appointment of Acting Medical Director
 - There is now flexibility in terms of who can appoint an Acting Medical Director, i.e. in case if the Medical Director is unable to appoint an Acting MD (due to illness, death, etc.).
 - An Acting Medical Director is now deemed to be the “Medical Director” in the CPSO’s view if he or she is in the role for more than three months – unless otherwise directed by CPSO”. Built in flexibility in wording to allow for circumstances where the CPSO is asked for an extension on the 3 months. This wording prevents a physician from being appointed in a temporary capacity indefinitely.
 - Urgent Transfer of Patients
 - Given the removal of item b) “A regulated health professional staff member should accompany the patient during transfer”, item a) was strengthened to incorporate what was removed, as follows:

"The patient must be transferred by appropriate transportation service; in most cases, this would mandate transfer by ambulance. It is expected that the most-responsible physician (MRP) will exercise clinical judgement on a case-by-case basis to determine 1) whether transfer by ambulance is required, and 2) whether a regulated health professional or another staff member should accompany the patient during the transfer."



Item b) under “Urgent Transfer of Patients” was originally removed because it was felt that in some situations it would be too onerous to send a member of staff (RHP) from the OHP with the patient if a transfer occurs. This could leave OHPs which have minimal staff in a position of not being able to care for the other patients in the facility if a nurse/physician was to accompany the patient on transfer to hospital.

- Professional liability
 - This section was reworded “The Medical Director is responsible for ensuring that the OHP staff who are members of regulated health professionals have “professional liability protection required by their regulatory body” in place of “adequate insurance”. Examples were removed as they were confusing.
- OHP Medical Director Qualifications
 - The language was modified to suggest that the OHP “may” be required to appoint a substitute Medical Director – at the discretion of the CPSO. This change was made, in part, to address concerns raised by the CMPA.

Feedback that was not addressed in revisions

Fail Outcome isn’t a Strong Enough Deterrent

- One stakeholder suggested a financial penalty should be in place in addition to a “Fail” designation. The added financial accountability will provide a stronger deterrent to for-profit OHPs. (*Ontario Trial Lawyers Association*)
 - CPSO response: CPSO has the authority to recover costs for any additional OHP inspections that are required outside of the regular review cycle, including inspections completed as follow-up to a “fail” outcome. Therefore, the existing cost recovery principle within the program supports this feedback related to financial accountability.



Failing to Provide Information

- Some stakeholders agreed that OHPs should communicate openly and quickly with the CPSO with respect to information such as adverse events. However, they were concerned that QMP requests for data shouldn't fall under the same umbrella for information requests as there is an extra administrative and financial burden on the OHP to provide that information. (*Ontario Association of Gastroenterology, Physician Members*)
 - CPSO response: Participation in the QMP is not optional and the changes made to the role of the Medical Director reiterate the requirement for premises to participate.

Education

- The Ontario Trial Lawyers Association recommended that physicians who wish to assume the role of Medical Director, but do not have any prior senior administrative experience, take a course operated by the CPSO to provide them with the skills necessary to safely operate an OHP.
 - CPSO response: Once the OHPIP Standards are finalized CPSO will host an educational symposium for Medical Directors to better communicate the changes and increased requirements.

NEXT STEPS:

- Should Council approve the revised OHPIP Standards, all OHPs (including Medical Directors and assessors), as well as stakeholders who responded to the consultation will receive notification of the updated OHPIP Standards. Stakeholders who provided significant feedback will be sent a letter thanking them for their participation in the consultation process.
- Based on the revisions made to the Standards, relevant assessment tools will be developed to guide the OHPIP inspection of these premises. OHPs will be given time to incorporate the revisions into their practice prior to being assessed.



DECISION FOR COUNCIL:

1. Does Council have any feedback on the draft OHPIP Standards?
 2. Does Council approve the revised OHPIP Standards and that they can be communicated to stakeholders?
-

CONTACT: Shandelle Johnson, extension 401
Kavita Sharma, extension 375
Wade Hillier, extension 636
Dr. Steven Bodley

DATE: November 8, 2016

Appendices: Appendix A - "DRAFT OHPIP Standards" – Changes to Sections: 2 (OHP Background, including CPSO and Medical Director Responsibilities); 5 (OHP Staff Qualifications); 7 (Infection Control) and 8 (Quality Assurance)

2 OHP Background

In April 2010, Regulation 114/94 provided a 60-day window for all CPSO members performing or assisting in procedures in Out-of-Hospital Premises (OHPs) to notify the College. By June 2012, all premises that existed prior to June 2010 had their inspection-assessment completed. New premises or relocating premises continue to be inspected within 180 days of notification.

Ontario Regulation 114/94¹, made under the **Medicine Act**, 1991 is amended by adding the following:

Part XI: Inspection of Premises and Equipment.

Out-of-Hospital Premises (OHP) means any non-hospital site at which a physician engages or proposes to engage in:

- (a) any act that, when performed in accordance with the accepted standard of practice on a patient, is performed under the administration of,
 - (i) general anesthesia,
 - (ii) parenteral sedation, or
 - (iii) regional anesthesia, except for a digital nerve block; and,
- (b) any act that, when performed in accordance with the accepted standard of practice on a patient, is performed with the administration of a local anaesthetic agent, including, but without being limited to,
 - (i) any tumescent procedure involving the administration of dilute, local anesthetic;
 - (ii) surgical alteration or excision of any lesions or tissue performed for cosmetic purposes,
 - (iii) injection or insertion of any permanent filler, autologous tissue, synthetic device, materials or substances for cosmetic purposes;
 - (iv) a nerve block solely for the treatment or management of chronic pain; or
 - (v) any act that, in the opinion of the College, is similar in nature to those set out in subclauses (i) to (iii) and that is performed for a cosmetic purpose;

but does not include,

- (c) surgical alteration or excision of lesions or tissue for a clinical purpose, including for the purpose of examination, treatment or diagnosis of disease, or
- (d) minor dermatological procedures including without being limited to, the removal of skin tags, benign moles and cysts, nevi, seborrheic keratoses, fibroepithelial polyps, hemangioma and neurofibromata.

¹ Please refer to Appendix 1 for a complete reference to the Regulation.

2.1 CPSO Responsibilities

CPSO is responsible to consider all issues related to the provision of anesthesia/sedation and procedural services within OHPs. The Out-of-Hospital Premises Inspection Program is overseen by the Premises Inspection Committee.

CPSO responsibilities include but are not limited to:

- 1) developing and maintaining “OHP Standards”
- 2) conducting inspection-assessments of the premises and medical procedures to ensure that services for patients are provided according to the standard of the profession
- 3) determining the outcome of inspection-assessments
- 4) maintaining a current public record of Inspection Outcomes (on the CPSO website).

2.1.1 Maintaining the “OHP Standards”

CPSO:

- 1) reviews the “OHP Standards” within a five year cycle, or as required, at the discretion of the Premises Inspection Committee
- 2) prepares revisions of the Standards and associated inspection-assessment tools
- 3) coordinates approval of revisions through an established external review process
- 4) makes revisions available to all relevant parties
- 5) issues notices for payment of OHP fees.

2.1.2 Conducting the Inspection-Assessment

1. **Timeframe:** The timeframe for conducting the inspection-assessment differs for new and existing OHPs.

For:	Inspection-assessment conducted:
CPSO members <i>planning</i> to use a premises for the purpose of performing procedures as defined by O. Reg. 114/94	within 180 days of CPSO receiving the CPSO member’s notice

2. **Process:** The inspection-assessment may involve but is not limited to:
 - 1) completion of the on-line notification process
 - 2) completion of a pre-visit visit questionnaire
 - 3) a site visit by a team of healthcare professionals including one or more physicians (with expertise in the appropriate area of medical practice) appointed by CPSO that includes:
 - a review of records and other documentation
 - observation of procedures performed at the OHP
 - review of the OHP's compliance with accepted standards
 - review of any other material deemed relevant to the inspection-assessment
 - 4) enquiries as may be relevant.
3. **Reports:** OHP assessors provide OHP inspection-assessment reports to CPSO; the CPSO provides a copy of the inspection-assessment report to all members performing procedures in the OHP.

2.1.3 Determining the Outcome of the Inspection-Assessment

1. The **Premises Inspection Committee** is responsible, as outlined in the Ontario Regulation 114/94, for determining the inspection-assessment outcome; see Table 01.

Table 01: Inspection-Assessment Outcomes

Note: Deficiency is anything that can negatively impact the safe and effective provision of medical services for patients.

Outcome	Comments
Pass	<p>“OHP Standards” are met for the specific procedures identified by the OHP at the time of the inspection-assessment; no deficiencies are identified.</p> <p>Note: If a “passed” OHP wishes to add procedures, CPSO must be notified of the intent and conduct an inspection before the new procedures may be performed.</p>
Pass with Conditions	<p>Deficiencies are identified.</p> <ol style="list-style-type: none"> 1) The OHP may be restricted to specific procedures. 2) The OHP may make submissions in writing to CPSO within 14 days of receiving the report. 3) A follow-up inspection-assessment may be conducted at CPSO’s discretion within 60 days of receiving the OHP written submission. 4) A “Pass” will be assigned when deficiencies have been corrected to CPSO’s satisfaction.
Fail	<p>Significant deficiencies are identified.</p> <ol style="list-style-type: none"> 1) The CPSO member(s) cease(s) performance of all procedures. 2) The OHP may make submissions in writing to CPSO within 14 days of receiving the report. 3) A follow-up inspection-assessment may be conducted at CPSO’s discretion within 60 days of receiving the OHP written submission. 4) A “Pass” or “Conditional Pass” will be assigned when deficiencies have been corrected to CPSO’s satisfaction.

2. “Pass” and “Pass with Conditions” outcomes are considered current to a maximum of five years from the date of outcome, but inspections can occur more often if, in CPSO’s opinion, it is necessary or advisable to do so.

2.2 Medical Director Responsibilities

All OHPs must have a Medical Director. The Medical Director is the main contact for the College in relation to information about the premises. The Medical Director is responsible for all duties outlined in this document. In situations where a Medical Director is not present, an “Acting Medical Director” must be appointed. The term “Acting Medical Director” applies in the event that the OHP is being overseen by a physician other than the Medical Director (Refer to section 2.2.3). In addition to all of the duties described in this section, the Medical Director is also responsible for Infection Control (Chapter 7), and Quality Assurance (Chapter 8).

Note: With the exception of Section 8 (Quality Assurance), whenever the term “Medical Director” is used in the Standards, the term “Acting Medical Director” applies in the event that the OHP is being operated by a physician other than the Medical Director (Refer to section 2.2.3).

2.2.1 Notification to Operate a New OHP

Notification by a Medical Director planning to operate a new OHP shall be made to the CPSO. Notification is accessed through the Member’s Portal log-in on the CPSO website at <https://www.cpso.on.ca/Login.aspx>

All physicians planning to work in an OHP must complete the online Staff Affiliation form by logging in to their membership account on the College Website. Upon completion of the form, an email will be sent to confirm the notification was sent. College staff will review and email the physician when the notification is approved. A copy of this approval email should be shared with the Medical Director prior to performing procedures in an OHP.

2.2.2 Inspection-Assessment Process

The **Medical Director** must inform patient(s) prior to the scheduled inspection-assessment that an observation of the procedure may be a component of the inspection-assessment process.

The **Medical Director** is the main contact for any information related to the premises. Any reports pertaining to the inspection-assessment of an OHP are directed to the Medical Director for review and response. The **Medical Director** must respond to CPSO requests for documentation in the form and timeframe required, as follows:

- Within 24 hours for adverse events submissions (as indicated in College By-law No. 77)
- Within 14 days for regular CPSO requests, or otherwise specified timeframe as identified by the CPSO for other CPSO requests

Failure to provide the information may result in an outcome of Fail by the Premises Inspection Committee.

The **Medical Director** must ensure that patient records are established and maintained, are accurate, legible, complete, follow a consistent format, meet legislative requirements and adhere to the CPSO *Medical Records* policy; a patient record shall include, but is not limited to:

- a) Consent form(s) for the procedure and anesthetic signed by the patient or substitute decision maker/legal guardian and witnessed
- b) Pre-procedure assessment

- c) "Surgical Safety Checklist" – a modified surgical safety checklist is required for endoscopy premises.
- d) "Anesthetic/sedation Record"
- e) Notes about procedural care
- f) Notes about post-procedure care
- g) Adverse event reports as required by CPSO.

The **Medical Director** must ensure that complete records are onsite on the date of the inspection-assessment. In carrying out an inspection of a premises under the regulation, the College may require any or all of the following: Examination and copying of books, accounts, reports, records or similar documents that are, in the opinion of the College, relevant to the performance of a procedure in the practice of the member.

2.2.3 Appointment of Acting Medical Director

In the event the Medical Director is unable or unavailable to perform all of his or her duties due to illness, leave, or other circumstance, then ~~the OHP Medical Director must appoint~~ an Acting Medical Director who is acceptable to the CPSO must be appointed. An agreement must be signed by the Acting OHP Medical Director that articulates all responsibilities, with emphasis on the need to respond to CPSO requests for documentation in the form and timeframe required, as follows:

- Within 24 hours for adverse events (as indicated in College By-law No. 77)
- Within 14 days for standard CPSO requests

~~In general, t~~The CPSO encourages Medical Directors to make prior arrangements that identify Acting Medical Director(s) at each of their premises to ensure systematic coverage during absences. The Acting Medical Director is deemed to be the Medical Director of the premises if he or she is in the role for more than three months - unless otherwise directed by the CPSO.

Failure to provide the information may result in an outcome of Fail by the Premises Inspection Committee, which means that the premises can no longer provide the services under the OHPIP regulation.

All staff working at the OHP must be notified in the event an Acting Medical Director is appointed.

In addition, any change to the Medical Director must be reported to the CPSO (see 2.2.4 "Notification of Changes to OHP") within 48 hours of the change.

All of the above applies with such modifications as are necessary in the event that the Acting Medical Director is unable or unavailable to perform his or her duties due to illness, leave, or other circumstance.

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

2.2.4 Notification OHP changes to the CPSO

The **Medical Director** must notify the CPSO forthwith in writing of any OHP changes with regard to the following:

- a) Ownership of the medical practice
- b) OHP Medical Director (within 48 hours of change)
- c) Name and/or address of the OHP
- d) Structural changes to patient care areas
- e) Types of procedures or practices
- f) Physicians performing procedures or administering anesthesia (additions/deletions)
- g) Numbers of procedures performed: any significant increase/decrease (>50% of the last reported assessment)
- h) there is a new arrangement to rent space to other physicians for the performance of any surgical or anesthetic technique covered by the OHP policy and procedures.
- i) If overnight stays are permitted
- j) Decision to cease operation of the OHP.

2.2.5 Annual Declaration of Responsibilities

The **Medical Director** must review, and sign an annual declaration of his/her responsibilities, which will include agreement to:

- perform his or her duties with due diligence and in good faith;
- ensure that the OHP meets its responsibilities;
- attend and chair QA Committee meetings at the OHP at a minimum of twice per year;
- ensure staff qualifications are current;
- ensure policies and procedures are reviewed and updated when necessary, and in accordance with relevant standards and guidelines including, but not limited to, the CPSO OHPIP Standards, updates to the Provincial Infectious Diseases Advisory Committee's (PIDAC) Infection Prevention and Control for Clinical Office Practice, Malignant Hyperthermia Association of the United States (MHAUS), etc.

2.2.6 OHP Policies and Procedures

1. The Medical Director is responsible for the regular review, update, and implementation of OHP policies and procedures, which must address the following areas:

2.2.6.1.1 Administrative:

- a) responsibility for developing and maintaining the policy and procedure manual
- b) organizational chart
- c) scope and limitations of OHP services provided
- d) overnight stays, if applicable.
- e) ensuring that records are kept for each RHP working in the OHP are current and include qualifications, relevant experience, and relevant hospital privileges as appropriate to the RHP.
- f) ensuring all physicians performing OHP procedures at the premises have provided online notification to satisfy the regulation requirements (see section 2.2.1), and documentation verifying approval (emails from College staff) is on file.

2.2.6.1.2 General Response to Emergencies:

Each OHP shall have a policy on management of relevant emergency situations, including, but not limited 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.

2.2.6.1.3 Urgent Transfer of Patients:

The OHP must have an established procedure to facilitate the urgent transfer of patients to the most appropriate acute-care hospital for the management of an urgent- adverse patient event; it should include the following:

- a) The patient must be transferred by appropriate transportation service; in most situations this would mandate transfer by ambulance. It is expected that the most-responsible physician (MRP) will exercise clinical judgement on a case-by-case basis to determine 1) whether transfer by ambulance is required, and 2) whether a regulated health professional or another staff member should accompany the patient during the transfer.
- ~~b) A regulated health professional staff member should accompany the patient during the transfer~~
- be) The most-responsible physician (MRP) ensures that essential medical information is sent with the patient (e.g., pre-op history, ECG strips, OR record, anesthesia record, consultation note); however, this information must not delay transfer
- ce) The MRP, if not accompanying the patient, must contact the receiving physician/premises immediately, by phone or in person. No other means of communication will be deemed sufficient
- de) If the MRP refers the patient to 1) a specialist or 2) other physician, the MRP must contact the specialist/other physician, by phone or in person, to ensure continuity of care.
- ef) The MRP must complete an adverse event report (see Section 8.1.2).

2.2.6.1.4 Job Descriptions:

- a) OHP staff job descriptions that define scope and limitations of functions and responsibilities for patient care
- b) responsibility for supervising staff.

2.2.6.1.5 Procedures:

- a) Adverse events: monitoring, reporting, and reviewing
- b) Adverse events: response to an adverse event
- c) Combustible and Volatile Materials
- d) Delegating controlled acts
- ~~e) Emergency evacuation~~
- f) Equipment: routine maintenance and calibration
- g) Infection control, including staff responsibilities in relation to the *Occupational Health and Safety Act*
- h) Medications handling and inventory
- i) Medical Directives
- j) Patient booking system

k) Detailed and clear patient selection/admission/exclusion criteria for services provided at the OHP

l) Patient consent (written or verbal) based on the scope of the OHP practice

m) Patient Preparation for OHP procedures

n) Response to Latex Allergies

o) Safety precautions regarding electrical, mechanical, fire, and internal disaster.

p) Urgent transfer of patients (see Section 6.5)

q) Waste and garbage disposal

2.2.6.1.6 Forms used

2.2.6.1.7 Inventories/Lists of equipment to be maintained

2.2.6.1.8 External (non-OHP) policies: as determined to be necessary by each OHP.

2. The **Medical Director** shall ensure that all staff:

a) read the P&P manual upon being hired, and confirm action with signature and date

b) review the P&P manual annually, and confirm action with signature and date

c) read their individual job descriptions of duties and responsibilities, and sign and date, indicating they have been read and understood.

3. The Medical Director is responsible for ensuring that OHP staff who are members of regulated health professions have professional liability protection required by their regulatory body, adequate insurance in place, e.g., Directors & Officers, Errors & Omissions, and general liability. Physicians need to have professional liability protection in accordance with CPSO bylaws.

2.2.7 CPSO Policies/Procedures & Regulations

The Medical Director is responsible for ensuring all CPSO policies and procedures, as well as applicable laws including Ontario Regulations enacted pursuant to Statute, are adhered to in the operation of the premises.

5 OHP Staff Qualifications

1. It is expected that physicians will manage medical and surgical conditions within the scope of their specialty training, certification and experience.
2. All staff ~~other than anesthesiologists who are Royal College certified~~: 1) who administer sedation, regional anesthesia, or general anesthesia; or 2) who monitor or recover such patients; must maintain a current ACLS certification.
Note: Basic (BLS), advanced (ACLS) or paediatric (PALS) life-saving training, as referenced in these standards, includes certification in both theory and hands-on components³.
3. If services are provided to infants and children, staff must be trained to handle paediatric emergencies and maintain a current PALS certification.
4. Physicians who do not meet OHP Physician Qualification standards must successfully complete a Change in Scope of Practice application process, which may include the necessity to demonstrate education, training, and/or competency in the area of practice. This may include physicians who are currently engaged in a CPSO approved change in scope of practice process.
5. Qualifications of all regulated health professionals (RHPs) must meet requirements of their respective regulatory college, and they must practice within their scope of practice.

Note: Change in Scope of Practice. For any Change in Scope of Practice requests from physicians that involve procedures or anesthetic in Out-of-Hospital Premises, the College's Quality Assurance Committee will provide oversight to the decision regarding the suitability of the request. The College may (based on the nature of the request) establish training and supervision requirements that must be completed before a final assessment is conducted to formally approve the physician in his/her new scope of practice.

5.1 OHP Medical Director Qualifications

A physician who is applying to become a The Medical Director must hold a valid CPSO certificate of registration and must **not** be the subject of any disciplinary or incapacity proceeding in any jurisdiction.

If, during the course of serving as a Medical Director, the Medical Director becomes the subject of a disciplinary or incapacity proceeding, the Medical Director must inform the Out-of-Hospital Premises program staff at the CPSO, and may be required to appoint a substitute Medical Director at the discretion of the CPSO. The Medical Director may only resume the role upon CPSO approval.

The OHP must have a Medical Director appointed at all times. Failure to have an appointed Medical Director will result in an outcome of Fail.

5.2 Physician Performing Procedures Qualifications

All physicians who perform procedures using local anesthesia in OHPs, as set out in O. Reg. 114/94, shall hold:

- 1) Valid CPSO certificate of registration
and
 - 2) **One** of the following:
 - a) RCPSC or CFPC 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 “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, *Changing Scope of Practice*). This may include physicians who are currently engaged in a CPSO approved change in scope of practice process.
-

Physician Administering Anesthesia Qualifications

5.3 Physicians Administering General Anesthesia

Physicians administering general anesthesia shall hold:

- 1) Valid CPSO certificate of registration
and
 - 2) RCPSC designation as a specialist in anesthesia **OR one** of the following:
 - a) Completion of a 12-month rotation in a program accredited by the College of Family Physicians of Canada (CFPC) under the category of “Family Medicine Anesthesia”.
 - b) CPSO recognition as a specialist in anesthesia as confirmed by CPSO “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 CPSO policy, *Changing Scope of Practice*). This may include physicians who are currently engaged in a CPSO approved change in scope of practice process.
-

5.4 Physicians Administering Regional Anesthesia

Physicians administering regional anesthesia shall hold:

- 1) Valid CPSO certificate of registration
and
 - 2) **One** of the following:
 - a) RCPSC designation as a specialist in anesthesia.
 - b) Completion of a 12-month rotation in a program accredited by the College of Family Physicians of Canada (CFPC) under the category of “Family Medicine Anesthesia”.
-

- c) CPSO recognition as a specialist in anesthesia, or other specialty pertinent to the regional anesthesia performed, as confirmed by CPSO “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 CPSO policy, *Changing Scope of Practice*). This may include physicians who are currently engaged in a CPSO approved change in scope of practice process.

5.5 Physicians Administering Sedation

1. Physicians qualified for administering general anesthesia are considered qualified to administer deep sedation.
2. Physicians administering deep sedation must hold 1) qualifications to administer general anesthesia (Section 5.3.1) or 2) approval according to CPSO policy, *Changing Scope of Practice*.
3. Physicians **not** qualified for administering general anesthesia or deep sedation, but administering minimal-to-moderate sedation, shall hold:
 - a) Valid CPSO certificate of registration
 - b) Education and experience to manage the potential medical complications of sedation/anesthesia, including ability to 1) identify and manage the airway and cardiovascular changes which occur in a patient who enters a state of general anesthesia, 2) assist in the management of complications, and 3) understand the pharmacology of the drugs used, and
 - c) Current ACLS certification, and PALS certification if providing care for patients fourteen (14) years and younger.

5.6 Nurse Qualifications

1. Registered nurses (RNs) and registered practical nurses (RPNs) working within their scope of practice in OHPs must hold:
 - a) current registration with the College of Nurses of Ontario
 - b) additional training and appropriate experience as required for procedures performed
 - c) current BLS certification
 - d) must have current ACLS if administering sedation to, monitoring or recovering patients (RNs only).
2. Registered Nurses (RNs) working with a pediatric population (14 years and younger), who are involved in monitoring, administering sedation or recovering patients must maintain a current PALS certification.

5.7 Other Staff Qualifications

Staff from other regulated health professions must be adequately trained and registered with their regulatory body.

Staff responsible for the sterilization and reprocessing of medical equipment must be adequately educated and trained. Please contact the College for an approved list of courses specific to reprocessing and sterilization in an OHP.

7 Infection Control

The CPSO, in partnership with Public Health Ontario (PHO), have developed accepted standards of practice for OHPs and physician offices for infection control. The document can be found at the following link: www.publichealthontario.ca/ClinicalPractice

The Medical Director is responsible for compliance with the requirements set out in the Provincial Infectious Diseases Advisory Committee (PIDAC) document. He or she is also responsible for ensuring periodic reviews of the CPSO and PHO website documents by the Medical Director, staff and physicians working in the OHP. All OHP staff, including the Medical Director must stay current with standards for infection prevention and control. The Medical Director is responsible for ensuring implementation and compliance by all physicians and staff of the OHP with the PHO requirements.

OHPs shall adhere to the following:

- 1) Accepted standard(s) of infection control practices that are pertinent to the specific procedures performed at the OHP.
- 2) The *Routine Practice* approach to infection control. According to the concept of Routine Practices, all human blood and certain human body fluids are treated as if known to be infectious for HIV, HBV and other blood borne pathogens.
- 3) Actions that minimize risk of infection in the operating room:
 - a) adherence to proper use of disinfectants
 - b) proper maintenance of medical equipment that uses water (e.g., automated endoscope reprocessors)
 - c) proper ventilation standards for specialized care environments (i.e., airborne infection isolation, protective environment, and operating rooms)
 - d) prompt management of water intrusion into OHP structural elements.
- 4) Accepted standards of handling regulated waste.

“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.

8 Quality Assurance (QA)

The Medical Director is responsible for OHP compliance with external regulatory requirements including all Acts relevant to the practise of Medicine¹, including the CPSO OHP Standards, Companion documents to the Standards, and other guidelines, such as, the Provincial Infectious Diseases Advisory Committee's (PIDAC) *Infection Prevention and Control for Clinical Office Practice*, Malignant Hyperthermia Association of the United States (MHAUS), etc. The Medical Director is also individually responsible for OHP compliance with all internal CPSO policies, guidelines and directives within their Policy and Procedure Manual.

The Medical Director is responsible for appointing other individuals as necessary to **assist** with OHP staff compliance with policies and procedures set out by the Medical Director, especially as it relates to monitoring and reporting on the quality of anesthetic and surgical procedures.

OHP Quality Assurance Committee

Each OHP must have a Quality Assurance (QA) committee for the purpose of creating processes to establish standards, monitor activity, and improve performance so that the care provided will satisfy requirements as appropriate to the volume and scope of service provided.

The Medical Director must attend and chair, at a minimum, two QA Committee meetings at each OHP site, per year. Meetings must include representation from all staff providing patient care for every type of anesthetic or surgical procedure. All meetings must be documented. The documentation of the QA Committee meetings must be available upon request by the Premises Inspection Committee and be available for OHP assessors to review.

At minimum, every QA Committee meeting must address the following topics:

- 1) Reports on Quality of Care for each service (8.1)
- 2) Infection Control– duties as set out in Section 7
- 3) Adverse Events
- 4) Staffing credentials

8.1 Monitoring Quality of Care

The purpose of monitoring activity is to identify problems and frequency, assess severity, and develop remedial action as required to prevent or mitigate harm from adverse events.

Monitoring OHP Activity

The OHP must have a documented process in place to regularly monitor the quality of care provided to patients. These activities include, but are not limited to, the following:

- 1) Review of non-medical staff performance
- 2) Review of individual physician care to assess
 - a) patient and procedure selection are appropriate
 - b) patient outcomes are appropriate
 - c) adverse events (see 8.2)

¹ RHPA, Medicine Act, etc.

The suggested protocol is, annually, random selection of 5-10 patient records to review:

- i) record completion and documentation of informed consent
 - ii) percentage and type of procedures
 - iii) appropriate patient selection
 - iv) appropriate patient procedure
 - v) where required, reporting results in a timely fashion
 - vi) evaluation of complications (see 8.2)
 - vii) assessment of transfer to hospital, where required
 - viii) follow up of abnormal pathology and laboratory results
- 3) Review a selection of individual patient records to assess completeness and accuracy of entries by all staff
 - 4) Review of activity related to cleaning, sterilization, maintenance, and storage of equipment
 - 5) Documentation of the numbers of procedures performed: any significant increase/decrease (>50% of the last reported assessment).

8.2 Monitoring and Reporting Adverse Events

1. All OHP staff must monitor adverse events. Indicators of adverse events generally include complications related to the use of sedation/anesthesia or to the procedure.
2. Every member who performs a procedure in an OHP shall report the following events to the College within 24 hours of learning of the event. These events are termed 'Tier 1 Events' to denote the potential serious nature of the event and the need to prevent a recurrence.

Tier 1 events are:

- a) Death within the premises;
 - b) Death within ten (10) days of a procedure performed at the premises;
 - c) Any procedure performed on the wrong patient, site or side; or,
 - d) Transfer of a patient from the premises directly to a hospital for care.
3. Members performing procedures in an OHP are required to document other quality assurance incidents (Tier 2) which are deemed less critical for immediate action. The premises' QA Committee and the Medical Director must submit Tier 2 events to the College after review (on an annual basis). Failure to do so may result in an outcome of Fail by the Premises Inspection Committee.

Tier 2 events include, but are **not limited to**:

- a) unscheduled treatment of a patient in a hospital within ten(10) days of a procedure performed at a premises
 - b) complications such as infection, bleeding or injury to other body structures
 - c) cardiac or respiratory problems during the patient's stay at the OHP
 - d) allergic reactions
 - e) medication-related adverse events
4. All OHP staff should report adverse events as follows:
 - 4.1 The member **must** report Tier 1 adverse events (see above) to the Medical Director and to the College in writing within 24 hours of learning of the event using the form provided on the College website. To access the form, the reporting physician must log in to his/her CPSO member portal on the CPSO website at <https://www.cpso.on.ca/Login.aspx>

4.2 Death occurring within the OHP **must** also be reported to the coroner.

4.3 The member should report in writing any Tier 2 adverse event (see above) to the Medical Director within 24 hours of the event.

The written report should include the following:

- a) name, age, and sex of the person(s) involved in the incident; includes staff and patients
- b) name of witness(es) to the event (if applicable)
- c) time, date, and location of event
- d) description of the incident and treatment rendered
- e) date and type of procedure (if applicable)
- f) analysis of reasons for the incident
- g) outcome.

Note: OHPs should identify and adhere to quality indicators specific to procedures performed in their premises.

8.3 Review of Adverse Events and other QA Monitoring Activities

The Medical Director **must**:

- 1) Review all adverse events reports and QA monitoring findings occurring over a 12-month period
- 2) Document the review and any relevant corrective actions and quality improvement initiatives taken
- 3) Provide feedback to all staff regarding identified adverse events.

COUNCIL BRIEFING NOTE

TOPIC: Opioid Update

CPSO

1. Narcotics Monitoring System (NMS)
2. Dialogue

Provincial

3. Minister's Strategy to Prevent Opioid Addiction and Overdose
4. Ontario Drug Policy Research Network (ODPRN)

National

5. Health Canada: Action on Opioid Misuse
6. Minister's Conference and Summit
7. ePrescribing
8. Opioid Guidelines

FOR INFORMATION/DISCUSSION

ISSUE

There has been continued attention focussed on opioid issues by media and government. This briefing note summarizes recent developments and the current status of on-going opioid work at the CPSO.

CPSO ACTIVITIES

1. Narcotics Monitoring System (NMS)

The NMS is a database which includes all monitored drugs that have been dispensed to Ontario patients. The database is not accessible to physicians or pharmacists. Pharmacists receive alerts in limited circumstances¹.

The *Narcotics Safety and Awareness Act* (NSAA) enables the Ministry of Health (MOH) to send information to the CPSO. However, the circumstances in which information is sent to

¹ 1) double-doctoring: 3 or more prescribers within past 28 days, 2) polypharmacy: 3 or more pharmacies in past 28 days, 3) refill too soon, 4) fill/refill too late and 5) duplicate drug other pharmacy.

the CPSO are not set out in the Act. The CPSO has been working with the Drug Programs Branch at the MOH to set out thresholds for referring information to the CPSO.

Most recently, the CPSO and MOH developed the following threshold, resulting in information being sent to us relating to physicians who met the following criteria:

- 8 or more patients receiving 650 OME/day; AND
- A single dispense of 20,000 OME (one opioid only).

This threshold is over 3x the watchful dose recommended by the Canadian guidelines and over 6x the dose most recently recommended by the US Centre for Disease Control.

Recent media coverage led to the release of statement from the President, which is available here <http://www.cpso.on.ca/Whatsnew/News-Releases/2016/Ensuring-Safe-Opioid-Prescribing>.

The College goal is to improve physician prescribing and minimize harm to patients where this is possible, while ensuring action is taken when necessary.

2. Dialogue

The recent Dialogue magazine included multiple articles about opioids addressing the following topics:

- Opioid Use and Misuse – emphasizing the importance of focussing on function, not pain
- New rules relating to Fentanyl patches
- Abrupt Cessation – emphasizing the importance of careful tapering to avoid harm
- Naloxone

The magazine also included a letter from the Registrar which referred specifically to the opioid investigations.

PROVINCIAL

3. Minister's Strategy to Prevent Opioid Addiction and Overdose

The Minister of Health released an opioid strategy on October 12, 2016. It includes multiple actions, organized around 3 themes: Opioid Prescribing/Monitoring, Pain Treatment and Harm reduction.

A: Modernizing opioid prescribing and monitoring

- Provincial Overdose Coordinator: Dr. David Williams, Ontario's Chief Medical Officer of Health will take on this new role. Dr. Williams will work with a number of key agencies and professionals to increase access to information concerning fatal and non-fatal opioid-

related overdoses. This work will also include launching a new overdose surveillance and reporting system.

- Quality Standards: Health Quality Ontario (HQO) will be developing evidence-based quality standards for health care providers in 2 areas: Opioid Use Disorder, and Opioid Prescribing for Pain. The process for developing these standards has just begun and the standards are anticipated to be released in early 2018.
 - The CPSO will be monitoring this work and has had discussions with HQO about coordination between these standards and the revised Canadian Guideline.
- Practice Reports: Provide reports through HQO to physicians that show how their opioid prescribing compares to that of their peers and to best practices.
 - The CPSO is very supportive of this activity.
- Appropriate Prescribing: Develop new, evidence-based training modules and academic programs in conjunction with educational institutions that will provide modernized training to all health care providers who prescribe or dispense opioids.
 - The CPSO has been working closely with the University of Toronto, which offers the Safe Opioid Prescribing Program and other educational programs.
- Patient Education: Improved access to medication information, including a patient guide, for all patients prescribed opioids, to help them better understand the associated risks.
- Narcotics Monitoring System: Make NMS data readily available to health care providers, including physicians and pharmacists so they have access to up-to-date dispensed medication information for their patients when making decisions concerning opioid prescribing.
 - As noted previously, neither physicians nor pharmacists have access to NMS data. The College has consistently indicated that enabling physicians to have real-time access to medication information about patients prior to prescribing would reduce instances of double-doctoring and inappropriate prescribing.
- De-listing of High-Strength Opioids: As previously announced, high-strength formulations of long-acting opioids will be delisted from the Ontario Drug Benefit Formulary on January 1, 2017.

B: Improving the Treatment of Pain

- Chronic Pain Network: The government will invest \$17 million annually in multi-disciplinary care teams, including 17 Chronic Pain Clinics across Ontario.
- Low Back Pain Strategy: This strategy, initially announced in 2014, will be expanded. This model of care, currently available in particular communities, includes a rapid low back pain assessment within two weeks, and evidence-based management plans and educational tools to help patients manage pain.
- Chronic Pain Training: Expand training and support to primary care providers, utilizing case-based learning and video-conferencing sessions with pain, addiction and mental health experts.

C: Enhancing addiction supports and harm reduction

- Expanded Access to Naloxone: Naloxone, an antidote for opioid overdose, is now available free of charge for patients and families through pharmacies and eligible organizations. Work is also beginning to provide free naloxone kits to at-risk inmates at the time of their release from provincial correctional institutions, and to explore providing naloxone in nasal spray form to first responders.
- Expand Access to Suboxone: Effective October 11, 2016, Suboxone is available as a General Benefit on the Ontario Drug Benefit Formulary. Suboxone is seen as an effective treatment to relieve opioid withdrawal symptoms with a lower risk of overdose than methadone. Expanding access to Suboxone was a key recommendation of the Methadone Treatment and Services Advisory Committee. This work also includes enabling Nurse Practitioners to prescribe Suboxone.
- Harm Reduction: The Minister intends to work with stakeholders to develop an evidence-based harm reduction framework, which could include expanding needle exchange programs and supervised injection services.

4. Ontario Drug Policy Research Network (ODPRN)

- The ODPRN is a network of researchers, funded by the MOHLTC, who look at drug utilization, safety, effectiveness and costs of drugs in Ontario.
- In November, the ODPRN released a report on Opioid Use and Related Adverse Events in Ontario. The full report is available here <http://odprn.ca/wp-content/uploads/2016/10/ODPRN-Opioid-Use-and-Related-Adverse-Events-Nov-2016.pdf>. Interactive maps have also been released which are available here <http://odprn.ca/rates-of-opioid-use-and-related-adverse-events-in-ontario-by-county/>.
- This report is specific to opioid use by Ontario Drug Benefit (ODB) recipients. Patients can also access opioids via private insurance, cash payments or the federal public drug program.
- The report concludes that the rate of opioid users and related adverse events is high in Ontario and there is considerable variation by region. For example, the rate of opioid deaths was 4-fold higher than the Ontario average in the northern counties of Thunder Bay and Timiskaming District in 2013.

FEDERAL

5. Health Canada

Health Canada's Action on Opioid Misuse

In July, Health Canada released a document outlining its action plan relating to opioid misuse. The elements of this plan are set out below.

1. **Better informing Canadians about the risks of opioids:** new warning stickers, patient information sheets, review of best practices
2. **Supporting better prescribing practices:** promote prescription monitoring programs, examine pharmacy records, share information with PT licensing bodies, Canada Health Infoway e-prescribing solution
3. **Reducing easy access to unnecessary opioids:** contraindications for approved opioids, requiring a prescription for low-dose codeine products, mandatory risk management plans for certain opioids
4. **Supporting better treatment options for patients:** better & faster access to naloxone, expediting the review of non-opioid pain relievers, re-examining special requirements for methadone
5. **Improving the evidence base:** bringing together experts in the field to discuss how to improve data collection and the Canadian evidence base

6. Opioid Conference and Summit

- The Federal Minister of Health and Ontario Minister of Health will be co-hosting an Opioid Conference and Summit on November 18 and 19 in Ottawa.
- The Conference is intended to discuss current priorities and effective approaches.
- The Summit will be a gathering of key leaders from across Canada who have committed to take action to address the crisis. The goal of the summit is to develop a Joint Action Plan with specific commitments to new initiatives with a milestone within the next 6-12 months.

7. ePrescribing

- ePrescribing has become a key issue in light of the opioid crisis discussions. Canada Health Infoway (CHI) has received \$40 million in federal funding to develop an ePrescribing solution by 2018. ePrescribing is seen as a mechanism to capture prescribing data (not just dispensing data).
- ePrescribing systems need to be able to authenticate the identity of physicians so that pharmacists can be confident that a prescription is valid. This coincides with our ongoing work on the Provincial Provider Registry, the ePrescribing pilots and collaboration with the Ontario College of Pharmacists.

8. Opioid Guidelines

- As previously noted, the Canadian Guideline² sets out multiple recommendations about appropriate prescribing, and says the following about dosing:
 - *Chronic non-cancer pain can be managed effectively in most patients with dosages at or below **200 mg/day** of morphine or equivalent. Consideration of a higher dosage requires careful reassessment of the pain and of risk for misuse, and frequent monitoring with evidence of improved patient outcomes.*
- The Centres for Disease Control (CDC) guidelines provide the following information about dosing:
 - *When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to **≥50** morphine milligram equivalents (MME)/day, and should avoid increasing dosage to **≥90** MME/day or carefully justify a decision to titrate dosage to **≥90** MME/day.*
- The Canadian Guideline is currently under review and while it is anticipated that the 'watchful dose' will be reduced, it is not yet clear how this will compare with the CDC guidelines. The revised Canadian Guidelines are anticipated to be ready in early 2017.

NEXT STEPS:

- Staff will continue to monitor the various initiatives and work with government, partners and stakeholders to move forward on opioid initiatives.
- Work will begin to articulate the next algorithm to identify potential high risk prescribing from NMS data. This could include large dispenses of more than one opioid, or combinations of opioids and benzodiazepines.

DECISIONS FOR COUNCIL:

For Information/Discussion

CONTACT: Maureen Boon, Extension 276

DATE: November 11, 2016

²Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain. Canada: National Opioid Use Guideline Group (NOUGG); 2010

COUNCIL BRIEFING NOTE

Topic: Strategic Update - Dashboard

FOR INFORMATION

The College's work is guided by its Strategic Plan which was approved by Council in September 2014. The Strategic Framework is attached for reference at Appendix A. The Strategic Plan charts the course to our vision: Quality Professionals - Healthy System - Public Trust.

College activities are focussed on this framework targeted toward 4 high level priorities:

1. Registration
2. Physician Competence
3. Investigations, Discipline and Monitoring, and
4. Operations.

The strategic framework has been modified slightly to reflect the fact that transparency includes some limited elements of Quality Assurance.

Progress towards the goals set out in the Strategic Plan is reflected in the attached Strategic and Operational Dashboards (Appendix B). The Dashboards provide an overview of performance against targets set for each area.

This is the third quarter dashboard for 2016.

The Strategic Initiatives were defined as follows: Quality Management Partnership, Education, Transparency and Information Management. Of these, QMP has generated a dashboard indicator, although data is not yet available.

The Dashboard will be presented as part of the Registrar's Report at Council.

CONTACT: Rocco Gerace

Maureen Boon, extension 276

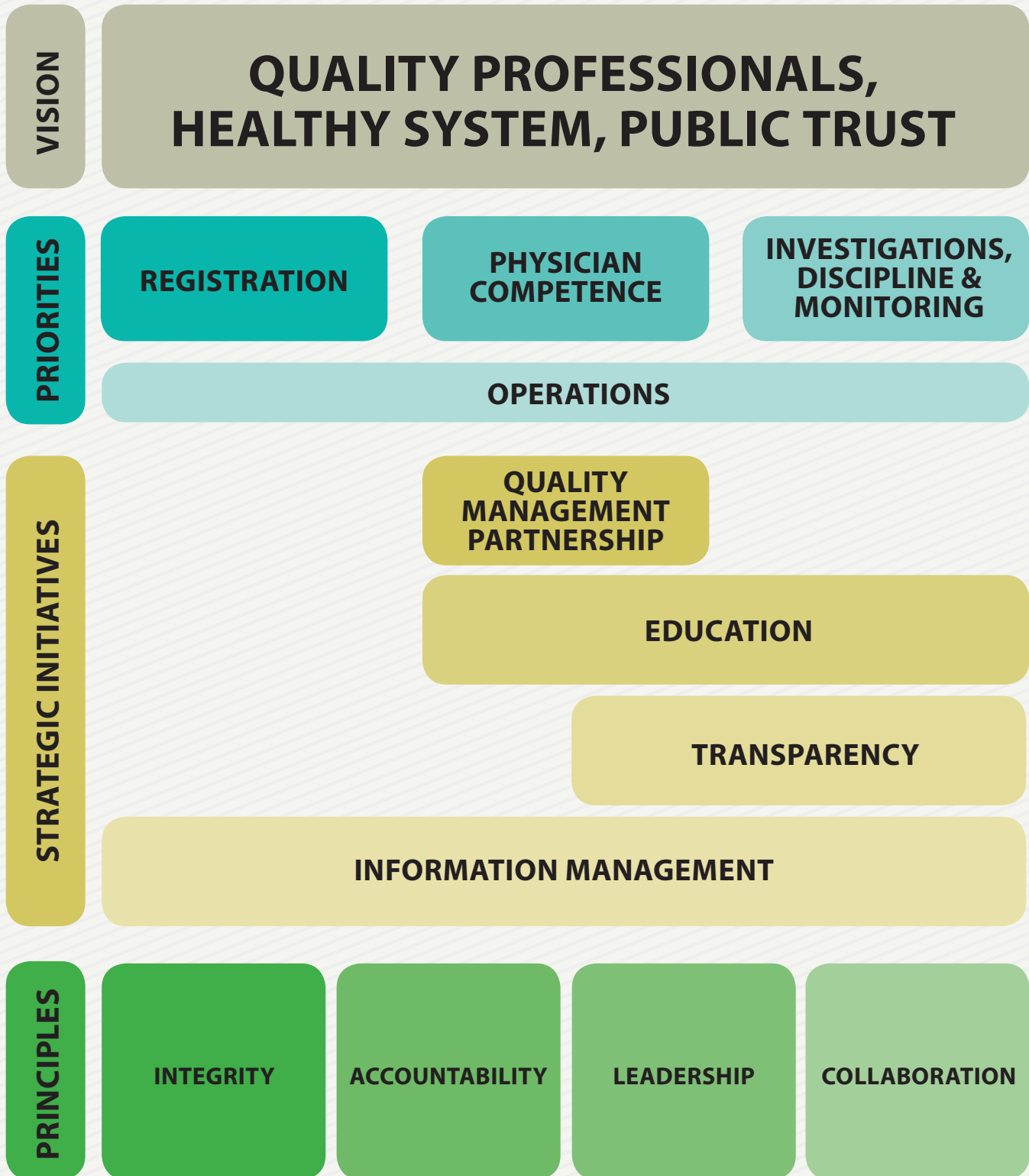
DATE: November 11, 2016

Appendix A: Strategic Framework

Appendix B: Strategic Update Q3 2016



CPSO Strategic Framework 2015-2018



Strategic Dashboard – Q3 2016

Strategic Priority	Objective	Measure/Target	Q1 Status	Q2 Status	Q3 Status	Comments
Optimize Registration	Target to be developed for 2017					
Assure/Enhance Physician Competence	Every physician assessed every 10 years (EDEX)	2600 assessments/year				As of September 30 - 1,949 assessments in total representing 75% completion Tracking to 2,600 assessments for the year
	Quality Management Partnership implementation: physicians receive information about quality	% of physicians in each program receiving quality reports 1 colonoscopy 2 mammography 3 pathology				Data not yet available Initial reports will be provided to physicians later in 2016/17

Operational Dashboard – Q3 2016

Strategic Priority	Objective	Measure/Target	Q1 Status	Q2 Status	Q3 Status	Comments	
119	Optimize Registration	Meets processing time for Registration Applicants 90% of applicants meet processing time of a) 3 wks b) 4 wks				Credentials Applications 2574 of 2587 applications (93%) Registration Committee Applications 913 of 966 applications (99%)	
	Assure/Enhance Physician Competence	130 responses/policy			Q3	Two consultations have taken place since September Council. They are currently underway, with a close date of November 25 2016. The average response rate to date is 24. Physicians and Health Emergencies (36) and Regulation Amendment-Fertility (12). The total year to date average is 112 (yellow), with a total volume of responses at 1012.	
		Existing policies ¹ current/relevant	80% of policies have been reviewed within 5 years			YTD	82% are either current (have been reviewed in the last 5 years) or under review.
	Optimize Investigations, Discipline and Monitoring	Reduce time for completion of high risk investigations	90% of high risk investigations completed in 243 days.				January 1 st - Sept 30 th , 2016: 90% of high risk investigations were completed in an average of 193 days, (28 investigations involving 25 unique physicians).

¹ Does not include registration policies

Strategic Priority	Objective	Measure/Target	Q1 Status	Q2 Status	Q3 Status	Comments
	Schedule discipline hearings more quickly	Time from referral to hearing date is 1 year				January 1 st - Sept 30 th , 2016: 90% of hearings (30) began on average, 356.2 days (11.7 months) from the NOH date
	Reduce decision release time	Time from hearing date to decision release date <u>2 months for uncontested (UC)</u>				January 1st - Sept 30th, 2016: 90% of contested decisions (17) were released, 154 days (5.1 months) from the last hearing date.
		<u>6 months for contested (C)</u>				January 1 st - Sept 30 th , 2016: 90% of uncontested decisions (19) were released , 43.5 days (1.4 months) from the last hearing date
Operational Excellence	Improve service level targets	85% live answer (PPAS, A&C)				A&C: 86% (23,480 of 27,161) calls managed live PPAS: 94% (11,457 of 12,239) calls managed live Combined: 89% (34,937 of 39,400) live response rate
	Improve service level targets	10% call abandonment				A&C 3,627 calls abandoned -13% PPAS 477 calls abandoned -4% Combined call abandonment rate is (10%)
	Media coverage	80-100% positive or neutral				Of 301 news items, 85% were positive or neutral and 15% were negative. We note this period included the release of the SATF recommendations.

LEGEND

	Objective	Measure	Target	On Track	Approaching Target	Attention Required
Optimize Registration	Reduce processing time for Registration Applications	Time from application received by College to (a) first application contact for non-registration committee cases; (b) first applicant contact for registration committee cases	90% of applications meet processing time of (a) 3 weeks (b) 4 weeks	= > 90%	70-89%	<70%
Assure and Enhance Physician Competence	Every physician assessed every 10 years	# of physician assessments in College programs	2600 assessments/year	Tracking to >= 2600	Tracking to 2300-2599	Tracking to <2300
	Quality Management Program – implementation	% of physicians in each program receiving quality reports 1 colonoscopy 2 mammography 3 pathology	80% of physicians receiving reports	80%+ receiving reports	50-79%	<50%
	Increase participation in development of policy	Average # of responses/policy	130 responses/policy	>130 responses	100-129 responses	<100 responses
	Existing policies are current & relevant	Policies reviewed and updated regularly	80% of policies reviewed within 5 years	80%+ reviewed within 5 years	60-79%	<60%
Optimize Investigations, Discipline and Monitoring Processes	Reduce time for completion of high risk investigations	# days to complete investigation	90% of High Risk investigations completed in 243 days or less.	90% High Risk investigations done in <=243 days.	90% High Risk investigations done in 244-256 days.	90% High Risk investigations done in 257 days+.
	Schedule discipline hearings more quickly	Time from referral (notice of hearing) to hearing date	Hearings begin within 1 year	90% began within 365 days (1 yr)	90% began w/i 366-457 days (12-15 mos)	90% began more than 457 days (15 mos)
	Reduce discipline decision release times	Time from hearing date to decision release date	Uncontested (UC): 2 months Contested (C): 6 months	90% released <= 2 mos (UC) <= 6 mos (C)	90% released 2-4 mos (UC) 6-8 mos (C)	90% released > 4 mos (UC) > 6 mos (C)
Operational Excellence	Improve service level targets	Live answer for PPAS and A&C	85% live answer	85% or greater	75-85%	Less than 75%
	Improve service level targets	Call abandonment rate	10% call abandonment	10% or less	11-15%	Greater than 15%
	Media coverage	Positive or neutral media coverage	80% positive/neutral media coverage	80-100%	60-80%	<60%



Registrar's Report

Council

December 2016



Overview

- **Report on Dashboard**
- **Divisional Reports**
- **Stakeholder Relations**



Council Reporting

**Strategic
Dashboard**

**Operating
Dashboard**

**Strategic
Initiative
Report**

Strategic Dashboard – Q3 2016

Area	Objective	Measure/Target	Status
Optimize Registration	Target to be developed for 2017		
Assure/Enhance Physician Competence	Every physician assessed every 10 years	2600 assessments/year	1949 (2,600 projected)
	QMP implementation: physicians receive info about quality	80% of physicians receiving quality reports in: 1 colonoscopy 2 mammography 3 pathology	Data not yet available

Operational Dashboard – Q3 2016

Area	Objective	Measure/Target	Status
Optimize Registration	Meets processing time for Registration Applicants	90% of applicants meet processing time of a) 3 wks b) 4 wks	a- 93% b- 99%
Assure/Enhance Physician Competence	Increase input in policy	130 responses/policy	Q3 24
	Existing policies current/relevant	80% of policies reviewed within 5 y	YTD 112 82%

Operational Dashboard – Q3 2016

Area	Objective	Measure/Target	Status
Optimize Investigations, Discipline & Monitoring	Reduce time for completion of high risk investigations	90% of <u>high risk</u> investigations completed in 243 days or less	193 days
	Schedule discipline hearings more quickly	Time from referral to hearing date: 1 year (365d) or less	356 days

Operational Dashboard – Q3 2016

Area	Objective	Measure/Target	Status
Optimize Investigations, Discipline & Monitoring	Reduce decision release time	Time from hearing date to decision release date	UC: 1.4 mos
		Uncontested (UC): 2 mos	
		Contested (C): 6 mos	C: 5 mos

Operational Dashboard – Q3 2016

Area	Objective	Measure/Target	Status
Operational Excellence	Improve service level targets	85% live answer	89%
	Improve service level targets	10% call abandonment	10%
	Media coverage	80-100% positive/neutral	85%

Strategic Initiative Report

Initiative	Description	Objective	Status
Quality Management Partnership	Partnership with CCO to standardize quality in 3 areas	Joint approach to quality and assessment	Facility and regional level reporting began in September 2016.
Transparency	Initiative to improve regulatory reporting and availability of member specific information	More information available to the public about the CPSO and individual physicians	Implementation complete Website improvements in 2017

Strategic Initiative Report

Initiative	Description	Objective	Status
Education	Integration/co-ordination of physician education across CPSO.	Ensure consistency	In progress
Info/Data Management	Principled approach to how College collects, manages, uses and releases data.	Create framework for data analysis, research & public reporting.	In progress

4 Government-initiated Reviews

Review	Status
Transparency	RHPA changes expected
OHP/IHF review by HQO	Implementation discussions ongoing
Sexual Abuse Task Force	RHPA changes expected
Goudge Review of processes	Pending

Overview

- **Report on Dashboard**
- **Divisional Reports**
- **Stakeholder Relations**



Divisional Reports – General Updates

Investigations &
Resolutions

Quality
Management

Policy &
Communications

Research &
Evaluation

Corporate
Services

Legal



Investigations & Resolutions



Investigations

- **Increased collaboration with Public Health Units in Ontario, as a result of changes to s. 36 of RHPA, which now includes the *Health Protection and Promotion Act*.**
- **Estimated 18% increase in the number of new investigations (PCs, RIs, Inc.) in 2016 over 2015.**



ECONOMY

Infrastructure plan may include tolls, fees

Canadians must be sold on the economic benefits of priv...

BILL CURRY OTTAWA

Canadians need to be sold on the economic benefits of private-sector investment in infrastructure - and the fees and tolls that may come with that, the chair of the federal government's council on growth says.

Dominic Barton, who heads Ottawa's Advisory Council on

Economic Growth, said Canada lags far behind many countries in taking advantage of private financing to help fund large-scale projects, adding that infrastructure needs in Canada far exceed the capacity of governments to pay for them alone.

After months of working with Finance Minister Bill Morneau and other officials, Mr. Barton's

cost data the Mi day Ota one that not gov rit's

PUBLIC HEALTH

Regulatory body probes 86 doctors for prescribing

U.S. ELECTION

Obama takes FBI to task ov



Officials looked for physicians who had eight patients or more for whom they had prescribed opioids in amounts equivalent to 650 milligrams of morphine a day, or who had prescribed the equivalent of 20,000 milligrams of morphine for a patient at one time, usually as a long-term prescription.

Investigations

- Based on information received from the Ministry's NMS 84 physicians are currently under investigation.
- Criteria: prescribed 650 OME/day of a single opioid to at least eight patients and who had at least one patient receiving a prescription of 20,000 OME.
- Objectives: support physicians to practise safely and reduction in total number of patients receiving ≥ 650 OME inappropriately.
- Coordinated approach to investigations by I&R and legal.



ICRC

- Launch of real time feedback survey about the complaints process and decision has begun for complainants and physicians. Participation is confidential. Aggregate results and trends will be reported to ICRC on an ongoing basis starting in the New Year.
- New/updated Sharepoint to assist committee operations and decision-making processes ready January 2017.

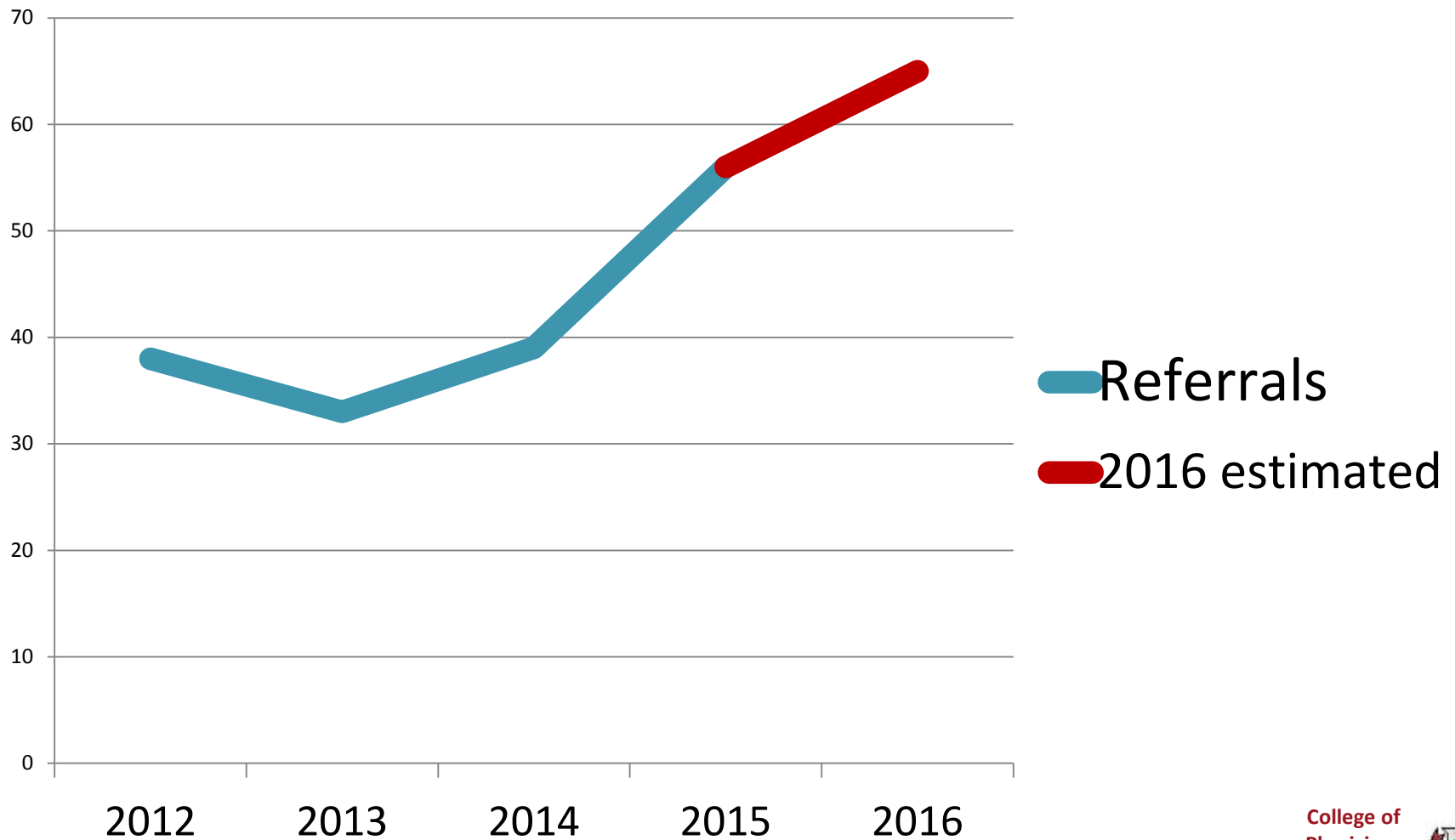


Hearings

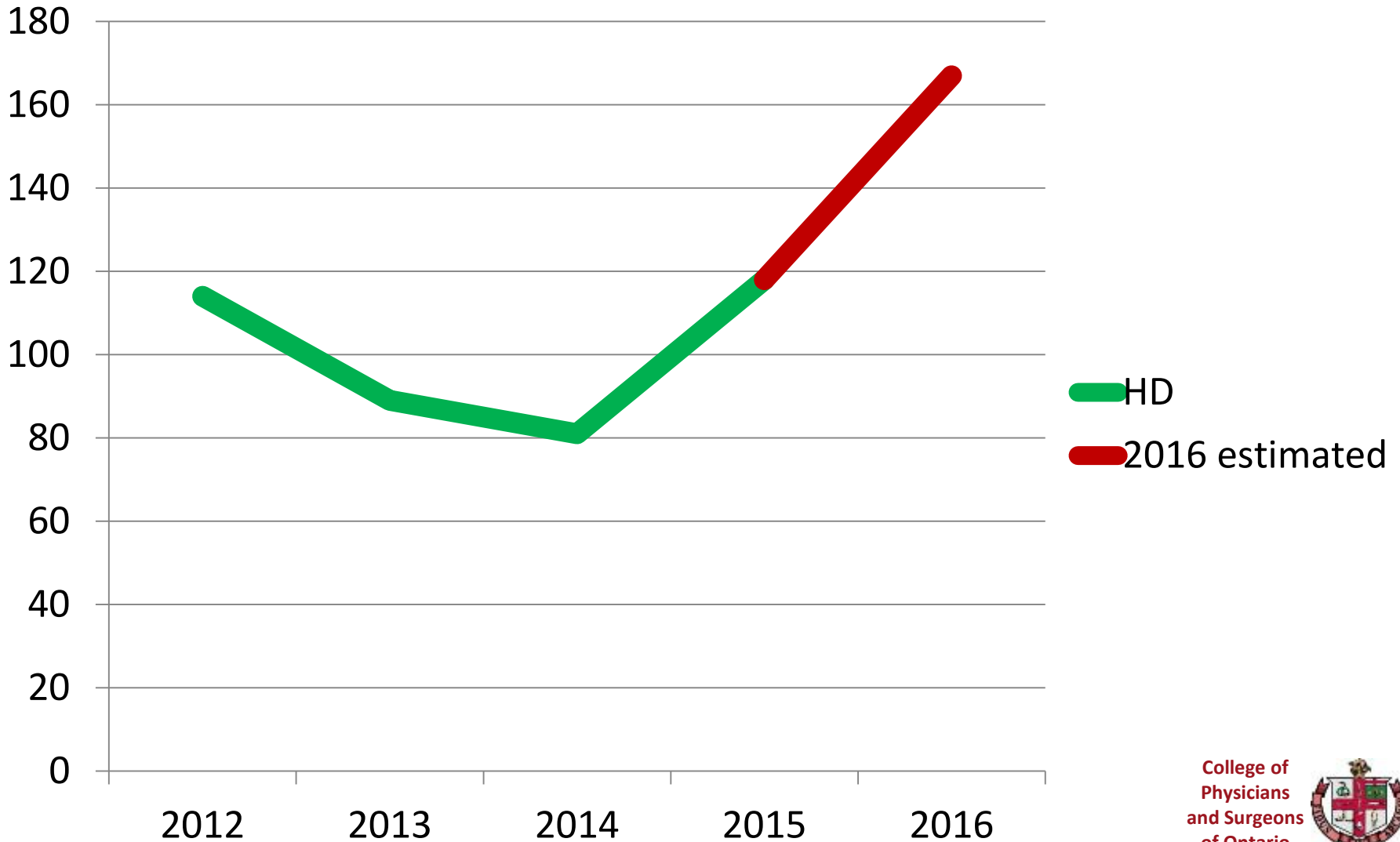
- **Volume for the discipline committee – a 30% increase in referrals in *2015* likely to be surpassed in *2016*.**



Referrals to Discipline



Hearing Days



Compliance Monitoring

- **An increased number of new monitoring undertakings following reassessments after completion of individualized educational and remediation plans flowing from some ICRC decisions and Discipline Committee Orders this past year.**



Quality Management Division



QM: Applications & Credentials 2017

- **Automated form for new applicant pre-screening of qualifications will be ready to launch: all new registrants excluding Final Year Med Students**
- **Invictus Games – Licensing Requirements underway**
- **Practice Ready Assessments for Family Medicine in Ontario in the final stages of Completed Licencing Requirements. To Council in 2017.**



QM: Practice Assessment & Enhancement

- **Methadone Conference: Nov 25 – focussing on Opioid Crisis**
- **Peer Assessment Process Review - improving real time delivery of key statistics almost complete**
- **Feedback from MSI Committees on Practice of Medicine definition almost complete**
- **2 task forces:**
 - **change of scope for Emergency Medicine in rural practice**
 - **update to Diagnostic Imaging CPPs**
- **Annual OHPIP Tier 2 Adverse Events Reporting complete – QI inspections for follow-up**
- **Collaboration with PHO, MOHLTC and Regional Public Health units to support infection control practices for members**



QM: Membership & Corporations

High volumes

Certificates of Professional Conduct:

- **Expect 7500 total issuances by year-end.**

Certificates of Authorization for Professional Corporations:

- **Expect 20,000 renewals/new issuances by year-end.**



QM: Membership & Corporations

CPD Compliance - Follow-up of Members Not in Enrolled in CPD:

- Annual renewal indicated 246 members not enrolled in CPD with RCPSC, CFPC or GPPA
- After staff follow-up, 25 remain outstanding.
- If proof of CPD enrolment or cease to practise undertaking not provided by early December, Notice of Intention to Suspend will be issued.

QM: QMP

- Colonoscopy, mammography and pathology facility quality management reports have been distributed
- OHA Webcasts & technical briefings to orient recipients to facility quality management reports
- Planning for implementation of 2017-18 physician level reporting has begun

QM: QMP

- **Development of public reporting strategy underway in collaboration with Citizens' Advisory Committee**
- **Each Provincial Quality Committee which oversees each clinical area has met**
- **A Learning Management System is in the process of being identified and training plan is under development for physician facility leads that will start the Fall of 2017**



Policy & Communications



P&C: Policy Reviews in Progress

1. **Accepting New Patients**
2. **Ending the Physician-Patient Relationship**
3. **Physician Behaviour in the Professional Environment**
4. **Block Fees and Uninsured Services**
5. **Changing Scope of Practice**
6. **Re-entering Practice**
7. **Practice Management Considerations**
8. **Test Results Management**

+ Continuity of Care



P&C: Policy

- **Professionalism and Practice Program: UME**
- **Newest module: Boundaries and Sexual Abuse - very positively received.**
- **Approached by PGE Deans re offering the module to PG learners.**
- **Additional modules on Social Media, Consent, Human Rights and Mandatory Reporting are in development.**



P&C: Communications



- **New whiteboard video about complaints process about to be launched**
- **Dialogue issue on opioids very well received - will continue to highlight this issue**
- **29 nominations for Council Award this year!**



P&C: Communications



- **PPAS has managed 200+ calls related to MAiD**
- **Chiefs Day on November 3rd**
- **Medical students' event in London Ontario. Spoke with hundreds of first year students about the College**



P&C: Government Relations

- **MAiD: Lessons Learned document developed in consultation with the Office of the Chief Coroner**
 - **reflects real-life themes/issues his office has seen to date in relation to MAiD deaths and continue to liaise with external stakeholders.**
- **Awaiting introduction of RHPA amendments**
- **Other issues: opioids, protecting patients from sex abuse, MAiD, public member appointments**
- **Met with the Patient Ombudsman**



Legal Office



Legal Office

- **90 open discipline referrals (record levels)**
- **Still waiting for Divisional Court decision in constitutional challenge to mandatory revocation provisions (argued in June)**
- **Delayed dates for constitutional challenge to effective referral requirement in policies on human rights and MAiD; to be scheduled early June in Divisional Court**
- **HPARB heard constitutional challenge to advertising regulations; on reserve**
- **Continued support for major projects including legislative reform (response to sex abuse task force, Goudge), opioid initiative, etc.**



Research and Evaluation



Research and Evaluation (RED)

Factors Projects:

- Factors associated with assessment outcomes
- Factors associated demographic shift and aging
- Factors associated with public advisory and complaints
- Identification of support factors
- National work to determine consistency of factors and outcomes



Research and Evaluation (RED)

Pathways:

- Data collection complete; ICES analysis complete
- Report to Council in Sept 2017

MSF:

- Report of all analyses to Council in May 2017

Peer re-design:

- Roll out of new assessment end of 2016
- Walk in and Family Practice to start
- Evaluation of program beginning 2017



Corporate Services



Facilities

- **Negotiated contract to replace dining room chairs**
- **Replacing other ergonomic chairs for staff**
- **Getting ready for annual fire inspection**
- **Finalized details for a housekeeping RFI. This will be tendered in the New Year.**



Remember.....

- **Estimated 18% increase in the number of new investigations (PCs, RIs, Inc.) in 2016 over 2015.**
 - NMS information – 84 physicians are currently under investigation
- **Volume for the discipline committee – a 30% increase in referrals in 2015 likely to be surpassed in 2016.**
- **An increased number of new monitoring undertakings**
- **90 open discipline referrals (record levels)**



Finance

- **2017 Budget presented to the Finance Committee**
- **1st \$10,000,000 of the GIC ladder matured and will be re-invested for 4 years as approved by Council**



Records Management

- **Records liaison project: trained staff in each department to monitor records practices and liaise with RMA**
- **Completed the off-site file recall and audit to ascertain that documentation in our tracking databases for off-site files is accurate**
- **Digitized and reorganized all on-site contracts and agreements**
- **Identified and scanned numerous photographs of staff and staff events from the CPSO archives to be used for the 150th anniversary at the long term service awards**



Human Resources



Human Resources

- **New performance management tools and salary step plan in place.**
 - **Early results suggest system is controlling growth of base salaries and recalibrating performance expectations as intended.**
- **Korn Ferry Hay - market survey of management salaries. Confirmation that salaries are well positioned within the market and are well managed.**



Business Services

- **Negotiated new lease for Canon copiers**
- **Implemented document verification process and new evidence policy**



Overview

- **Report on Dashboard**
- **Divisional Reports**
- **Stakeholder Relations**



Stakeholder Relations

- **Meetings with senior Ministry staff on multiple files**
- **Chiefs' Day**
- **Ontario Medical Association**
- **Canadian Medical Protective Association**



Mifegymiso (RU-486) – Medical Abortion

- Approved by Health Canada July 2015 and anticipated to be available in 2017
- HC approved drug based on monograph submitted by drug company:
 - Drug only prescribed/dispensed by physicians
 - Physicians would undergo training and be registered
 - Physician shall confirm gestational age via U/S and exclude ectopic pregnancy
 - Physician supervises administration
- Issue: Requirement for physician dispensing seen to impede access



Mifegymiso (RU-486) – Medical Abortion

- CPSO and OCP writing jointly to Health Canada, seeking confirmation that pharmacist-dispensing of Mifegymiso will be acceptable and considered ‘off-label’
- BC has taken a similar approach and HC has confirmed that pharmacist-dispensing would be considered ‘off-label’ (the product monograph is non-binding)



Avoiding Abuse, Achieving a Balance:

Tackling the Opioid Public Health Crisis



College of
Physicians and Surgeons
of Ontario

AGENDA

Opioid CONFERENCE

NOVEMBER 18, 2016

111 Sussex Drive
Ottawa, ON

CO-HOSTED BY
the Honourable Jane Philpott,
Federal Minister of Health and
the Honourable Eric Hoskins,
Ontario Minister of Health and Long-Term Care

Hosted in partnership by:



Federal Opioid Conference and Summit

Joint Statement of Action to Address the Opioid Crisis

- **Collaborating with the Ontario Ministry of Health and Long-Term Care on the recently released strategy and development of a plan to use Narcotics Monitoring System data held by the Ministry to promote patient safety. This includes:**
 - **identifying possible high risk prescribing and referring to regulatory bodies for follow up; and**
 - **developing a plan to identify low risk prescribing and providing a variety of educational interventions, including tools, that are tailored to individual needs of prescribers.**



Federal Opioid Conference and Summit

- **Publicly reporting, as permitted by legislation, on the outcomes of the current approach.**
- **Updating existing policy to reflect revised Canadian Guidelines and Health Quality Ontario Quality Standards (if available).**
- **Once all physicians have access to narcotics profiles, inclusion of expectation in policy for physicians to check the medication profile prior to prescribing narcotics.**



Federal Opioid Conference and Summit

- **Using prescribing information (comparative prescribing reports or prescribing data), when available, to inform educational approaches in conjunction with assessment of physician practice.**
- **Supporting and contributing to a broader strategy to ensure necessary supports are available to patients and other health professionals.**



150 *Years*
1866-2016



THE
COLLEGE
OF
PHYSICIANS
AND
SURGEONS
OF
ONTARIO

Examination Questions, 1900=1901.

1. Describe the formation, relations, and name the branches of the lumbar plexus. State the distribution of the obturator nerve.

2. Give the origin, insertion, and nerve supply of the muscles attached to the shaft of the fibula.

3. Describe the deep fascia of the neck.

M.R.C.S., Examiner.

Primary.

PHYSIOLOGY AND HISTOLOGY.

compounds: Potassium permanganate, sodium hypophosphite, sodium thiosulphate, ammonium alum, paraldehyde, maltose, benzoic aldehyde, pyrogallol, sodium arsenate, carbamide, ammonium bichromate.

3. Write an account of the chemistry of sulphuric acid.

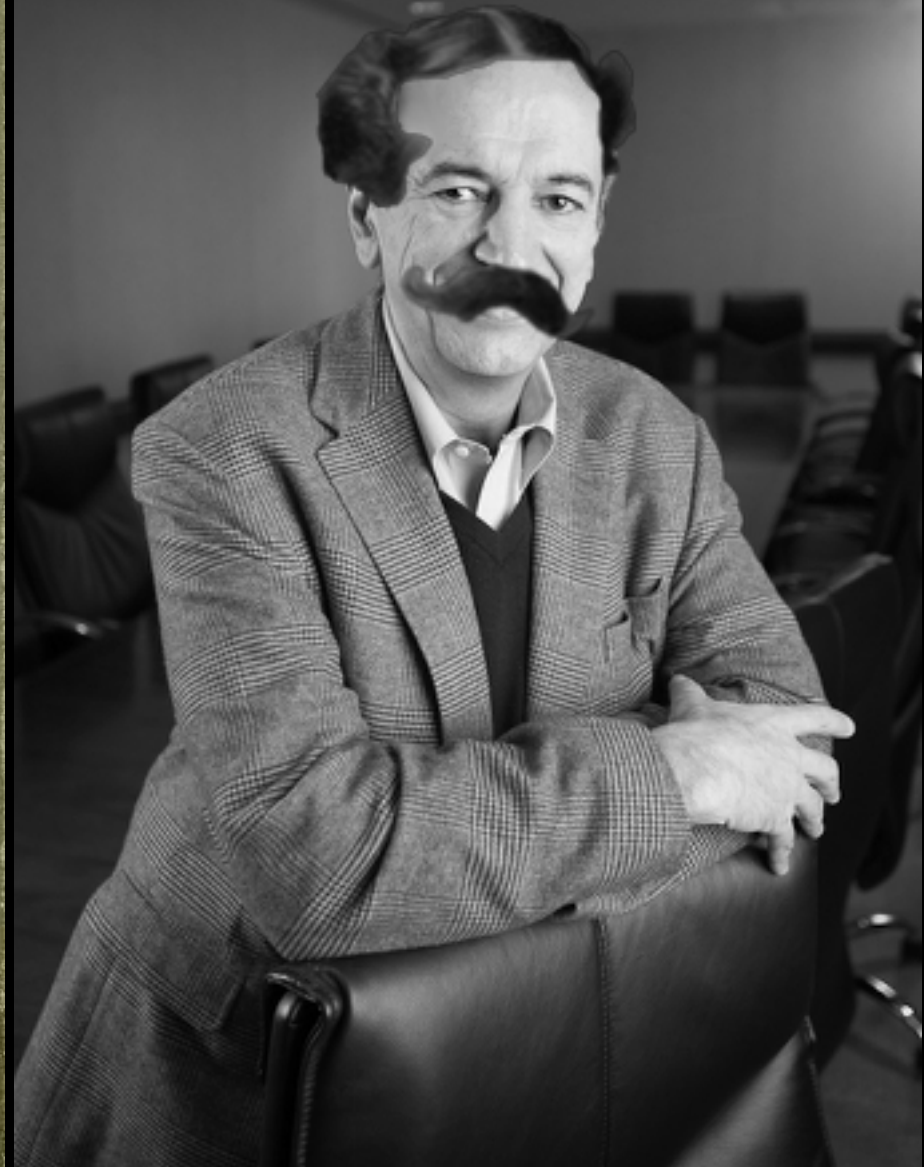
6. Describe the rectum.

the microscope, by which the examination is to be made.

will be required to prepare one litre of



Dr. Henry Strange



CPSO

HERITAGE

Minutes

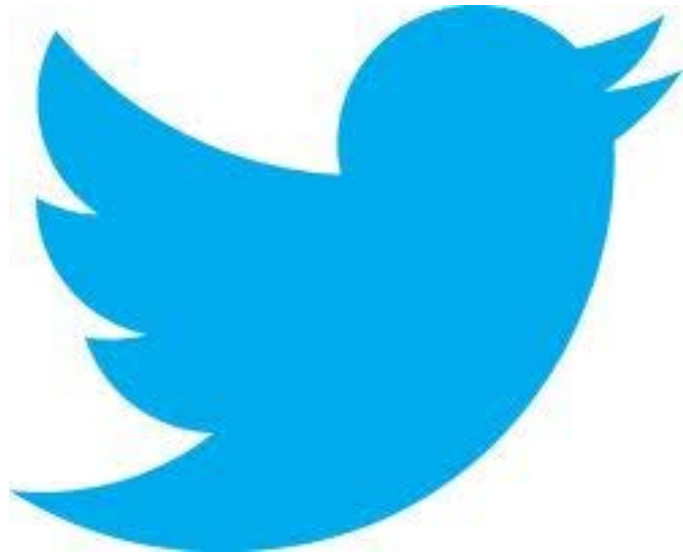
Departing Council Members

- **El-Tantawy Attia**
- **John Jeffrey**
- **Ron Pratt**
- **Eric Stanton**
- **Peter Tadros**
- **Ron Wexler**

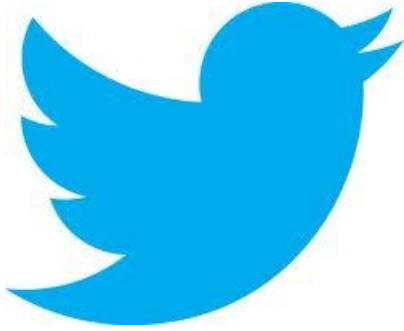


Presidents in Hard Hats





Presidents and Twitter



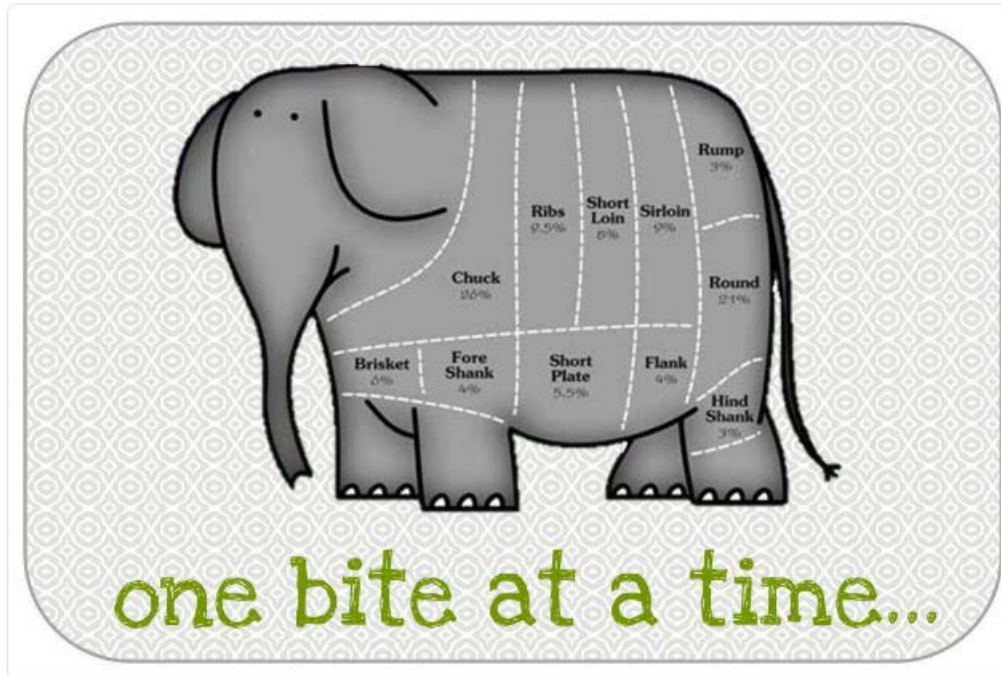
**Dr. Joel Kirsh –
President & ‘CET’**

**‘Chief Executive
Tweeter’**



Joel Kirsh @joelakirsh · Jun 13

"No law addresses all #EOL situations" (paraphrased) Yves Robert
[@CMQ_org](#) [#MAID](#) [#C14](#) [#FMRAC2016](#) [#howtoeatanelephant](#)



Dr. Kirsh – A better Tweeter than the President Elect



Joel Kirsh @joelakirsh · Oct 20

If you read one thing on Twitter this evening, make it a [#TrumpBookReport](#) !

Daniel Morrison @danielmorrison

I proposed #TrumpBookReport in July. Happy to see it randomly taking off tonight! [twitter.com/danielmorrison...](https://twitter.com/danielmorrison)



Donald J. Trump

@TrumpInsulter

When will Joel Kirsh start to apologize to me?

2:17 PM - 29 NOV 2016

Share this for real →



Dr. Kirsh – Tweeting about things that matter (and no insults)

Joel Kirsh @joelakirsh · Aug 10

🎵 "just sittin' by the dog at the bay . . ." #MisheardLyrics



Joel Kirsh @joelakirsh · Jun 15

Traffic woes @SickKidsNews



👉 2 ❤️ 10 ⋮



Questions?





COUNCIL BRIEFING NOTE

TOPIC: REPORT OF THE FINANCE COMMITTEE & APPLICABLE MOTIONS

FOR DECISION

ISSUE: Activities of the Finance Committee since the last annual meeting of Council including decisions for the following motions:

- 2017 Budget
- 2017 Fee Increase
- 2017 Increase for per diems
- Certificate of Incorporation (fee increase)
- Certificate of Professional Conduct (fee increase)
- Application fee for Independent Practice (fee increase)
- Application fee for Postgraduate Practice (fee increase)
- New fee: Expedited Review application fee

BACKGROUND:

- At the annual budget meeting of the Finance Committee on October 11, 2016, the Finance Committee recommended to Council the approval of the above motions.
-

DECISION FOR COUNCIL: Approval of the annual budget for 2017 as well as the above motions.

CONTACT: Mr. Pierre Giroux, Chair, Finance Committee
Mr. D. Anderson, Corporate Services Officer
Ms. Leslee Frampton, Manager, Finance & Business Services

DATE: November 7, 2016

The Finance Committee convened three times this year. They met: January 18, 2016 (Orientation/Education), April 5, 2016 and October 11, 2016.

At each meeting of the Finance Committee, the conflict of interest policy (based on the “Not-for-Profit Corporation Act, 2010”) was reviewed and any conflicts were declared. Furthermore, the Finance Committee reviewed its goals and objectives to ensure that they remain appropriate and on target; statements and variance analysis to confirm budget tracking; space planning for future growth; and any educational needs for the Committee.

In addition, the Committee reviewed the following topics:





- January 18, 2016
 - Audit Engagement and Planning
 - Insurance and Risk
 - Defined Benefit Pension Plan (Statement of Investment Policies and Procedures)
 - Investment Review





- April 5, 2016
 - Auditor’s Report and Year-end Financial Statements
 - Internal Controls
 - Appointment of Auditor
 - In-Camera Session with the Auditor
 - Defined Contribution Pension Plan
 - Insurance (coverage and cyber-risk review – presentation from HIROC)
 - FMRAC Integrated Risk Management System (FIRMS) – presentation from HIROC
 - Payment Card Industry Data Security Standard (compliance)
 - Business Continuity
 - Budget Objectives for 2017






- October 11, 2016
 - 2016 Budget
 - Compensation Plan
 - CPSO IT Security (review)
 - Cost Awards in Discipline Hearings
 - Statutory Requirements for Pension Plans
 - Business Continuity
 - Corporate Tax Returns




2016 GOALS OF THE FINANCE COMMITTEE




Goal: a financially stable organization with control processes in place to appropriately manage all relevant College matters.



	Objective is complete		Work in Progress and on schedule		Work in Progress but may not meet the target date		Work on Hold, will not meet target.
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

Objective	Work Plans	Outcome	Target	Actual	Status	Notes
Ensure College Meets Operating Goals						
Oversee the development and approval of the 2017 budget	Discuss with Management the parameters for the 2017 budget	At the spring meeting, the Finance Committee will provide guidelines and direction for Management to follow in preparing 2017 budget.	Spring	April 5		At the spring meeting, the committee reviews the budget process. The budget is divided into two stages: 1) the base budget and 2) the business cases for new projects, staffing, etc.
	Review and comment on proposed budget	At the fall meeting, the proposed budget is submitted to the Committee for discussion and feedback on the appropriateness of the budget and implication to the fees required to fund the operation	Fall	Oct 11		Finance Committee is given the budget detail at the fall meeting. At that meeting the Finance Committee will review base budgets and assumptions and meet with department heads requesting new projects, staffing and capital projects
	Present Budget to Council for approval	Once the Committee has reviewed and makes any changes to the budget it will recommend to Council that the budget be approved.	Fall	Dec 1/2		Finance Committee will be recommending to Council the acceptance of the budget
Ensure all Council decisions are fully reflected in financial projections	Review all major College initiatives	Each initiative recommended to Council by the Finance Committee shall be accompanied by a Financial	On-going	April 5 Oct 11		At each meeting of the Finance Committee any new initiatives with budget implications will be presented for review.






Objective	Work Plans	Outcome	Target	Actual	Status	Notes
		Impact Analysis and Business Case.				
Ensure plans are in place to provide adequate space for College operations	Continually monitor real estate market for long-term permanent solutions for future expansion	Keep the committee up to date regarding potential opportunities for space	On-going		 	Funds have been directed to the College's building reserve to assist in savings for future building needs. The Committee agreed to transfer any surplus funds to the building reserve. Staff are continually reviewing options with regards to acquiring space.
On-going review of the financial statements	The Committee will be provided the latest financial statements at spring & fall meetings. The Committee will receive Financial Statements and a variance report in the summer and winter so that the Committee will have quarterly financial information	A variance analysis will be provided explaining the large variances between the actual expenditures versus the budget allocation.	Spring & Fall	April 5 Oct 11		
Ensure the College continuously improves business processes and achieves cost savings.	Review management report on College process improvements annually	Feedback provided to Management on continuous improvement program	On-going	Work in Progress		The IT Steering Committee regularly reviews the IT priorities at the College. When a project is undertaken part of the development of the new system or a change to an existing system is to complete a process review to ensure the changes contribute to continuous program improvement and efficiencies
Financial Indicators and Ratios						
	Working Capital	Ensure the College has	1.00	0.92		This ratio measures the ability of an



Objective	Work Plans	Outcome	Target	Actual	Status	Notes
		enough money to cover its current obligations				organization to pay its current obligations. The major contributing factor to the decrease of 0.15 is that during the month of November 2015, \$10M was transferred from our bank account, which is consider a Current Asset, was placed in a Long Term Investment. Care has been taken to ensure the CPSO will always have enough cash to meet our obligations over the course of the year. The \$10M will come due in November 2016
	Operating Expense Ratio	In a not for profit organization expenses should match revenue	100%	99.4%		This ratio is an indication of the percentage of operating revenue which is being absorbed by operating expenses, but does not include the purchase of capital items. An 8.4% increase from the same time last year is a concern and we are monitoring
	Days in Accounts Receivable (A/R only)	Ensure the College is collecting outstanding receivables in a timely fashion	10.00	9.02		Determines the average number of days a customer takes to pay an invoice once it is entered in to the accounting system.
	Days in Accounts Payable (A/P only)	Ensure the College is paying its bills in a timely fashion	2.00	3.26		Determines the average number of days it takes to pay a suppliers' invoice once it has been entered in to the accounting system. This does not

Objective	Work Plans	Outcome	Target	Actual	Status	Notes
						measure the time from actual receipt of the payable at the College to the time it gets to Finance and processing before being entered into the system.
Ensure that Risk Management Processes are in Place						
Monitor development of a formal risk management program at the College	Submit RMSAM modules for 4-year review as required for regular cycle	The HIROC risk management program ensures that the College has a risk assessment program in place	2014/15			The RMSAM program is evolving to FMRAC Integrated Risk Management Systems (FIRMS). This new program is designed specifically for the Medical Regulatory Authorities (MRAs) and will be implemented in the future. To date, we have received a 5% discount applied to our insurance premiums.
Ensure College's short term investments are managed appropriately	Review recommendations from Management regarding the investment of the short term funds.	Invest College's short-term funds prudently and ensure the best rate of return at the lowest risk.	Spring Fall	April 5 Oct 11		This is revenue from the annual membership fees. Currently, it resides in the College's current account; however, it also may be in Government of Canada Treasury bonds (depending on the highest net interest rate). We have been able to negotiate an increase from 1.1% to 1.25% in our current account.
Ensure College's long term investments are managed appropriately	Review recommendations from Management and 3 rd party consultants regarding the asset mix of the longer term	To position the portfolio in a manner that could be utilized to fund any capital projects such as a new building and to	Spring	Nov 2015		The Finance Committee recommended to and Council approved the transfer of longer term investments from the current asset mix to a 5 year

Objective	Work Plans	Outcome	Target	Actual	Status	Notes
	investments.	protect our capital				ladder GIC - including a GIC for one, two and three years and a 4 and 5 year market linked GIC.
Ensure College's maintain its fiduciary responsibility to the Defined Benefit Pension Plan and the Defined Contribution Pension Plan	Chair of the Finance Committee sits on the Pension Committee and is kept apprised of the issues	To ensure that the pension plans are administered in compliance with the Pension Benefits Act and Financial Services Commission of Ontario requirements	On-going			Council delegated the oversight of the College's pension plans to the Executive Committee, who in turn delegated to the Finance Committee. The Finance Committee has direct oversight of the Defined Benefit Pension Plan. The Defined Benefit Plan is review every three years to determine the financial status of the plan. It should be noted that the Defined Benefit Plan is closed. There are 12 retired members and 1 inactive member. The Finance Committee has delegated the administration of the College's Defined Contribution Pension Plan to the Pension Committee. There is Finance Committee, management representation on this committee and staff representatives who are elected by their peers.
Risk Management for Not –for –Profit Organizations	Review questions developed by the Canadian Institute of Chartered Accountants	To ensure the College has an effective Risk Management program	On-going			The Canadian Institute of Chartered Accountants has developed a list of 20 questions that directors of boards should be asking about risk at the

Objective	Work Plans	Outcome	Target	Actual	Status	Notes
						organization. The Finance Committee was provided a copy of this document in the Orientation Package.
Business Continuity Plan	Work continues in updating the current Business Continuity Plan to current best practices.	A business continuity document that is comprehensive but easy to use and implement	On-going			In 2011 the College developed a business continuity plan. The plan needs to be updated to reflect current best practices. The College engaged the services Marsh Risk Consulting to assist in this process. It is anticipated that this will be completed by the end of 2016. Once the plan has been drafted the Finance Committee will review
Ensure Proper Financial Safe-Guards in Place						
Ensure College operates in compliance with generally accepted accounting principles and not for profit rules	Review and comment on the results of the annual external audit. Meet in camera with External Auditors to discuss the results of the audit.	Comments provided to auditor.	Spring	April 5		The College's audit firm, Tinkham & Associates will review the audited financial statements for the year ended December 31, 2015 comparing the actual expenditures to those of the previous year. The Committee will hold an in camera meeting with the Auditor at the Spring meeting.
	Arrange for auditor to present results of audit to Council.	Audit report presented to Council	Spring	May 30/31 Council		College's external auditor to present 2014 audited financial statements to Council
Internal Control Questionnaire	Each year staff in conjunctions with the external auditor, will update an internal control	Confirms the strength of the internal controls at the College	Spring	April 5		The Finance Committee is responsible for maintaining oversight for management's

Objective	Work Plans	Outcome	Target	Actual	Status	Notes
	questionnaire that assesses the strength of the internal controls at the College					efforts to create a strong control environment. Best practices dictates that the Finance Committee's review should include an evaluation of management's risk assessments and processes for identifying and addressing business and fraud risks.
Conflict of Interest and Code of Conduct for individuals sitting on Finance Committee	Ensure at each meeting that Committee members declare any potential conflicts of interest	Declaration to be noted in the minutes.	Each meeting	Each meeting		Any conflicts of interest would be noted in the minutes
Ensure Adequate Orientation/Education for Members						
Ensure all Committee members are adequately trained and have appropriate tools to fulfill their Committee responsibilities.	Prepare a detailed orientation/ education document	Members receive education as needed	On-going	Jan 18, April 5, Oct		Continuous education throughout the year from various consultants and investment managers.
	Develop a glossary of financial terms	Glossary provided to Committee members		Complete		The glossary is updated on an on-going basis.
	Hold an annual formal orientation session for members	The objective is to brief new members regarding the financial matters of the College, and bring them up to date with the existing members of the Committee.	Jan 18	Jan 18		An orientation/education session is scheduled for January 18, 2016
	Role/Mandate of Committee	Ensure that the Committee members understand the role and mandate of the Committee	On-going	Each meeting		The Chair of the Committee ensures that the members of the Committee understand the role and mandate of the Committee and

Objective	Work Plans	Outcome	Target	Actual	Status	Notes
						address any educational needs
	Timely distribution of materials	Ensure materials are distributed to the Committee in a timely manner	Each meeting	Each meeting		Generally materials are sent to the Committee one week prior to the meeting
	Development and strengths	Receive feedback from Committee regarding any development or educational needs.	Each meeting	Each meeting		At each meeting the Chair reviews any educational needs the Committee might need.

The Finance Committee meeting of October 11, 2016, is reported below. The bulk of the meeting focused on the proposed budget for 2017:

- The College is accountable for a \$65M budget, and must regularly demonstrate to members and the public our fiscal accountability and resource utilization that delivers programs and fulfills our public interest mandate in the most effective and efficient manner possible.
- Senior leadership is committed to the ongoing pursuit of efficiencies and prudent choices, as well as to the provision of comprehensive financial information to the Finance Committee and Council for consideration.
- This year, the 2017 budget process consisted of the following stages:
 - In March, preliminary consideration by the senior management team (SMT) of anticipated workload increases, ongoing and new projects, existing and expected external demands, and high level resource estimates for 2017.
 - From May - August, development by all departments of more specific resource needs for new staff, program workload adjustments and capital costs.
 - From May – September, identification and review of specific areas for focused analysis including potential revenue options and savings/efficiencies (more detail is provided below of these considerations).
 - In September, focused discussions by SMT to refine the final budget with additional consideration of our needs and priorities, and decisions on our choices to bring the budget to a level that translates to a \$30 increase in membership fees, representing a 1.9% increase (other user fees are also impacted in this budget to balance the need for full membership contribution to professional regulation with services that are supported by users of those services).

- The 2017 budget is impacted by several factors:
 - Revenue that is beginning to flatten from a membership base that is not growing as much as it was in the last 10 years (this may be a trend that will continue).
 - Continued stress on our resource base with increased demands across the organization, such as:
 - Several Government reviews and related management of developing and communicating College positions, ad hoc data requests, legislative amendments, etc.
 - Internal program needs driven by factors out of our control such as registration applications, complaints and investigative volume, and hearing days.
 - Demands to demonstrate transparency and regulatory impact to the public requiring close attention to our data and evaluation infrastructure.
 - The Council's commitment to our strategic priorities – which require cross-departmental involvement - and the need for development and delivery of results.

- In addition to the budget 2017 process described above, SMT is:
 - Developing and refining a College internal/external project inventory to manage our staff resources into projects that balance strategic priorities, operations and process improvement.
 - Reviewing ways to more effectively integrate our planning processes for program delivery, IT, HR and budgeting.
 - Reviewing options to manage our the use of existing space (80 College St and 800 Bay St) with growing needs for staff and meeting rooms.
 - Developing processes to regularly identify and address efficiency and saving opportunities through the engagement of all staff and management.

The Finance Committee reviewed the budget submission in detail at its meeting of October 11, 2016.

The Committee reviewed the following recommendations from staff in the following areas:

Revenues

1. Incorporation Fees

A survey of the other MRAs and a couple of like organizations has determined that there is room to expand this source of revenue.

Recommendation: increase the cost of both the initial application and renewal application fees. This would generate an additional \$1,030,000.

	Current	Number	Rate	\$50 Increase
New	\$350	1,600	\$400	\$80,000
Renewal	\$125	19,000	\$175	\$950,000

Below is a comparative chart between the other MRAs in Canada and the Royal College of Dental Surgeons

	Initial Fee	Renewal Fee
Alberta	\$525	\$157.50
Newfoundland & Labrador	\$450	\$150.00
Ontario – Proposed	\$400	\$175.00
Saskatchewan	\$350	\$150.00
Ontario - Current	\$350	\$125.00
PEI	\$300	\$250.00
Quebec	\$250	\$25.00
Nova Scotia	\$150	\$100.00
New Brunswick	\$100	\$100.00
British Columbia	\$300	\$125.00
Manitoba	Included in Fees	
Royal College of Dental Surgeons	\$750	\$175.00

2. Certificate of Professional Conduct

A detailed analysis of the costs to produce a CPC indicates that we are not covering our costs, so a \$25 increase would appear to be reasonable. We have not increased this fee since 2008.

Recommendation: increase the CPC fee to \$75 in 2017 and review the fee again in 2018. For 2017 this would generate an additional \$200,000

Current	Number	Rate	\$25 Increase
\$50	8,000	\$75	\$200,000

PEI	\$125
British Columbia	\$105 (includes 5% GST)
Nova Scotia	\$100
Saskatchewan	\$100
Alberta	\$100 for first certificate, \$25 for each additional certificate (requested at the same time)
Newfoundland & Labrador	\$80
Quebec	\$70 member, \$150 non-member
Manitoba	\$52.50
Ontario	\$50
New Brunswick	Free (may be fee in some cases)

3. Application fees

As demonstrated by the chart below, the College does not currently cover the costs of the Registration Process. In 2016 it is projected that we will lose \$825,149.

			2013 Actuals	2014 Actuals	2015 Actuals	2016 Budget
APPLICATION FEES						
Revenue						
Independent Practice	Accts 3210 + 3230	\$802.50 / \$398.75	\$1,451,714	\$1,550,158	\$1,653,330	\$1,811,780
Short Duration	Acct 3280	\$324	\$5,845	\$6,687	\$3,828	\$0
Post Graduate Education	Acct 3220	\$164.50	\$425,204	\$444,762	\$463,320	\$437,402
			\$1,882,763	\$2,001,607	\$2,120,478	\$2,249,182
Expenses						
	CC 5300	Registration Committee	\$221,510	\$186,793	\$231,206	\$283,455
	CC 7940	Applications & Credentials	\$1,598,646	\$2,359,943	\$2,559,862	\$2,790,876
	CC 7980	No Longer Used	\$537,387	\$0	\$0	\$0
			\$2,357,543	\$2,546,735	\$2,791,069	\$3,074,331
Net Revenue/(Expense)			-\$474,780	-\$545,129	-\$670,591	-\$825,149

Recommendation: increase the application fee for an Independent Practice Licence from 50% of the membership fee to 60% and the Post Graduate Licence from 10% to 25% of the membership fee. This would generate additional revenue of \$918,786

	Rate	Current	Number	Rate	60%	25%
IPL	\$797.50	50%	1,900	\$957.00	\$303,050	
PGE	\$159.50	10%	2,574	\$398.75		\$615,736

4. Expedited Review – **New Fee**

All applications need to be assessed (credentialed) which includes a review of documentation to ensure requirements meet the regulation. The service standard on the dashboard indicates we get back to applicants in 4 weeks for restricted and 3 weeks for those who qualify under the regulation. Applicants normally have a start date for work, whether it's to do rounds in a residency position or their first day in a hospital or clinic. Unfortunately applicants do not look to our deadline posted on line for summer registration. In reality many come after such date, even the last week prior to the deadline. There are approximately 100 to 500 per year.

	Rate	Proposed	Amount	Number	
IPL	\$797.50	75%	\$598	150	\$89,719
PGE	\$398.75	50%	\$199	150	\$29,906

Recommendation: Charge 50% the Application Fee for whatever type of licence they are applying for. This would generate additional revenue of \$119,625

5. Tariff Rate

As per Finance Committee direction we will review this annually

Recommendation: An increase of 10% (from \$5,000 to \$5,500) to the tariff rate for 2017.

The Finance Committee made the following motions:

It was moved by Dr. Rouselle, seconded by Mr. Pielsticker, and **CARRIED**.
That the Finance Committee recommends to Council that the tariff rate for a day's discipline hearing be increased from \$5,000 to \$5,500 effective January 1, 2017

As directed by the Finance Committee, the Finance Department (in consultation with the Legal Department) is developing a recommendation regarding collecting costs awards that will be presented to the Executive Committee and Council at a future date.

The budget can be summarized as follows:

	2017 – Base	2017 – New	2017 - Total
Total Revenues	\$64,399,108		\$64,399,108
Base Budget	\$65,462,968		\$65,462,968
New Initiatives Requested			
Per Diem Increase (1%)		\$99,850	\$99,850
HST Increase		\$5,062	\$5,062
Salary Increase (2.5%)		\$677,105	\$677,105
New Requests – Operating (Appendix 1)		\$717,855	\$717,855
Capital and depreciation		\$447,569	\$447,569
Building Reserve		\$0	\$0
Sub-total		\$1,947,441	
Total Expenditures	<u>\$65,462,968</u>		<u>\$67,410,409</u>
New Revenue Initiatives (Appendix 2)		<u>\$2,268,505</u>	<u>\$2,268,505</u>
Deficit	-\$1,063,860		-\$742,796

The base budget submissions for 2017 totalled \$65,462,968 which is a 1% increase over the previous year (2016).

Projected Deficit	-\$742,796
Committee breakage	<u>\$209,826</u>
Sub-total	-\$532,970
33,700 members @ \$30 (we can only recognize 7/12)	<u>\$589,750</u>
Surplus	\$56,780

The Finance Committee reviewed business cases relating to an increase in rates for per diems and salaries, capital expenditures and additional staffing requests. The staffing requests included: 1 new full time, 3 new contracts, 1 conversion to full time, a reclassification, an increase in time for a Medical Advisor and 8 contract renewals for a total of 15 requests.

CURRENT STATUS:

After a fulsome discussion of the budget for 2017, the Finance Committee is recommending to Council the adoption of the expenses as detailed, the new revenue proposals as presented and a fee increase of \$30 to \$1,625. The following motions were made:

1. It was moved by Dr. Rouselle, seconded by Dr. Chan and **CARRIED**. *That the Committee recommends to Council that the fee from an initial application from a Certificate of Incorporation be raised from \$350 to \$400 and the fee for a renewal of a Certificate of Incorporation be raised from \$125 to \$175 effective January 1, 2017.*
2. It was moved by Dr. Rosenblum, seconded by Dr. Kirsh and **CARRIED**. *That the Finance Committee recommends to Council that the fee for a Certificate of Professional Conduct be raised from \$50 to \$75 effective January 1, 2017.*
3. It was moved by Dr. Rouselle, seconded by Dr. Chan and **CARRIED**. *That the Finance Committee recommends to Council that the fee for an application for a certificate of registration for an independent practice be increased from 50% of the membership fee for a certificate of independent practice to 60% upon approval of Council and the associated by-law change.*
4. It was moved by Dr. Rouselle, seconded by Mr. Pielsticker and **CARRIED**. *That the Finance Committee recommends to Council that the fee for an application for a certificate of registration for a post graduate licence be increased from 10% of the membership fee for a certificate of post graduate licence to 25% upon approval of Council and the associated by-law change.*
5. It was moved by Mr. Pielsticker, seconded by Dr. Chan and **CARRIED**. *That the Finance Committee recommends to Council that a new Expedited Review fee be established as follows: 75% of the independent practice certificate application fee and 50% of the post graduate certificate application fee upon approval of Council and the associated by-law change.*
6. It was moved by Mr. Pielsticker, seconded by Dr. Chan, and **CARRIED**. *That the Finance Committee recommends to Council that the budget for 2017 be approved as revised and presented.*
7. It was moved by Dr. Chan, seconded by Dr. Rosenblum, and **CARRIED**. *That the Finance Committee recommends to Council that the membership fee be \$1,625, effective June 1, 2017.*
8. It was moved by Mr. Pielsticker, seconded by Dr. Rosenblum and **CARRIED**. *That the Finance Committee recommends to Council that per diems be increased by 1% effective January 1, 2017.*

Appendix 1

CPSO
Budget 2017

Staffing Requests	Number	
Corporate Services	4	
Legal	1	
Quality Management	3	
Investigations & Resolutions	5	
Total		\$717,855
New Full Time Position	1	
New Contract Positions	3	
Reclassification of Existing Position	1	
Renewal of Existing Contract Positions	8	

Appendix 2

CPSO
Budget 2017

		\$	#	Potential Impact on the budget	Per Member
Revenues					
Increase to Incorporation Fees	Increase by \$50				
New		50.00	1,600	\$80,000	\$ 2.40
Referrals		50.00	19,000	\$950,000	\$ 28.50
Certificates of Professional Conduct	Increase by \$25	25.00	8,000	\$200,000	\$ 6.00
Application Fees - Independent Practice Lic	Increase from 50% to 75%	159.50	1,900	\$303,050	\$ 9.09
Application Fees - Post Graduate	Increase from 10% to 25%	239.25	2,574	\$615,830	\$ 18.47
Expedited Review Fee - IPL	50% of IPL Application Fee	598.13	150	\$89,719	\$ 2.69
Expedited Review Fee - PG	50% of PG Application Fee	199.38	150	\$29,906	\$ 0.90
				\$2,268,505	\$ 68.05

COUNCIL BRIEFING NOTE

TOPIC: Governance Committee Report – Part I

FOR DISCUSSION:

1. 2016 Council Performance Assessment Results

FOR DECISION:

2. Review of Council's Nominations Guidelines

FOR DISCUSSION:

1. 2016 Council Performance Assessment

BACKGROUND:

- Council's 2016 performance assessment was distributed with the meeting materials for the September meeting of Council.
- This is the 13th year that the assessment has been conducted and the results were again quite positive.
- The goals of the performance assessment include the following:
 - to gauge Council's performance in a number of areas over the past year;
 - to identify areas for improvement;
 - to obtain general feedback, both positive and negative.
- Of the 33 questionnaires distributed, 25 were completed, representing a response rate of 76%.
- Number of years on Council:

○ 1 year <	–	16%
○ 1-2 years	–	24%
○ 3-4 years	–	12%
○ 5-6 years	–	8%
○ >7 years	–	32%
○ no response	–	8%

A. VISION AND MANDATE

QUESTIONS	RATING			
	Yes	Somewhat	No	Don't Know
1. I understand the vision and the mandate of the College.	100%			
2. The Council formally reviews its vision.	88%	8%	4%	

Summary:

- The College vision and mandate is understood by Council. A handful of Council members may believe that the time has come to review the College's vision.

Comments:

- *Vision spoken but not examined.*
- *Vision and mandate are well defined and are focused. Consistently reminded to everyone.*

B. STRATEGIC PLAN AND PRIORITIES

QUESTIONS	RATING			
	Yes	Somewhat	No	Don't Know
1. The College's strategic plan is documented	100%			
2. The Council creates a set of key priorities that must be implemented in support of the strategic plan of the College	100%			
3. The Council establishes a small number of strategic initiatives to focus attention and resources to help achieve the College vision.	100%			
4. The dashboard report presented by the Registrar clearly reports progress on College priorities.	100%			

Summary:

- All Council members are aware that the College has a documented strategic plan and that priorities are established to help achieve the plan.

- The dashboard report presented by the Registrar is perceived to be clear and is viewed positively.
- The results in this section are the best ever.

Comments:

- *Given the level of high priority issues, the College (staff) has done an exceptional job keeping them all in focus*
- *Dashboard clear and easy to understand*
- *Council consistently reviews the objectives/priorities based on the overall philosophy. Registrar reviews this information in his dashboard presentation. It is consistently under the radar.*

C. COUNCIL'S ROLE AND RESPONSIBILITIES

QUESTIONS	RATING			
	Yes	Somewhat	No	Don't Know
1. I am familiar with the College's governance practices and policies.	96%	4%		
2. The Council effectively develops and approves principles and policies that fulfill its duty to protect the public interest.	92%	8%		
3. The Council effectively discharges its statutory functions.	96%			4%
4. The Council periodically monitors and assesses its performance against its strategic direction and goals.	96%			4%
5. The College has an effective system of financial oversight.	88%	8%		4%
6. The Council meets with external auditors, reviews their reports and recommendations and, ensures any deficiencies are corrected.	96%			4%

Summary:

- The results in this section are again very positive.
- Respondents also feel familiar with the College's Governance practises and policies.
- Respondents feel that the Council:
 - develops and approves policies that full fill its public interest mandate
 - effectively discharges its statutory functions
- Respondents feel that the College has an effective system of strategic oversight
- Respondents who rated *don't know* response have been on Council for less than one year.

Comments:

- *Policy – like to see more early Council involvement*
- *Policies often very verbose, detailed and lengthy. Need a brief summary to increase readership by the average physician*
- *There is no interim financial reporting*
- *Excellent input from external auditor and College financial staff to Council; reports to support status. Registrar's dashboard report clearly reflects status of performance against goal.*
- *Performance excellent re- checking progress against goals – policies are slow moving – advantage: thorough vetting – disadvantage: timing for policies important to the public*
- *Policy development and review well done. Excellent support by College staff*

D. GOVERNANCE OPERATIONS

QUESTIONS	RATING			
	Yes	Somewhat	No	Don't Know
1. As a Council member I understand my fiduciary obligations.	100%			
2. I know and understand the Code of Conduct.	100%			
3. I understand the Conflict of Interest Policy.	100%			
4. As a member of Council, I declare potential conflicts of interest according to Council's conflict of interest requirements.	100%			

Summary:

- There is a clear sense amongst respondents that in the area of governance operations that they as members of Council:
 - Understand their fiduciary obligations;
 - Know and understand the Code of Conduct;
 - Understand the COI policy;

- Declare conflicts.
- The results in this section are the best in the 13 years that the assessment has been conducted.

Comments:

- *This is all clearly defined in the Governance Committee and manual. Conflict of interest is paramount to fairness and equal treatment*

E. COUNCIL OPERATIONS

QUESTIONS	RATING			
	Yes	Somewhat	No	Don't Know
1. I receive appropriate information for Council meetings.	100%			
2. I receive information for Council meetings on a timely basis.	88%	12%		
3. Council's meetings are effective and efficient.	96% ¹			
4. The President chairs Council meetings in a manner which enhances performance and decision-making.	96%	4%		
5. I feel comfortable participating in Council discussions	96%	4%		
6. Council has a formal written orientation package for Council members.	82%	8%	4%	4%
9. My orientation to the College Council was effective.	76%	12%	8%	4%
10. I am aware that Council has a mentorship program.	92%	4%	4%	
11. Council's mentorship program is helpful.	52% ²	24%	4%	16%
12. I find Council's continuing education activities useful.	96%	4%		

¹ One person did not answer.

² One person did not answer.

Summary:

- Overall, results in this section are very positive demonstrating that Council members are quite satisfied with Council meetings and the quality of the materials.
- Council members are satisfied that they receive appropriate and timely information for Council meetings.
- Council feels that meetings are carefully planned, effective, efficient and chaired (95%).
- There is an opportunity and feeling that more orientation for new members of Council would be helpful.
- The mentorship program was strengthened last year. There is growing awareness of the program. All but one Council member who has participated in the program has found the mentorship helpful or somewhat helpful.

Comments:

- *For the September meeting some Council members did not see the briefing note on sexual abuse as it was made available just prior to the meeting (NOTE: because SATF report released on day 2 of Council meeting)*
- *Council September 17 – e-mail with info sent 24 hours before*
- *Re #4 – excellent job by Dr. Joel Kirsh – Congrats!*
- *Sometimes president rushes a bit and feels like we are being pushed too much to accept things/not enough discussion*
- *Meeting well run by current president*

F. RELATIONSHIP WITH REGISTRAR

QUESTIONS	RATING			
	Yes	Somewhat	No	Don't Know
1. I understand that a committee of Council that reports to the Executive Committee approves the Registrar's annual performance objectives and conducts the Registrar's annual performance review.	96%	4%		
2. The President asks Council for feedback which informs the Registrar's performance review and advised Council of the outcome of the review.	96%	4%		
3. The Council maintains a collegial working relationship with the Registrar	100%			
4. The Council <u>does not</u> get involved in day-to-day operational matters.	100%			
5. Committees <u>do not</u> get involved in day-to-day operational matters.	92%	8%		

Summary:

- Council maintains a collegial working relationship with the Registrar (100%).
- There appears to be a much better understanding of the processes in place to establish performance expectations and provide feedback to the Registrar.
- There appears to be a much better understanding with respect to the role of Council and College committees in day-to-day operational matters.

Comments:

- *Is council too disengaged?*
- *Sometimes unavoidable for committees to get involved in day-to-day matters*

STRENGTHS AND DEVELOPMENTAL NEEDS

1. List two strengths of the Council.

- *Council meetings are well organized and well run – the materials are clear and comprehensive and the speakers are excellent*
- *Member participation is encouraged and always received with respect and consideration, regardless of the input provided.*
- *Membership and public well represented*
- *Discussion is generally balanced and opposing views educational*
- *Respectful of others' opinions*
- *Seems open to keep moving policies through process. Policies have been progressive and staff support is excellent regarding clearly understanding the issues*
- *Members of Council are responsible dedicated and hard-working. Meetings are well-run*
- *Open and transparent*
- *Well organized agenda*
- *Motivated articulate members. Great administrative support*
- *Highly committed, wise. Collegial, professional*
- *Breath of experience of Council to resolve complicated matters. Work effectively as a team.*
- *Transparent. Stay ahead of the curve on issues, i.e. assisted death, sexual abuse.*
- *Collegiality. President presides well.*
- *Efficient meetings, friendly and supportive staff*
- *Very effective meetings. Great support staff*
- *Meetings are well conducted, timely and efficient*
- *Collegiality. Open, frank discussions. Impressive background info and preparation for meetings*
- *Collegial. Good mix of lay and physician members*

2. List two ways Council could be improved.

- *More input into public/government relations*
- *Improved initial orientation*
- *Need more than one week's time to review documents re complicated matters*
- *More diversity to reflect public it serves.*
- *Smaller?*
- *Encourage members to submit topics for Members Topics well in advance*
- *I suggest the mentorship program be strengthened. As a new council and committee members, I would have benefitted for a more formalized approach. I think the mentorship guideline is valuable but it needs to be followed. Perhaps a briefing session for mentors would help.*
- *As trivial and challenging as this suggestion may appear, I would appreciate more frequent opportunities to stand during Council meetings.*

ADDITIONAL COMMENTS:

- *What is the process for dealing with council members who do not carry their weight?*
- *On behalf of many council members and public members, I say that the College is very fortunate to have a great Registrar who provides us with a magnificent leadership and vision. Also we are blessed to have a very dedicated group of senior managers.*
- *I have found my short experience on Council to be equal parts stimulated, challenging and rewarding. I very much appreciate the work of the Executive and the staff in preparing thoughtful agendas and excellent meeting materials. I also appreciate the opportunity to provide feedback on a regular basis.*

Suggested Next Steps:

- Governance Committee to consider ways of strengthening orientation programming in 2017. This will be important as we anticipate the appointment of three new public members and four physician members of Council.
- Discussion at Council regarding the policy development process and College policies.
- Discussion at Council on other topics including but not limited to stakeholder engagement, government relations and communications.

Questions for Consideration:

- How do you feel about the results and the proposed next steps?
- Should any other areas be considered?

FOR DECISION:**2. Review of Council's Nominations Guidelines****BACKGROUND:**

- The Governance Committee has reviewed and is recommending updates to Council's nominations guidelines.
- The guidelines were first developed to provide guidance and inform nominations related decision-making (appointment of committee chairs and members). They are also meant to facilitate and support transparency in the College governance processes.
- They were developed by the Governance Committee and adopted by the College Council in April 2005.
- They are contained in the Governance Practices and Policies section of the Governance Process Manual. The manual is available on the College website.
- The guidelines provide guidance in a number of areas including the following:
 - Length of committee member terms;
 - Length of committee chair terms;
 - Competencies and characteristics required to chair specific college committees;
 - Measures to facilitate succession-planning;
 - Overall commitment to succession planning.
- As part of the review process, committee support staff has provided feedback (in particular, managers of MSI committees).
- They are meant to be concise and reference related material that is available online such as role descriptions and eligibility criteria set out in the General Bylaw.
- The updated nomination guidelines can be found at Appendix 1. The existing guidelines are contained in Appendix 2.

SUMMARY OF PROPOSED CHANGES:

- General updates to reflect the College in 2016.
- The chair and committee membership sections are more clearly divided.
- New sections have been added including:
 - Technical competence and diversity
 - There is an expectation that Council and committee members are proficient with technology
 - There is recognition of other considerations including proficiency in French and a need for other diversity interests including gender balance

- Council and committee eligibility and disqualification
 - Council and committee eligibility and disqualification provisions that apply to elected members of Council, members of the Academic Advisory Committee and professional committee members are included in an appendix.
 - Committee-specific chair characteristics/competencies have been refined and updated.
 - The orientation and training section has been strengthened. There is now a clear expectation that chairs and committee members participate in mandated training (this has included sexual harassment and awareness training and diversity training). There is recognition that there needs to be some flexibility and the orientation program should be recorded or available online.
 - Committee membership (consecutive years of eligibility) has moved from four to five years for operating committees.
 - Statutory committees are more clearly exempt from this new five-year committee member term limit (consecutive years).
 - The point that appointments are made on an annual basis, and no one is entitled to be reappointed has been reinforced.
 - The recommendation that chairs serve for no more than three consecutive years as chair of a specific committee is maintained.
 - Many of these changes are highlighted in Appendix 1.
-

DECISION FOR COUNCIL:

- Approval of the updated Nomination Guidelines.
-

CONTACTS: Carol Leet, Chair
Louise Verity
Debbie McLaren

DATE: November 10, 2016

Appendix 1: Proposed updated nominations guidelines

Appendix 2: Current nominations guidelines

**Governance Practices and Policies
Nominations Guidelines**

APPENDIX 1

Governance Practices and Policies

Nominations Guidelines (Revised Draft)

Purpose

The Nominations Guidelines contain eligibility criteria and other information utilized to inform and guide nominations related decisions made by the Governance Committee and the College Council. They apply to the selection of committee chairs and committee members.

The guidelines are also a resource to members of Council and committees, staff, members of the profession and others. They help explain the processes and basis upon which nomination recommendations and decisions are made.

Overview

A key goal in the College's 2001 strategic plan was to establish an effective and transparent governance model for the College. The College's General Bylaw and the Governance Process Manual contain the foundational elements of this model. The Nominations Guidelines reside in the Governance Process Manual.

Pursuant to the General Bylaw, committee chairs and committee members are nominated and appointed annually.

The General By-Law also sets out eligibility and disqualification criteria for members of Council and College Committees (Appendix 1).

The Governance Process Manual sets out governance roles and responsibilities, governance practices and procedures, College Committee mandates, a key behavioural competency model and a performance feedback process.

Relevant to nominations, the Governance Manual sets out role descriptions and key behavioural competencies for Council and Non-Council Committee Chairs and Council and Non-Council Committee Members.

Council members provide annual expressions of interest, and non-Council members apply and are recruited to work on College committees. Committee chairs are asked by the Governance Committee to identify committee needs and requirements.

Every new committee member undergoes screening. The screening process includes an interview usually with the Chair of the Governance Committee and the chair of the relevant committee.

The Governance Committee oversees the entire nominations process and recommends nominations for committee Chairs and membership to Council for approval. Council makes nominations related

Comment [LV1]: For ease of reference have added an appendix that includes all eligibility and disqualification provisions in the General By-Law

Comment [LV2]: Feel we can enhance accessibility of the Governance Process Manual. The document is currently on the website as a pdf and is difficult to navigate. Looking to create a series of links to each of the major sections. Will do this once the nominations guidelines are updated

Comment [LV3]: Note: Will also include reference and links to committee competence frameworks (DC, ICR and QMD when they are posted publicly. They need to be reviewed for this purpose).

Governance Practices and Policies Nominations Guidelines

decisions. The Nominations Guidelines are based on best practices in areas including but not limited to:

- Defined competencies for committee chairs and members
- Commitment to orientation and training
- Commitment to succession planning and renewal

All committee appointments are for one year, coinciding with the College's **AGM**.

A. Chairs

Committee Chair Selection

The nomination and appointment of qualified committee chairs is essential to effective committee governance.

The majority of College committees have one chair, though some committees have co-chairs. In addition, one College committee; the Inquiries, Complaints and Reports Committee, has a number of vice-chairs who are responsible for chairing specific specialty panels.

All chairs and vice-chairs are nominated and appointed annually pursuant to the General Bylaw.

It is recommended that chairs serve for no more than three consecutive years as chair of a specific committee.

Annual reappointment during the three year term depends on criteria, including link to Council, role requirements, demonstrated key leadership and committee-specific competencies, succession planning, term limits and performance, as described below.

Link to Council

Many College committees exercise independent decision-making authority. Examples include the Discipline, Fitness to Practise, ICR, and Quality Assurance Committees. However, the College Council develops and sets the overall policy framework for the work of College committees within and consistent with the legislative framework. Therefore, it is critical that committees have a strong link to Council.

It is recommended that all College Committees be chaired by a member of College Council or a member of Council's Academic Advisory Committee. Non-Council members may chair when the chair responsibility is shared with a member of Council. The exception is the Patient Relations Committee (PRC). There are no Council members on the PRC to avoid conflict and any perception of bias in relation to other College committee processes. PRC membership is set out in the Council By-Law.

Committee Chair Role Descriptions

Role descriptions and key behavior competencies for Council and non-Council Committee Chairs are set out in the Governance Process Manual.

Comment [LV4]: Added to reinforce fact that appointments are made annually.

Comment [LV5]: Updated guidelines - create separate sections chairs and committee members

Comment [LV6]: This section has been expanded.

**Governance Practices and Policies
Nominations Guidelines**

Committee Chairs must have an understanding of and a commitment to the public interest mandate of the College.

Committee Chairs must also have an understanding of and commitment to the mandate of the committee they lead and have expertise relevant to its mandate. The Chair must provide leadership so that committee goals are achieved in a fair, effective, and efficient, manner. The Chair liaises with staff and reports the work of the committee to Council and facilitates Council’s understanding of committee work. Further, Committee Chairs are required to assess whether their committee members have the resources and training to perform effectively within the mandate of the committee.

Key Behavioural Competencies

Key behavioural competencies for committee chairs accompany the role descriptions in the Governance Process Manual. Key competencies include:

Managing Competencies

- leadership
- planning and initiative
- continuous learning

Thinking Competencies

- creativity
- strategic thinking

Influencing Competencies

- relationship building
- effective communications

Achieving Competencies

- results oriented
- stakeholder focus
- team work



The managing competency, namely the ability to take on a role as leader, is required for the role of College President and Chair of Council as well as a Committee Chair. Leaders have integrity and create positive morale and spirit on their teams. They share wins and success and demonstrate a positive attitude, energy, resilience and stamina. Leaders also have the courage to take risks.

It is expected that all committee chairs will demonstrate these key behavioural competencies and, the additional committee-specific competencies as described in the chart below,

Committee	Committee-specific Chair Competencies
Council Award	Past-President*
Education	Academic. Knowledge of educational initiatives and policies (CPD), Awareness of issues / matters affecting Ontario medical education.
Executive	President*

Governance Practices and Policies Nominations Guidelines

Discipline	Knowledge and understanding of administrative law principles, committee practices and College processes. Acquired, or actively developing, adjudicative skills (writing and panel chair). Commitment to hearing schedule and case management.
Finance	Good understanding of financial processes, significant budgeting experience.
Fitness to Practise	Knowledge and understanding of administrative law principles, committee practices and College processes. Acquired, or actively developing, adjudicative skills (writing and panel chair). Commitment to hearing schedule and case management.
Governance	Past-President* (Whenever possible, it is recommended that the Chair should be a past president on Council or a past president who has not been off the Council more than 3 years)
Inquiries, Complaints and Reports (ICR)	Knowledge and understanding of administrative law principles, proper investigation practices, and College processes. Past or recent experience chairing a College screening committee.
Methadone	Familiar with methadone program, legislation, regulations, standards, guidelines.
Outreach	Interest and knowledge of member and public communications and stakeholder management.
Patient Relations	Proven awareness and understanding of sexual abuse and the impact of sexual abuse on patients, knowledge and understanding of boundary issues, knowledge of the field of psychological issues.
Premises Inspection	Familiar with College's premises inspection program and applicable legislation, regulations, standards and guidelines. Knowledge of I and R and QA processes.
Quality Assurance	Familiar with College practice assessment and enhancement activities, I and R and QA processes, legislation, regulations, standards and guidelines.
Registration	Familiar with College's registration policies, general understanding of credentialing, registration and certification processes. Understanding of medical academic issues an asset. Knowledge of QA and I&R processes.

*As per General By-Law

Comment [LV7]: When committee competency frameworks are made public they will be cited.

Succession Planning

Succession planning is essential to maintaining and enhancing committee capacity.

It is vital to:

- retain well qualified and experienced members to act in leadership roles, such as the role of Chair, and to mentor new members; and,
- bring in new appointments to refresh the membership on an ongoing basis.

This process of maintenance and renewal is necessary to ensure consistent committee capacity, and for ongoing succession planning.

Governance Practices and Policies Nominations Guidelines

Early identification and training of potential chairs as well as setting and adhering to term limits aid effective succession planning.

Length of Terms

Prior to 2006, there were no term limits for committee chairs. Council established term limits to guide nomination decisions and to foster committee renewal.

It is strongly recommended that chairs serve no more than three consecutive years as chair of a specific committee.

In cases where committees have two chairs or vice chairs, chair appointments are staggered where possible, to ensure consistency in leadership from one year to the next and for mentoring of new chairs.

Participation in Training Opportunities

Participation in College-mandated training is essential for all members of Council and committees. Committee chairs are expected to participate in all mandated training. This includes participating in Council's annual orientation day (February) and maintaining CPD. This may also include other prescribed training or development programming.¹

Governance Committee key considerations in making chair nomination decisions:

- 1. Does the candidate demonstrate the key leadership competencies?***
- 2. Does the candidate possess the committee specific chair competencies?***
- 3. If the candidate has served as chair of the committee, or has previously chaired a College committee, what were the results of the chair performance assessment?***
- 4. How many years of eligibility does the candidate have on the College Council?***
- 5. If the candidate is a current committee chair, has he or she reached the 3 year term limit?***
- 6. Is the candidate willing to chair the committee?***

B. COMMITTEE MEMBERS

Committee Composition

Just as College committees need to be led by skilled chairs, they also need the right mix of members who together have the ability to effectively discharge the responsibilities of the Committee. Committees must also be rejuvenated with new ideas and people through adequate succession planning.

As per the College's by-laws, committee members are nominated and elected annually. Reappointment will depend on performance, length of tenure and committee-specific factors.

Committee requirements vary with the size, structure, mandates and panel composition and quorum requirements.

¹ This has included for example sexual harassment and awareness training and diversity training.

Comment [LV8]: This is much stronger -training is mandatory. GC intends to review participation: Council orientation, other training such as sexual harassment training. Will need to beef up orientation to ensure that it is available on more than one date (create video, online module etc.)

Governance Practices and Policies Nominations Guidelines

Annual reappointment criteria include, role requirements, demonstrated or commitment to develop committee-specific competencies, term limits, performance assessment, and succession planning as described below.

Committee Member Role Description

Role descriptions and key behavioral competencies for Council committee members and non-Council committee members are set out in the *Governance Process Manual*.

Committee members must have an understanding of and a commitment to the public interest mandate of the College.

Committee members must also have an understanding of and a commitment to the mandate of the Committee.

Key Behavioral Competencies

The key behavioral competencies for Council and non-Council committee members are as set out in the *Governance Manual*.

The Governance Committee also considers committee-specific competencies and resource requirements.

Technical Competence and Diversity

Proficiency with technology is essential as the College utilizes webmail and sharepoint, conducts meetings with electronic materials and anticipates further technical advancement.

Other considerations include proficiency in French and the fulfillment of regional, practice area and other diversity interests including gender balance.

Succession Planning

Succession planning is critical to ensuring balance and renewal on College committees. Ensuring the delivery of orientation and training programs, as well as setting and adhering to committee membership term limits, are important components to succession planning.

Length of Terms

In the past, there were no term limits for committee members. As a consequence, committee renewal was limited and inconsistent. As a general principle, it is recommended that committees have a 20% turnover (where possible) in membership on an annual basis.

It is also recommended that committee members should serve no longer than five consecutive years on operating committees. Operating committees include the Outreach, Finance, Governance committees. This five year membership limit would not apply to committee chairs.

Capping the length of committee member terms has the added benefit of clearly managing expectations, facilitating succession planning.

Comment [LV9]: This section is new.

Comment [LV10]: Note: this rule has not been followed and requires some further discussion. This is why it is recommended that we identify operating committees specifically and move from 4-5 years as a committee member on an operating committee.

Governance Practices and Policies Nominations Guidelines

Certain statutory committees, such as the Discipline, QA, Registration and ICR committees, are exempt from the five-year committee member term limit. They are exempt to ensure that they are able to meet statutory panel composition and quorum requirements as well as to ensure they have a roster able to perform the work of the committee. The work of these committees is technical and complex and committee members require considerable training and experience to facilitate performance.

Orientation and Training

The College supports the orientation, training and mentorship of Council and non-Council committee members to ensure that the College's statutory obligations and committee mandates are carried out in a fair, effective and efficient manner.

To this end, the College delivers an annual Council and Committee Orientation program. All Council and non-Council committee members are strongly encouraged to participate in the orientation program, held typically in February each year.

Council also has a mentorship program designed to welcome and support new members of Council. The assigned mentor is on Council and where possible, is on a Committee to which the new member is also appointed.

Annual committee-specific orientation, training and mentorship is developed and delivered by Committee Chairs and College support staff and may take place on multiple days throughout the year.

Council and committee members are expected to participate in defined training programs (i.e. annual orientation day, sexual harassment training as well as other training that may be identified).

Governance Committee key considerations in making committee membership nomination recommendations:

- 1. Does the committee have the necessary expertise and core competencies/skills to adequately discharge its mandate?***
- 2. Are there any new members on the committee?***
- 3. How many more years of eligibility does the candidate have on the committee?***
- 4. How many more years of eligibility does the candidate have on the Council?***
- 5. How has the committee member performed?***
- 6. Does the candidate member function in the public interest?***

Adopted by the College Council in April 2005

Comment [LV11]: This paragraph is new .

Governance Practices and Policies
Nominations Guidelines

Appendix 1

Comment [LV12]: New Appendix

Eligibility and Disqualification Provisions in College By-Law

A summary of Council and committee eligibility and disqualification provisions that apply to elected members of Council, members of the Academic Advisory Committee and professional committee members in the College By-Law are contained below.

I Elected Members of College Council

Eligibility For Election

- 13.** (1) A member is eligible for election to the council in an electoral district if, on the date of the election,
- (a) the member is engaged in the practice of medicine in the electoral district for which he or she is nominated or, if the member is not engaged in the practice of medicine, is resident in the electoral district for which he or she is nominated;
 - (b) the member is not in default of payment of any fees prescribed in any regulation made under the *Regulated Health Professions Act, 1991* or the *Medicine Act, 1991*;
 - (c) the member is not the subject of any disciplinary or incapacity proceeding;
 - (d) the member's certificate of registration has not been revoked or suspended in the six years preceding the date of the election;
 - (e) the member's certificate of registration is not subject to a term, condition or limitation other than one prescribed in any regulation made under the *Regulated Health Professions Act, 1991* or the *Medicine Act, 1991*;
 - (f) the member is not a director or officer of the Ontario Medical Association, the Canadian Medical Protective Association, the Canadian Medical Association, or the Coalition of Family Physicians and Specialists of Ontario;
 - (g) the member does not hold a position which would cause the member, if elected as a councillor, to have a conflict of interest by virtue of having competing fiduciary obligations to both the College and another organization;
 - (h) council has not disqualified the member during the three years before the election date, and
 - (i) the member has completed and filed with the registrar a Conflict of Interest form by the deadline set by the registrar.
- (2) A member is not eligible for election to the council who, if elected, would be unable to serve completely the three-year term prescribed by section 11 by reason of the nine-consecutive-year term limit prescribed by subsection 5(2) of the Health Professions Procedural Code.

Governance Practices and Policies
Nominations Guidelines

Disqualification of Elected Members

- 22.** (1) An elected member is disqualified from sitting on the council if the member,
- (a) is found to have committed an act of professional misconduct or is found to be incompetent by a panel of the discipline committee;
 - (b) is found to be an incapacitated member by a panel of the fitness to practise committee;
 - (c) with respect to a council member elected after October 1, 2011, ceases to hold a certificate of registration that is not subject to a term, condition or limitation other than one prescribed in any regulation made under the *Regulated Health Professions Act, 1991* or the *Medicine Act, 1991*;
 - (d) fails, without cause, to attend three consecutive meetings of the council;
 - (e) fails, without cause, to attend three consecutive meetings of a committee of which he or she is a member;
 - (f) ceases to either practise or reside in the electoral district for which the member was elected;
 - (g) is in default of payment of any fee prescribed by College by-law for more than thirty (30) days;
 - (h) fails, in the opinion of council, to discharge his or her duties to the College, including having acted in a conflict of interest or otherwise in breach of College by-law, the *Regulated Health Professions Act 1991*, or the College's governance policies;
 - (i) is or becomes a director or officer of the Ontario Medical Association, the Canadian Medical Protective Association, the Canadian Medical Association, or the Coalition of Family Physicians and Specialists of Ontario; or
 - (j) holds a position which would cause the member to have a conflict of interest by virtue of having competing fiduciary obligations to both the College and another organization.

II Academic Advisory Committee Members of Council

Academic Advisory Committee

24. (1) An Academic Advisory Committee shall be established and shall be composed of members appointed under this section.

(2) Between one and two months before the meeting of the council when the term of office of newly elected councillors starts, the dean of each faculty of medicine of a university in Ontario may appoint one member to the academic advisory committee.

(3) A member is eligible for appointment to the academic advisory committee if, on the date of the appointment,

- (a) the member is on the academic staff of the faculty of medicine;
- (b) the member is not in default of payment of any fee payable to the College;
- (c) the member is not the subject of any disciplinary or incapacity proceeding;
- (d) the member's certificate of registration has not been revoked or suspended in the six years preceding the appointment;
- (e) the member's certificate of registration is not subject to a term, condition or limitation other than

Governance Practices and Policies
Nominations Guidelines

one prescribed by a regulation; the member is not a director or officer of the Ontario Medical Association, the Canadian Medical Protective Association, the Canadian Medical Association, or the Coalition of Family Physicians and Specialists of Ontario; and

- (f) the member does not hold a position which would cause the member, if appointed to the Academic Advisory Committee, to have a conflict of interest by virtue of having competing fiduciary obligations to both the College and another organization.

Disqualification of Selected Councillors

27. (1) A person selected as a councillor is disqualified from sitting on the council if the member,
- (a) is found to have committed an act of professional misconduct or is found to be incompetent by a panel of the discipline committee;
 - (b) is found to be an incapacitated member by a panel of the fitness to practise committee;
 - (c) with respect to a council member selected after October 1, 2011, ceases to hold a certificate of registration that is not subject to a term, condition or limitation other than one prescribed through regulation;
 - (d) fails without cause, to attend three consecutive meetings of the council;
 - (e) fails, without cause, to attend three consecutive meetings of a committee of which he or she is a member;
 - (f) ceases to be on the academic staff of the faculty of medicine from which the member was selected;
 - (g) is in default of payment of any fee prescribed by College by-law for more than thirty (30) days;
 - (h) fails, in the opinion of council, to discharge his or her duties to the College, including having acted in a conflict or otherwise in breach of a College by-law, the *Regulated Health Professions Act, 1991*, or the College's governance policies;
 - (i) is or becomes a director or officer of the Ontario Medical Association, the Canadian Medical Association, or the Coalition of Family Physicians and Specialists of Ontario; or
 - (j) holds a position which would cause the member to have a conflict of interest by virtue of having competing fiduciary obligations to both the College and another organization.

III Non-Council Committee Members of Council

Appointment of Members to Committees

1. (1) The council may appoint a member of the College to a committee only if, on the date of the appointment,
- (a) the member practises medicine in Ontario or resides in Ontario;
 - (b) the member is not in default of payment of any prescribed fees;
 - (c) the member is not the subject of any disciplinary or incapacity proceeding;
 - (d) the member's certificate of registration has not been revoked or suspended in the six years preceding the date of the appointment; and

Governance Practices and Policies
Nominations Guidelines

- (e) the member's certificate of registration is not subject to a term, condition or limitation other than one prescribed by a regulation.

Appointment of Non-Members to Committees

- (2) The council may appoint a person who is not a member of the College or a councillor to a committee.

DRAFT

GOVERNANCE PRACTICES AND POLICIES

Nominations Guidelines

Introduction

Background

Nominations guidelines were adopted by the College Council in April 2005.

They were developed to address certain policy gaps faced by the Governance Committee in making recommendations to Council which included:

- the length of committee member terms;
- the length of committee chair terms;
- the specific competencies required to chair various committees; and
- over-all succession planning.

Council eliminated the College's former guidelines in 2002. The College's former Nominating Committee had used them previously.¹

Purpose

The adoption and ongoing adherence to the nominations guidelines are central to achieving a key goal in the College's 2001 strategic plan, *to establish an effective and transparent governance model for the College*.

They were developed to ensure the transparency of decisions and enhance the quality of nominations recommendations to Council from the Governance Committee, and ultimately the nominations decisions made by Council.

The guidelines are designed to assist members of Council and CPSO committees to understand the processes and basis upon which nominating recommendations and decisions are made. They also convey important background information to individuals interested in participating in College activities. It is also hoped that they will be a useful tool in recruiting members who may wish to participate in the regulation of medicine in Ontario.

¹The CPSO Governance Committee replaced the Nominating Committee. The Council Organization Renewal Committee had recommended the creation of the Governance Committee, which combined the College's nominating and governance policy function into one committee.

Committee Chair Selection

The nomination and selection of committee chairs is a very important function of the Governance Committee and Council. Committee chairs should have the necessary leadership characteristics and committee specific competencies. In addition, they need to meet nominations criteria, including the length of their tenure, as well as committee-specific chair characteristics outlined later.

Desirable Characteristics

A key behavioural competency model is set out in the *Governance Process Manual*. It identifies desirable characteristics for members of Council, as well as members of committees.

Desirable competencies outlined include:

Thinking Competencies

- creativity
- strategic thinking

Self-managing Competencies

- planning and initiative
- continuous learning

Influencing Competencies

- relationship building
- effective communications

Achieving Competencies

- results oriented
- stakeholder focus
- team work

Managing Competencies

- leadership

The managing competency, ability to take on a role as leader of the Council or a committee, is required to take the role of College President and Chair of Council as well as a College committee. Leaders create positive morale and spirit on their teams. They share wins and success and demonstrate a positive attitude, energy, resilience and stamina. Leaders also have the courage to take risks. Integrity is also recognized as a necessary leadership trait.

Committee Chair Role Description

Role descriptions for the key officers of the CPSO as well as committee chairs are also set out in the *Governance Process Manual*.

Chairs should have an understanding of and a commitment to the public interest mandate of the College. It is expected that all committee chairs will possess competencies, which include: strong knowledge of the regulatory processes; effective meeting management skills; excellent judgment; and strong leadership skills. Following is a summary of required competencies specific to individual committees.

Committee	Desirable committee-specific chair characteristics
Council Award	Past-President*
Education	Academic, strong foundation of knowledge and experience with Ontario medical schools
Executive	President*
Discipline	Effective manager, knowledge of I and R and QA processes, effective decision-writer
Finance	Good understanding of financial processes, significant budgeting experience
Fitness to Practise	Knowledge of I and R and QA processes
Governance	Past-President* (Whenever possible, it is recommended that the Chair should be a past president on Council or a past president who has not been off the Council more than 3 years)
Inquiries, Complaints and Reports (ICR)	Possesses considerable knowledge and understanding of the principles of administrative law and fairness, and proper conduct of an investigation, has past recent experience chairing a member-specific issue College screening committee, communicates effectively ²
Methadone	Familiarity with methadone program, ability to manage conflict of interest scenarios
Outreach	Interest in member and public communications
Patient Relations	Understanding of boundary issues, knowledge of the field of psychological issues
Premises Inspection	Possesses considerable knowledge and understanding of the College's premises inspection program and applicable legislation, effective manager, knowledge of I and R and QA processes
Quality Assurance	Knowledge of I and R and QA processes, commitment to ongoing education
Registration	Strong technical understanding of registration/certification, understanding of academic issues would be an asset, able to evaluate credentials

² Inquiries, Complaints and Reports ("ICR") Committee Competence Framework for Chairs and Panel Members, April 14, 2009

*As per General By-Law

Succession Planning

Succession planning is a critical component of the nominations process. Early identification and training for potential chairs as well as setting and adhering to term limits are two ways of planning for future selection.

Participation in Training Opportunities

The College occasionally brings in external expertise to conduct a chair training session. Council members interested in chairing a College committee are also encouraged to participate in training when these opportunities are available and accommodations can be made.

Length of Terms

Prior to 2006, there were no term limits for committee chairs. Term limits had been discussed prior to that time, but were not adhered to. Although chairs are nominated and elected annually, it was found to be very difficult to make changes to the leadership of College committees. This absence of any rules to guide leadership nominations decisions blocked succession planning and committee renewal. This was a major problem and one of the reasons why the nominations guidelines were developed.

Currently, nominations recommendations must be based on a number of factors including succession planning and the results of performance assessments. Chair performance assessment results now assist the Governance Committee make chair nominations recommendations.

It is recommended that chairs serve for no more than three years as chair of a specific committee. As per the College's by-laws, chairs will continue to be nominated and elected annually. Reappointment will depend on performance and other factors that have been identified. In cases where committees have two chairs, it is recommended that chair turnover be staggered, to ensure that there is some consistency in leadership from one year to the next.

Capping or prescribing the length of chair terms has the added benefit of clearly managing expectations, facilitating succession planning and renewal of College committees.

Link to Council

It is critical that committees have a strong link to Council. Many College committees are independent in their decision-making. Examples include the Discipline, ICR, and Quality Assurance Committees. It is the College Council, however, that develops and sets the overall policy framework that guides, together with relevant statutes, the work of these committees. Many other College committees make recommendations to Council. Examples include the Outreach and Governance Committees.

APPENDIX 2

Both Council and non-Council members chair CPSO committees. Generally, in the cases where non-Council members chair CPSO committees, a member of Council also chairs them. It is recommended that all College Committees be chaired by a member of College Council. Non-Council members can chair when the chair responsibility is shared with a member of Council.

Following are the key considerations that are made by the Governance Committee in making any chair nominations recommendations to Council.

Governance Committee checklist in making chair nominations decisions:

- 1. Does the candidate have the necessary leadership skills to chair a committee?***
- 2. Does the candidate have the required committee-specific characteristics to effectively chair the committee?***
- 3. If the candidate chaired a CPSO committee previously, how did he/she perform in the chair performance feedback assessment?***
- 4. Is the candidate willing to chair the committee?***
- 5. How many more years of eligibility does the candidate have on the College Council? (for succession planning)***

Committee Composition

Just as College committees need to be led by skilled chairs, they also need to be balanced with of the right mix of members who together have the ability to effectively discharge the responsibilities of the Committee. Committees must also be rejuvenated with new ideas and people on an annual basis. This helps ensure that adequate succession planning measures are in place.

Desirable Characteristics

A key behavioural competency model was discussed earlier. Desirable characteristics for members of Council as well as members of committees are highlighted.

Committee Member Role Description

Role descriptions for Council members, Council committee members and non-Council committee members are set out in the Governance Process manual.

Succession Planning

Succession planning is critical to ensuring balance and renewal on College committees. Ensuring the implementation of committee-specific orientation and training programs, as well as setting and adhering to committee membership term limits, are two important components to succession planning.

Participation in Training Opportunities

Council and committee members have a formal orientation program. All members of Council as well as members of College committees are strongly encouraged to participate in the annual orientation program, normally held in February each year.

Committee-specific orientation is also necessary for all committee members. This orientation and training should be led by committee chairs and supported by College staff.

Length of Terms

In the past, there were no term limits for committee members. As a consequence, committee renewal was limited and inconsistent. As a general principle, it is recommended that committees have a 20% turnover (where possible) in membership on an annual basis.

It is also recommended that committee members should serve no longer than four consecutive years on a committee. This would not apply to committee chairs. The committees that are exempt from this term limit include the Discipline and ICR Committees. They are exempt from the four-year rule to ensure that they are able to meet the quorum rules set out in the RHPA as well as to ensure they have a roster able to perform the work of the Committee.

As per the College's by-laws, committee members are nominated and elected annually. Reappointment will depend on performance and other factors that have been identified.

Capping the length of committee member terms has the added benefit of clearly managing expectations, facilitating succession planning and renewal of College Committees.

Following are the key considerations that are made by the Governance Committee in making any committee membership nominations recommendations to Council.

Governance Committee checklist in making committee membership nominations recommendations:

- 1. Does the committee have the necessary expertise and core competencies/skills to adequately discharge its mandate?***
- 2. Are there any new members on the committee?***
- 3. How many more years of eligibility does the candidate have on the committee?***
- 4. How many more years of eligibility does the candidate have on the College Council? (for succession planning)***
- 5. How has a committee member performed?***
- 6. Does the candidate member function in the public interest?***

Annual Committee Reports

1. Discipline Committee
2. Education Committee
3. Executive Committee
4. Fitness to Practise Committee
5. Governance Committee
6. Inquiries, Complaints and Reports Committee
7. Methadone Committee
8. Outreach Committee
9. Patient Relations Committee
10. Premises Inspection Committee
11. Quality Assurance Committee
12. Registration Committee

Member Topics

No Meeting Materials

November 2016

REPORT OF THE DISCIPLINE COMMITTEE

Discipline Committee Objectives

In keeping with Council's strategic priority to optimize the discipline process, the Discipline Committee's objectives are aimed at the effectiveness and efficiency of the discipline process, while ensuring fairness.

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

To further these values and Council's strategic priority, the objectives of the Discipline Committee are to:

- I. Provide orientation and specialized education to committee members;
- II. Review committee processes, practices and procedures to improve the timeliness and efficiency of hearings, while ensuring fairness;
- III. Improve timeliness and enhance the quality of committee decisions;
- IV. Improve transparency and communication of committee activities and decisions.
- V. Review Costs and Expenditures

I. Orientation and Specialized Education Sessions

In 2016, the Discipline Committee delivered the following training sessions:

New Member Orientation	January 2 and February 5, 2016
Decision Writing	February 18, 2016
Chairing Case Conferences / Hearings	April 18, 2016

Business Meetings

The Discipline Committee also employs biannual business meetings to provide education on hearing topics, policies and practices of the Committee and the College and the decisions of other committees, tribunals and courts. As well, the Committee reviews its performance against the hearings and decision benchmarks and its rules of procedure. Business meetings were held on May 12 and October 26, 2016.

a) *New Rule regarding Reciprocal Disclosure*

In May 2016, the Discipline Committee approved new Rules of Procedure 7.01 to 7.04 regarding reciprocal disclosure. The reciprocal disclosure rules apply to referrals to the Discipline Committee made after August 1, 2016.

Prior to the implementation of this Rule, the College disclosed all relevant, non-privileged, information it has in relation to the member. The member was required to disclose only the identity of experts and expert reports, pursuant to statute.

The reciprocal disclosure rules requires each party to disclose to the other party the existence of every document and thing that the party or a witness called by or on behalf of the party, may seek to adduce in evidence or put to any witness at a hearing.

The Committee anticipates that reciprocal disclosure will considerably assist the efficiency of the discipline hearing process in a number of ways:

- a) it will give both the physician and the College a better sense of the strengths or weaknesses of the College's case and will do so much earlier to the benefit of possible resolution;
- b) it will encourage both parties to be realistic as to the probable outcome of a contested hearing, should one occur;
- c) it will allow both parties to obtain clearer instructions regarding resolution;
- d) it will provide the pre-hearing conference chair with more information on which to attempt to achieve a resolution; and
- e) it will enhance the possibility of the parties achieving agreements with respect to complete resolution, resolution of issues, agreed statements of facts, and/or dispensing with formal proof, all of which aid efficiency.

The Committee's Independent Legal Counsel has long supported the adoption of such a rule by the Discipline Committee. The reciprocal disclosure rules level the playing field, reduce surprise at the hearing and it is anticipated, will result in the earlier resolution of cases.

The Discipline Committee will assess the process impact of the reciprocal disclosure rules from their implementation date going forward.

b) *Social Context Education*

In May 2016, Professor Rosemary Cairns Way, professor of criminal law, constitutional law and legal theory with the Faculty of Law at the University of

Ottawa and senior educator at the National Judicial Institute, presented regarding the National Judicial Institute's Social Context Education Program, a national education program for the Canadian judiciary on equality, diversity and the judicial role. Professor Cairns Way facilitated discussion about judicial continuing education regarding social context and the transfer and use of those principles in professional discipline. Professor Cairns Way will continue to work with the Discipline Committee on its training programs.

c) *Task Force on Prevention of Sexual Abuse of Patients*

In October 2016, the Discipline Committee considered the recommendations in the September 2016 report - *To Zero: Independent Report of the Minister's Task Force on the Prevention of Sexual Abuse of Patients and the Regulation Health Professions Act, 1991* – in relation to the processes and practices of the Committee.

d) *Case Rounds*

A standing item at Discipline Committee business meetings is case rounds to discuss court cases, cases from other colleges and appropriate Discipline Committee cases (appeal waived or appeal period expired) that raise learning points or practice and procedure before or within the Committee.

Two cases discussed in 2016 are of broad significance to regulators.

i) *The College of Nurses of Ontario v. Mark Dumchin (2016) DivCt*

In the *College of Nurses of Ontario v. Mark Dumchin*, the Divisional Court overturned a decision of the Discipline Committee of the College of Nurses of Ontario in which it concluded that it lacked jurisdiction to revoke a nurse's certificate of registration because the nurse had resigned in advance of the discipline hearing.

Dumchin had resigned his certificate of registration with the College while under investigation for professional misconduct in 2013. In March 2015, he was found to have engaged in professional misconduct in that he was convicted criminally of possession of child pornography and making available child pornography. The College sought revocation of Dumchin's certificate of registration, to take effect if and when he applied for and obtained an active certificate in the future. The panel of the Discipline Committee believed that the revocation of his certificate of registration would be the appropriate penalty; however, it concluded that it did not have the statutory authority to impose such a penalty on the basis that Dumchin had resigned and did not have a certificate that could be revoked. As a result, the panel imposed only a reprimand.

The College appealed the penalty to the Divisional Court, arguing that the panel's interpretation of its statutory powers was unreasonable and that Dumchin's certificate of registration should have been revoked. Dumchin argued to the Divisional Court that the penalty was reasonable and should be upheld. The Federation of Health Regulatory Colleges of Ontario was granted intervener status to explain the legislative regulatory regime and the significant consequences to the activities and mandate of the colleges operating under the RHPA if the appeal was unsuccessful.

Under the RHPA, health regulatory colleges regulate their respective professions in the public interest by enforcing standards of practice and conduct through investigations and disciplinary proceedings. The Code gives the Colleges' discipline committees permission to hold adjudicative hearings, make findings of professional misconduct and incompetence, and impose a wide range of penalties, including suspensions and revocations of a member's certificate of registration. The Code also permits the Discipline Committee to hold a hearing where a member whose certificate has been revoked later requests re-instatement into the profession.

At issue was Section 14 of the Code, which grants the Discipline Committee the authority to make findings of professional misconduct regarding both current and former members:

14. (1) A person whose certificate of registration is revoked or expires or who resigns as a member continues to be subject to the jurisdiction of the College for professional misconduct or incompetence referable to the time when the person was a member and may be investigated under section 75.

(2) A person whose certificate of registration is suspended continues to be subject to the jurisdiction of the College for incapacity and for professional misconduct or incompetence referable to the time when the person was a member or to the period of the suspension and may be investigated under section 75.

The Divisional Court considered whether the College's continuing jurisdiction under s.14 applies to all of the possible sanctions that the Discipline Committee can order under the Code, including revocation.

The Divisional Court found that the Code must be given a broad and purposive interpretation in keeping with the College's obligation to protect the public.

The Court found that the panel's interpretation of its statutory authority under s.14 was unreasonable, formalistic and inconsistent with the text, context and purpose of the legislation.

The Court also found that the panel's interpretation would lead to "absurd results," such as the ability of a member to circumvent the statutory requirement that applications for reinstatement by members whose certificates have been revoked are dealt with by the Discipline Committee.

The Divisional Court agreed with the College of Nurses that section 14 of the Code makes even a former college member subject to all stages of the investigation and disciplinary process, including investigation, hearing, findings and penalties. Consequently, the Divisional Court set aside the panel's interpretation and reprimand respecting Dumchin, and replaced it with an order revoking his certificate of registration.

This decision confirms that health regulatory colleges have continuing jurisdiction over their members, including the authority to impose the entire range of penalties (even revocation) on a no longer existent certificate of registration. Regulated health professionals cannot avoid the disciplinary consequences of professional misconduct by unilaterally resigning. Colleges maintain the authority to investigate, refer to the Discipline Committee and prosecute alleged misconduct that occurred while a person was a member.

ii) *R. v. Anthony-Cook (2016) SCC*

The case of *R. v. Anthony-Cook* is an important decision of the Supreme Court of Canada on joint submissions on sentencing and when trial judges (and by analogy, Discipline Committee panels) may depart from them. The case was a criminal one, but decisions from the courts in criminal matters on joint submissions on sentencing have been accepted as setting the appropriate test for whether to accept a joint submission on sanction in matters before the College.

In this case, the accused pleaded guilty to manslaughter on the basis of a joint submission as to sentence. The joint submission was that he would serve a further 18 months in custody in addition to the period of about a year he had spent in pre-trial custody, with no period of probation. In pleading guilty, he gave up the right to a trial including the possibility of raising a defence of self-defence. The trial judge rejected the plea. He increased the amount of time in jail by six months and imposed a three-year probation order. The Supreme Court of Canada allowed the appeal and varied the sentence to bring it into conformity

with the joint submission. In so doing, the court made a number of interesting comments about joint submissions including:

- Resolution discussions between counsel are essential in the criminal justice system. Properly conducted, they permit the system to function smoothly and efficiently. However, they are not sacrosanct. Trial judges may depart from them.
- The test against which to measure the acceptability of a joint submission is called the “public interest test”. It states: trial judges should not depart from a joint submission unless the proposed sentence would bring the administration of justice into disrepute, or is otherwise not in the public interest.
- In clarification, the court cited an earlier decision from Newfoundland which stated that - “a joint submission will bring the administration of justice into disrepute or be contrary to the public interest if, despite the public interest considerations that support imposing it, it is so markedly out of line with the expectation of reasonable persons aware of the circumstances of the case that they would view it as a breakdown in the proper functioning of the criminal justice system”.
- The Supreme Court also referred to another Newfoundland case that had held that when assessing a joint submission, trial judges should avoid rendering a decision that causes an informed and reasonable public to lose confidence in the institutions of the courts.
- The Court also stated that a joint submission should not be rejected lightly: “Rejection denotes a submission so unhinged from the circumstances of the offence and the offender that its acceptance would lead reasonable and informed persons, aware of all the relevant circumstances, including the importance of promoting certainty in resolution discussions, to believe that the proper functioning of the justice system had broken down. This is an undeniably high threshold - and for good reason ...”

The Court’s reasons for applying such a stringent test include:

- Joint submissions enable the accused to minimize stress and legal costs associated with trials, and for those who are truly remorseful, an opportunity to begin making amends. They also maximize certainty as to the outcome.

- The guarantee of a conviction makes resolution desirable, and the Crown avoids the risk of trial. The Crown may also be able to obtain useful information or other cooperation from the accused.
- The guilty plea with the joint submission will spare victims and witnesses the emotional cost of a trial and victims may obtain comfort from a guilty plea given the accused's acknowledgement of responsibility and possibly expression of remorse.
- Joint submissions contribute to the administration of justice at large by saving time, resources and expenses that can be channelled into other matters, thus allowing the justice system to function more efficiently.

The Court highlighted that for joint submissions to be possible, the parties must have a high degree of confidence that they will be accepted. The accused will be reluctant to forego a trial if joint submissions come to be seen as an insufficiently certain alternative.

The Court also offered guidance to trial judges (and by extension to panels) on the approach to follow if they are troubled by a joint submission:

- The public interest test applies whether the judge is considering varying the proposed sentence or adding something to it that the parties have not mentioned.
- Trial judges should apply the test when they are considering either increasing the penalty set out in the joint submission or reducing it.
- When faced with a contentious joint submission, trial judges will want to know the circumstances leading to the joint submission, and in particular any benefits obtained by the Crown or concessions made by the accused. The greater the benefits obtained by the Crown and the more concessions made by the accused, the more likely it is that the trial judge should accept the joint submission even though it may appear to be unduly lenient.
- Counsel must be able to inform the trial judge why the proposed sentence would not bring the administration of justice into disrepute or otherwise be contrary to the public interest.
- If the trial judge is not satisfied with the proposed sentence, he or she should notify counsel of the concerns and invite further submissions on

the concerns, including the possibility of allowing the accused to withdraw his or her guilty plea.

- If the trial judge's concerns about the joint submissions are not alleviated, the judge may allow the accused to apply to withdraw his or her guilty plea.
- Trial judges who remain unsatisfied by counsel's submissions should provide clear and cogent reasons for departing from the joint submission.

II. Processes, Practices and Timelines

The Discipline Committee reviews continually its processes, practices and timelines.

a) *Stages of the Discipline Process*

The stages of the discipline process are:

- Referral of the matter by the Inquiries, Complaints and Reports Committee
- Reciprocal Disclosure (as of August 1, 2016)
- Pre-hearing processes, including case management conferences and pre-hearing conferences
- Resolution resulting in withdrawal or an uncontested hearing
- Hearing
- Written Decision and Reasons for Decision

The Discipline Committee manages each case from the time of referral to decision.

b) *Caseload*

There has been a 30% increase in the number of referrals to the Discipline Committee in 2015, which has continued through to 2016 Q3. The number of referrals from 2007 to 2016 Q3 was as follows:

Year	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016Q3
Referrals	39	41	53	39	45	38	33	39	56	49

The Committee is keeping pace with the increase in caseload by completing cases. The number of closed cases (i.e., written decision and reasons on finding / penalty released) from 2007 to 2016 Q3 was:

Year	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016Q3
Closed	23	22	28	22	34	38	37	27	35	35

Thirty-four of the closed cases related to allegations of professional misconduct and / or incompetence and one case was a motion to vary a prior order.

The number of withdrawals in this same time period was:

Year	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016Q3
W/Ds	8	10	10	9	12	7	7	5	7	3

The end caseload from 2007 to 2016 Q3 was:

Year	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016Q3
Cases	52	60	72	81	78	69	57	65	76	87

As of 2016 Q3, 37% of the cases referred related to allegations of failing to maintain the standard of practice and/or incompetence, 36% related to allegations of sexual abuse or sexual impropriety, 22% related to allegations of disgraceful, dishonourable or unprofessional conduct, and 3% to allegations of found guilty of offence relevant to the member's suitability to practice.

As of 2016 Q3, thirty-one physicians against whom allegations of professional misconduct and / or incompetence were referred (36%) were subject to an interim order under s.37 of the *Code* or an interim undertaking (four s.37 suspensions, thirteen s.37 restrictions and fourteen undertakings) pending disposition of the case by the Discipline Committee. The Committee is required to give precedence to s.37 cases.

There continue to be complex, contested hearings involving motions before and during the hearing.

c) Managing the Caseload

In managing its cases, the Committee must balance process efficiency, effectiveness and fairness. Recognizing that there will always be a percentage of cases that for legitimate reasons take longer to commence and complete, the Committee's aim is to eliminate *unreasonable* delay in the hearings process and, in doing so, to reduce case time span.

The Committee put into effect a Practice Direction on Requests for Adjournment on May 20, 2013 and a Practice Direction on Case Management on January 6, 2014.

i) Case Management Conferences and Pre-Hearing Conferences

Seven members of the Discipline Committee conduct case management conferences (CMCs) and pre-hearing conferences (PHCs): Dr. Carole Clapperton, Dr. Pamela Chart, Dr. Melinda Davie, Dr. Marc Gabel, Dr. William King, Dr. Barbara Lent, and Dr. John Watts.

Case Management Conferences (CMCs)

CMCs provide enhanced committee oversight of cases throughout the discipline process and are conducted typically by teleconference.

Pursuant to the Practice Direction on Case Management, the Committee is conducting three types of CMCs:

- 1. Early Case Management Conference (Early CMC):** An Early CMC is scheduled if a pre-hearing conference (PHC) is not scheduled within 120 days of referral. The purpose of the Early CMC is to determine what steps need to be taken for an effective PHC to take place and if appropriate, to schedule a date for the PHC.
- 2. Interim Case Management Conference (Interim CMC):** Interim CMCs may be scheduled after a PHC, as the needs of the case require.
- 3. Hearing Case Management Conference (Hearing CMC):** Hearing CMCs are scheduled three weeks before the commencement of a contested multiple-day hearing to identify any new issues, and to ensure an adequate number of hearing days and the efficient use of hearing time.

Pre-Hearing Conferences

PHC's are also integral to the effective determination and scheduling of cases. PHCs, like CMCs, have a case management function. However, PHCs also have an important resolution function. The purpose of the PHC is to determine:

- Whether any or all of the issues can be settled
- Whether the issues can be simplified or clarified
- Whether there are facts that can be agreed upon
- Whether further disclosure or pre-hearing motions are required
- The scheduling of motions and the hearing

The number of PHCs from 2007 to 2016 Q3 and the number of CMCs from 2014 to 2016 Q3 was as follows:

Year	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016Q3
PHCs	40	39	40	30	52	54	36	44	43	71
CMCs	-	-	-	-	-	-	-	55	75	73

As is shown by the figures above, in 2014, the Committee increased its prior case management activity by 64% through the addition of CMCs. To effectively manage the increased number of referrals and caseload, as of 2016 Q3, the Committee marshalled an additional 30% increase in its case management activity.

ii) Conducting Timely Hearings

The Discipline Committee also manages its caseload by conducting hearings of the cases referred to it. The number of hearing days (HD) for which Committee members sat in 2007 to 2016 Q3 was:

Year	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016Q3
HD	111	69	104	121	80	114	89	81	118	125

As of 2016 Q3, the Committee has sat for more days than in each of the years from 2007 to 2015. One hearing regarding allegations of sexual abuse in 2016 had a total of 37 hearing days, the second longest hearing of record. The Committee's decision in that case is currently under reserve.

iii) Council's Strategic Indicator for Hearings

In 2014, Council established a strategic objective to schedule discipline hearings more quickly. The strategic indicator is the time period from the date of referral to the first date of the hearing, consistent with the Discipline Committee's hearings benchmark.

The current strategic target is for 90% of hearings to commence within 12 months of referral.

As at the end of 2016 Q3, 90% of hearings (24) began on average within 356.2 days (11.7 months) of referral.

iv) Case Time Span Analysis

To further understand the factors that influence case timelines, the Discipline Committee continues to track the number and percentage of cases that result in a single day hearing (ranging from 52.4 to 80.8%) and a multiple day hearing (ranging from 19.2 to 47.6%) in each year. The Committee is also tracking the average case time span, the average time span between process stages (e.g., time from referral to a pre-hearing conference, and time from the pre-hearing conference until the first date of hearing) and the percentage of multiple day cases that do not complete within the time initially scheduled.

The Committee reports that its enhanced case management practices have resulted in a 27% decrease since 2014 in both the average time from referral to the first hearing date and the average case time span and that all multiple day cases that completed as of 2016 Q3, save one, completed within the hearing time scheduled.

III. Timeliness and Quality of Decisions and Reasons for Decision

a) Council's Strategic Indicator for Decisions

In 2016, Council established a strategic objective for discipline decisions. The strategic indicator is the time period from the last hearing date to the release of the written decision and reasons.

The strategic targets for decisions are:

- for 90% of written decisions and reasons in *uncontested cases* to be released within two months of the last hearing date; and
- for 90% of written decisions and reasons in *contested cases* to be released within six months of the last hearing date.

As of 2016 Q3:

- 90% of decisions in *uncontested cases* (19) were released on average 43.5 days (1.4 months) from the last hearing date; and
- 90% of decisions in *contested cases* (17) were released on average 154.0 days (5.1 months) from the last hearing date.

b) Appeals

From 2006 until 2011, there were no successful challenges on appeal to the Divisional Court on the basis of findings, rulings or orders made by the Discipline Committee.

In 2012, one matter was returned for rehearing.

In 2013, one matter was returned for rehearing, appeals by the physician were dismissed in three other cases and in one case, leave to appeal by the physician to the Supreme Court of Canada was denied.

In 2014, the Divisional Court dismissed the physician's appeal in one case and returned one matter for rehearing.

In 2015, the Divisional Court dismissed the physician's appeal in one case and one physician abandoned his appeal.

In 2016 to date, the Divisional Court dismissed two appeals by physicians and one physician abandoned his appeal.

On February 19, 2016, the Divisional Court dismissed the physician's appeal of the Discipline Committee's penalty decision, which directed revocation for

disgraceful, dishonourable and unprofessional conduct, in the case of *Dr. B.G. Minnes v. CPSO*. The Divisional Court found that the penalty was reasonable in the circumstances. The Committee found that Dr. Minnes had failed to respect appropriate boundaries when he engaged in unwanted and inappropriate touching of several female hospital employees over the course of many years. The Committee also found that he had engaged in unwanted and coercive sexual activity with a 17 year old camp counsellor while he was acting as a camp doctor. The Divisional Court found that the Committee carefully set out the factors to be considered when determining an appropriate penalty and that revocation was within the range of reasonable outcomes. The Court stated:

“Here, the Committee was concerned primarily with the protection of the public and the maintenance of public confidence in the system of self-regulation of the medical profession. The findings of professional misconduct were very serious, involving the misuse of a position of trust and authority in order to take sexual advantage of a vulnerable adolescent. The penalty was reasonable when considered in the context of other cases, in light of the facts of the present case including the boundary limitation issues, and the lack of evidence respecting risk of future misconduct.”

On March 8, 2016, the Divisional Court dismissed the physician’s appeal of the finding of the Discipline Committee in the case of *Dr. E.H. Noriega v. CPSO*, a case that Court had previously returned to the Committee for rehearing. The Discipline Committee found that Dr. Noriega had engaged in sexual impropriety regarding a teenage female patient during a medical appointment at a teen health clinic in 1979 and directed revocation. On the appeal, Dr. Noriega argued that the Discipline Committee had assessed his evidence on a more exacting standard than they had the College’s evidence. Dr. Noriega also alleged that the Discipline Committee had forced him to prove his innocence, in effect reversing the College’s burden of proof. Dr. Noriega also said that the Discipline Committee did not use similar fact evidence properly. The Divisional Court rejected these arguments. The Divisional Court noted that it is legal error to subject one side’s evidence to a higher scrutiny than the other but Dr. Noriega failed to prove that the Discipline Committee had done this. The Discipline Committee did not reverse the onus of proof; rather, it did not accept Dr. Noriega’s evidence, after carefully considering it. The Discipline Committee’s finding of sexual impropriety was entirely reasonable. The Divisional Court found no merit in the suggestion that the Discipline Committee relied on the similar fact evidence to come to its conclusion.

On June 6, 2016, the physician in the case of *Dr. W.A. Botros v. CPSO* abandoned his appeal of a 2015 decision of the Discipline Committee finding that he failed to maintain the standard of practice of the profession, engaged in disgraceful, dishonourable or unprofessional and that he is incompetent in relation to his practice of sleep medicine. The Discipline Committee ordered a six month suspension, practice restrictions, a reprimand and costs of \$53,520.00.

Seven appeals to the Divisional Court are awaiting determination.

IV. Transparency of Committee Activities and Decisions

Decisions

The Discipline Committee posts hearing dates, case status (whether a case is adjourned or a decision is under reserve) and its findings and orders on the College's website under Doctor Search. The decisions are also posted on the LexisNexis and Carswells legal databases and on CanLII, a free publicly accessible legal database managed by the Federation of Law Societies of Canada.

V. Costs and Expenditures

The Discipline Committee tracks its costs and expenditures. Discipline hearing costs are directly related to the number, length and complexity of hearings.

Paid hearing days (PHD) = Days used + Days not used but paid (due to late cancellation). The number of paid hearing days (\$ days) for 2007 to 2016 Q3 was as follows:

Year	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016Q3
PHD	171	122	174	160	145	171	90	109	210	178

Late cancellation costs continue to be incurred due to the late resolution or adjournment of cases or early completion of hearings. The number of late cancelled days (LCD) for 2007 to 2016 Q3 was:

Year	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016Q3
LCD	60	53	70	39	65	57	56	28	92	53

In 2014, there were only 28 late cancelled days, an aspirational benefit of the new case management practices. In 2015, late cancellation increased due to late settlement in four cases and the withdrawal, dismissal and the loss of hearing days in three cases, respectively, in which patients did not wish to attend to testify. Late cancellation costs up to 2016 Q3 relate to late settlement and late adjournment of cases. The Committee will continue to explore case management practices to reduce the late settlement of cases and will assess the impact of the reciprocal disclosure rule on the incidence of late settlement.

In June 2007, Council adopted a policy that the usual amount of costs sought by the College in appropriate discipline cases would be in accordance with the Discipline Committee tariff, which Council increased on May 30, 2013 from

\$3,650 to \$4,460 per day. Council further increased the costs tariff to \$5,000 per day as of January 1, 2016. The referring committee retained the discretion to change the amount sought in specific cases. As of 2016 Q3, the Discipline Committee has ordered \$312,074 in costs awards to the College including costs in specific cases of \$36,200 (*Dr. P.M. Porter*), \$35,680 (*Dr. J.P. Peirovy – under appeal*), \$28,098 (*Dr. R. J. Kamermans – under appeal*), \$24,656 (*Dr. W.A. Botros*), and \$22,300 (*Dr. R. Patel*).

2017 Initiatives

In accordance with the strategic plan, the Committee will continue to focus on ways to improve the effectiveness and efficiency of the discipline process while ensuring fairness, including ways to achieve early settlement. The Committee is reviewing its governance strategies including its training and education cycle and recruitment practices to ensure succession planning. Also, the Committee is enhancing its qualitative data regarding physicians who are referred to discipline (e.g., age, gender, place and area of practice, length of time in practice) with a view to better inform and educate the public and the profession. The Committee will also work to post additional information on the website to enhance transparency and understanding of its processes for the benefit of hearing participants, the public and the profession.

We commend our Committee members who have dedicated significant time and effort to the hearing schedule.

The Committee would like to thank the Hearings Office staff and the Independent Legal Counsel team for their outstanding work in assisting the Committee to fulfil its mandate and for their support throughout the year.

Dr. Carole Clapperton
Co-Chair, Discipline Committee

Dr. Peeter Poldre
Co-Chair, Discipline Committee

EDUCATION COMMITTEE

2016 Annual Report to Council

Committee Mandate and Objectives

The Education Committee's mandate and objectives, as defined in by-law are to:

- a) review and make recommendations to Council respecting matters of undergraduate and postgraduate medical education in Ontario;
- b) establish mechanisms to enhance continuing professional development by College members including:
 - (i) systematically tracking College-observed trends of needs in physician education;
 - (ii) advocating for these needs to be met by external educational providers; and
 - (iii) endorsing methods for measuring outcomes of educational interventions by the College.
- c) approve, monitor and/or evaluate methods for use by the College, which may include the following:
 - (i) assessment methods and tools for competence and performance;
 - (ii) programs to promote and enhance professionalism; and
 - (iii) supervision roles.

Year in Review

In 2016, the Education Committee engaged in and provided feedback on CPSO initiatives pertaining to medical education (undergraduate, postgraduate and physicians in practice), continuing professional development (CPD), and physician assessment. In addition, the Education Committee has played, and will continue to play, a key advisory role in the development of the CPSO Education Strategic Initiative (ESI) that was initiated this year.

1. CPSO Education Strategic Initiative (ESI)

1.1 Scoping ESI

The Committee began the year by contributing to the scoping for ESI. In a facilitated, half-day workshop, Committee members shared their expertise and perspectives on current and emerging trends in medical education, and potential roles for the CPSO in medical education. Feedback collected during this session, and in a follow-up survey, has been used to inform the overall approach and content of ESI.

1.2 Feedback and Advice on Key ESI Projects

ESI has three draft goals:

- 1) To map all medical education activity at the CPSO;

- 2) To scope a long term vision for the CPSO in medical education; and
- 3) To undertake three foundational projects:
 - i. Develop a new credentialing requirement for all CPSO applicants for implementation in 2018 (pending Council approval);
 - ii. Create an evaluation framework for systematically evaluating the remedial components of committee decisions that address professionalism and communication issues to begin in 2017; and
 - iii. Identify educational data requirements across member specific committees in 2017.

Throughout 2016, the Education Committee provided input on the conceptualization of ESI and its constituent projects, and will be asked for ongoing feedback in 2017.

2. Undergraduate Student (UGME) and Postgraduate (PGME) Engagement

In May 2011, Council approved five priorities that focus the Committee's involvement in medical student engagement:

- 1) Engage students in self-regulation, ethics, and professionalism to ensure a consistent understanding of professional expectations from the outset of medical school through to practice.
- 2) Ensure a longitudinal register that documents student details from the initiation of training and continues through their practice career.
- 3) Support faculty in recognition and management of remediation of professional behaviours in students.
- 4) Facilitate the general flow of information between the CPSO and medical schools, including between the undergraduate and postgraduate departments of medical schools.
- 5) Maintain a record of medical students coming from outside of Ontario to complete electives.

The Education Committee focused its 2016 involvement around priorities 1 and 4.

2.1 CPSO Professionalism and Practice Undergraduate Medical Education (UME) Program

The Committee was kept apprised of developments in the Policy Department's *Professionalism and Practice* program and provided input into two new components that were deliverables under the 2014-2015 CPSO Sexual Abuse Review Education Plan:

- 1) A new module on the *Maintaining Boundaries to Prevent Sexual Abuse* policy; and
- 2) Creation of [dedicated space](#) on the CPSO website to make Professionalism and Practice resources available, as needed, to undergraduate faculty and medical students.

2.2 Working with the Ontario Medical Student Association (OMSA)

In 2012, Council endorsed an annual appointment to the Education Committee from the Ontario Medical Students Association (OMSA).

- The OMSA representative is a full participant of the Committee and provides quarterly updates on the activities of OMSA.
- A new representative attended their first meeting in September 2016.

Throughout the year, OMSA reported on their involvement in a national initiative related to student run clinics (SRCs) and formerly presented to Committee in September.

- In support of this initiative, the CPSO Policy Department representative to Committee, and the Education Lead worked with OMSA to draft general regulatory content, and an Ontario specific appendix for the next iteration of the supporting handbook, *Developing and Sustaining Student Run Clinics: A Toolkit - Developing and Sustaining Student Run Clinics: a Toolkit (OMSA)*.
 - Once finalized, this content will be shared, by OMSA, with other medical regulators as a potential template for other provinces.

2.3 Working with the Professional Association of Residents (PARO)

There is also an annual appointment of a representative from the Professional Association of Residents Ontario (PARO).

- The PARO representative is a full participant in the Committee and provided quarterly updates on PARO activities throughout the year.
- In September 2016 the new PARO representative began their appointment.

2.4 Focusing Role of Academic Representatives

In 2016, the Committee began discussions around better integrating the role of Academic representatives on the Committee with the CPSO's work in medical education. This will be a focus of activity in 2017.

3. Continuing Professional Development (CPD)

3.1 Follow up with CPD Component of Quality Assurance Regulation

The CPD component of the Quality Assurance regulation requires physicians to track their CPD with one of the Royal College of Physicians and Surgeons of Canada (RCPSC), College of Family Physicians of Canada (CFPC) or the Medical Psychotherapy Association of Canada (MDPAC, formerly the General Practice Psychotherapy Association (GPPA))

- Over 2016, the Committee received updates and provided final input into the Practice Assessment and Enhancement (PA&E) initiative to ensure all CPSO members are enrolled with one of the three CPD tracking organizations.
 - This included providing feedback on a draft definition for the practice of medicine that is fundamental to the CPSO's approach to following up with CPD non-reporters.

3.2 Approving the Medical Psychotherapy Association of Canada 's (MDPAC/GPPA) Continued Status as a Third Pathway (Alternative CPD Tracking Organization)

In September, the Committee received the Medical Psychotherapy Association of Canada's (MDPAC, formerly the GPPA) third-year report and hosted a presentation by MDPAC representatives about their work as an alternative CPD tracking organization. Originally approved by the Education Committee and Council in 2013 for three years, MDPAC's status was reviewed by the Education Committee on behalf of the College.

The Committee approved MDPAC for an additional three years as an alternative CPD tracking organization, and will continue to require annual written reports. This decision will go to Council for consideration in 2017.

3.3 New CPD/Practice Improvement Section on the CPSO Website

In early 2016, the Education Committee provided final feedback regarding the launch of the [CPSO's new section on the CPSO website](#) that provides members with consolidated information about the CPD regulatory requirement, links to CPD and practice improvement resources, and shares CPD credit information for members participating in CPSO programs or initiatives, e.g., Peer Assessment.

3.4 Continuing Professional Development (CPD) Ontario (CPD-O)

The CPSO continues to be a member of CPD-Ontario (CPD-O) - a multi-stakeholder partnership attempting to coordinate continuing professional development (CPD) activity in Ontario.

- Throughout 2016, the Committee received updates from the CPD-O Chair who is a member of the Committee, including a presentation on provincial activity and resources around medical assistance in dying.

4. Peer Assessment Redesign

The Committee was updated and provided input into the multi-year Peer Assessment Redesign project, including:

- The development, maintenance and evaluation of Quality Improvement Resources (QIRs);
- Planned consultations on Peer Assessor Handbooks and QIRs, and implementation pilots; and
- The evaluation strategy for the entire initiative.

5. New Supervision Lead

In 2016, the Education Committee was introduced to the new Supervisor Lead in the Compliance and Monitoring Department. This position is responsible for standardizing the recruitment, role requirements, reporting and evaluation of supervisors across the CPSO. The creation of this position was a key recommendation of a 2014 retrospective analysis of individualized education plans – an initiative for which the Education Committee provided significant input over 2013-2015.

Respectfully submitted,

Barbara Lent,
Chair, Education Committee

2016 Executive Committee Annual Report to Council

The Executive Committee has 2 main functions:

1. Under section 12 (1) of the *RHPA*, between meetings of Council, the Executive Committee has almost all the powers of the Council with respect to any matter that, in the Committee's opinion, requires immediate attention. The only power it does not have is to make, amend or revoke a regulation or by-law.
2. In order to ensure that the work of the College is able to proceed between Council meetings, the Executive Committee also guides the response to significant issues. Executive Committee gives direction to staff about what may be required before the matter is ready to go to Council. In addition, the Executive Committee makes recommendations to Council as to outcome.

Communication with Council:

1. Executive Committee Update: A summary of Executive Committee's deliberations and direction circulated to all Council members within a day or two of each Executive Committee meeting.
2. Telephone Calls: Executive Committee members contact each Council member to ensure that Council members understand what was considered and have access to further information.
3. Executive Committee's Reports to Council: The Executive Committee provides quarterly reports to Council in accordance with *Section 12 HPPC*.

Council members are invited to attend Executive Committee meetings and several Council members took advantage of this opportunity in 2016.

The Executive Committee held 7 meetings and 4 teleconferences in 2016. Specific issues considered included:

Policies: Physician Treatment of Self, Physician Assisted Dying/Medical Assistance in Dying, Prescribing (naloxone, fentanyl updates), Continuity of Care, Accepting New Patients, Ending the Physician-Patient Relationship, Marijuana

Guidelines/Other Documents: What to Expect during Medical Encounters, Interventional Pain Management Procedures, Changes to OHPIP standards

Feedback on other professions: RN Prescribing, Optometrist Prescribing

Other Issues: Governance Modernization, Pilot Project for Independent Legal Advice to Complainants/Witnesses in Discipline Hearings re Sexual Misconduct, Oversight of Fertility Services (Regulation Change), Supervised Injection Sites

Registration: Restricted Policy, Practice Ready Assessment

The Executive Committee also had the opportunity to hear from a physician with early experience with Medical Assistance in Dying, and Dr. Malcolm Sparrow with an overview of what it means to be a risk-based regulator. Malcolm K. Sparrow is Professor of the Practice of Public Management at the John F. Kennedy School of Government, Harvard University.

ANNUAL REPORT OF THE FITNESS TO PRACTISE COMMITTEE

Mandate:

The Fitness to Practise Committee hears matters of possible member incapacity.

If the Fitness to Practise Committee finds that the member is incapacitated it can make an Order:

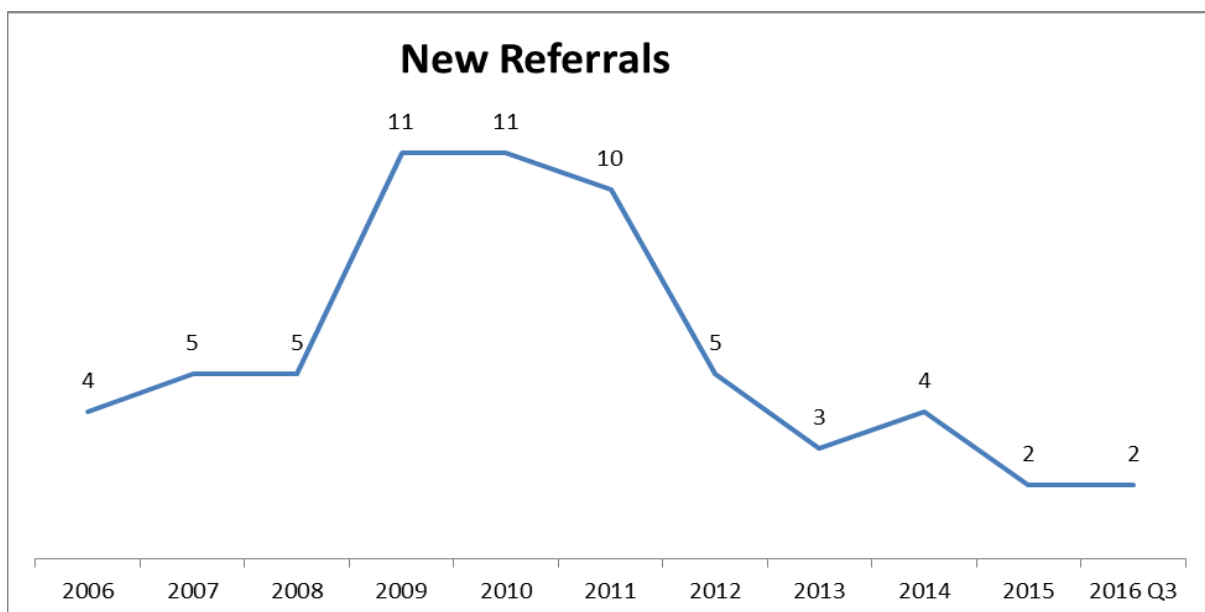
1. directing the Registrar to revoke the member's certificate of registration.
2. directing the Registrar to suspend the member's certificate;
3. directing the Registrar to impose specified terms, conditions or limitations on the member's certificate.

An Order made by a Fitness to Practise panel seeks to address the member's capacity to practise safely while ensuring public protection from a member who is found to be incapacitated. Revocation or suspension may be required, or a member may be able to practise safely subject to terms, conditions and limitations on his or her certificate of registration that require monitoring and/or treatment.

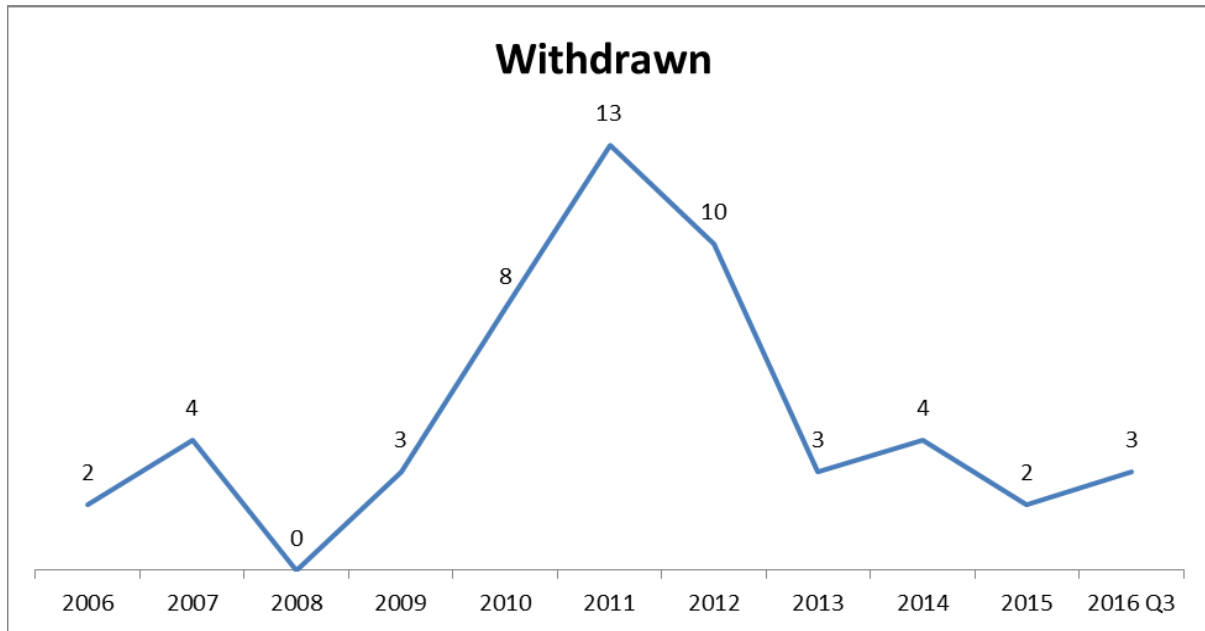
Core Activities:

Referrals

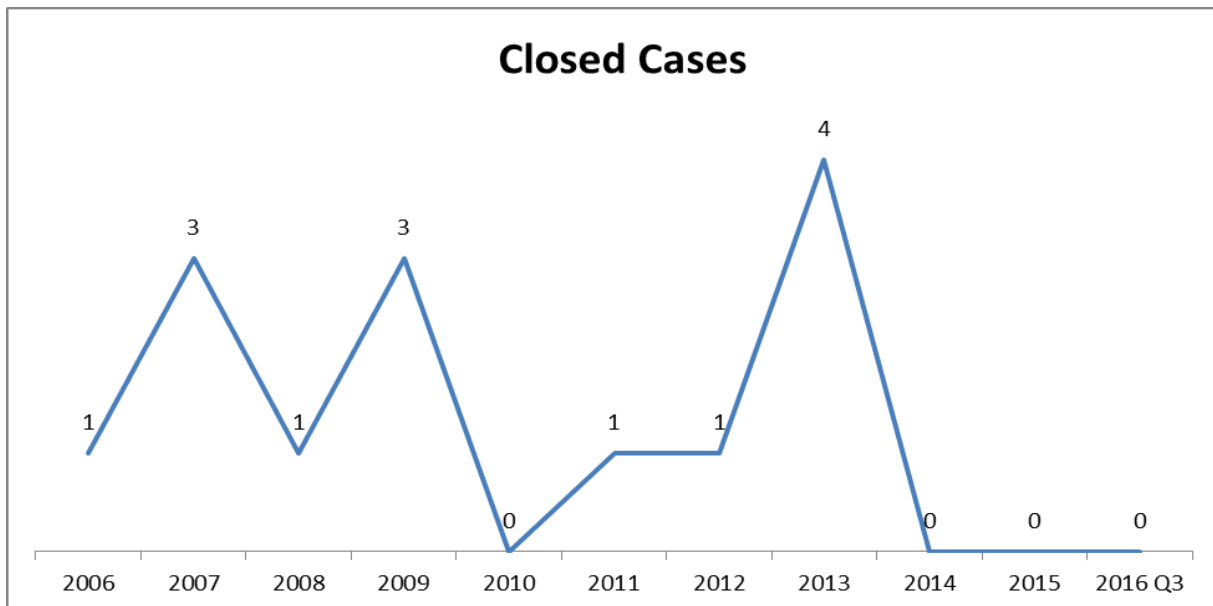
There has been a decrease in the number of referrals to the Committee. The Committee received two referrals in 2015 and has received two referrals as of September 30, 2016 (2016 Q3). This is in contrast to ten to eleven referrals in the years from 2009 to 2011.



The practice to resolve incapacity matters through monitoring agreements continues. As of 2016 Q3, three matters were resolved and the referrals withdrawn.



Consequently, there was also a decrease in the Committee's pre-hearing and hearing activity. There have been five pre-hearing conferences (PHCs) and no hearings to date in 2016; there were no hearings in 2014 and 2015. The following table shows the number of closed cases, i.e., cases that went to a hearing and a written decision and reasons on finding / disposition was released, from 2006 to 2016 Q3.



There are seven matters currently before the Committee, six referrals regarding an allegation of incapacity and one motion to vary a prior order. One physician is subject to an undertaking to cease practice pending the disposition of the referral.

The Fitness to Practise Committee commends the effort to achieve early intervention and resolution of these matters and the involvement of the Physician Health Program and monitoring physicians in assisting physicians in their recovery.

Orientation and Business Meeting

The Committee will hold an educational and business meeting for Fitness to Practise Committee members on November 30, 2016.

Although infrequent, the issues that are involved in Fitness to Practise hearings and motions to vary previous fitness orders are unique and the stakes are high in terms of protection of the public and the consequences for the physician. The Fitness to Practise Committee provides an annual education program to address the unique requirements of the FTP process so that members are well prepared to conduct a hearing or motion when required. FTP members are also members of the Discipline Committee and, therefore, receive transferable training regarding hearing processes, chairing a panel, chairing a pre-hearing conference and decision writing.

Future Initiatives:

In 2017, the Fitness to Practise Committee will continue to focus on educational programs for its members.

Dr. Dennis Pitt
Chair
Fitness to Practise Committee

Governance Committee 2016 Annual Report

Overview

The Governance Committee oversees and makes recommendations to enhance the College's governance structure. The Committee oversees all aspects of the nominations process, orientation and mentoring programming, the Council and committee performance assessment process, as well as the governance policy function.

The Committee strives to ensure effective and current governance practises. College governance resources are maintained and consolidated in the *Governance Process Manual* available on the College website.

2016 Highlights

The Governance Committee's areas of focus in 2016 included the following:

- Oversight of College nominations processes;
- Revised nominations guidelines;
- Continued focus on orientation, mentoring and training;
- Oversight of the performance assessment/feedback process;

Oversight of College nominations processes

Chair and committee membership appointments are a focus of the Governance Committee each year. All committee appointments are made on an annual basis. The Governance Committee oversees the recruitment and screening processes for these positions. The Nominations Guidelines are utilized to guide nominations decision-making.

The Governance Committee has worked to support membership renewal and succession planning on College committees. Finding that right balance of bringing in new committee members and retaining expertise is important, yet can be challenging. All committee members who are not members of Council undergo conflict of interest screening and an interview led by the Chair of the Governance Committee and the appropriate committee chair. The Governance Committee in its December report to Council makes committee membership recommendations for the next year. The process to identify opportunities and recruit qualified members for College committees now occurs throughout the year.

The Committee actively works with committee chairs to identify committee membership requirements. Chairs are also asked to help identify future leaders of College committees. This

approach of looking and planning for the future is designed to better facilitate and support succession planning.

Extensive discussion takes place to ensure that committees have the required expertise. Committee applicants who are not members of Council are interviewed prior to any recommendation by the Governance Committee for appointment to a College committee.

The Committee is again very supportive and appreciative of the contribution made by Council's public members. Public members of Council have heavy workloads and perform invaluable work.

Updated nominations guidelines

The Committee reviewed and updated the Nominations Guidelines. This work was initiated by the Governance Committee in 2015. The guidelines contain eligibility criteria and other information utilized to inform and guide nominations related decisions. They help explain the processes and basis upon which nomination recommendations and decisions are made. The changes include general updates to reflect the College in 2016, an expectation that chairs and committee members participate in mandated training (this includes sexual harassment and awareness training and diversity training). There is also recognition of other considerations including proficiency in French and a need for other diversity interests including gender balance on College committees.

Many provisions have been maintained such as the commitment to succession planning and the practise of having chairs serve for no more than three consecutive years.

The revised guidelines will be considered by Council at their December 2016 meeting.

Continued focus on orientation, mentorship and training

Council's mentorship program is a work in progress. All new members of Council are assigned mentors to help support their transition onto the College Council and College committees. A special thank you to our Council members who have served as mentors in 2016: Dr. Dennis Pitt, Dr. Marc Gabel, Dr. Steven Bodley, Dr. Carol Leet, Ms. Lynne Cram, Dr. James Watters, Ms. Diane Doherty and Dr. El-Tantawy Attia.

We will soon be asking all Council members who have recently participated in the program to complete a program survey. The results of the survey will help inform the ongoing development of the program.

Looking also at Council's orientation program more generally the Committee recognizes the need to expand and enhance the orientation program. The annual day-long session open to members of Council and committees in February is highly rated. This programming needs to be available throughout the year. The Committee has suggested that it be available on more than one date and that it be available in other forms (such as by video, online module). Public members join the Council at various points during the year and orientation is vital.

There is a growing expectation that members of Council and committees complete mandated training programming. All members of College committees have been asked to complete an e-learning training module covering sexual harassment. We anticipate that all committee members will have completed the training by early December.

Oversight of Assessment/Feedback Program

The Committee continues to oversee the Council Performance Feedback program. The program consists of a number of different feedback surveys that together provide valuable feedback to Council as a whole, committees, committee chairs, Council members and committee members. The program is designed to help individual Council and committee members grow in their roles with the goal of improving performance.

The committee and chair assessment surveys were updated this year. In addition to minor changes to the questionnaires, improvements have been made to the survey format to collect and capture information. The objective is to ensure a more efficient process to collect information and improve the user experience. A new and improved combined committee and chair survey will be distributed in November. Results will be tabulated and distributed by the end of the year.

The assessment/feedback program in 2016 includes the following:

- Committee performance assessment by committee members;
- Committee chair assessment by committee members;
- Council performance assessment by Council members;

Council's 2016 performance assessment report is contained in the Governance Committee's December Council report. The results are extremely positive.

Looking ahead to 2017

The Committee will continue to focus and strengthen orientation and mentorship programming to support new members of Council and College committees.

There is recognition that the College staff who support College Committees also require

ongoing education and support to ensure awareness of governance policies and nominations processes. The staff will work to enhance this support and knowledge in 2017.

The Committee will continue work to ensure that Council governance policies are up to date and representative of “best” governance practises.

**ANNUAL REPORT OF THE
INQUIRIES, COMPLAINTS AND REPORTS COMMITTEE (“ICRC”)
2016**

A. Mandate

(i) ICRC Implementation

The Inquiries, Complaints and Reports Committee (the “ICRC”) came into effect on June 4, 2009, as a result of *The Health System Improvements Act, 2007*. The ICRC has assumed jurisdiction over all College investigations and oversees three kinds of investigations:

- Complaints investigations (formerly managed by the Complaints Committee);
- Registrar’s investigations (formerly managed by the Executive Committee); and
- Incapacity investigations (formerly managed by the Board of Inquiry and the Executive Committee).

(ii) Composition of the Committee

The entire ICRC is currently composed of 62 members.

The members may be: physicians who are members of Council; physicians who are not members of Council; staff physicians and public members of Council.

A quorum consists of 3 panel members, at least one of which must be a public member of Council.

(iii) ICRC Review and Disposition Powers

The ICRC may consider a variety of factors when reviewing any particular investigation, including:

- facts of the case;
- number and seriousness of care and/or conduct concerns at issue;
- standard of care expected of practitioners;
- whether the physician is practising within his or her area of expertise;
- physician’s response to the investigation;
- insight; self-identification of areas for improvement and changes to practice;
- physician’s apparent capacity for remediation;
- physician’s investigative and disciplinary history;
- expert opinions obtained in the course of the investigation;
- other documentary and witness information;

(iv) Complaints and Registrar’s Investigations

Following a complaints or Registrar’s investigation, the ICRC may:

- refer allegations of professional misconduct and/or incompetence to the Discipline Committee;
- require a member to appear in person to be cautioned before an ICRC panel;
- refer a complaints or Registrar’s investigation for incapacity proceedings; or
- take any action not inconsistent with the legislation (including “no action,” “advice,” “caution in person,” “direct or accept remedial agreements and or undertakings,” etc.).
- The ICRC cannot refer any clinical information to the College’s Quality Assurance (QA) Committee; instead, the ICRC now has the power to “require the member to complete a specified continuing education or remediation program” (“SCERP”).
- In the event that an allegation has been referred to the Discipline Committee, and the ICRC is of the opinion that the member’s conduct exposes or is likely to expose patients to harm or injury, it may also direct the Registrar to impose terms and conditions upon or suspend the member’s certificate of registration.

(v) Incapacity Inquiries

Now that the ICRC is investigating and making decisions regarding incapacity inquiries (e.g., inquiries regarding possible addictions or other health issues, formerly managed by the Board of Inquiry and Executive Committee), it has the power to require the member to participate in health examinations or assessments.

Following the completion of the incapacity inquiry, the ICRC has the power to refer the matter of the member’s capacity to the Fitness to Practise Committee, if appropriate and if the matter has not been addressed through an undertaking with the College or a monitoring agreement with the Physician Health Program.

If a matter has been referred to the Fitness to Practise Committee and the ICRC is of the opinion that the member’s condition exposes or is likely to expose patients to harm or injury, it may also direct the Registrar to impose terms and conditions upon or suspend a member’s certificate of registration.

B. Core Activities

(i) Panel Meeting Types and Formats

The ICRC meets in a variety of different panel types, including:

- “general” panels;
- “specialty” panels, i.e.:
 - Surgical Panel
 - Obstetrical Panel
 - Mental Health Panel
 - Family Practice Panel
 - Internal Medicine Panel;
- weekly teleconferences, for urgent matters;
- fast-track panels for abbreviated investigations;
- medium track panels for low risk matters
- incapacity (or “health”) inquiry panels;
- settlement panels;
- oral caution panels; and
- business/policy meetings.

(ii) Reviews by the Health Professions Appeal and Review Board

Most *complaints* decisions¹ issued by the ICRC are subject to review, on request of either the complainant or the physician, to the Health Professions Appeal and Review Board (“HPARB”, or the “Board”).

Upon holding a review, the Board may confirm the Committee’s original decision, make recommendations to the Committee, or require the Committee to do anything the Committee could have done at the first instance.

Committee members discuss matters returned by HPARB at the semi-annual business/policy meetings, to highlight trends and to enhance future decision-making.

¹ Decisions to refer allegations of professional misconduct or incompetence to the Discipline Committee or to refer a member for incapacity proceedings cannot be reviewed by the Board.

	2011	2012	2013	2014	2015	<i>*2016 Jan-June</i>
ICRC Appealable Decisions Issued	2252	2406	2161	2326	2162	1097
Total HPARB Reviews Completed	550 (24%)	459 (19%)	349 (16%)	336 (14%)	308 (14%)	231 (21%)
HPARB Returns	71 (13%)	47 (10%)	34 (10%)	33 (10%)	26 (8%)	30 (13%)
Total HPARB Decisions Upheld	479 (87%)	412 (90%)	412 (90%)	303 (90%)	282 (92%)	201 (87%)
Appeals requested by Complainant	n/a	n/a	n/a	n/a	340/431 (79%)	183/221 (83%)
Appeals requested by Respondent	n/a	n/a	n/a	n/a	91/431 (21%)	38/221 (17%)

*2016 = 6 months of data

- Not all ICRC decisions can be appealed to HPARB. The number of appealable decisions issued by ICRC in each of the past four years has ranged from 2161 to 2406. The number for the first six months of 2016 indicates that the number may be on a slight increase compared to 2015 but relatively constant overall.
- The rate of HPARB reviews (as a percentage of appealable ICRC decisions) has decreased steadily over the last three years to 14% in 2015. The number of reviews for the first six months of this year indicates that this percentage is on the increase this year, at 21%.
- The number of HPARB returns (as a percentage of HPARB reviews) has dropped from 13% in 2011 to 10% in 2012, and remained constant for 2013 and 2014 and then dropped further to 8% in 2015. The first six months of this year 2016, shows that the percentage of HPARB returns has increased back to 13% and could rise further by yearend.
- The Board continues its policy of aggressively scrutinizing the quality, depth and reasonableness of ICRC investigations and decisions.
- The percentage of appeals by the complainant versus the respondent in the first six months of 2016 indicates that the vast majority of appeals are brought by complainants versus respondents (83% versus 17% and 2016).

(iii) Trends

Over the past few years, some notable trends have included, and continue to be, investigations about:

- screening potential patients for admission into practices;
- physician advertising;
- care and record keeping in walk-in clinics;
- billing concerns;
- infection control practices;
- reports to MOT and involuntary admissions;
- diagnostic testing without clinical indication;
- narcotic prescribing;
- pathology and radiology practices;

“Systems” issues which arise in the course of investigations continue to be identified and tracked by the Committee. Examples of systems issues that the Committee noted over the past year included:

- resource issues (e.g., hospital funding, equipment and staffing shortages);
- resident supervision; and
- electronic medical records in clinics and hospitals.

(iv) Volume of Matters Considered and Disposed of by the ICRC

The ICRC’s workload reflects the increased investigation workload evidenced in recent years. For 2016, the estimated 6 month figures suggest MSIs with possibility of an increase by yearend but decisions remaining relatively constant.

Workload of Matters Considered and Decisions Issued

YEAR	MSI Considered	MSI TRENDS	Decisions Issued	Decision TRENDS
2010	3189	---	2237	---
2011	3794	↑ 19%	2660	↑19%
2012	3871	↑ 2%	2696	↑2%
2013	3652	↓ 6%	2436	↓10%
2014	4206	↑ 15%	2651	↑9%
2015	3802	↓ 10%	2527	↓5%
*2016 6 month estimate	1988 (3976 yearend estimate)	↑5% estimate	1277 (2554 yearend estimate)	↑1% estimate

- MSI = Total of all Member Specific Matters that went before all ICRC panels
- Decisions = Written Outcome Decision and Reasons
- **Statistics for 2016 are estimates for 6 months.*

(v) ICR Committee Meetings

For 2016, the ICRC total meeting days schedule is 81 days which is equivalent to 275 of panels. This is a slight increase from 2015 with 77 days and 270 panels.

Committee panels have met as many as four times in some weeks throughout 2016. In any given week, there might have been a general or specialty panel(s), a health inquiry panel, and a teleconference, in addition to oral cautions. Three-member panel meetings were struck to hear less complex cases.

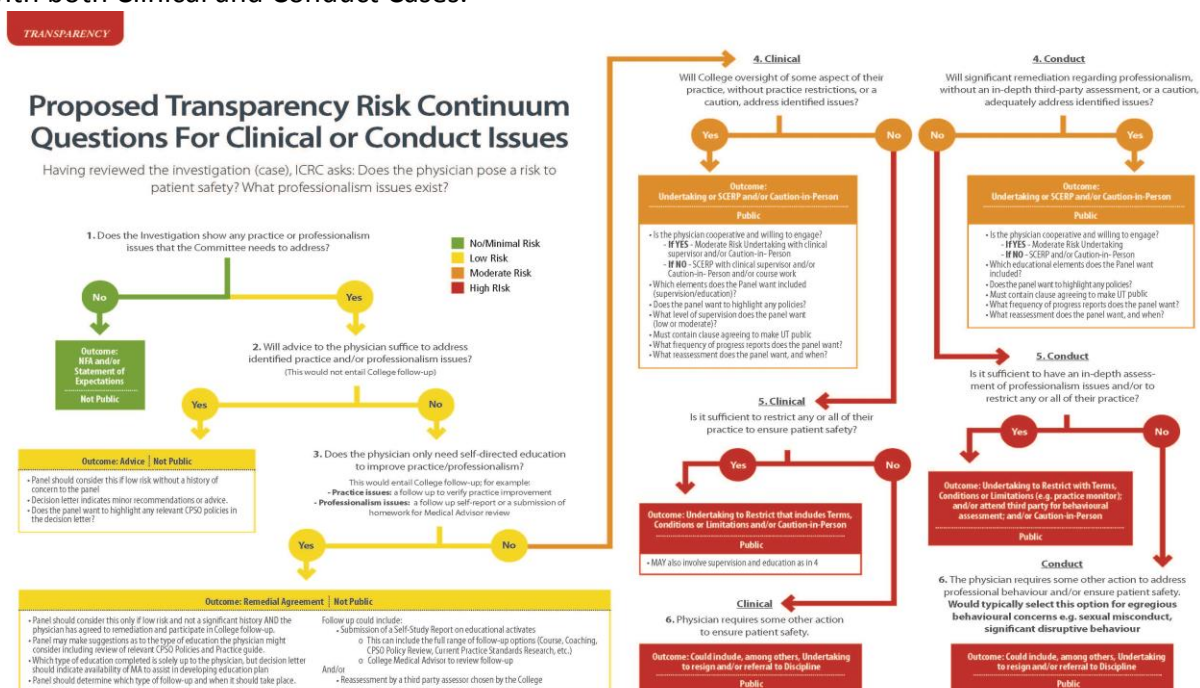
The ICR Committee administered 124 oral cautions in 2015. For the first 6 months of 2016, 57 cautions have been administered.

(vi) Transparency Initiative Update:

On May 29, 2015 Council approved a range of by-laws as part of its Transparency Initiative that provides more information on the public register. The new information includes criminal charges, cautions-in-person, specified continuing education or remediation program (“SCERP”), and discipline findings and licenses in other jurisdictions.

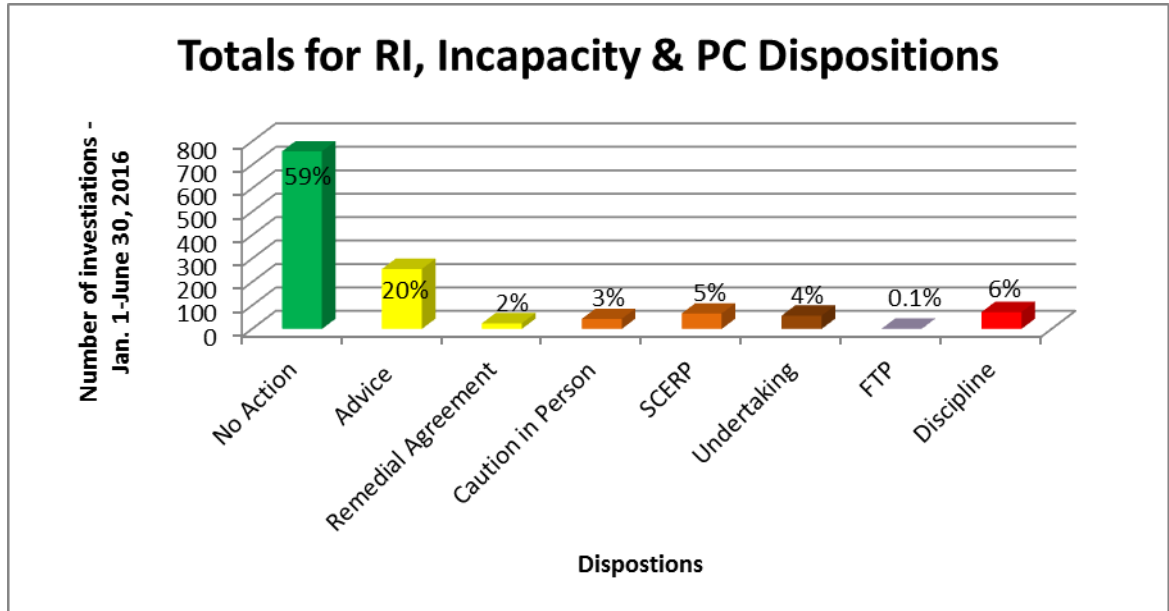
Risk Continuum Tool:

An updated version of transparency Risk Continuum Questions has been created to deal with both Clinical and Conduct Cases.



Transparency by Numbers:

Committee Support has been tracking ICRC Outcomes under the new Framework the chart below reflects data from January 1, 2016 to June 30th, 2016.



RI, Incapacity & PC Decisions

Dispositions	# of investigations Jan1-June 30th 2016	# of investigations received info prior to June 1, 2015	# of investigations received info after June 1, 2015
No Action	758		
Advice	256		
Remedial Agreement	24		
Caution in Person	43	25	18
SCERP	66	33	33
Undertaking	57	39	18
FTP	1		
Discipline	72	59	13
Total	1277		

Remedial Agreements:

Under the new transparency initiative, the ICR Committee proposes Remedial Agreements in low risk cases where minor education needs are identified, and where the Committee would like confirmation (follow-up) that those needs have been addressed by the physician.

In 2015 the ICR Committee has issued 69 Remedial Agreements to subject physicians and 3 declined to sign and 9 were appealed. For the first 9 months of 2016(Jan-Sept), 83 Remedial Agreements had been issued and 2 declined to sign with 6 appealed.

Public Summaries:

Committee Support has been tasked with drafting public summaries for SCERPs and Cautions. At the end of June 2016, the following is the count of public summaries published.

TRANSPARENCY CASE SUMMARY TRACKING as of June 2016:

Summaries Published to Date for ICRC Meetings of June 2015 – May 4, 2016		
	CPSO Register	Appealed
Caution in Person	39	6(15%)
SCERP`	31	8(26%)
Caution in Person and SCERP	12	2(17%)
TOTAL:	82	16(20%)

vii) Settlement Panels:

During 2015, a group of staff reviewed the College's internal processes and practices related to investigations and prosecutions of sexual abuse matters. As Discipline Committee outcomes are dependent upon ICR Committee instructions to College prosecutors, the group recommended the formation of a specialized ICR Committee panel for considering post discipline referral settlement proposals and penalty instructions.

The goal of the panel is to enhance consistency in settlement and penalty instructions through standardizing the legal case memos and materials that are reviewed and enhancing the panel's training in discipline processes and penalty principles.

This specialized panel consists of standard membership of 12 physician and public members, representing varied specialties, genders, and those with experience with

discipline or legal matters. This group received training in August 2015.

On November 11, 2015 we commenced our Settlement Panel meetings. These were monthly 2 hour teleconferences and additional ad-hoc meetings were booked as needed to deal with high risk cases promptly.

In 2016 the panel increased its meeting frequency to meet twice a month for 2 hours teleconferences. This also allowed for the panel to start reviewing Compliance Monitoring matters as well. Compliance Monitoring provides oversight and monitoring of various activities and restrictions of members who are required to comply with the terms of ICR Committee decisions, orders and undertakings.

Monitoring and supervision is not required by law (i.e., Code, common law, bylaw, etc.); the College provides this service because it's prudent – part of the CPSO's duty to protect the public. When a Compliance Monitoring Case is brought back to the ICRC, the options and outcomes available to the panel are limited can as the matter had already been disposed of. The following outcomes are available in most Compliance Monitoring Case Scenarios:

- Take no further action
- Request the matter be brought before the Registrar for RPGs
- Direct terms of an undertaking (which the member must agree to)
- Request a remedial agreement
- Refer the matter to discipline

Similar to matters that appear before the Settlement Panel, Compliance Monitoring cases do not require a decision to be written but merely further instruction from the ICRC. With that in mind, operationally the settlement panel when convenient will consider these types of cases in order to

- Approval in step down of supervision/consistent negative supervisor reports – this is for high risk cases only
- Undertaking negotiations

This would keep within the spirit of the settlement panel and also free up some of the Compliance Cases that are currently being directed to General, Surgical, and Family practice panels.

C. Strategic Initiatives

Council's Strategic Directions include optimizing investigations, discipline and monitoring processes, and facilitating physician enhancement. The ICRC's investigations and decision-making are an integral aspect of this strategic priority.

To that end, the ICRC has launched a number of pilots and on-going activities.

(i) The ICRC “Leadership Team”

Given the size and complexity of the ICRC’s workload and meeting schedule, the Chair of the ICR Committee is assisted by five Vice-Chairs of the specialty panels, as well as a Vice-Chair of general panels, a senior Public Member.

This “Leadership Team” meets quarterly each year in order to develop processes (e.g., proper process for following up on an issue flagged at a member-specific issue meeting); deal with ICRC operational policy and administrative matters; set agendas for business meetings, etc.

(ii) Enhancing High-Risk Investigations

The ICRC continues to look at how best to focus resources on serious and high-risk investigations. These efforts include:

- categorizing investigations based on nature of issues and risk to patient safety, and allocating resources accordingly;
- pursuing joint investigation opportunities with hospitals and other colleges;
- making use of assessments generated in other College processes, such as the Out-of-Hospital Premises Inspection Committee and the Independent Health Facilities Program;
- enhancing assessor activities, including: the Assessor Networking Forum, a recurrent forum, meeting 4-5 times per year, for outreach with and training of assessors and staff; a “standard of care” paper developed with ICR Committee members, assessors and Medical Advisors; refinement of assessor tools and information, e.g., report templates and retainer instructions;
- use of individualized educational plans (IEPs) to remediate practice and conduct deficiencies, with Medical Advisors involved in developing draft IEPs;
- implementation of abbreviated investigation strategies for less serious matters, including more robust streaming of “frivolous and vexatious” complaints;
- organizing meeting agendas to maximize efficiency and decision making.

(iii) The “Risk Assessment Tool” Pilot

This pilot involves the use of a risk-based approach to case assessment and committee decision-making. The aim is to develop a simple tool that will assist panels in deciding whether to take action on a complaint with a view to minimizing potential risk to a

future patient. The tool consists of 9 questions about the physician's clinical care, conduct, insight, record-keeping and complaints history. Members are asked to consider and evaluate these factors and rate how concerning they perceive them to be.

The Leadership Team tested the tool in June 2014 using active cases. Results showed 90% congruency between level of risk and outcome -- a positive result.

In 2015, members of the ICR Committee's Surgical, Family Practice, Mental Health, Obstetrics and Internal Medicine Panels have tested the tool for both Public Complaints and Registrar's investigations.

The Leadership Team agreed to continue testing the tool throughout 2016 on specialty and general panels. Staff are currently working with I.T. to automate the tool on Sharepoint for 2017.

(iv) Analysis of Investigations

ICRC has begun to analyse its investigations data about physician specialties to better understand issues, risks, and trends associated with that speciality. In the past, Dr. Bob Byrick reported results for Anaesthesiologists. An analysis of Obstetrics/ Gynaecology and General Surgery investigations is underway and will be reported to ICRC leadership in due course.

(v) ICRC Goals

The Committee developed a program evaluation in 2014. Following a program logic model the Committee defined three broad program goals:

Enhance Public and Member Trust in ICRC Processes through:

- (1) Quality Services
- (2) Consistent and Reasoned Decisions

Enhance the Quality of the Profession through:

- (3) Physician Performance

Each program goal identifies activities, associated measures, and indicators which tie to short and long-term outcomes. ICRC plans to use this framework over the next five years to evaluate the effectiveness of its work.

It can be noted that in 2015 and 2016, the goal focus for ICRC was on the transparency initiative implementation. The focus for 2016 will include continued work on transparency along with a focus on the following:

- Review and Revise Communication Protocol
- Revise Processes to increase Resolution
- Real-Time Feedback about Complaints Process
- On-going Shadow Panel Analysis
- Recidivism and Related Outcomes

D. Other Process Improvement/Quality Assurance Initiatives

(i) Decision Timeline Reduction Plan (“DTRP”)

In 2011, the ICR Leadership Team and support staff implemented a number of strategies to reduce timelines for decision release which had increased in early 2011 (from 8–12 weeks post-meeting for Complaints Committee, to 16–18 weeks post-meeting for ICRC).

These included streamlined decision templates, a new model for meeting preparation and work assignment amongst support staff, and additional training for committee members to assist panel chairs with decision review. These initiatives resulted in an average decision-release timeline decrease from 18 weeks to 14 weeks at the end of 2011.

The average decision-release timeline in 2014-2015 was 8-12 weeks. At the 2016 six-month point, decision-release timelines continue to ranges from 8-12 weeks.

(ii) Case Deferrals Analysis

Staff track, analyse and report back to ICR Leadership Team on deferred cases. Together they identify common problems leading to unnecessary deferrals that add to Committee and College resources and investigation time lines.

The deferral rate in the past few years has been 8% and continued at that rate between 2013-2015. Analysis of deferrals for 2016 will be done at the end of the year.

(iii) “Shadow Panel” Project

The ICR Committee’s predecessor, the Complaints Committee, conducted two previous “Shadow Panel” projects in 2006 and 2008.

These projects were quality assurance initiatives designed to review consistency of decision-making between different panels of the Committee.

These studies involved providing cases to two different and blinded ICR Committee panels. The first panel issues the “actual” decision and reasons, which are sent to the parties. The second panel’s proposed decision and reasons are noted by staff. The results were compared, and the analysis considered at business meetings.

Consistent application of physician history factored critically in the results of the first two projects.

The Committee conducted a third shadow panel in at the end of 2013 into 2014. As the transparency initiative was the focus for 2015, the shadow panel project was held in abeyance until it commenced again on June 1, 2016. This timing will allow for one year after the introduction of the Transparency Initiative.

In June 2016 (one year after the introduction of the Transparency Initiative), a working group consisting of the Manager of Committee Support , two Decisions Administrators (and the I&R Statistician have been working this project and have been incorporating shadow panel cases onto meeting agendas on an on-going basis. The statistician is assisting with the methodology and how ongoing analysis will happen. The hope is to report back in the new year.

(iv) Complaints Feedback Survey

In August 2016, the launch of a real time feedback survey began. Parties (Complainants and Physicians for Public Complaint Files) have been instructed that they can visit a separate web portal that has been created by Environics Research and complete a confidential survey.

The survey is completed in two phases:

- 1) Phase 1 - satisfaction with investigation (end of investigation pre decision) explores:
 - Speed of process
 - Objectivity/neutrality of investigator
 - Ability of investigator to understand the issues and details of the concerns
 - Degree to which the parties were kept informed about the progress of the investigation
 - Degree to which they felt their complaint was taken seriously(complainants only)
- 2) Phase 2 - satisfaction with the decision (post receipt of decision) explores:
 - Whether the decision adequately provides clear reasons for the decision

Results and feedback will be anonymous and Environics Research will provide aggregate data and trends to the College on an ongoing basis.

(v) Educational and Training

The ICRC Leadership Team continues to identify opportunities for Committee member education, with the goal of enhancing consistency and reasonableness of committee decisions.

It should be noted that an education training day for Chairs/Vice Chairs and Alternates was held in February 2015. Topics included key principles of natural justice and their application to ICRC, the decision making framework under transparency and various thresholds and referrals to discipline and settlements. This training day proved to be useful for Chairs/Vice-Chairs and Alternates and will be offered again in 2017.

The ICRC also developed a number of tools and frameworks to facilitate consistent and reasonable decision-making, including reference guides, information sheets and FAQs. These tools were further enhanced and revised accordingly in 2016 to assist with the transparency initiative as noted above.

DECISION MAKING TOOL: SEXUAL ABUSE INVESTIGATIONS

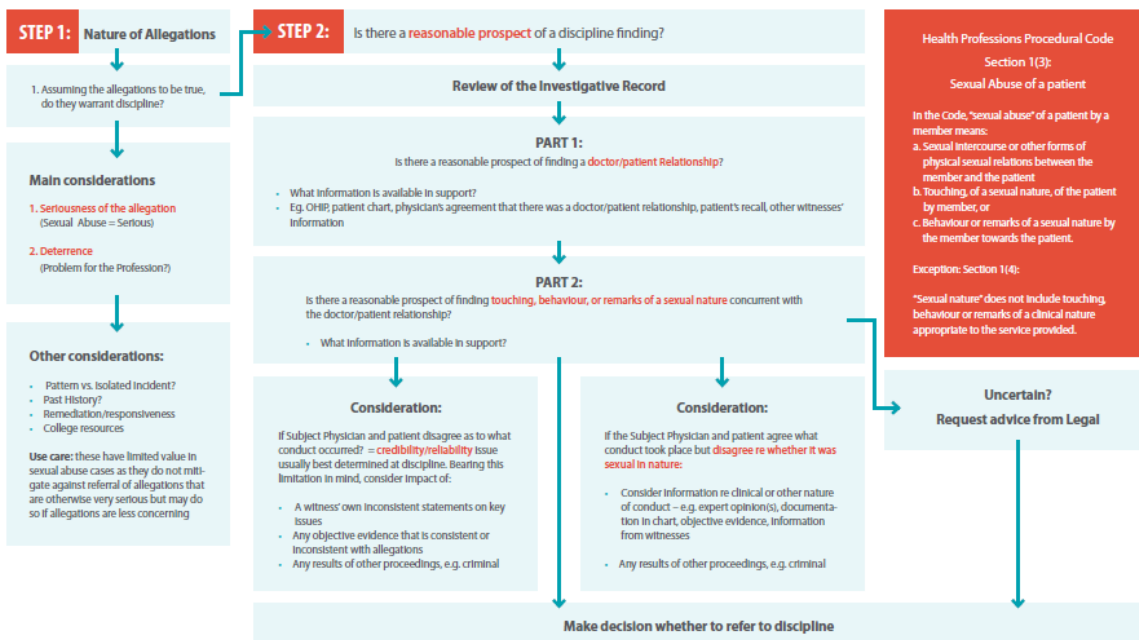
LEGAL ADVICE – PRIVILEGED – DO NOT DISCLOSE

GUIDING PRINCIPLES:

1. Section 1(1) of the Health Professions Procedural Code – **ultimate purpose of sexual abuse provisions is to eradicate sexual abuse of patients by members.**
2. June 2015 – Council recommended legislative amendments so that any physical sexual contact between a physician and a patient results in mandatory revocation of the physician's certificate of registration
3. When **reviewing the investigative record**, consider whether the information gathered during the investigation is:
 - i. Likely to be **available** at a discipline hearing (e.g. witness availability, admissibility problems as advised by Legal)
 - ii. **Sufficient** to support a discipline case: is there a reasonable prospect of a finding?
4. ICRC must exercise its discretion to decide whether to refer to discipline based on weighing the **appropriate factors**.
5. As a general rule, ICRC should not consider the **credibility or reliability of witnesses** – that is the Discipline Committee's job as it hears live witnesses and makes findings of fact, while the ICRC is a screening committee
6. Don't rely on **myths or stereotypes** about sexual assault/abuse
 - i. Myth: someone will struggle or protest immediately when sexually abused (e.g. cry out and leave exam room).
 - ii. Myth: someone will not voluntarily interact again with their sexual abuser (e.g. will not return for a follow-up).
 - iii. Myth: someone with a history of drug abuse, mental illness, or sex work can't be believed or relied on when complaining of sexual assault.
7. **Corroborating evidence is never required** in cases of alleged sexual misconduct. Consider its absence only when striking. Consider any objective evidence inconsistent with the allegations.
8. Consider a **witness' own statements that contradict each other on key elements of the allegations**, along with any explanation for the inconsistency, but keep in mind that at a discipline hearing the witness will have an opportunity to offer an explanation, and the mere fact that a witness has made inconsistent statements about the incident may be insufficient reason to reject their evidence at a hearing. Human memory is imperfect and inconsistencies are common.

LEGAL ADVICE – PRIVILEGED – DO NOT DISCLOSE

Decision Making Tool: Sexual Abuse Allegations



ICRC Outcome Assessment Guidelines

No or Minimal Risk of Harm

NO ACTION

- The panel has no concerns regarding care or conduct
- No follow-up by the College
- No previous history
- A No Action can include a Statement of Expectations
- Not posted on the public register

Low Risk of Harm

ADVICE

- Panel identifies area (care or conduct) for improvement
- Member could benefit from specific guidance to improve practice
- Member acknowledges (shows insight)
- No concerning history
- Advice to highlight suggestions for improvement
- No College follow-up or monitoring required
- Not posted on the public register

OR

REMEDIAL AGREEMENT

- Panel identifies area (care or conduct) for improvement
- Issue, while minor, is slightly more concerning and warrants follow-up with the College
- Opportunity for member to improve conduct/care through Self-Directed Education
- Member shows insight
- Panel may make broad suggestions about the type of follow-up/education needed:
 - Self study report
 - Reassessment (by a third party assessor):
- IF REFUSED: The matter is returned to the ICRC where it may direct SCERP
- Not posted on the public register

Moderate Risk of Harm

MODERATE RISK UNDERTAKING

- Concern about member care or conduct
- Impact on patient care, safety or public interest
- Oversight/supervision necessary to ensure good practice
- Member shows insight
- Member agrees to a plan to improve conduct/care in a timely manner (prior to the Committee decision)
- Panel specifies elements of undertaking
 - Level of supervision required
 - Course(s)
 - Chart review
 - Observation
 - Relevant CPSO policies
 - Reassessment: Type & Time
 - Progress reports: Frequency
- College monitoring required
- Practice restriction not required
- The Undertaking itself is posted on the public register but removed once all its terms have been completed

OR

SCERP

- Concern about member care or conduct
- Member needs to upgrade skills to improve practice
- Impact on patient care, safety or public interest
- College monitoring required to assure good practice
- History: Serious single concern or pattern
- Member does not show insight; and/or is uncooperative; and/or does not show a timely willingness to sign Undertaking or Remedial Agreement.
- Panel specifies elements of SCERP:
 - Level of supervision required
 - Course(s)
 - Chart review
 - Observation
 - Homework
 - Relevant CPSO Policies
 - Reassessment: Type & Time
 - Progress Reports: Frequency
- Practice restriction not required
- A summary of the SCERP decision is posted, and remains, on the public register (even when complete)

AND/OR

CAUTION IN PERSON

- Significant concern about member conduct/care
- Impact on patient care, safety or public interest
- Member's lack of insight and/or cooperation and/or the panel's concerns warrants face-to-face discussion.
- History:
 - Serious single concern
 - Unsuccessful past remediation
- Member required to appear before the Panel
- Significant outcome, short of a discipline referral
- Caution in person could be issued along with a SCERP or a Moderate Risk Undertaking
- A summary of the caution decision is posted, and remains, on the public register (even when complete)

High Risk of Harm		
UNDERTAKING: RESTRICT	UNDERTAKING: RESIGN	DISCIPLINE
<ul style="list-style-type: none"> - Serious concern about member care or conduct - Impact on patient care, safety, or public interest - Concerns cannot be addressed through education alone - Oversight necessary to assure good practice - History <ul style="list-style-type: none"> • Egregious single concern • Pattern - Panel specifies elements of undertaking: <ul style="list-style-type: none"> • Level of supervision required • Terms, limitations, or conditions • Course(s) • Chart review • Observation • Relevant CPSO policies • Reassessment: Type & Time • Progress reports: Frequency - College monitoring required - Practice restriction required - Posted on the public register 	<ul style="list-style-type: none"> - Serious concerns about conduct or care - Egregious single concern or pattern - Concerns cannot be addressed through education, oversight, or restriction - Member resigns and undertakes not to reapply - And/or referral to discipline 	<ul style="list-style-type: none"> - Professional misconduct: <ul style="list-style-type: none"> • Sexual abuse • Failure to maintain the standard of practice • Lack of knowledge, skill or judgement • Disgraceful, dishonourable or unprofessional conduct • Conduct unbecoming • Failure to respond to the College (governability) • Found guilty of offence relevant to suitability to practice - Incompetence - Considerations: <ul style="list-style-type: none"> • Seriousness of the allegation • Single error vs. pattern • Care concerns • Risk of re-offending • Type of conduct in issue is problem in the profession and should be dealt with at Hearing (member deterrence) • Member response to concerns - Sufficiency of evidence <ul style="list-style-type: none"> • Is there a reasonable prospect that allegations could be proven at Discipline? • Balance of probabilities

The ICRC Panel members regularly incorporate educational sessions into the Committee's semi-annual business meetings. At its spring business meeting, Dr. Diane Hawthorne and Dr. Sandra Northcott of the University of Western Ontario attended to discuss 'Understanding Boundaries and Managing the Risks Inherent in the Doctor-Patient Relationship'. The Committee also received an 'Update on Dementia' from Dr. Sharon Cohen is a Behavioural Neurologist and Medical Director of the Toronto Memory Program. At its Fall Business Meeting, Mr. Ian Scott, former Director of the provincial Special Investigations Unit presented to the Committee on oversight of sexual abuse investigations.

Staff Support

The members of the ICRC wish to thank staff for their excellent work in assisting the Committee to implement operations and fulfil its mandate.



Dr. David Rouselle
Chair, Inquiries, Complaints and Reports Committee

METHADONE COMMITTEE
2016 Annual Report to Council

Mandate:

The goal of the College's methadone program in Ontario is to improve the quality and accessibility of methadone maintenance in the treatment of opioid dependence. The College actively manages the practice of methadone prescribing in partnership with the Mental Health and Addictions Branch of the Ministry of Health and Long Term Care (MOHLTC). The Program receives funding for activities including staffing, outreach and assessment/education.

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

- I. Brief programs of education in addiction medicine,
- II. The establishment of guidelines or standards applicable generally to the use of opioid agonists in the management of opioid dependence,
- III. A program to review prescribing of opioid agonists by members in the management of opioid dependence, and
- IV. Decide whether to issue, refuse to issue, or withdraw a permit for a member to administer, prescribe or otherwise furnish opioid agonists for the management of opioid dependence.

Assessments

The core activities of the Methadone Program are to support physicians in obtaining an exemption under the Controlled Drugs and Substances Act from Health Canada to prescribe methadone, assess their practice and provide educational opportunities to ensure their prescribing practices meet the standard of practice.

All physicians wishing to obtain an initial exemption must complete the following:

- Hold a certificate of registration in Ontario
- Be in good standing with the CPSO
- Opioid Dependence Treatment Certificate Program provided by the Centre for Addiction and Mental Health (all modules to be completed within 3 years of initiating the exemption process) and the certificate requirements include a core MMT Prescribing course in addition to elective courses, for a total of 39 or more hours; the physician must complete the core course before applying for an exemption
- Following completion of the core course, a 2-day (or 4 half day) preceptorship with a College approved methadone prescriber

- Complete an application to the CPSO: all requirements must be completed within 1 year.

Upon completion of the above, and if the physician is in good standing with College, the application is forwarded to Health Canada for the initial exemption to prescribe methadone for the treatment of opioid dependence.

After the physician has been prescribing methadone for a year, the program conducts an assessment to ensure the physician is adhering to the Methadone Maintenance Treatment Standards and Clinical Guidelines. If successful, the Committee supports the renewal of the Methadone exemption for a 3 year period. The physician is assessed again at the end of 3 years. If that assessment is successful, the physician then enters a 5-year assessment cycle. In addition to physician assessments, the program completes assessments of methadone practices where physicians delegate the administration only of methadone to another qualified regulated health professional (Registered Nurse (RN) or Registered Practical Nurse (RPN)). In these clinics, physicians have been given an expanded exemption by Health Canada that allows them to delegate the administration of methadone. This offers patients increased access and convenience by receiving their methadone doses from their physician's office or clinic, rather than attending a pharmacy. The assessment focuses primarily on issues related to the transportation, safety and storage of methadone. The College retains a pharmacist assessor to conduct these assessments.

This year applications for 43 exemptions were approved and 69 prescriber assessments and 6 delegation assessments were completed.

Annual Methadone Prescribers Conference

The Annual Methadone Prescribers' Conference will be held on November 25th, 2016. We anticipate attendance well in excess of 280 including prescribers, pharmacists, methadone case managers, MOHLTC staff and addiction treatment providers. The conference will include sessions on physician civility, aging and addiction, opioid prescribing/non-pharmacological treatment of chronic pain, refusal skills, advanced issues in trauma informed care, Project Echo and obesity & other co-morbidities.

Methadone Newsletter

This past year has seen the continuation of the quarterly newsletter provided now in electronic format on the CPSO website. Feedback remains positive on the content; especially the Q&A section. The program receives a number of inquiries from prescribers related to patient care as a result of the newsletter. Additionally prescribers receive emails specific to particular issues throughout the year for example addressing co-prescribing of methadone and medical marijuana.

Methadone Committee Education Day

The Committee is scheduled to meet with methadone assessors at the December policy meeting. This is an annual event to share information, discuss issues and provide direction on what the Committee requires from methadone assessors in their reports.

Methadone Treatment and Services Advisory Committee Final Report

The Committee reviewed a draft of the task force report commissioned by the Minister of Health and provided feedback for the CPSO submission to government in response to the final report.

Methadone Committee Process Improvements

The Committee continued to work on improving processes in support of committee functioning including the development of an interview template to increase standardization and consistency in conducting prescriber interviews and agreeing on common criteria for decision making.

CAMH Simulation Pilot – Prescriber Preceptorship Requirement

The Committee approved a project for CAMH to pilot a more structured approach to providing the preceptorship component required for potential prescribers to be approved for a Section 56 exemption from Health Canada. The pilot consists of several simulated patient encounters. Staff from CAMH will present the results of the pilot at a future Methadone Committee policy meeting where a decision to formally approve the simulation as another option to meeting the existing preceptorship requirement.

Respectfully submitted,



Diane Doherty, Public Member
Chair, Methadone Committee

Outreach Committee 2016 Annual Report

Overview

The Outreach Committee works with staff to:

- *Develop major communications and outreach initiatives for the profession and the public;*
- *Assist in the development of major communications initiatives and government relations activities;*
- *Develop plans to deliver on each of the communications and outreach-related components of the College's strategic direction.*

The Committee is supported by the Policy and Communications division.

Areas of Focus

The Committee focused on outreach and communications-related priorities contained in the College's strategic direction. They include the following:

- Media monitoring and measurement
- Integrated social media/communications strategy
- Membership/public outreach strategy
- Public engagement
- Government relations activities

Following is a summary of the each of the major initiatives.

Media Monitoring and Measurement

The Outreach Committee considers the results and analysis of media monitoring and measurement at each meeting. Media Relations Rating Points (MRP) is a system used to measure and evaluate media activity related to the College. It is 10-point system that measures coverage across several dimensions including tone, (whether the overall story is positive, negative or neutral) and criteria including whether the College is mentioned, if a spokesperson is quoted, if a key message is included, if the mandate is mentioned or evident and accuracy. Using this point system, every type of media (print, radio, online, television) is rated.

Highlights:

Media attention has been very high in 2016, with 957 news items about the College measured

in the first three quarters. By comparison, in 2015, there were 776 news items in the entire year.

Importantly, the tone of the media coverage has been very good, with 18% (170 news items) positive; 70% neutral (670); and only 12% negative (117).

Although CPSO discipline cases received extensive media attention this year as usual, the media was also focused on the national introduction of a legal framework for the provision of medical assistance in dying, with the CPSO a key player. In the first nine months of the year, our interim guidance and subsequently our Medical Assistance in Dying policy was mentioned in many articles. The CPSO was often perceived as a leader in providing good guidance to the profession, and in collaborating with government to ensure a smooth introduction of this service.

In total, the CPSO's leadership and/or our policy about medical assistance in dying was mentioned in 288 stories by the end of the 3rd Quarter, and the tone of the coverage was very good, with 74 positive, 187 neutral and only 27 negative. Although many articles did not mention the "effective referral" requirement, the negative coverage did so, as did some of the positive coverage.

Other stories capturing media interest in 2016 include:

- Sexual abuse discipline cases; the Minister's Task Force on Sexual Abuse of Patients; and the College's Sexual Abuse Initiative
- Transparency of information pertaining to particular physicians; the College's Transparency Initiative.

Communications/Social Media

In 2016, the College continued to build its social media audience across its four key platforms: Twitter, Facebook, LinkedIn and YouTube. These platforms now have a total combined audience of over 4,200 users.

We continue to hold regular social media campaigns for all open consultations, and use of these tools to promote job openings, issues of *Dialogue* and other College publications, and to provide real-time customer service to both physician members and the general public.

Other specific initiatives for 2016 include:

- We re-launched our popular Policy Trivia Tuesdays on Twitter – 10-week campaign where we asked users to tweet back the correct answers to CPSO policy questions and

gave out prizes.

- We were able to share or re-tweet positive media coverage directly from our social media channels including several stories from the *Toronto Star*
- We added two new videos to our YouTube channel: one introducing Pam Greenberg, our sexual abuse intake coordinator; and one from the Doors Open Toronto event in May.

Public/Profession Outreach

Our goals for the 2016 Outreach program focused on reaching out to members of the public, educating medical students on the role of the College and professionalism and generating opportunities to meet with and talk to members and other stakeholders about policies, current issues and medical regulation. There was a significant interest from all groups this year on physician-assisted dying.

Highlights:

- Regular engagement at medical school milestones: Registrar, President and Academic Representatives gave welcome and congratulatory remarks at medical class orientation sessions and convocation ceremonies across the province.
- Participated in Ontario Medical Students' Weekend 2016, Western University.
- CPSO medical advisors and policy analysts participated in a number of undergraduate and postgraduate education sessions on a variety of topics throughout the year ranging from medical professionalism, medical records and physician-patient communication.
- The President and Past-President participated in numerous outreach events throughout the province all year. Often the Fall is the busiest time of year, but the interest in physician assisted dying was extensive and Dr. Kirsh, Dr. Leet and staff participated in many, many events including speaking engagements, round tables, and panel discussions throughout the year. The College was well represented on this important issue.
- Building on our public engagement initiatives last year, we were also participated in several well-attended public events on topics like physician-assisted dying, the complaints process and our end-of life policy.
- As of the writing of this report, College representatives have completed nearly 60 speaking engagements including 6 public outreach sessions.

Public/Profession Engagement

The College has had a formal public engagement plan for the past several years and continues to increase public engagement in College initiatives through consistent and regular public opinion polling. In 2016, one survey cycle has been undertaken to date. The survey polled on

issues relating to Medical Assistance in Dying, Continuity of Care, Test Results Management and Transitions in Care. As with all polling conducted, the results will be considered by the Outreach Committee and will be used to inform Working Groups, Committees, and Council on policy issues. |

As reported previously, several new components have been integrated in the policy consultation process over the past few years to increase engagement with stakeholders including both the public and the profession. In 2016, focused social media promotion, dedicated policy newsletters and user-friendly functionality continue to make it as easy as possible for anyone to participate in a consultation. Stakeholder engagement can vary quite significantly depending on the subject of the consultation, and whatever the subject, efforts are focused on receiving quality feedback from a variety of stakeholders. Starting in 2015, we have added a new element to our process: we have started developing a policy consultation summary page which is posted to the web once policies have been approved by Council. This web page includes a summary of the quantity of feedback received and a breakdown of who we heard from, highlights of the key things heard during the consultation and other relevant considerations, how the feedback was responded to including what changes were made and the rationale for those changes. Links to the final policy as well as some of the key messages are also included in this summary page. It was felt that it was really important to demonstrate, particularly to those who participate in consultations, that their feedback is carefully considered and how we evaluate and integrate all the feedback we receive.

Government Relations Activities

The College's government relations activities in 2016 have been significant and directed at a variety of issues and initiatives including:

- working closely with government on the prevention of sexual abuse of patients;
- physician-assisted death;
- compensation of public members of Council;
- ongoing work to increase College transparency;
- regulation of fertility services;
- overhaul of out-of-hospital facility regulation, and
- issues surrounding opioids and medication management.

In order to carry out this work, the College is in contact with a variety of government decision-makers. This includes regular interaction with the Minister of Health's office, the Premier's office, senior Ministry staff, and the opposition parties at Queen's Park.

In Summary:

2016 was a productive year for the Outreach Committee. The College's profile was raised in a

myriad ways – and physician assisted death was an important component of all our outreach and engagement this past year. We have seen real growth in public engagement and continue to look for opportunities for feedback to help inform our decision-making and over the last two years much work has been done to build our relationship with the Minister and his team particularly on areas of shared focus.

Patient Relations Committee

2016 Annual Report

Mandate and Objectives

The Patient Relations Committee (PRC) is a statutory committee of Council. The *Regulated Health Professions Act, 1991 (RHPA)* requires all colleges to have a patient relations program that includes measures for preventing and dealing with sexual abuse of patients by members.

The PRC is responsible for advising Council with respect to the patient relations program, as necessary.

The PRC is also responsible, under Section 85.7 of the *Health Professions Procedural Code*, for administering a program of therapy and counselling for persons who, while patients, were sexually abused by members. The PRC administers the fund for therapy and counselling by:

- Determining eligibility for funding; and
- Dispersing funds to eligible applicants' therapists.

The PRC advises Council with respect to its activities by way of an annual report.

Committee Composition

The PRC is composed of three physician non-Council members and two public non-Council members. A physician who is the subject of an application for funding for therapy and counselling may also be the subject of concurrent or future complaints or discipline matters, therefore only non-council members are appointed to this committee in order to avoid any apprehension of bias or conflict issues that could arise. The Committee members have experience in the areas of mental health, psychotherapy, psychiatry as well as knowledge of sexual abuse issues.

The Policy Department provides policy and administrative support to the PRC, and a representative from the Legal Department provides legal advice.

Core Activities & Statistics

The PRC's primary activity is administering funding for therapy and counselling. The PRC also advises Council with respect to the patient relations program and broader sexual abuse issues.

Administering Funding for Therapy and Counselling

Patients who were sexually abused by their physician can apply for funding for therapy and counselling. If eligible, patients are provided with funding for therapy and counselling if the

services are not covered by the Ontario Health Insurance Plan (OHIP) or a private insurer.

The PRC makes two determinations upon receipt of a funding application: whether the applicant is eligible for funding, and if so, the amount of funding that should be awarded. Regulation 59/94 made under the *RHPA* states that the maximum amount for funding is the amount that OHIP would pay for 200 half-hour sessions of individual out-patient psychotherapy with a psychiatrist. The maximum amount of funding has increased over time in accordance with changes to the OHIP rate. Currently, the amount is \$16,060; at the program's inception, the amount was approximately \$10,000. Typically, the PRC awards eligible applicants the maximum amount of funding allowed by regulation.

The PRC has approved 162 applications since its inception (1994-2016), and has denied 14 applications. The total amount awarded for the same period is \$1,968,045. The total amount paid out to date is \$1,179,547. The monies are paid out to therapists as applicants use therapy. Some may not use the full award and some use it at different intervals over a period of time. The following chart summarizes the funding for therapy and counselling that has been approved and used over the last nine years:

	2016 (Jan-Oct)	2015	2014	2013	2012	2011	2010	2009	2008
Applications Approved	12 (19 ¹ were reviewed)	10 (13 ² were reviewed)	4 (5 were reviewed)	3 (4 were reviewed)	8	4 (5 were reviewed)	5	4 (5 were reviewed)	4
Funding Approved	\$192,720	\$160,060	\$64,240	\$48,180	\$128,480	\$63,120	\$71,740	\$56,800	\$52,520
Money Paid Out ³	\$94,455	\$79,258	\$42,570	\$78,502	\$53,583	\$33,575	\$51,870	\$29,676	\$35,352

The number of applications received by the PRC has remained relatively consistent at approximately 4 to 5 applications per year. However, in 2012 and for the past two years (2015 and 2016), the PRC received an unusually high number of applications.⁴ It is not clear what might have caused these increases, but it is possible that the increase in 2012 was a result of the administrative improvements made to ensure all potential applicants receive an application for funding for therapy and counselling, and are supported in the application process. It is also possible that the increase in 2015 and 2016 was a result of the steps the College has taken to promote the existence of the funding for therapy and counselling program as part of its Sexual

¹ Five of these applications were deferred (one was later approved) and three applications were denied.

² Three of these applications were deferred. One of these three was later denied in 2016, while the remaining applications are still deferred as of October 2016.

³ To therapists of approved applicants.

⁴ 2012: 8 applications reviewed; 2015: 13 applications reviewed; 2016: 19 applications reviewed.

Abuse Initiative (e.g. via media releases, enhancing the information on the College’s website, and developing patient-specific resources such as the [Educational Brochure](#) and [What to Expect During Medical Encounters document](#)). It is unclear whether the increase in number of applications will be a trend that will continue.

In addition to reviewing new applications for funding for therapy and counselling, the PRC has also considered new requests to fund specific types of therapy from eligible patients who had been awarded funding in previous years.⁵ To use the fund for therapy and counselling, eligible patients must select the therapist/counsellor they would like to receive therapy/counselling from. Because the *Health Professions Procedural Code* specifies that the funding must only be used to pay for ‘therapy or counselling’, with some limited restrictions, the PRC has been determining on a case-by-case basis what constitutes ‘therapy or counselling’ in relation to sexual abuse by a physician.

Given the considerable amount of choice the *Health Professions Procedural Code* affords eligible patients in selecting a therapist/counsellor, the PRC has funded a range of therapies, including some therapists/counsellors who are not regulated health professionals. Eligible patients are advised of the implications associated with selecting an unregulated therapist/counsellor, and must confirm that they understand the therapist/counsellor would not be subject to regulatory oversight. Ultimately, eligible patients are entitled to select the therapist/counsellor that best meets their needs.

Other Activities

Due to the high number of applications for funding for therapy and counselling, the PRC’s main focus in 2016 was to consider funding applications. However, the Committee closely monitored the results of the College’s Sexual Abuse Initiative and Minister’s Sexual Abuse Task Force and looking forward to 2017, the PRC’s activities and processes will be adjusted to be consistent with any legislative changes that the Government may make to the funding for therapy and counselling program.

The PRC also made some changes at the operational level to enhance the funding for therapy and counselling program and better support survivors of sexual abuse. Once the review of the College’s [Maintaining Appropriate Boundaries and Preventing Sexual Abuse](#) policy⁶ is commenced, the PRC will assist in the review by providing its advice and content expertise.

⁵ As of the date of this report, the PRC has considered seven requests to fund specific types of therapy in 2016.

⁶ This policy is up for review in accordance with the regular policy review cycle but is on hold pending the implementation of any legislative changes Government may make in response to the Sexual Abuse Task Force Report that could affect the policy review process.

**PREMISES INSPECTION COMMITTEE
2016 Annual Report to Council**

MANDATE:

The Premises Inspection Committee shall administer and govern the College's premises inspection program in accordance with Part XI of Ontario Regulation 114/94 and its duties shall include, but not be limited to:

- (a) Ensuring appropriate individuals are appointed to perform inspections or re-inspections as authorized by Ontario Regulation 114/94;
- (b) Ensuring adequate inspections and re-inspections are undertaken and completed in a timely way using appropriate tools and mechanisms;
- (c) reviewing premises inspection reports and other material referred to in Ontario Regulation 114/94 and determining whether premises pass, pass with conditions or fail an inspection;
- (d) Specifying the conditions that shall attach to each "pass with conditions";
- (e) Delivering written reports as required under Ontario Regulation 114/94; and
- (f) Establishing or approving costs of inspections and re-inspections and ensuring the member or members performing the procedures on the premises are invoiced for those costs.
- (g) Reviewing reports of adverse events from premises.

COMMITTEE ACTIVITIES:

The Out-of-Hospital Premises Inspection Program (OHPIP) is overseen by the Premises Inspection Committee (PIC). Committee members reflect the breadth of inspection assessment activities that occur in out-of-hospital (OHP) settings. Members on PIC practice in areas such as anesthesia, colonoscopy, interventional pain, and general surgery. For the 2016 program year, there have been 34 individual committee panels to review inspection assessment reports, as well as 3 policy meetings to give overall direction to the program. Below is a list of the 2016 program activities and milestones:

OUT-OF-HOSPITAL PREMISES PROCEDURES:

Procedures performed in OHPs include, but are not limited to, cosmetic surgery, endoscopy, hair transplantation and interventional pain management that are performed using specified types of anesthesia (e.g. general anesthesia, sedation, most types of regional anesthesia and, in some cases, local anesthesia).

STAKEHOLDER ENGAGEMENT ACTIVITIES:

Interventional Pain Management Workgroup

An Interventional Pain Management (IPM) Working Group was convened to address concerns raised by physicians regarding interventional pain management (IPM) procedures being

performed in out-of-hospital premises. Working Group members consisted of assessors practicing IPM in the hospital and community settings.

The most contentious issues about procedures are reportedly the misuse of terminology, allegations of misrepresentation of the actual procedure being performed, and the indications for the interventional pain procedures.

The Premises Inspection Committee approved recommendations made by the IPM Working Group including the addition of standardized definitions for each nerve block in order to provide consistency in physicians' understanding of each procedure (i.e. pain physicians, supervisors, and assessors involved in any College process). The Committee also approved key recommendations that were communicated to stakeholders and resulted in revisions to College documents, *"Expectations of Physicians who have changed, or plan to change their scope of practice to include IPM"* and *"Applying the Out-of-Hospital Standards in Interventional Pain Premises"*.

OHPIP Standards Update: Role of Medical Director

A Working Group was convened to consider ways to increase the accountability of the Medical Director role in Out-of-Hospital Premises. This work was undertaken in response to a number of concerns raised specific to the accountability associated with this role, included but not limited to, Absenteeism; Authority for Appropriate Patient Selection/Admission; and Infection Prevention and Control.

The Working Group proposed key changes to the OHPIP Standards that enhanced the responsibilities and accountability of the Medical Director. Proposed revisions were supported and approved by the Committee and will be communicated to all physicians performing procedures in an OHP as well as the general membership.

Fertility Services Expert Panel

In August 2015, the Deputy Minister wrote to the College requesting our participation in establishing a quality and inspections framework for the fertility services sector, including Out-of-Hospital Premises (OHPs) and hospital settings.

The quality and inspections framework will be captured under regulation 114/94 which currently governs the OHPIP. Under OHPIP, the College is responsible for all of the program elements: the CPSO develops the standards and assessments tools; coordinates and conducts the facility assessments, and through the Premises Inspection Committee (PIC), determines the appropriate outcome as outlined above for each facility.

In March 2016, an Expert Panel on Fertility Services was convened by the College to assist with the work of developing a set of standards to support a quality oversight system. The Expert

Panel is comprised of physician leaders in reproductive medicine and other health professionals such as embryologists.

The CPSO Expert Panel on Fertility Services has developed a draft companion document “Applying the Out-of- Hospital Premises Inspection Program (OHPIP) Standards in Fertility Services Premises” to help fertility services practitioners plan for and participate in their inspection assessments. The document is intended to be applied to facilities in conjunction with the OHPIP Standards. The document will be released for external consultation with stakeholders in the coming weeks.

Ongoing Collaboration with Public Health Ontario

The CPSO has become involved in a variety of initiatives with system stakeholders to improve infection prevention and control (IPC) practices among members, and to develop consistent approaches to managing IPC lapses.

PIC continues to be involved with conducting joint IPC assessments with regional public health units across the province. Collaboration has also included ongoing consultation regarding the selection of appropriate assessors and infection control experts, and discussions related to the public posting of inspection outcomes.

In order to provide guidance on roles and responsibilities, current inspection practices, and contact information for use during infection prevention and control lapse investigations, the Ministry of Health and Long Term Care provided communication to Medical Officers of Health and Associate Medical Officers of Health regarding new resources to assist public health units in responding to community infection prevention and control (IPAC) lapses in Ontario. These resources included a document titled *Roles and Responsibilities in Community Health Care Settings During Potential Infection Prevention and Control Lapse Investigations*. The document includes information for Public Health Units and Stakeholders, developed by the Ministry of Health and Long-Term Care (MOHLTC), in collaboration with Public Health Ontario (PHO), the College of Physicians and Surgeons of Ontario (CPSO) and public health units.

PHO continues to provide ongoing support with training initiatives and literature reviews for concerns identified by OHPIP assessors and Committee workgroups. This past summer PHO has also completed updates to a series of IPC checklists designed to support IPAC lapse investigations in clinical office practice settings. These checklists are posted on the PHO website and will be posted on the OHP website once training is completed with OHP assessors and communication provided to medical directors. The checklists will also be used by most of the public health units across the province.

Quality Management Partnership (QMP)

In December 2015 the Ministry of Health and Long-Term Care mandated that the Quality Management Partnership, a CPSO strategic initiative, start implementing Quality Management Programs (QMPs) in colonoscopy, mammography and pathology.

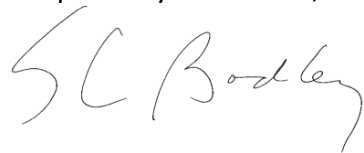
At each of its policy meetings, PIC continues to receive updates related to the partnership, specifically components related to early quality initiatives for endoscopy which form a major component of the current out-of-hospital premises inspection program.

Specifically, QMP has proposed that the addition of the Colonoscopy Quality Management Program Facility Lead role be embedded in the OHPIP Standards similar to the role of the Medical Director. Embedding the role of Facility Lead into the OHPIP Standards will help ensure the delivery of the QMP in OHPs and the goals of the Partnership, including that of fostering continuous quality improvement the delivery of the QMP in OHPs and the goals of the Partnership, including that of fostering continuous quality in the delivery of the QMP in OHPs and the goals of the Partnership, including that of fostering continuous quality improvement

Education

A number of education sessions have been undertaken to continue communication with the membership about the program. These have included: Program representation and updates provided at Assessor Network Group meetings, presentation at the Biannual Assessor Meeting, Presentation at the annual Ambulatory Endoscopy Clinic Day (AECD) conference, and most recently presentation about program initiatives at the annual Canadian Public Health Inspectors conference, to name a few.

Respectfully Submitted,

A handwritten signature in black ink that reads "S C Bodley". The signature is written in a cursive, flowing style.

Dr. Steven Bodley
Chair, Premises Inspection Committee

QUALITY ASSURANCE COMMITTEE 2016 Annual Report to Council

MANDATE

The Quality Assurance Program must include:

- Self, peer and practice assessments
- A mechanism for the College to monitor members' participation in, and compliance with, the quality assurance program
- Continuing education or professional development designed to promote continuing competence and quality improvement among the members, address changes in practice environments and incorporate standards of practice, advances in technology, changes made to entry to practice competencies and other relevant issues at the discretion of Council

This report covers activities of the Committee for this year to date.

STRATEGIC PROJECTS

There are two strategic priorities under the direction of, or with significant input from, the Quality Assurance Committee:

1. ASSURE AND ENHANCE PHYSICIAN COMPETENCE

The objectives of this priority include:

- Ensuring the effective assessment of every doctor every 10 years
- Determining whether College interventions produce change
- Ensuring policies improve quality of care/safety

As noted in last year's report the Research and Evaluation Department is leading a multiyear project under the Assessment Revisioning mantle to redesign the protocols used for peer assessment. Under the direction of a dedicated RED research associate the following activity / targets have occurred in 2016:

- 16 of the assessor network groups are or will be in the process of developing their Assessor Handbook by December.
- The proposed date to pilot some of the handbooks will be first quarter of 2017 and include: Walk In Clinics, Family Medicine/General Practice, GP-Psychotherapy, Hospitalist and Dermatology
- Research & Evaluation Department staff in conjunction with assessors have developed a new tool for assessors to engage in knowledge transfer with physicians being assessed called "Quality Improvement Resources" or "QIR". To date 45 have been externally reviewed and/or endorsed by physician specialty organizations (with overall positive feedback, particularly for the Endocrinology group who received an official endorsement from the Canadian Society for Endocrinology and Metabolism).

- Extensive external stakeholder consultation: 5 groups (the pilot groups) have finished their external consultation with overall positive results. Additionally, Emergency Medicine, Cardiology, Psychiatry & Endocrinology consultations are underway right now and will close in December with Rheumatology and Diagnostic Radiology scheduled to begin in 2017.
- Planned for next year will be an additional 6 networks (as well as Geriatric Medicine and Long Term Care begun late 2016). Work on a protocol for Pathology is being done with consideration and consultation from the Quality Management Partnership.

2. CPD NON-REPORTERS

As noted in last year's report a concerted effort began in 2014 to ensure 100% compliance with the CPD regulation. For the 2016 Annual Renewal there were only 300 non-compliers and these were first year physicians with independent certificates who had not transitioned from their residency status. Phase Two of this project, to address compliance with the three accrediting body's requirements both annually and for the five year cycle as well as revisiting CPSO criteria to become a third pathway, will commence in 2017.

OTHER ACTIVITIES

QAC Education Day

A second successful Education Day was held in May addressing both the ongoing work of the Peer Redesign project, providing an update on the Pathways project including introducing the stakeholder consultation process involving committee members set to commence in the fall and lastly, discussion and agreement on implementation of a number of suggested improvements to committee process. What also emerged was a commitment to conduct, in late 2016 or early 2017, a focus group for public members who serve on QMD committees to explore their role and learning needs in support of informed decision making.

QAC Working Group

A sub-group was formed in late 2015 to review all Pathways and Peer Redesign pilot cases and to provide input into the ongoing use of MSF and the revision of the Assessor Feedback form. This group has met monthly and has developed considerable confidence and expertise in reviewing Pathways cases as well as providing a valuable sounding board for policy items considered for presentation at main QAC policy meetings and providing guidance and support with respect to the ongoing work of the Peer Redesign project. The group will continue in 2017 with a combination of existing and new members.

Ongoing QAC Training

It was agreed last year that each policy meeting would contain an education component and this section of the policy meetings has been well received. In addition to the all-day education session provided in May, this year the Committee heard presentations on the role of CPSO policy in support of decision making, received a review of the Committee's regulatory powers,

an overview of the University of Toronto's Medical Record Keeping course and the Recidivism Project conducted by the Inquiries, Complaints & Reports Committee.

Expansion of Committee Orientation for Public Members

This year new public members received additional orientation with respect to reviewing and presenting cases, understanding committee decision making options and the contributions they bring as public members. This training, which was well received, will be expanded next year to all new committee members including physicians.

Process Improvements

The Committee has continued to be involved in streamlining processes to improve the efficiency of the meetings and to continue to improve consistency in decision making. These include; changes to information provided to physicians attending an interview; the creation of a standardized email for members to send to external experts who attend in support of interviews; arranging for the interview facilitator to speak with those experts prior to the meeting to discuss clinical scenarios and issues to address during the interviews; and, panels debriefing after each MSI meeting to reflect on the meeting

Registration Pathways Evaluation

In February 2012, Council approved an evaluation of the College's alternative routes to registration for physicians who do not meet the requirements for membership set out in the Registration Regulation. The goal of the evaluation is to

- Ensure appropriateness of policies/pathways (are they meeting the intended purpose of licensing a qualified, safe practitioner?)
- Gain insight to inform decisions about changes to alternative pathways to registration (is the threshold for policy too high, too low, just right?)
- Understand educational needs of physicians for quality improvement purposes.

Since the project began in November 2013, 100% of all assessments have been completed and the final cases are coming to the working group for decision. Additionally the Research and Evaluation (RED) staff assigned to the project are conducting focus group and individualized interviews with committee members and staff as part of the evaluation component of the project to determine the ongoing applicability and usefulness of MSF at CPSO.

QAC Member Interviews

Committee co-chairs agreed as part of their role to ensure that they talk to each member in person or by phone annually to reflect on their satisfaction with the role and any concerns or learning needs they might have.

Committee Internal Policy Review

Staff have committed to bringing to the committee all policies that require revision or updating beginning with the policy: **Proof of Compliance Continuing Professional Development Reporting Requirement (CPD)** which involved seeking additional consultation with all other “member specific committees” to obtain their feedback on the practice of medicine definition included in this policy. This work will continue into 2017 on this and other internal policies requiring updating.



Dr. Brenda Copps and Dr. Patrick Safieh
Co-Chairs
Quality Assurance Committee

**REGISTRATION COMMITTEE
2016 ANNUAL REPORT TO COUNCIL**

MANDATE

The Registration Committee's mandate is described in the *Health Professions Procedural Code*, to consider applications for certificate of registration to practice medicine in Ontario of individuals who, in the opinion of the Registrar, do not fulfill the registration requirements, prescribed in the Regulation.

When an individual applies to the College for registration, the Registrar has the following two options:

1. Register the applicant; or
2. Refer the application to the Registration Committee for its consideration.

The referral to the Registration Committee may be made for the following reasons:

- The applicant does not fulfill the registration requirements (examinations) set out in the Regulation; or
- The Registrar has doubts on reasonable grounds whether the applicant fulfills the non-Exemptible requirements in the Regulation (requirements that pertain to conduct, character and competence).

Additionally, the Registration Committee is responsible for the development of policies and programs on issues pertaining to granting of certificates of registration to practice medicine in Ontario.

The Registration Committee is guided by the strategic direction established by Council. The Committee is committed to reducing barriers to registration for qualified individuals by facilitating the development of new registration policies that are fair and objective, while maintaining the registration standard.

The Registration Committee continues to collaborate with external stakeholders to identify alternative ways to evaluate the competence and performance of physicians. External stakeholders include the other provincial licensing authorities across Canada, Royal College of Physicians and Surgeons of Canada, College of Family Physicians of Canada, Medical Council of Canada, Ontario medical schools, Ministry of Health and Long Term Care, and Health Force Ontario.

CORE ACTIVITIES

Review of Applications

The Registration Committee, after considering an application, may make an Order directing the Registrar to issue a certificate of registration prescribed in the Regulation, to issue a certificate of registration with terms, conditions and limitations, or to refuse to issue a certificate of registration.

When the Registration Committee makes an Order to refuse the applicant's request, it must give written reasons for its decision. An applicant, who is dissatisfied with the Registration Committee decision may appeal the decision to the Health Professions Appeal and Review Board (HPARB) and may request a written review or an oral hearing.

If the applicant or the Registration Committee is dissatisfied with the Order of the HPARB, either party may appeal the HPARB Order to the Divisional Court of Ontario.

Volume of Applications:

The Registration Committee's annual workload has continued to increase over the year. The increase in applications is a direct result of the College's commitment to reduce barriers to registration for qualified individuals by approving new registration policies. Complete data pertaining to the actual number of applications and the type of applications considered will be provided to Council in the Spring 2017 report.

Efficiency in review with types of cases

The Committee and staff are always looking for ways to increase efficiency without compromising quality. With changes to the administrative processes and procedures, the Committee and staff have been successful in managing increasing caseloads without increasing the in-person meeting days.

Here is how we did it:

- The addition of memos for exemption policies that are deemed no discussion cases
- Moving the exemption cases that do not result in a restricted certificate to the assessor team
- Additional Monthly Panel meetings by Teleconference
- Re-organizing the agenda to cover complex cases first (greatly reduced the meeting times)
- Grouping cases where only one member wishes to discuss case together quickens the response time by staff

- In March 2015, Council approved the Registration Committee’s recommendation to institute a fee for applications to modify the terms, conditions or limitations of his or her restricted certificate of registration. Effective June 1, 2015 all restricted certificate holders were subject to the new application fee.
- A 50% in repeat applications, seeking to modify its terms in 2016

Timeliness of Review of Applications and Issuance of Decisions:

Review time on the application is reported on the Council dashboard, and results remained in “the green” for the entire year. A benchmark of 5-7 business days was established for issuing the decision letter, following the Committee meeting. 100% of decisions were out in this timeline for 2016. The Orders with Reasons have been moved to staff to process to ensure content remains accurate and timely. The timelines for issuance of Orders with Reasons is 12 weeks. The Identification of Postgraduate Trainees who may need committee review was expedited. The process is now triggered at the time of the CaRMS match whereby staff sends personalized packages vs. waiting for the applicant to self-report. The Committee is pleased to report that 90% of cases continue to be adjudicated within the established benchmarks.

Registration Committee Goals and Objectives

At the beginning of 2016, the Registration Committee agreed to a set of goals and objectives for this year. The following provides an update:

Objective #1: Remove barriers to registration for qualified individuals – creating and maintaining mechanisms to enable registration of individuals who may not fulfill the requirements outlined in the Regulation, while maintaining the registration standard.

- The registration data for 2016 shows that for the 12th year in a row there has been an increase in the number of certificates of registration being granted by the College and this is a direct result of the policies approved by Council.
- The Registration Committee is continuing to review the registration policies on an on-going basis to determine if the policy is still relevant and if further changes are warranted.
- As a result of this review, the Registration Committee recommended the following revisions:

Council Policy: ALTERNATIVES TO DEGREES IN MEDICINE FROM SCHOOLS LISTED IN THE WORLD DIRECTORY OF MEDICAL SCHOOLS PUBLISHED BY THE WORLD HEALTH ORGANIZATION was created to enable directories of accredited medical schools to be approved.

Practice Ready Assessments for Family Medicine in 2017 is a pilot initiated by the Ministry of Health. The Registration Committee approved initial certificates of registration to facilitate this mandate.

RESTRICTED CERTIFICATES OF REGISTRATION FOR EXAM

ELIGIBLE CANDIDATES was updated with modern language. The committee re-emphasized its power to ask for a practice assessment if the candidate has failed an exam a significant number of times.

- CPSO successfully completed its bi-annual assessment on fairness and transparency by the Office of Fairness Commissioner in 2015. Its re-assessment was moved to 2017 by the new Interim Commissioner.

Objective # 2: Provide evaluation of applications for registration in a timely manner.

- There continues to be a process in place, "panel meetings" (teleconference), enabling expedited review of cases that are urgent and/or are not complex in nature
- 90% of cases were reviewed within published dashboard timelines

Objective #3: Web-based registration improvements

- Significant changes were made to the website under Registration to include Change of Scope and Re-entry as formal applications and checklist including the questionnaire for those seeking to do cosmetic procedures.
- The Website now includes new FAQ's for Registration Committee Process, Supervision and cases requiring an assessment.
- The College is participating, through FMRAC, in the development of an on-line national application process for Independent Practice Certificates. Scoping of this project has begun and a model is being chosen this year
- The website has been updated to reflect the new process and timelines to ensure transparency and facilitate better understanding of the Registration and Registration Committee process.

Objective #4: Effectiveness of Compliance Monitoring

- Compliance Monitoring and Supervision (CMS) continues to monitor physicians who require clinical supervision, are obligated to have health monitoring or a PHP agreement or require him/her to engage in education/remediation. All reports, including supervisor reports, health/PHP updates and certificates of completion, are received and reviewed by CMS staff who alert the appropriate registration staff when further action may be required by Registration Committee.
- 450 applicants are currently on restricted certificates under supervision

- The new position in CMS, the Lead for Supervisor Development, started this past summer. This individual has begun to lay the foundation for supervisor training, reporting and follow up. The Committee will be kept up to date with the progression of a program for College supervisors.

Objective #5 - Tracking quality of registration pathways

- A program evaluation of alternative registration pathways and policies began in 2012. The evaluation will seek to determine if there are potential performance differences between physicians who were registered through alternative pathways and those who registered with Canadian training. The purpose of the study is to ensure that all doctors are performing competently regardless of where training was obtained. Physicians will be compared on their complaints profiles, administrative data (e.g. prescribing rates) and data collected through a chart review and multisource feedback (MSF).
- For further details please refer to the RED report in the Council material

Objective # 6 – Proactively regulates the profession

- Development of National Standards – The Registration Committee continues to be active in its participation in the development of national standards for licensure.
- Development of reports and creation of new queues within its Inquiries teams has made reaching the profession quicker and more streamlined with the appropriate expertise.
- Blood Borne Viruses –approved new reporting which commenced for all new applicants in 2016.
- Annual Renewal for Changing Scope of Practice follow-up was automated this year thus greatly expediting the process.

UPDATE ON OTHER ACTIVITIES: Significant changes to process and staffing structure resulted in more effective process efficiencies. These efforts resulted in improved timelines for initial assessments and issuance of certificates of registration.

Appeals to HPARB

Five applicants appealed to HPARB this year; one has withdrawn and six are waiting disposition.

UPDATE ON STAKEHOLDER INITIATIVES

CFPC: Recognized Training and Certification Outside Canada
(<http://www.cfpc.ca/recognizedtraining/>)

- After a comprehensive review of the Accreditation Standards for Postgraduate Family Medicine training and Certification Standards in Australia, USA, United Kingdom and Ireland, and concluding that these standards are **comparable** and **acceptable** to the CFPC’s own standards, this route to Certification has been certifying eligible family

physicians who have trained in the aforementioned jurisdictions since 2010. As of December 1, 2015, a total of 1091 candidates applied, and 603 candidates have been certified. The majority of successful candidates were trained and certified in the USA (41.8%) and United Kingdom (49.8%).

- The CFPC is currently discussing a review of this Route to Certification and has approached Health Canada with a funding request.
 - **Alternate Route to Certification (<http://www.cfpc.ca/ARC/>)**
- This route to Certification was active between 2008 and 2015 and certified practicing Canadian physicians. It was launched in 2008, in conjunction with the declaration of family medicine as a specialty, as a time-limited opportunity for CFPC members to achieve Certification without examination. It is anticipated that all accepted applications to this program will complete their requirements by 2018.
 - **Practice-based assessment route to Certification**
- With the closing of ARC, the opportunity to develop a practice-based assessment route to Certification in Family Medicine is being discussed. The CFPC welcomes input from CPSO regarding how such a route to Certification may impact or be coordinated with the CPSO's current summative peer assessment process.

Royal College of Physicians and Surgeons of Canada (RCPSC)

The Practice Eligibility Route (PER) to certification has been developed by the Royal College to allow assessment of specialists practicing in Canada access to assessment against a national standard. Route A (access to the standard examinations) is now open to applicants in all primary specialties. Route B is a more practice-based assessment/examination developed for Psychiatry and administered twice, with ongoing plans for annual delivery.

Internal Medicine has indicated they may be ready to pilot test their Route B assessment in 2017. The development of these assessments is work intensive and has taken several years for both named specialties to develop. We are pleased to report after two administrations of the Psychiatry Route B assessment it is discriminatory with respect to medical knowledge and ability. In both administrations, CPSO Assessors participated as examiners. Pass rates are similar to the standard examination. A number of specialties have indicated, as they move forward in the transition to a competency based model of education and assessment, they would have the capacity to develop a practice-based assessment as part of PER. The development of Route B in the absence of the Specialty Committees deliberations on CBME has been challenging for many of the members. Discussions related to site of assessment, examiners from other regions and differing specialty specific components have posed challenges moving forward. Route A is open

now for eligible candidates in all entry-level disciplines and planning for further development of Route B will be coordinated with Competence by Design.

The development of the Subspecialty Exam Affiliate Program (SEAP) was introduced to assess those individuals who were practicing the sub-specialty, but not the parent/base discipline (therefore making them ineligible for PER in the base discipline as it depends upon scope of practice). This has been administered to selected individuals to develop the process, and in the coming years, this will be open to sub-specialists practicing in Canada. Although SEAP candidates will be assessed against a national standard, they will not be eligible for certification as they lack the base specialty examination. They will be recognized by a special category of affiliate status.

Medical Council of Canada

Subject: Report to CPSO from Medical Council of Canada (MCC)

Assessment Evolution

- MCC's examination program will undergo significant changes that will take effect in 2018 and 2019. Impacts will include changes to exam sequencing; requirements and content; rating changes and new standards; increased frequency to take exams Medical Council of Canada Qualifying Examination (MCCQE Part I); how exams can be challenged; increased complexity in some of the competencies to be assessed; and new vendor procurement/roles.
- To communicate these changes, the MCC has developed a communications program entitled Assessment Evolution. As part of upcoming communications activities, the MCC is developing a microsite to house all the latest developments and updates regarding upcoming changes. This site, mcc evolution.ca, will launch in November 2016.

MCCQE Part I International

- On March 31, 2015, the Government of Canada announced the approval of \$6.7 million over 3.5 years to the MCC for Streamlined and Equitable Assessment for Foreign-Trained Physicians. This funding will support an international and more flexible delivery of the Medical Council of Canada Qualifying Examination (MCCQE) Part I, starting in 2019.
- The MCCQE Part I International project is a transformation of the current exam to provide international medical graduates (IMGs) with access to this critical assessment prior to their arrival in Canada. The project involves significant back-end changes to enable a more flexible and widely accessible delivery.

- With a projected 2019 launch date at dedicated test centres both domestically and abroad, the MCC has been ramping up on content development cycles, and is developing a new common MCC item bank – MOC5 – to meet the demands of a more frequent and flexible delivery of the MCCQE Part I.

MCCQE Part II capacity

- The MCC continues to work on expanding MCCQE Part II site capacity with its partners. For the fall 2016 session, the MCC has had to “bump” a much smaller number of candidates than expected. For the spring 2017 session, the organization anticipates being able to provide a spot for all candidates who are in their second year of residency and above, and will allocate all remaining capacity to PGY-1 candidates.

MCCEE standard setting exercise

- A standard setting exercise will be taking place in November 2016 for the Medical Council of Canada Evaluating Examination (MCCEE). The outcome of this exercise will be a review of the current standard with a possible updated pass score for the examination.
- The new pass score will be implemented starting with the May 2017 session. MCCEE scores will continue to be reported on the same scale and will be comparable before and after May 2017.

Upload of medical degree image

- 2016 graduates from most medical schools in Canada are being invited to upload an image of their degree to their physiciansapply.ca account. Doing so will facilitate their applications to medical regulatory authorities and sharing with other stakeholders.

Application for Medical Registration (MRA onboarding)

- The latest medical regulatory authority to start using the Application for Medical Registration is the College of Physicians and Surgeons of British Columbia as of Sept. 6, 2016.
- In total, six medical regulatory authorities are now using this functionality in physiciansapply.ca, with more to come onboard in 2016 and 2017.

Transition from IMED to the World Directory

- Candidates can confirm whether their school of medicine is recognized in Canada by accessing the World Directory of Medical Schools (World Directory) and locating their school. A note feature for “Canada” on the Sponsor Notes tab indicates that the medical school is recognized in Canada.

Mandatory translation service

- As of Oct. 3, 2016, candidates are required to use the translation service offered through their physiciansapply.ca account, and the option to provide their own translation has been discontinued. MCC offers the service in partnership with the Translation Bureau of the Public Services and Procurement Canada.
- This change streamlines the translation process and is expected to significantly reduce delays and improve candidate service.

MCC 360 and multi-source feedback

- The MCC has embarked on a national project to incorporate multisource feedback into physician quality assurance and improvement programs. The project builds on a “360-degree” evaluation tool. The tool uses surveys to collect feedback from the physician, coworkers, colleagues and patients. A report is produced to identify strengths and areas for improvement.

NAC PRA candidate fee introduction

- The MCC is developing a pan-Canadian practice ready assessment process for international medical graduates (IMGs). This route will be available to IMGs seeking a provisional licence to enter independent practice.
- For additional information, visit the following link: <http://mcc.ca/wp-content/uploads/Fact-Sheet-PRA-sustainability-EN.pdf>.

Respectfully submitted,
Barbara Lent

COUNCIL BRIEFING NOTE

TOPIC: Policy Report

ITEMS FOR INFORMATION

External Consultation Responses:

1. Ministry of Health and Long-Term Care: Amending Regulation 1094 (General) made under the *Vital Statistics Act*.
2. Ministry of Transportation: Proposed list of medical, visual and functional impairments that will warrant mandatory reporting under the *Highway Traffic Act*.

Updates:

3. Planning for and Providing Quality End-of-Life Care Policy – Organ and Tissue Donation.
4. Policy Consultation Update
 - I. Physicians and Health Emergencies.
 - II. Proposed Regulation Change: College Oversight of Fertility Services
5. Policy Status Table.

1. Ministry of Health and Long-Term Care: Amending Regulation 1094 (General) made under the *Vital Statistics Act*

- The Ministry of Health and Long-Term Care (MOHLTC) sought feedback on a proposed amendment to Regulation 1094 (General) made under the *Vital Statistics Act*.
- If approved, the amendment would allow registered nurses to independently complete and sign the medical certificate of death in certain circumstances: within the context of an existing nurse-patient relationship; where death is expected; there is a documented medical diagnosis of a terminal disease; and there is a predictable pattern of decline for the deceased with no unexpected events or complications.

- Currently only physicians and, in certain circumstances, nurse practitioners can complete and sign the medical certificate of death. This requirement is captured in the College's *Planning for and Providing Quality End-of-Life Care* policy.
- In light Executive Committee feedback and staff analysis, the College's submission (**Appendix A**) was supportive of the proposed regulation amendment, viewing this systems level change as a positive step to improving access, while optimizing the utilization of health care resources and personnel. More specifically:
 - The College believes the proposed amendment is in keeping with the principle that those health care professionals, including registered nurses, who are involved in or who are knowledgeable of the patient's condition are best positioned to complete and sign the medical certificate of death.
 - In the College's view, registered nurses have the clinical expertise required to complete and sign the medical certificate of death in the circumstances prescribed. Although the submission notes that we defer to the College of Nurses of Ontario for specific comment on this matter.
 - The College believes that the proposed amendment will further strengthen the interprofessional relationship between physicians and registered nurses by ensuring that physicians are responsible for making the necessary diagnoses and assessments of the patient's predicted pattern of decline, while more optimally utilizing the clinical expertise of registered nurses.
 - Finally, the College also recognizes that many patients are choosing to be at home when death is expected and believes that the proposed amendment will support patient autonomy in this regard by helping to ensure that the supports necessary for a quality death at home experience are more readily available.
- At present time, it is unclear when the proposed amendment will be approved by government. However, once approved, a minor amendment to the College's *Planning for and Providing Quality End-of-Life Care* policy will be required in order to inform the profession of the circumstances where registered nurses can assume responsibility for this important service.
- The Executive Committee and Council will be kept apprised of any developments relating to or flowing from this regulation amendment.

2. Ministry of Transportation: Proposed list of medical, visual and functional impairments that will warrant mandatory reporting under *the Highway Traffic Act*

- The *Highway Traffic Act* contains a mandatory reporting obligation related to fitness to drive. This obligation is captured in the College's, [Mandatory and Permissive Reporting](#) policy.
- The mandatory reporting obligation is framed broadly, with the Act requiring that every legally qualified medical practitioner report to the Registrar (of the Ministry of Transportation) the name, address and clinical condition of every person sixteen years of age or over attending upon the medical practitioner for medical services who, in the opinion of the medical practitioner, is suffering from a condition that may make it dangerous for the person to operate a motor vehicle.¹
- For a number of years, the Ministry of Transportation (MTO) has been working to try to clarify the reporting obligation, principally by developing a regulation to specify conditions that will warrant mandatory reporting and those where the reporting would be discretionary.
- Over the summer, the MTO invited the CPSO to provide informal feedback on a proposed list of mandatory reporting requirements that will ultimately be included in a regulation.
- The proposed list provides for broad categories of medical, visual and functional impairments that will warrant mandatory reporting. Categories include: Cognitive Impairment, Consciousness or Awareness, Motor Impairment, Visual Impairment, Substance Use Disorder, and Psychiatric Illness. A description of the requirements for reporting are set out under each subsection.
- The proposed list is attached as **Appendix B** and was reviewed with the assistance of Medical Advisor, Dr. Bill McCauley.
- An informal response, incorporating Dr. McCauley's feedback was provided to MTO staff. These included:
 - Recommendation to clarify the threshold for which conditions are reportable.
 - Suggestion to change the term 'uncontrollable' to 'uncontrolled' throughout the materials in order to expand the situations requiring reporting.
 - Request for clarification on the section Consciousness or Awareness as it was felt to be overly broad and would trigger a reporting obligation in many instances where it may not be warranted.

¹ Section 203(1) of the Highway Traffic Act, R.S.O. 1990, c. H.8

- Suggestion to add the qualifier ‘uncontrolled’ to the section Substance Use Disorder, as it was believed that the risk to the public exists primarily where the disorder is not being managed.
- Suggestion to clarify and broaden the section on Psychiatric Illness to include illnesses that would align with the DSM-V manual terminology.
- The MTO is in the process of consolidating all the feedback so they can assess whether further changes to the proposed mandatory list are necessary.
- It is anticipated that in the coming months, the MTO will circulate the draft regulation including the proposed list of reportable conditions for external consultation.
- At that point, the College will have the option to submit a formal response.
- The Executive Committee and Council will continue to be kept apprised of any developments to the regulation.

3. Planning for and Providing Quality End-of-Life Care Policy – Organ and Tissue Donation

- At its September meeting, Council heard a presentation from the Trillium Gift of Life Network (TGLN) titled “Donation and Transplantation in Ontario – Our Message and Call to Action”.
- TGLN’s message was twofold. First, that organ and tissue donation is an integral part of quality end-of-life care and second, when considered eligible by TGLN, every patient or family should be provided the opportunity to speak with a uniquely trained expert in a timely manner, in order to make an informed decision about donation.
- The presentation reviewed a number of barriers to timely referrals to TGLN (e.g., lack of ownership among the team to coordinate the referral, etc.) as well as barriers that prevent patients or their families from having the opportunity to make informed decisions with respect to organ and tissue donation (e.g., notification to TGLN after a time has been set for withdrawal of life-support, etc.).
- At the end of the presentation, TGLN included a “Call to Action” directed at the College and seeking our endorsement of their message and commitment that all eligible patients or families be given the opportunity to speak with a donation expert in a timely manner.
- In response, the Executive Committee considered what, if any, action the College should take in response to TGLN’s call to action. Options considered included

taking no action, amending the *Planning for and Providing Quality End-of-Life Care* policy, and/or developing an article for *Dialogue*.

- The Executive Committee chose not to consider amendments to the policy at this time, believing that the policy already addressed these issues in a manner that is consistent with TGLN's request.
 - In particular, the policy already recognizes that organ and tissue donation is a part of quality end-of-life care.
 - Moreover, the legislative framework for organ and tissue donation currently places the responsibility for notification to TGLN on designated facilities (i.e., a specific class of hospital) and requires those facilities to develop policies or procedures to comply with this legislative responsibility. The policy outlines this framework and requires that physicians working within these facilities comply with those policies set out by the facility.
- Instead, the Executive Committee directed that an article be developed for *Dialogue* that would emphasize the importance of organ and tissue donation, remind physicians of the important role they play in this process, and explore barriers to timely referrals. TGLN will be invited to collaborate with the College in the development of this article.

4. Policy Consultation Update

I. Physicians and Health Emergencies

- The *Physicians and Health Emergencies* policy is currently under review
- As part of the policy review process, a preliminary external consultation was conducted on the current policy between Sept 21 and November 25, 2016.
- As of the writing of this report, the College has received 50 responses to this consultation. These include 8 comments on the College's consultation page (7 physicians, 1 other healthcare professional), and 42 online surveys (36 physicians, 1 medical student, 4 members of the public and 1 person who preferred not to say).
- All [written feedback](#) is posted on our website in keeping with regular consultation processes and posting guidelines. A report of the survey results will be available on the College's website shortly.
- A sampling of the feedback received is included below.

- Eighteen physician respondents indicated that they had provided care during a health emergency, and the majority indicated it was an experience that they feel had great meaning for them upon reflection. Some went so far as to encourage all physicians to seek out an experience of providing care during a health emergency.
- A number of respondents made suggestions on how the policy could be improved, including:
 - Providing more guidance the application of the policy with regards to providing care outside ones scope of practice;
 - Providing a list of examples to definitions used in the policy to add clarity. This could include defining what a health emergency is, and what events or circumstances could be considered a health emergency (e.g. Natural disasters, pandemics, terrorist attacks);
 - Adding a statement that governments and health authorities also have a responsibility to support physicians who provide care during a health emergency;
 - Providing guidance to physicians on where to access emergency preparedness and planning information.
- Respondents who indicated that the policy could use a definition of the term 'health emergency' indicated that a list of examples may be helpful, but that there may also be events or situations that arise in the future that can't be anticipated. Because of this, a list of examples should not be considered exhaustive.
- A number of physician respondents expressed concerns that the policy may be too broad with regards to providing care outside ones scope of practice. There were concerns that without physicians maintaining their basic and advanced life support skills, their ability to provide care during a health emergency may be compromised.
- A few physician respondents questioned the need for a policy given the profession's values include 'altruism' and 'service', and these values can be interpreted to assume a physician would naturally help if people are in need regardless of the situation.
- All feedback received will be carefully reviewed alongside the research findings in the development of a new draft policy.
- Once a draft policy has been developed, it will be presented to the Executive Committee and Council for consideration.

II. Proposed Regulation Change: College Oversight of Fertility Services

- In 2015, the College was asked by the Ministry of Health to develop and implement a quality and inspections framework for the delivery of fertility services across the province.
- To respond to the Ministry's request, we have taken steps to bring fertility clinics under the Out-of-Hospital Premises Inspection Program (OHPIP). This involves making an amendment to the existing *Ontario Regulation 114/94, Part XI (Inspections of premises where certain procedures are performed)* made under the *Medicine Act, 1991* which authorizes the OHPIP.
- At its September meeting, Council approved for consultation a draft regulation amendment to *Ontario Regulation 114/94*.
- A consultation was undertaken between September 21 and November 25, 2016.
- As of the writing of this report, the College had received 19 responses. These include 14 comments on the College's online discussion page (all from physicians) and 5 received via email (4 from a physician and 1 from a member of the public). An online survey was not used in this consultation.
- All [written feedback](#) is posted on our website in keeping with regular consultation processes and posting guidelines.
- The vast majority of respondents expressed support for the College's oversight of fertility services.
- A number of respondents raised specific concerns about the regulation or the proposed oversight of fertility clinics. Highlights include:
 - Whether it is appropriate to capture fertility clinics that only offer intra-uterine insemination (IUI) and not in vitro fertilization (IVF);
 - The need for greater oversight of uninsured services at fertility clinics that may not be evidence based;
 - Concern about the qualifications and training of future inspectors under this program;
 - The cost of the new inspection regime and its impact on increasing physician's fees to the College.
- Only one physician respondent expressed opposition to the proposed regulation and the College's oversight of premises where fertility services are performed.
- All feedback received will be carefully reviewed and will inform any revisions made to the proposed regulation change.

- Once a revised regulation has been developed, it will be presented to the Executive Committee and Council for consideration.

5. Policy Status Table

- The status of ongoing policy development and reviews, as well as target dates for completion, is presented for Council's information as **Appendix C**. This table will be updated at each Council meeting.
- For further information about the status of any policy issue, please contact Andréa Foti, Manager, Policy, at extension 387.

DECISIONS FOR COUNCIL: For information only.

CONTACTS: Andréa Foti, ext. 387

DATE: November 10, 2016

Appendices:

Appendix A: CPSO Consultation Response - Amending Regulation 1094 (Gen) Vital Statistics Act

Appendix B: Proposed List of Mandatory Reporting Requirements

Appendix C: Policy Status Table

September 14, 2016

Ministry of Health and Long-Term Care
Nursing Policy and Innovation Branch
12th Floor, 56 Wellesley Street West
Toronto, ON M5S 2S3



THE
COLLEGE
OF
PHYSICIANS
AND
SURGEONS
OF
ONTARIO

Rocco Gerace MD
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Re: Amending Regulation 1094 (General) made under the *Vital Statistics Act*

The College of Physicians and Surgeons of Ontario (the “College”) appreciates the opportunity to comment on the Ministry of Health and Long-Term Care’s proposed amendment to Regulation 1094 (General) made under the *Vital Statistics Act*.

The proposed amendment would allow registered nurses to independently complete and sign the medical certificate of death in certain circumstances. More specifically, within the context of an existing nurse-patient relationship and when death is expected, there is a documented medical diagnosis of a terminal disease, and there is a predictable pattern of decline for the deceased with no unexpected events or complications. The College is strongly supportive of this systems level change that in our view will increase access, result in the more timely delivery of health care, and promote the optimal use of health care resources and personnel.

In particular, the College recognizes that the timely completion of the medical certificate of death is a key component of quality end-of-life care, and articulates the importance of this legislative responsibility in our *Planning for and Providing Quality End-of-Life Care* policy. However, we are aware that access and efficiency problems relating to this important responsibility persist. We believe granting registered nurses the ability to complete and sign the medical certificate of death in the prescribed circumstances will go a long way to addressing these problems.

Moreover, the proposed amendment is in keeping with the principle that those health care professionals who are involved in or who are knowledgeable of the patient’s condition are best positioned to complete and sign the medical certificate of death. Currently the *Vital Statistics Act* embodies this principle with respect to physicians and nurse practitioners, but we believe that this principle applies equally well to registered nurses.

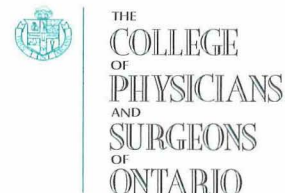
Further to this, the College also believes that completing and signing the medical certificate of death in the circumstances prescribed by the amendment is within the clinical expertise of registered nurses. In the College’s view, this is a natural extension of the already important role registered nurses play in providing quality and compassionate end-of-life care that often includes the pronouncement of death. However, we defer to the College of Nurses of Ontario for specific comments relating to the competence and expertise of registered nurses as it applies in this context.



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Ministry of Health and Long-Term Care
Nursing Policy and Innovation Branch
September 14, 2016



Likewise, the College also believes that the proposed amendment will further strengthen the interprofessional and collaborative relationship that already exists between physicians and registered nurses. More specifically, it ensures that physicians are responsible for making the necessary diagnoses and assessments regarding the patient's predicted pattern of decline, while increasing the role and responsibility of nurses in a manner that is commensurate with their clinical expertise and in a way that will improve access and promote the timely delivery of health care.

Finally, the College recognizes that many patients are choosing to be at home when death is expected and is supportive of promoting patient autonomy in this regard. In our view, the proposed amendment will help promote patient autonomy by improving access to the supports that are necessary to ensure a quality death at home experience for both patients and their loved ones.

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

Yours truly,

A handwritten signature in black ink that reads "Rocco Gerace". The signature is written in a cursive style.

Rocco Gerace, MD
Registrar

Proposed List of Mandatory Reporting Requirements

1. Cognitive Impairment

A requirement to report any individual who has a condition or disorder resulting in severe and uncontrollable cognitive impairment affecting any of the following:

- attention,
- judgment and problem solving,
- reaction time,
- planning and sequencing,
- impulsivity, visuospatial perception, or
- memory.

2. Consciousness or Awareness

A requirement to report any individual who has a condition or disorder that has resulted in any degree of impaired consciousness or awareness.

3. Motor Impairment

A requirement to report any individual who has a condition or disorder resulting in severe motor impairment that affects any of the following:

- coordination,
- muscle strength and control,
- flexibility and motor planning.

4. Visual Impairment

A requirement to report any individual who has any of the following:

- a) corrected distance visual acuity that falls below 20/50 as measured with both eyes open.
- b) continuous binocular horizontal visual field of less than 120 degrees along the horizontal meridian both 15 degrees above and 15 degrees below fixation. Any individual who has diplopia within 40 degrees of fixation point (in all directions) of primary position, unless;
 - i. The diplopia can be corrected using prism lenses so that the person no longer has diplopia within the central 40 degrees of primary gaze, and provided that,
 - Visual acuity and visual field standards are met,
 - The ophthalmologist or optometrist indicates that adequate adjustment has occurred.

5. Substance Use Disorder

A requirement to report any individual who currently has a diagnosis of substance use disorder, excluding caffeine and nicotine, who is non-compliant with treatment recommendations.

Proposed List of Mandatory Reporting Requirements

6. Psychiatric Illness

A requirement to report any individual who currently has a diagnosis of a severe and uncontrollable psychiatric condition or disorder involving any of the following:

- Acute psychosis
- Abnormalities of perception
- Has a suicidal plan involving vehicle or intent to use vehicle to harm others

POLICY STATUS REPORT – DECEMBER 2016 COUNCIL

POLICY REVIEWS

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
Re-entering Practice	The current policy sets out expectations for physicians who wish to re-enter practice after a prolonged absence from practice and sets out requirements of physicians in demonstrating their competency in the area of practice they are returning to.	This policy is currently under review. A preliminary consultation was undertaken between June and August, 2016. Further updates with respect to the status of this review will be provided at a future meeting.	2017
Changing Scope of Practice	The current policy sets out expectations for physicians who have changed or intend to change their scope of practice and sets out requirements of physicians in demonstrating their competence in the new area of practice.	This policy is currently under review. A preliminary consultation was undertaken from April 4 to June 2, 2016. This consultation will also inform work happening at the national level regarding physician scope of practice. Further updates with respect to the status of this review will be provided at a future meeting.	2017
Block Fees and Uninsured Services	The current policy sets out the College's expectations of physicians who charge patients for services not paid for by the Ontario Health Insurance Plan	This policy is currently under review. Initial stages of the review are underway, and a preliminary consultation was undertaken between September and November, 2015. Further updates with respect to the status of	2017

POLICY STATUS REPORT – DECEMBER 2016 COUNCIL

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
	(OHIP).	this review will be provided at a future meeting.	
Accepting New Patients	The current policy provides guidance for physicians on accepting new patients for primary care.	This policy is currently under review. A Joint Working group has been struck to undertake this review along with the review of the <i>Ending the Physician-Patient Relationship</i> policy. The Working Group has now developed an updated draft of the policy which is presented for Council's consideration to release for external consultation. Further information can be found in the Briefing Note contained in Council's December, 2016 meeting materials.	2017
Ending the Physician Patient Relationship	The current policy provides guidance to physicians about how to end physician-patient relationships.	This policy is currently under review. A Joint Working Group has been struck to undertake this review along with the review of the <i>Accepting New Patients</i> policy. The Working Group has now developed an updated draft of the policy which is presented for Council's consideration to release for external consultation. Further information can be found in the Briefing Note contained in Council's December, 2016 meeting materials.	2017
Maintaining Appropriate Boundaries and Preventing Sexual Abuse	This policy provides guidance to physicians and to help physicians understand and comply with the	This policy review will be informed by the College's Sexual Abuse Initiative and the Minister of Health and Long-Term Care's Task	tbd

POLICY STATUS REPORT – DECEMBER 2016 COUNCIL

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
	legislative provisions of the <i>Regulated Health Professions Act, 1991 (RHPA)</i> regarding sexual abuse. It sets out the College's expectations of a physician's behaviour within the physician-patient relationship, after the physician-patient relationship ends, and with respect to persons closely associated with patients.	Force on the Prevention of Sexual Abuse of Patients. The specific timing of the review is dependent on the Ministry's work in the context of the Task Force.	
Practice Management Considerations for Physicians Who Cease to Practise, Take an Extended Leave of Absence or Close Their Practice Due to Relocation	This policy explains the practice management measures physicians should take when they cease to practise or will not be practising for an extended period of time.	This policy is currently under review. Initial stages of the review are underway and a preliminary consultation was undertaken between June and August, 2016. Further updates with respect to the status of this review will be provided at a future meeting.	2017
Physicians and Health Emergencies	The purpose of this policy is to reaffirm the profession's commitment to the public in times of health emergencies.	This policy is currently under review. Initial stages of the review are underway and a preliminary consultation was undertaken between September and November 2016.	2017

POLICY STATUS REPORT – DECEMBER 2016 COUNCIL

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
		Further updates with respect to the status of this review will be provided at a future meeting.	
Management of Test Results	The current policy articulates a physician's responsibility to: 1. Have a system in place to ensure that test results are managed effectively in all of their work environments, and 2. Follow-up appropriately on test results.	This policy is currently under review. A joint Working Group has been struck to undertake this review alongside the development of a new <i>Continuity of Care</i> policy. A preliminary consultation was undertaken between June and August, 2016. The working group will consider the feedback received and the research findings as it works to revise this policy.	2018
Continuity of Care	The College does not currently have a policy on <i>Continuity of Care</i> .	In May 2016, Council reviewed and discussed a <i>Continuity of Care Planning and Proposal</i> document providing analysis and recommendations relating to the development of a new policy. A joint Working Group has been struck to undertake this policy development process alongside the review of the <i>Test Results Management</i> policy. A preliminary consultation was undertaken between June and August, 2016. The working group will consider the feedback received and the research findings as it works to develop a new draft policy.	2018

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POLICY STATUS REPORT – DECEMBER 2016 COUNCIL

POLICIES SCHEDULED TO BE REVIEWED

POLICY	TARGET FOR REVIEW	SUMMARY
Disclosure of Harm	2015/16	This policy provides guidance to physicians on disclosing harm to patients.
Fetal Ultrasound for Non-Medical Reasons	2015/16	The purpose of this policy is to clarify physician obligations with respect to ordering and performing fetal ultrasounds.
Anabolic Steroids	2016/17	This policy sets out the expectation that physicians should not prescribe anabolic steroids or other substances and methods for the purpose of performance enhancement in sport.
258 Female Genital Cutting (Mutilation)	2016/17	This policy sets out physicians' obligations with respect to female genital cutting/mutilation.
Complementary/Alternative Medicine	2016/17	This policy articulates expectations relating to complementary and alternative medicine.
Dispensing Drugs	2016/17	This policy sets out the College's expectations of physicians who dispense drugs.
Professional Responsibilities in Postgraduate Medical Education	2016/17	This policy sets out the roles and responsibilities of most responsible physicians, supervisors, and trainees engaged in postgraduate medical education programs.
Confidentiality of Personal Health Information	2016/17	<p>This policy sets out physicians' legal and ethical obligations to protect the privacy and confidentiality of patients' personal health information.</p> <p>The review of this policy is currently on hold pending the introduction of new legislation by the Ministry.</p>
Third Party Reports	2017/18	This policy clarifies the College's expectations regarding physicians' roles in and standards of care for conducting medical examinations and/or preparing reports for

POLICY STATUS REPORT – DECEMBER 2016 COUNCIL

POLICY	TARGET FOR REVIEW	SUMMARY
		third parties.
Delegation of Controlled Acts	2017/18	This policy assists physicians to understand when and how they may delegate controlled acts. The policy also offers guidelines for the use of medical directives.
Medical Records	2017/18	This policy sets out the essentials of maintaining medical records.
Mandatory and Permissive Reporting	2017/18	This policy sets out the circumstances under which physicians are required by law, or expected by the College, to report information about patients.
Criminal Record Screening	2017/18	This policy sets out circumstances in which applicants for certificates of registration and existing physicians are required to submit to a criminal record screen.
Professional Responsibilities in Undergraduate Medical Education	2017/18	This policy sets out the roles and responsibilities of most responsible physicians and supervisors of medical students engaged in undergraduate medical programs.
Medical Expert: Reports and Testimony	2017/18	This policy sets out the College's expectations of physicians who act as medical experts.
Prescribing Drugs	2017/18	This policy sets out the College's expectations of physicians who prescribe drugs or provide drug samples to patients.
Social Media – Appropriate Use by Physicians (Statement)	2018/19	This document provides guidance to physicians about how to engage in social media while continuing to meet relevant legal and professional obligations.
Providing Physician Services During Job Actions (formerly Withdrawal of Physician Services During Job Actions)	2018/19	This policy sets out the College's expectations of physicians during job actions. Council approved the Providing Physician Services During Job Actions policy at its March 2014 meeting. The policy was posted on the College's website, and published in <i>Dialogue</i> , Volume 10, Issue 1, 2014.

POLICY STATUS REPORT – DECEMBER 2016 COUNCIL

POLICY	TARGET FOR REVIEW	SUMMARY
Physicians' Relationships with Industry: Practice, Education and Research (formerly Conflict of Interest: Recruitment of Subjects for Research Studies and MDs Relations with Drug Companies)	2019/20	The draft policy sets out the College's expectations for physicians who interact with industry in a number of key areas. Council approved the Physicians' Relationships with Industry: Practice, Education and Research policy at its September 2014 Meeting. The policy was posted on the College's website, and published in <i>Dialogue</i> , Volume 10, Issue 3, 2014.
Telemedicine	2019/20	The policy sets expectations for physicians using telecommunications technologies to interact with patients in different locations, in actual or stored time.
Marijuana for Medical Purposes	2020/21	The policy sets expectations for physicians relating to the prescribing of dried marijuana for medical purposes.
Professional Obligations and Human Rights	2020/21	The policy articulates physicians' existing legal obligations under the Ontario <i>Human Rights Code</i> , and the College's expectation that physicians will respect the fundamental rights of those who seek their medical services.
Consent to Treatment	2020/21	The policy sets out expectations of physicians regarding consent to treatment.
Planning for and Providing Quality End-of-Life Care (formerly Decision-Making for the End of Life)	2020/21	This policy sets out expectations of physicians regarding planning for and providing quality care at the end of life.
Blood Borne Viruses	2020/21	This policy sets expectations with respect to reducing the risk of acquiring or transmitting a blood borne virus, as well as expectations for physicians if they are exposed to a blood borne virus, and lastly, if they are infected with a blood borne virus.

POLICY STATUS REPORT – DECEMBER 2016 COUNCIL

POLICY	TARGET FOR REVIEW	SUMMARY
Physician Treatment of Self, Family Members, or Others Close to Them (formerly Treating Self and Family Members)	2021/22	This policy sets out the circumstances in which it may be acceptable for physicians to provide treatment for themselves, family members, or others close to them.
Physician Behaviour in the Professional Environment	2021/22	This policy provides specific guidance about the profession's expectations of physician behaviour in the professional environment.
Medical Assistance in Dying	2021/22	This policy articulates the legal obligations and professional expectations for physicians with respect to medical assistance in dying, as set out in the federal legislation, provincial legislation, and relevant College policies.

COUNCIL BRIEFING NOTE

TOPIC: Medical Assistance in Dying Update

FOR INFORMATION

ISSUE

- In this brief, Council is provided with an update on new and ongoing College and stakeholder activities with respect to Medical Assistance in Dying.
- This item is for information only.

BACKGROUND

- Bill C-14, the federal government's legislation on medical assistance in dying (MAID), received royal assent on June 17th, 2016. The College and other key stakeholders have undertaken various activities to ensure that MAID-related policies, resources and tools comply with the new legislation.
- The College has published a number of resources, in addition to the *Medical Assistance in Dying* policy, to assist the membership in fulfilling their legal and professional obligations in the medical assistance in dying context. These resources include FAQ documents for the public and profession, a fact sheet on 'Effective Referrals', as well as a new resource outlining early lessons learned from the Office of the Chief Coroner (further details provided below).

CURRENT STATUS

a) College Activity

- The College continues to be actively engaged in MAID in a variety of respects. An overview of these key activities follows.

i. *New Resource: MAID Early Lessons Learned*

- In collaboration with the Office of the Chief Coroner, and with input and direction from the MAID Working Group, the College has developed a document titled ['Medical Assistance in Dying: Early Lessons Learned'](#).

- The goal of this resource is to highlight trends that have been identified by the Coroner in the course of investigating MAID cases. These include circumstances, for instance, where physicians have misinterpreted MAID legislation and/or experienced challenges arising from a lack of communication/coordination between members of the care team.
- In light of the trends identified, the *Early Lessons Learned* document reminds physicians of relevant legal obligations and professional expectations found in College policies, particularly the *MAID* policy. The *Early Lessons Learned* document also points to external resources that will assist physicians in fulfilling their obligations in the MAID context.
- The *Early Lessons Learned* document is available online on the MAID policy page.

ii. Calls Received by Public and Physician Advisory Services (PPAS)

- The College's Public and Physician Advisory Services (PPAS) continues to provide guidance and information to callers with MAID related inquiries.
- Since April 2016, over 100 calls have been received by PPAS with respect to MAID. 64% of those calls were made by physicians; the remaining 36% were calls from members of the public.
- Broadly speaking, the majority of calls from the public were from individuals seeking information about how to go about initiating a request for medical assistance in dying; and finding a willing provider.
- The majority of physician calls were related to the College's effective referral requirement, as contained in the College's MAID policy; medication protocols; technical questions about how to apply/interpret legislative provisions; and the scope of practice required to provide MAID.

b) Stakeholder Activities

- The College remains in regular communication with the College of Nurses of Ontario (CNO), the Ontario College of Pharmacists (OCP), and the Ontario Ministry of Health and Long-Term Care regarding MAID-related work. Recent stakeholder activities include the following:

i. Updated Policies / Resources

- Much like the College, both the OCP and CNO are engaged in the ongoing exercise of determining what companion resources/educational tools would best support their members and help mitigate any operational difficulties.
- For instance, the [OCP](#) and [CNO](#) have produced FAQ documents to support their members when aiding in/providing MAID.

ii. Government Activity

- The Ontario government is currently considering legislative amendments as part of the implementation of a full-system approach to MAID.
- The Ontario government continues to work towards the implementation of a monitoring and reporting regime for 2017, in tandem with future federal regulations with respect to MAID monitoring. In the interim, the Office of the Chief Coroner collects MAID data in the course of mandatory investigations of MAID cases.
- The MOHLTC's toll-free referral support line continues to assist Ontario physicians to arrange referrals for patients requesting MAID, and to identify physicians and/or nurse practitioners who are willing to provide a second opinion, as required under the federal legislation.

NEXT STEPS:

- The College will continue to monitor all aspects of MAID closely and will keep Council apprised of developments.

DECISION FOR COUNCIL

- This item is for information only.

CONTACT: Policy Department

DATE: November 10, 2016

COUNCIL BRIEFING NOTE

TOPIC: GOVERNMENT RELATIONS REPORT

FOR INFORMATION

Items:

1. Ontario's Political Environment
 2. Legislative Issues of Interest
 3. Government Relations Activities
-

1. Ontario's Political Environment

- The fall session of the Ontario Legislature has been underway since September 15th and is scheduled to rise on December 8th.
- The next provincial election will be held on or before June 7, 2018, soon in political terms.
- The Liberal government is struggling to reverse low polling numbers that have the Premier's approval rating trending downward and hitting an all-time low of 14% as of mid-October.
- The Liberal government continues to be plagued by the February 2015 Sudbury byelection with the OPP laying *Election Act* bribery charges against the Premier's former deputy Chief of Staff and 2018 Liberal campaign CEO and director, Patricia Sorbara on November 1, 2016. Following the charges, Ms. Sorbara stepped down from her Liberal party posts.
- These charges follow the September 2015 criminal charges laid against Liberal party activist Gerry Lougheed for counseling an offence not committed and unlawfully influencing or negotiating appointments. However, these charges were stayed in April 2016.
- With this renewed attention, both opposition parties have been calling for the resignation of Sudbury Liberal MPP and Minister of Energy, Glenn Thibeault and questioning the Premier's integrity.
- Affordability issues and the cost of hydro as well as concerns over health care – specifically hospital funding, and the ongoing negotiations with Ontario's doctors – have also dominated at Queen's Park and beyond.
- Byelections in Ottawa-Vanier and Niagara West—Glanbrook will be held on November 17th.
- Ottawa-Vanier, previously held by former Attorney General Madeleine Meilleur who retired in June 2016, is expected to be a close race. André Marin, Ontario's former Ombudsman is running for the PCs and the Liberals have lawyer Nathalie Des Rossiers, dean of common law at the University of Ottawa and former general counsel at the Canadian Civil Liberties Association, as their candidate. New Democrats have nominated Claude Bisson, former RCMP

- executive and brother of long-serving NDP MPP Gilles Bisson, to run for them.
- Niagara West—Glanbrook was previously held by former PC leader and MPP, Tim Hudak, who resigned in September to be the CEO at the Ontario Real Estate Association after a 21 year career in politics.
- In a surprise turn of events, 19 year-old Brock university student and outspoken social conservative, Sam Oosterhoff won the PC nomination for Niagara West-Glanbrook over PC party president and former MP Rick Dykstra, as well as regional councillor Tony Quirk. Oosterhoff has been outspoken about his anti-abortion, anti-marriage equality, and anti sex education views that stand in opposition to PC leader Patrick Brown's recent public parting with social conservatives and commitment to move the party to the centre.
- There is considerable speculation with respect to the implications for the PC party should Oosterhoff be elected in November.
- Also running in Niagara West-Glanbrook is Hamilton lawyer Vicky Ringuette for the Liberals and former Hamilton police officer Mike Thomas for the NDP.
- These two byelections will be telling indicators of the political prospects for both the Premier and Patrick Brown as they lay the groundwork for the next general election.

2. Legislative Issues of Interest

- The government has been moving legislation through the House at a fairly fast pace this session and we are expecting that the pace will only increase in the coming months.
- Two key bills on the government's agenda, currently under debate, are *Bill 41, Patients First Act, 2016* and *Bill 2, Election Finances Statute Law Amendment Act, 2016*.
- *Bill 41* would expand the role of Ontario's Local Health Integration Networks (LHINs) to include home and community care, and provide the LHINs with the authority to manage and monitor primary care directly. The Bill also expands the role of the Minister of Health and Long-Term Care and transfers the operations of Community Care Access Corporations (CCACs) to the LHINs.
- Although some amendments were made to *Patients First* from the previous version introduced last spring, strong opposition to the Bill continues to be voiced by organizations such as the OMA.
- *Bill 2*, would ban corporate and union donations to political parties, forbid MPPs and candidates from attending party fundraisers, and reduce contribution limits to \$3,600 from \$33,250. If passed, the changes would take effect on January 1, 2017.
- In the coming weeks and months, we anticipate that the government will introduce new legislation in a number of areas.
- The government has announced its intention to introduce amendments to the Regulated Health Professions Act in response to its September 9 announcement in conjunction with the release of the recommendations of the Sexual Abuse Task Force report.
- We also anticipate the introduction of a Bill that would establish the monitoring and enforcement provisions in relation to MAID together with other housekeeping amendments in relation to MAID.

- On September 14th, PC MPP and Associate Health Critic, Bill Walker made a Member's Statement in the House that recognized and congratulated the College on our 150th anniversary. The full statement is attached as Appendix 1.

3. Government Relations Activities

- The College's government relations activities as of late have been significant and directed at a variety of issues and initiatives.
- The College is working closely with government on the prevention of sexual abuse of patients, Medical Assistance in Dying including our policy and the implications of the federal legislation, the compensation of public members of Council, the ongoing work to increase College transparency, the regulation of fertility services, the overhaul of out-of-hospital facility regulation, and issues surrounding opioids and medication management.
- Following the release of the Sexual Abuse Task Force report recommendations, the College President and Registrar wrote to the Minister of Health congratulating him on his work in this area and offering the College's full support as the government moves forward and develops legislation. The letter is included as Appendix 2.
- The College is in contact with a variety of government decision-makers and officials.
- College President, Dr. Kirsh, along with staff has met with a number of MPPs from all three political parties over the past year.
- It is anticipated that the government relations activities on these, and other files, will continue over what will be a busy coming year.

CONTACT: Louise Verity: 416-967-2600 x466
Miriam Barna: 416-967-2600 x557

DATE: November 10, 2016

Appendix 1: MPP Bill Walker Statement on CPSO 150th Anniversary

Appendix 2: September 2016, Letter to Minister Hoskins

Members' Statements

College of Physicians and Surgeons of Ontario

Mr. Bill Walker: I rise on behalf of the Progressive Conservative caucus to recognize our medical and health professionals as they celebrate the 150th anniversary of the College of Physicians and Surgeons of Ontario.

Since its founding in 1866, the CPSO has been ensuring that Ontarians are served by some of the best doctors in the world who have made great medical breakthroughs, all in an effort to save human lives. Let's remind ourselves of some of that amazing progress:

- 30 years added to the average lifespan and a 90% drop in the infant death rate;
- public immunization and eradication of diseases that both killed millions and left millions more paralyzed;
- the discovery of insulin and diabetes treatment; and
- the ability to transplant bone marrow, a lung or a heart and even to resuscitate one that stopped.

When we consider these remarkable achievements, we are reminded they are possible because of our dedicated professionals and the strong institutions and regulatory bodies like the CPSO.

When the college was established, there were about 1.5 million residents in Ontario. They were served by about 1,770 doctors. Today, there are 13.5 million Ontarians and 35,000 doctors licensed by the college.

Initially, the CPSO had only two women licensed to practise: Jennie Trout in 1875 and Emily Stowe in 1880. By 2000, women made up over 30% of the physician population, and this number continues to increase every year. From Dr. Trout and Dr. Stowe to Dr. Frederick Banting, CPSO members have a strong track record of achieving what once seemed improbable and now imminently possible.

Some of them were also war heroes. While the war years claimed the lives of 50 CPSO-registered doctors, including John McCrae, also known for his poem *In Flanders Fields*, and front-line surgeon Dr. Norman Bethune, their courage and legacy lives on.

In 1992, the CPSO became the first in Canada to ban its doctors from performing female circumcision. It also adopted a zero tolerance policy towards sexual abuse.

Challenging as some of these changes may be, we're confident that the CPSO will continue to be a thriving organization that plays a key role in Ontario's health system. With that, we ought to stay confident that with a strong regulatory body such as the CPSO and its dedicated medical and health professionals we will continue to conquer many more battles, like cancer, and save lives.

Congratulations on all of your achievements and thank you.



Sept 16, 2016

The Honourable Dr. Eric Hoskins, MPP
Minister of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, Ontario M7A 2C4

Dear Minister,

We write to congratulate and support your recent announcement with respect to your government's planned action to strengthen Ontario's legislative framework governing sexual abuse of patients by health professionals.

As you know, this College has, as part of our own sector-leading sexual abuse initiative, taken action to enhance our practises and make recommendations to strengthen our governing legislation. This includes advocating for a number of changes to the legislation that will both strengthen penalties and make sexual misconduct investigations and prosecutions more effective and efficient; as well as better empower patients involved in the discipline process.

We share your objective of patient protection and will do all that we can to ensure that Ontario's medical regulatory system effectively empowers patients and protects them from sexual abuse.

We offer our support as you and your team move forward to develop legislation. We look forward to working closely with government and our health-care partners to determine how to best continue the change process in a manner that will evolve our legislative and regulatory system to protect and empower patients who have been sexually abused. As we all know, regulatory issues are complex and the College is committed to working with you and your team to share our knowledge and experience, and reach the desired outcome.

We also offer our full cooperation and expertise in working with an external advisor and look forward to learning more about the role. Our commitment to patient safety is unwavering and we will do all that we can to ensure Ontario's medical regulatory system effectively empowers patients, and protects them from sexual abuse.

Yours truly,

Joel Kirsh MD, MHCM, FRCPC
President

Rocco Gerace, MD
Registrar

- c. Dr. Robert Bell, Deputy Minister of Health and Long-Term Care
Mr. Derrick Araneda, Minister's Chief of Staff, MOHLTC
Ms. Denise Cole, ADM, Health Workforce Planning and Regulatory Affairs Division, MOHLTC
Ms. Louise Verity, Associate Registrar, Director, Policy and Communications, CPSO



COUNCIL BRIEFING NOTE

**TOPIC: UPDATED: INDEPENDENT HEALTH FACILITIES CLINICAL
PRACTICE PARAMETERS AND FACILITY STANDARDS FOR
SLEEP MEDICINE**

FOR INFORMATION

ISSUE:

- For your information, the “[Independent Health Facilities: Clinical Practice Parameters and Facility Standards for Sleep Medicine](#)” document has been updated as part of the regular review cycle for all CPSO documents.
- A consultation process on the draft document which was completed between June and August 2016 resulted in a moderate amount of feedback. In response to that feedback, the IHF Sleep Medicine Task Force made some final revisions to the document.
- Currently there are 67 IHFs providing sleep medicine services in Ontario.
- Since this is an operational document, it is being provided to Council for information only.

BACKGROUND:

- The primary purpose of the parameters is to assist physicians in developing their own quality management program and act as a guide for assessing the quality of patient care provided in sleep medicine facilities.
- The *Independent Health Facilities Act* (IHFA) gives the College of Physicians and Surgeons of Ontario the primary responsibility for carrying out quality assessments in Independent Health Facilities, which includes responsibility for developing and regular updating of clinical practice parameters and facility standards.



Key changes between the 2010 Parameters and Updated (October 2016) Parameters

- A number of Appendices have been re-categorized as Chapters within the document, as the Task Force decided that the content was sufficiently important that it should become part of the core document.
- The revised document identifies what constitutes “Standards” versus “Guidelines” in some of the Chapters. This was done in order to assist assessors and facilities in understanding the College’s expectations with regard to compliance with various aspects of the parameters. Definitions for each are included in the Preface of the parameters, as follows:
 - A Standard is a generally accepted patient care strategy that reflects a high degree of clinical certainty.
 - A Guideline is a generally accepted patient care strategy that reflects a moderate degree of clinical certainty. Guidelines may be adopted, modified, or rejected according to clinical needs, individual patient considerations, local resources, and physician discretion. Guidelines do not establish inflexible protocols for patient care nor are they meant to replace the professional judgment of physicians.
- Chapter 7 – Performance, Diagnosis and Management of Pediatric Sleep Related Disorders – In addition to minor modifications throughout the Chapter, the definitions section was significantly updated.
- Chapter 13 - Sleepiness and Driving: Patient assessment, Patient Education and Obligations to Report – This Chapter was updated to provide clarity on reporting to the Ministry of Transportation of Ontario (MTO) in terms of who is responsible for making those reports, and when the reports should be made.
- Appendix II - Change in Scope of Practice Requirements and Forms – This appendix (which is also a Companion document to the CPSO’s Changing Scope of Practice policy), was due for review as per the College’s regular review process for all documents. With the exception of a few minor modifications, it was determined that the document is still current and not in need of any significant changes.



- Where applicable, the parameters were updated to coincide with changes to the recently updated (April 1, 2016) American Academy of Sleep Medicine Scoring Manual Version 2.3.

A. Report on Consultation

Consultation process

- A targeted stakeholder consultation process was undertaken. Invitations to participate in the consultation were sent via email and regular mail to IHF sleep medicine assessors, sleep medicine facilities, IHF sleep medicine review panel (comprised of experts from other provinces) and relevant stakeholder organizations.
- Stakeholders had the option of submitting their feedback in writing, via email or regular mail, and through an online survey.
- The consultation was held between June 2016 and August 2016.

Number of responses

- The CPSO received a total of 11 consultation feedback responses. 10 individuals and 1 organization (College of Respiratory Therapists of Ontario) responded.

B. Task Force’s Revisions in Response to Feedback

- All of the feedback received has been carefully reviewed and considered by the IHF Sleep Medicine Task Force.

Key revisions following consultation

- In response to the feedback, the Task Force made some minor wording changes, and also did some revisions to improve clarity on the following sections:
 - Section 5.2 on “Referrals” was re-written to clarify the process for triage.
 - Section 13.4 on “Reporting Guidelines Recommended by this Task Force” was revised to improve clarity on reporting on fitness to drive for non-commercial drivers.



- The IHF Sleep Medicine Task Force, which updated the parameters included representatives from the following organizations: Canadian Sleep Society (CSS), Ontario Medical Association (OMA) Section on Sleep Medicine; in addition, IHF owner/operator, hospital-based rep; community-based rep; non-IHF academic rep; paediatric specialist; IHF assessors (physician and technologist), hospital-based physician/quality advisor of an IHF, and; CPSO staff members.

CURRENT STATUS:

- Since this is an operational document, it is being provided to Council for information only.

NEXT STEPS:

- All sleep medicine facilities, as well as stakeholders who responded to the consultation will receive notification of the updated IHF Sleep Medicine parameters. Stakeholders who provided significant feedback will be sent a letter thanking them for their participation in the consultation process.
- Based on the revisions made to the document, relevant assessment tools will be updated to guide the assessment of these facilities. IHFs will be given time to incorporate the revisions into their practice prior to being assessed.

DECISION FOR COUNCIL:

For information only

CONTACT: Tracey Marshall, extension 223
Kavita Sharma, extension 375
Wade Hillier, extension 636

DATE: November 9, 2016

COUNCIL BRIEFING NOTE

TOPIC: 2016 District Council Elections FOR INFORMATION

ISSUE:

- This note contains the 2016 district election results, as well as information about the election process and a description of the College's ongoing efforts to ensure the efficiency of this process.

BACKGROUND:

- District Council elections were held in Districts 1 and 4 between September 20 and 4:00 p.m. October 11.
- Eligible voters elected one District 1 Councillor, two District 4 Councillors. Candidates in Districts 2 and 3 were acclaimed.

CURRENT STATUS:

1. Results

- Dr. Deborah Hellyer was elected in District 1.
- Dr. Robert Gratton was acclaimed in District 2.
- Dr. Jerry Rosenblum was acclaimed in District 3.
- Dr. Brenda Copps was re-elected and Dr. Scott Wooder was elected in District 4.
- See Appendix 1 for the complete results.

2. Election Process

- Elections were conducted online for the fourth consecutive year using an electronic ballot distributed by email.
- The electronic voting method has proven effective and efficient.
- Voters in the 2016 election provided positive feedback about the online process with few questions about how to vote. (Please see Appendix 2 for all anonymized feedback.)

- The level of participation relative to past elections in these districts was slightly lower than participation in previous elections. In total, 29.6% of eligible voters participated in the District 1 and 4 elections.
- 32.8% participated in District 1.
- 28.9.0% participated in District 4.
- Almost half (45.2%) of voters cast their votes utilizing a mobile device.
- Eight reminders were sent out to eligible voters who had not yet voted.

3. Commitment to ongoing Process Improvement

- The College implemented changes to the 2016 election process in an effort to continue to improve the efficiency of the process.
- Changes made to the 2016 election process stemmed from best practice research undertaken after the 2014 election and candidate satisfaction surveys undertaken after the 2015 election.
- Voter feedback was again quite positive.

NEXT STEPS

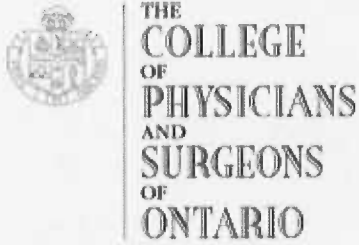
- We will continue to look at ways of improving and enhancing the process.
- We plan to reach out to all 2016 candidates with a survey to help inform ongoing process improvement.

CONTACT: Rocco Gerace
Louise Verity, ext. 466
Tanya Terzis, ext. 545

DATE: October 12, 2016

Attachments:

Appendix 1: Poll Results from Big Pulse
Appendix 2: Anonymized Voter Feedback



Poll Result

2016 Council Elections

Report date: Tuesday 11 October 2016 16:01 EDT

District 1

College of Physicians and Surgeons District 1 Council Election

Poll ID: 129745

As at Poll close: Tuesday 11 October 2016 16:00 EDT

Number of voters: 347 · Group size: 1057 · Percentage voted: 32.83

Ranked by votes

Rank	Candidate ID	Candidate	Votes	%
1	15854472	Dr. Deborah Hellyer	206	59.37
2	15854473	Dr. David Scarfone	141	40.63

District 4

College of Physicians and Surgeons District 4 Council Election

Poll ID: 129746

As at Poll close: Tuesday 11 October 2016 16:00 EDT

Number of voters: 1427 · Group size: 4940 · Percentage voted: 28.89

Ranked by votes

Rank	Candidate ID	Candidate	Votes	%
1	15854476	Dr. Brenda Copps	527	36.93
2	15854475	Dr. Scott Wooder	499	34.97
3	15854477	Dr. Cynthia Jennifer-Marie Horner	403	28.24
4	15854481	Dr. Ashok Sharma	355	24.88
5	15854474	Dr. Sangita Sharma	243	17.03
6	15854478	Dr. Maynard Luterman	170	11.91
7	15854480	Dr. Sheetal Sapra	168	11.77
8	15854479	Dr. Jane Morgan	115	8.06

Voter feedback and comments

Poll Group: 2016 Council Elections

Date: Thursday 13 October 2016 10:32 EDT

Comment category:

- All
- General comment
- A comment on the technology voting experience
- Ballot configuration or vote security
- Unable to vote
- Received an unexpected Vote Receipt
- Unable to sign-in

Poll: College of Physicians and Surgeons District 1 Council Election

No comments.

Poll: College of Physicians and Surgeons District 4 Council Election

	Date	Comment	Category	Sign-in	Name	Email
1	12 Oct 16 18:40:51	Hello.Late to vote,sorry.Signed as jafNw6KA does not represent me.Not related to me at all. Sincerely ,	General	jafNw6KA		
2	12 Oct 16 18:32:49	Dear College, due to unexpected family related trip. Arrived on Oct 12,tried to vote realized you were closed.Clicked -would have voted for	General	jafNw6KA		
3	11 Oct 16 11:51:56	This was a very easy-to-use process. I also liked that one could print out the candidates statements from within the voting screen list. Also thanks for the email reminders including on the last day. Kudos to the College on this one!	Technology feedback	anon	anon	
4	11 Oct 16 00:35:57	Easy to vote over internet.	General	S32gLWlu		
5	07 Oct 16 05:49:59	It was very easy to vote . Thank you	Technology feedback	RHMEkfbG		
6	05 Oct 16 08:23:24	I don't recognize the username from your vote confirmation email I suspect that it was assigned to me, but I didn't select it. I did vote on October 4, from my home computer Not sure of the IP address or how to find it	Ballot and security	iffCdhaz		
7	24 Sep 16 11:10:22	I think that the setup is great and the way that the ok formation was presented is great. The format is good.	Technology feedback	nQvEbgWv		
8	21 Sep 16 21:31:38	I voted 2 candidates but I notice in the e- mail that only voted for one candidate.What do I do now	Ballot and security	mliNZ8l7		
9	21 Sep 16 08:32:16	Nicely organized process. Easy to access information and easy to vote. Well done!	General	IPB4sdh3		
		The OMA could learn a lot from your excellent example.				

10	20 Sep 16 09:48:53	Excellent simple process. An excellent, very impressive slate of candidates, with significant diversity.	General	CNQaLb8G		
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COUNCIL BRIEFING NOTE

TOPIC: Registration Program Evaluation: project update

ISSUES:

- This Evaluation of Registration Pathways is integral to the Council's strategic priority to "Optimize the Registration System."
- The purpose of the evaluation is to understand the effectiveness of registration pathways and policies.
- The evaluation will focus on learning what, if any, differences exist between practicing physicians who achieved licensure through alternative routes to registration and the traditional route to registration.
- The Registration Committee is overseeing the project and the Quality Assurance Committee (QAC) is overseeing a significant component of the project requiring the College's assessment expertise and infrastructure.
- This note will provide Council with:
 - a status update on the various components of the multi-year initiative in advance of sharing results of the evaluation in May and September 2017; and
 - An article that has been accepted for publication by the Canadian Medical Education Journal entitled *The Influence of Globalization on Medical Regulation: A Descriptive Analysis of International Medical Graduates Registered through Alternative Licensure Routes in Ontario*.

BACKGROUND:

- In the early 2000s, a severe physician shortage was experienced in Ontario. Numerous provincial policy initiatives were developed to address physician shortages (e.g. increased undergraduate medical enrollment, increased residency positions, active recruitment of internationally trained medical graduates). As part of the overall strategy, the CPSO developed various alternative registration (commonly referred to as licensure) routes between 2001 and 2009 to facilitate entry to practice for qualified internationally trained medical graduates.
- In December of 2009, the Government of Ontario proclaimed Bill 175, the Ontario Labour Mobility Act that implemented the pan-Canadian Agreement on Internal Trade (AIT), which requires regulatory bodies to issue an equivalent license to candidates who hold an out-of-province certificate (in another Canadian jurisdiction) without requiring any additional material training, experience, examinations or assessments.
- In 2010, in response to the new legislation, the notion of College assessments based on registration licensure route was approved in principle by the QAC. The Executive Committee directed further study of the available options to monitor the movement of physicians to Ontario through AIT.
- In 2011, the Registration Committee and the QAC worked with the Research and

Evaluation team to design the program evaluation. The design included a retrospective analysis of available data and a prospective use of the assessment authority of the QAC to review specified physicians. The existing peer assessment program is limited to a review of clinical competence and record-keeping skills, so the plan also included using an enhanced approach that augments the current peer assessment model with multisource feedback (MSF) to assess CanMEDS roles that are not captured (e.g. communication and collaboration).

- The evaluation design was brought forward to the Executive Committee and Council for decision in early 2012. Please refer to Appendix 1 for a detailed chronology of the activities described above.

OBJECTIVES OF THE PROGRAM EVALUATION

- The purpose of the project is to determine what, if any, differences exist in the practice/performance outcomes of physicians who achieve registration through alternative versus traditional routes.
- The objectives of the program evaluation in registration are to:
 - Contribute to the validation of alternative routes to ensure that pathways and policies are meeting their intended purpose,
 - Gain insight into the ways in which alternative route process changes may be useful, and
 - Better understand the educational needs of different physician subgroups to enable the development of appropriate quality improvement indicators.
- Information learned from the evaluation will be valuable for the following reasons:
 - The results will enable evidence-informed decisions about changes, if any, that are needed to the pathways and policies
 - The Registration Committee and the QAC will understand more about the specific quality improvement needs of certain physician groups
 - The results will contribute to the QAC and Council's understanding of MSF as one component of an assessment program in order to make future program decisions; and
 - The results will contribute to the QAC and Council's understanding of the benefits and challenges of focused selections for peer assessment (i.e. selections that are not random but based on studied indicators that are associated with performance).

PROGRAM EVALUATION DESIGN

- 783 physicians who accessed alternative registration pathways and policies between 2000 and 2012 were included in the study (this group of interest will be referred to as ARP). ARPs were selected to represent four alternative registration pathway cohorts (described in Appendix 3 on p. 25).
- ARPs will be compared to physicians who met all of the registration requirements at the time of licensure. This comparator group accessed the traditional licensure route and will be referred to as TRP. ARPs were matched to TRPs based on defined variables (e.g. gender, scope of practice, years of practice experience).
- A key strength of the study design is the inclusion of multiple measures of physician performance to provide a comprehensive picture of physician practice. ARPs and TRPs will

be compared on the following measures of performance:

- Peer assessment
- Multisource feedback
- Complaints
- Quality indicators available through the Institute of Clinical Evaluative Sciences (ICES) for Family Medicine practitioners.
-
- The prospective component using peer assessment and MSF formed part of the QAC's annual allocation of peer assessments (i.e. assessments were "live" assessments that were conducted in addition to the random and age-selected cohorts).
- All selected physicians were informed about the evaluation project and the reason behind their selection to ensure transparency.

UPDATE ON CURRENT STATUS

Data collection and Analytics:

- Nearly 1800 prospective assessments using peer assessment and MSF will be completed by January 2017. Analysis will be completed by second quarter in 2017.
- Analysis of quality indicators at ICES will be completed by the end of 2016.
- Analysis of CPSO complaint profiles will be completed by the end of second quarter in 2017.

Communications

- Status updates on the project have been provided to Registration Committee, QAC and Council regularly since the project started. The project design has also been presented at academic conferences and relevant external meetings (e.g. FMRAC, Research Advisory Group). Most recently, the project was presented at the International Association of Medical Regulatory Authorities in Melbourne, Australia in September 2016.
- A manuscript describing the demographic and practice characteristics of ARPs was accepted for publication in the Canadian Journal of Medical Education to be released in November 2016 (Appendix 3). A summary of key findings is presented in Appendix 2.
- The project team will focus on analytics related to ARP performance in the first half of 2017. Full reports on the results of this complex initiative will be presented to Council over several meetings next year.

DECISIONS FOR COUNCIL:

- This is an information only item for Council.
-

DATE: December, 2016

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Appendices

Appendix 1

Overview of key activities leading up to the February 2012 session of Council

Appendix 2

Summary of key findings of manuscript

Appendix 3

Manuscript to be published in the Canadian Medical Education Journal in November 2016:

The Influence of Globalization on Medical Regulation: A Descriptive Analysis of International Medical Graduates Registered through Alternative Licensure Routes in Ontario

Appendix 1: Overview of key activities leading up to the February 2012 session of Council

Overview of key dates & activities

Date	Key Activity
December, 2009	New AIT legislation is enacted.
Spring 2010,	Executive Committee considers a number of actions in response to the labour mobility legislation.
June 17, 2010	QAC agrees in principle to select physicians for peer assessment based on their route to registration.
June 2010; October 2011	Recruitment of Research Associates to Research & Evaluation team.
Fall 2010; Winter 2011	Consultations with external researcher (Dr. Elizabeth Wenghofer).
Spring/Summer 2011	Development of evaluation design with in-house expertise.
November 14, 2011	Legal opinion provided on the proposed evaluation design.
October 5, 2011	QAC reviewed proposed evaluation design and provided feedback.
December 15, 2011	Registration Committee formally requests that the QAC conduct assessments on physicians that have been registered via alternative pathways.
December 19, 2011	QAC endorses proposed evaluation design.
January 4, 2012	Senior Management Group approves bringing the initiative to the Executive Committee meeting.
January 17, 2012	Executive Committee approves bringing the project forward to Council for a decision about targeted peer assessments and the phased-implementation of Multisource Feedback (inclusive of a pilot).
February 24, 2012	Council approves all components of the project.

Appendix 2: Summary of key findings

The Influence of Globalization on Medical Regulation: A Descriptive Analysis of International Medical Graduates Registered through Alternative Licensure Routes in Ontario

A descriptive paper looking at the demographic and practice characteristics of a subset of the alternatively registered physicians (ARP) will be published in a special edition of the *Canadian Medical Education Journal* focusing on globalization in medicine. The paper presents the demographic characteristics of traditionally registered physicians (TRP) and 3 sub-groups of alternatively licensed IMGs, while exploring broader intersections between globalization, health policy, and medical regulation. The study highlighted the following:

- The historical context of the predicted physician shortage in Ontario in the 2000's and the CPSO's role in increasing opportunities for licensure by developing various programs and policies for qualified IMGs, the alternative registration routes.
- Of the 11, 250 physicians licensed from 2000 – 2012, the majority were TRPs (94%), of which 73% completed undergraduate training in Canada or the US and 23% were IMGs. The 655 ARPs in the study (of which all were IMGs) were divided into 3 sub-groups. Twenty percent (20%) migrated to Ontario from another province, 22% were considered practice ready, and 58% completed Canadian or American postgraduate training.
- In general, all IMGs were older than and more likely to be male than non-IMGs. The ARP group that migrated from another province were both the oldest at time of registration (44 yrs) and had the most men (73%), and were predominantly physicians who accessed AIT.
- The majority of IMGs completed undergraduate medical training in the Indian sub-continent, Middles East, Europe, and the Caribbean; whether they were TRPs or ARPs. Traditionally registered IMGs were made up of relatively more Family Physicians (57%) than TRPs from Canada or the US (47%), while the ARP group who migrated from another province were 67% Family Physicians. The practice-ready ARPs were only 32% Family Physicians but 21% Surgical Specialists, 16% Medical Specialists and 15% Anesthesiology/Critical Care. The ARP group who did North American postgraduate training had the highest proportion of Medical Specialists (21%) and Psychiatrists (11%).
- All physicians predominantly practice in urban centres and no more than 7% of physicians practiced in rural areas irrespective of sub-groups. ARPs practiced proportionally more in suburban areas (18%) than TRPs (11%).
- The findings are discussed in the context of the pathways and policies that shaped the physician population in that time and their unintended consequences. Linkages between IMGs practicing in Ontario, health policy, and recent globalization phenomena are presented, such as physician migration and recruitment, the composition of the Canadian physician workforce, and global health equity. Finally, future health policy is considered and addresses the need to understand the physician population, for pan-Canadian collaboration, and inter-system coordination, to effectively address health human resource planning in a globalized world.

Appendix 3: Manuscript

The Influence of Globalization on Medical Regulation: A Descriptive Analysis of International Medical Graduates Registered through Alternative Licensure Routes in Ontario

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Abstract

The increasing globalization of the medical profession has influenced health policy, health human resource planning, and medical regulation in Canada. Since the early 2000s, numerous policy initiatives have been created to facilitate the entry of international medical graduates (IMGs) into the Canadian workforce. In Ontario, the College of Physicians and Surgeons of Ontario (CPSO) developed alternative licensure routes to increase the ability of qualified IMGs to obtain licenses to practice. The current study provides demographic and descriptive information about the IMGs registered through the CPSO's alternative licensure routes between 2000 and 2012. An analysis of the characteristics and career trajectories of all IMGs practicing in the province sheds light on broader globalization trends and raises questions about the future of health human resource planning in Canada. As the medical profession becomes increasingly globalized, health policy and regulation will continue to be influenced by trends in international migration, concerns about global health equity, and the shifting demographics of the Canadian physician workforce. Implications for future policy development in the complex landscape of medical education and practice are discussed.

The Influence of Globalization on Medical Regulation: A Descriptive Analysis of International Medical Graduates Registered through Alternative Licensure Routes in Ontario

Globalization is not a new phenomenon, but technology and policy development in the past few decades has spurred unprecedented increases in cross-border trade, investment and migration.(1) The increasing globalization of the medical profession has influenced health policy, health human resource planning, and medical regulation in Canada. Developing effective policies to address Canada's health human resource needs has historically been complex but globalization trends such as the outsourcing of medical education and increased physician migration has introduced new challenges for policy makers, educators and regulators.(2) This paper explores demographic trends in a subset of internationally trained medical graduates (IMGs) who enter the licensure process through alternative pathways developed by the College of Physician and Surgeons of Ontario (CPSO). In the process, we will also characterize the diverse routes to licensure of all IMGs in Ontario and highlight the broader intersections between globalization, health policy, and medical regulation.

Physician migration has grown in the twenty-first century and Canada continues to be a primary recipient of IMGs.(3,4) Nearly 25% of practicing physicians in the country are IMGs, with reliance varying by province.(5) Ontario, the largest and most populous province in Canada, is central to the ebbs and flows of national and international migration, with 28% of its physician workforce having trained internationally.(6) Canada has long relied on IMGs to fulfill health human resource needs, but in the last decade there has been more attention paid to facilitating the entry of these physicians into the Canadian workforce.(7)

In the early 2000s, physicians and policy-makers in Ontario predicted a significant physician shortage; tens of thousands of Ontarians were projected to be at risk of having poor

access to physician services.(8–10) Since then, a number of policy initiatives were implemented to increase integration of IMGs and to ameliorate predicted physician shortages.(8–10) These policies included increased number of government funded residency positions for IMGs, increased enrolment in undergraduate medical education, increased flow of IMGs from other provinces, and targeted marketing and recruitment efforts.(9,10) In Ontario, the CPSO created new policies for licensure and developed methods to ensure the competence of IMGs once registered.

As the medical regulator in Ontario, the CPSO issues certificates of registration (i.e., licenses) to physicians and monitors and maintains standards of practice to ensure patient safety. The CPSO was a key stakeholder in the Task Force on Licensure of International Medical Graduates that provided recommendations for the entry of IMGs into Canada.(11) In response to the predicted physician shortages, and in accordance with the Task Force recommendations, the CPSO developed a number of alternative licensure routes to increase the opportunities for qualified IMGs to obtain licenses to practice in Ontario.

In order to be eligible for a license in Ontario, physicians need to meet the registration requirements articulated in the Medicine Act of 1991. This includes successful completion of both the Medical Council of Canada Qualifying Examinations and one of the national certification examinations (i.e., the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College of Family Physicians of Canada (CFPC)). We refer to this as the *traditional licensure route*, and it represents the route for the majority of physicians in the province. Beginning in 2000, *alternative licensure routes* were created for physician applicants who did not meet all the regulatory requirements but who met a series of alternative qualifications set out by the CPSO, primarily for those with recognized training and experience obtained internationally (see Figure 1). Practice ready assessment programs were implemented for IMGs and various policies were developed to recognize previous practice experience to meet

eligibility requirements to write RCPSC and CFPC exams. Federal labour mobility legislation, the Agreement on Internal Trade (AIT)(12), was also introduced that allows for increased migration of physicians across provinces.

Previous studies have examined IMGs who are practicing or training in Canada through other policy initiatives, most of whom completed a Canadian residency program and met the traditional licensure requirements in Ontario.(13–15) The current study provides demographic trends and descriptive information about a unique group of IMGs: those who registered through the CPSO's alternative licensure routes. One of the key criticisms of the current literature on IMGs is the tendency to treat all IMGs as a single homogenous group despite key differences in training, credentialing and practice experience.(16) Our analysis of medical regulatory data captured at the CPSO is the first to examine specific subgroups of IMGs and aims to strengthen the IMG literature base by exploring the demographic characteristics and career trajectories of all IMGs.

The purpose of this study is to describe the physician population in Ontario and highlight how globalization has influenced health policy, medical regulation, and trends in the physician workforce. Monitoring and reporting on the training, practice, and demographic characteristics of various groups of IMGs is an important first step in understanding how globalization and related policy initiatives have shaped the physician population over the last 15 years. The unintended consequences of these policies will be explored and new policy initiatives that have been developed to respond to trends in globalization will be described. As medical education and practice continues to globalize, future policy development will be impacted by steady increases in international migration, concerns about global health equity and the changing demographics of the physician workforce. Given the constantly evolving nature of this area of research, it behooves researchers and policy makers to continue to mine physician data to inform future policy development at the level of the medical regulator and the health care system.

Methods

Sample

This was a retrospective cohort study using the CPSO Registry database. The analytical sample used was a subset of physicians registered with the CPSO between 2000 and 2012. The CPSO membership includes both IMGs, defined as physicians who received an undergraduate medical degree outside of Canada and the United States, and DMGs (domestic medical graduates), defined as physicians who received an undergraduate medical degree in Canada or the United States. Both Canadian- and American-trained physicians were considered domestic graduates because of the joint accreditation between Canadian and American medical schools.(17)

All physicians can broadly be dichotomized into two categories based on their credentials at the time of licensure: Traditionally Licensed Physicians (TLP) and Alternatively Licensed Physicians (ALP) (see Figure 1). In the twelve-year analytical time period, the majority of ALPs were IMGs. Understanding the characteristics of these IMGs (ALP-IMGs) was a primary focus of this study. Therefore, we examined the demographic and practice characteristics of these physicians in comparison to IMGs who were registered through the traditional licensure route (TLP-IMGs). TLP-DMGs were included for reference. We also further examined the ALP-IMGs by dividing them into three sub-groups based on migration patterns and eligibility criteria to practice in Ontario. Each of the study groups are described in Table 1.

All physicians in the analysis held an active licence in Ontario as of March, 2015. Traditionally licensed physicians with a postgraduate training certificate or a restricted certificate as of March, 2015 were excluded from analyses. Alternatively licensed DMGs were also excluded as they were not the focus of the present study.

Insert Figure 1.

Insert Table 1.

Variables

The variables used in this study to describe the demographic and practice characteristics of physicians in Ontario were age at time of registration, sex, location of undergraduate medical school (grouped by geographical region and Human Development Index (HDI (18)), current specialty, and practice location (as of March, 2015).

Geographic regions were included in this study to provide a more nuanced description of the training location and career path of IMGs. The Human Development Index is a measure of the development of a country based on life expectancy, education, and standard of living as it relates to gross national income per capita. This measure has been used previously to classify and compare IMGs. (19) HDI provides a rank order of each country and classifies countries into four strata based on their ranking: very high, high, medium, and low human development (18).

Specialty was grouped into seven practice foci: Family Medicine, Medical Specialties, Surgical Specialties, Diagnostic Specialties, Psychiatry, Pediatrics, and Anesthesiology & Critical Care. This allowed for practice characteristics to be divided into clinically meaningful groups while maintaining anonymity of individual physicians. Rurality was used to examine differences in physicians' current practice location and was based on primary practice address. Using 2008 Rurality Index of Ontario (RIO) codes (20), physicians were grouped into one of three classifications: urban, suburban, or rural (21). All physicians held an active licence in Ontario as of March, 2015; missing practice location data was due to physicians having a primary practice location outside of Ontario.

Data Extraction and Analysis

Ethical approval to undertake this study was obtained from the University of Toronto

Research Ethics Board. Data were obtained from the CPSO Registry database and from physician-reported registration files. Descriptive statistics were generated for each of the variables using SPSS.

Results

The demographic and practice characteristics of the physicians included in this study are displayed in Table 2. Cell sizes of less than six have been suppressed for anonymity.

Insert Table 2.

1: Routes to licensure

A total of 11,250 physicians were included in the study. Of the 10,595 traditionally licensed physicians (TLPs), 73% were domestically trained (DMGs) and 27% were internationally trained (IMGs). The 655 alternatively licensed IMGs (ALP-IMGs) accounted for 6% of the total study population. Twenty percent (20%) of the ALP-IMGs migrated to Ontario from another province and obtained licensure either through labour mobility legislation (AIT) or by becoming eligible for the CFPC licensing exams due to prior experience ALP-Canadian Practice Experience IMGs). The ALP-IMGs who were considered practice ready either through assessment or completion of post-graduate training in a RCPSC-approved jurisdiction (ALP-Practice Ready IMGs) comprised 22% of the ALP group and those who completed North American postgraduate training comprised 58% of ALPs (ALP-North American Trained IMGs).

2: Demographic Characteristics

On average, ALP-IMGs were nine years older than TLPs at time of registration (40 vs. 31 years). TLP-DMGs were the youngest (29 years), followed by TLP-IMGs (37 years), and ALP-IMGs (40 years). Within the ALP-IMGs, the Canadian Practice Experience IMGs were the oldest

sub-group at 44 years at time of registration.

There were proportionally more male ALP-IMGs than male TLPs (59% vs. 49%). TLP-DMGs had the lowest proportion of males (48%), followed by TLP-IMGs (54%) and then by ALP-IMGs (59%). The ALP-Canadian Practice Experience IMGs had the highest proportion of males (73%).

3: Education and Training

The regions of medical school for ALP-IMGs were diverse: those who completed their undergraduate medical degree in the Indian Subcontinent made up the largest proportion (28%), followed by those who trained in the Middle East (17%), the Caribbean (13%), and Eastern Europe (12%). The top five countries of medical school for ALP-IMGs were India, Pakistan, Egypt, South Africa and Iran; the top five countries for TLP-IMGs are almost the same: India, Pakistan, Egypt, and Ireland. Nearly 50% of both TLP-IMGs and ALP-IMGs attended medical school in the Indian Subcontinent and the Middle East. There were slightly more IMGs from Western and Eastern Europe in the TLP group compared to the ALP-IMG group (24% vs. 18%).

More TLP-IMGs were trained in countries with a very high HDI compared to ALP-IMGs (23% vs. 13%). The top five countries of medical school for TLP-IMGs from very high HDI countries were Ireland, United Kingdom, Saudi Arabia, Australia and Poland, accounting for nearly 80% of the very high HDI group. Despite the elevated number of TLP-IMGs from very high HDI countries, about half of all IMGs are from countries with a low or medium HDI. While only a small proportion of all IMGs are from very high HDI countries, the majority of these IMGs registered through the traditional licensure route compared to the alternative routes.

4: Practice Characteristics

Specialty

The practice focus of physicians differed slightly across the study groups. TLP-IMGs had a higher proportion of Family Medicine physicians than TLP-DMGs (57% vs.47%). There were proportionally fewer ALP-IMGs practicing in Family Medicine (44%) than either TLP-IMGs or -DMGs. The sub-group with highest proportion of physicians specializing in Family Medicine (67%) was the ALP-Canadian Practice Experience IMGs while the ALP- Practice Ready IMGs had the highest proportion of surgical specialists (21%) and physicians practicing in anesthesiology and critical care (15%). ALP-North American Trained IMGs had the highest proportion of medical specialists (21%) and psychiatrists (11%).

Practice Location

There were no substantial differences in rurality of practice location across groups; the majority of all physicians practiced in urban centers. TLPs had a relatively higher disparity between urban and rural practices (85% vs. 4%) compared to ALP-IMGs (78% vs. 4%). A higher proportion of ALP-IMGs practiced in suburban areas compared to TLPs (18% vs. 11%). The ALP-Practice Ready IMGs had the highest proportion of suburban practice (24%) and the lowest proportion of urban practice (72%). Approximately 5% of all physicians in this study practiced in northern Ontario. Thirty-three percent (33%) of TLPs in northern Ontario had rural practices, whereas 50% of ALP-IMGs in northern Ontario practiced rurally.

Discussion

To our knowledge, this is the first study that has examined the demographic and practice characteristics of all IMGs practicing in Ontario. By reporting on the IMGs registered between 2000 and 2012, we hope to shed light on the diverse routes to licensure of IMGs in Ontario and highlight some of the intersections between globalization, health policy, and medical regulation.

Routes to Licensure

In Ontario, nearly 3,500 IMGs entered the healthcare system in a 12-year timeframe, with 655 IMGs accessing CPSO alternative licensure routes (ALP-IMGs). Of the ALP-IMGs, the majority were ALP-North American Trained IMGs, who entered practice in Ontario by completing postgraduate training in North America. This includes IMGs who trained in the US as well as those who trained in Canada but had not yet written the certification exams at the time of requesting licensure. The second largest sub-group was the ALP-Practice Ready IMGs, who were deemed ready to practice by completing postgraduate training in a jurisdiction approved by the RCPSC (e.g. the United Kingdom, Australia, New Zealand, Hong Kong, South Africa) or by undergoing a practice ready assessment in Ontario. Practice-ready assessments were designed for internationally trained medical specialists, most of whom had foreign practice experience prior to entering Ontario.

The third sub-group, the ALP-Canadian Practice Experience IMGs who migrated to Ontario from another Canadian province, comprised 20% of ALP-IMGs. This is unsurprising given that Ontario has long had the highest net gain of physicians nationally, while other provinces such as Newfoundland, Saskatchewan and Manitoba regularly have net losses of practicing physicians.(22) These three provinces have historically recruited internationally trained physicians to address their physician shortages; however, upon completion of return-of-service agreements to practice in underserved areas, many IMGs move to urban regions or to other provinces, particularly Ontario, British Columbia, and Alberta.(23)

Multiple studies have demonstrated that smaller provinces provide an entry point for IMGs to practice elsewhere in Canada.(24–26) In some of these jurisdictions, IMGs were permitted to practice without Canadian post-graduate training and/or the necessary certification exams. In an effort to standardize licensure requirements, the Federation of Medical Regulatory Authorities of Canada has facilitated the development of common medical licensure approaches for all Canadian jurisdictions.(27) In addition, there is a pan-Canadian initiative under the

Medical Council of Canada to develop and implement a common examination for IMGs seeking a first year Canadian postgraduate position as well as common standards for the delivery of practice ready assessments across provinces.(28) This will not limit mobility between provinces, but will serve to standardize the evaluation of IMGs' qualifications and the assessment of competence. As physician migration continues to increase both nationally and internationally, policies that facilitate access to licensure while ensuring consistent, high quality patient care are imperative.

Demographic Characteristics

All IMG groups were older and had proportionally more males than the TLP-DMG group. Earlier comparisons of IMGs and DMGs in Canada have also found these phenomena.(13,29,30) The noted age difference can be explained, at least in part, by the fact that many IMGs have completed training or have practiced (in their home countries or in Canada) prior to registering in Ontario. ALP-IMGs, specifically, enter Ontario later in their careers than TLP-IMGs. On average, ALP-IMGs had almost five years of training and over four years of practice outside of Canada prior to registering in Ontario. Those who migrated from another Canadian province, the ALP-Canadian Practice Experience IMGs, were the oldest and had 12 years of practice experience prior to registering in Ontario. Physicians who utilized labour mobility legislation (AIT) who were, on average, 45 years of age at time of registration. The ALP-Practice Ready IMGs and ALP-North American Trained IMGs were slightly younger, and had nine and five years of prior experience, respectively.

These findings highlight the diversity of experience of IMGs and the often circuitous routes to licensure taken by these physicians. They also suggest that IMGs may have shorter careers in Ontario than DMGs since they are older when they enter the workforce. Given that increasing access to licensure for IMGs is intended to contribute to overall physician supply,

policies to recruit younger IMGs and reduce potential barriers to entry would allow IMGs to have longer careers in Ontario and have a greater impact on the healthcare system (13).

Education and Training

The diverse paths of IMGs are evident in the wide range of source countries of IMGs now practicing in Ontario. The majority of IMGs in the present study trained in the Indian Subcontinent, the Middle East, Europe, and the Caribbean. It is worth noting that approximately half of all IMGs are from countries with medium or low HDI, countries that may be in significant need of skilled healthcare workers. According to the World Health Organization, 37% of the world's healthcare professionals are living in North America despite Canada and the United States carrying only 10% of the global disease burden.(31)

These trends in international physician migration give rise to concerns about global health equity. Increasingly, there is a limited supply of healthcare workers in many low- and middle-income countries and the “brain drain” phenomenon has been the subject of exploration in recent studies.(4,14,32,33) In 2007, the CPSO published a statement on ethical recruitment based on policy papers put forth by the World Health Organization.(34) Despite this effort at ethical recruitment aimed at discouraging “poaching” from low-income countries, IMGs have the prerogative to choose the country in which they wish to practice medicine and may continue to migrate to higher-income locations in spite of these policies (3,14). Policy developers must continuously balance physician autonomy with health human resource distribution and global health equity.

Trends in physician migration also underscores policy questions that have been raised about who should make up the physician workforce in Canada.(35) Given that Canada is becoming an increasingly diverse country, IMGs play an important role in serving the heterogeneous patient population in this country. As we collectively consider this issue, the

demographic profile of IMGs is changing as more and more Canadians study abroad with the intention of returning to Canada for post-graduate training and employment. Canadians Studying Abroad (CSAs) now comprise a significant and distinct subset of IMGs in this country. The number of CSAs has grown dramatically since 2000 (36) and an increasing proportion of IMGs who apply for Canadian residency programs each year are CSAs (25% in 2011 compared to 12% in 2008).(37) It is also becoming increasingly common for CSAs to complete postgraduate training in the United States (38) and use an alternative licensure route to enter practice in Ontario, highlighting an unanticipated use of the licensure route originally created for American-trained IMG physicians. As the profile of IMGs evolves, we may begin to see even more diverse international migration trends and potentially further use of alternative licensure policies.

Practice Characteristics

The practice characteristics of physicians in this study differed slightly by licensure route. Of the physicians who were registered through the traditional licensure route between 2000 and 2012, more TLP-IMGs practiced Family Medicine compared to TLP-DMGs. This may be because prior to 2007, IMGs seeking postgraduate placements in Canada could only apply to the second round of residency matches, at which time most specialty (i.e. non-Family Medicine) placements were already secured by DMGs.(13) ALP-IMGs, on the other hand, had a higher proportion of specialists compared to either TLP-IMGs or -DMGs, possibly due to the increased ability of internationally trained specialists to gain entry through alternative licensure routes. This is reflected in the ALP-Practice Ready IMGs, who either completed their specialist training in an approved jurisdiction or underwent a practice ready assessment in Ontario, as well as in the ALP-North American Trained IMGs.

However, the ALP-Canadian Practice Experience IMGs, who migrated from another Canadian province, had the highest proportion of physicians specializing in Family Medicine

than all other groups. This may reflect the fact that some provinces used to issue provisional licenses to IMGs to practice in underserved areas, but after two years of practice experience, these IMGs gained eligibility to write the College of Family Physicians of Canada (CFPC) exams and would often move elsewhere in Canada. The trend for IMGs to obtain provisional licenses in one province, practice for two years in order to qualify for a full license in Family Medicine, and then migrate to other provinces such as Ontario has been observed previously.(24) In the future, the use of smaller provinces to access licensure in Ontario will likely subside as licensure requirements become standardized across provinces.

All physicians, regardless of licensure route, practiced predominantly in urban compared to rural locations. Given that increasing physician supply in rural and underserved areas was a key driver in the development of many health policies, including alternative licensure policies (11), this may be evidence of both the ineffectiveness of the current policies and the great need for them. It is possible that some of the ALP-IMGs in this study originally practiced in rural regions through return-of-service agreements but later migrated to urban locations within the province. (23,24,39) Urban centers provide more ethnic diversity than rural regions which is preferable for many IMGs (40), however this pattern of migration had considerable implications for continued shortages in rural and remote areas and for the continuity of care of patients in those regions.(39) In 2010, the restrictions on practice locations for return-of-service agreements were reduced, allowing IMGs more choice in where they can begin practicing, and a more comprehensive strategy for northern and rural recruitment of physicians was established.(41) Research has shown that using IMGs to fill rural needs is not effective (33), but physicians coming from a rural background or completing undergraduate or postgraduate training in rural areas are more likely to enter rural practice.(42) The newly opened Northern Ontario School of Medicine (NOSM) has an explicit goal of physician retention in Northern Ontario and early research shows promise for this self-sufficient model.(43)

Health policies often respond to changing trends in physician demographics and, in turn, the demographic and practice characteristics of physicians influence ongoing policy development. By tracking and reporting on the practice patterns of physicians in Ontario, we aim to contribute to future health human resource planning and facilitate an understanding of the diverse groups of IMGs in the province. This study describes the physicians registered in Ontario between 2000 and 2012, focusing on those who accessed CPSO's alternative licensure routes. Since 2012, an increasing number of physicians access alternative licensure routes. For example, the number of physicians utilizing the route developed for American-trained physicians has more than doubled in the last three years. Continuing to monitor the characteristics and career trajectories of all IMGs will be necessary to guide effective policy development to be responsive to globalization trends that may impact the medical profession.

One IMG group underrepresented in the literature are the physicians who do *not* successfully obtain licensure. Brain drain from countries with physician shortages often results in brain waste, as many foreign trained doctors are not able to utilize their education and training when they migrate to higher income countries.(14,44–46) This phenomenon is due to many factors including lack of coordination between various policy initiatives, lack of knowledge before emigrating about the chances of successfully obtaining licensure, high competition for residency positions, and inability to pass assessments. Although little information currently exists on how many of these unlicensed physicians are in Ontario, one estimate suggests the number may be in the several thousands.(45)This issue has been recognized by the federal government, which has provided funding for the development of retraining programs for internationally educated health professionals, most of whom are physicians.(47)

Policy development to address physician supply and distribution has always been complex but the evolving nature of globalization compounds these issues. Going forward, policy

developers will need to collaborate across systems to carefully consider issues such as global health equity, access to medical education and licensure, ongoing shortages in rural and indigenous communities, and ultimately, the characteristics of the future physician labour force in Ontario. In 2013, the Physician Resource Planning Task Force was developed to coordinate a pan-Canadian health human resources strategy to ensure the appropriate mix, distribution and number of physicians practicing in the country.⁽⁴⁸⁾ A pan-Canadian approach to HHR planning is imperative to ensure policy alignment in light of increasing physician mobility and global complexity.

The ultimate goal of health human resource planning is to ensure that patients receive timely, quality care that is accessible and equitable. In helping to achieve this goal, medical regulators have the challenging role of balancing the provision of access to licensure for physicians while ensuring public protection. The analysis described in the current paper represents the first phase of a comprehensive evaluation focusing on the CPSO's registration policies and licensure routes. Using the current data for this cohort of IMGs as a starting point, future studies will seek to assess the quality of medical practice of these physicians. Such lines of research may shed light on how regulation can improve integration and education for doctors already in the system and the future resource of internationally trained physicians. The medical regulator is but one player in a complex system attempting to address health human resource challenges in an increasingly globalized landscape. Developing effective strategies to address the above issues will not be easy and will rely on sound research, a willingness to address difficult questions, and a tolerance for the constantly evolving nature of globalized medical education and practice.

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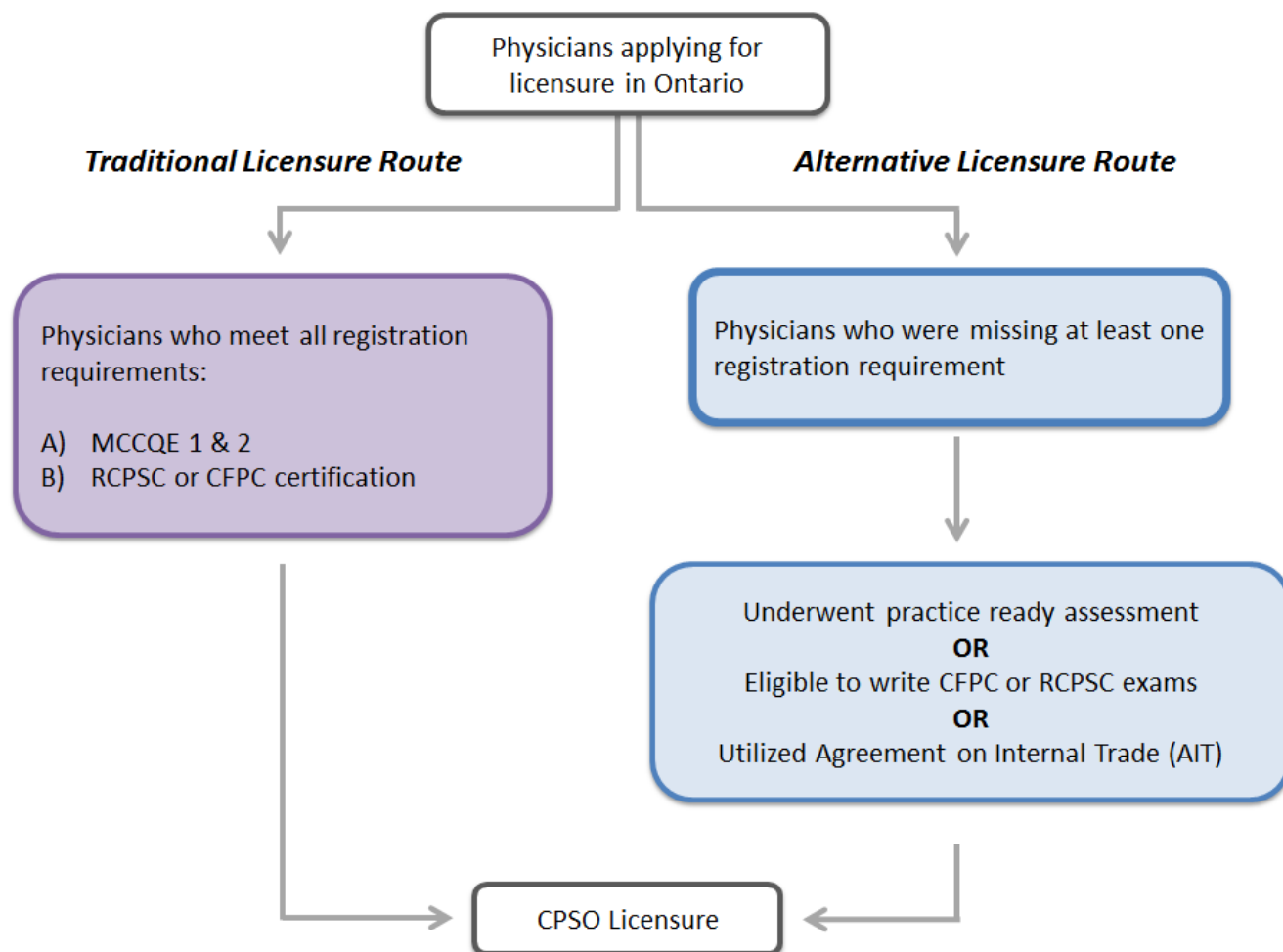
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Figure 1. Traditional and alternative licensure routes for physicians in Ontario

MCCQE – Medical Council of Canada Qualifying Examinations || RCPSC – Royal College of Physicians and Surgeons of Canada || CFPC – College of Family Physicians of Canada || Agreement on Internal Trade (AIT) – labour mobility legislation that allows free movement of physicians across provinces

Table 1. Description of the Traditionally Licensed Physicians and the Alternatively Licensed IMGs

Physician Group	Physician Sub-Groups	Description	Undergrad Location	Postgrad Location
Traditionally Licensed Physicians (TLP)	DMG	Physicians who completed undergraduate medical education in North America (Canada and the US), post-graduate training in Canada, and passed the Canadian licensing examinations.	North America	Canada
	IMG	Physicians who completed undergraduate medical education abroad, post-graduate training in Canada, and passed the Canadian licensing examinations.	Abroad	Canada
Alternatively Licensed IMGs (ALP-IMG)	Canadian Practice Experience IMG	Internationally trained physicians who gained eligibility to practice in Ontario by practising in another Canadian province. <i>Includes IMGs who utilized either AIT legislation or who were eligible to write CFPC exams route through a minimum of two years of Canadian practice experience.</i>	Abroad	Abroad
	Practice Ready IMG	Internationally trained physicians who were deemed eligible to practice in Ontario without completing additional Canadian training or practicing in another Canadian province. <i>Includes IMGs who completed training in a RCPSC-approved jurisdiction or underwent a practice ready assessment (APIMG) in Ontario and were deemed practice ready.</i>	Abroad	Abroad
	North American Trained IMG	Internationally trained physicians who gained eligibility to practice in Ontario by completing postgraduate training in North America (Canada and the US). <i>Includes IMGs who completed postgraduate training exclusively in North America and those who completed postgraduate training abroad and completed additional North American training.</i>	Abroad	North America

DMG – Domestic Medical Graduate || IMG – International Medical Graduate || Agreement on Internal Trade (AIT) – labour mobility legislation that allows free movement of physicians across provinces || APIMG – Assessment Program for International Medical Graduates|| CFPC – College of Family Physicians of Canada RCPSC – Royal College of Physicians and Surgeons of Canada ||

Table 2. Demographic and practice characteristics of physicians registered from 2000 to 2012

DMG – Domestic Medical Graduate || IMG – International Medical Graduate || ± SD or

	Traditionally Licensed Physicians (TLP)			Alternatively Licensed IMGs (ALP-IMGs)			
	Total	DMG	IMG	Total	Canadian Practice Experience IMG	Practice Ready IMG	North American Trained IMG
Total (n)	10,595	7,762	2,833	655	132	146	377
Age at registration, mean ± SD	31.1 ± 6.5	28.9 ± 4.5	36.9 ± 7.4	39.6 ± 7.8	44.2 ± 10.5	39.2 ± 6.1	38.1 ± 6.6
Sex, % male (n)	49% (5203)	48% (3684)	54% (1519)	59% (387)	73% (96)	55% (80)	56% (211)
Region of medical school, % (n)							
Canada	72% (7633)	98% (7633)	-	-	-	-	-
United States	1% (129)	2% (129)	-	-	-	-	-
Middle East	6% (680)	-	24% (680)	17% (111)	23% (30)	15% (22)	16% (59)
Caribbean	2% (258)	-	9% (258)	13% (88)	9% (12)	-	19% (71)
Indian Subcontinent	6% (621)	-	22% (621)	28% (185)	24% (31)	23% (33)	32% (121)
Africa (excl. South Africa)	2% (237)	-	8% (237)	9% (60)	14% (19)	7% (10)	8% (31)
South Africa	1% (114)	-	4% (114)	6% (38)	10% (13)	17% (25)	-
Eastern Europe	3% (362)	-	13% (362)	12% (78)	8% (10)	6% (9)	16% (59)
Western Europe	3% (315)	-	11% (315)	6% (41)	9% (12)	12% (17)	3% (12)
Australia & New Zealand	1% (76)	-	3% (76)	1% (7)	-	-	-
South & Central America	1% (75)	-	3% (75)	4% (27)	-	12% (17)	2% (8)
Asia (South & East)	1% (95)	-	3% (95)	3% (20)	-	-	4% (15)
HDI of medical school country, % (n)							
Very high human development	79% (8404)	100%	23% (642)	13% (83)	15% (20)	16% (24)	10% (39)
High human development	9% (974)	-	34% (974)	35% (230)	21% (28)	30% (44)	42% (158)
Medium human development	8% (883)	-	31% (883)	37% (241)	46% (60)	44% (64)	31% (117)
Low human development	3% (334)	-	12% (334)	15% (101)	18% (24)	10% (14)	17% (63)
Specialty/Practice Focus, % (n)							
Family Medicine	49% (5264)	47% (3641)	57% (1623)	44% (287)	67% (89)	32% (47)	40% (151)
Medical Specialties	18% (1916)	19% (1484)	15% (432)	17% (114)	8% (11)	16% (23)	21% (80)
Surgical Specialties	13% (1342)	14% (1093)	9% (249)	9% (57)	-	21% (30)	6% (21)
Diagnostic Specialties	6% (600)	5% (422)	6% (178)	6% (37)	6% (8)	-	7% (27)
Psychiatry	5% (527)	5% (394)	5% (133)	9% (56)	7% (9)	-	11% (40)
Pediatrics	4% (432)	4% (335)	3% (97)	8% (53)	-	10% (15)	9% (35)
Anesthesiology & Critical Care	5% (514)	5% (393)	4% (121)	8% (51)	5% (6)	15% (22)	6% (23)
Practice Location % (n)							
Urban	85% (8086)	85% (5984)	84% (2102)	78% (457)	78% (78)	72% (101)	81% (278)
Suburban	11% (1035)	10% (702)	13% (333)	18% (107)	15% (15)	24% (34)	17% (58)
Rural	4% (415)	5% (344)	3% (71)	4% (22)	7% (7)	4% (6)	3% (9)

prevalence (%) and n || - represents values that are not applicable or suppressed due to small cell sizes and/or to maintain privacy ||

Discipline Committee Report of Completed Cases November 2016

Covering cases completed between May 12, 2016 and November 9, 2016

Note: This report covers discipline cases completed (i.e., the written decision and reasons on finding and, if applicable, penalty have been released) between May 12 and November 9, 2016. The decisions are organized according to category, and then listed alphabetically by physician last name.

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Sexual Abuse – 7 cases

1. Dr. H. S. Einstoss

Name:	Dr. Howard Sheldon Einstoss
Practice:	Family Medicine
Practice Location:	Toronto
Hearing:	Contested
Decision Date:	April 12, 2016
Written Decision Date:	August 11, 2016

Allegations and Findings

- Engaged in sexual abuse of two patients: **proved**
- Disgraceful, dishonourable, or unprofessional conduct: **proved**

Summary

Patient A is a middle-aged woman who began seeing Dr. Einstoss as her sole family physician in her late 20s. Dr. Einstoss provided psychotherapy for her mental health issues and prescribed medications for her.

One December while she was his patient, Patient A had taken a Christmas gift to Dr. Einstoss, who responded by giving her a kiss. Eventually, during subsequent appointments, Dr. Einstoss started touching Patient A inappropriately, leading to sexual intercourse in his office.

Patient A testified that although she would attend Dr. Einstoss' office for psychotherapy appointments, he never provided any therapy. Instead, Patient A would have sexual intercourse with Dr. Einstoss on the floor, using a sleeping bag he kept under his examination table. Patient A's sexual encounters with Dr. Einstoss at his office occurred roughly every two to four weeks for about three to four years.

Patient A would usually arrive at Dr. Einstoss' office at 4:30 or 5:00 p.m. She would stay in Dr. Einstoss' office with him until about 7:00 p.m. After having sex, the two would sit on the sleeping bag and he would have "a couple of drinks" containing vodka. They would then both leave to go home.

Patient A testified that she would either call for an appointment or Dr. Einstoss would call her to tell her to come in to the office, if she wanted her medications. Patient A testified that if she didn't go into the office and have sex with Dr. Einstoss, she wouldn't get her medications.

Patient A recalled attending Dr. Einstoss' office occasionally for medical appointments. During those instances, Dr. Einstoss would often tell her to come back after hours and they would have sex at that time. Patient A testified that Dr. Einstoss made her feel she couldn't tell anyone about the sexual encounters and she felt she could do nothing to stop them.

Because of the sexual encounters, Patient A ultimately no longer felt comfortable seeing Dr. Einstoss as her doctor. When she called Dr. Einstoss' office to request her medical records, she was told he had retired. She was never able to obtain her medical records.

Patient B saw Dr. Einstoss for mental health issues and substance abuse issues. Dr. Einstoss provided frequent psychotherapy sessions and prescribed medication for Patient B in her late teens and early 20s.

Patient B testified that, in 2009, she was heavily self-medicating on a daily basis and was worried she had damaged her liver. She therefore made an appointment to see Dr. Einstoss.

At her appointment, Dr. Einstoss examined Patient B and ordered blood work. When she went to the lab for the blood testing, Patient B was surprised to see that Dr. Einstoss had ordered testing for sexually-transmitted diseases (STDs). Patient B testified that she now believes that Dr. Einstoss "set her up to have sex with him" by ordering the STD testing that had not otherwise seemed medically necessary.

At her subsequent appointment, Patient B told Dr. Einstoss that she was still feeling unwell. However, Dr. Einstoss did not address her medical concerns; he instead told her about his problems with his medical practice and that he might be suspended. Dr. Einstoss asked her to write a favorable letter regarding his character to his lawyer, which she did, using the words he had given her.

At that same visit, Dr. Einstoss took Patient B's hands and told her he would take care of her forever. Patient B testified that she and Dr. Einstoss then took a bus to a hotel, stopping to have a meal at a nearby restaurant, which she paid for. They had sex at the hotel. They then left the hotel together, each taking a cab home. Dr. Einstoss called her later that evening and told her that he loved her.

The next week, Patient B went to Dr. Einstoss' office. She waited for him to finish seeing another patient, and again they left his office together to go to a hotel together by cab and again had sex.

Patient B's credit card billings showed she had made charges on several occasions for hotel rooms, a meal at a restaurant, and several taxis. She testified that these charges for the dates indicated on the credit card statements all corresponded to times she had sex with Dr. Einstoss in various hotels. The dates for the credit card charges in her statement correspond to visit dates billed for Patient B to OHIP by Dr. Einstoss.

Patient B testified that she continued to feel unwell during the time period of her second sexual encounter with Dr. Einstoss. She repeatedly called and went to Dr. Einstoss' office to try to see him. On these occasions, Dr. Einstoss' receptionist told her he was

not available. Patient B tried contacting Dr. Einstoss at his office throughout the summer of 2009. Dr. Einstoss ignored and did not return her calls.

In October 2009, Dr. Einstoss called Patient B and apologized for hurting her. He asked if he could call her weekly, and she agreed. In late October 2009, Patient B met Dr. Einstoss again, and they had sex at a hotel. For approximately one year thereafter, Dr. Einstoss would meet Patient B at a hotel on a set day of the week and have sex. Patient B would pay for the hotel, and Dr. Einstoss would give her \$100.00 towards the bill every other week. They occasionally had sex at Patient B's home as well.

When Patient B tried to obtain her medical records from Dr. Einstoss, she was told there was a \$75.00 charge. When Patient B asked Dr. Einstoss to waive the charge, Dr. Einstoss told her that she didn't need her chart. She was never able to obtain her medical records.

After Patient B made her complaint to the College, Dr. Einstoss repeatedly called her on the phone and yelled at her. Dr. Einstoss emailed Patient B and her child. He tried repeatedly to reach Patient B through various social media websites. Patient B last heard from Dr. Einstoss six months ago.

Patient B's substance abuse issues relapsed. Patient B had difficulty finding a doctor and even seeking medical care because she did not trust that anyone would actually listen to her. She testified that she has an ongoing "incredible distrust" of others.

The Committee found that Dr. Einstoss had a doctor-patient relationship with both Patient A and Patient B at the time of his sexual relationships with them. The Committee therefore found that Dr. Einstoss sexually abused both Patient A and Patient B.

The Committee found that Dr. Einstoss engaged in the following conduct that would reasonably be regarded by members as disgraceful, dishonourable, or unprofessional as follows:

With respect to Patient A:

Dr. Einstoss had diagnosed Patient A with having significant mental health and addictions issues. Patient A was, accordingly, a particularly vulnerable patient who was sexually abused by Dr. Einstoss.

Dr. Einstoss linked the prescribing of medications for Patient A to attending his office for sexual intercourse. Patient A testified that she would not receive the medications she needed if she did not have sex with Dr. Einstoss.

Dr. Einstoss billed OHIP for multiple psychotherapy sessions for Patient A in 2009. Patient A testified while she had received psychotherapy from Dr. Einstoss in the past, he had not provided psychotherapy at the visits billed for in 2009.

Dr. Einstoss disclosed personal information about himself and his family to Patient A, breaching professional boundaries.

With respect to Patient B:

Dr. Einstoss had diagnosed Patient B with significant mental health and addiction issues. He had provided medication and psychotherapy for mental health issues and substance abuse issues when she was in her late teens and early 20s. As a result of the sexual abuse by Dr. Einstoss, Patient B relapsed into substance abuse issues and it took her years to recover her sobriety. Patient B was clearly a vulnerable patient, exploited by Dr. Einstoss.

Dr. Einstoss failed to adequately address Patient B's medical concerns. Her medical concerns were never addressed beyond ordering blood work and reviewing the results with her. The visits instead led to sexual abuse by Dr. Einstoss. Patient B had to ultimately seek care at a walk-in clinic because Dr. Einstoss eventually refused to see her. She was then sent to hospital and underwent a surgical procedure.

Dr. Einstoss sent Patient B for STD testing when this was not a legitimate medical concern of hers. He did not advise Patient B that he had included these tests on a requisition he gave her for blood work. Patient B was made aware of this by the technician at the lab she attended. The inclusion of these tests did not reflect Patient B's concern nor was there any rationale for ordering these tests discussed with her at the time. The ordering of these tests was most likely self-serving on Dr. Einstoss' part, given he subsequently had sexual intercourse with her.

Dr. Einstoss billed OHIP for psychotherapy sessions provided to Patient B in 2009. Patient B testified that, while she had received psychotherapy from Dr. Einstoss in the past, he had not provided psychotherapy at the visits billed for in 2009.

Dr. Einstoss disclosed personal information to Patient B regarding himself and his family, breaching professional boundaries.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar revoke Dr. Einstoss' certificate of registration effective immediately;
- Dr. Einstoss reimburse the College for funding provided to patients for therapy by posting an irrevocable letter of credit or other security acceptable to the College, by September 6, 2016, in the amount of \$32,120.00;
- Dr. Einstoss appear before the panel to be reprimanded on or before June 12, 2016; and,
- Dr. Einstoss pay costs to the College in the amount of \$14,460.00, by June 12, 2016.

2. Dr. G. Glumac

Name:	Dr. George Glumac
Practice:	Psychiatry
Practice Location:	Guelph
Hearing:	Uncontested Facts and Joint Submission on Penalty

Decision Date: March 21, 2016
Written Decision Date: June 13, 2016

Allegations and Findings

- Engaged in sexual abuse of a patient - **proved**
- Disgraceful, dishonourable, or unprofessional conduct – **proved**
- Incompetence – **proved**
- Failed to maintain the standards of practice of the profession – **proved**

Summary

Around 2008, Patient A sought a psychiatrist to assist with the care and treatment of one of her children with special needs. Patient A, who has had frequent surgeries, chronic pain, and limited mobility, also has a history of childhood sexual abuse. Patient A's husband, Patient B, has a developmental disorder. Patient A and her family have faced significant financial challenges, receive financial assistance, and have no additional income.

Dr. Glumac agreed to see the family for therapy for issues arising with one of Patient A's children.

In early 2009, Patient A asked to see Dr. Glumac alone. At their first private appointment in January 2009, Dr. Glumac suggested that Patient A would benefit from seeing someone, and he suggested she see him regularly as a "place to vent." He told her he would see her as a friend. Patient A agreed and began to see Dr. Glumac regularly without her children. Occasionally, Patient B, her husband, would join her in these sessions for joint counseling.

Around May 2009, Dr. Glumac began managing Patient A's chronic pain and prescribed an anti-depressant; a narcotic; an amphetamine; a bupropion; a narcotic; benzodiazepine; an SSNRI; an SSRI; and a synthetic cannabinoid.

Dr. Glumac made personal disclosures to Patient A including that he was a practising fundamentalist Christian, details about his relationship with his wife and his medical history, and information about his childhood.

Dr. Glumac would begin his sessions with Patient A by praying with her, either by placing his hands on her shoulders and invoking a blessing; or by having Patient A kneel on the floor at his feet with her body between his knees, placing his hand on her head, and invoking a blessing.

In their sessions, Dr. Glumac referred to Patient A as his "little buddy" and told her that he was seeing her as a friend. Dr. Glumac and Patient A also exchanged gifts during the doctor-patient relationship.

Patient A frequently told Dr. Glumac about her marital and financial problems during her sessions. Dr. Glumac recommended that Patient B retain his friend, Mr. X, as a business manager. Patient A trusted Dr. Glumac and therefore she and Patient B hired Mr. X as a business advisor. Ultimately, Mr. X caused Patient A and Patient B to incur significant debt. Mr. X has remained unaccountable for their financial losses.

In November 2009, Patient A underwent a mastectomy and went to a respite facility. In December 2009, Dr. Glumac visited Patient A there. The two went to the basement to be alone. When Dr. Glumac asked her to sit on the couch next to him, she obliged. Dr. Glumac then embraced her, placing his arms around her waist and rear end, kissing her neck, her ears, her mouth, and her lips for about 15 minutes. Eventually, Patient A stood up and walked across the room. Dr. Glumac followed her and continued to kiss and hug her. Patient A escorted Dr. Glumac to the door and he left.

A few days later, Patient A called Dr. Glumac and asked him to return to the respite facility to explain his behaviour. Dr. Glumac returned and the two entered an empty bedroom together. When Patient A asked Dr. Glumac what his intentions were, he told her not to worry and that his intentions were not sexual. Dr. Glumac invited her to lay on the bed with him and asked if he could hug her. They lay on the bed together in a spooning position and he kissed her from behind. She felt his erection pressing against her. Patient A got off the bed and asked Dr. Glumac to leave the respite facility.

As a result of these incidents, Patient A had planned not to return to see Dr. Glumac. But after enduring a difficult chemotherapy, she reached out for his support once again. At subsequent appointments, Dr. Glumac kissed Patient A on the lips and hugged her frequently, with his hands around her waist and hips.

In June 2011, Patient A and Patient B inherited \$40,000.00. Patient A, who felt relieved and excited, shared this news with Dr. Glumac. Two weeks later, Dr. Glumac telephoned Patients A and B to tell them he had a charitable organization but that he was short of \$20,000.00. Dr. Glumac asked whether he could borrow \$20,000.00 from Patients A and B. Patients A and B provided Dr. Glumac with \$20,000.00 within a few days. Dr. Glumac then gave Patients A and B a Promissory Note acknowledging receipt and promising to repay \$2500 monthly beginning in September 2011.

Dr. Glumac failed to repay the funds within the first three months. He also failed to abide by the rest of the terms of the Promissory Note. After Patient B repeatedly requested funds, Dr. Glumac gave Patient B a \$2000.00 cheque in November 2011. Patient A then began emailing Dr. Glumac asking for their money back. Patient A indicated that they would have no choice but to commence legal action or report Dr. Glumac to the College.

Patient A terminated the doctor-patient relationship on January 30, 2012.

Dr. Glumac made further payments in the spring of 2012. Dr. Glumac ultimately admitted to Patient A that he had borrowed the money to support his real estate management and investment company, and not for charitable purposes.

Dr. Glumac and his wife telephoned Patients A and B and pleaded with them not to report him to the College. Dr. Glumac attended at their home and threatened them in order to prevent them from reporting him to the College. Dr. Glumac threatened to cease providing medications to Patient A. He also offered to pay Patients A and B an additional \$20,000.00 if Patient A agreed not to report him to the College.

In June 2012, Patients A and B reported Dr. Glumac to the College.

In July 2012, Dr. Glumac provided Patients A and B with a certified cheque for \$8000.00, which finally satisfying the debt owed.

The College retained Dr. C to opine on the care and treatment provided by Dr. Glumac to Patient A.

The first expert, Dr. C, concluded that Dr. Glumac failed to maintain the standard of practice of the profession regarding Patient A's pain management and her psychiatric care and treatment.

(i) Pain Management: Dr. C opined that Dr. Glumac did not manage Patient A's opioid therapy appropriately and displayed a lack of knowledge and skill in said management. He escalated her dose of morphine over a short period of time and did not record whether he reviewed side effects, including the development of addiction. Evidence suggested that Patient A might have had "too much" medication. Dr. Glumac never appeared to have considered other pain management strategies besides opioids. He also failed to change antidepressant medication in a timely fashion once the issue of bupropion's effect on her breast cancer medication was noted.

(ii) Psychiatry Practice: Dr. C opined that at various points in her treatment, Patient A's depression was so severe that she was at risk of suicide. There is no evidence that Dr. Glumac performed an assessment for suicide risk, even where Dr. Glumac recorded what appeared to be suicidal gestures.

Dr. C also identified multiple boundary issues including: having a patient call him by his first name, visiting the patient at her home, borrowing from and giving money to the patient, creating a relationship between the patient and a personal friend of the psychiatrist, praying with the patient, creating the image that the patient was special, and intimately touching the patient.

Dr. C concluded that Dr. Glumac poses a risk to other patients, that Dr. Glumac does not have requisite skills to manage opioids, and should not be doing so.
Inappropriate OHIP Billing regarding Patient A

Dr. Glumac also billed the Ontario Health Insurance Plan for services he did not provide to Patient A. For example: he billed and was paid for 9 sessions of psychotherapy which

he did not provide, and he billed and was paid for three sessions of psychiatric care which he did not provide. Dr. Glumac either billed for services he did not provide, or failed to keep clinical records on 16 occasions.

On March 6, 2015, Dr. Glumac entered into an undertaking in lieu of the Inquiries, Complaints and Reports Committee making an order under section 37 of the Health Professions Procedural Code which required, among other things, that he cease prescribing narcotics and that he video monitor all patient encounters.

The Compliance Case Manager who subsequently visited Dr. Glumac noted that he was conducting patient sessions over the telephone, and was billing OHIP for it. Consultations and assessments rendered by telephone (including services such as psychotherapy, counselling, primary mental health and psychiatric care), are not insured services and are not payable by OHIP. The College retained Dr. D to review Dr. Glumac's OHIP billing. In all but one of 32 patient charts that Dr. D reviewed, he found that the OHIP billing Dr. Glumac submitted failed in some way to meet the standard of practice of the profession.

Dr. D observed that while many insured services were correctly billed to OHIP, Dr. Glumac billed OHIP for services that are uninsured. This suggested that Dr. Glumac understood and followed the general payment rules such as the minimum duration for time for unit based services and the time documentation requirements. Dr. Glumac billed OHIP for services such as telephone communication, Skype sessions, faxing prescriptions, certain reports, dictations, and research on behalf of his patients. When these uninsured services were provided, there was no evidence in the charts that an accompanying insured service was provided in order to justify the billing Dr. Glumac submitted to OHIP. In addition, Dr. Glumac billed for special visit premiums when the visits attached to those premiums were not eligible for premiums.

Dr. E, another College-appointed medical inspector who reviewed Dr. Glumac's patient charts also noted billing irregularities. Dr. E noted that Dr. Glumac inappropriately used psychiatric care codes and psychotherapy fee codes to bill for other services such as report writing, communicating with third parties, and faxing prescriptions, which are uninsured services.

Disposition

The Discipline Committee ordered and directed that:

- the Registrar revoke Dr. Glumac's certificate of registration effective immediately.
- Dr. Glumac reimburse the College for funding provided to patients under the program required under section 85.7 of the Code, and to post an irrevocable letter of credit or other security acceptable to the College to guarantee payment of such amounts within thirty (30) days of the date this Order becomes final, in the amount of \$16,060.00;
- Dr. Glumac appear before the panel to be reprimanded; and
- Dr. Glumac pay costs to the College in the amount of \$5,000.00 within thirty (30) days of the date this Order becomes final.

3. Dr. A. R. E. Laws

Name: Dr. Anthony Richard Eldon Laws
Practice: General with ADD specialty
Practice Location: Hamilton
Hearing: Uncontested Facts and Joint Submission on Penalty
Decision Date: July 14, 2016
Written Decision Date: August 19, 2016

Allegations and Findings

- Engaged in sexual abuse of a patient - **proved**
- Disgraceful, dishonourable, or unprofessional conduct – **proved**
- Failed to maintain the standards of practice of the profession – **proved**

Summary

Dr. Laws was a general practitioner with a practice in Hamilton from 1986 until his certificate of registration expired in April 2015 when he resigned. He focused on treating patients with attention deficit disorder (“ADD”).

Patient A, then in his mid-30s, was Dr. Laws’ private practice patient from about March 2012 to June 2014. Dr. Laws treated Patient A for ADD and prescribed him stimulant medications.

Dr. Laws, on several occasions, invited Patient A to Dr. Laws’ home office. Patient A and Dr. Laws did not spend any time in his home office; rather, Patient A would go to Dr. Laws’ house and “hang out,” drinking alcohol and using Dr. Laws’ hot tub together.

On one of these occasions at Dr. Laws’ home, Dr. Laws kissed Patient A.

On another occasion at Dr. Laws’ home, Dr. Laws gave a massage to Patient A while they were both naked. During the massage, Dr. Laws put Patient A’s penis in his mouth.

Patient A slept at Dr. Laws’ house two or three times because he had been drinking alcohol and did not want to drive home. Patient A told the College that “there isn’t really a clear boundary between friend and doctor and it’s always been kind of frustrating to me.”

Patient A and Dr. Laws also exchanged numerous emails about both social and medical issues while their doctor-patient relationship existed.

On one occasion at Dr. Laws’ house, during the time that Dr. Laws was prescribing stimulant medication to Patient A, Dr. Laws provided Patient A with a marijuana cookie,

which Patient A ate. This led to Patient A experiencing psychotic symptoms and ultimately his admission to the Emergency Room of the local hospital.

The College retained a psychiatrist to provide his opinion on the care and treatment Dr. Laws provided to Patient A. This expert opined that Dr. Laws fell short of the standard of practice of the profession in his use of excessive doses of stimulants for ADD with poor documentation and without appropriate careful follow up. His giving this patient an illicit street drug is also reprehensible and immoral and put a patient with mental illness already on medications, at risk of destabilization – all of this falling short of the standards of the profession.

Patient B, then in his early 30s, was Dr. Laws' private practice patient from about May 2003 to at least August 2010. Dr. Laws treated Patient B for ADD.

In 2004, Patient B became Dr. Laws' tenant in 2004, while they had a doctor-patient relationship. Patient B rented a room in Dr. Laws' house for \$450/month and Patient B would assist in the yard and house maintenance as required. This arrangement lasted for several years.

While Patient B was his patient and tenant, Dr. Laws completed a medical document regarding Patient B's ability to participate in employment-related activities, in support of Patient B's receipt of social assistance.

While Patient B was his patient and tenant, Dr. Laws and Patient B also opened a joint bank account. Patient B's social assistance payments were deposited directly into their joint account.

Dr. Laws also prescribed narcotics to Patient B during their doctor-patient and landlord-tenant relationships.

Although Dr. Laws told College that Patient B ceased being his tenant in 2009 or 2010, he did hire Patient B to work on his property at later dates.

The College retained another psychiatrist to provide his opinion on the care and treatment Dr. Laws provided to Patient B. This expert opined, among other things that Dr. Laws did not demonstrate insight or acknowledgement with regards to the boundary issues, nor did he express any sense of responsibility with regards to his role in this doctor-patient relationship. Dr. Laws also did not provide an adequate explanation regarding his prescription of opiates to [Patient B], and did not mention the use of these drugs in subsequent reports to other physicians.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar revoke Dr. Laws' certificate of registration effective immediately.

- Dr. Laws reimburse the College for funding provided to patients under the program required under section 85.7 of the Code, by posting an irrevocable letter of credit or other security acceptable to the College, by August 15, 2016, in the amount of \$16,060.00.
- Dr. Laws appear before the panel to be reprimanded.
- Dr. Laws pay costs to the College in the amount of \$5,000.00 by August 15, 2016.

4. Dr. IJK

Name: Dr. IJK
Practice: Obstetrics and Gynaecology
Practice Location: Redacted
Hearing: Contested
Decision / Written Decision Date: July 25, 2016

Allegations and Findings

- Engaged in sexual abuse of a patient - **not proved**
- Disgraceful, dishonourable, or unprofessional conduct - **not proved**

5. Dr. LMN

Name: Dr. LMN
Practice: Dermatology
Practice Location: Redacted
Hearing: Contested
Decision / Written Decision Date: July 26, 2016

Allegations and Findings

- Engaged in sexual abuse of a patient - **not proved**
- Disgraceful, dishonourable, or unprofessional conduct - **not proved**

6. Dr. OPQ

Name: Dr. OPQ
Practice: Family Medicine
Practice Location: Redacted
Hearing: Contested
Decision / Written Decision Date: July 29, 2016

Allegations and Findings

- Engaged in sexual abuse of a patient - **not proved**
- Disgraceful, dishonourable, or unprofessional conduct - **not proved**

7. Dr. P. M. Porter

Name: Dr. Paul Michael Porter
Practice: Psychiatry
Practice Location: St. Catharines
Hearing: Contested
Finding / Written Decision Date: February 11, 2016
Penalty / Written Decision Date: September 28, 2016

Allegations and Findings

- Engaged in sexual abuse of a patient - **proved**
- Disgraceful, dishonourable, or unprofessional conduct – **proved**

Summary

Patient A was a patient of Dr. Porter, a psychiatrist, from April 2008 until her last visit in April 2012. Dr. Porter's certificate of registration had been subject to certain limitations at that time, which included the following:

"Dr. Porter shall install in his office a video system which will, with the consent of each patient, tape each entire psychiatric session and which can be monitored by the office staff and preserved for inspection."

Patient A testified that Dr. Porter first hugged her about a year and a half after started seeing him, when she was dwelling on the death of her relative. She thought Dr. Porter felt bad for her because her relative had passed away and so he said "Here, let me give you a hug." After that, she said they would hug just before she left.

She testified that the hugs were frequent in 2011. At the end of a session she would stand up and move towards the window and he would hug her there. He said he was hugging her in that location because it was out of the camera's view.

At first the hugs ended when she said "I have to go" and then later on as the relationship developed, they would each say "I love you." The hugs which were captured on video were initiated by Dr. Porter by standing and holding his arms open, welcoming Patient A to the embrace. Dr. Porter would generally stand in an area or move to behind his chair where the video camera was unlikely to fully capture the hug. The hug was a full body hug with their torsos in contact. A rocking motion from side to

side was also observed. All the hugs took place in the privacy of Dr. Porter's office with the door closed in the context of a psychotherapy session.

It was clear to the Committee that the hugs that were observed went beyond purported therapeutic hugs. The Committee accepted that the hugs were tender and mutually satisfying, reflecting an enjoyable, romantic gesture. This, in the Committee's view, accords with the meaning of "sexual nature" in the legislation. These hugs were wrong especially in a psychotherapy context and in the Committee's view, constitute sexual abuse. The Committee found that Dr. Porter repeatedly hugged Patient A in a sexualized manner.

Patient A testified that she recalled three occasions when Dr. Porter kissed her. The first time occurred when they were standing by the window in his office, a second time when she was sitting on his lap and another when they were both in the secretary's office together. Dr. Porter denies any kissing took place.

The Committee carefully reviewed the evidence available and considered the credibility of both Patient A and Dr. Porter. The Committee found that Dr. Porter kissed Patient A, that he held her hand in the hallway of his office, and that she sat on his lap in his office on one or more occasions.

Patient A testified that Dr. Porter made sexual comments to her on numerous occasions. These include telling her he loved her; telling her that they would have a future together in two years; complimenting her on her appearance; saying that he would like to hold her hands on an airplane; and telling her that they would look funny making love together because of their bad backs. Dr. Porter denied that he made any of these remarks.

The Committee again rested its decision on its assessment of their respective credibility, and found that Dr. Porter made sexual remarks to Patient A just as she testified he did.

The Committee found that Dr. Porter has engaged in disgraceful, dishonourable or unprofessional conduct in sexually abusing Patient A as set out above. In addition, the Committee found that Dr. Porter also engaged in such conduct as set out below:

- Dr. Porter disclosed personal information inappropriately to Patient A when he told her details of his health, personal history, marriage and family;
- Dr. Porter disclosed sensitive and personal information inappropriately about his adopted son;
- Dr. Porter disclosed information about the mental health of another patient, Patient B, and the personal details of another patient, Patient C. In both cases this was inappropriate;
- Dr. Porter purposefully acted to undermine the safeguards put in place to protect patients by having Patient A move to an area of his office which could not be captured on video; and

- Dr. Porter failed to preserve all videos, as he was required to do under a prior College order.

For the above reasons, the Committee found that Dr. Porter engaged in conduct which would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar revoke Dr. Porter's certificate of registration effective immediately;
- Dr. Porter provide to the College an irrevocable letter of credit in the amount of \$16,060.00, or other security acceptable to the College, within thirty (30) days of the date this Order becomes final.
- Dr. Porter appear before this panel to be reprimanded and that the fact of the reprimand be recorded on the register;
- Dr. Porter pay costs to the College in the amount of \$36,200.00; and

Incompetence – 4 cases

1. Dr. R. J. Kamermans

Name:	Dr. Rob Joseph Kamermans
Practice:	General Practice
Practice Location:	Coe Hill
Hearing:	Contested
Finding / Written Decision Date:	November 7, 2014
Penalty / Written Decision Date:	July 26, 2016

Allegations and Findings

- Failed to maintain the standard of practice of the profession: **proved**
- Incompetence: **proved**

Summary

Dr. Kamermans failed to maintain the standard of practice of the profession in his care and treatment in the Emergency Department of six patients (Patients 1 to 6) and in his medical documentation regarding nine patients (Patients 1 to 6, 12, 14, and 22). Dr. Kamermans' deficiencies in his care and treatment of the six patients displayed a lack of knowledge and judgment of a nature and to an extent that the allegation of incompetence was proved.

Regarding Patient #1, a child who presented with fever, stomach ache, and vomiting, Dr. Kamermans failed to maintain the standard of practice in his documentation and care. Dr. Kamermans failed to do an ultrasound to rule out appendicitis, a significant differential diagnosis, and was deficient in his assessment and treatment of what he described as pharyngitis. Dr. Kamermans' deficiencies in his care of this patient displayed a lack of knowledge and judgment.

Regarding Patient #2, an adult patient with rectal bleeding, rectal pain, and a recent diagnosis of metastatic rectal cancer, Dr. Kamermans' documentation and care failed to meet the standard of practice. Dr. Kamermans failed to properly evaluate the rectal bleeding and failed to adequately manage the rectal pain. Dr. Kamermans displayed a lack of knowledge and judgment in his investigation and management of the patient and in his inability to outline his approach to this patient.

Regarding Patient #3, an elderly patient with chest tightness, intermittent shortness of breath for the preceding twelve hours, heart rate of 162 and an implanted pacemaker/defibrillator, Dr. Kamermans diagnosed supraventricular tachycardia (SVT), rather than the correct diagnosis of ventricular tachycardia (VT), and prescribed Diltiazem, a medication which was contraindicated for this patient. When his treatment failed and the patient's symptoms worsened, Dr. Kamermans called in a consultant who properly treated the patient. The Committee found that Dr. Kamermans' care and documentation for this patient failed to meet the standard of practice and that he displayed a lack of judgment and a cavalier attitude considering the urgency of the situation. The Committee found that Dr. Kamermans demonstrated a lack of knowledge and judgment that the evidence established persists to the present day.

Regarding Patient #4, a child with respiratory distress, shortness of breath, a slightly dusky appearance and moderate to severe croup, Dr. Kamermans' care of this patient failed to meet the standard of practice both in terms of documentation and treatment of this sick child. Dr. Kamermans used medication that was not helpful for croup and was not up to date with the current medication standards. The Committee found that Dr. Kamermans demonstrated a lack of knowledge and judgment with regard to the treatment of croup and that his knowledge deficits are current.

Regarding Patient #5, a child who was brought to Emergency with a history of possible antifreeze ingestion, Dr. Kamermans failed to maintain the standard of practice and was cavalier in the treatment of this patient. Dr. Kamermans appropriately obtained information from the Poison Control Centre but did not use it. He failed to order the recommended blood work, he failed to order an adequate observation period, and he assumed the child had not ingested much without any grounds to make that assumption, and he failed to appreciate the serious risk to the child of ingesting even a small amount. It was the Committee's view that Dr. Kamermans' knowledge and judgment deficiencies persist with respect to how to properly address the issue of the ingestion of antifreeze by a child.

Regarding Patient #6, an elderly patient with dementia who presented to the Emergency after an unwitnessed fall, Dr. Kamermans failed to maintain the standard of practice in his investigation, evaluation and documentation. The Committee found Dr. Kamermans' investigation of the causal factors rudimentary. Although he said his physical examination of the heart would rule out some cardiac causes, he did not do an ECG, which would have been indicated. Similarly, he did not do further x-rays or a CT scan of the neck, which was indicated by Canadian standards. The Committee found Dr. Kamermans' knowledge and judgment in the care of this patient deficient, and that those deficiencies are current.

Disposition

The Committee ordered and directed that:

- The Registrar revoke Dr. Kamermans' certificate of registration at 11:59 p.m. on the date of this Order.
- Dr. Kamermans appear before the Committee to be reprimanded within 3 months of the date that this Order becomes final.
- Dr. Kamermans pay costs to the College in the amount of \$28,098.00 within 6 months of the date that this Order becomes final.

Appeal

On August 24, 2016, Dr. Kamermans appealed the Discipline Committee's decision to the Divisional Court of the Ontario Superior Court of Justice.

2. Dr. J. D. Marcin

Name:	Dr. Judi Dianne Marcin
Practice:	General Practice
Practice Location:	Coe Hill
Hearing:	Agreed facts and Uncontested Facts; Joint Submission on Penalty; Contested Costs
Finding Decision Date:	March 30, 2016
Penalty / Written Decision Date:	July 28, 2016

Allegations and Findings

- Incompetence: **proved**
- Failed to maintain the standard of practice of the profession: **proved**
- Found guilty of an offence that is relevant to her suitability to practice: **proved**
- Disgraceful, dishonourable or unprofessional conduct: **proved**
- Engaged in conduct unbecoming a physician: **proved**
- Failed to maintain the standard of practice of the profession: **proved**

- Contravened a term, condition or limitation on a member's certificate of registration:
proved

Summary

On March 22, 2012, Dr. Marcin was convicted of defrauding the Ministry of Health and Long-Term Care of \$100,356.60 contrary to s. 380(1)(a) of the Criminal Code. Dr. Marcin received a suspended sentence and 18 months' probation. She was ordered to perform 100 hours of community service and to make \$100,356.60 in restitution.

In 2002, Patient A began seeing Dr. Marcin after he was referred to her by a counsellor at a residential treatment center where he had been receiving treatment for addiction. Dr. Marcin was Patient A's psychotherapist as well as his family doctor.

In approximately March 2010, Patient A told Dr. Marcin that he had developed romantic feelings for her. Dr. Marcin explained to him that his romantic feelings were not for her personally but for an ideal of someone like her.

Between April 2010 and June 2010, records demonstrate that 17 separate phone calls took place between Dr. Marcin and Patient A outside office hours while Dr. Marcin was still providing care to Patient A.

In the summer of 2010, Dr. Marcin told Patient A that she would be vacationing in an area in Ontario. Patient A concocted a story about his substance abuse sponsor heading to a retreat in the same area and explained that, if Dr. Marcin could give him a ride, Patient A would then be able to meet his sponsor at that retreat. Dr. Marcin agreed.

Once at Hotel Z, Patient A revealed to Dr. Marcin that he had invented the entire story to be alone with her in an attempt to initiate a romantic relationship.

Dr. Marcin expressed her disappointment with Patient A for misleading her, telling him that she was hurt that he had lied to her, and that she had to fire him as her patient. Nevertheless, Dr. Marcin allowed Patient A to sleep on her hotel room floor at Hotel Z for the duration of the multi-day vacation.

On the dates in August 2010 in which Dr. Marcin allowed Patient A to stay with her in her room at Hotel Z, several other vacant rooms were available at Hotel Z. There were also approximately 20 other hotels in the surrounding area.

On the drive home from Hotel Z in August 2010, Dr. Marcin told Patient A he should no longer see her as his doctor. However, Dr. Marcin continued to fill his prescriptions after this date.

Phone records demonstrate that Dr. Marcin and Patient A spoke on the phone and texted multiple times between August 2010 and February 2011.

In his letters, Patient A had indicated that he and Dr. Marcin could write emails while logged into the Gmail account but leave them in the draft folder as a way of communicating without actually having to send an email. Dr. Marcin accessed the shared Gmail account on or after May 18, 2010 and composed and/or read emails in the drafts folder of the account.

The College-retained information systems expert recovered 12 emails and email fragments written between October 2010 and January 2011 which had been deleted from Dr. Marcin's computer.

On December 18, 2012, the College received Dr. Marcin's original patient chart for Patient A, containing a letter from Dr. Marcin to Patient A bearing a date in November 2010 purporting to formally terminate her doctor-patient relationship with Patient A.

However, the information systems expert determined that the document entitled "letter of termination [Patient A] nov 2010.wps", bearing a date in November 2010, was in fact created by Dr. Marcin on December 5, 2012.

Among other billing and record-keeping issues, between 2009 and 2011, Dr. Marcin billed for OHIP 93 times for individual psychotherapy for Patient A for which there are no corresponding patient notes. This includes billing for services in August 2010 while she was with Patient A at Hotel Z.

Patient A told the College he did not receive psychotherapy on weekends. In 2010, Dr. Marcin billed OHIP 36 times for individual psychotherapy for Patient A on Saturdays.

On February 11, 2013, the Inquiries, Complaints and Reports Committee ("ICRC") imposed terms on Dr. Marcin's certificate of registration, ordering that she retain a Health Monitor. On October 21, 2013, the ICRC gave notice of its intention to vary that Order based on information that Dr. Marcin may be in breach of it.

On November 11, 2013, Dr. Marcin entered into an undertaking with the College, in which she agreed to cease to practice medicine in all jurisdictions. Prior to entering into this November 11 Undertaking, Dr. Marcin issued 8 patients multiple prescriptions for narcotics between November 1 and November 11, 2013.

The College expert found that Dr. Marcin's November 1 to 11, 2013 prescribing of Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines/Other Targeted Substances, and all other Monitored Drugs failed to maintain the standard of practice of the profession in seven of the charts she reviewed.

The assessor concluded that Dr. Marcin exposed all of the reviewed patients to harm or injury by prescribing high doses of opioid/benzodiazepines at times in combination with other medications.

The assessor concluded that Dr. Marcin showed a disregard for pharmacists who had expressed concern to Dr. Marcin regarding the risk of prescribing high doses opioids and/or benzodiazepines and in some patients a high dose of SSRI's in conjunction with these drugs, significantly increasing the risk of Serotonin Syndrome.

Dr. Marcin issued multiple prescriptions for narcotics for eight patients in the two weeks prior to signing an undertaking with the College in which she agreed to cease to practice medicine in all jurisdictions.

The College expert concluded that Dr. Marcin displayed a lack of knowledge, skill, and judgment, and she exposed all of the patients reviewed to harm or injury. Dr. Marcin exhibited a total disregard for well-accepted guidelines for routine addiction management. By issuing multiple prescriptions, Dr. Marcin increased the risk of overdose, abuse, and diversion of drugs.

The Committee found that Dr. Marcin contravened a term, condition, or limitation on her certificate of registration in respect of her March 26, 2014 undertaking involved prescribing narcotics and other monitored drugs when she was expressly prohibited from doing so.

The Committee also found that Dr. Marcin contravened a term, condition, or limitation on her certificate of registration in respect of her December 17, 2014 undertaking.

Dr. Marcin's breach of her December 17, 2014 undertaking involved a failure to fulfill the terms of a monitoring and rehabilitation plan. Dr. Marcin had not completed a CPD Plan and had not completed the Psychotherapy Certificate Program as she had undertaken to do. While the Committee believed that Dr. Marcin has made some effort to comply with the monitoring terms, it is clear from the totality of the record that she repeatedly failed to comply. The College monitor repeatedly reminded Dr. Marcin of the terms of her undertaking throughout the monitoring.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar revoke Dr. Marcin's certificate of registration effective immediately;
- Dr. Marcin appear before the panel to be reprimanded; and
- Dr. Marcin pay costs to the College in the amount of \$10,000.00 within thirty (30) days of the date this Order becomes final.

3. Dr. H. Y. C. Ng

Name:	Dr. Herman Yip-Chi Ng
Practice:	General Practice
Practice Location:	Toronto

Hearing: Agreed Facts and Uncontested Facts; Joint Submission on Penalty
Finding Decision Date: November 16, 2015
Penalty / Written Decision Date: March 16, 2016

Allegations and Findings

- Disgraceful, dishonourable, or unprofessional conduct: **proved**
- Failed to maintain the standard of practice of the profession: **proved**
- Incompetence: **proved**

Summary

Patient A was Dr. Ng's patient for approximately ten years. On February 13, 2015, the College received a Complaint Form from Patient A expressing concerns about how Dr. Ng conducted himself during an appointment on February 7, 2015. Patient A was also concerned that Dr. Ng failed to maintain adequate cleanliness in his office environment.

On February 27, 2015, the College conducted an unannounced inspection at Dr. Ng's clinic which revealed significant cleanliness concerns, including:

- the disposing of used non-safety engineered syringes in a dirty sink;
- no clear delineation between soiled and clean areas;
- improper cleansing and disinfecting of instruments; and
- a dirty and cluttered examination/utility/consultation room.

On April 15, 2015, Dr. Ng provided the College with what he purported to be Patient A's original patient chart.

The College investigator sent a letter to Dr. Ng on dated May 11, 2015 asking for Dr. Ng to confirm that he had not altered the chart in any way or made any changes to it, and that all entries were made on the dates shown on the chart.

Dr. Ng's counsel sent a letter to the College on May 13, 2015 stating that Dr. Ng had not altered the chart in any way, and that all entries had been made contemporaneously.

The College then retained a forensic document examiner to review Patient A's chart. The forensic report confirmed that parts of Dr. Ng's chart for Patient A had been substituted and backdated.

The College retained an expert, Dr. Z, to review Dr. Ng's care for Patient A, Dr. Ng's infection control procedures, and Dr. Ng's maintenance of equipment in his practice.

Dr. Z's review of Dr. Ng's care of Patient A was based on Dr. Ng's chart, which had been altered by Dr. Ng.

Dr. Z's comments on Dr. Ng's infection control procedures included the following:

"Dr. Ng did not meet the standard of practice of the profession as of March 12, 2015 with respect to infection control procedures and maintenance of equipment in his practice. [His] care in relation to infection control as of March 12, 2015 displayed a lack of knowledge, care and judgment in that he was unaware of and/or did not implement basic office infection control processes and procedures that are readily available to all Ontario physicians through Public Health Ontario. In my opinion, his deficit is severe as the breaches in infection control were numerous and place patients at risk. Dr. Ng's practice, behaviour, and conduct in relation to infection control as of March 12, 2015 exposed his patients to harm and was likely to expose his patients to injury. Significant risks resulting from his practice, behaviour and conduct include transmission of respiratory pathogens such as influenza, enteric pathogens such as C difficile and blood borne pathogens such as hepatitis B or C."

Dr. Ng wrote to the College on August 7, 2015 in response to the forensic document report as well as Dr. Z's report. Dr. Ng maintained in his response that he had not altered Patient A's chart, despite the forensic document report.

Based on Patient A's letter of complaint and the College's unannounced inspection of Dr. Ng's clinic on February 27, 2015, the Inquiries, Complaints and Reports Committee approved the appointment of investigators to conduct a broader investigation into Dr. Ng's practice under section 75(a) of the Health Professions Procedural Code on March 10, 2015.

On March 3, 2015, the College notified Toronto Public Health that Dr. Ng was using unacceptable infection prevention and control practices while providing patient care at his office.

On March 6, 2015, an inspection by Toronto Public Health concluded that Dr. Ng failed to use adequate infection prevention and control practices. On the same day, Toronto Public Health gave a verbal order under section 13 of the Health Protection and Promotion Act, requiring Dr. Ng to close his office until further notice.

On March 11, 2015, Toronto Public Health served a written order requiring Dr. Ng to make improvements to his office, including disposing sharps in an approved sharps container; ensuring the premises is clean and in good repair at all times; ensuring there is an area that has a sink for cleaning and disinfecting instruments; and ensuring that single-use items are discarded safely after use.

On March 23, 2015, Toronto Public Health re-inspected Dr. Ng's practice and concluded that he made the necessary corrective infection prevention and control measures and reopened the premises for patient care.

On July 2, 2015, the College conducted a re-inspection of Dr. Ng's office which revealed continuing infection control issues.

The College retained Dr. Z to review Dr. Ng's standard of care. Based on an office inspection, an observation of Dr. Ng's practice, an interview with Dr. Ng, and a review of 26 patient charts as well as a review of five patient charts whose care she observed on June 8, 2015, Dr. Z stated that:

- In 25 charts, Dr. Ng failed to properly maintain a CPP, medication record or immunization record.
- In 16 charts, Dr. Ng failed to meet the standard in assessing, documenting, investigating and managing patients with a thyroid nodule, microcytic anemia, low hemoglobin/ hematocrit, ulcer pain, infected heel wound, ongoing albuminuria, diabetes, toothache and not referring patients for dental care, using non-evidence based treatments for prostatitis, H-pylori titers, zoster infections, carpal tunnel syndrome, enuresis in a 2 year old child, in having performed a laryngoscopy on a patient, and not having used a growth chart and not following the Ontario immunization schedule.
- Dr. Ng failed to meet the standard of care in 5 out of 5 of the patients observed, including performing blood pressure assessment, assessing a patient's complaint of fatigue and back pain, following up on an abnormal HgA1C, assessing a patient's complaint of chest pain and shortness of breath, managing a patient's oral pain.
- Dr. Ng demonstrates a lack of knowledge/skill/judgment in the areas of pap screening, use of glucometer, use of otoscope, H pylori screening, ordering diagnostic testings such as mammography, pelvic ultrasound, thyroid ultrasound and abdominal ultrasound, office emergency procedures, periodic screening, management of diabetes, chest pain assessment, use of Rourke or developmental record and Ontario immunization schedule.
- In 15 out of 23 charts, Dr. Ng's practice is likely to expose his patients to harm/injury.
- In 5 out of 5 patients observed, Dr. Ng's practice may expose his patients to harm/injury.

With respect to Dr. Ng's Infection Control Practice, Dr. Z opined as follows:

- Dr. Ng carried out improper reprocessing multi-use equipment and displayed a lack of knowledge of proper reprocessing process.
- Once hygiene product was available in his office after the Toronto Public Health investigation, he did not utilize it once during the patient observations on June 8, 2015; he did not manage sharps appropriately; he did not document hepatitis B status properly; he did not manage multi-dose vials properly; he did not have controls for refrigerated items; he did not understand or carry out syndromic surveillance.
- "Dr. Ng's clinical practice created a definite risk of harm for patients who attended his office prior to February 27, 2015. The risk was one of transmission of respiratory, enteric and bloodborne pathogens, and transmission of multi-drug resistant organisms such as methicillin-resistant *Staphylococcus aureus*

(MRSA).The nature of the harm ranged from possible acute infection to colonization with a risk of future infection. Depending on the pathogen, infection could have caused significant morbidity and even mortality. It is not possible to quantitate the probability of the harm...any patient may have been exposed to harm.”

On February 22, 2016, Dr. Ng resigned from the College and has agreed never to apply or reapply for registration as a physician in Ontario or any other jurisdiction.

Disposition

In light of the undertaking to resign and never to reapply, the Discipline Committee ordered and directed that:

- Dr. Ng appear before the panel to be reprimanded.
- Dr. Ng pay costs to the College in the amount of \$4,460.00 within 30 days of the date of this Order.

4. Dr. RST

Name: Dr. RST
Practice: Cardiology
Practice Location: Redacted
Hearing: Contested
Decision / Written Decision Date: October 25, 2016

Allegations and Findings

- Incompetence – **not proved**
- Failure to maintain standards of practice of the profession – **not proved**
- Disgraceful, dishonourable, or unprofessional conduct – **not proved**

Failure to maintain standards – 4 cases

1. Dr. J. H. Dubins

Name: Dr. Jacques Henri Dubins
Practice: Family Medicine
Practice Location: Toronto
Hearing: Agreed Facts and Joint Submission on Penalty
Decision Date: August 29, 2016
Written Decision Date: September 29, 2016

Allegation and Finding

- Failure to maintain standards of practice of the profession – **proved**
- Disgraceful, dishonourable, or unprofessional conduct – **proved**

Summary

Dr. Dubins, a 72-year-old family physician with an interest in hypnotherapy, has had an independent practice in Toronto.

In March of 2013, the College received a complaint about Dr. Dubins from Patient A, a patient who had attended Dr. Dubins twice in early 2013 for hypnotherapy for smoking cessation.

Patient A complained that:

- Dr. Dubins' office was dirty;
- During the appointment, Dr. Dubins asked unnecessary and inappropriate questions of a sexual nature that made him feel uncomfortable, such as whether he is gay or straight and whether he is sexually active;
- During the hypnotherapy session Dr. Dubins used graphic and offensive sexual images that caused Patient A to be very uncomfortable; and
- During the session, Dr. Dubins told Patient A to unbutton his pants, lower his fly and lower his pants.

On March 18, 2013, College investigators attended at Dr. Dubins' office to inspect for cleanliness, where they found the following:

- Garbage cans in examination rooms and common areas were filled with garbage;
- The radiator in the examination room was peeling paint and the paint chips were lying on the floor around it;
- Dr. Dubins' office was cluttered with numerous items including soft drink bottles covered in dust;
- Blinds in the examination room were stained and dusty; paint on the walls was peeling; and
- A plant pot at the front door was filled with dirt and garbage; there was no plant.

In response, Dr. Dubins explained that he used "Aversive Imagery" techniques in his hypnotherapy practice, and that patients (including Patient A) are informed of and consent to the use of these techniques. He explained that the purpose is to develop strong negative associations with the behaviour that the patient seeks to stop (such as smoking). For example, he stated, when he asked Patient A to imagine a cigarette in "fishy-smelling vaginal discharge", his intention was to create a negative association with the taste and smell of cigarettes to assist Patient A in quitting smoking. He also said he asked Patient A to undo his belt and pants button and lower his fly

approximately one inch in order to make him more comfortable. He stated that he has improved the cleanliness of his office.

The expert retained by the College concluded that although the vast majority of Dr. Dubins' care of Patient A met the standard, he demonstrated a lack of judgment in some areas:

"The vast majority of the aspects of care provided by Dr. Dubins, as far as I am able to discern, and based on the information I have, do meet the threshold of standard of clinical practice. However, the reliance upon sexually themed aversive imagery (extrapolated from questions related to sexual orientation/identity) for simple and discrete chemical-addiction hypnosis is in my opinion excessive, not specifically required for positive clinical effect and in a minority of cases could render the treatment modality ineffective or even be potentially harmful (i.e., triggering past traumatic memories/emotions)...Likewise, comments (particularly during session) related to having a patient unbutton or otherwise loosen their pants may – even if solely intended for the purposes of increasing patient comfort – cause anxiety and/or unease in a subset of patients...[These] aspects of care ... reflect a lack of judgment on the practitioner's part as opposed to a lack of skill or knowledge."

In January 1995, the Complaints Committee cautioned Dr. Dubins in person in relation to a complaint by a patient who complained that Dr. Dubins made inappropriate comments and used inappropriate and unnecessarily intimate images in his smoking cessation therapy. The Committee stated that it was "very concerned" about the use of extremely graphic and sexual images during the smoking cessation therapy. It said that his approach in his care of this patient was "inappropriate". It also expressed concern that the patient had not been advised in advance that sexual material and extremely graphic images would be used during the therapy. He was cautioned by the Committee regarding the nature of his treatment of the patient and his failure to provide her with an adequate explanation prior to proceeding with the treatment.

On August 29, 2016, Dr. Dubins executed an undertaking with the College to resign and never re-apply to practise medicine in Ontario or any other jurisdiction, effective August 29, 2016.

Disposition

In light of the undertaking to resign and not reapply, the Discipline Committee ordered and directed that:

- Dr. Dubins appear before the panel to be reprimanded; and
- Dr. Dubins pay to the College costs in the amount of \$5,000.00 within 30 days of the date of this Order.

2. Dr. A. A. A. Mansour

Name: Dr. Ali Ali Abdulla Mansour
Practice: General Practice
Practice Location: Toronto
Hearing: Agreed Facts and Joint Submission on Penalty
Decision Date: July 27, 2016
Written Decision Date: September 23, 2016

Allegation and Finding

- Failure to maintain standards of practice of the profession – **proved**
- Disgraceful, dishonourable, or unprofessional conduct – **proved**
- Incompetence – **withdrawn**

Summary

Dr. Mansour, a family physician, practised at the Parliament Walk-In Clinic located at 1 Oak Street in downtown Toronto, Ontario (the “Clinic”).

On July 30, 2013, the College received an anonymous call from a physician who indicated she had concerns with Dr. Mansour’s use of a PA, namely, that a PA was seeing and treating patients without proper supervision, while Dr. Mansour was not in the clinic and was in fact on vacation. The College launched a section 75(1)(a) investigation into Dr. Mansour’s practice in August 2013 after receiving this information.

On August 14, 2013, representatives of the College attended unannounced at the Clinic and spoke with the receptionist, the PA, and the Clinic Manager. Dr. Mansour was not present.

The receptionist said Dr. Mansour was away for a month and that Dr. Mansour’s PA was seeing patients with no physician on the premises. The PA initially denied any knowledge of Dr. Mansour being out of the country on vacation, saying she understood Dr. Mansour was not in the clinic that day because he was home sick.

Once the PA was told that the College understood Dr. Mansour was away, the PA said Dr. Mansour was in Libya and had been gone for a month. The PA also said that she was working on her regularly scheduled days in Dr. Mansour’s absence, and did not work under the supervision of any other physician. She worked only under the supervision of Dr. Mansour. She stated that she communicated electronically with Dr. Mansour about any difficult cases. The PA confirmed Dr. Mansour had remote access to the patient records and could look at them (with the exception of lab results) and discuss the plan with her. If she was ordering medication, she would enter the medications into the electronic record and print it out, then use a stamp of Dr. Mansour’s. She would not prescribe narcotics or controlled drugs. Some of the patients she would see were walk-in patients and did not have an established physician-patient relationship with Dr. Mansour.

Around August 14, 2013, Dr. Mansour spoke on the telephone with a College representative and said that he was sick and therefore had been unable to go to work that day. Dr. Mansour states that this telephone conversation took place after Dr. Mansour spoke with the Clinic Manager, during which the Clinic Manager advised Dr. Mansour he ought not to have let the PA see patients in his absence, among other things. Dr. Mansour states that he panicked and told the College representative he was not at the Clinic because he was sick. In actuality, Dr. Mansour was out of the country at that time.

On March 26, 2014, the College requested various documents and information pertaining to when Dr. Mansour was on vacation/out of the country, where he was during that period, and copies of any supporting documentation, as well as dates when the PA worked at the clinic and information about what Dr. Mansour billed OHIP during that period from Dr. Mansour's counsel.

Dr. Mansour advised the College he was checking his records regarding where he was in July and August of 2013, and whether bills were submitted to OHIP during this time period, and would write again once this information had been compiled.

On May 13, 2014, Dr. Mansour told the College he had not found any records documenting where he was in July and August of 2013, and that his recollection was that he was in Libya from July 3 to 8, 2013, and in Turkey from August 9 to 15 or 16, 2013. He told the College that his PA worked at the clinic for 3 days in July and 4 days in August while he was away. Dr. Mansour further advised he was in Turkey when he spoke with the College representative on August 14, 2013, that he had "panicked and spoke without thinking first" and that he "is very anxious about this issue and until now has not known how to make things right."

Dr. Mansour also told the College that he billed OHIP when he was out of the country and his PA was seeing patients, should not have done so, and was conducting a self-audit of these amounts in order to repay OHIP.

On May 23, 2014, the College wrote to Dr. Mansour's counsel requesting clarification about where Dr. Mansour was between July 9 and August 8, 2013. On June 3, 2014, Dr. Mansour's counsel told the College that Dr. Mansour was in Ontario between July 9 and August 8, 2013 and was in Toronto on any day on which he was scheduled to work during that time period.

The College then asked Dr. Mansour to attend at the College with his passport and any other supporting documents to verify he was in Ontario between July 9 and August 8, 2013. The College sent a further letter dated July 24, 2014, requesting confirmation of a date upon which Dr. Mansour could attend the College, and a further request on August 7, 2014.

Dr. Mansour's counsel wrote to the College on August 7, 2014, saying that Dr. Mansour was in Libya and his return to Canada had been delayed. Counsel advised Dr. Mansour would not be in a position to provide the requested documents until his return, which

was expected on August 10, 2014. Counsel further advised dates upon which Dr. Mansour was available to attend at the CPSO for an interview by the Medical Inspector.

Dr. Mansour's counsel told the College in an August 14, 2014 letter that Dr. Mansour had had to surrender his Libyan passport (which he used for his trip in July/August 2013) when he changed to a Canadian passport. Counsel also provided the billing and medication records requested by the College.

Dr. Mansour's counsel told the College in a September 22, 2014 letter that the information previously provided to the College by Dr. Mansour was incorrect in the following ways: i) Dr. Mansour had not surrendered his Libyan passport; and ii) Dr. Mansour was in Libya and Turkey continuously between July 5 and August 15, 2013, returning to Canada on August 16, 2013. He was not in Ontario between July 9 and August 8, 2013 as previously advised. Enclosed with the letter was a copy of Dr. Mansour's Libyan passport used in 2013. Dr. Mansour apologized through his counsel for having provided inaccurate information in the past and indicated that, having now shared the information about his whereabouts, he was eager to fully cooperate with the College's investigation.

The College interviewed the PA, who confirmed she saw patients at the Clinic without Dr. Mansour being present, at his request. The PA advised she initially worked under verbal orders from Dr. Mansour, and that she created Medical Directives later, and sent them to the Clinic for its use. Dr. Mansour confirms this is true.

The PA had graduated from a PA program at McMaster University in 2012, and started working with Dr. Mansour, in about May, 2013. Dr. Mansour spent a couple of weeks seeing patients with her, assessing her skills, and discussing cases and patient management with her in breaks between seeing patients.

The PA told the College that Dr. Mansour personally asked her to see patients when he was not there.

When Dr. Mansour was away in July and August 2013, he directed the PA to contact him if she needed him. The PA told the College that at no time did Dr. Mansour discourage the PA from contacting him to discuss patient care and that she was usually able to reach him.

After a self-audit, Dr. Mansour repaid \$16,734.32 to the Ministry of Health and Long-Term Care in respect of billings made in relation to patient visits in the months of July and August 2013, where the patients were seen by the PA but not by Dr. Mansour.

A College-retained expert opined that Dr. Mansour failed to meet the standards of practice in the following respects:

His use of a PA fell below the standard of care in respect of 19 patients, primarily with respect to supervision and delegation. The criteria for delegation were met in only one chart. These deficiencies could expose his patients to harm.

His medical documentation fell below the standard of care in respect of 15 to 17 patients. In some cases, there were notes which appeared to be copied and pasted in patient charts.

The care provided demonstrated concerns about his knowledge and judgment in almost all charts reviewed. In various files, this related to one or more of timely or appropriate follow-up of abnormal test results, lack of knowledge of current guidelines, and over-extensive investigations without apparent clinical reasoning documented or explained.

Dr. Mansour responded to the expert's report and said that he had not used a PA in his practice since these issues arose in August 2013. Dr. Mansour told the College that he has since completed the U of T medical record keeping course and had become more comfortable with the Clinic's EMR system. He told the College that, in response to Dr. Walker's concerns about his knowledge of various guidelines, Dr. Mansour reviewed five CPSO policies, as well as a number of clinical guidelines. Dr. Mansour also told the College had registered to take a course on diabetes management and a review course in internal medicine and had performed a self-audit and repaid to OHIP the amounts he billed during the times he was not present at the Clinic. Dr. Mansour completed the Medical Record Keeping course at the University of Toronto in November 2014.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Mansour's certificate of registration for a period of nine (9) months commencing immediately.
- The Registrar to place the following terms, conditions and limitations, effective immediately, on Dr. Mansour's certificate of registration:
 - Restriction
 - Dr. Mansour shall not delegate any acts or any care of any patients to any unregulated health professional.
 - Education
 - Dr. Mansour shall, at his own expense, participate in and successfully complete the following educational courses:
 - Ontario College of Family Physicians course entitled "Practising Wisely" within six months from the date of this order; and
 - Individualized instruction in ethics approved by the College at the instructor's earliest availability. Dr. Mansour will provide proof of successful completion within three (3) weeks of completing the instruction. The instruction will involve one-on-one sessions with a College-approved instructor, incorporating principles of guided reflection, tailored feedback, and other modalities customized to the specific needs of Dr. Mansour as assessed by the instructor. The instructor will report to the College regarding Dr. Mansour's progress and compliance.
 - Clinical Supervision & Re-Assessment

- Dr. Mansour shall retain a clinical supervisor, approved by the College, who will sign an undertaking in the form attached hereto as Appendix “A” (the “Supervisor”) no later than 30 days prior to Dr. Mansour’s return to practice after the suspension referred to in paragraph 4 above. Dr. Mansour shall practice under the guidance of the Supervisor for a period of six (6) months. Dr. Mansour shall meet with the Supervisor monthly to discuss any concerns related to patient care.
- Within six (6) months after the completion of the Clinical Supervision, Dr. Mansour will submit to a reassessment of his practice (the “Reassessment”) by an assessor or assessors selected by the College (the “Assessor(s)”). The Reassessment may include a chart review, direct observation of Dr. Mansour’s care, interviews with colleagues and co-workers, feedback from patients and any other tools deemed necessary by the College. The Reassessment shall be at Dr. Mansour’s expense and he shall co-operate with all elements of the Reassessment. Dr. Mansour shall abide by all recommendations made by the Assessor(s) subject to paragraph (e) below, and the results of the Reassessment will be reported to the College and may form the basis of further action by the College.
- If Dr. Mansour is of the view that any of the Assessor(s)’s recommendations are unreasonable, he will have fifteen (15) days following his receipt of the recommendations within which to provide the College with his submissions in this regard. The Inquiries Complaints and Reports (“ICR”) Committee will consider those submissions and make a determination regarding whether the recommendations are reasonable, and that decision will be provided to Dr. Mansour. Following that decision Dr. Mansour will abide by those recommendations of the Assessor(s) that the ICR Committee has determined are reasonable.
- Other
 - Dr. Mansour shall submit to, and not interfere with, unannounced inspections of his practice location(s) and to any other activity the College deems necessary in order to monitor his compliance with the provisions of this Order.
 - Dr. Mansour shall comply with the College Policy on Practice Management Considerations for Physicians Who Cease to Practise, Take an Extended Leave of Absence or Close Their Practice Due to Relocation in respect of his period of suspension, a copy of which forms Appendix “B” to this Order.
 - Dr. Mansour shall inform the College of each and every location where he practices, in any jurisdiction (his “Practice Location(s)”) within fifteen (15) days of this Order, and shall inform the College of any and all new Practice Locations within fifteen (15) days of commencing practice at that location, until the report of the assessment of his practice have been reported to the College.

- Dr. Mansour shall consent to the College making appropriate enquiries of the Ontario Health Insurance Plan and/or any person who or institution that may have relevant information, in order for the College to monitor his compliance with this Order.
- Dr. Mansour shall be responsible for any and all costs associated with implementing the terms of this Order.
- Dr. Mansour appear before the panel to be reprimanded.
- Dr. Mansour pay to the College costs in the amount of \$5,000.00, within 30 days of the date of this Order.

3. Dr. P. F. Straka

Name: Dr. Pavel Frantisek Straka
Practice: Anesthesiology
Practice Location: Toronto
Hearing: Agreed Facts and Joint Submission on Penalty
Decision Date: June 2, 2016
Written Decision Date: June 29, 2016

Allegation and Finding

- Incompetence – **withdrawn**
- Failure to maintain standards of practice of the profession – **proved**
- Disgraceful, dishonourable, or unprofessional conduct – **withdrawn**

Summary

Dr. Straka is an anesthesiologist who received his certificate of independent practice in 1982. In February 2015, pursuant to an undertaking from Dr. Straka to the College, the College received an assessment report outlining concerns regarding deficiencies in Dr. Straka's practice.

Dr. Straka provided the College with a report from an anesthesiologist after allegations were referred to discipline. The defence expert disagreed with the College assessor about some aspects of the care Dr. Straka provided but agreed there were deficiencies in Dr. Straka's practice, including significant deficiencies in documentation and certain concerns regarding judgment and knowledge.

Dr. Straka failed to maintain the standard of practice of the profession of anesthesiology in a hospital setting by:

- failing to document an appropriate pre-anesthetic assessment or to adequately document intraoperatively in his care of multiple patients;
- failing to document discussion of the risks and benefits of invasive procedures with multiple patients and not having any discussion with a patient regarding a transversus abdominis plane (TAPP) block which he later administered;

- when administering general anesthesia, inappropriately using 100 percent oxygen during the maintenance phase as a matter of routine in every case;
- failing to organize and prioritize medical issues in two complex patients undergoing emergency surgery; administering an inappropriately small dose of analgesic to a patient undergoing gynecological surgery, as indicated by the patient's respiratory rate and end tidal carbon dioxide; and although Dr. Straka ultimately successfully intubated a patient after several attempts due to the patient's difficult airway, there were concerns regarding Dr. Straka's level of situational awareness. The patient experienced a marked hypertensive response as a result of an inadequate level of anesthesia for the multiple attempts at intubation, and Dr. Straka did not document the difficult airway, including the number of attempts.

Several recommendations were made in the February 2015 report, including that Dr. Straka practise under high level supervision with respect to critically ill patients, that the supervisor be immediately available when conducting airway management, that he engage a clinical preceptor for other aspects of his hospital practice, and that he take educational courses.

Dr. Straka practised under supervision pending the hearing as a result of an interim order in this proceeding. Since January 2016, the supervisor has reviewed and approved of all pre-operative assessments and treatment plans in advance of Dr. Straka providing general anesthesia, and has observed intubation in each case. The reports by Dr. Straka's clinical supervisor have been positive.

In April 2016, an expert retained by Dr. Straka found that Dr. Straka's documentation had improved significantly, that his preoperative assessments were complete, and that there were no issues with Dr. Straka's performing of technical tasks under observation. When observed by this expert, Dr. Straka discussed the risks and benefits of blocks with patients. However, the expert identified that Dr. Straka appeared to have some gaps in his knowledge, that his practice of doing regional anesthesia without monitoring was potentially unsafe, that his reaction to stress could lead to poor judgment, and that his management of complicated cases was an area for improvement. The expert recommended that Dr. Straka not do on-call coverage in anesthesia until completion of education and a reassessment, and that he continue to be subject to clinical supervision with pre-operative review of his plans for higher risk patients and the supervisor's presence at intubation if necessary. The expert stated that the "gaps in [Dr. Straka's] practice are remedial."

Disposition

The Discipline Committee ordered and directed that:

- The Registrar impose the following terms, conditions and limitations on Dr. Straka's certificate of registration:
 - Subject to paragraphs 3(ii)(f) and 3(vi) below, Dr. Straka shall not perform anesthesia in a hospital setting on an on-call basis;

- Dr. Straka retain a College-approved clinical supervisor or supervisors (the “Clinical Supervisor”) with respect to his hospital-based anesthesia practice, who will sign an undertaking in the form attached hereto as Schedule “A.” For a period of at least six (6) months commencing on the date this Order is made, Dr. Straka may practise hospital-based anesthesia only under the supervision of the Clinical Supervisor and will abide by all recommendations of his Clinical Supervisor with respect to his practice, including but not limited to practice improvements, practice management, and continuing education. Clinical supervision of Dr. Straka’s practice may end after a minimum of six (6) months, upon the recommendation of the Clinical Supervisor and, in its discretion, approval by the College. Clinical supervision of Dr. Straka’s hospital-based anesthesia practice shall contain the following elements:
 - Dr. Straka shall facilitate review by the Clinical Supervisor of twenty (20) patient charts per month or, should Dr. Straka treat fewer than twenty (20) hospital patients in any month, the charts of all patients treated in that month;
 - Dr. Straka shall have an initial meeting with his Clinical Supervisor regarding the process for obtaining and documenting patient consent, at which they will develop a plan regarding the same, and thereafter the Clinical Supervisor’s consideration of Dr. Straka’s consent process and documentation of the same shall form part of the monthly chart review described at paragraph 3(ii)(a) above;
 - Dr. Straka shall pre-operatively review with the Clinical Supervisor his plan for management of any patient who is a Class ASA 3 or higher anesthetic risk, as well as his plan for management of any patient with a known history of difficult intubation or whom Dr. Straka anticipates may have a difficult airway. During such review, Dr. Straka shall with his Clinical Supervisor identify when and how he will call for help during the procedure if required;
 - The Clinical Supervisor may be present for intubation of any patient, if deemed necessary or desirable by the Clinical Supervisor;
 - Dr. Straka shall have an initial meeting with his Clinical Supervisor regarding Dr. Straka’s practice with respect to nerve blocks, and thereafter consideration of Dr. Straka’s practice with respect to nerve blocks shall form part of the monthly chart review described at paragraph 3(ii)(a) above, and if deemed necessary or desirable by the Clinical Supervisor Dr. Straka shall also engage in pre-planning with his Clinical Supervisor regarding particular cases and permit the Clinical Supervisor to directly observe his practice regarding nerve blocks;
 - After four (4) months of Clinical Supervision, if agreed to by the Clinical Supervisor (which agreement may be withdrawn at any time), Dr. Straka may perform anesthesia on an on-call basis for the remainder of the period of Clinical Supervision under Clinical Supervision consisting of the following:
 - At least one (1) month during which the Clinical Supervisor shall directly observe Dr. Straka’s pre-anesthetic assessment, induction and emergence, and the Clinical Supervisor shall be immediately available during the remainder of the procedure in order to assist or consult with Dr. Straka if necessary or desirable;

- Followed by, if the Clinical Supervisor is of the view that Dr. Straka is ready, at least one (1) further month during which Dr. Straka shall review the case with his Clinical Supervisor before its commencement and debrief the procedure with his Clinical Supervisor following its completion, with the Clinical Supervisor to observe the procedure if he or she deems it necessary or desirable to do so and in any case to be readily available to assist Dr. Straka if needed throughout the procedure.
- Dr. Straka shall successfully complete and provide proof thereof to the College within six (6) months of the date of the Order:
 - Simulator-based education in anesthesia acceptable to the College;
 - Education in regional anesthesia acceptable to the College;
 - Education in difficult airway management acceptable to the College;
 - An evaluation of his practice knowledge acceptable to the College, to result in development and submission to the College of an individualized education plan within ninety (90) days of the date of the Order identifying any further education and remediation to be completed by Dr. Straka in response to any deficiencies in his knowledge identified by the evaluation, with Dr. Straka to complete such education and remediation within six (6) months of the date of the Order.
- During the period of Clinical Supervision, Dr. Straka shall ensure prior to performing intubation that another anesthesiologist is present on the premises and available to assist him if necessary.
- If Dr. Straka fails to retain a Clinical Supervisor as required above or if, prior to completion of Clinical Supervision, the Clinical Supervisor is unable or unwilling to continue in that role for any reason, Dr. Straka shall retain a new College-approved Clinical Supervisor who will sign an undertaking in the form attached hereto as Schedule “A,” and shall cease to practise hospital-based anesthesia until the same has been delivered to the College.
- Approximately four (4) months after the completion of Clinical Supervision, Dr. Straka shall undergo a reassessment of his hospital-based anesthesia practice by a College-appointed assessor (the “Assessor”). The assessment may include a review of Dr. Straka’s patient charts, direct observations, interviews with staff and/or patients, and a formalized evaluation of Dr. Straka’s knowledge base. The results of the assessment shall be reported to the College after which, should it be recommended by the Assessor, the College may in its discretion permit Dr. Straka to practice without restriction.
- Dr. Straka shall consent to sharing of information among the Assessor, the Clinical Supervisor, the College, and any education providers under paragraph 3(iii) above as any of them deem necessary or desirable in order to fulfill their respective obligations.
- Dr. Straka shall consent to the College providing any Chief(s) of Staff or a colleague with similar responsibilities at any hospital where he practices or has privileges (“Chief(s) of Staff”) with any information the College has that led to this Order and/or any information arising from the monitoring of his compliance with this Order.

- Dr. Straka shall inform the College of each and every location where he practices, in any jurisdiction (his “Practice Location(s)”) within fifteen (15) days of this Order and shall inform the College of any and all new Practice Locations within fifteen (15) days of commencing practice at that location.
- Dr. Straka shall cooperate with unannounced inspections of his hospital-based anesthesia practice and patient charts by a College representative(s) for the purpose of monitoring and enforcing his compliance with the terms of this Order.
- Dr. Straka shall consent to the College making appropriate enquiries of the Ontario Health Insurance Plan and/or any person who or institution that may have relevant information, in order for the College to monitor and enforce his compliance with the terms of this Order.
- Dr. Straka shall be responsible for any and all costs associated with implementing the terms of this Order;
- Dr. Straka pay to the College costs in the amount of \$10,000.00, within thirty days of the date of this Order.

4. Dr. A. M. Wojcicka

Name: Dr. Anna Maria Wojcicka
Practice: Radiation oncology and internal medicine
Practice Location: Newmarket
Hearing: Agreed Facts and Joint Submission on Penalty
Decision Date: February 17, 2016
Written Decision Date: June 9, 2016

Allegation and Finding

- Incompetence – **withdrawn**
- Failure to maintain standards of practice of the profession – **proved**

Summary

Dr. Wojcicka is a radiation oncology and internal medicine specialist who currently provides radiation oncology consultation services and practices general medicine in an office located at 6165 Vivian Road, Mount Albert, Ontario. She also provides complex medical rehabilitation care at Southlake Regional Health Centre in Newmarket, Ontario.

The College initiated an investigation into Dr. Wojcicka’s Bioidentical Hormone Replacement Therapy (BHRT) practice in 2012 after the College received information about membership fees and services relating to the Vivian Medical Spa, also located at 6165 Vivian Road, Mount Albert, Ontario.

The College retained an expert, Dr. Z, to provide an opinion on the care of 22 patients who were receiving BHRT from Dr. Wojcicka at 6165 Vivian Road. On the basis of her chart reviews and an interview, Dr. Z concluded that Dr. Wojcicka’s care did not meet

the standard of practice of the profession in all 22 cases in that she failed to meet some component of the College's Policy on Complementary and Alternative Medicine for each patient.

In 14 of the 22 cases, Dr. Z also found that Dr. Wojcicka's care demonstrated a lack of knowledge, skill and judgment and that her practice posed a risk of harm to patients.

Dr. Z's concerns with respect to Dr. Wojcicka's BHRT practice included:

- 17 cases of prescription BHRT administered without performing a pelvic exam;
- 3 cases where BHRT was prescribed and no physical exam was documented in the chart;
- 4 cases of pelvic ultrasound being performed without reasonable cause;
- 15 charts where a conventional diagnosis is not listed;
- 17 charts where salivary or blood hormone levels are used to guide treatment;
- 1 chart in which there is no documented discussion or consent surrounding administration of BHRT;
- 1 chart in which a woman who has had a total hysterectomy received a Pap test;
- 3 charts in which BHRT is prescribed to a smoker over 40; 1 in a patient with history of migraine; 1 with undiagnosed vaginal bleeding;
- 1 chart in which a patient's method of contraception is discontinued without proper counselling; and
- 1 chart in which a patient's diastolic blood pressure is read as over 100 and they are not directed to urgent care.

In response to Dr. Z's report, Dr. Wojcicka provided her own rebuttal defending her care of the patients reviewed. Dr. Wojcicka also retained Dr. Y to provide an opinion with respect to her BHRT practice.

Dr. Y reviewed the same 22 patient charts that were reviewed by Dr. Z and provided a report, dated July 8, 2015. The concerns noted in Dr. Y's report included:

- Dr. Wojcicka seemed reluctant in some cases to do pelvic examinations and PAP smears. She also does not undertake endometrial biopsies and so this would necessitate referring to a Gynaecologist.
- She relies heavily on saliva levels and it is not generally agreed that this is accurate testing. Dr. Y expressed concern in this regard, particularly looking at progesterone levels in saliva when they do not appear to be the same in blood or tissue levels.
- The literature suggesting that compounded therapy using such things as BiEst and progesterone cream is not strong. There is great literature from Europe showing that transdermal estrogen such as Estrogel and oral progesterone such as Prometrium do have many of the benefits that Dr. Wojcicka is attributing to the compounded medications and Dr. Y did not think that is true.
- Dr. Wojcicka does not appear to be letting patients know that so-called BHRT is available in the form of Estrogel and Prometrium. These are often covered by

Drug Plans, whereas compounded therapy often is not and in addition, there are traditional physicians who do offer this type of BHRT.

- Dr. Wojcicka does a lot of redundant testing in her practice. She does salivary levels which cost the patient money and then she does blood levels. Dr. Y was not sure why she is doing blood levels if she is doing salivary levels,. In addition, there is often an abdominal ultrasound as well as a pelvic ultrasound and in many cases, this is not necessary.
- Dr. Y saw no clear delineation of who is responsible for various conditions in patients. Dr. Y reported that Dr. Wojcicka says that she is doing BHRT, but then she is looking into other things that family doctors would look at such as liver problems, cholesterol testing and a lot of other blood work that she is doing, Dr. Y felt this should be left to the Family Doctor who is doing this anyway. It seems that there is a real potential here for double doctoring on some conditions.
- Dr. Y reported that physical examination in women, particularly pelvic examination is a staple in looking after women with vaginal symptoms and in menopause and so he does not think this should be avoided by Dr. Wojcicka. Dr. Y also agreed with Dr. Z's statement that the first thing to be done is not an ultrasound, but physical examination. Dr. Y also agreed with Dr. Z's statement that there are good clinical trials showing the use of BiEst and TriEst for hormone replacement therapy. Studies using Estrogel and oral progesterone are readily available. Studies using transdermal progesterone are few and far between and this is not equivalent to choosing oral progesterone.

Despite his concerns, Dr. Y concluded that he did not see that Dr. Wojcicka's patients had undergone any harm.

Dr. Z reviewed Dr. Y's report and agreed with many of the issues raised by Dr. Y. Dr. Z's opinion, contained in her report and addendum, did not change.

On February 2, 2015, after referring allegations of professional misconduct to the Discipline Committee, the Inquiries Complaints and Reports Committee directed the Registrar to impose terms, conditions and limitations on Dr. Wojcicka's certificate of registration pursuant to s. 37 of the Health Professions Procedural Code. The Order required that Dr. Wojcicka cease to provide care with regards to BHRT to patients.

Dr. Wojcicka admitted to the allegations and agreed that the conduct described above constitutes professional misconduct, and that she has failed to maintain the standard of practice of the profession.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Wojcicka's certificate of registration for one month, commencing on February 29, 2016;
- The Registrar impose terms, conditions and limitations on her certificate of registration, including:
 - Dr. Wojcicka is prohibited from practicing CAM;

- Dr. Wojcicka is prohibited from consulting and/or treating patients with respect to BHRT;
 - Dr. Wojcicka shall refer to a gynecologist any female patient requesting or requiring hormonal or menopausal care or treatment;
 - Dr. Wojcicka shall post a sign in the waiting room and the examination rooms at every location wherever she provides primary care that reflects the three restrictions listed above; and
 - Dr. Wojcicka shall submit to an assessment of her office practice within three to six months of the date of the Order.
- Dr. Wojcicka be reprimanded; and
 - Dr. Wojcicka pay costs to the College in the amount of \$5,000.00 within thirty days.

Guilty of offence – 1 case

1. Dr. D. R. Marshall

Name: Dr. Daniel Robert Marshall
Practice: Pediatrics
Practice Location: Hamilton
Hearing: Uncontested Facts; Sexual Impropriety Allegation
Contested; Penalty Contested
Finding Decision: March 28, 2016
Penalty / Written Decision: September 16, 2016

Allegation and Finding

- Engaged in sexual impropriety with a patient – **not proved**
- Found guilty of an offence that is relevant to his suitability to practise – **proved**
- Disgraceful, dishonourable, or unprofessional conduct – **proved**

Summary

Dr. Marshall, a paediatrician practising since 1983, primarily treated children with behavioural, attention and mood problems, particularly involving attention deficit disorder.

Dr. Marshall volunteered at a local high school where he stood on the sidelines of sports games in his medical capacity and helped coach one of the sports teams. He was part of a religious group which had a presence in the school. Dr. Marshall was a camp counsellor at that religious group's summer camp.

Dr. Marshall often hosted groups of male high school students at his home to watch football, review games videos and discuss the Bible.

On September 17, 2012, Dr. Marshall was charged with 32 counts of touching for a sexual purpose contrary to s. 151(a) and sexual assault contrary to s. 246.1(1) of the

Criminal Code of Canada, and one count of breach of recognizance contrary to s. 145(3).

Allegations from 20 of Dr. Marshall's former patients related to genital exams before or during puberty and comprised 29 of the counts of sexual assault and touching for a sexual purpose.

The remaining three counts involved two complainants, including Complainant A, who alleged that Dr. Marshall had touched them improperly on occasions outside of his office.

On April 29, 2013, Mr. Justice Reid of the Ontario Superior Court of Justice found Dr. Marshall guilty of sexual assault in respect of Complainant A. Dr. Marshall was acquitted on the rest of the charges (R. v. Marshall, 2013 ONSC 2603).

Complainant A is a member of the Canadian Armed Forces whose service has earned him a medal.

Complainant A was in grade 9 when he first met Dr. Marshall. Complainant A was a vulnerable person.

Dr. Marshall befriended Complainant A because he was present on the sidelines of a team sport as a medical doctor and Complainant A was on the team.

Through Dr. Marshall, Complainant A became involved in Dr. Marshall's religious group. When he was about 15 and 16, Complainant A twice attended that group's summer camp with Dr. Marshall as a counsellor.

Throughout high school, Complainant A and his friends went over to Dr. Marshall's house in high school to watch football on TV or for Bible discussion many times. Other than occasional boarders, Dr. Marshall lived alone. He would take the boys out for dinner and pay for them. He bought new shoes and groceries for Complainant A.

Dr. Marshall sexually assaulted Complainant A. Complainant A testified at the criminal trial regarding the four incidents of sexual assault by Dr. Marshall:

While at summer camp operated by the religious group when he was 15 or 16, Complainant A descended on a zip line. Two friends were waiting at the bottom to slow him down. Dr. Marshall was also there and grabbed Complainant A's genitals with one open hand. Nothing was said but Complainant A considered the touching very inappropriate.

When Complainant A was about 16 years of age, he was at Dr. Marshall's house with a group of guys. He was standing in the doorway between the living room and the kitchen: Dr. Marshall came up from behind, put his hand around Complainant A's waist under his pants and underwear and grabbed his genitals for a couple of seconds. Complainant A pushed Dr. Marshall away.

When Complainant A was living in a rooming house, he asked Dr. Marshall to examine him because he had a sore back. Dr. Marshall told him to take his shirt off and bend

over. Once Complainant A bent over, Dr. Marshall stood behind and put his hands on Complainant A's back, feeling both sides of the spine. Dr. Marshall's hands went to the sides of Complainant A's hips and Dr. Marshall rubbed his erect penis against Complainant A's bum.

Complainant A was alone with Dr. Marshall at Dr. Marshall's home sitting on the couch and having a serious discussion about God and about how Complainant A's family had abandoned him. Dr. Marshall got up off the couch, stood in front of Complainant A and then moved towards him as if he was coming in for a hug, but instead lay on top of Complainant A. One of Dr. Marshall's hands was on Complainant A's wrist and the other one was working down to his waist. Complainant A was frightened and tried to wriggle out and bolt for the door. Dr. Marshall said words to the effect: "I'm just hugging; I'm not trying to [] you yet."

Reid J. convicted Dr. Marshall of sexual assault based on the incidents described in paragraphs 2, 3, and 4 above. Reid J. did not rely on the incident at the summer camp because it occurred outside of the Court's jurisdiction.

On July 3, 2013, Dr. Marshall was sentenced to eight months imprisonment, less six days pre-trial custody.

Dr. Marshall appealed his conviction and sentence to the Court of Appeal for Ontario. On July 9, 2015, the Court dismissed Dr. Marshall's appeal.

Dr. Marshall applied for leave to appeal the Court of Appeal for Ontario's decision to the Supreme Court of Canada. On January 28, 2016, the Supreme Court of Canada dismissed Dr. Marshall's application for leave.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar revoke Dr. Marshall's certificate of registration effective immediately;
- Dr. Marshall appear before the panel to be reprimanded; and
- Dr. Marshall pay to the College costs in the amount of \$10,000.00 within 30 days of the date of this Order.
-

Finding of misconduct in another jurisdiction – 1 case

1. Dr. C. Hui

Name: Dr. Creighton Hui
Practice: Family Medicine

Practice Location: Newmarket
Hearing: Agreed Facts and Joint Submission on Penalty
Decision Date: April 28, 2016
Written Decision Date: May 16, 2016

Allegation and Finding

- Disgraceful, dishonourable, or unprofessional conduct – **withdrawn**
- Governing body of a different jurisdiction's health profession found that Dr. Hui committed an act of professional misconduct that would be an act of professional misconduct in Ontario – **proved**

Summary

Dr. Hui has practised emergency medicine at a hospital in Ontario since February 2012. Prior to that, Dr. Hui lived in Manitoba for a fellowship in emergency medicine.

In August 2010, Dr. Hui began seeing patients at Clinic A in Manitoba and providing house calls.

Between April 2011 and January 2012, Dr. Hui entered into an arrangement with a nurse practitioner from Clinic A. The arrangement was that this nurse practitioner would make house call visits to patients which would be billed to Manitoba Health in Dr. Hui's name.

The nurse practitioner proposed that Dr. Hui could attend house call visits via live video stream. While Dr. Hui did attend some house call visits by live video stream, he did not attend all of them.

For these visits described above, the nurse practitioner would enter Dr. Hui's user identifier and password in the electronic medical record. It was therefore unclear from the medical record that Dr. Hui had not personally attended the patient or made the entry.

To facilitate this arrangement, Dr. Hui gave the nurse practitioner his password for the electronic medical record system so that the nurse practitioner could sign on and make chart entries under Dr. Hui's name. This was done in spite of the fact that the nurse practitioner had his own user identifier and password, could have made entries under his own name, and could have written prescriptions under his own name.

Between April 2011 and January 2012, Manitoba Health was billed approximately \$201,223.00 for house call services provided by the nurse practitioner and billed in the name of Dr. Hui. Dr. Hui ultimately voluntarily repaid the entire \$201,223.00 to Manitoba Health.

The College of Physicians and Surgeons of Manitoba (the "CPSM") commenced an investigation of Dr. Hui in February 2012. During the investigation, Dr. Hui made a number of statements to the CPSM that he subsequently admitted were not true, for

example that he supervised all patient visits by the nurse practitioner via live video link as well as that he subsequently reviewed all of the nurse practitioner's chart entries.

Dr. Hui subsequently admitted that he was not always present on the video link system; that he believed he should have been present on the video link system to comply with Manitoba Health's fee guideline; that he did not always review the nurse practitioner's chart entries; and that he never left the hospital when he may have been required on an urgent basis.

An Inquiry Panel of the CPSM held proceedings regarding Dr. Hui's conduct and found that Dr. Hui had committed acts of professional misconduct. Because Dr. Hui was not licensed to practice in Manitoba at the time of the hearing, the penalty ordered by the CPSM Inquiry Panel was a reprimand, a fine of \$10,000 in lieu of a period of suspension, costs of \$28,160.25 payable to the CPSM, and publication of Dr. Hui's name and the Inquiry Panel's decision.

Dr. Hui cooperated with the Ontario College's investigation into his conduct in Manitoba.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Hui's certificate of registration for a period of five (5) months, commencing from May 29, 2016 at 12:01 a.m.
- The Registrar place the following terms, conditions and limitations on Dr. Hui's certificate of registration:
 - Dr. Hui will participate in and successfully complete, within 6 months of the date of this Order, individualized instruction in medical ethics with an instructor approved by the College, with a report or reports to be provided to the College regarding Dr. Hui's progress and compliance;
 - For a period of one year after he resumes practice following the suspension of his certificate of registration described in paragraph 3, Dr. Hui will, at his own expense, retain a practice monitor approved by the College who will sign an undertaking in the form attached hereto as Schedule "A" (the "Practice Monitor") to review Dr. Hui's Ontario Health Insurance Plan ("OHIP") billings and the corresponding patient records to ensure his compliance with the Health Insurance Act, as follows:
 - In respect of Dr. Hui's Emergency Medicine practice, the Practice Monitor will review once every month Dr. Hui's ER triage records and the associated billings submitted to OHIP for a minimum of ten percent (10%) of Dr. Hui's patient encounters;
 - In respect of any house call practice of Dr. Hui during the one-year period of monitoring, Dr. Hui will notify the College if he resumes providing house calls, in which case the Practice Monitor will review once every month Dr. Hui's patient records and the associated billings submitted to OHIP for a minimum of twenty-five percent (25%) of Dr. Hui's patient encounters or, if Dr. Hui's house call practice volume is greater than a volume of approximately 30-50

- patients per month, a reasonable number or percentage of patient records to be determined by the College based on the volume of Dr. Hui's house call practice when resumed;
- In respect of any other practice of Dr. Hui during the one-year period of monitoring, Dr. Hui will notify the College prior to commencing such practice and the Practice Monitor will review once every month a reasonable number or percentage of Dr. Hui's patient records and associated billings submitted to OHIP in respect of this practice, with the number or percentage of patient records to be determined by the College based on the volume of this practice once known;
 - The Practice Monitor will be solely responsible for randomly selecting the patient records to be reviewed in accordance with paragraph 4b of this Order;
 - Dr. Hui shall provide his Practice Monitor with his monthly OHIP reconciliation from all Practice Locations, as defined below, and the Practice Monitor shall review the reconciliation;
- If a Practice Monitor who has given an undertaking in Schedule "A" to this Order is unable or unwilling to continue to fulfill its terms, Dr. Hui shall, within twenty (20) days of receiving notice of same, obtain an executed undertaking in the same form from a similarly qualified person who is acceptable to the College and ensure that it is delivered to the College within that time;
 - If Dr. Hui is unable to obtain a Practice Monitor in accordance with the terms of this Order, he shall cease to remit billings to OHIP until such time as he has done so;
 - Dr. Hui shall consent to the disclosure by his Practice Monitor to the College, and by the College to his Practice Monitor, of all information the Practice Monitor or the College deems necessary or desirable in order to fulfill the Practice Monitor's undertaking and to monitor Dr. Hui's compliance with this Order;
 - For a period of one year after he resumes practice following the suspension of his certificate of registration described in paragraph 3, Dr. Hui shall inform the College of each and every location where he practices including, but not limited to hospitals, clinics, and offices, in any jurisdiction (collectively, his "Practice Location(s)"), within fifteen (15) days of this Order, and shall inform the College of any and all new Practice Locations within 15 days of commencing practice at that location, for the purposes of monitoring his compliance with this Order;
 - For a period of one year after he resumes practice following the suspension of his certificate of registration described in paragraph 3, Dr. Hui shall submit to, and not interfere with, unannounced inspections of his Practice Location(s) and patient records by a College representative for the purposes of monitoring his compliance with this Order;
 - Dr. Hui shall provide consent to the College to make appropriate enquiries of OHIP, for a period of one year after he resumes practice following the

- suspension of his certificate of registration described in paragraph 3, for the purpose of monitoring his compliance with the terms of this Order; and
- Dr. Hui shall be responsible for any and all costs associated with implementing the terms of this Order.
 - Dr. Hui attend before the panel to be reprimanded.
 - Dr. Hui pay to the College costs in the amount of \$5,000.00, within thirty (30) days of the date of this Order.

Disgraceful, Dishonourable, or Unprofessional Conduct – 9 cases

1. Dr. D. E. Brooks

Name:	Dr. Douglas Earl Brooks
Practice:	General Practice
Practice Location:	Sault Ste Marie
Hearing:	Agreed Facts and Joint Submission on Penalty
Decision Date:	May 19, 2016
Written Decision Date:	July 22, 2016

Allegation and Finding

- Disgraceful, dishonourable, or unprofessional conduct - **proved**

Summary

Dr. Brooks, a general practitioner in Sault Ste Marie, also works as an investigating coroner. He maintains a family practice at the Group Health Centre and hospital privileges at the Sault Area Hospital.

Patients A and B had a close personal connection to Dr. Brooks and his wife.

The family physicians of Patients A and B practised at the Group Health Centre, which maintained patient medical records in an electronic medical records system. Patients A and B also had medical records from hospital visits that were maintained in the Hospital's electronic medical records system.

Patient A, who suffered from mental health and addictions issues, died by suicide in 2014. Dr. Brooks was the investigating coroner on call at the time of Patient A's death and attended at the scene. Due to his connection to Patient A, arrangements were made to have the case transferred to another coroner. Dr. Brooks accordingly did not act as the coroner in the investigation of Patient A's death.

After Patient A's death, her relatives, concerned about potential unauthorized access to their records by Dr. Brooks, requested audit reports of access to Patient A and Patient B's electronic medical records from both the Group Health Centre and the Hospital.

Dr. Brooks accessed Patient A's electronic medical records from the Group Health Centre on six dates between September 2005 and March 2014. Dr. Brooks accessed Patient A's electronic medical records from the Hospital on eight dates between August 2011 and August 2014. Multiple records were accessed on each of the above dates.

Dr. Brooks accessed Patient B's electronic medical records from the Group Health Centre on eight dates between April 2003 and October 2006. Multiple records were accessed on each of these dates.

Dr. Brooks' access to the electronic records was unauthorized because he did not have the consent of Patient A and Patient B to access their respective medical records. Further, there was no medical reason for Dr. Brooks to access the records.

The medical records that were accessed by Dr. Brooks included information related to general family medicine care, as well as highly personal information of a very sensitive nature, namely information related to psychiatric care, addictions-related issues and obstetrical care.

In 2006, after a period of estrangement, during the first trimester of Patient B's pregnancy, Patient B initiated contact with Dr. Brooks' wife. The attempt at reconciliation was unsuccessful. Subsequent to this contact, Dr. Brooks accessed Patient B's electronic medical records at the Group Health Centre six times during the remainder of her pregnancy.

In 2011, Patient A was admitted to the Mental Health Inpatient Unit at the Hospital. During this time, Dr. Brooks accessed Patient A's records almost daily over a period of seven days, with additional access during the week after her discharge.

In 2014, Patient A was struggling and refusing access to crisis care. Patient A's father reports that when he asked Patient A if there was anything he could do to help, Patient A requested that he seek out Dr. Brooks' wife to meet with her. Patient A's father went to Dr. Brooks' home, requesting Dr. Brooks and his wife join him in an intensified effort to help Patient A. At that time, he also asked Dr. Brooks' wife if she would meet with Patient A the next day.

Later that day, Dr. Brooks' wife discussed this with Dr. Brooks. He expressed concern to her that it was not safe to meet Patient A where she was living. Dr. Brooks' wife then called Patient A's father in the evening and told him that she would not be able to meet Patient A the next day. That same evening, Dr. Brooks accessed Patient A's medical records.

Dr. Brooks and his wife had no further contact with Patient A from this point forward.

On November 24, 2003, Dr. Brooks signed a Confidentiality Agreement with the Hospital, confirming that except where he was legally authorized or required to do so,

he would not inspect or receive paper or electronic patient-related information from Health Records or from notes, charts, and other material related to patient care. The Hospital's policy stated that it was a breach of confidentiality to access patient or health information when not required to provide care to a patient or in the performance of duties.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Brooks' certificate of registration for a period of five months commencing from the date of this Order.
- The Registrar impose the following term, condition and limitation on Dr. Brooks certificate of registration:
 - Dr. Brooks will participate in and successfully complete, within 6 months of the date of this Order, individualized instruction in medical ethics with an instructor approved by the College, with a report or reports to be provided to the College regarding Dr. Brooks' progress and compliance.
- Dr. Brooks appear before the panel to be reprimanded, with the fact of the reprimand to be recorded on the register.
- Dr. Brooks pay to the College costs in the amount of \$5,000.00 within 30 days of the date of this Order.

2. Dr. J. L. Clowater

Name:	Dr. Julie Lee Clowater
Practice:	Pediatrics
Practice Location:	Sudbury
Hearing:	Agreed Facts and Contested Penalty
Finding Decision Date:	May 19, 2016
Penalty / Written Decision Date:	July 22, 2016

Allegation and Finding

- Disgraceful, dishonourable, or unprofessional conduct - **proved**

Summary

The certificate of registration of Dr. Clowater, a pediatrician with a community-based practice in Chatham, was suspended between September 7 and October 6, 2011 because of non-payment of fees. Despite being notified of this suspension, Dr. Clowater continued to practise during this time.

On September 7, 2011, the College sent Dr. Clowater a Notice of Suspension of Certificate of Registration advising her that her certificate of registration was suspended for non-payment of fees. The Notice stated that if Dr. Clowater wished to resume practice in Ontario, she would have to apply to the College for reinstatement. The Notice also advised her that, if she were to reapply, her reinstatement would not be automatic; rather, it would take time to review and process her reinstatement application. Lastly, this September 7, 2011 Notice instructed Dr. Clowater not to resume practice until the College had advised her that her certificate had been issued.

The College received Dr. Clowater's reinstatement application fee on September 19, 2011. College staff emailed Dr. Clowater on September 28, 2011 to advise that her application was incomplete and that she therefore was not authorized to practice medicine. The College staff member asked Dr. Clowater to confirm whether she had practiced medicine after September 7, 2011.

Dr. Clowater emailed the College staff member back on September 28, 2011, saying, "I have not been practicing since september (sic.) 7th 2011. I am awaiting your email to resume practice."

Dr. Clowater later acknowledged that the statement that she had not practiced since September 7, 2011 was untrue.

Dr. Clowater practised medicine without professional liability coverage between November 1, 2010 and June 17, 2011. She submitted claims to OHIP for the period during which she did not have coverage.

In response to a College inquiry regarding her lapse in professional liability coverage, Dr. Clowater claimed that she first became aware that there had been a period of time during which her professional liability membership had not been in good stead after she received the College's October 2013 letter. This was not true.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Clowater's certificate of registration for a period of three months, to commence on September 1, 2016;
- The Registrar impose the following term, condition and limitations on Dr. Clowater's certificate of registration:
 - Dr. Clowater shall complete a course in medical ethics approved by the College within six months of release of this decision and shall provide evidence of completion of this course to the College;
- Dr. Clowater appear before the Committee to be reprimanded and the fact of the reprimand shall be recorded on the Register; and
- Dr. Clowater pay to the College costs in the amount of \$5,000.00 within 60 days of the date of this Order.

3. Dr. C. J. Foote

Name: Dr. Clary Jefferson Foote
Practice: Orthopedic surgery resident
Practice Location: N/A
Hearing: Agreed Facts and Contested Penalty
Finding Decision Date: January 7, 2016
Penalty / Written Decision Date: July 19, 2016

Allegation and Finding

- Disgraceful, dishonourable, or unprofessional conduct - **proved**

Summary

Dr. Foote completed four years of an orthopedic surgery residency at McMaster University. He held a restricted Postgraduate Education Certificate with the College of Physicians and Surgeons of Ontario from July 1, 2009 to September 30, 2015. He does not currently hold an active certificate of registration with the College.

In the course of his orthopedic surgery residency, Dr. Foote planned to complete an elective offered through Dalhousie University at a Hospital in Nova Scotia, to begin on October 22, 2013.

In order to be accepted for the elective, Dr. Foote was required to submit letters of support from his program director and program chair at McMaster. In addition, he was required to obtain an educational license from the College of Physicians and Surgeons of Nova Scotia, for which he was required to submit a letter from his program director confirming that the elective had been approved by McMaster.

Dr. Foote submitted two letters of support to the Hospital, one purportedly signed by his program director, and one purportedly signed by his program chair. In fact, neither of them had reviewed, approved or signed the letters prior to their submission to the Hospital by Dr. Foote. Dr. Foote created the letters of support by modifying letters of recommendation on his behalf previously written by these physicians and affixing their signatures electronically. Dr. Foote had submitted drafts of the letters of support to the program director and program chair prior to affixing their signatures to the letters. However neither of them had approved the letters, provided his consent to have his signature affixed to the letter, or agreed that the letters could be submitted to the Hospital prior to Dr. Foote doing so.

Dr. Foote also submitted a letter to the Nova Scotia College purportedly signed by his program director confirming that the elective had been approved by McMaster. His program director had orally advised Dr. Foote that the elective had been approved, however, Dr. Foote created the letter and affixed the program director's signature to the letter without Dr. Petrisor's knowledge, consent or approval.

Dr. Foote advised the College that he affixed the signatures to the three letters and submitted these letters to the Hospital and the Nova Scotia College without the knowledge, consent or approval of his program director and program chair because Dr. Foote had given himself insufficient time to complete the application process for the elective at the Hospital and was concerned that he would miss the deadline for application.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Foote's Certificate of Registration for a one month period, to commence at 12:01 a.m. on the date of this Order;
- The Registrar impose the following as a term, condition and limitation on Dr. Foote's certificate of registration:
 - At his own expense, Dr. Foote shall participate in and successfully complete, within 6 months of the date of this Order, 5 hours of individualized instruction in medical ethics with an instructor approved by the College. The instructor shall provide a summative report to the College including his or her conclusion about whether the instruction was completed successfully by Dr. Foote; and
- Dr. Foote appear before the panel to be reprimanded;
- Dr. Foote pay to the College its costs of this proceeding in the amount of \$5,000 within thirty (30) days from the date of this Order.

4. Dr. A. M. S. Ghali

Name:	Dr. Atef Malak Shehata Ghali
Practice:	Family Medicine
Practice Location:	Ottawa and Casselman
Hearing:	Agreed Facts and Joint Submission on Penalty
Decision Date:	May 24, 2016
Written Decision Date:	July 22, 2016

Allegation and Finding

- Sexual abuse of a patient – **withdrawn**
- Disgraceful, dishonourable, or unprofessional conduct – **proved**

Summary

Dr. Ghali, who practised family medicine in Egypt until 2006, obtained his Certificate of Independent Practice in Ontario 2012.

Dr. Ghali treated Patient A at a family health clinic for depression, anxiety, and other health issues.

In May 2014, Patient A made a report of unwanted hugging and kissing by Dr. Ghali to staff at the family health clinic, who then initiated the mandatory report to the College.

On two occasions, Dr. Ghali concluded the appointment by kissing Patient A on the cheek and hugging her. Patient A was upset by the kisses and hugs and felt that Dr. Ghali's conduct was inappropriate in the context of a medical appointment.

While Dr. Ghali intended his conduct to be supportive of Patient A, he now recognizes that his conduct was not appropriate conduct for a physician towards his patient, that it breached appropriate physician-patient boundaries and was not welcomed in any way by Patient A.

Disposition

The Committee ordered and directed that:

- The Registrar suspend Dr. Ghali's Certificate of Registration for a three month period effective immediately;
- The Registrar impose the following term, condition and limitation on Dr. Ghali's certificate of registration, to be removed once the College receives proof of completion of the course:
 - Dr. Ghali shall successfully complete the next available course in Understanding Boundaries, at his own expense;
- Dr. Ghali appear before the panel to be reprimanded; and
- Dr. Ghali pay costs to the College for a one day hearing in the amount of \$5,000.00 within 30 days of the date of this Order.

5. Dr. I. M. Price

Name:	Dr. Ira Michael Price
Practice:	General Practice; medical cannabis
Practice Location:	Hamilton
Hearing:	Agreed Facts and Joint Submission on Penalty
Decision Date:	August 22, 2016
Written Decision Date:	August 30, 2016

Allegation and Finding

- Disgraceful, dishonourable, or unprofessional conduct - **proved**

Summary

Dr. Price, who received an independent practice certificate from the College in 2010, is the medical director of Synergy Health Services Inc. in Hamilton, Ontario, where he provides care to patients being treated with medical cannabis.

Patient A sought treatment from Dr. Price for chronic pain with medical cannabis between December 2012 and April 2014. Following an email exchange with Dr. Price in April 2014, in which Patient A requested that his next appointment be rescheduled, Patient A was terminated from Dr. Price's practice.

On April 24, 2014, the College received a complaint from Patient A that Dr. Price acted unprofessionally while Patient A was his patient, including by being unwilling to accommodate his request to reschedule his appointment and by terminating Patient A from his practice.

Dr. Price provided details of his interactions with Patient A in response to the complaint. Some of these details were inconsistent with Patient A's descriptions of his appointments with Dr. Price, including Dr. Price's statement that Patient A refused, during an appointment, to consent to a physical examination.

While Patient A denied ever having refused a medical examination by Dr. Price, the medical records provided by Dr. Price supported his version of events as set out in his response letter.

A College investigator asked Dr. Price whether his chart entries were made contemporaneously to Patient A's visits or whether there were any changes, additions or deletions made to any of the chart entries following the date-time of Patient A's visits.

Dr. Price wrote in response that "All chart entries made regarding [Patient A]'s visits were made at a time that was contemporaneous to the visits" and "All entries were made on the dates indicated in [Patient A]'s records, and at the same time as the other entries included under each date-entry." Dr. Price claimed this was consistent with his "regular charting practice."

The College retained a forensic examiner who concluded that multiple entries in Patient A's chart were written during different writing episodes from the remainder of the handwriting on that page, including the following:

- The phrase "/day → pt must Show to f/u to keep", purporting to be written on a date in December 2012, was indented onto a form from a particular date in January 2013, suggesting that the note was written on or after that date in January, 2013; purporting to be written on a date in December 2012, was indented onto a form from a particular date in January 2013, suggesting that the note was written on or after that date in January, 2013;
- The phrase ", discussed pain Scale Score to be 20", purporting to be written on a date in early April 2013, was written in a different writing episode than the rest of the handwriting on the Progress Notes from the same date in early April 2013. The entry was indented onto a document that was printed on a date in late April 2013, indicating that the note was written on or after that date in late April 2013;
- The phrases "1yr", "no renewal", "Refusing exam." and ", May have to D/C licence if this continues", purporting to be written on a date in January 2014, were written in different writing episodes than the rest of the handwriting in the Follow-up Report dated that day in January 2014;

- The phrase “— Secretary feels threatened by conversation”, purporting to be written on a date in April 2014, was written in a different writing episode than the rest of the note from that same date in April 2014.

The College investigator sent the forensic report to Dr. Price in May 2015 and requested his comments. In his June 2015 response, Dr. Price did not dispute the forensic conclusions reached by the forensic expert. In his June 2015 response, Dr. Price advised the College, for the first time, of the following:

- He frequently writes chart notes in different sittings and with different pens;
- It is often the case that chart entries are not fully completed at the end of the appointment;
- It is his practice to make additions to his charts when doing dictations, performing chart audits, and during subsequent visits;
- He is sometimes unable to complete his charting until “a couple weeks” after appointments or within a “reasonable time period” thereafter;
- He often brings his patient charts home to complete his charting;
- Entries are made from different locations at different times;
- He is present at the medical cannabis clinic only on Mondays and uses the rest of the week to complete chart entries;
- He cannot recall when he completed the entries in Patient A’s chart;
- He may have backdated his notes in Patient A’s chart;
- He may have written “, discussed pain Scale Score to be 20”, purporting to be written on the date in early April 2013, after he received the late April 2013 document;
- He would have written the phrase “— Secretary feels threatened by conversation”, purporting to be written on a date in mid-April 16, 2014, on the next day or later;
- He may have written the phrases “1yr”, “no renewal”, “Refusing exam.” and “, May have to D/C licence if this continues”, purporting to be written on a date in mid-January 2014, weeks after mid-January 2014.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Price’s certificate of registration for a period of three (3) months, to commence at 12:01 a.m. on September 1, 2016.
- The Registrar impose the following terms, conditions and limitations on Dr. Price’s certificate of registration:
 - Education
 - Dr. Price must successfully complete, at his own expense, the first available courses acceptable to the College in ethics and medical recordkeeping, within four (4) months of the date of this Order.
 - Recordkeeping

- Dr. Price will obtain and use as his only medical recordkeeping system in all his office-based Practice Locations in Ontario, an Electronic Medical Recordkeeping (“EMR”) System acceptable to the College within six (6) months of the date of this Order.
- Other
 - Dr. Price shall comply with the College Policy on Practice Management Considerations for Physicians Who Cease to Practise, Take an Extended Leave of Absence or Close Their Practice Due to Relocation in respect of his period of suspension, a copy of which forms Appendix “A” to this Order.
 - Dr. Price shall inform the College of each and every location where he practices, in any jurisdiction (his “Practice Location(s)”) within fifteen (15) days of this Order, and shall inform the College of any and all new Practice Locations within fifteen (15) days of commencing practice at that location.
 - Dr. Price shall submit to, and not interfere with, unannounced inspections of his Ontario Practice Location(s) and to any other activity the College deems necessary in order to monitor his compliance with the provisions of this Order.
 - Dr. Price shall consent to the College making appropriate enquiries of the Ontario Health Insurance Plan and/or any person who or institution that may have relevant information, in order for the College to monitor his compliance with this Order.
 - Dr. Price shall be responsible for any and all costs associated with implementing the terms of this Order.
- Dr. Price appear before the panel to be reprimanded.
- Dr. Price pay costs to the College in the amount of \$5,000.00 within thirty (30) days of the date this Order becomes final.

6. Dr. S. S. Rai

Name: Dr. Sherapartap Singh Rai
Practice: Family Medicine
Practice Location: Brampton
Hearing: Contested Allegations; Joint Submission on Penalty
Finding / Written Decision: January 19, 2016
Penalty Decision Date: May 6, 2016
Written Penalty Decision: July 20, 2016

Allegation and Finding

- Sexual abuse of a patient – **not proved**
- Disgraceful, dishonourable, or unprofessional conduct – **proved**

Summary

During the relevant time period, Dr. Rai practised in an emergency room at the only hospital in a small town. He was also engaged in a sexual relationship with the woman in issue, Ms. A, throughout that period. It was undisputed that Dr. Rai assessed, diagnosed and treated Ms. A on one occasion in a clinic and on nine occasions at the hospital ER over a number of years. The Discipline Committee determined that the medical treatments did not give rise to a physician-patient relationship, however. It noted that there was no evidence that Dr. Rai provided regular care to Ms. A and that there was no evidence the ER visits were arranged ahead of time, or that there was another physician available in the ER to see her when she visited. All of the treatment occasions constituted “incidental care.” In particular, the Committee held that “given the context of the small town ER, Dr. Rai had no choice but to attend to [her] medical needs and to provide care for her problems,” finding that the ER visits were “incidental care to a spouse, given the nature of the visits and the unique set of circumstances in this case.” The clinic treatment was ill-advised, but it did not create a doctor-patient relationship.

Dr. Rai was found to have engaged in disgraceful, dishonourable or unprofessional conduct with respect to treating Ms. A at a clinic visit at which he performed a Pap test and ordered blood work, by treating a family member in a non-emergency situation.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Rai’s certificate of registration for period of two months, to commence at 12:01 a.m. on May 7, 2016.
- The Registrar place the following terms, conditions or limitations on Dr. Rai’s certificate of registration:
 - Dr. Rai shall participate in and successfully complete the next available course on “Understanding Boundaries and Managing the Risks Inherent in the Doctor-Patient Relationship” offered by Western University, or an equivalent program acceptable to the College, and shall forthwith thereafter provide proof of completion thereof to the College.
- Dr. Rai appear before the panel to be reprimanded.
- Dr. Rai pay the College its costs of this proceeding in the amount of \$4,460.00, within 120 days of the date upon which the suspension of his certificate of registration is lifted.

7. Dr. M. N. Ramzy

Name:	Dr. Medhat Nader Ramzy
Practice:	Family Medicine
Practice Location:	Scarborough
Hearing:	Agreed Facts and Joint Submission on Penalty
Decision Date:	August 9, 2016

Written Decision Date: August 22, 2016

Allegation and Finding

- Disgraceful, dishonourable, or unprofessional conduct – **proved**

Summary

Dr. Ramzy, a family physician who obtained his certificate of registration in 1999, practises in Scarborough at a walk-in clinic called the Pro Care Medical Clinic.

Ms. A was treated by Dr. Ramzy at Pro Care Medical Clinic from June 2007 until June 2011. In June 2011, she decided she did not want to be treated by Dr. Ramzy anymore and the doctor-patient relationship was terminated.

Ms. A's spouse, Mr. B, was Dr. Ramzy's patient until Mr. B's death in 2011.

In July 2012, over a year after the termination of the doctor-patient relationship, Ms. A attended the clinic with her teenage son, C, for his annual physical examination. This was C's only appointment with Dr. Ramzy.

During C's appointment, Ms. A learned from Dr. Ramzy that he was single. After the examination, Dr. Ramzy left C in the examination room and went to his personal office to complete C's paperwork. Ms. A went to Dr. Ramzy's office. Ms. A and Dr. Ramzy agreed to go out socially together. Plans were made for Ms. A and Dr. Ramzy to go out for dinner together that night. C remained in the examination room while these arrangements were made in Dr. Ramzy's office

That evening Ms. A and Dr. Ramzy ate dinner at a restaurant. Following dinner, Dr. Ramzy drove Ms. A to his home, where they engaged in sexual intercourse.

A sexual relationship between Ms. A and Dr. Ramzy followed, which commenced in July 2012 and ended in August 2012. After this time, Dr. Ramzy and Ms. A no longer engaged in sexual relations.

After Dr. Ramzy ended their social relationship, Ms. A threatened Dr. Ramzy that she would complain to the College about Dr. Ramzy's care of her late husband. On August 15, 2012, Ms. A wrote to Dr. Ramzy that he "will pay the price for your irresponsible behavior." On August 26, 2012, Ms. A wrote that she was "starting to file a complain [sic] about your reckless behaviour on my late husband case." Ms. A also referenced filing the complaint about her late husband in her email of September 1, 2012.

On a date in October 2012, Ms. A attended at the Pro Care Medical Clinic, seeking treatment for shortness of breath and an irregular heartbeat. The cardiologist at the clinic required a referral to see Ms. A. Dr. Ramzy was the only family physician at the clinic at that time and agreed, because of the apparent urgency, to see Ms. A on that day. Dr. Ramzy's entry in Ms. A's chart indicates that she attended to manage her chest pain. She requested a flu shot, a referral to a gynaecologist for contraception and a CT

scan for chest and heart. Dr. Ramzy referred Ms. A to the cardiologist who was in the office the same day to manage her chest pain.

Three days later, Ms. A returned to Pro Care Medical Clinic, where she received care from Dr. Ramzy. Dr. Ramzy's entry in Ms. A's chart indicates that she attended that day for a CT scan for her chest, reporting a chronic cough.

On a date in September 2013, Ms. A attended Dr. Ramzy's practice for a cardiac work report and a stress echo test. Dr. Ramzy's entry reads: "she threatened me regarding her husband case, he died ... 3 years ago, she wants money from me or she is going to complain to the College. She was told that nothing wrong in her husband case. I will not give her money if she wants to complain she can [sic]."

In October 2013, Ms. A made two complaints to the College against Dr. Ramzy: one with respect to the care her late husband had received and one with respect to feeling "used" after Dr. Ramzy dated her for two months.

The College obtained an Independent Opinion with respect to Dr. Ramzy's care of Mr. B. The assessor found Dr. Ramzy to have met the standard of care. As such, the Inquiries, Complaints and Reports Committee took no further action with respect to Ms. A's complaint about the care her husband received from Dr. Ramzy.

Dr. Ramzy admitted that he engaged in an act of professional misconduct in that he engaged in conduct that, having regard to all of the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional by planning a social encounter during C's medical appointment and by treating Ms. A too soon, given their recent sexual relationship.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Ramzy's certificate of registration for a period of three months, to take effect at 12:01 a.m. on August 23, 2016.
- The Registrar impose the following terms, conditions and limitations on the certificate of registration of Dr. Ramzy:
 - Dr. Ramzy shall successfully complete the next available course in "Understanding Boundaries", at his own expense.
- Dr. Ramzy attend before the panel to be reprimanded.
- Dr. Ramzy pay to the College costs in the amount of \$5,000.00, within 30 days of the date of this Order.

8. Dr. S. K. Syan

Name:	Dr. Swaran Kaur Syan
Practice:	Family Medicine
Practice Location:	Sudbury

Hearing: Agreed Facts and Joint Submission on Penalty
Decision Date: May 16, 2016
Written Decision Date: July 8, 2016

Allegation and Finding

- Disgraceful, dishonourable, or unprofessional conduct - **proved**

Summary

Dr. Swaran Kaur Syan, a family physician with a cosmetic practice who graduated from medical school at Punjabi University, breached a past Order of the Discipline Committee that had suspended her certificate of registration when she saw 11 patients in May 2015.

On April 14, 2015, a prior Panel of the Discipline Committee found that Dr. Syan had committed an act of professional misconduct in that she had failed to maintain the standard of practice of the profession in respect of 20 patients. The Committee directed the Registrar to suspend Dr. Syan's certificate of registration for a period of two months commencing on April 14, 2015.

On May 4, 2015, Dr. Syan saw four patients in her cosmetic practice, and on May 5, 2015, she saw a further seven patients. Dr. Syan saw all of these patients in breach of the April 2015 Order of the Discipline Committee which had suspended her certificate of registration. The Committee in the present case found that, in breaching the April 2015 Order, Dr. Syan engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, or unprofessional.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Syan's certificate of registration for a two month period, to commence at 12:01 a.m. on May 17, 2016.
- The Registrar impose the following as a term, condition and limitation on Dr. Syan's certificate of registration:
 - At her own expense, Dr. Syan shall participate in and successfully complete, within 6 months of the date of this Order, individualized instruction in medical ethics satisfactory to the College, with an instructor approved by the College. The instructor shall provide a summative report to the College including his or her conclusion about whether the instruction was completed successfully by Dr. Syan.
- Dr. Syan appear before the panel to be reprimanded.
- Dr. Syan pay to the College its costs of this proceeding in the amount of \$5,000.00 within thirty (30) days from the date of this Order.

9. Dr. Mr. R. Virani

Name: Dr. Mirza Rajabali Virani
Practice: Family Medicine
Practice Location: Markham
Hearing: Agreed Facts and Contested Penalty
Finding Date: June 20, 2016
Penalty / Written Decision: September 21, 2016

Allegation and Finding

- Disgraceful, dishonourable, or unprofessional conduct – **proved**

Summary

Dr. Mirza Rajabali Virani, a family physician who obtained his medical degree in Iran, had a company called MRV International with an account at the Royal Bank of Canada.

In 2006, Mr. Arshad Latif, a purported businessman from Pakistan, proposed an investment opportunity to Dr. Virani. Within a week or two of investing \$25,000.00, Dr. Virani lost all the money he had invested with Mr. Latif.

Patient A, who is originally from Iran, was Dr. Virani's patient between about 1989 and 2011. One of the reasons he chose Dr. Virani as his physician was because Dr. Virani speaks Farsi. Patient A has referred relatives as well as other members of the Iranian-Canadian community as patients to Dr. Virani's practice over the years.

Patient A considered Dr. Virani to be successful, trustworthy, and wealthy, as well as a respected member of the community.

Patient A had told Dr. Virani during medical appointments that he had a successful business and a line of credit and was building a new home for his family. Dr. Virani suggested they become business partners and made requests for money. Patient A's lawyer advised that Patient A should obtain collateral; however Patient A trusted Dr. Virani and did not obtain collateral or enter into written agreements with Dr. Virani regarding the loans he made to him.

In August 2006, Dr. Virani telephoned Patient A while he was abroad and told him that he needed \$60,000.00 right away.

Patient A told his wife to obtain a bank draft payable to Dr. Virani out of Patient A's line of credit, which she delivered to Dr. Virani on August 30, 2006.

Dr. Virani introduced Patient A to Mr. Latif in September 2006. Dr. Virani did not inform Patient A that he had lost \$25,000.00 in an earlier deal with Mr. Latif.

Mr. Latif told Patient A that if he were to invest \$448,000.00, he would make a \$33,000.00 profit in one month. A few weeks later, Mr. Latif proposed another business investment to Dr. Virani to try and recoup the losses from the previous failed investment.

Although uninterested in the investment, Patient A agreed to loan \$448,000.00 to Dr. Virani. Dr. Virani was aware that the money was borrowed from Patient A's line of credit. Dr. Virani agreed to pay the interest on the line of credit. Ultimately, Dr. Virani paid only four interest installments on the line of credit, totaling \$15,134.82.

On October 16, 2006, Patient A went to the Royal Bank of Canada with Dr. Virani and Mr. Latif and provided a \$448,000.00 draft to MRV International. Next, Dr. Virani wrote a \$448,000.00 cheque to Mr. Latif's company from the MRV account.

RBC informed Dr. Virani that it would not deal with the Pakistani bank because RBC viewed it as a dubious transaction. Dr. Virani did not pass this information along to Patient A.

Months elapsed, and Dr. Virani provided various reasons for not repaying Patient A's loan.

In February 2007, Dr. Virani promised to pay back the original \$60,000.00 plus the subsequent \$448,000.00 if Patient A loaned him a further \$53,410.00. Dr. Virani told Patient A that he needed this new loan to have a shipment of plastic goods released, which he claimed was worth \$629,000.00. Patient A loaned him another \$53,410.00 on February 16, 2007.

On the same date, Dr. Virani provided Patient A with cheques in the amounts of \$448,000.00, \$33,000.00 and \$53,410.00. Patient A, when attempting to cash the cheques, was told by the bank that Dr. Virani had put stop payments on the cheques on the same day they were written.

On April 15, 2007, Dr. Virani provided a cheque in the amount of \$53,410.00 that Patient A was able to cash.

Patient A contemplated legal action against Dr. Virani but did not pursue an action on the belief that he would not get any money back.

Patient A and his family continued to see Dr. Virani as their physician in the hope that Dr. Virani would eventually pay the money back.

Dr. Virani repaid Patient A \$128,544.82 prior to the bankruptcy proposal, including the freight charge reimbursement of \$53,410.00, interest payments of \$15,134.82, and reimbursement of the \$60,000 loaned in August 2006.

Dr. Virani also borrowed funds from another patient, Patient B, in relation to Mr. Latif's investment proposals. He also introduced the second patient to Mr. Latif. Dr. Virani did not inform the second patient about the initial failed investment with Mr. Latif in which Dr. Virani lost \$25,000.00.

Patient B, who is also originally from Iran, was Dr. Virani's patient between about 1990 and 2007. Patient B trusted Dr. Virani and eventually several members of Patient B's family became Dr. Virani's patients as well.

Patient B and Patient A did not know one another and also did not know that Dr. Virani had another patient lending him funds.

Dr. Virani became aware of Patient B's business affairs and financial success over the years. Patient B felt comfortable with Dr. Virani, sharing details of his business as well as the fact that he had a substantial line of credit available for his business.

In September 2006, Dr. Virani introduced Mr. Latif to Patient B. Dr. Virani told Patient B about an investment opportunity that he wanted to discuss with Patient B. Patient B told Dr. Virani that he was not interested in the investment, and indicated that, due to the nature of his business, he did not trust anybody.

Dr. Virani asked Patient B if he trusted him. Patient B replied that he trusted Dr. Virani "one hundred percent." He agreed to lend money to Dr. Virani and to use his line of credit to do so. Dr. Virani offered to pay interest on the loan. Patient B refused, as his religious beliefs do not permit interest payments.

Patient B loaned Dr. Virani \$150,000.00 from his line of credit, which Dr. Virani immediately wired to Mr. Latif's company, Pakistan Trading Co. Dr. Virani agreed to repay the loan within one month.

On November 10, 2006, Dr. Virani again approached Patient B and asked for another \$51,000.00. Patient B agreed, obtaining the money from his line of credit. At Patient B's request, Dr. Virani wrote out a promissory note on his prescription pad for the total loan of \$201,000.00, undertaking in that note to return the amount unconditionally within three months, which would have been February 10, 2007.

In February 2007, Patient B attempted to collect the money owing. Dr. Virani told Patient B he was not able to repay the loan. Dr. Virani told Patient B that he needed more money to pay taxes and duties on a shipment of goods, without which he would be unable to repay any part of the loan already made. However, if Patient B were to give Dr. Virani some more money, Dr. Virani would be able to repay everything immediately.

On the basis of Dr. Virani's representations, Patient B loaned him another \$34,633.00 on February 9, 2007. On the same date, at Patient B's request, Dr. Virani wrote three undated cheques, representing the total amount of all three loans, namely; \$235,633.00.

Dr. Virani told Patient B that he would be able to pay him within a few days and would tell Patient B what dates to put on the cheques. Dr. Virani never provided this information to Patient B and did not repay the loans.

Patient B subsequently took legal action against Dr. Virani and obtained judgment in the amount of \$235,633.00 from the Superior Court of Justice. Patient B has never collected on that judgment.

On June 30, 2011, Dr. Virani made a bankruptcy proposal. Both Patient A and Patient B are listed as unsecured creditors.

By the time the proposal expires, Patient A, who is listed as a creditor in the amount of \$448,000.00, will have received total payments of approximately \$42,000.00. Patient B, who is listed as a creditor in the amount of \$289,096.00, will have received total payments of approximately \$27,000.00.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Virani's certificate of registration for an eight (8) month period effective immediately;
- The Registrar impose the following term, condition and limitation on Dr. Virani's certificate of registration, to be removed once the College receives proof of completion of the course:
 - o Dr. Virani shall successfully complete the next available course in Ethics that is approved by the College, at his own expense.
- Dr. Virani appear before the Committee to be reprimanded within three (3) months of the date this Order becomes final;
- Dr. Virani pay costs to the College for a one-day hearing in the amount of \$5,000.00 within 30 days of the date of this Order.

Appeal

On September 27, 2016, Dr. Virani appealed the decision of the Discipline Committee to the Divisional Court of the Superior Court of Justice.

COUNCIL BRIEFING NOTE

TOPIC: Governance Committee Report – Part II

NOMINATIONS

FOR DECISION:

- 1. 2016-17 Governance Committee Election**
- 2. Committee Membership Appointments for 2016-17**

FOR INFORMATION:

- 3. Completion of Annual Declaration of Adherence Form**
-

FOR DECISION:

1. 2016-17 Governance Committee Election

- There will be an election for one physician member and two public members for the 2016-2017 Governance Committee (if more than one physician member is nominated and more than 2 public members are nominated). Three Council physician members have submitted their nomination information for the one physician member position as of November 10-16:
 - Dr. Brenda Copps
 - Dr. Haidar Mahmoud
 - Dr. Jerry Rosenblum
- One public member of Council has submitted nomination information for the two available public member positions as of November 10-16:
 - Ms. Diane Doherty
- Nomination Statements from the candidates are contained in Appendix A.

2. Committee Membership Appointments for 2016-17

- The Governance Committee is responsible for recruiting committee members and for making nominations recommendations for committee and chair positions.

- In making these recommendations, the committee follows Council's nominations guidelines contained in the Governance Process Manual: [Governance Process Manual](#)¹
- The Governance Committee identified non-Council committee opportunities in August. All new non-Council committee members will be interviewed. Particular attention is taken to avoid potential apprehension of bias and conflicts.
- As a number of interviews for the new committee positions are pending, the proposed 2016-17 committee rosters will be circulated to Council closer to the meeting date. It is anticipated that most interviews will be completed in advance of the December AGM.
- The committee membership rosters will be circulated prior to the annual meeting of Council. (as Appendix B). They represent the committee nomination recommendations for the upcoming year.
- The proposed committee membership rosters reflect a combination of factors set out in the nominations guidelines including: competencies; individual preferences; length of time on a committee; and succession planning.
- The Governance Committee works to ensure that every committee has the required expertise to meet statutory duties and other obligations set out in the College's governing legislation and by-laws.

FOR INFORMATION:

3. Completion of Annual Declaration of Adherence Form for 2016-2017

- The Governance Committee has revised the timing of the signing of the annual Declaration of Adherence Form for Council and committee members, to align with Council and committee appointments at the annual meeting of Council.
- Council members are requested to sign and submit your annual Declaration of Adherence Form for 2016-2017 at the annual meeting of Council.
- The purpose of signing the annual Declaration of Adherence Form on an annual basis is to ensure that all members of Council adhere to our legislative obligations and respect the by-laws and policies applicable to the Council including the following:
 - Statement on Public Interest
 - Council Code of Conduct
 - Conflict of interest Policy
 - Impartiality in Decision-Making Policy
 - Confidentiality Policy
 - Role Description of a College Council Member

¹ Governance Practices and Policies, Nominations Guidelines, pgs. 44-49

- A copy of the Declaration of Adherence Form (for completion) and the relevant governance policies are attached (as Appendix C).
- A current copy of the CPSO General By-Law is available on the College's website: [General By-Law](#)

Governance Committee Recommendations:

- Vote for elected positions for 2016-2017 Governance Committee, 1 physician member and 2 public members.
- Election of nominated Committee members to committees as set out in Appendix B (will be circulated to Council prior to the annual meeting of Council).
- All Council members are asked to sign and submit their annual Declaration of Adherence Form (Appendix C) at the December Council meeting.

CONTACTS: Carol Leet, Chair
Louise Verity
Debbie McLaren

DATE: November 10, 2016

MEMORANDUM

To: All Council Members

From: Dr. Carol Leet, Chair, Governance Committee

Date: **October 17, 2016**

Subject: **Nomination/Election Process for 2016-2017 Governance Committee Vote at December Council Meeting**

At the upcoming Council meeting in December, there will be a vote for the three elected positions on the 2016-2017 Governance Committee.

The three elected positions are: one physician member on Council who is not a member of the Executive Committee, and two public members on Council who are not members of the Executive Committee.

The *General By-Law 44-(3)* states the mandate of the Governance Committee:

44-(3) The Governance Committee shall,

- (a) monitor the governance process adopted by the Council and report annually to the Council on the extent to which the governance process is being followed;
- (b) consider and, if considered advisable, recommend to the Council changes to the governance process;
- (c) ensure nominations for the office of president and vice-president
- (d) make recommendations to the Council regarding the members and chairs of committees; and
- (e) make recommendations to the Council regarding any other officers, officials or other people acting on behalf of the College.

Please refer to the Governance Process Manual for role descriptions and key behavioural competencies that are necessary to fill the positions.

All Council members who wish to be nominated for an elected position on the Governance Committee are invited to submit an optional **Nomination Statement**. **The Nomination Statement is limited to 200 words**. The Nomination Statement will include brief biographical information and a CPSO photo, or alternatively, you may submit your own photo. **Nomination Statements that are submitted by the deadline** will be circulated to all Council members by e-mail, prior to the December Council meeting, and will be included in the Governance Committee Report to Council.

Nomination Statements will assist Council members to identify candidates who are running for election, and provide more information regarding a candidate's background, qualifications and reasons for running for a Governance Committee position.

In addition, to the **Nomination Statement**, a completed **Nomination Form** is due on the first day of the Council meeting to validate Council's support of candidates. Each nomination requires the signatures

of a nominator, a seconder, and the agreement of the nominee. A Council Contact list will be provided for you to facilitate your communication with Council members.

For your reference, a list of proposed 2016-2017 Governance Committee members as per the General By-Law, a list of the current composition of the 2016 Governance Committee, and a list of the 2016-2017 Executive Committee membership are attached.

1. **The deadline for submission of your completed Nomination Statement is: Thursday, November 3, 2016 at 5:00 p.m.**
2. **The deadline for submission of your completed Nomination Form is Thursday, December 1, 2016, prior to the commencement of the Council meeting.**
3. **The vote (if applicable) will take place at the December Council meeting on Friday, December 2, 2016.**

Election Process:

1. If there is more than one nomination for the position of physician member and/or more than two nominations for the 2 positions of public member on the Governance Committee, a vote will take place at the Council meeting on the second day.
2. Each nominee will have the opportunity to address Council, if they wish, for a maximum of two minutes about his/her candidacy for the position before the vote takes place. Audio/visual presentations will not be accepted.
3. 2016-2017 Council members will vote for Governance Committee positions.

If you have any questions regarding the nomination process, please contact Debbie McLaren at dmclaren@cpsy.on.ca or by phone: 416-967-2600, ext. 371 or toll free: 1-800-268-7096, ext. 371).

Thank you,



Carol Leet, MD, FRCPC
Chair, Governance Committee
att.

Proposed 2016-2017 Governance Committee:

Dr. Joel Kirsh, (Past President), Chair♦×
Dr. David Rouselle, (President) ♦
Dr. Steven Bodley, (Vice President)♦
Physician Member of Council*
Public Member of Council*
Public Member of Council*

2016 (current) Governance Committee:

Dr. Carol Leet, (Past President), Chair ♦×
Dr. Joel Kirsh, (President) ♦
Dr. David Rouselle, (Vice President) ♦
Dr. Peeter Poldre (Physician Member) (*has served for 1 year, ineligible for 2016-17, member of 2016-17 Executive Committee*)
Ms. Lynne Cram (*has served for 1 year, ineligible for 2016-17, member of 2016-17 Executive Committee*)
Ms. Diane Doherty (*has served for 1 year*)

♦The Governance Committee is composed of, the president, the vice-president and a past president as per the *General By-Law 44.-(1)(a)*

*A physician member of Council and two public members of Council who are appointed by Council at the annual meeting, and are not members of the Executive Committee as per the *General By-Law 44.-(1)(b) and 44.-(1)(c)*

×A past president chairs the Governance Committee as per the *General By-Law, 44(2)*

2016-2017 Executive Committee:

(appointed by Council at the May 2016 Council meeting)

(Physician member and two public members on the Executive Committee are not eligible for 2016-2017 Governance Committee)

Dr. Steven Bodley, (Vice President)
Ms. Lynne Cram, (Public Member)
Mr. Pierre Giroux (Public Member)
Dr. Joel Kirsh, (Past President)
Dr. Peeter Poldre (Physician Member)
Dr. David Rouselle (President and Chair)



**GOVERNANCE COMMITTEE
NOMINATION FORM**

FOR PHYSICIAN MEMBER ON THE GOVERNANCE COMMITTEE:

I _____ am willing to be
Print name here

nominated for the Physician Member on the Governance Committee.

Signed: _____
Signature of Nominee *Date*

Nominated by: _____
Signature *Date*

Seconded by: _____
Signature *Date*



**GOVERNANCE COMMITTEE
NOMINATION FORM**

FOR THE 2 PUBLIC MEMBERS ON THE GOVERNANCE COMMITTEE:
(You may nominate 1 or 2)

I _____ am willing to be
Print name here

nominated for the Public Member on the Governance Committee.

Signed: _____
Signature of Nominee Date

Nominated by: _____
Signature Date

Seconded by: _____
Signature Date

Please fill out below for 2nd public member if you are nominating 2 public members.

I _____ am willing to be
Print name here

nominated for the Public Member on the Governance Committee.

Signed: _____
Signature of Nominee Date

Nominated by: _____
Signature Date

Seconded by: _____
Signature Date

**NOMINATION STATEMENT
CANDIDATE FOR PHYSICIAN MEMBER, GOVERNANCE COMMITTEE**



DR. BRENDA COPPS
District 4 Representative
Hamilton, Ontario

Principal Area of Practice or Specialty:
Family Medicine

Elected Council Terms:
2013-2016
2016-2019

CPSO Committees/Positions Held and Other CPSO Work:

Education Committee:	2015-2016
Quality Assurance Committee:	2013-2015, Co-chair: 2015-2016
Quality Assurance Working Group member	2016-Present
Policy Working Group: <i>Accepting New Patients/Ending the Physician-Patient Relationship</i>	2015 - Present
Policy Working Group: <i>Continuity of Care and Test Results Management</i>	2016 – Present, Chair
FMRAC Annual Meeting Delegate	2015

NOMINATION STATEMENT:

I am happy to report that I was just successfully re-elected to our Council for a second three-year term. This district 4 election process and my recent candidacy for our Executive have inevitably challenged me to better formulate my goals as relates to my future contribution to our Board and College. I am reaffirming my commitment and putting my name forward for the Governance Committee.

Strong committee structure and representation are central to all high functioning organizations and never more important than in our work of protecting the public.

I think I have the potential to be an able member of this committee. On the one hand, I have accumulated sufficient committee, policy and board experience to understand our framework and the self-regulation landscape. On the other hand, I am contemporary enough to bring a fresh lens to our work and by virtue of still maintaining a full scope family practise, bring needed relevance.

If the Council sees fit, I do see more leadership in my future, and a position on the Governance Committee presents an opportunity to contribute, consolidate and develop.

I appreciate your support.

**NOMINATION STATEMENT
CANDIDATE FOR PHYSICIAN MEMBER, GOVERNANCE COMMITTEE**



DR. HAIDAR MAHMOUD
District 10 Representative
Toronto, Ontario

Principal Area of Practice or Specialty:
Obstetrics and Gynecology

Elected Council Terms:
2014-2017

CPSO Committees/Positions Held and Other CPSO Work:

Inquiries, Complaints and Reports Committee	2014 – 2016
Peer Assessor	2004 – 2014 (as non-Council member)

NOMINATION STATEMENT:

I believe that I would be a strong candidate for the Governance Committee. I believe that I've demonstrated many of the skills desirable for members of this committee. These skills have developed as a result of the committee positions I've held in the past, especially within the ICRC.

My experience on the ICRC demonstrates my ability to form strong relationships within a group environment, as well as my enhanced and effective communication skills. The ICRC requires an extremely high level of cooperation within a group, as many of the cases discussed may not always have a clear outcome.

Working in this group has allowed me to hone in on skills that I developed being chief of the department, and I believe that these skills are adequately transferred to this Governance Committee. Additionally, this role has allowed to me to develop skills related to stakeholder interest, since there is quite a bit on the line in the situations that we deal with as a committee.

I hope that my experience within a College committee speaks for itself and demonstrates how suitable I would be as a part of the Governance Committee.

**NOMINATION STATEMENT
CANDIDATE FOR PHYSICIAN MEMBER, GOVERNANCE COMMITTEE**



DR. JERRY ROSENBLUM

**District 3 Representative
Waterloo, Ontario**

**Principal Area of Practice or Specialty:
Anesthesiology**

**Elected Council Terms:
2013-2016
2016-2019**

CPSO Committees/Positions Held and Other CPSO Work:

Finance Committee:	2014 – 2016
Inquiries, Complaints and Reports Committee	2013 – 2016 2010 – 2013 (as non-council member)
Outreach Committee	2014 – 2016
Medical Review Committee	2001 – 2004 (as non-council member)
Patient Relations Committee	1996 – 2000 (as non-council member)
Peer Assessor	2004 – 2010 (as non-council member)

NOMINATION STATEMENT:

I have been involved with the College since 1996. My first role was as a member of the Patient Relations Committee. Then, after a short stint on the MRC, I served as a peer assessor for six years. In 2010, I joined the ICRC on which I continue to serve. I now also sit on the Outreach and Finance Committees.

As I begin my second three year term on Council, I am now seeking to further increase my involvement with the CPSO by running for Governance Committee. My knowledge and experience with the College over the past twenty years, and my proven dedication to the people of this province and the CPSO in particular, makes me an ideal candidate to serve on this important committee.

The skill set that gives me the tools to serve effectively on this committee includes my familiarity and understanding of the CPSO and its governance, my dedication, my ability to work well with others and my leadership skills. I now work part time at the hospital, which will allow me to meet the added time commitments.

Please support me in the upcoming vote for physician member of the Governance Committee.

**NOMINATION STATEMENT
CANDIDATE FOR PUBLIC MEMBER, GOVERNANCE COMMITTEE**



MS. DIANE DOHERTY
Public Member of Council
Toronto, Ontario

Occupation: Management Consultant

**Appointed Council Terms:
2010-2017**

CPSO Committees and Other CPSO Work:

Discipline Committee:	2010-2016
Education:	2011-2016
Fitness to Practise Committee:	2011-2016
Governance Committee:	2015-2016
Methadone Committee:	2010-2016, Chair- 2014-2016
Outreach Committee:	2011-2015
Policy Working Group : Consent to Medical Treatment	2014-2015
Policy Working Group: Test Results Management	2010-

NOMINATION STATEMENT:

With one year of service, as a member of the Governance Committee, I am keen to serve for another year in 2017.

For those of you who don't know me; my experience spans 35 years in correctional services, most of them as a senior manager, followed by seven years in the mental health field, as CEO of the Canadian Mental Health Association, Halton. Previously, I served thirteen years as a board member at the Hamilton branch.

My experience as a senior manager has allowed me to learn and practice skills such as strategic planning, problem solving, and human resources, including grievance administration, bargaining and many others.

I appreciate the opportunity to serve, and if successful, shall continue to give my best effort at the CPSO.

The 2016-17 Committee nomination rosters will be distributed to Council, prior to the December 1 and 2, 2016 meeting.

**Declaration of Adherence Form for Members of Council
2016-2017**

I acknowledge that, as a **member of Council** of the College of Physicians and Surgeons of Ontario:

- I have read and am familiar with the College's By-laws and governance policies.
- I stand in a fiduciary relationship to the College.
- I am bound to adhere to and respect the By-laws and policies applicable to the Council, including without limitation, the following:
 - Statement on Public Interest
 - Council Code of Conduct
 - Conflict of Interest Policy
 - Impartiality in Decision Making Policy
 - Confidentiality Policy
 - Role Description of College Council Member
- I am aware of the obligations imposed upon me by Sections 36 (1) (a) through 36 (1) (j) of the *Regulated Health Professions Act, 1991*.
- I have also read Section 40 (2) of the *Regulated Health Professions Act, 1991*, a copy of which is attached to this undertaking, and understand that it is an offence, carrying a maximum fine on conviction for a first offence of \$25,000.00, to contravene subsection 36 (1) of the *Regulated Health Professions Act, 1991*. I understand that this means in addition to any action the College or others may take against me, I could be convicted of an offence if I communicate confidential information in contravention of subsection 36 (1) of the *Regulated Health Professions Act, 1991*, and if convicted, I may be required to pay a fine of up to \$25,000.00 (for a first offence).

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

Signature: _____

Print Name: _____

Date: _____

Updated and Approved by Council: September 6, 2012

GOVERNANCE PRACTICES AND POLICIES

Statement on Public Interest

Introduction

The College of Physicians and Surgeons of Ontario is the self-regulating body for the province's medical profession. In carrying out its role as a regulator, it is the duty of the College to "serve and protect the public interest"³. All members of Council and committees, both public and professional, work together to regulate in the public interest.

Role of Council and Committee Members

Professional and public members are members of the College Council and College Committees.

When making decisions on behalf of the College, Council and committee members must act in the public interest; that is, for the common good, not in the interest of its members or some of its members. The public interest must always be in the forefront of Council and committee decision making.

All members of Council must act in the public interest. This includes:

- Physician members who are elected to Council. They do not represent their electoral districts or "constituents". Rather, they are elected to act in the public interest. Council's "constituents" are the public and patients of Ontario.
- Academic professional members who are appointed to the College Council by their academic institutions are not appointed to represent the interests of their institutions.
- Public members of Council who are appointed by the Lieutenant Governor in Council to represent the public interest and not government.

It is possible that while advancing the public interest, the College can also collectively advance the interests of the profession. However, there may be times when the public interest and the interest of the profession may not align and when this occurs precedence shall be given to the public interest to ensure public protection.

Approved by Council: November 20, 2009

Updated:

³ Subsection 3(2) of the *Health Professions Procedural Code*

Council Code of Conduct

Purpose

In carrying out its objects, the College has a duty to serve and protect the public interest.

Council is committed to ensuring that in all aspects of its affairs it maintains the highest standards of public trust and integrity.

Application

This Code of Conduct applies to all members of Council and to all non-council members of Committees of Council.

Council Members' Duties

All members of Council and Committees of Council stand in a fiduciary relationship to the College and are bound by the obligations that arise out of their fiduciary duties. As fiduciaries, Council and Committee members must act honestly, in good faith and in the best interests of the College.

Members will be held to strict standards of honesty, integrity and loyalty. A member shall not put personal interests ahead of the best interests of the College.

Members must avoid situations where their personal interests will conflict with their duties to the College. Members must also avoid situations where their duties to the College may conflict with duties owed elsewhere. These obligations are set out in greater detail in the College's Conflict of Interest Policy.

Members must respect the confidentiality of information about the College. This duty is set out in greater detail in the College's Confidentiality Policy.

Best Interests of the College

Members must act solely in the best interests of the College. All members are held to the same duties and standard of care. Members who are appointed or elected by a particular group must act in the best interests of the College even if this conflicts with the interests of that group.

Confidentiality

It is recognized that the role of Council member may include representing the College in the community. However, such representations must be respectful of and consistent with the Council member's duty of confidentiality. Every Council member, committee members, officer and employee of the College shall respect the confidentiality of information about the

College whether that information is received in a meeting of the Council or of a committee or is otherwise provided to or obtained by the member, officer or employee.

A member is in breach of his/her duties with respect to confidentiality when information is used or disclosed for purposes other than those of the College. The duty of confidentiality owed by members is set out in greater detail in the College's Confidentiality Policy.

Council Spokesperson

The President is the official spokesperson for the Council. It is the role of the President to represent the voice of Council to all stakeholders.

Media Contact and Public Discussion

News media contact and responses and public discussion of the College's affairs should only be made through the authorized spokespersons. Any member who is questioned by news reporters or other media representatives should refer such individuals to the Communications and Government Relations Department of the College, as set out in the Media Relations Policy.

No member of Council or a Committee of Council shall speak or make representations on behalf of the Council or the College unless authorized by the President (or, in the President's absence, the Vice-President) and the Registrar. When so authorized, the member's representations must be consistent with accepted positions and policies of the College.

Respectful Conduct

It is recognized that members bring to the Council and its committees diverse background, skills and experience. Members will not always agree with one another on all issues. All debates shall take place in an atmosphere of mutual respect and courtesy.

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

Corporate Obedience – Council Solidarity

Members acknowledge that properly authorized Council actions must be supported by all members. The Council speaks with one voice. Those Council members who have abstained or voted against a motion must adhere to and support the decision of a majority of the members.

Council Member Commitments

In addition to these general obligations, each member commits to:

- regularly attending all Council and/or committee meetings, being on time and engaging constructively in discussions undertaken at these meetings;
- preparing prior to each Council/committee meeting so that he or she is well-informed and thus able to participate effectively in the discussion of issues and policies;
- recognizing the President of the College as the principal spokesperson for Council and referring all requests for information as set out in the Media Relations Policy of the College;
- promoting the objectives of the College through outreach activities;
- stating to fellow councillors, committee members and College staff the member's ideas and beliefs in a clear and respectful manner;
- where the views of a Council or committee member differ from the views of the majority of Council members, working together with Council toward an outcome in service of the highest good for the public, the profession and the College;
- upholding the decisions and policies of the Council;
- behaving in an ethical, exemplary manner;
- preserving confidentiality;
- being respectful of others in the course of a member's duties and not engaging in verbal, physical or sexually harassing behaviour;
- respecting the boundaries of College staff whose role is neither to report to nor work for individual Council members;
- respecting the Conflict of Interest Policy of the College, including declaring all conflicts of interest and deriving no personal gain from being a Council or committee member;
- participating fully in both a self-evaluation and a peer evaluation process and endeavouring to address developmental needs in the member's performance;
- willingly sharing committee work and actively stating the member's preference for the committees with which he or she wishes to work;

- if a member becomes the subject of a hearing by the Discipline Committee or the Fitness to Practice Committee of the College, withdrawing from the activities of any committee on which the member serves until those proceedings are formally concluded.

Any member of Council or a Committee of Council who is unable to comply with this Code of Conduct, including any policies referenced in it, shall withdraw from the Council and/or Committees of Council.

Amendment

This Code of Conduct may be amended by Council.

Updated and approved by Council: November 24, 2006

Conflict of Interest Policy

Purpose

This policy defines conflict of interest and explains the duties of Council and committee members with respect to conflicts of interest.

Application

This policy applies to Council members and non-Council members of College committees (together referred to as “Members”).

Policy

All Members have a duty to act solely in the best interest of the College, consistent with the mandate of the College to act in the public interest, and to maintain the trust and confidence of the public in the integrity of the decision making processes of Council and College committees. To this end, Members must avoid or resolve conflicts of interest while performing their duties for the College. Even if there is no actual conflict of interest, Members must make best efforts to avoid situations that College members or a member of the public might consider or perceive as a conflict of interest.

Definition and Description of Conflict of Interest

Section 55 of the College’s General Bylaw (the “bylaw”) defines conflict of interest as follows:

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

The situations in which a potential conflict of interest may arise cannot be exhaustively set out. Conflicts generally arise in the following situations:

1. Interest of a Member: when a Member enters into any business arrangement either directly or indirectly with the College, or has a significant interest in a transaction or contract with the College;
2. Interest of a relative or association: when a Member’s immediate family or practice/business partner(s) enters into any business arrangement with the College;
3. Gifts: when a Member or a member of the Member’s household or any other person, company or organization chosen by the Member, accepts gifts, credits, payments, services or anything else of more than a token or nominal value from a party with whom the College may enter into a business arrangement (including a supplier of goods or

services) for the purposes of (or that may be perceived to be for the purposes of) influencing an act or decision of the Council or a committee of the Council;

4. Other motivating or competing interests:

(a) Self-interest: when a Member exercises his or her powers motivated by self-interest or any purpose other than the public interest;

(b) Competing Fiduciary Obligations and Roles in Other Organizations: when a Member has competing “fiduciary obligations” (see below) to both the College and another organization, and the interests or mandate of that other organization may, or may be perceived to, conflict with or be inconsistent with the interests or mandate of the College. For example, the Member holds a position on the governing body of an organization that advocates for physicians generally or for particular specialists. This could conflict with, or be seen to conflict with, the Member’s duty to act in the public interest in his or her role with the College. Members are asked to identify, on the Declaration of Adherence form, any relationships with other organizations that may create a conflict of interest by virtue of having competing fiduciary obligations.

A Member should avoid placing him/herself under an obligation to or entering into a relationship with another organization that gives rise to competing professional interests in the performance of his/her duties with the College, even if the Member’s role in the other organization falls short of being a “fiduciary”.

What do we mean by “fiduciary”? A person who is in a special relationship of trust and confidence with an organization (or an individual) is said to be a fiduciary of that organization, and as such, is obligated to act in the interests of that organization over the interests of others, including the person’s own interests. By virtue of a Member’s position on Council, the Member is a fiduciary of the College. A physician who has an executive position on the OMA, for example, would be a fiduciary to the OMA.

5. Failure to disclose information: when Members fail to disclose information that is relevant to a vital aspect of the affairs of the College.

Process for Resolution of Conflicts of Interest

Acting in a conflict of interest is a breach of College policy and may be the basis for removal from Council or a Council committee. Section 56 to 59 of the General By-law (attached) contain a process for disclosing and resolving a potential conflict of interest. If Council is not satisfied that a conflict is resolvable through the process in the General By-Law, Council may ask the Member to resign or disqualify the Member.

Amendment

Council may amend this policy.

Updated and approved by Council: December 4, 2014

Appendix 1

Conflict of Interest Provisions in College By-Law

Definition of Conflict of Interest

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

Process for Resolution of Conflicts in Council Matters

56. A council member who has or may have a conflict of interest in connection with council business shall consult with the registrar and disclose the conflict to council at the earliest opportunity, and in any case before council considers the matter to which the conflict relates. If there is any doubt as to whether a conflict exists, the member must declare it to council and accept council's decision as to whether a conflict exists.

57. A council member who has a conflict of interest shall:

- (a) disclose the conflict;
- (b) leave the room when council is discussing the matter; and
- (c) not vote on the matter, or try to influence the vote.

Process for Resolution of Conflict in Committee Matters

58. A committee member who has or may have a conflict of interest in connection with a matter before a committee shall consult with the appropriate committee support representative. For adjudicative committees, the committee member should consult with the Hearings Office. The committee member should disclose the conflict at the earliest opportunity, and in any case before the committee considers the matter. The committee member shall accept the Chair's direction as to whether there is a conflict of interest and any steps the Chair takes or requires to resolve the conflict. Where the Chair has or may have a conflict of interest, the Chair shall accept the executive committee's direction as to whether there is a conflict of interest and any steps the executive committee takes or requires to resolve the conflict.

Record of Declarations

59. Declarations with respect to conflicts of interest shall be recorded in the minutes of the meeting.

Impartiality in Decision Making Policy

Purpose

The purpose of this policy is to set out the appropriate processes for identifying and dealing with situations where a lack of impartiality might arise that could disqualify a member of a College committee from making a decision in a particular matter.

Application

Part I of this policy applies to all members of the Discipline and Fitness to Practice Committees in the context of a hearing involving a decision directly affecting the rights, interests or privileges of a named physician.

Part II of the policy applies to all members of College committees in the context of a meeting involving a decision directly affecting the rights, interests and privileges of a named physician or person.

This policy applies in addition to the Conflict of Interest Policy. This policy should be read in combination with Council's policy on the Provision of Opinions by Committee Members, attached as Appendix 1 to this policy.

PART I

Avoiding Perceptions of Bias in Adjudicative Decisions of the Discipline and Fitness to Practice Committees

Background

The Regulated Health Professions Act, 1991 calls upon the Discipline and Fitness to Practice Committees in certain circumstances to make final decisions in the context of a hearing which could affect a physician's rights, interests or privileges. Such final decisions are referred to in this policy elsewhere as "adjudicative decisions."

A Council or non-Council committee member sitting in an adjudicative role, for example, in a disciplinary hearing, must be free of a reasonable apprehension of bias. Whether actual bias exists or can be demonstrated is largely irrelevant. A physician whose rights and privileges may be curtailed as a result of an adjudicative decision is entitled to decision-makers who are neither biased, nor appear to a reasonable person to be biased.

A reasonable apprehension of bias exists where a reasonable and informed person, viewing the matter realistically and practically, and having thought the matter through, would conclude that the decision-maker, whether consciously or unconsciously, may not decide the matter fairly and impartially.

Policy

A committee member should not adjudicate in a hearing where circumstances may give rise to a reasonable apprehension of bias on the part of the member.

Identifying the Potential for Bias

It is impossible to outline all circumstances in which a reasonable apprehension of bias could arise, or to give definitive answers in the abstract. There are many different kinds of relationships, events and conduct that may give rise to a reasonable apprehension of bias. Committee members should be aware of the potential for bias and seek advice whenever a potential, even remote, likelihood of bias exists. By way of example, the following circumstances will often create a reasonable apprehension of bias on the part of the decision-maker in respect of a particular proceeding:

- The member has an association, relationship, non-financial interest or activity that would be seen to be incompatible with his or her responsibilities as an impartial decision-maker. Examples of these include:
 - The panel member provided an opinion in a case for or against the subject physician;
 - The panel member is the current or former practice partner of the subject physician; or
 - The panel member is a close friend or relative of the subject physician or the complainant.
- The member has prior knowledge of a matter, for example if a party is appearing before the member for a second time (but see note below), or the member obtained information about the matter through previous employment or other form of work or activity. Note that prior knowledge of a matter obtained through work at the College may not always create a reasonable apprehension of bias, depending on the context and the committees involved; the member should consult the Hearings Office or his/her committee support representative.
- The member has made past statements or expressed views about issues relevant to the matter before him or her that suggests prejudgment of the issue, or the member's past conduct or actions indicate prejudgment. The provision by a member of a letter of support (i.e. a character reference) to the College or a College committee in respect of a physician or facility for whom or which there is an investigation or review at any stage by the College may create a reasonable apprehension of bias; members should not provide these letters of support.
- An appearance of bias may arise from the member's conduct during the hearing; examples include communicating with one party without the knowledge or inclusion of the other, overly aggressive questioning of one party, refusing to hear evidence,

constant interruptions of one party, and laughing and making exasperated noises during testimony.

The following circumstances generally would not, of themselves, be considered to create a reasonable apprehension of bias on the part of a decision-maker in respect of a particular proceeding before a committee on which the member sits:

- The decision-maker went to medical school with the subject physician; or
- The decision-maker has attended educational conferences that the subject physician also attended.

Nothing set out above should be taken to interfere with the entitlement of a potential panel member to refuse to sit on a particular matter on the basis that he or she is of the view that an apprehension of bias may exist.

Process for Dealing with Potential Bias in an Adjudicative Proceeding

Prior to a particular matter coming before a panel of a committee, the Hearings Office, directly or indirectly through the independent legal counsel, should:

- provide each panel member with some basic information about the identity of the parties and their respective counsel or other representatives; and
- ask each panel member to advise whether he or she has had any interactions or relationship with the subject physician that could lead to a reasonable apprehension of bias in respect of that matter.

A committee member may at any time consult with the Hearings Office as to whether he or she should serve as a member of a panel hearing a particular matter, having regard to circumstances that might create a reasonable apprehension of bias on the part of the decision-maker.

Where at any time a committee member becomes aware of a circumstance or circumstances that might give rise to a reasonable apprehension of bias in respect of an adjudicative proceeding, he or she should immediately advise the Hearings Office. If the circumstance arises during the conducting of a hearing, the committee member should immediately notify independent legal counsel.

PART II

Maintaining Impartiality in Non-adjudicative Decisions of College Committees

Background

Most decisions made by College committees are non-adjudicative; that is, they are not final decisions which affect a physician's rights, interests or privileges, which a committee arrives at through a hearing. However, similar principles of fairness may apply to these decisions as to adjudicative decisions. Accordingly, committee members must be aware of circumstances which could give rise to a perception that they are not able to decide a matter fairly and impartially because of some connection to or relationship with the physician or person about whom they are making a decision.

Policy

A committee member should not take part in a decision if a reasonable and informed person would conclude that the member is not able to decide fairly and impartially, for example, because of some connection to or relationship with the physician or person about whom they are making a decision.

Maintaining Impartiality

The standard of impartiality for non-adjudicative decisions may be lower than that for adjudicative decisions. In other words, circumstances that could create a reasonable apprehension of bias for an adjudicative decision may not raise concerns about the ability of a committee member to decide a matter fairly and impartially in a non-adjudicative context. Generally, committee members should appear amenable to persuasion and keep an open mind in making a decision about a physician or person outside the adjudicative or hearing context.

The factors that are relevant for determining whether there may be a reasonable apprehension of bias in adjudicative decisions are also relevant in the context of non-adjudicative decisions. The circumstances listed above under the heading "Identifying the Potential for Bias" in Part I should be used as a tool for determining whether circumstances create the potential for the appearance that a decision lacks fairness and impartiality. It may not be the case that a committee member has to refrain from making a decision due to these circumstances. However, committee members should be aware of the potential that a personal relationship or strongly held opinion may give rise to the perception that the member has a "closed mind". Committee members should seek advice with respect to any concerns about maintaining impartiality.

Process for Maintaining Impartiality in Non-Adjudicative Decisions

When a committee member receives an agenda for a meeting, before reviewing the supporting materials, the member should review the names of the physicians and persons under consideration. The member should identify any physician or person about whom the member may not be able to reach an impartial and fair decision, or who may give rise to a perception that the member would not make an impartial and fair decision.

If the committee member identifies any such physician or person, the member should advise the committee support representative, who will consult with College counsel to determine if the member should or should not participate in the decision. The committee support representative will advise the member accordingly. The committee member should not review any materials relevant to such a physician or person until the matter is resolved.

If it is determined that there is a potential that the committee member would not make an impartial and fair decision, or a potential for a perception that the member would not make an impartial and fair decision, the member will leave the room or not participate in the conference call while the committee considers the particular physician or person's case. The committee will not ask the committee member to review or discuss any materials regarding the matter.

Amendment

Council may amend this policy.

Updated and approved by Council: December 4, 2014

Appendix 1

Provision of Opinions by Committee Members

- A.** No member of Council or of any College Committee shall provide an opinion in respect of matters that are currently being investigated or reviewed in any College department or by any College Committee.
- B.** (1) Prior to agreeing to provide any professional opinion for any type of proceeding or potential proceeding outside of the College, Council or non-Council Committee members shall:
- i. satisfy themselves that the matter is not at any stage of investigation or review in any College department or by any College Committee by:
 - a. asking the party who wishes to retain them if the matter is at the College; and
 - b. contacting their committee support person to confirm that the matter is not at the College; and
 - ii. satisfy themselves that the party who is retaining them does not intend to bring the matter to the College, and has received no indication that the opposing party has any intention to bring the matter to the College.
- (2) After being retained to provide an opinion or act as an expert, the Council or Committee member must advise support staff for Council or the relevant Committee of his or her involvement in a proceeding or potential proceeding involving a member of the College (“subject member”), in order to ensure that the appropriate internal College screen be established, to be used if the need arises. This is to ensure that the expert Council or Committee member is not involved in any future College matter involving the subject member.
- C.** If the College begins an investigation or review of the subject matter after a Council or relevant Committee member has been retained to provide an opinion or act as an expert, but prior to the Council or Committee member providing a draft or final opinion or testifying (whichever comes first), the Council or Committee member shall (i) immediately end his or her retainer to provide an opinion or act as an expert, (ii) ensure that no confidential information about the matter is provided to any other Council or Committee member, and that no College information is provided to any participant in the matter outstanding with the College, and (iii) recuse him/herself from the matter outstanding with the College.

- D.** If the College begins an investigation or review of the subject matter after a Council or Committee member provides any draft or final opinion or testifies in a proceeding, the Council or Committee member shall (i) immediately notify the College support person of the Council or Committee member's involvement in the case, (ii) ensure that no confidential information about the matter is provided to any other Council or Committee member, and that no College information is provided to any participant in the matter outstanding with the College, and (iii) recuse him/herself from the matter outstanding with the College.

FAQs relating to the Conflict of Interest Policy and Impartiality in Decision Making Policy are available at [FAQs relating to Conflict of Interest and Impartiality in Decision Making Policy](#)

Confidentiality Policy

Purpose

To ensure that confidential matters are not disclosed until disclosure is authorized by the Council.

Policy

Council and Committee members owe to the College a duty of confidence; not to disclose or discuss with another person or entity or to use for their own purpose confidential information concerning the business and affairs of the College received in their capacity as Council and/or Committee members unless otherwise authorized by the Council.

Every Council or Committee member shall ensure that no statement not authorized by the Council is made by him or her to the press or public.

Application

This policy applies to all Council and non-Council Committee members.

Confidential Matters:

All matters which are the subject of closed sessions of the Council are confidential until disclosed in an open session of the Council.

All matters which are before a committee or task force of the Council are confidential until disclosed in an open session of the council.

All matters which are the subject of open sessions of the Council are not confidential.

Notwithstanding that information disclosed or matters dealt with in an open session are not confidential, no Council member shall make any statement to the press or the public in his capacity as a Council member unless such statement has been authorized by the Council. Council members are referred to Council's Media Relations Policy.

1. Every Council member and Committee member is subject to section 36 (1) of the *Regulated Health Professions Act, 1991* which provides as follows:

36. (1) Every person employed, retained or appointed for the purposes of the administration of this Act, a health profession Act or the *Drug and Pharmacies Regulation Act* and every member of a Council or committee of a College shall keep confidential all information that comes to his or her knowledge in the course of his or her duties and shall not communicate any information to any other person except,

- (a) to the extent that the information is available to the public under this Act, a health profession Act or the *Drug and Pharmacies Regulation Act*;
- (b) in connection with the administration of this Act, a health profession Act or the *Drug and Pharmacies Regulation Act*, including, without limiting the generality of this, in connection with anything relating to the registration of members, complaints about members, allegations of members' incapacity, incompetence or acts of professional misconduct or the governing of the profession;
- (c) to a body that governs a profession inside or outside of Ontario;
- (d) as may be required for the administration of the *Drug Interchangeability and Dispensing Fee Act*, the *Healing Arts Radiation Protection Act*, the *Health Insurance Act*, the *Independent Health Facilities Act*, the *Laboratory and Specimen Collection Centre Licensing Act*, the *Ontario Drug Benefit Act*, the *Coroners Act*, the *Controlled Drugs and Substances Act (Canada)* and the *Food and Drugs Act (Canada)*;
- (e) to a police officer to aid an investigation undertaken with a view to a law enforcement proceeding or from which a law enforcement proceeding is likely to result;
- (f) to the counsel of the person who is required to keep the information confidential under this section;
- (g) to confirm whether the College is investigating a member, if there is a compelling public interest in the disclosure of that information;

- (h) where disclosure of the information is required by an Act of the Legislature or an Act of Parliament;
- (i) if there are reasonable grounds to believe that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons; or
- (j) with the written consent of the person to whom the information relates. 2007, c. 10, Sched. M, s. 7 (1).

2. Every individual who contravenes subsection 36 (1) of the *Regulated Health Professions Act, 1991* is guilty of an offence and on conviction is liable to a fine of not more than \$25,000.00 for a first offence.

40. (2) Every individual who contravenes section 31, 32 or 33 or subsection 34 (2), 34.1 (2) or 36 (1) is guilty of an offence and on conviction is liable to a fine of not more than \$25,000 for a first offence and not more than \$50,000 for a second or subsequent offence. 2007, c. 10 Sched. M, s. 12.

Procedure for Maintaining Minutes

1. Minutes of closed sessions of the Council shall be recorded by the Secretary or designate or if the Secretary or designate is not present, by a Council member designated by the President of the College.
2. All minutes of closed sessions of the Council shall be marked confidential and shall be handled in a secure manner.
3. All minutes of meetings of committees and task forces of the Council shall be marked confidential and shall be handled in a secure manner.

Amendment: This policy may be amended by Council.

Approved by Council: November 24, 2006

Updated: February, 2010

ROLE DESCRIPTION

College Council Member

Reports to (Title): Council
Administratively to President
Updated: February, 2010

Overview:

A Council member functions as a director of the CPSO and has the duty of participating fully in the governance of the CPSO, which is the self-regulating body for physicians and surgeons in the province of Ontario. In the fulfillment of the role of Council member, each Council member is responsible for upholding the vision of the CPSO, contributing to its mission, and acting in accordance with its values.

The major function is to establish College policy. Council members are both elected and appointed, bringing expertise relating to their constituencies. However, upon election or appointment, a Council member accepts a fiduciary responsibility for the management and administration of the College's affairs.

A Council member provides a link between the College and those who elect and appoint them, and supports the President of the College who is the principal spokesperson for the College. Council members must act in the public interest at all times.

Major Responsibilities:

- Maintain a working knowledge of the legislation under which the College operates.
- Read and become familiar with the College's By-laws and governance policies.
- Participate in establishing policy, strategic direction, and goals of the College to successfully meet its mission and purpose.
- Adhere to, respect and model behaviour described in the Statement on Public Interest, Council Code of Conduct, Conflict of Interest Policy, Apprehension of Bias Policy and Confidentiality Policy.
- Stay current on issues and events important to the medical profession and its stakeholders.
- Prepare for each Council meeting by reviewing meeting materials in order to understand the topics to be discussed, and the implications of policy and directional decisions.

- Attend each Council meeting and debate issues and policies pertaining to the College's mandate. Once a decision has been taken, align fully with the decision and uphold its implementation.
- Apply prudent and responsible thinking to the management of the affairs of the College in order that fiscally sound policies are applied in safeguarding the College's assets.
- Follow the established policies and processes of the College regarding communications and committee programs to enhance the effectiveness of the College's operations.
- When appointed to College committees, participate in the work of the committee toward the fulfillment of the purpose, mission, and vision of the College.
- Participate in the selection and appointment of a Registrar; monitor the performance of the Registrar through feedback reports by the College President or a designated committee; and participate in the determination of the annual compensation package of the Registrar.
- Ensure that appropriate succession planning of both Council leadership and the Registrar occurs so that the ongoing successful management of the CPSO is maintained.
- Engage in both an annual self and peer evaluation process to maintain successful performance of Council members.

Role Outcomes:

To define policy and monitor outcomes so that the College shall:

- regulate the practice of the medical profession in accordance with the laws of the province;
- develop, establish, and maintain standards of qualifications for physicians seeking certificates of registration to practice medicine in Ontario;
- develop, establish, and maintain standards of quality of the practice of medicine and the ethics of physicians and surgeons in the province;
- develop, establish, and maintain educational programs to ensure continuing competence of College members;
- adjudicate complaints against members of the profession ensuring the rights of the physician and the public are upheld;
- provide leadership by addressing health issues.

Principle Interfaces:

- Internal: Other Council members
- Non-Council committee members
- Staff supporting committees

- External: Members of the College (*serves as an ambassador to the profession*).
- The public

Desirable Behavioural Competencies:

Key behavioural competencies that are essential for successfully performing this role:

Continuous Learning – Involves taking actions to improve personal capability, and includes the ability to quickly understand and apply information, concepts, and strategies. Demonstrates an interest in continuous personal learning.

Creativity – Is generating new solutions, developing creative approaches, and implementing new approaches that lead to improved performance. It requires the ability to anticipate and lead change that contributes to organizational success.

Effective Communication – Is willing and able to see things from another person’s perspective. Demonstrates the ability for accurate insight into other people’s/group’s behaviour and motivation, and responds appropriately. It is the ability to accurately listen, understand, and respond effectively with individuals and groups.

Planning & Initiative – Recognizes and acts upon present opportunities or addresses problems. Displays effective use of time management skills. Is able to plan and organize workflow and meetings in an efficient manner to address the opportunity or problem.

Relationship Building – Is working to build or maintain ethical relationships or networks of contacts with people who are important in achieving Council-related goals and the College mission.

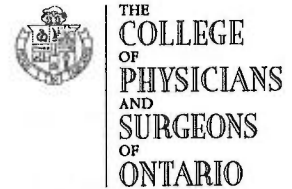
Results Oriented – Makes specific changes in own work methods or systems to improve performance beyond agreed standards (i.e., does something faster, at lower cost, more efficiently; improves quality; stakeholder satisfaction; revenues, etc.).

Stakeholder Focused – Desires to help or serve others, meets the organization’s goals and objectives. It means focusing one’s efforts on building relationships, and discovering and meeting the stakeholders’ needs. Partnerships between internal colleagues within the College are essential to meet external stakeholders needs.

Strategic Thinking – Understands the implications of decisions and strives to improve organizational performance. It requires an awareness of organizational issues, processes, and outcomes as they impact key stakeholders and the organization’s strategic direction.

Teamwork – Demonstrates cooperation within and beyond the Council or the College. Is actively involved and “rolls up sleeves”. Supports group decisions, even when different from one’s own stated point of view. Is a “good team player”, does his/her share of work. Compromises and applies rules flexibly, and adapts tactics to situations or to others’ response. Can accept setbacks and change own immediate behaviour or approach to suit the situation. Is candid about opinions and raises justified concerns.

2016 Public Members' Annual Report



I am pleased to present the 2016 report on behalf of the public members of Council.

We started the year with a full complement of members. However, due to a resignation and the pending departures of Dr. Attia and me, we will be ending 2016 down three, but hopeful of near term government appointments.

From my own perspective, I was appointed 11 years ago and I now think of my time at the College as my 3rd career, after Engineering and Business Management. Interestingly, when I started, public members served for a maximum term of 6 years. This year, we have had 7 public members serving more than 6 years. Thus, our experience factor has grown significantly.

Public member contribution

As members of Council we have the opportunity to make a contribution to the College and bring the public perspective to its work and, hopefully, ensure that all aspects of the College endeavours contribute to an improved health system for the people of Ontario.

As a group we come from across the province and have a range of skills, perspectives and experiences. We comprise 44% of the College's 34 person Council and are involved in all aspects of Council and committee work. We are members of all College committees, serve on all panels where member-specific decisions are made and serve on policy working groups. We also serve in leadership roles as committee and panel chairs as part of our work at the College. Pierre Giroux chairs Finance, Lynne Cram heads Outreach, Diane Doherty leads the Methadone committee and I have been one of the Vice-Chairs of ICRC for the past several years.

In reflecting on what public members find most surprising is the sheer volume of the work. It is estimated that public members serve an average of 80 days a year on College business and some public members contribute significantly more time. In 2015, the 4 ICRC members, and perhaps others, each spent over 100 days on College business and I believe that this is a very conservative estimate of time. Much of the work performed by public members is not captured in the expense submissions.

As we reflect on the time we spend on the key member specific panels, it may be worthwhile commenting on our outputs. The government has heard via some of their task forces and the media that these panels are often "soft" on the physician members in question. However, we public members who sit on every one of these panels see little evidence of bias and could report that there is broad consensus among the physician and public members on almost all decisions.

2016 Highlights

Much of the work that kept the College busy in the past year has major interest for the public at large.

The College has been a leader in developing a policy for Physician-Assisted Death. Starting in 2015, we learned from experts in the field, including those from Oregon and Quebec. With the Supreme Court deadline of Feb. 2016, we thought it important to develop guidance for the medical profession. Our foresight paid off as neither the provincial nor federal governments had such direction in place. Our interim policy helped guide the profession until the Federal government finally passed Medical Assistance in Dying legislation in June of this year. Work continues as we assist with implementation related issues.

Another major piece of work has been our development of updated recommendations on sexual abuse. The College's sexual abuse initiative was launched in 2014 to not only prevent sexual abuse by physicians but improve support for patients. In late 2014, the provincial government announced its own Task Force. As part of the initiative, the College has contributed to the work of the Minister's Task Force, identified a number of ways to strengthen the Regulated Professions Act (RHPA), and identified and implemented a number of other changes to support patients, prevent sexual abuse and improve College processes. Finally, in September of 2016, the government announced its Task Force recommendations, many of which dovetail with our work. We have strongly advocated for changes that will strengthen the legislative provisions with respect to sexual abuse, and will help us to better support and protect patients.

During 2016 there was also significant work on other fronts that will be important to the public. The College in partnership with the government is working to improve regulation of facilities outside of hospitals. As more and more patients will be utilizing such facilities, the strong regulatory process being put in place will benefit the public for years to come. Similarly, the joint effort between the College, Cancer Care Ontario will improve performance through strict quality measures being implemented for colonoscopies, mammography and pathology procedures.

Also, our hard working public members contributed to the College policy work. A number of policies were updated including: Physician Treatment of Self, Family Members and Others Close to them; Prescribing Drugs: Naloxone edit; Physician Behaviour in the Professional Environment; and an update on Marijuana for Medical Purposes.

This work is informed by a robust consultation and review process. I can think back to when I started at the College and consultation was largely with the membership and physician organizations. While the public was asked to participate, in reality we got the physician perspective and little else. Today, we routinely poll the public, use our website, Facebook page, and announce via Twitter. We also publish in Patient Compass (the College's public e-newsletter). This robust consultation process represents a major improvement in our efforts to ensure that our policies reflect the public's wishes.

2017 will see no letup in these efforts. Policy work important to the public will include: Ending the Physician-Patient Relationship; Accepting New Patients; Block Fees; Change in Scope/ Re-entering

Practice; Continuity of Care; Test Results Management; Prescribing Drugs: fentanyl edit + fact sheet; Practice Management Considerations and Physicians and Health Emergencies. Based on current government and media focus opioid usage and prescribing will result in much consultation and action. Of course the unexpected will happen and thus ensure that Dave and Rocco are not able to rest on past glories!

Message to the Government

I am not sure if this report is ever read by anyone in government but thought I would convey some thoughts in any case.

In past editions of the public member report, the issues around pay and inappropriate administration of payment has been highlighted and while they have not gone away we understand efforts are being made to address them. We hope for a conclusion!

We also encourage greater interaction with the government who appoints us. Although there have been a few meetings with the Health Board Secretariat, it would be helpful to engage in dialogue regularly about the actual nature of the work that we are performing and to seek guidance of its appropriateness. In my 11 years on Council I have never had any direct conversation, input or direction from government other than the administrators telling us how to fill in our expense reports

Also, as it relates to workload mentioned earlier, there should be easy remedies. To put in perspective on ICRC there are over 50 physician members and only a few are Council members. There are only 4 to 5 public members, thus the stretched workloads. Other committees face similar issues. The College has suggested a simple remedy, which would require a small legislative change: allow non-council members of the public to sit on panels as well.

Advice to the College on use of public members

As we give advice to government, we have some for the College as well. Research has shown that the public views the College much more favourably once they are aware that members of the public are part of panels. While on a few occasions, public members have been utilized (notably Harry), there is an opportunity here to significantly enhance the College's image.

Looking Ahead to 2017

While I will be leaving Council, I will continue to work on the Continuity of Care working group. Plus, I look forward to finding some other health-related organization that might consider my service.

For the remaining public members I am sure you will continue to spend your time generously contributing to the work of Council and College Committees. I suspect that you will remain committed to the work and appreciative of the collegiality, and the clear commitment of the College to the public interest.

Ron Pratt, Public Member