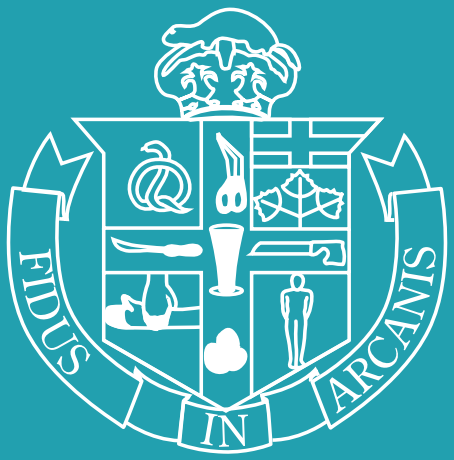
The College of Physicians and Surgeons of Ontario

Meeting of Council



February 23, 2018

NOTICE

OF

MEETING OF COUNCIL

A meeting of The College of Physicians and Surgeons of Ontario will take place on Friday February 23, 2018 in the Council Chamber of the College, at 80 College Street, Toronto, Ontario.

The meeting will convene at 9:00 a.m. on Friday February 23, 2018

Rocco Gerace, MD
Registrar

02/Feb/2018

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

MEETING OF COUNCIL
February 23, 2018
Council Chamber, 3rd Floor, 80 College Street, Toronto

CALL TO ORDER

9:00 President's Announcements

9:10 Closing a Medical Practice – Draft for Consultation 25

- ***For Decision***

The College's *Practice Management Considerations for Physicians Who Cease to Practice, Take an Extended Leave of Absence or Close Their Practice Due to Relocation* policy is under review.A new draft policy entitled *Closing a Medical Practice* has been developed. Council is asked whether the draft policy can be released for external consultation.

9:35 Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice – Consultation Report and Revised Draft Policy 39

- ***For Decision***

An updated and newly titled *Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice* draft policy was released for external consultation following the September meeting of Council. Council is asked whether the revised draft policy can be approved as a policy of the College.

10:00 Public Health Emergencies – Consultation Report and Revised Draft Policy .....

- ***For Decision***

The College's *Physicians and Health Emergencies* policy is under review. The newly-titled

draft *Physician Services During Disasters and Public Health Emergencies* policy was released for external consultation following the September meeting of Council. Council is asked whether the re-titled and revised *Public Health Emergencies* draft policy can be approved as a policy of the College.

10:15 ***Break***

FINANCE COMMITTEE REPORT

10:30 Fee By-Law and Cost Awards..... 72

2018 Membership Fee 72

Tariff Rate Increase for Discipline Hearings 78

- ***For Decision***

In October, the Finance and Audit Committee recommended to Council that the membership fee be set at $1725. The fee change has been circulated to the membership. Council is asked to approve the membership fee.
The Finance and Audit Committee also recommends to Council that the Discipline Committee's Tariff Rate be set at $10,180. Council is asked to approve this rate.

PRESENTATIONS

11:00 Education Strategic Initiative Update 84

- ***For Discussion***

Council will be provided with an update on the status of the Education Strategic Initiative and related activities planned for 2018 to 2020.

11:10 Opioid Strategy – Update..... 90

- ***For Discussion***

COUNCIL AWARD PRESENTATION

11:30 Council Award Winner: Dr. Bill I. Wong of Toronto, Ontario 95

12:00 IN CAMERA

12:15 ***LUNCH***

PRESENTATION

1:15 Continuity of Care and Test Results Management Policy Development Update 98

- ***For Discussion***

Work is currently underway to develop new policies relating to a number of Continuity of Care issues and to update the current Test Results Management policy. Council is provided with an update on these activities and an overview of the issues that will be addressed in these policies, as well as planned next steps.

GOVERNANCE COMMITTEE REPORT

2:15 For Information: 108

1. **New Public Member of Council**
2. **Committee Appointments**
3. **Current Committee Vacancies**

***For Discussion*: 110**

1. **Non-LGIC Public Members on Committees: Premises Inspection**
2. **Governance Review**

***For Decision*: 113**

1. **2019-2021 District Election Dates**

2. ***Committee Appointments for New Council Members***

MEMBER TOPICS

REGISTRAR'S REPORT

INFORMATION ITEMS

ADJOURNMENT

PROCEEDINGS OF THE
MEETING OF COUNCIL
OF
THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
NOVEMBER 30, 2017

Members:

Dr. David Rouselle (President)
Dr. Steven Bodley
Dr. Brenda Copps
Ms. Lynne Cram
Mr. Harry Erlichman
Ms. Joan Fisk
Dr. Marc Gabel
Ms. Debbie Giampietri
Mr. Pierre Giroux
Dr. Rob Gratton
Dr. Deborah Hellyer
Major Abdul Khalifa
Dr. Joel Kirsh
Mr. John Langs
Dr. Carol Leet
Dr. Barbara Lent
Dr. Haidar Mahmoud
Ms. Ellen Mary Mills
Ms. Judy Mintz
Mr. Peter Pielsticker
Dr. Dennis Pitt
Dr. Judith Plante
Dr. Peeter Poldre
Ms. Joan Powell
Dr. John Rapin
Mr. Arthur Ronald
Dr. Jerry Rosenblum
Ms. Gerry Sparrow
Mr. Emile Therien
Dr. Andrew Turner
Dr. James Watters
Dr. Scott Wooder

Non-voting Academic Representatives on Council: Dr. Akbar Panju, Dr. Robert (Bob) Smith, and Dr. Janet van Vlymen

Regrets: Dr. Richard (Rick) Mackenzie

CALL TO ORDER

President's Announcements

Dr. David Rouselle called the meeting to order at 9:10 a.m.

Council Meeting Minutes of September 8, 2017

1-C-11-2017

It is moved by Major A. Khalifa and seconded by Dr. Deborah Hellyer that:

The Council accepts the minutes of the meeting of the Council held on September 8, 2017.

CARRIED

Executive Committee's Report to Council – August to November 2017

Received with no comments.

PRESENTATION

Policy: Enhancing Accessibility

Andréa Foti, Manager of Policy, provided an update on work that is currently underway to enhance the readability, navigability and accessibility of CPSO policies (a copy of the presentation forms Appendix "A" to the minutes of this meeting).

FOR DECISION

Uninsured Services: Billing and Block Fees – Consultation Report and Revised Draft Policy

2-C-11-2017

It is moved by Dr. Marc Gabel and seconded by Dr. Barbara Lent:

The Council approves the revised policy "Uninsured Services: Billing and Block Fees", formerly titled "Block Fees and Uninsured Services", (a copy of which forms Appendix "B" to the minutes of this meeting).

CARRIED

Motion to go In-Camera

3-C-11-2017

It is moved by Dr. Peeter Poldre and seconded by Dr. Deborah Hellyer that:

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

CARRIED

IN-CAMERA

Council entered into an in-camera session at 10:50 a.m. and returned to open session at 11:25 a.m.

COUNCIL AWARD PRESENTATION

Dr. Marc Gabel presented the Council Award to Dr. Kenneth Fung of Toronto, Ontario.

REPORT OF THE FINANCE COMMITTEE – 2018 BUDGET

Mr. Pierre Giroux presented the report of the activities of the Finance Committee.

By-law Change:

04-C-11-2017

It is moved by Mr. Peter Pielsticker and seconded by Dr. Jerry Rosenblum that:

The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 118:

By-law No. 118

1. Subsections 2(1), 4(1)(d), 4(3)(b)(ii) and 6(7)(a) of the General By-Law are amended by deleting all references in those subsections to "finance committee" and substituting them with "finance and audit committee".
2. Section 41 of the General By-Law is amended by revoking "3 Finance Committee" and substituting it with "3 Finance and Audit Committee".
3. Section 43 of the General By-Law is amended:
   (a) by deleting all references in that section to "finance committee" and substituting them with "finance and audit committee"; and
   (b) by deleting the title "Finance Committee" and substituting it with the title "Finance and Audit Committee".

CARRIED

Safe Disclosure:

5-C-11-2017

It is moved by Dr. Deborah Hellyer and seconded by Mr. John Langs that:

The Council approve the Safe Disclosure Policy (a copy of which forms Appendix "C " to the minutes of this meeting) as presented.

CARRIED

Budget 2018:

6-C-11-2017

It is moved by Mr. Peter Pielsticker and seconded by Dr. Steve Bodley that:

The Council approve the "Budget for 2018" (a copy of which forms Appendix "D" to the minutes of this meeting) authorizing expenditures for the benefit of the College during the year 2018.

Amended Motion:

7-C-11-2017

It is moved by Dr. Joel Kirsh and seconded by Dr. Marc Gabel that:

The Council approve the "Budget for 2018" (a copy of which forms Appendix "D" to the minutes of this meeting) authorizing expenditures for the benefit of the College during the year 2018.

Council directs staff to work towards connecting financial reporting and budget requests to quantitative measures of volume and complexity in member-specific committees,

and

Council directs staff and committee chairs that financial reporting and budget forecasts be included in the annual reports from member-specific committees.

CARRIED

Per Diem Increase, By-law Change:

8-C-11-2017

It is moved by Harry Erlichman and seconded by Dr. Barbara Lent that:

The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 117:

By-law No. 117

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, 2018:

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) $633 per half day for the president,
  (ii) $522 per half day for the vice-president, and
  (iii) $486 per half day for the other members, and

CARRIED

Annual Fee Increase, By-law Change:

9-C-11-2017

It is moved by Mr. Emile Therien and seconded by Dr. Steve Bodley that:

The Council of the College of Physicians and Surgeons of Ontario proposes to make the following By-law No. 116, after circulation to stakeholders:

By-law No. 116

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

Annual Fees

4. Annual fees for the year beginning June 1, 2018, are as follows:

    (a) $1725 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; and

CARRIED

PRESENTATION

Bill 160, Schedule 9 *Oversight of Health Facilities and Devices Act, 2017*

Wade Hillier, Director of Quality Management, provided an overview of the changes contained in Schedule 9 of Bill 160 and the College's assessment and suggested amendments to the Bill, including the latest developments at Queen's Park in regards to amendments to the Bill and next steps, (a copy of which forms Appendix "E" to the minutes of this meeting).

REGISTRAR'S REPORT

Corporate Report and Dashboard – 2017 Q3

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

ADJOURNMENT DAY 1

The President adjourned the meeting at 4 pm.

_____
Dr. David Rouselle, President

_____
Ms. Franca Mancini, Recording Secretary

PROCEEDINGS OF THE
MEETING OF COUNCIL
OF
THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
December 1, 2017

Members:

Dr. David Rouselle (President)
Dr. Steven Bodley
Dr. Brenda Copps
Ms. Lynne Cram
Mr. Harry Erlichman
Ms. Joan Fisk
Dr. Marc Gabel
Ms. Debbie Giampietri
Mr. Pierre Giroux
Dr. Rob Gratton
Dr. Deborah Hellyer
Major Abdul Khalifa
Dr. Joel Kirsh
Mr. John Langs
Dr. Carol Leet
Dr. Barbara Lent
Dr. Haidar Mahmoud
Ms. Ellen Mary Mills
Ms. Judy Mintz
Mr. Peter Pielsticker
Dr. Dennis Pitt
Dr. Judith Plante
Dr. Peeter Poldre
Ms. Joan Powell
Dr. John Rapin
Mr. Arthur Ronald
Dr. Jerry Rosenblum
Ms. Gerry Sparrow
Dr. Andrew Turner
Dr. James Watters
Dr. Scott Wooder

Non-voting Academic Representatives on Council: Dr. Akbar Panju, Dr. Robert (Bob) Smith, and Dr. Janet van Vlymen

Regrets: Dr. Richard (Rick) Mackenzie, Mr. Emile Therien

CALL TO ORDER

President's Announcements

Dr. Dave Rouselle called the meeting to order at 9:05 a.m.

PRESENTATION

Registration Pathways Program Evaluation

Wendy Yen, Senior Researcher, Research and Evaluation and Dan Faulkner, Deputy Registrar, provided an update of the evaluation findings and the value that data and evidence can bring to

the regulatory work of the College, including the ability to report on effectiveness in an evidence-informed way, (a copy of which forms Appendix “F” to the minutes of this meeting).

PRESENTATION

Physician Health Program Update

Dr. Joy Albuquerque, Medical Director of the Ontario Medical Association's Physician Health Program, provided an overview of the Program and the services it offers (a copy of the presentation forms Appendix "G" to the minutes of this meeting).

REGISTRAR’S FORUM

Reflections on Regulation

Dr. Rocco Gerace provided some reflections on the future of regulation, based on his experience.

PRESIDENT’S TOPICS

Presidential Address

Dr. David Rouselle delivered his Presidential Address to Council and reflected on his experiences during his year as President. He thanked his fellow Council members for their time, particularly Mr. Sudershen Beri, Ms. Diane Doherty, Dr. Marc Gabel, Dr. Joel Kirsh, Dr. Carol Leet, Dr. Rick MacKenzie, Mr. Arthur Ronald, Mr. Emile Therien and Dr. Jim Watters, whose terms on Council had come to an end. Dr. Rouselle thanked the Registrar and College staff for their support throughout his presidential term on Council.

Induction of New President: Dr. Steven Bodley

Dr. Rouselle presented Dr. Bodley with a President’s pin and the chains of office.

Induction of New Members of Council

Dr. Bodley presented Council pins to Dr. Mary Bell, Dr. Paul Hendry, Dr. Elizabeth Samson, Dr. Philip Berger and Dr. Patrick Safieh, and invited them to take their seats at the Council table.

GOVERNANCE COMMITTEE REPORT

Dr. Joel Kirsh presented the Governance Committee report.

2018 Governance Committee Election:

10-C-12-2017

It is moved by Mr. Pierre Giroux and seconded by Ms. Lynne Cram that:

The Council appoints Dr. Jerry Rosenblum, (physician member), Mr. John Langs (as public member), and Ms. Joan Powell, (as public member), to the Governance Committee for 2017-18.

CARRIED

Appointment of Vice Chair of the Methadone Specialty Panel of the QualityAssurance Committee:

11-C-12-2017

It is moved by Dr. Deborah Hellyer and seconded by Dr. Peter Pielsticker that:

The Council appoints Dr. Meredith MacKenzie as Vice Chair of the Methadone Specialty Panel of the Quality Assurance Committee for 2017-18.

CARRIED

2017-2018 Committee Nominations:

12-C-12-2017

It is moved by Ms. Joan Powell and seconded by Dr. Judith Plante that:

The Council appoints the following people to the following committees:

Council Award Selection Committee:

Dr. Steven Bodley
Ms. Lynne Cram

Dr. Joel Kirsh
Dr. Carol Leet
Dr. David Rouselle

Discipline Committee:

Dr. Ida Ackerman
Dr. Philip Berger
Dr. Vinita Bindlish
Dr. Carole Clapperton
Dr. Pamela Chart
Dr. Paul Casola
Dr. Melinda Davie
Dr. Marc Gabel
Dr. Paul Garfinkel
Ms. Debbie Giampietri
Mr. Pierre Giroux
Dr. Kristen Hallett
Dr. Deborah Hellyer
Dr. Paul Hendry
Major Abdul Khalifa
Dr. William L. M. King
Mr. John Langs
Dr. Barbara Lent
Dr. Bill McCready
Ms. Ellen Mary Mills
Dr. Veronica Mohr
Dr. Tracey Moriarity
Dr. Joanne Nicholson
Mr. Peter Pielsticker
Dr. Dennis Pitt
Dr. Peeter Poldre
Dr. John Rapin
Dr. Patrick Safieh
Dr. Elizabeth Samson
Dr. Harvey Schipper
Dr. Robert Sheppard
Dr. Fay Sliwin
Ms. Gerry Sparrow
Dr. Eric Stanton

Dr. Peter Tadros
Dr. Andrew Turner
Dr. David Walker
Dr. James Watters
Dr. John Watts
Dr. Scott Wooder
Dr. Sheila-Mae Young
Dr. Paul Ziter

Education Committee:

Dr. Mary Bell
Dr. Brenda Copps
Dr. Paul Hendry
Dr. Barbara Lent
Dr. Akbar Panju
Ms. Joan Powell
Dr. Suzan Schneeweiss
Dr. Robert Smith
Dr. Janet Van Vlymen

Finance Committee:

Dr. Thomas Bertoia
Dr. Steven Bodley
Mr. Pierre Giroux
Mr. Harry Erlichman
Mr. Peter Pielsticker
Dr. Peeter Poldre
Dr. Jerry Rosenblum

Fitness to Practise Committee:

Dr. Pamela Chart
Dr. Carole Clapperton
Dr. Melinda Davie
Dr. Marc Gabel
Dr. Paul Garfinkel
Ms. Debbie Giampietri
Dr. Deborah Hellyer
Major Abdul Khalifa
Dr. William L. M. King
Dr. Barbara Lent

Dr. Bill McCready
Dr. Tracey Moriarity
Dr. Dennis Pitt
Dr. Robert Sheppard
Dr. Eric Stanton
Dr. John Watts
Dr. Paul Ziter

Governance Committee:

Dr. Steven Bodley
Dr. Peeter Poldre
Dr. David Rouselle
Dr. Jerry Rosenblum
Mr. John Langs
Ms. Joan Powell
Public member of Council

Inquiries, Complaints and Reports Committee:

Dr. George Arnold
Dr. Haig Basmajian
Dr. Mary Bell
Dr. Harvey Blankenstein
Dr. Brian Burke
Dr. Bob Byrick
Dr. Angela Carol
Dr. Anil Chopra
Ms. Lynne Cram
Dr. Nazim Damji
Dr. Naveen Dayal
Dr. William Dunlop
Dr. James Edwards
Mr. Harry Erlichman
Dr. Thomas Faulds
Ms. Joan Fisk
Dr. Rob Gratton
Dr. Daniel Greben
Dr. Andrew Hamilton
Dr. Christine Harrison
Dr. Keith Hay
Dr. Elaine Herer

Dr. Robert Hollenberg
Dr. Nasimul Huq
Dr. Francis Jarrett
Dr. John Jeffrey
Dr. Carol Leet
Dr. Edith Linkenheil
Dr. Haidar Mahmoud
Dr. Jack Mandel
Dr. Edward Margolin
Dr. Bill McCauley
Dr. Robert McMurtry
Dr. Patrick McNamara
Dr. Dale Mercer
Ms. Judy Mintz
Dr. Lawrence Oppenheimer
Dr. Akbar Panju
Dr. Judith Plante
Ms. Joan Powell
Dr. Peter Prendergast
Dr. Anita Rachlis
Dr. Jerry Rosenblum
Dr. Nathan Roth
Dr. David Rouselle
Dr. Ken Shulman
Dr. Wayne Spotswood
Dr. Michael Szul
Mr. Emile Therien
Dr. Lynne Thurling
Dr. Donald Wasylenki
Dr. Stephen White
Dr. Stephen Whittaker
Dr. Lesley Wiesenfeld
Dr. Jim Wilson

Methadone Committee:

Dr. Lisa Bromley
Dr. Michael Franklyn
Dr. Trevor Gillmore
Dr. Barbara Lent
Dr. Meredith MacKenzie

Outreach Committee:

Dr. Steven Bodley
Ms. Lynne Cram
Mr. Pierre Giroux
Dr. Deborah Hellyer
Mr. John Langs
Dr. Peeter Poldre
Dr. Jerry Rosenblum
Dr. David Rouselle
Ms. Gerry Sparrow

Patient Relations Committee:

Dr. Philip Cheifetz
Dr. Timothy Frewen
Ms. Julie Kirkpatrick
Ms. Lisa McCool-Philbin

Premises Inspection Committee:

Dr. Bob Byrick
Dr. Wayne Carman
Dr. John Davidson
Dr. Bill Dixon
Dr. Marjorie Dixon
Dr. Pawan Kumar
Ms. Ellen Mary Mills
Dr. Gillian Oliver
Dr. Dennis Pitt
Dr. Jerry Rosenblum
Dr. Andrew Turner
Dr. James Watson

Quality Assurance Committee:

Dr. Lisa Bromley
Dr. Brenda Copps
Dr. Jacques Dostaler
Dr. Mariam Ghali Eskander
Dr. Michael Franklyn
Ms. Debbie Giampietri

Dr. Trevor Gillmore
Mr. Pierre Giroux
Dr. Natasha Graham
Dr. Deborah Hellyer
Dr. Hugh Kendall
Mr. John Langs
Dr. Barbara Lent
Dr. Meredith MacKenzie
Dr. Bill McCready
Mr. Peter Pielsticker
Dr. Deborah Robertson
Dr. Patrick Safieh
Dr. Bernard Seguin
Dr. Robert Smith
Dr. Leslie Solomon
Dr. Tina Tao
Dr. Smiley Tsao
Dr. Janet Van Vlymen
Dr. James Watters

Registration Committee:

Dr. Bob Byrick
Mr. Harry Erlichman
Dr. John Jeffrey
Dr. Barbara Lent
Dr. Akbar Panju
Dr. Judith Plante
Ms. Joan Powell
Dr. Jay Rosenfield

CARRIED

Chair of the 2017-2018 Methadone Committee:

13-C-12-2017

It is moved Dr. Barbara Lent and seconded by Ms. Gerry Sparrow that:

The Council appoints Dr. Meredith MacKenzie as Chair of the Methadone Committee for 2017-18.

CARRIED

Completion of Annual Declaration of Adherence Forms:

Council members were provided with the Annual Declaration of Adherence Form for completion.

MEMBER TOPICS

i. Dr. Haidar Mahmoud re: Walk-in Clinics
ii. Dr. John Rapin re: College Outreach Program coming to communities in Ontario

ANNUAL COMMITTEE REPORTS

Council reviewed the following Annual Committee Reports:

Discipline Committee
Education Committee
Executive Committee
Fitness to Practise Committee
Governance Committee
Inquiries, Complaints and Reports Committee
Methadone Committee
Outreach Committee
Patient Relations Committee
Premises Inspection Committee
Quality Assurance Committee
Registration Committee

TOPICS FOR INFORMATION

Opioid Strategy Update

Government Relations Report

2017 District Elections

Policy Report

Physicians Assistants

Quality Management Partnership: Proposed changes to the companion document *"Applying the Out-of-Hospital Premises Inspection Program (OHPIP) Standards in Endoscopy/Colonoscopy"* – Role of the Medical Director

Discipline Committee – Report of Completed Cases – November 2017

ADJOURNMENT DAY 2

There being no further business, the President adjourned the meeting at 12:30 pm.

_____
Dr. David Rouselle, President

_____
Ms. Franca Mancini, Recording Secretary

Special Council Teleconference of February 6, 2018

No Meeting Materials

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

February 2018

TOPIC: Executive Committee's Report to Council
December 2017 – February 2018
In Accordance with Section 12 HPPC

FOR INFORMATION

October 31, 2017 Executive Committee Meeting

5. *Oversight of Health Facilities and Devices Act* (Schedule 9 of Bill 160)

The *Oversight of Health Facilities and Devices Act, 2017*(OHFDA) will, if passed, establish a single legislative framework for:

- community health facilities (including Independent Health Facilities (IHFs), Out-of- Hospital Premises (OHPs), private hospitals, and other facilities prescribed in regulation, and
- energy applying and detecting medical devices (EADMDs) (e.g. conventional X-rays, CTs and fluoroscopy, MRIs, ultrasounds, nuclear or molecular imaging devices).

Overall, the legislation is consistent with the College's recommendations for a consolidated regime. Unlike the current IHF Program, ownership of the assessment process and decision outcomes from an inspection will now reside with the College. The College will also be able to act immediately through the inspector to order a facility to cease performing services that pose a patient safety concern. This program, like the OHPIP program, will operate on a cost-recovery basis.

The Executive Committee approved the College's proposed submission to government. It voices support for the Schedule, but will raise concerns with respect to a focus on regulating "services" rather than locations and persons and propose some amendments to address them. Another concern is timing of enactment, which needs to be, at minimum, a year in the future, to allow the College time to do the needed preparation. Amendments are also required to ensure that the payment of fees is a condition for the issuance, transfer, or renewal of a CHF license.

10. Bill 163*, Protecting a Woman's Right to Access Abortion Services Act, 2017*

The Executive Committee was provided with an overview of the Bill's contents and a summary of the steps taken by the College to voice support for the Bill.

11. Mandatory and Permissive Reporting Policy - Housekeeping Amendments

The Committee was provided with an overview of the amendments and the revised Mandatory and Permissive Report policy.

12. Physician Assistants

The Committee was provided with an overview of the Ministry of Health and Long-Term Care's work related to Physician Assistants (PAs). Minister Hoskins has asked the College to work with the Ministry on an approach to provide appropriate regulatory oversight for PAs.

December 14, 2017 Executive Committee Meeting

1. Public Appointment Issues and Rising Caseloads

The Executive Committee was provided with an overview of serious issues with the public appointments system in relation to rising caseloads.

The most pressing issue is the fact that as of January 4, 2018, the College will be short three public members of Council. As a result, the College may have no choice but to postpone discipline hearings in January and February because the Discipline Committee is not able to meet the quorum requirement of two public members of Council on each panel. The College's public Council member resources are stretched at a time when caseloads are growing.

Even with the appointment of 15 available public members of Council, the College will continue to experience problems putting together discipline panels given anticipated caseloads. Given the magnitude of the problem, system change is necessary.

To that end, the Executive Committee directed that a letter be sent to the Minister of Health and Long-Term Care that clearly outlines the ramifications of having insufficient number of public members available for hearings. The letter will indicate that issues with the public appointments system and process require the minister's immediate attention.

The short term solution is for government to appoint three qualified and available public members to the College Council. The 2018 solution is to work with the College beginning in January to attain regulatory or statutory change to expand the pool of individuals who are eligible to act as public members for the College on its Discipline Committee.

2. Letter to Minister re: Physician Assistants

In August 2017, the Minister of Health and Long-Term Care asked the College to work with the Ministry on an approach to provide appropriate regulatory oversight for Physician Assistants (PAs). A proposed response to the Minister's letter was drafted and the Executive Committee approved the response.

The College recommends a phased approach to enhancing the accountability structure for PAs. The phased approach would involve two strategies to support and strengthen the accountability framework. The first would be the development of a resource document for physicians to clarify the application of the Delegation of Controlled Acts policy to PAs. The College would lead this work. The second would be the development of a prototype medical directive specific to physician assistants, similar to the Emergency Department Medical Directives Implementation Kit, jointly developed by the Ontario Hospital Association, the Ontario Medical Association and the Ministry of Health and Long-Term Care. It is recommended that the Ministry PA Integration Working Group lead this work.

3. Draft CPSO Statement: Physician Administration of Edaravone

The Executive Committee approved a draft statement articulating the College's expectations of physicians who administer the drug Edaravone, which is for the treatment of amyotrophic lateral sclerosis (ALS).

Edaravone is not currently approved for use in Canada. Physicians have contacted the College to inquire whether they are permitted to administer Edaravone which has been imported from abroad by patients.

The statement indicates that while Edaravone's status as an unapproved drug restricts physicians from prescribing it, physicians are not restricted from administering Edaravone, provided that they have the necessary knowledge, skills and judgment to do so safely and effectively. In addition to administering Edaravone directly to a patient, physicians are also permitted to delegate the administration of Edaravone, in accordance with the College's Delegation of Controlled Acts policy, or issue an initiating order to a Registered Nurse or Registered Practical Nurse to administer it.

As with any other treatment or procedure, physicians must ensure that they meet the standard of care when administering Edaravone, and ensure that all other professional and legal duties are met when doing so, including obtaining informed consent, documenting consent in the patient's record, and managing any adverse events that may arise.

Contact: Steven Bodley, President
Lisa Brownstone, ext. 472

Date: February 5, 2018

FOR DECISION

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

February 2018

TOPIC: Closing a Medical Practice – Draft for Consultation

FOR DECISION

ISSUE:

- The College's *Practice Management Considerations for Physicians Who Cease to Practise, Take an Extended Leave of Absence or Close Their Practice Due to Relocation* policy is currently under review. After considering the research, as well as the feedback received during the preliminary consultation, a draft policy entitled *Closing a Medical Practice* has been developed.

- Council is provided with an overview of the review process undertaken to date, as well as a copy of the draft policy. Council is asked whether the draft policy can be released for external consultation.

BACKGROUND:

- The College's *Practice Management Considerations for Physicians Who Cease to Practise, Take an Extended Leave of Absence or Close Their Practice Due to Relocation* policy is currently under review in accordance with the regular policy review cycle.

- As detailed below, the revisions proposed to the policy are motivated by a lack of clarity in the current policy and gaps identified in the consultation feedback and research. Expectations around patient notification, physicians' obligations in facilitating continuity of care, and the scope of the policy have all been updated.

- The policy was first approved by Council in September 2006 and last updated in 2007. It sets out expectations for physicians with respect to the practice management measures they should take before they stop practising or in situations where they will not be practising for an extended period of time due to retirement, relocation, leave of absence, or as a result of disciplinary action by the College.

- The policy review is being undertaken with the assistance Dr. Judith Plante (Council Member), Ms. Judy Mintz (Public Council Member), Dr. Michael Szul (Medical Advisor), and Ms. Elisabeth Widner (Legal Counsel).

- The draft policy presented for Council's consideration has been informed by extensive research and external consultation. Highlights of the issues and content considered as part of the review are set out below.

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 scholarly articles, research papers, media articles, and professional publications was conducted. The topics considered included, but were not limited to:
        - Adequate notification of patients and the impact of "patient abandonment";
        - Physician responsibilities in providing assistance in ensuring ongoing care; and
        - Medical records obligations when a physician closes a medical practice.

    - **Jurisdictional Research:** A jurisdictional review of Canadian medical regulators was undertaken with respect to expectations for closing a medical practice. A number of the key themes of this review were:
        - The detailed requirements for the timing, contents, and methods of notification;
        - The expectations to provide patients with assistance in finding a new physician; and
        - Obligations surrounding medical records, prescription drugs, and access to test results.

    - **Internal Data Collection:** A review of common questions and concerns that are heard by staff (in the Physician Advisory Service) pertaining to closing a medical practice was conducted. Matters considered by the Investigations, Complaints and Resolutions (ICR) Committee, where this policy was relied upon, was also examined.
        - Adequate notification to patients of a practice closure emerged as a primary issue. ICRC decisions noted inadequate notification and confusion with the current policy's expectations regarding mandatory and permissive forms of notification.

- A review of relevant legislation, case law, and related materials to closing a medical practice from the Ontario government (i.e. HealthForceOntario) were also conducted to identify opportunities for improved clarity or precision in the policy.

B. Preliminary Public Consultation and Committee Feedback

Consultation Process

- An external preliminary consultation took place from June 13 and August 12, 2016.[1]

- The College received a total of 35 responses to this consultation. These included 11 comments on the College's online discussion page (8 physicians and 3 organizations), and 24 online surveys (22 physicians and 2 members of the public). [2]

- 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, stakeholders expressed support for the current policy. The majority of respondents found the current policy to be clear – it is easy to understand, well organized and clearly written. As well, the majority of respondents found the current policy to be comprehensive.

- A number of respondents made suggestions on how the policy could be improved, including:

    - Providing more guidance on situations where a physician takes a leave of absence or ceases to practise due to a sudden or unexpected illness or death;
    - Clarifying the application of the policy to specialists;
    - Establishing a minimum timeline for patient notification of a practice closure and clarifying what classifies as a leave of absence;
    - Providing additional resources for physicians in order for them to help patients obtain care from another health care provider;

[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] Approximately 86% of respondents to the consultation identified themselves as physicians, 9% as organizations, and 5% as members of the public. The organizational respondents were the Office of the Information and Privacy Commissioner of Ontario, the Professional Association of Residents of Ontario, and the College of Physicians and Surgeons of Saskatchewan.

  - Providing additional information about the duties physicians have in safeguarding and retaining personal health records; and
  - Clarifying the expectations that apply to physicians who are relocating rather than ceasing to practise.

- A number of physician respondents expressed concern that the inability to arrange for another physician to assume care of their patients was outside of the physician's control due to factors such as inadequate physician supply. A couple of physician respondents expressed opposition to the policy; one stating that the expectations are so onerous it is not worth retiring, and the other stating that "no one physician is so central and irreplaceable" that the policy is needed.

CURRENT STATUS:

- Building upon the research and feedback gathered to date, a draft *Closing a Medical Practice* policy has been developed. The draft policy is attached as Appendix A.

- Overall, the draft policy retains the key content and central principles of the current policy. However, a number of changes have been made to enhance clarity and flow or to address gaps identified in the literature review and jurisdictional research. The key revisions and additions reflected in the draft policy are set out below.

<u>Key revisions and additions</u>

1) Executive Summary:

- An Executive Summary has been included at the beginning of the draft policy in order to provide a quick overview of the top issues and key expectations that are addressed in the policy (Lines 3-18).

2) The scope of policy has been revised and further defined:

- The scope of the draft policy has been narrowed to physicians who are **permanently** closing a medical practice. The current policy applies to both permanent closures and temporary leaves of absence. Temporary absences from a medical practice – for any reason – will be addressed in the Continuity of Care policies currently being developed.

- This narrowed scope is consistent with other Canadian medical regulatory authorities and will eliminate confusion around what steps need to be taken for a leave of absence and those that are required for a permanent practice closure.

- The draft policy title has been significantly shortened and revised to clearly indicate the new scope of the draft policy.

- A scope section has been added to the draft policy to further clarify and remove any doubt that the principles and expectations set out in the draft policy apply to physicians in all practice areas and specialties. In response to feedback, clarity is provided on what steps must be taken in relation to the relocation of a medical practice (Lines 42-45).

- The policy's application to a sudden practice closure due to illness or death has also been clarified (Lines 58-63).

3) Additional clarity and expectations regarding notification related to a practice closure:

- In response to both research and feedback, the draft policy now states that physicians must provide ninety days' notice to patients prior to a planned practice closure. This expectation is currently set out by other Canadian medical regulatory authorities.[3]

- The draft policy clarifies expectations on providing patients with notice of a practice closure. The draft policy clearly sets out the information that must be included in this notice and the mandatory and permissive methods of providing notification.

- Following most other Canadian medical regulatory authorities,[4] the Ontario Medical Association and the Canadian Medical Association, the draft policy now sets a requirement for physicians to notify the CPSO of a practice closure as well as the arrangements made for storing and accessing patient medical records (Lines 114-126).

- Although the current policy does not contain the expectation that the College be directly notified of a practice closure, there is already an obligation to notify the College of a change in practice address and where a physician is resigning. The College also has existing processes in place for collecting information about the location of medical records and providing this information to the public, when available. Staff are currently working on an operational plan to implement the new notification requirements prior to the approval of the final policy (estimated to be fall/winter 2018).

4) Additional details for facilitating continuity of care:

- The various expectations related to facilitating continuity of care have been reorganized and additional details have been included.

[3] The College of Physicians and Surgeons of Alberta, Manitoba, British Columbia, Saskatchewan, New Brunswick, and Newfoundland and Labrador all require or recommend ninety days/three months' notice.
[4] For example, similar requirements are set out by both the College of Physicians and Surgeons of Alberta and Manitoba.

- The current policy only requires physicians to try and arrange ongoing care for specific patients such as those in hospital or other care facilities. The draft policy now advises physicians to take reasonable steps to arrange for the ongoing care of all patients and consider providing additional assistance to complex or marginalized patients. However, the draft policy also recognizes that arranging ongoing care for patients will not be possible in many circumstances (Lines 131-142).

- On the basis of stakeholder feedback from the Office of the Information and Privacy Commissioner of Ontario, research, and a review of applicable legislation, the expectations regarding medical records have been expanded.

- The draft policy now clearly outlines the two options that are available to physicians, in respect to medical records, upon the closure of a medical practice: that they either be transferred or retained. The draft policy also notes the exception contained in regulation[5] that allows for a shortened period of retention for medical records of family medicine and primary care. Finally, the draft policy provides information related to medical records in the event of a physician's death.

5) Expectations specific to physicians under revocation, suspension (etc.):

- As noted previously, given the development of the Continuity of Care policies and confusion arising from combining expectations for permanent closures and temporary absences, the draft policy only applies to a permanent practice closure. Therefore suspensions from practice are no longer included in the scope of this policy.

- Physicians under revocation would continue to be included in the scope of the draft policy as expectations are the same regardless of whether the practice closure is imposed or voluntary. Any exceptions to the general expectations are noted where applicable.

CONSIDERATIONS:

- A sample letter of notice to patients will be developed as an appendix to the *Closing a Medical Practice* policy.

[5] O. Reg. 114/94, General, enacted under the Medicine Act, 1991; S.O. 1991, c. 30, s. 19(1)(2).

- As the expectations of the draft policy are not yet final, the production of the sample letter of notice has been postponed until after the consultation, when a revised draft policy is brought forward to Executive Committee and Council for review and feedback.

- A document outlining Frequently Asked Questions will also be developed as the policy is finalized. This document will provide more information on specific permanent practice closure scenarios and other resources physicians may want to consult.

NEXT STEPS:

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

- Subject to Council's approval, the consultation will be held following the February 2018 Council Meeting and stakeholder feedback will be shared with both the Executive Committee and Council in the spring of 2018.

DECISION FOR COUNCIL:

1. Does Council have any feedback on the draft Closing a Medical Practice policy?

2. Does Council recommend that the draft policy be released for external consultation?

Contact: Miriam Barna, ext. 557

Date: February 2, 2018

Attachments:

Appendix A: Draft *Closing a Medical Practice* policy

Closing a Medical Practice

Executive Summary:

This policy sets out the College's expectations for physicians when permanently closing a medical practice. Physicians may close their medical practice for a variety of reasons including retirement, resignation, relocation, revocation of a member's certificate of registration by the College, or where the sudden illness or death of a physician forces the practice to close. Key topics and expectations include:

- *Notification:* A minimum of ninety days' notice must be provided to patients prior to a planned practice closure. Notification must also be provided to hospitals or other facilities where the physician holds privileges, employers, and to the College of Physicians and Surgeons of Ontario. The contents of this notice, timelines for providing it, and acceptable methods of communication are set out in the policy.
- *Facilitating Continuity of Care:* When a physician closes a medical practice, steps must be taken to minimize the impact on patients and to not impede patients' ability to access care. This includes assisting patients in arranging care from another health-care provider, meeting expectations around medical records, facilitating access to prescription medication, and managing any outstanding test results.

INTRODUCTION

Physicians may permanently close their medical practice for a variety of reasons including retirement, resignation, relocation, revocation of a member's certificate of registration by the College, or where the sudden illness or death of a physician forces the practice to close. In order to minimize the impact on patients, physicians, or a designate in the event of a closure due to sudden illness or death, must take positive steps to preserve continuity of care in the best interests of patients. This policy sets out what is expected of physicians when they permanently close their medical practice.

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:

1. Acting in the best interests of their patients;

2. Communicating and collaborating effectively with patients and other health-care providers to minimize breakdowns in continuity of care and risk to patient safety;
3. Maintaining public trust in the profession by not abandoning patients;
4. Participating in the self-regulation of the medical profession by complying with the expectations set out in this policy.

SCOPE

This policy applies to all physicians regardless of practice area or speciality who are permanently closing their medical practice. A physician who closes a medical practice may be ceasing to practise medicine (due to retirement, resignation, revocation, illness or death) or may be continuing to practice at a new location (i.e. relocation).[1]

In cases where physicians are closing their medical practice due to relocation, the physician is required to take the steps outlined in the 'Notification' section of the policy, but would only have to meet the expectations set out in the 'Facilitating Continuity of Care' section of the policy for patients who will not be moving to the relocated practice.

This policy does not apply in situations where the physician is temporarily absent from practice but is planning to return to the same practice (e.g., parental leave, educational leave, suspension of the physician's certificate of registration). Temporary absences from practice will be addressed in the Continuity of Care suite of policies, currently under development.

POLICY

Physicians must comply with the expectations set out in this policy when permanently closing a medical practice.

This policy begins by setting out expectations related to notification including the timeline, method, and contents that must be included in this notice, and then outlines the steps that physicians are expected to take in order to facilitate continuity of care when closing a medical practice.

Planning

The College recognizes that in some cases a practice closure may be sudden, due to illness or death of the physician. All physicians are advised to take steps to ensure their medical practice is appropriately managed in the event of an unexpected illness or death. This includes

[1] Please see the Frequently Asked Questions (FAQ) document for more information about specific scenarios and details regarding closure of a medical practice including relocating a practice and a physician's departure from a group practice.

identifying a designate to facilitate compliance with the policy in the event the physician is unable to do so. Physicians may wish to contact the Canadian Medical Protective Association or the Ontario Medical Association for further information or practice management resources.

Notification

Notice must be provided to the following:

- Patients or their substitute decision-maker;
- Hospitals and other facilities where the physician holds privileges, and employers; and
- College of Physicians and Surgeons of Ontario.

Physicians are advised to give consideration to others that may require notification. This may include other health-care providers actively involved in a patient's care that would benefit from awareness of the practice closure, the Ministry of Health and Long-Term Care[2], and frequently used laboratories or pharmacies.

i. Notice to Patients

Notice to patients or their substitute decision-maker must be provided a minimum of ninety days' prior to a planned practice closure. The physician is only expected to notify patients to whom they are actively providing care.[3]

There will be circumstances where it will not be possible to provide ninety days' notice due to unforeseen circumstances such as sudden illness or death or where a member's certificate of registration is revoked by the College. In these circumstances, physicians, or a designate in the case of illness or death, must provide notice as soon as they learn of the need for the practice closure.

Physicians are reminded that they must meet their legal and ethical obligations to protect patient confidentiality when providing notification of a practice closure.[4]

ii. Contents of Notice

Notice to patients must include the following:

[2] For more information see HealthForceOntario, "Transition Out of Practice: A Guide for Physicians" available at: http://www.healthforceontario.ca/UserFiles/file/ToPS/TransitionOutOfPractice-en.pdf.

[3] For example, where a specialist's involvement with a patient has already reached its natural or expected conclusion prior to the practice closure, notification would not be required. Please see the FAQ document for more information on this and other scenarios.

[4] For more information on physicians' obligations to maintain patient confidentiality see the Confidentiality of Personal Health Information policy.

- The date of the closure;
- Information about whether another health-care provider is available to assume responsibility for the patient's care, either through designating a successor or through a potential transfer of the patient to another medical practice. In this case, direction must be given to patients about how to proceed, depending on whether the patient wants their care to be transferred or if the patient wishes to pursue other options for care;
- If applicable, notice of a transfer of records to a physician's successor[5] and any timelines for retaining the records;
- If no physician is available to assume responsibility for the medical practice or patients, then notice of that fact; and
- Where patients can access their medical records or where a request for access or transfer can be made.

iii. Methods of Notification

Physicians must take the following steps:

- In all cases, each patient must be directly notified of the intended practice closure with written notice, either by letter mail or secure email. A sample letter of notice is contained in Appendix A.
- Physicians must also ensure that the office voicemail message is up to date and accurate and indicates the planned closure date.

Notification can also be supplemented with one or more of the following methods.

- In person, at a scheduled appointment;
- Telephone call;
- Printed notice, posted in the office;
- A notice posted on a website; and/or
- Newspaper advertisement.

iv. Notification to Hospitals, Facilities and Employers

Physicians are advised to exercise judgement about the contents and methods of notification provided to hospitals, facilities, and employers.

v. Notification to the College of Physicians and Surgeons of Ontario

[5] The *Personal Health Information Protection Act, 2004* s. 42(2) states, "where this is not reasonably possible to notify patients in advance of a transfer of records, physicians must notify patients as soon as possible after the transfer has occurred."

With the exception of physicians who have had their certificate of registration revoked, all physicians who are closing a medical practice must notify the College through one of two options:

- Physicians who are resigning from membership are required to complete a resignation form as soon as reasonably possible.[6]
- For those physicians who are closing a medical practice, but are remaining a member of the College,[7] they are required to notify the College of a change in their practice address within 30 days of it occurring. [8] Physicians are advised to consult the College webpage for additional information on how to report this change.

All physicians who have closed a medical practice must notify the College of the arrangements made for storing and accessing patient medical records by contacting the College's Membership Services department.

Facilitating Continuity of Care

When closing a medical practice, physicians must take steps to minimize the impact on patients and to not impede a patient's ability to access care. The following outlines the College's expectations of physicians in facilitating continuity of care.[9]

i. Arranging Ongoing Care

Physicians must take reasonable steps to arrange for the ongoing care of their patients. Although some physicians may be able to arrange for a successor to take over their entire practice or a part of their practice[10], the College recognizes that this will not be possible in many circumstances. Physicians must be as helpful as possible to the patient in finding a new health-care provider and are advised to consider the specific needs of the patient when considering what assistance to provide.

[6] Additional information and the resignation form can be accessed here: http://www.cpso.on.ca/Member-Information/Membership-Info-Fees/Resignation-from-Membership

[7] This could include circumstances such as where a physician is relocating their practice; maintaining their membership with the College but practicing outside of the province; or where a physician is ceasing to practise (i.e. retiring) but is maintaining their certificate of registration. Please see the FAQ document for more information about these specific scenarios.

[8] College by-law requires physicians to report any change of a practice address within 30 days.

[9] Broader expectations for physicians' role in facilitating continuity of care, unrelated to closing a medical practice, will be set out in the forthcoming Continuity of Care policies.

[10] 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. For more information on physicians' professional and legal obligations when accepting new patients, see the Accepting New Patients policy.

For many patients, it will be sufficient to provide them with information about how they can access ongoing care, using the resources listed on the College website. Patients who may be categorized as higher-need, marginalized and/or complex[11] may require additional assistance in transferring to another health-care provider and physicians are advised to make particular efforts to arrange for the ongoing care of these patients.

ii. Medical Records

Patients must have access to their medical records even if the physician has closed their medical practice. As such, the College advises all physicians to proactively plan for how they will meet their obligations under the *Personal Health Information Protection Act, 2004 (PHIPA)* and ensure patients have continued access to their medical records in the event of a planned or unplanned practice closure. In all cases, the physician will continue to be the custodian of the records until complete custody and control passes to another person or entity that is legally authorized to hold them.

When a physician closes a medical practice two options are available with respect to patient records:

- They may be transferred to another person legally authorized to hold them; or
- They may be retained for the periods set out in the College's Medical Records policy.

In accordance with regulation, a physician who ceases to practise medicine can destroy records of family medicine and primary care after two years, as long as patients are notified of this timeline and given the option to transfer the records to another physician within those two years.[12] Physicians are advised to refer to the College's Medical Records policy for detailed information on obligations with respect to the transfer, retention, and destruction of medical records.

If a physician dies, the estate trustee of the physician is deemed to be the custodian of the records until custody and control of the records passes to another person who is legally authorized to hold them.[13] Where uncertainty arises over responsibilities with regard to the medical records of a deceased physician, the College suggests seeking independent legal advice or contacting the College's Physician Advisory Service.

iii. Facilitating Access to Prescription Medication

[11] These patients include those requiring urgent access to care, those with chronic conditions, an activity-limiting disability, mental illness, or other socio-economic factors.
[12] O. Reg. 114/94, General, enacted under the *Medicine Act*, 1991; S.O. 1991, c. 30, s. 19(1)(2).
[13] *PHIPA* s. 3(12). Where there is no estate trustee, the person who has assumed responsibility for administration of the deceased custodian's estate is deemed to be the custodian of the records.

The physician must make reasonable efforts to facilitate access to prescription medication. This will involve one of the following:

- Where medically appropriate, and where the physician is maintaining a license to practise in Ontario, provide the patient with renewals or repeats of the required medication(s) in order to allow the patient reasonable time to find alternative care;[14] or
- Arrange for or advise the patient to attend another physician as soon as possible to have their prescription(s) renewed.

The physician must also advise patients that repeats or renewals for prescriptions written prior to the date of the resignation or revocation will not be legally valid after the date of resignation or revocation.

Physicians are reminded of their obligation to keep their prescription pads safe and must take steps to destroy[15] these upon ceasing to practise.

iv. Test Results Management and Reports

Physicians must comply with the College's Test Results Management policy[16].

Physicians who are resigning or have had their license revoked must advise patients that standing orders for laboratory or other tests will not be legally valid after the date of resignation or revocation.

Further, following resignation or revocation, physicians are not permitted to interpret test results, prepare reports, or provide follow-up care. However, if only administrative work is required to finalize a report, a physician may complete this report following resignation or revocation. Administrative work includes editing draft reports, summarizing conclusions, or signing reports completed prior to resignation or revocation.

[14] If a physician is providing patients with repeats or renewals of prescriptions, the physician is reminded of their obligation under College by-law to hold professional liability protection.

[15] The Information and Privacy Commissioner (IPC) of Ontario provides guidance on the secure destruction of personal information. For paper records, the IPC notes that destruction "means cross-cut shredding, not simply continuous (single strip) shredding, which can be reconstructed". More information can be found on the IPC website.

[16] The Test Results Management policy is currently under review and will be included in the Continuity of Care suite of policies, once revised and approved.

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

February 2018

TOPIC: Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice – Consultation Report and Revised Draft Policy

FOR DECISION

ISSUE:

- The College's Changing Scope of Practice and Re-entering Practice policies are currently under review in accordance with the regular policy review cycle.
- An updated and newly titled *Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice* draft policy was released for external consultation following the September meeting of Council.
- Council is provided with a report on the consultation feedback received, and an overview of the proposed revisions to the draft policy.
- Council is asked whether it approves the revised draft *Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice* as a final policy of the College.

BACKGROUND:

- The Changing Scope of Practice and Re-entering Practice policies, which were originally approved by Council in 2000, and last reviewed in 2008, respectively articulate expectations for physicians who have changed or intend to change their scope of practice and for physicians who wish to re-enter practice after a prolonged absence.
- The policies have been reviewed in tandem due to their common processes and principles related to ensuring competence.
- This policy review was undertaken with the assistance of Dr. Bill McCauley (Medical Advisor), Ms. Lisa Wilson (Re-entry and Change of Scope Coordinator), and Ms. Alice Cranker (Legal Counsel).

- The policy review process has been informed by:
    - an extensive research review, which included a comprehensive literature review and a jurisdictional comparison of guidance provided by medical regulators, both within Canada and abroad;
    - a preliminary consultation on the current policies;
    - feedback from the program area involved in changing scope and/or re-entry to practice applications; and
    - feedback from the Quality Assurance and Registration Committees, the committees that review applications of physicians who want to change their scope of practice and/or re-enter practice.

- An updated and newly titled *Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice* draft policy was developed in light of the research undertaken and the feedback obtained.

- Council may recall that the draft policy retained the key content and central principles of the current policies. However, two substantive changes were made in order to strengthen and clarify existing expectations:

    - The threshold for reporting an intention to change scope of practice or to re-enter practice after an extended absence was shortened from three years to two years; and
    - The draft policy no longer captures physicians in part-time practice (physicians who have practised less than six months in the preceding five-year period).

- The draft policy was approved for external consultation at the September 2017 meeting of Council.

CURRENT STATUS:

- Council is provided with a report on the consultation, as well as a summary of the revisions proposed in response to the consultation feedback received.

a) Report on Consultation

Consultation Process

- In accordance with standard practice, an external consultation[1] was held on the draft policy from September 14th to December 4th, 2017. Generally consultations are held for 60 days

[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-

but due to the relatively low number of responses both on the online discussion page and the survey, the consultation was extended for approximately three additional weeks.

Number of responses

- In total, 40 submissions were received in response to this consultation. This included 18 comments either submitted by email or posted to the online discussion page and 22 online surveys. Approximately 80% of respondents identified themselves as physicians, 7.5% as members of the public, and 12.5% as organizations.[2]

b) Feedback Received

- All written feedback and a report of survey results can be found on the consultation-specific page of the College's website.

General Comments

- **Reasonableness of policy expectations:** The majority of online survey respondents supported the draft policy expectations. They agreed that the following expectations were important:

    - that physicians wishing to change their scope of practice and re-enter practice report this intention to the College;
    - that physicians undergo the College process for ensuring competence before changing scope of practice and re-entering practice; and,
    - that the College approves requests before physicians change their scope of practice or re-enter practice.

- **Clarity:** The majority of survey respondents, including the OMA and PARO, felt that the draft policy and appendices were clearly written, easy to understand, and well organized.

- **Comprehensiveness:** A majority of survey respondents felt the draft policy, including the description of "significant change in scope of practice" and the description of the College process for changing scope of practice and re-entering practice was comprehensive. However, respondents were divided about whether the definition of "scope of practice" was comprehensive. When asked how the policy could be made more comprehensive, a few respondents suggested that the policy include more examples of significant changes in scope of practice.

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 organizations that submitted written feedback included: the Ontario Medical Association (OMA); the Professional Association of Residents of Ontario (PARO); the Medical Psychotherapy Association of Canada (MDPAC); The OMA Section on Chronic Pain; and the Information and Privacy Commissioner of Ontario (IPC).

Specific Feedback and/or Recommendations for Improvement

Two year reporting threshold

- Respondents were generally divided about whether the requirement to report an intention to re-enter practice or return to a scope of practice after an absence of two years or more is reasonable.

- The OMA stated that in many cases the new two year timeframe for reporting is reasonable; however, in some instances it may be challenging or unreasonable (i.e., for physicians taking parental leave, medical leave and leaves for research). They suggested encouraging physicians to keep up on practice standards during an absence instead of having a formal policy.

Part Time Practice

- Respondents were also generally divided about the removal of reporting obligations for part time physicians. However, more survey respondents supported this position than those that did not.

- The OMA noted that some specialties and hospitals have minimum practice standards for certain procedures and suggested the College include a minimum practice standard in the policy to ensure that physicians in all specialities are treated equitably.

CPSO's role in facilitating changes in scope of practice

- Some stakeholders expressed concern that the CPSO's changing scope of practice process undermines the Royal College of Physicians and Surgeons of Canada's (RCPSC) certification process and allows physicians to practice in a speciality area without meeting the RCPSC requirements.

- The OMA echoed this sentiment and suggested that the CPSO defer to the RCPSC and the College of Family Physicians of Canada when determining whether a physician has the necessary competence to change their scope of practice.

Change in Scope of Practice to Fertility Medicine

- In a similar vein, a few physician respondents expressed concern that physicians who have not completed the RCPSC sub-specialty program in Gynecologic Reproductive Endocrinology and Infertility (GREI) can change their scope of practice to practise in fertility medicine. In reviewing the stakeholder feedback, it became apparent to staff that these respondents interpreted the example included in Appendix 1 to the policy (*Description of Significant Change in Scope of Practice*) to mean that undergoing the Changing Scope of Practice

process would allow a physician to practice within the full scope of the GREI speciality. This was not the intention of the example nor is it reflective of the types of changes that are facilitated through the College's Changing Scope of Practice process.

Significant changes in "Practice Environment" and impact on rural practice settings

- A few stakeholders expressed concern about including "practice environment" in the definition of scope of practice and in particular that a significant change in practice environment would be considered a significant change in scope of practice.

- Some respondents felt that the inclusion of "practice environment" in the definition of scope of practice would hinder the ability to attract physicians to rural areas. The OMA echoed this sentiment and expressed concern that the policy is a disincentive for urban physicians to move to rural settings. The OMA suggested the policy recognize the unique challenges of practice in rural and northern areas and not require physicians to complete an unduly onerous process when pursuing work in a rural setting.

Gender neutral language to be used throughout policy

- The OMA recommended using gender neutral terms throughout the policy (i.e., replace "his/hers" with "one's").

c) Revisions in Response to Feedback

- All of the feedback received was carefully reviewed and considered. Overall, the revised draft policy and appendices retain the key content and central principles of the materials that were released for consultation. However, the revised draft policy and appendices have been revised primarily to enhance the clarity of the documents.

- Key revisions are highlighted for the Executive Committee's reference below and can be found in the revised draft materials, attached as Appendix A, Appendix B, and Appendix C.[3]

<u>Key Revisions and Additions</u>

Executive Summary

- Both external and internal stakeholders have commented that it is sometimes difficult to navigate policies to identify relevant policy content, due in part to the increasing length and detail of our policies. Council provided similar feedback at its September 2017 meeting.

[3] Only substantive changes were highlighted in the revised draft policy and appendices- minor editorial changes were not left in *track changes* form.

- In response to this feedback and Council's direction, an Executive Summary has been included at the beginning of the revised draft policy in order to provide an overview of the key expectations that are addressed in the policy (*Lines 3-15*).

Definition of Scope of Practice

- In response to some survey respondents who felt the definition of scope of practice could be more comprehensive, the definition of scope of practice has been expanded to include what scope of practice *is* along with the factors that determine a physician's scope of practice (Lines 54-55).

Change in scope of practice

- To reflect the reporting requirements set out in the policy, the definition of change in scope of practice has been updated to include "returning to a scope of practice in which a physician has not practised for two consecutive years or more" (Lines 63-65).

- In response to consultation feedback, Appendix 1 to the revised draft policy has been updated to include more examples of a *significant* change in scope of practice and an *evolution* in practice (*Lines 57-60 and 76*).

The College's role in facilitating changes in scope of practice

- The appendix to the policy (*Description of Significant Change in Scope of Practice*) has been updated in response to concerns that the CPSO change in scope of practice process undermines the RCPSC and CFPC certification process.

- The appendix notes that physicians who have undergone the Changing Scope of Practice process do not practise in the same capacity as specialists. The appendix reiterates that changes in scope of practice are only permitted once the physician has demonstrated their competence to the College regarding the specific changes they intend to incorporate into their practice (Lines 39-42).

- As well, in response to concerns raised in the feedback, the revised draft policy has been updated to include a footnote reminding physicians who change their scope of practice that they must continue to comply with the *Use of Specialist Title* regulation and describe their practice using the appropriate framework set out in the regulation[4] (e.g., Family Physician, *practising in pediatrics*) (footnote #7).

[4] S. 9 of O. Reg. 114/94 under the *Medicine Act, 1991* S.O. 1991, C.30.

A change in scope of practice to include fertility medicine

- Physicians that undergo the change of scope process to include fertility medicine are not practising in the same capacity as specialists; they are practising components of fertility medicine (e.g., cycle monitoring, ultrasound, etc.).

- As part of the changing scope of practice process, physicians must specify in their application the specific fertility procedures and treatments they wish to incorporate into their practice and must demonstrate their competence in performing those procedures throughout the changing scope of practice process.

- In response to the concerns of GREI specialists regarding the inclusion of fertility medicine in the list of significant changes in scope of practice, and the College's Changing Scope of Practice process undermining the RCPSC certification process, Appendix 1 to the revised draft policy has been updated to specify that the changing scope of practice process permits physicians to change their scope of practice to include *components* of fertility medicine (Line 50).

Gender Neutral Language

- In response to OMA feedback and the Policy Department's focus on inclusivity, the revised draft policy has been updated to include gender neutral language (i.e., *their* instead of *his/hers*).

d) Revisions not made in response to feedback received

Inclusion of "Practice Environment" in the definition of scope of practice

- The revised draft policy has maintained "practice environment" as a factor in determining scope of practice and as such those wishing to significantly change their practice environment will continue to be captured by the policy (i.e., physicians who wish to practise in a rural setting from an urban setting will continue to be required to report this intention and undergo the change of scope process).

- Practising in different practice environments may require the use of different skills and knowledge specific to the practice context.[5] For example, differences in access to resources often result in physicians in rural settings having a wider scope of practice than those practising in urban settings.

[5] Wenghofer EF, Williams AP, Klass DJ. Factors Affecting Physician Performance: Implications for Performance Improvement and Governance. *Healthcare Policy*. 2009;5(2):e141-e160.

- The requirement to report significant changes in practice environments is not meant to pose a barrier to those wishing to practise in rural settings but instead it is meant to recognize the unique challenges of practising in rural practice settings and ensure that physicians have the competence required to practise in these settings.

- There are programs in place to help support physicians making the transition from urban to rural practice settings. These programs assist physicians in gaining practical experience.[6] The existence of these programs reinforces the fact that there are significant distinctions between practising in rural and urban settings.

Reporting threshold

- The 2 year threshold for reporting has been maintained in the revised draft policy as the requirement to demonstrate competence after an absence of two years instead of three better protects the public and reflects research that skills have been shown to degrade from periods ranging between 6-18 months out of practice.[7]

Part Time Physicians

- The revised draft policy has not been amended to capture part time physicians or to set a minimum threshold for practice.

- The decision to not capture part time physicians has been retained due to the low numbers of physicians who report practising less than 2 days per month and the other systems in place that help to ensure that part time physicians maintain competence.

- For example, as the OMA indicated, hospitals and some specialties already have minimum practice standards for some procedures.

- Furthermore, all physicians are required to comply with the College`s Continuing Professional Development requirements as set out in regulation.[8] These requirements are meant to ensure that physicians maintain the medical knowledge and skills necessary to provide the highest possible quality of care to patients.

- There is also a general expectation that all physicians meet the standard of practice of the profession. Where there are concerns about a physician's standard of practice, there are tools available to the College to review such concerns.

[6] For example the University of Toronto`s Department of Family and Community Medicine and the Ministry of Health and Long-Term Care's Supplemental Emergency Medicine Experience program.
[7] Literature review undertaken by the UK's General Medical Council.
[8] S. 29 of O. Reg. 114/94 under the *Medicine Act, 1991* S.O. 1991, C.30.

- Furthermore, setting out expectations for minimum practice would be difficult to do in College policy as they may be quite varied (for example, different depending on the specialty).

NEXT STEPS:

- Should Council approve the draft policy, as revised, it will be published in Dialogue and will replace the current Changing Scope of Practice and Re-entering Practice policies on the CPSO website.

- The Annual Renewal Survey questions that pertain to changing scope of practice and re-entering practice will also be updated to reflect any changes made to the policy.

DECISION FOR EXECUTIVE COMMITTEE:

1. Does Council have any feedback on the revised draft *Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice* policy?

2. Does Council approve the revised draft policy as a policy of the College?

Contact: Lynn Kirshin, Ext. 243
Tanya Terzis, Ext. 545

Date: January 8, 2018

Attachments:

Appendix A: Revised Ensuring Competence: Changing Scope of Practice policy

Appendix B: Revised Description of Significant Change to Scope of Practice

Appendix C: Revised Process for Changing Scope of Practice and/or Re-Entering Practice

Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice

Executive Summary:

This policy sets out the College's expectations related to reporting and demonstrating competence prior to changing scope of practice and/or re-entering practice. It also outlines the College review process for ensuring competence when physicians change their scope of practice and/or re-enter practice. Key topics and expectations include:

- *Reporting:* Physicians must report an intention to change their scope of practice and/or to re-enter practice after an absence of 2 years or more. The policy sets out the definitions of scope of practice and change in scope of practice.
- *Participating in a College Review Process:* All physicians who wish to change their scope of practice and/or re-enter practice must participate in a College review process to demonstrate their competence in the area in which they intend to practise.
- *College Approval:* Physicians must not practise in a new scope of practice or re-enter practice unless the College has approved their request.

Introduction

Physicians may wish to change their scope of practice if they become interested in a different area of medicine or if their personal circumstances change. Physicians may also be absent from practice for a period of time for a variety of reasons. They may go on an extended parental leave, take a sabbatical, or take on a teaching role, for example.

Physicians are responsible for maintaining the medical knowledge and clinical skills necessary to provide the highest possible quality of care to patients. All physicians who wish to change their scope of practice and/or re-enter practice must participate in a College review process to demonstrate their competence in the area in which they intend to practise.

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:

1. Acting in the best interests of their patients by ensuring that they have acquired the necessary training and knowledge prior to changing their scope of practice and/or re-entering practice.

2. Demonstrating continued professional competence, by meeting the standard of care and acting in accordance with all relevant and applicable legal and professional obligations.

3. Being committed to lifelong learning and maintaining the medical knowledge and skills necessary to provide the highest possible quality of care to patients.

4. Upholding professionalism and trust and protecting patient safety by only practising in the areas in which they are both educated and experienced.

5. Participating in self-regulation of the medical profession by complying with the expectations set out in this policy.

Purpose

This policy sets out the College's expectations for reporting and demonstrating competence with respect to changing scope of practice and/or re-entering practice and outlines the applicable College process related to ensuring competence.

Scope

This policy applies to physicians who wish to change their scope of practice or who wish to re-enter practice after an extended absence, even if they have continuously maintained their certificate of registration during their absence. The policy also applies to physicians who would like to both re-enter practice and change their scope of practice simultaneously.

This policy does not apply to physicians who intend to change their scope of practice or intend to re-enter practice in positions focused on teaching, research, or administration, where there is no assessment or treatment of patients.[1,2]

[1] The College requires all physicians to maintain competence regardless of type of practice. For those physicians changing their scope of practice or re-entering practice in positions that involve teaching, research or administration there are separate processes at universities and hospitals for ensuring competence.

[2] Physicians who are intending to change their scope of practice to an area which involves reviewing medical records for individuals with whom the physician does not have a treating relationship for the purpose of providing third party reports (i.e. Independent Medical Examiners) are captured by this policy and must report their intention to change their scope of practice.

Terminology

Scope of practice: Scope of practice is a term that describes a physician's practice at a particular point in time. A physician's scope of practice is determined by a number of factors including:

- education, training, and certification;
- the patients the physician cares for;[3]
- the procedures performed;
- the treatments provided;
- the practice environment.[4]

Change in scope of practice: A change in scope of practice occurs when there has been a *significant* change to any of the factors set out in the description of scope of practice above. A change in scope of practice also occurs when physicians wish to return to a scope of practice in which they have not practised for two consecutive years or more.[5] For information regarding whether a change is significant and must be reported to the College please refer to Appendix 1.

Policy

The College expects physicians to practise medicine competently. As such, physicians must only practise in the areas of medicine in which they are educated and experienced.[6]

Physicians may wish to change their scope of practice and/or may take a break from practising for a variety of reasons. In order to ensure that physicians are able to practise competently, the following expectations will apply to physicians before they change their scope of practice and/or re-enter practice:

1. Reporting to the College; and
2. Participating in a College Review Process.

[3] This would include populations (e.g. where a physician is practising as a Medical Officer of Health).

[4] Practice environment may include colleague supports, access to resources, payment systems, geographic or health system demands.

[5] For example, a family physician focusing in emergency medicine who wishes to return to family medicine after an absence from this clinical area for two or more years.

[6] The requirement that physicians practise in the areas of medicine in which they are educated and experienced is a term, condition and limitation on a physician's certificate of registration. The *Professional Misconduct* regulation 856/93 under the *Medicine Act*, *1991*, S.O. 1991, sets out that it is professional misconduct for a physician to contravene a term, condition or limitation on their certificate of registration (Section 1(1)1).

Physicians must not practise in a new scope of practice or re-enter practice unless the College has approved their request.[7]

Reporting to the College

Physicians must report to the College when they:

- wish to re-enter practice and have not been engaged in practice for a period of two consecutive years or more; and/or
- wish to change their scope of practice. This includes physicians who are making a significant change in scope of practice or who wish to return to a scope of practice in which they have not practised for two consecutive years or more[8].

Reporting can be initiated by completing the applicable application form.[9] Physicians must also indicate in the Annual Renewal Survey that they have made this report.[10]

If physicians are uncertain about whether they are required to report an intention to change their scope of practice or an intention to re-enter practice, they should contact the Inquiries Section in the Applications and Credentials Department of the College for further guidance at 416-967-2617 or by email at inquiries@cpso.on.ca.

College Review Process

All physicians who wish to change their scope of practice and/or re-enter practice must participate in a College review process to demonstrate their competence in the area in which they intend to practise. The process for re-entry and change in scope of practice will be individualized for each physician but in general includes a needs assessment, training, supervision, and a final assessment.

During the College review process, consideration will be given to the physician's specific situation including prior experience, any training the physician has undertaken, the continuing

[7] Physicians are reminded that when they work in areas of medicine that are different from their area of primary certification they must comply with the *Use of Specialist Title* regulation. For more information on the requirements under the regulation please refer directly to Section 9 of O. Reg. 114/94 under the *Medicine Act, 1991* S.O. 1991, C.30 and the College's article, *Describing your credentials in advertising and promotional materials*.

[8] This expectation applies even if the physician has previously trained and had experience in the scope of practice to which they are returning.

[9] The application to request a change in scope of practice can be found here. The application to request re-entry to practice can be found here.

[10] In accordance with section 51(3) of the College's *General By-Law*.

professional development the physician has engaged in, the potential risk of harm to patients, the length of time the physician has been away from practice, and the degree to which the discipline has advanced during the physician's absence.

For greater detail on the requirements for changing scope of practice and/ or re-entering practice, please refer to Appendix 2.

Appendix 1: Description of *Significant* Change in Scope of Practice

Scope of practice is defined in the *Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice* policy. The policy states that scope of practice is a term that describes a physician's practice at a particular point in time. It states that a physician's scope of practice is determined by a number of factors, including:

- education, training, and certification;
- the patients the physician cares for;[1]
- the procedures performed;
- the treatments provided;
- the practice environment.[2]

The policy states that a change in scope of practice occurs when there has been a *significant* change to any of the factors set out in the description of scope of practice above or when physicians wish to return to a scope of practice in which they have not practised for two consecutive years or more.[3] Physicians may have questions about whether a change in scope of practice would warrant reporting to the College (i.e., is significant) or whether the change would simply be considered an evolution of practice.

Significant Change in Scope of Practice

Significant changes in scope of practice are all determined on a case-by-case basis. A change in scope of practice has been considered by the College to be "significant" in the following circumstances:

i. Physicians completely change their type of practice (e.g. a surgeon wants to practise in family medicine); or

ii. Physicians are adding something to their practice that
   a) they have not done before, and
   b) is not something that is considered a usual part of the discipline (e.g. a pediatrician who wants to start working in an emergency department caring for adult patients); or

[1] This would include populations (e.g. where a physician is practising as a Medical Officer of Health).
[2] Practice environment may include colleague supports, access to resources, payment systems, geographic or health system demands.
[3] For example, a family physician focusing in emergency medicine who wishes to return to family medicine after an absence from this clinical area for two or more years.

iii. ~~A physician is changing the focus of his or her practice to an area in which he or she has not been active for at least two years; or~~

iv. Physicians begin to practise in a location where the healthcare system is significantly different from where they had been practising previously (e.g. an urban setting versus a rural setting).

Physicians who have undergone the Changing Scope of Practice process do not practise in the same capacity as specialists. Changes in scope of practice are only permitted once the physician has demonstrated their competence to the College with respect to the specific changes they intend to incorporate into their practice.

Examples of changes in scope of practice that have been considered significant by the College include **but are not limited to:**

- A family physician who wishes to perform cosmetic surgical procedures;
- A family physician who wishes to primarily practise and receive referrals for psychotherapy, disorders of the skin, or palliative care;
- A family physician who wishes to practise components of fertility medicine;
- A physician who practises in chronic pain management but who wishes to practise in interventional pain management;
- A psychiatrist who wishes to practise in sleep medicine;
- A neurosurgeon who wishes to practise in palliative care;
- An orthopedic surgeon who wishes to practise in family medicine;
- An emergency medicine physician who wishes to practise in sports medicine.
- A physician who has been working in primary care in a developing country wishes to return to Ontario;
- A physician who wishes to relocate from an urban, academic practice to a rural, underserviced area.

Evolution in Practice

When there is a change to one of the factors set out in the definition of scope of practice but the change is not significant, the College considers this to be an evolution in practice. An **evolution in practice** is characterized by the gradual development or progression of a physician's practice within a certain area in keeping with the direction of the specialty. An

evolution in practice may include narrowing or limiting a practice, performance of innovative techniques or procedures or prescribing new medications within the context of a specialty. Examples include:

- a family physician who, within their general area of training, decides to narrow the focus of their practice to women's health issues;
- an emergency medicine physician who is incorporating bedside ultrasound into their practice; or
- the transition from a solo practice to a Family Health Team.

If physicians are uncertain about whether a change of scope is considered significant or is an evolution in practice, they should contact the Inquiries Section in the Applications and Credentials Department of the College for further guidance at 416-967-2617 or by email at inquiries@cpso.on.ca.

Appendix 2 Process for Changing Scope of Practice and/or Re-Entering Practice

The changing scope of practice[1] and/or re-entering practice process is composed of four stages: a needs assessment, training, supervision, and a final assessment. Decisions about the specific stages that must be undertaken will be determined on an individual basis. Physicians must not practise in a new scope of practice or re-enter practice unless the College has approved their change in scope of practice and/or re-entry request.

A description of the four stages of the process is set out below.

Needs Assessment

After physicians report their intention to change their scope of practice or to re-enter practice, they are required to submit an application.[2] The College will review the application and consider which stages of the College's process require participation by the physician; in particular whether the physician requires supervision and/or training. Decisions regarding training and/or supervision will be informed by a number of factors, including the physician's prior experience, any training the physician has undertaken, the continuing professional development the physician has engaged in, the potential risk of harm to patients, the length of time the physician has been away from practice, and the degree to which the discipline has advanced during the physician's absence.

Training

Completing relevant training is an important part of ensuring competence. The College will review the physician's application and determine whether the physician requires training.

If the College determines that the physician requires training, the physician must provide the College with a proposed Individualized Education Plan (IEP), to be approved by the College. The IEP must include a description of the training the physician will undertake. If the physician has undergone training prior to reporting to the College, they must provide the College with evidence of the training.

[1] This process only applies to changes in scope that are significant.
[2] The application to request a change in scope of practice can be found here. The application to request re-entry to practice can be found here.

Physicians should note that the College has developed frameworks which set out the training that is required for areas of clinical practice where there are no recognized Canadian specialty training programs. These frameworks inform the College's decisions about the training a physician will be required to undertake. More information about the frameworks that have been developed can be accessed here.[3]

Supervision

Where the College determines that supervision is required, physicians must find one or more physicians who will act as their Clinical Supervisor. The Clinical Supervisor must be approved by the College and the supervision must take place in accordance with the Guidelines for College-Directed Supervision.

As competency is gained and demonstrated, the level of supervision will decrease and the physician will be afforded a greater level of autonomy. There are three levels of supervision. Physicians typically start out under high level supervision, and then will move on to moderate and then low level supervision. The level and duration of supervision will be at the discretion of the College with input from the Clinical Supervisor, and will be dependent on the content and duration of the training completed, if training was required.

A description of the different levels of supervision is set out below.

High Level Supervision

A physician must arrange to work in another physician's practice. This physician will act as Clinical Supervisor and must be practising in the same discipline in which the physician wishes to practise. During high level supervision the Clinical Supervisor is the Most Responsible Physician (MRP) for all patients.

The physician will continue to practise under a high level of supervision until the Clinical Supervisor is satisfied that the physician can work as the MRP under a moderate or low level of supervision.

[3] Frameworks that are currently developed include expectations for: cardiologists intending to interpret nuclear cardiology studies in independent facilities, physicians intending to practise sleep medicine, physicians intending to practise as Medical Officers of Health, physicians who intend to change their scope of practice to include endo-colonoscopy, physicians who intend to change their scope of practice to include interventional pain management, physicians who intend to change their scope of practice to include surgical cosmetic procedures, radiologists intending to interpret and supervise nuclear medicine studies in Independent Health Facilities, physicians who intend to change their scope of practice to include caesarean section for non-obstetricians.

The Clinical Supervisor will notify the College when they are of the view that the physician has the required knowledge and skills to practise in a less supervised environment (moderate and low level supervision). The College will review the recommendation from the Clinical Supervisor and determine whether the physician may move on to a lower level of supervision.

The length of high level supervision will vary depending on the circumstances of each individual physician. It may be brief if the physician is capable of practising independently or it may be longer if the physician is not yet capable of practising independently.

Moderate and Low Level Supervision

In moderate and low level supervision the physician works in his or her own practice, makes decisions independently and is considered the MRP. The Clinical Supervisor will periodically visit with the physician to review charts and cases, and discuss patient management to ensure appropriate care is provided. The Clinical Supervisor will submit written reports to the College on a periodic basis. The frequency of visits from the Clinical Supervisor is initially weekly, but will become less frequent when the College determines that physician competency has been demonstrated. Once the Clinical Supervisor is satisfied that the physician is able to practise independently, the Clinical Supervisor will notify the College. The College will then determine whether the physician is ready for their final assessment.

The length of the periods of moderate and low level supervised practice will vary, but generally they will be longer than the time spent under high level supervision.

Final Assessment

Once physicians have completed the required training and/or supervision, they generally will be required to undergo a College-directed assessment of their practice. There may be an observational component to the assessment. For example, where the care involves performing new procedures the assessor may observe the physician performing the new procedures. Assessments may also involve interviews with colleagues and co-workers to provide feedback on care provided.

The College will review the final assessment report and will make a determination as to whether the physician is competent to practise independently.

Costs

The physician undergoing the changing scope of practice and/or re-entering practice process must pay for the costs related to training, supervision, and the final assessment.

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

February 2018

TOPIC: **Public Health Emergencies – Consultation Report and Revised Draft Policy**

FOR DECISION

ISSUE:

- The draft *Physician Services During Disasters and Public Health Emergencies* policy was released for external consultation following the September meeting of Council.
- Council is provided with a report of the feedback received during the consultation period and an overview of the revisions that are proposed.
- Council is asked whether it approves the newly titled revised draft *Public Health Emergencies* policy (attached as Appendix 'A') as a final policy of the College.

BACKGROUND:

- The College's *Physicians and Health Emergencies* policy, which was developed in preparation for an anticipated H1N1 pandemic and approved by Council in 2009, is currently under review in accordance with the College's regular policy review cycle.
- This policy sets out expectations of physicians during health emergencies, such as pandemics.
- An Advisory Group is assisting with this policy review, and is comprised of Council members and College Staff. Dr. Janet Van Vlymen (physician member of Council), Mr. Harry Erlichman (public member of Council), Dr. Bill McCauley (College staff – Medical Advisor) and Lindsay Cader (College staff – Legal Counsel) are members of this Advisory Group.
- Based on a comprehensive literature and jurisdictional review, as well as feedback received during a preliminary consultation on the current policy, a newly titled draft *Physician Services During Disasters and Public Health Emergencies* policy was developed. The draft policy was approved for external consultation at the September 2017 meeting of Council.

CURRENT STATUS:

A. Report on Consultation

- In accordance with standard practice, an external consultation was held on the draft policy following the September Council meeting[1]. The original consultation period was September 14th to November 14th. Due to a lower than average response rate, the consultation was extended 3 weeks to December 4th.

- In total, the College received 36 responses (78% physicians, 11% organizations[2], 5% other health care professionals, and 5% preferred not to say). This includes 15 comments on the College's online discussion page and 21 online surveys.[3]

- In keeping with the College's consultation posting guidelines, all written feedback and a report of survey results can be found on the consultation-specific page of the College's website.

- At Chiefs and Presidents Day on November 2nd, 2017, Dr. Rouselle presented the draft policy to 21 physicians who are Chiefs and Presidents of medical staff at various hospitals across the province. The feedback received from this group is included in the summary of feedback presented below.

B. Overview of Feedback Received

General Comments

- The majority of respondents were supportive of the draft policy, and made suggestions for ways it could be made clearer and more comprehensive.

- Some respondents were comfortable with the level of flexibility the draft policy affords, while others felt that the draft policy was too vague and superficial.

[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 were: Ontario Medical Association, Medico-Legal Society of Toronto, Professional Association of Residents of Ontario, and the OMA section on General and Family Practice.
[3] 24 respondents started the survey, but of these, 1 did not complete any substantive questions, and 2 respondents were duplicates. This leaves 21 for analysis.

- A few respondents expressed concern that this policy would be used after a public health emergency to punish physicians who did not volunteer assistance, did not document patient encounters or who practiced outside their scope of practice temporarily.

Specific Comments and Suggestions for Improvement

- ***Adding to the title:*** Although the majority of respondents indicated it was clear in which circumstances this draft policy would apply, a couple respondents noted that it may benefit from the addition of either "providing" or "expectations" to the title as a way to make it even clearer.

- ***Terminology Section:*** The inclusion of a terminology section was positively received. Several respondents requested that the policy itself include examples, or that a companion document include examples in order to illustrate the application of the policy.

- ***Reasonableness of draft policy:*** Although the majority of respondents supported the principles of the draft policy, several expressed concern with requiring physicians to provide services in general. Some respondents were concerned that the presence of physicians without the needed skillset in a public health emergency situation would require personnel management that would detract from direct patient care. Others were concerned that the requirement for physicians to provide services is not reasonable, does not account for their familial responsibilities nor does it account for physicians experiencing severe illness or who are immunocompromised. It appears these respondents misread the content of the draft policy, as the draft policy accounts for familial responsibilities and ability limitations.

- ***Planning and preparation:*** Feedback provided by attendees at Chiefs and Presidents day spoke to the challenges of annual planning and preparation activities, as well as the need for all physicians to participate in simulation exercises and related activities.

- ***Temporary licensure and hospital privileges:*** At the September meeting of Council a question was raised about the College's process for temporary licensure during public health emergencies, as well as whether there was a process in place at the hospital level for granting privileges. These questions were echoed in the feedback received on the online discussion forum and through the online survey.

- ***Protection for physicians:*** Several respondents to the online survey highlighted their concern about liability coverage in the event they provided care to someone during a public health emergency. Feedback received from Council as well as through the online discussion forum echoed these concerns. Relatedly, several respondents provided feedback that they

felt the provincial government had a responsibility to provide compensation to them and their families if they were injured or died as a result of providing care during a public health emergency.

- ***Beyond College mandat*e:** Several comments were made that fell outside of the College's mandate to regulate the practice of medicine to protect and serve in the public interest. These included suggestions to include the following in the draft policy: criteria for when a disaster or public health emergency could be declared; assigning authority for which officials could declare a public health emergency; dictating how physicians should be compensated for the services they provide; and, developing communications infrastructure and regional plans for emergency preparedness.

C. Proposed Revisions

- Overall, the revised draft policy retains the key content and central principles of the draft policy. However, in light of the feedback received, a number of revisions are proposed and have been incorporated into the revised draft policy, attached as Appendix 'A'. A summary of the key proposed revisions is set out below.

<u>Key Revisions and Additions</u>

Executive Summary

- Both external and internal stakeholders have commented that it is sometimes difficult to navigate policies to identify relevant policy content, due in part to the increasing length and detail of our policies. Council provided similar feedback at its September 2017 meeting.

- In response to this feedback and Council's direction, an Executive Summary has been included at the beginning of this revised draft policy in order to provide a quick overview of the top issues and key expectations that are addressed in the policy (Lines 2-15).

Focus on Public Health Emergencies

- The inclusion of disasters added a level of confusion for the reader that detracted from the policy's application. The draft policy has been revised to focus on public health emergencies rather than to signify that the cause of these emergencies could be the occurrence of disasters.

Title

- The draft policy title was intended to clarify the circumstances in which this policy would apply. The length of the title was a concern, and with the focus of the policy being broader than the act of providing physician services, the title was re-examined.

- The title has been streamlined to focus on the event to which this policy applies, rather than attempt to further clarify the title by adding the word “expectations” or “providing” as suggested in the feedback. This simplified title is in line with a new approach the Policy and Communications Department will be using to simplify titles moving forward.

Affirming the profession’s commitment during public health emergencies

- The revised draft policy affirms the profession’s commitment to providing physician services by acknowledging the role physicians have always played (Lines 19-21) and recognizing the unique position they occupy in society to provide assistance to people in need (Lines 48-54).

Enhancing Clarity

  - Principle #1 now connects the expectation to provide care with the values of service and altruism. Principle #2 has been slightly altered to focus on collaborating with others, rather than supporting others (Lines 28-29).

  - A sentence has been added to clarify that public health emergencies are declared by governments (Lines 45-46).

  - The introduction to the policy sections has been streamlined. It acknowledges the addition of the section on planning and preparation, the slight change to the providing physician services section, and clarifies the requirement related to practising outside of scope of practice (Lines 55-58).

  - Directives from public health agencies have been added to the list of relevant information sources (Lines 76-77).

Planning and Preparation Section

- In response to consultation feedback, a section on planning and preparation has been added. This section sets expectations for physicians to plan and prepare for public health emergencies and provides information on liability protection available through legislation and the CMPA (Lines 60-69).

Providing Physician Services Section

- In response to consultation feedback, this section has been revised to provide clarity on the expectations surrounding providing physician services. This includes:

    - Requiring that physicians must be available to provide physician services, rather than stating they must provide services. This change reduces the risk that physicians will interpret this expectation in such a way as to force them to be physically present at a hospital for all public health emergency declarations (Line 86).

    - The addition of a sentence to clarify that physician services include both direct medical care, as well as administrative and other indirect activities that support the public health emergency response effort (Lines 87-90).

    - Clarifying that the expectation that physicians document patient encounters is dependent on whether or not the specific circumstances allow (Lines 95-98).

    - Clarifying that physicians with familial or ability limitations are expected to help the response effort in indirect ways, such as through administrative or other support roles, or increasing the capacity in their existing practice (Lines 102-105).

D. Companion Document

- Throughout the preliminary consultation on the existing policy, and the general consultation on the draft policy, certain topics arose that were not appropriate to address in the policy. Nevertheless, these topics would be helpful for physicians. A companion document will be developed as a response.

- Topics include information on temporary licensure and hospital privileges, death and disability insurance, compensation, the role of residents and medical students, and will provide examples of public health emergencies.

NEXT STEPS:

- Should Council approve the revised draft policy it will be published in *Dialogue* and will replace the current version of the policy on the CPSO website.

- Should Council approve the revised draft policy, a companion document will be developed and posted alongside the policy on the CPSO website.

DECISION FOR EXECUTIVE COMMITTEE:

1. Does Council have any feedback on the revised draft *Public Health Emergencies* policy?

2. Does Council approve the revised draft policy as a policy of the College?

Contact: Delia Sinclair Frigault, ext. 216

Date: February 2, 2018

Attachments:

Appendix A: *Public Health Emergencies* – Revised Draft Policy

Public Health Emergencies

Executive Summary:

This policy sets out the College's expectations for physicians in relation to preparing for and providing physician services during public health emergencies. Key topics and expectations include:

- *Planning and Preparation:* It is recommended that physicians prepare for the occurrence of public health emergencies.
- *Staying Informed:* Physicians must make reasonable efforts to stay informed during public health emergencies.
- *Providing Physician Services:* Physicians must be available to provide medical care and/or other physician services during public health emergencies, and must document patient encounters to the extent to which the specific circumstances allow.
- *Practising Outside of Scope of Practice:* If certain criteria are met, as laid out in this policy, physicians may temporarily practice outside of their scope of practice during public health emergencies.

Introduction

In the event of a public health emergency, the public relies on physicians. Federal, provincial and local responses to public health emergencies require extensive involvement of physicians. Physicians are integral to an effective response and have always provided medical care and other physician services in times of crisis. Providing care during public health emergencies often involves placing oneself at risk for harm, above and beyond routine care provision.

This policy articulates the College's expectations of physicians and reinforces the profession's commitment to the public during public health emergencies.

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 the values of the profession and uphold the profession's reputation by:

1. Providing care for those in need in line with the values of service and altruism.
2. Collaborating with colleagues, other health professionals, law enforcement, emergency response personnel and others when public health emergencies occur.

3. Maintaining current knowledge of relevant information available prior to and during public health emergencies.
4. Balancing competing professional and personal obligations in accordance with the values, principles and duties of medical professionalism.
5. Participating in the regulation of the medical profession by complying with the expectations set out in this policy.

Scope

This policy applies to all physicians during public health emergencies, regardless of practice setting or specialty.

Terminology

A **public health emergency** is a current or impending situation that constitutes a danger of major proportions with the potential to result in serious harm to the health of the public, and is usually caused by forces of nature, a disease or other health risk, an accident or an act whether intentional or otherwise[1].

Public health emergencies are declared by governments and public health authorities at the federal, provincial and municipal levels[2].

Policy

Governments, public health agencies, and health care institutions are responsible for ensuring resources are in place to facilitate the provision of medical care during public health emergencies.

Physicians are uniquely positioned to provide care during public health emergencies, and have an ethical duty to provide medical care and/or other physician services. This ethical duty is derived from the values of medical professionalism set out in the Practice Guide – compassion, service, altruism and trustworthiness.

The expectations of physicians articulated in this policy include physician responsibilities to plan and prepare, to stay informed, to be available to provide physician services, and to only practise outside one's scope during public health emergencies when specific conditions are met. The policy expectations exist for the duration of the public health emergency.

[1] Adapted from *Emergency Management and Civil Protection Act,* R.S.O. 1990, Chapter E.9
[2] Public Health in Canada - https://www.canada.ca/en/public-health/corporate/mandate/about-agency/federal-strategy.html

Planning and Preparation

Simulation exercises and related activities are an important part of emergency preparedness and typically feature as part of planning activities. The College recommends that physicians participate in simulation exercises and other emergency planning and preparation activities[3], and take advantage of training offered to them for tasks which they may be required to perform during a public health emergency[4].

Ontario's Good Samaritan legislation offers legal protection to people who give emergency assistance to those who are, or who they believe to be, injured, ill, in peril, or unconscious[5]. Additionally, the Canadian Medical Protective Association has indicated that liability coverage is available to physicians who provide medical care during public health emergencies[6].

Staying Informed

Physicians are advised to be proactive and inform themselves of the information available which will assist them in being prepared for a public health emergency. Once a public health emergency arises, however, physicians must make reasonable efforts to access relevant information and to stay informed for the duration.

Relevant information can include federal legislation[7], provincial legislation[8], emergency management plans developed by federal[9], provincial[10] and municipal governments[11], directives from public health agencies, and advice provided by the CMPA[12]. A physician's practice setting

[3] For example, mock disaster exercises, public health emergency simulations, developing emergency management plans for individual practice settings or following hospital/organizational plans.

[4] Physicians of all specialties are best placed to provide direct medical care during public health emergencies if they maintain their basic and advanced life support skills.

[5] *Good Samaritan Act,*S.O. 2001, Chapter 2

[6] CMPA Public Health Emergencies and Catastrophic Events - https://www.cmpa-acpm.ca/en/principles-of-assistance/-/asset_publisher/U9cW4gOU1zuo/content/public-health-emergencies-and-catastrophic-events-the-cmpa-will-help

[7] *Emergencies Act,* R.S.C., 1985, c. 22 (4th Supp.)
Emergency Management Act, S.C. 2007, c. 15
Quarantine Act, S.C. 2005, c. 20

[8] *Health Promotion and Protection Act,* R.S.O. 1990, Chapter H.7
Emergency Management and Civil Protection Act, R.S.O. 1990, Chapter E.9
*Good Samaritan Act,*S.O. 2001, Chapter 2

[9] Public Safety Canada: Emergency Management https://www.publicsafety.gc.ca/cnt/mrgnc-mngmnt/index-en.aspx

[10] Ministry of Community Safety & Correctional Services: Emergency Response Plans https://www.emergencymanagementontario.ca/english/emcommunity/response_resources/plans/plans.html

[11] Ministry of Municipal Affairs: List of Ontario Municipalities http://www.mah.gov.on.ca/page1591.aspx

[12] CMPA: Public Health Emergencies and Catastrophic Events https://www.cmpa-acpm.ca/en/membership/protection-for-members/principles-of-assistance/public-health-emergencies-and-catastrophic-events-the-cmpa-will-help

may afford access to additional sources of information. This may include, but is not limited to, hospital protocols, directives from community settings where medical services are provided, or organizational plans and/or policies.

In order for physicians to provide the best possible care, governments and public health authorities are responsible for ensuring that physicians receive timely, accurate and complete information both prior to and during public health emergencies.

Providing Physician Services

In fulfilling their individual commitment to patients, professional commitment to colleagues and collective commitment to the public, physicians must be available to provide physician services during public health emergencies. Physician services include direct medical care, as well as administrative or other indirect activities that support the response effort. Decisions about what role to undertake during public health emergencies must be made in accordance with the values, principles and duties of medical professionalism[13]. Considerations for temporarily practising outside of one's scope of practice during a public health emergency are addressed in the next section.

Physicians providing direct medical care to people in need must do so in accordance with relevant legislation and emergency management plans. Physicians must document these patient encounters to the best of their ability given the circumstances. As resources may become scarce during public health emergencies, documentation of the facts and circumstances of the patient encounter as well as the rationale for the medical decisions made is recommended, when possible.

There may be reasons related to the physicians' own health, that of family members or others close to them[14] which may place limits on the physicians' ability to provide direct medical care to people in need during a public health emergency. In those instances, physicians who have a personal health and/or ability limitation must engage in indirect activities that support the response effort during public health emergencies. This can include performing administrative or other support roles. Additionally, physicians can increase capacity in their existing practice to offset the increased strain placed on physician resources during public health emergencies.

Practising Outside of Scope of Practice

In non-emergency situations, there are clear expectations for physicians around scope of practice. A physician must practice only in the areas of medicine in which the physician is

[13] As set out in the Practice Guide
[14] As defined in the College's *Physician Treatment of Self, Family Members and Others Close to Them* policy

educated and experienced.[15] If a physician wishes to change their scope of practice the physician must do so in accordance with College policy[16].

During public health emergencies, it may be necessary for physicians to temporarily practise outside of their scope. To ensure competence while temporarily practising outside of one's scope of practice during public health emergencies, physicians are expected to exercise their professional judgement, and work with their colleagues in health care, in determining what appropriate medical care they can provide to persons in need of care, in accordance with relevant legislation and emergency management plans.

Physicians must only practice outside of their scope of practice during disasters and/or public health emergencies if:

- the medical care needed is urgent;
- a more skilled physician is not available; and,
- not providing medical care may result in greater risk or harm to the patient or public than providing it.

Once the public health emergency is over, physicians must not practise outside of their scope, unless they elect to change their scope of practice in accordance with College policy[17].

[15] Subsection 2 (5) of Ontario Regulation 865/93 under the *Medicine Act, 1991*.
[16] *Changing Scope of Practice* policy (NOTE: currently under review – to be updated once review complete)
[17] *Changing Scope of Practice* policy (NOTE: currently under review – to be updated once review complete)

FINANCE COMMITTEE REPORT

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

February 2018

TOPIC: 2018 Membership Fee

FOR DECISION

ISSUE:

At its December meeting, after reviewing the proposed budget for 2018, Council supported a $100 fee increase that would establish the 2018 membership fee for an independent practice certificate at $1,725 beginning June 1st. The recommended 2018 membership fee was circulated to the membership following the December meeting of Council.

BACKGROUND:

Council supported the 2018 membership fee which includes a $100 increase in December 2017. Following is an overview of the process and factors that informed Council's support of the 2018 fee.

2018 Budget Process

The 2018 budget process consisted of the following:

- In Q2 and Q 3, the management team reviewed the 2017 corporate plan and considered program, project and staffing needs into 2018. Some key issues were:
    - Focus on activity trends and resource needs for the entire investigative process, compliance, hearings and the associated needs for legal support (both in-house and external counsel). The respective Directors were asked to prepare a comprehensive review of current activity, trends and the impact of maintaining the status quo for staffing levels.
    - Identification of discretionary work activity could be stopped or deferred in order to manage the work-related activities of existing staff in all areas, but specifically in investigations and legal support.
    - A direction from the Registrar for all Divisions to cut more than $1.3 million from the existing base budget. A direction from the Registrar for all Directors to prepare efficiency plans for 2018.

- From May - August, development by all departments of specific resource needs for staff, Committees, programs and capital costs.
- From August – September, preparation of budget scenarios to support and manage growing caseloads consider various levels of increased staffing in I&R and Legal to meet our statutory obligations and benchmarks.

Key features of the 2018 budget preparation include:

- The College's budget is largely determined by:
    - Statutory obligations – the College has no choice but to comply with the required programs and, in many cases, prescribed processes and timelines. Staff is always looking for ways to be efficient and effective within the legislative parameters.
    - External drivers – Numerous issues arrive at the College and require – based on risk, public safety, stakeholder relationships or direction by Government – concentrated work efforts which sometime involves numerous departments and staff (e.g. Bill 87 implementation and the opioid strategy require significant resources).
    - Strategic priorities – This encompasses priorities determined by Council and other issues that are deemed to be important for the long term sustainability of programs. While these are discretionary decisions, they are not always easy to contain or stop, because of the commitment to the protection of the public on the part of Council, Committees and/or staff. The senior management team is becoming more rigorous in its approach to planning and budgeting.
    - Emerging issues (currently not included in the 2018 budget) – there are always issues that may strain the College's resources, but we have little or no information about what, if any, impact the College will experience. This year we are carefully monitoring a number of issues that could impact our budget but for which we have little information in order to take definitive action.
        - Physician Assistants – the Minister of Health and Long Term Care has asked us to consider oversight models for PAs in collaboration with Ministry staff.
        - Potential incorporation changes under consideration by the Canadian government could impact whether physicians apply for, or renew existing, incorporation status.
        - Patient sexual abuse therapy fund – Bill 87 amended the RHPA in a variety of ways, including changes to the criteria to access patient funding for treatment and therapy related to sexual abuse. The relevant sections have not yet been proclaimed and the associated financial impact is unknown.
        - Public member compensation – Legislative change and political will are required, and it is difficult to assess when or if this may transpire.

The Finance Committee heard from senior managers including detailed presentations of the current activities, trends and needs identified by the Investigations & Resolutions Division and the Legal Department. Background information on College volumes and longitudinal trends is attached to this report.

- The nature and volume of the work in both Legal and I&R is not always predictable; external issues can change the volume or intensity of the work (high risk, urgency). For example:
    - Estimates are made of the probable number of annual complaints and investigations, but certain unknown events have dramatically changed the numbers and complexity of cases (for example, the number of referrals to the Discipline Committee in 2017, and the number of opioid investigations and their intensity)
    - The Legal Department provides legal advice and services to the entire College and is responsible for the corporate integrity and regulatory compliance of the College. The nature of the work spans the entire College and includes case management and support for all statutory activities, as well as external litigation, policy and program support, and many corporate issues. External legislation, media and public issues also can consume considerable legal resources while the case volume continues to climb (eg. Bill 87, Sexual abuse, MAID, Community Clinic Legislation, etc.).
- In both areas, on a per staff basis, individuals have carriage of case file volumes that are well above previous years. Trending in the investigations and legal functions shows growth in activity that is not stabilizing or decreasing. This applies to number of investigations, ICRC decisions, compliance cases, discipline referrals, and open hearings.
- The complexity of cases is also changing, with a greater proportion of cases requiring immediate attention based on potential patient and public safety issues. This also translates into added need for Legal advice and services with respect to outcomes like hearings, restrictions and undertakings.
- Timelines cannot improve without additional staff resources to manage the increasing volumes and complexities.
- The impact to the College is experienced in many ways: inability to reduce timelines for public and physicians, negative impact on staff, and a need for more costly external legal counsel.
- Notwithstanding the ongoing changes being adopted, there is an urgent need for additional staff to support and manage the case load growth faced by the I&R and the Legal Departments. These details are provided in the attached budget – new staff requests.

The Finance Committee recommends to Council a fee increase of $100 per member. This will move the membership fee for an independent practice license from $1,625 to $1,725.

The Finance Committee recommends this fee increase of $100 per member to support a growing and unsustainable workload in the Investigations and Resolutions area and Legal area, specifically in support of additional staff as described in the accompanying documents.

The budget can be summarized as follows:

	2018 – Base	2018 – New	2018 - Total
Total Revenues	$67,083,858		$67,083,858
Base Budget	$65,746,913		$65,746,913
New Initiatives Requested			
Per Diem Increase (2%)		$190,991	$190,991
HST Increase		$11,173	$11,173
Salary Increase (2.5%)		$721,150	$721,150
Strategic Planning Project		$100,263	$100,263
Conversion/Contract Extension, Upgrades and New Positions		$2,212,428	$2,212,428
Capital and depreciation		$206,249	$206,249
Building Reserve		$0	$0
Sub-total		$3,312,161	
Total Expenditures	$65,746,913		$69,059,074
New Revenue from $100 fee increase		$1,976,917	$1,976,917
Surplus	$1,336,945		$0

CURRENT STATUS:

The proposed increase was circulated to the membership following the December meeting of Council as required under the Health Professions Procedural Code. No feedback or comments have been received to date.

DECISION FOR COUNCIL:

Does Council approve the recommended annual fee for members at $1725 in 2018?

Contact: Douglas Anderson, Corporate Services Office, ext.607

Leslee Frampton, Manager, Finance and Business Services

Date: January 29, 2018

Does Council approve the recommended annual fee for members at $1725 in 2018?

Contact: Douglas Anderson, Corporate Services Office, ext.607
Leslee Frampton, Manager, Finance and Business Services

Date: January 29, 2018

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

February 2018

TOPIC: **Tariff Rate Increase for Discipline Hearings**

FOR DECISION

ISSUE:

The Finance Committee is recommending to Council that the tariff rate for a day of discipline hearings be increased from $5,500 per day to $10,180 per day to cover direct cost as currently prescribed in the Disciple Code.

BACKGROUND:

The Health Professions Procedural Code (the "Code") allows a panel of the Discipline Committee, "in an appropriate case", to require a member who has committed an act of professional misconduct or who is incompetent to pay all or part of:

1. The College's *legal* costs and expenses;
2. The College's costs and expenses incurred in *investigating* the matter; and
3. The College's costs and expenses incurred in *conducting the hearing*.[1]

While the Code allows the Discipline Committee to award costs in the three categories above, in order for the College to obtain costs in the three categories above, College counsel would be required in every case to call or file evidence to prove the actual costs incurred and to make legal argument that the costs incurred were reasonable. At present the College does not have systems in place to provide evidence of the actual costs incurred in categories one and two above (e.g. a docketing system to accurately track investigative time and expenses and legal time and expenses in any particular matter). In addition, proving and arguing costs is itself a time-consuming and litigious process even where a docketing system is in place, essentially resulting in a separate hearing on costs after the hearing on the merits is complete.

[1] Health Professions Procedural Code, Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, s. 53.1.

The tariff rate represents an exception to the requirement to call or file evidence to prove actual costs incurred and the associated obligation to make argument that those costs are reasonable, with respect to the third category set out in the Code.

More specifically, the Rules of Procedure of the Discipline Committee (the "Rules") provide that where the College's request for costs includes "the cost to the College of conducting a day of hearing" (i.e. the 3rd category set out in the Code), no evidence is needed to prove that cost, provided that the request is equal to or less than the amount set out in Tariff A to the Rules.[2] The amount set out in Tariff A to the Rules is known as the "tariff rate".

Given that it is possible to request and obtain tariff rate costs without the need to call or file evidence to prove actual costs incurred or to make legal argument that the costs incurred were reasonable, it has historically been the practice of College counsel to request costs at the tariff rate per day of hearing, regardless of whether the hearing is settled in advance or proceeds on a contested basis.

Very rarely, College counsel will obtain instructions from the ICRC to seek costs greater than the tariff rate. In such cases, as indicated above, College counsel is required to call or file evidence to prove the actual costs incurred in all three categories (to the extent possible, given the lack of docketing systems in place) and to make legal argument that the costs incurred were reasonable.

How the tariff rate is calculated

As indicated above, the tariff rate is defined in the Rules to be "the cost to the College of conducting a day of hearing".

The fixed costs of conducting a day of hearing can vary significantly. The tariff rate has historically been calculated based on the elements of a day of hearing time set out in the chart below. The numbers in this chart reflect the best estimates of fixed costs in 2017:

[2] Rules of Procedure of the Discipline Committee of the College of Physicians and Surgeons of Ontario (1 January 2017), Rule 14.04.

Table 1

Item[3]	2017
3 physician Discipline Committee panel members - time[4]	$2,880
3 physician Discipline Committee panel members – transportation and maintenance (lodging and food) expenses[5]	$1,500
Independent legal counsel - time[6]	$3,429.55
CPSO prosecutor - time[7]	$2,100
Court reporter - time[8]	$271.20
Total:	**$10,180.75**

The elements included in the tariff rate have not historically included an estimate of the time spent by physician Discipline Committee panel members for travel time, deliberation days or for writing the decision (for which physician panel members are paid), or for expenses incurred by College counsel (e.g. photocopying costs for briefs of evidence, authorities and argument filed with the Committee). Moreover, the elements included in the tariff rate do not include certain variable costs associated with conducting a contested hearing, such as witness expenses (including travel and lodging), expert fees and expenses (including travel and lodging), and the cost of transcripts of the evidence (prepared by the court reporter) for members of the Committee. It also does not include the cost of the hearing space. As such, the estimate reflected in Table 1 represents a conservative estimate of the College's actual costs of conducting a day of hearing, and a fraction of the actual investigative and legal costs and expenses incurred in conducting an investigation and preparing for a hearing.

Increase of the tariff rate over time

In 2013, Council endorsed a tariff rate reflecting approximately 50% of the estimated fixed costs of a day of hearing time (comprised of the elements set out in Table 1 above). The increases in the tariff rate since 2013 have continued to reflect approximately 50% of the estimated fixed costs of a day of hearing time.

Over the past 5 years, the tariff rate has increased as follows:

[3] All estimates include HST where relevant.

[4] Three physician members * $160/hour * 6 hours/day. Public members of the Discipline Committee are paid by the Province of Ontario, not by the College.

[5] Travel and lodging costs vary widely depending on where physician members of the panel reside; this represents an estimated average based on annual charges by physician members of the Discipline Committee.

[6] This reflects the actual charge by independent legal counsel for a single day of hearing time.

[7] $300/hour * 7 hours/day.

[8] This reflects the actual charge by the court reporter for a single day of hearing time.

Table 2

2013	$3,650/day
2014	Increased to $4,460/day
2015	No increase
2016	Increased to $5,000/day
2017	Increased to $5,500/day
2018	Proposed increase to **$10,180**/day

In the past year, as part of an overall effort to address rising costs within the College (which are ultimately passed along as increases in membership fees to the College's members), the Finance Committee has indicated a desire to recover a greater portion of the College's fixed costs associated with running a Discipline hearing from the member who is the subject of the hearing. Accordingly, the Finance Committee would like the tariff rate to reflect a greater total of the estimated cost of a day of hearing time.

The College can expect costs awards by the Discipline Committee to be challenged by subject physicians and scrutinized by the courts, particularly where there is a significant year-over-year increase in the tariff rate. College counsel is aware of court decisions upholding costs awards by other tribunals at rates significantly higher than the College's current tariff rate. In the circumstances at hand, College counsel is comfortable defending an increase in the tariff rate from $5,500/day to $10,180/day.

The Finance Committee determined that in an effort to address the rising costs of Discipline hearings the rate should be increased to $10,180/per day and made the following motion:

> It was moved by Peter Pielsticker, seconded by Harry Erlichman, and **CARRIED.** *That the Finance Committee recommends to Council that the tariff rate of a day's discipline hearing be increased from $5,500 to $10,180 upon approval of Council.*

DECISION FOR COUNCIL:

Does Council support the Finance Committee's recommendation to increase the tariff rate for Discipline Hearings from $5,500 to $10,180?

Contact: Peter Pielsticker, Chair Finance Committee

Douglas Anderson, Corporate Services Officer, ext. 607
Leslee Frampton, Manager Finance and Business Services, ext. 311

Date: January 29, 2018

PRESENTATIONS

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

February 2018

TOPIC: Education Strategic Initiative Update

FOR INFORMATION

ISSUE:

- The Education Strategic Initiative was approved by Council as a component of the CPSO Strategic Framework for 2014 through 2017.
- This briefing note provides an update on the development of this activity and presents the CPSO Education Strategic Initiative Framework that outlines the activities from 2018 to 2020 to move toward the desired state.
- The Education Strategic Initiative Framework is presented as Appendix A.

BACKGROUND:

- In 2010, Council directed change in College's role in education in three areas: identify trends in physician learning needs, work with educational stakeholders to ensure needs are met, and measure outcomes of learning activities.
- In September 2014, Council approved Education as one of four Strategic Initiatives for 2014-2017 (Transparency, Quality Management Partnership (QMP), Data Management and Education).
- Specifically, the Education strategy aimed to integrate and coordinate physician education across all College Committees, programs and staff, and to ensure consistency with respect to physician needs assessment, educational activities and resources, data collection, outcome measurement and reporting.
- Since then, several initiatives were undertaken that further informed the Education Strategic Initiative.
    - The Individualized Education Plan (IEP) analysis helped obtain information on physician learning needs, interventions, and outcomes across committees between 2010-2012, and proposed several recommendations to support further streamlining of educational activities across the College.
    - The sexual abuse review pointed to a further need to support consistency in committee decision-making and training, to create a model for remediation of physicians with identified learning need and to ensure that new members are familiar with College policies and processes.

- A staff (Visioning) working group collectively developed a Role for the College in Education along with a Vision and Goal for education at the College.
- The Role, Vision and Goal for Education were approved by Council in May 2017 and are at the foundation of the Education Strategic Initiative Framework. These statements are included in Appendix A.
- The long-term plan for education was also developed through the work of the Visioning working group, revised and ultimately reviewed and approved by them.
- The Education Strategic Initiative will serve as a roadmap for educational activity across the College and includes projects that are currently underway as part of the CPSO Corporate Plan for 2018.
- The ESI Framework supports the Vision of the College of Quality Professionals, Healthy Systems, and Public Trust:
    - Quality Professionals
        - ESI will influence the education of physicians along the spectrum of their careers both proactively and in response to defined needs.
        - Medical students will learn more about professionalism and professional regulation through the Professionalism and Practice Program.
        - An evidence-informed approach to remediation will improve the quality of care provided by physicians in practice.
    - Healthy Systems
        - New Member Orientation will enhance the experience of new members of the College.
        - The Data Mapping initiative along with evidence-informed remediation will use measurement and outcome data to improve our processes and enhance our accountability.
        - Many of the projects involve working with external stakeholders.
    - Public Trust
        - Through consistent, purposeful and evaluated remediation, the College will be able to build a greater understanding that our remedial efforts are effective.
        - Patients will have enhanced trust in our work through a focus on preventative education for new applicants as well as a focus on the non-Medical Expert CanMEDS roles.
        - Building ongoing relationships with external partners and stakeholders will contribute to the College being recognized as a key collaborator in the education of students, residents and physicians in practice in the interest of safe and effective patient care.

CURRENT STATUS:

- The Education Strategic Initiative Framework has four long-term goals:
    - **Consistent decision-making:** all education elements across Committees are evidence-informed, consistent, achieving desired outcomes and evaluated.
    - **Supporting physicians with learning needs:** individual physicians with identified learning needs are supported in addressing them.
    - **High quality Continued Professional Development:** physicians are supported in participating in meaningful, effective, and individualized CPD.
    - **Education on key areas of importance to the College:** CPSO supports students and physicians throughout their professional careers by facilitating education focused on CanMEDS roles, professional regulation and current system needs.
- Four main projects are being undertaken over the next 3 years that align with the above goals:
    - developing a long-term vision and strategy for education (now referred to as ESI);
    - New Member Orientation, a credentialing requirement for new registrants focusing on regulation and the role of the College approved by Council in September 2018;
    - developing an evidence-informed approach to the remediation of physicians found to have difficulty with opiate prescribing;
    - Educational Data Mapping (in tandem with the Data and Analytics Strategy which was presented to Council in May 2017).
- College projects/activities that are framed within the above goals will support physicians along the spectrum of their careers in a wide variety of targeted, consistent and evidence-based educational activities.
- Built-in evaluation of projects will allow the College to ensure that its interventions are impactful and contributing to the vision of quality professionals, healthy systems and public trust.
- The Education Strategic Initiative Framework will achieve greater consistency in educational decision-making, and will relieve some operational pressures, redundancies and streamline decision-making processes.
- Through such activities as the New Member Orientation, the College will create an innovative mechanism to engage with its members early on in their careers, build an understanding of regulation and the College expectations among new members, and create a mechanism to incorporate topics of importance to the CPSO and the medical profession.

CONSIDERATIONS:

- The Education Strategic Initiative Framework has been developed and is attached for your review.

- Many of the projects contained within the framework are already well underway, with project charters, timelines and defined deliverables already developed.
- No new resources will be contemplated for this initiative at this time.
- Implementation of the Framework will be through projects that are managed and feasible.
- The plan covers three years, recognizing that with the transition to a new leadership and a new organizational strategic plan some elements of this framework may be reviewed in the future.

NEXT STEPS:

- Implementation will be supported by staff, where appropriate.
- Committees will have the opportunity to participate in this initiative as implementation unfolds.
- Collaborations with external partners, where appropriate, will continue as planned.

DECISION FOR COUNCIL:

This item is for information

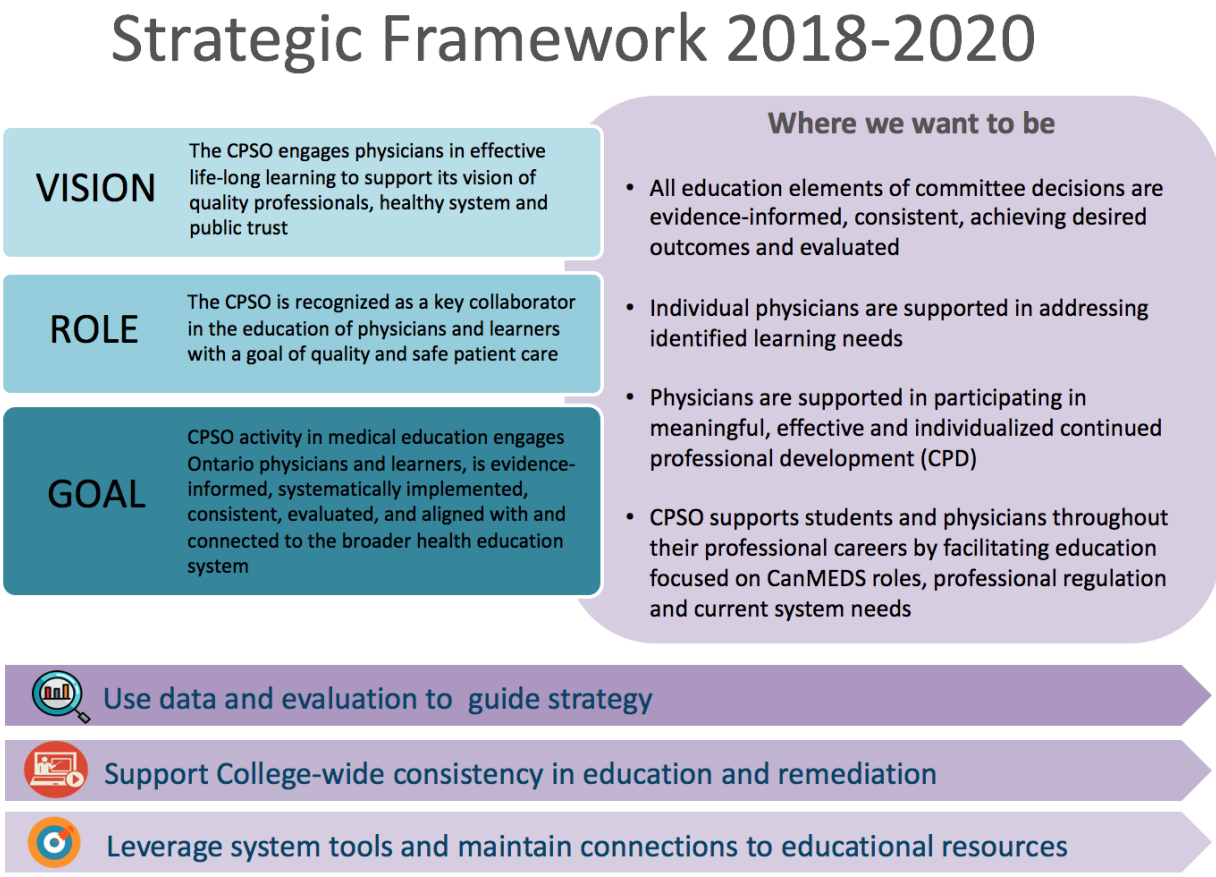
Contact: Natalia Ronda, ext. 523
Dr. Bill McCauley, ext. 434

Date: February 1, 2018

Attachments:

Appendix A: Education Strategic Initiative Framework

Appendix A: Education Strategic Initiative Framework



* - activities in progress

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

February 2018

TOPIC: Opioid Strategy: Update

FOR INFORMATION

ISSUE:

- This briefing note provides an update on progress on the Opioid Strategy.

CURRENT STATUS:

- The Opioid Strategy, attached as Appendix A, was approved by Council at its May 2017 meeting.
- A status update on all elements of the strategy is set out below.

	Elements	Status
1 Guide	Review Prescribing Drugs policy to include updated guidelines and new expectations, as required	A full review of the policy will be conducted in 2018.
	Facilitate review of MMT guidelines	This work is currently on hold, pending resolution of the possible s56 methadone exemption changes and development of the HQO standards.

	Elements	Status
2 Assess	Continue focused methadone assessments via methadone program	Methadone assessments are continuing.
	Expand focus on assessments to opioid prescribing via QAC	Work is underway to incorporate an opioid prescribing review into the existing random assessments.
	Identify & assess moderate opioid prescribing risk, avoiding need for investigations	Planning is underway to explore an alternate approach to responding to moderate opioid prescribing risk, within the context of work already being done by other partners like ICES and HQO.

	Elements	Status
3 Investigate	Identify, investigate and monitor high risk (problem) opioid prescribing	95% of NMS investigations completed in one year. Objective of facilitating appropriate prescribing and avoiding patient abandonment achieved. An evaluation is underway. Work is underway to identify high risk prescribing, within the context of work already being done by other partners (ICES and HQO).

	Elements	Status
4 Facilitate Education	Work with partners to ensure multiple educational offerings, targeted at multiple stages of practice: general education, awareness and remediation	Regular communication with education providers, medical schools, and CPD programs is occurring to maintain an up-to-date list of resources.
	Work with partners to Develop an Opioid Prescriber's Education Series, focused on the fundamentals of appropriate prescribing and particular areas of focus to be determined	Planning underway for sessions beginning in 2018 in collaboration with the Ontario College of Family Physicians (OCFP) to focus on College policy and expectations relating to opioids.

ENABLING ACTIVITIES

	Elements	Status
A Communicate	Continue Dialogue coverage from multiple perspectives, including patients and families	ACHIEVED: 20+ articles, letters, and infographics in Dialogue in 2017. Coverage to continue in 2018.
	Compile all Dialogue articles into a resource for other educational initiatives	COMPLETE: All Dialogue articles relating to opioids have been consolidated on the web hub. These will also be incorporated into the Opioid Prescriber's Education Series, in development.
	Communicate directly with patients and the public	COMPLETE: A message to patients was released September 8, 2017.
	Develop an Opioids Statement that clearly sets out the role of the College, physicians and system partners.	COMPLETE: Opioids Position Statement released September 8, 2017.

	Elements	Status
B	Accessing, analyzing and acting on	Collaboration with ICES and HQO to develop an

Use Data and Analytics	prescribing data are key enablers of the strategy framework	opioid prescribing risk score.
	Physicians need information to prescribe appropriately	Physicians associated with hospitals and some FHTs are able to access this information but it is not clear yet how solo physicians or physicians without EMRs will obtain access. Further advocacy required.
	The CPSO needs data to fulfill its regulatory responsibilities and to identify factors that support appropriate prescribing.	CPSO is working with ICES to receive de-identified information in order to determine next steps.

	Elements	**Status**
C Collaborate	For activities that are not the CPSO's primary responsibility, collaborate with key stakeholders – Health Quality Ontario, the MOH, eHealth Ontario, and others – to promote safe prescribing and access to information for physicians	Ongoing work with HQO and education providers to identify the supports that will be offered to physicians. Ongoing work with the MOH and the Prescription Monitoring Leadership Roundtable to establish algorithms and data transfer processes.

COMMUNICATIONS

- On September 8, 2017, various communications products were released, including a NMS backgrounder, which provided a status update on the investigations. http://www.cpso.on.ca/CPSO/media/documents/Positions%20and%20Initiatives/Opioids/Opioid-Investigations-Backgrounder.pdf. At the time, 56 of 84 investigations had been completed.
- Currently, the majority of investigations are complete.
- A further update on the status of the investigations will be provided to Council at the meeting.

OTHER UPDATES

Minister/Ministry of Health

- The Minister announced the creation of an Opioid Emergency Task Force in October 2017. The group, which includes front line workers in harm reduction, addiction medicine and community-based mental health and addiction services, will advise the government on an education campaign to raise awareness of the risks associated with opioid use. The CPSO has recently been added to this group.

Prescription Monitoring Leadership Roundtable (PMLR)

- The PMLR's purpose is to ensure that NMS data is used by the MOHLTC in a consistent and evidence-based manner to ensure that potentially inappropriate prescribing and dispensing practices are identified and handled appropriately.
- The group is intended to deal with the development of algorithms to identify areas of highest risk and appropriate intervention methods when questionable prescribing and dispensing behaviour is identified.

Health Quality Ontario (HQO)

- **myPractice reports (formerly 'primary care practice reports')** for physicians relating to opioids were released in November. The CPSO has encouraged primary care physicians to access their myPractice reports and released an article in collaboration with HQO https://simplycast.ca/files/8000303/files/HQOArticleNEW.pdf?recipient_id=14_c8YE-pYxXbWgTh-FvZjH7TdDPMbcW-8.

- **New Starts report:** On January 25, HQO released its latest report 'Starting on Opioids: Opioid prescribing patterns in Ontario by family doctors, surgeons, and dentists, for people starting to take opioids' http://startingonopioids.hqontario.ca/. The report provides the following information:
    - Many Ontarians continue to be started on opioids.
    - High-dose new starts of opioids by surgeons varies by LHIN region.
    - New starts of hydromorphone and tramadol are increasing.
    - Nearly half of new starts of opioids by family doctors and more than 1 in 10 new starts by surgeons were for a supply of more than 7 days.

DECISION FOR COUNCIL:

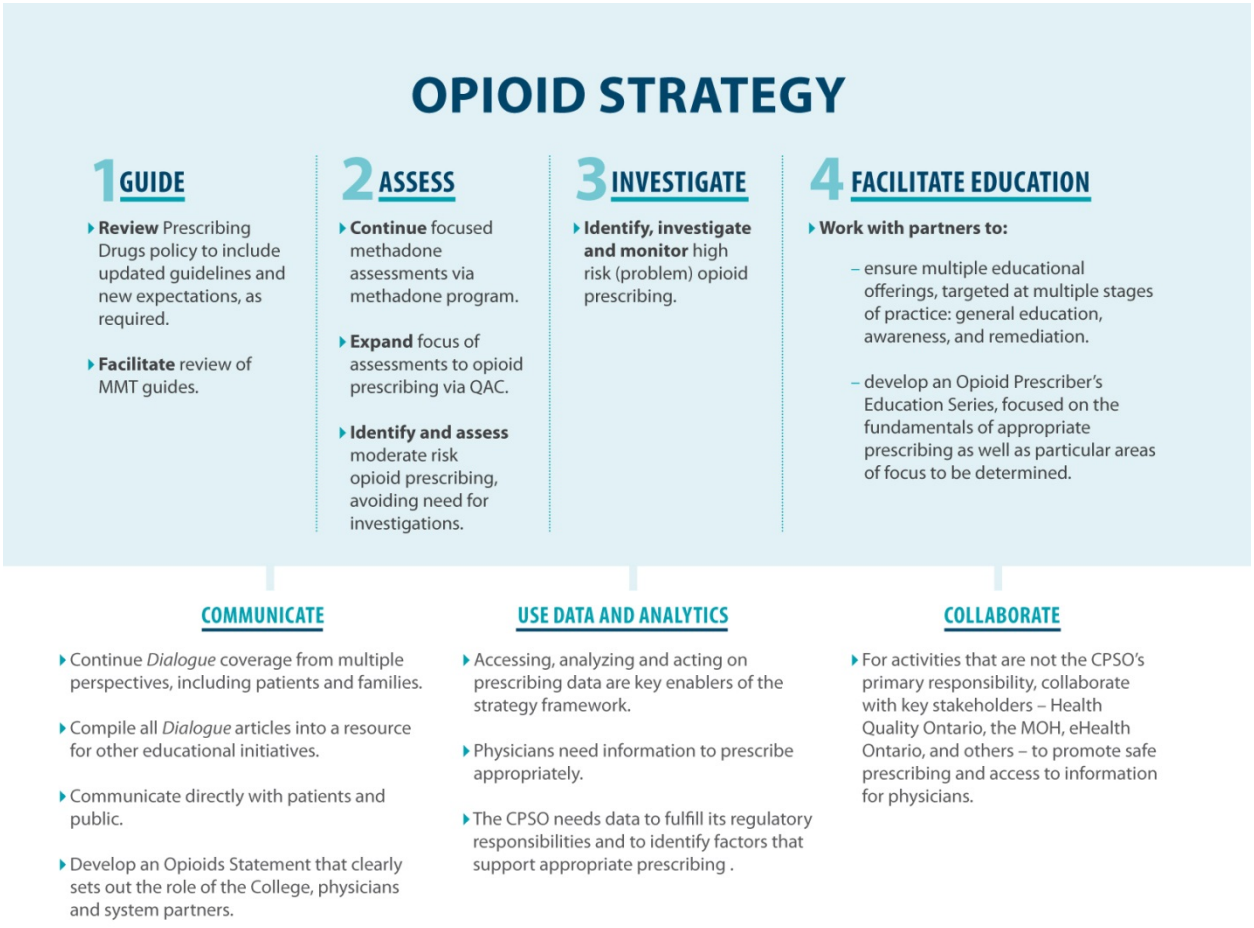
FOR INFORMATION ONLY

Contact: Maureen Boon, extension 276

Date: January 30, 2018

Attachments:
Appendix A: Opioid Strategy

Appendix A: Opioid Strategy



Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

February 23, 2018

TOPIC: COUNCIL AWARD RECIPIENT

FOR INFORMATION

ISSUE:

At the February 23rd meeting of Council, **Dr. Bill I. Wong** of Toronto will receive the 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

DECISION FOR COUNCIL:

No decisions required.

Contact: Tracey Sobers, Ext. 402
Date: February 2, 2018

IN CAMERA

PRESENTATION

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

February 2018

TOPIC: Continuity of Care and Test Results Management Policy Development Update

FOR DISCUSSION

ISSUE:

- Work is currently underway to develop new policies relating to a number of Continuity of Care issues and to update the current Test Results Management policy.

- Council is provided with an update on these activities and an overview of the issues that will be addressed in these policies, as well as planned next steps.

BACKGROUND:

- In March 2014, the Executive Committee directed staff to undertake preliminary work on the issue of continuity of care, including providing analysis and recommendations regarding the development of a new policy.

- After being delayed by competing priorities, preliminary work was conducted in early 2016. This work culminated in a presentation to Council in May 2016 where Council reviewed and discussed a Continuity of Care Planning and Proposal document which provided analysis and recommendations relating to the development of new policy content.

- A Working Group was struck to oversee the development of new policy content relating to Continuity of Care and to revise the current Test Results Management policy.

    - The Working Group is comprised of Dr. Brenda Copps (Chair), Dr. Kevin Glasgow,[1] Dr. Barbara Lent, Dr. Peeter Poldre, Ms. Joan Powell, Mr. Ron Pratt, Mr. Arthur Ronald,[2] and Dr. David Rouselle. The Working Group is also supported by Alice Cranker (Legal Counsel) and Dr. Keith Hay (Medical Advisor).

[1] Dr. Glasgow is a College Assessor with expertise in walk-in clinics.
[2] Mr. Arthur Ronald has left the College effective December 2017 and has declined to be a part of the Working Group going forward.

- As part of the policy development and review process, preliminary external consultations relating to both to the topic of Continuity of Care and the current Test Results Management policy were held between June and August 2016. A summary of the feedback received was provided to Council in September 2016.

    - Broadly speaking, stakeholders were supportive of the College's efforts to address continuity of care issues. That said, both the Ontario Medical Association (OMA) and the OMA Section on General and Family Practice (OMA SGFP) expressed concern that new expectations may hold physicians responsible for systems issues or may compromise physician health and/or work-life balance.

    - Stakeholders were also generally supportive of the Test Results Management policy, but constructive feedback was provided on a number of issues. This included issues with patients not getting tests done or not booking follow-up appointments, physicians' responsibilities when in receipt of a test result in error, and whether 'no news is good news' practices are appropriate.

- To facilitate increased engagement in the process and to provide the Working Group with different perspectives on the issues, speakers representing primary care, hospitals, patients, and those developing and advocating for technological developments made presentations to the Working Group.

- A comprehensive literature review was also conducted in support of the policy development and review process. This included a review of scholarly articles, research papers, media publications, as well as a jurisdictional review of other medical regulatory authorities in Canada. Moreover, decisions of the Inquiries, Complaints, and Reports Committee (ICRC) were reviewed to identify frequent or persistent problems relating to test results management.

CURRENT STATUS:

- The Working Group has approached this project with the goal of identifying and addressing breakdowns in continuity of care that can compromise patient safety. As part of this, the Greg Price case from Alberta, where a young man died of testicular cancer following numerous preventable breaks in continuity of care, has been an important reminder of why this work is being undertaken and what issues need addressing.

- The focus of the Working Group has been on those issues where physicians have a role to play in facilitating continuity of care and articulating expectations in relation to the nature and scope of that role.

    - Recognizing that some continuity of care issues may be 'systems' issues, the Working Group has committed to developing a 'white paper' that will set out the College's view and recommendations regarding systems issues that inhibit or facilitate continuity of care.

- Additionally, the Working Group is alive to the realities of practice and the burdens currently facing practicing physicians. This has been a central component of the Working Group's analysis when contemplating new or revised expectations. At the same time, the Working Group is focused on and committed to making sure that physicians provide quality care that minimizes breakdowns in continuity of care which risk patient safety.

- While continuity of care is a broad concept that could include a number of issues, with the above objectives and considerations in mind, the Working Group has prioritized four key areas as the focus of this current work: Availability and Coverage (e.g., availability to patients and other health-care providers, after-hours and vacation coverage); Test Results Management (e.g., ordering, tracking, communicating results); Transitions in Care (e.g., hospital discharges, the consultation process); and Walk-in Clinics (e.g., connection to primary care, managing orphan patients).

- The Working Group has also endorsed a new organizational approach to capture the policy content of this project. Namely, developing a 'suite' of policies that address a range of related issues. More specifically, the Working Group is developing discrete draft policies for each of the four key areas set out above and organizing them under an 'umbrella' Continuity of Care policy which will set out core expectations that apply broadly. This approach was introduced to Council at the December 2017 meeting.

- The drafting process is well underway. In response to the feedback received and the research conducted to date, the Working Group has provided direction regarding the new policy positions they would like developed and revisions they'd like to make to the current Test Results Management policy.

    - It is anticipated that the Working Group will be seeking permission from Council to consult externally on draft policies at the May 2018 meeting.

    - Given the nature and scope of this work, the Working Group felt it was important to provide Council with an update on this work and to give Council the opportunity to engage in a discussion on this work prior to seeing draft policies at a future meeting. In particular, to assess whether Council generally agrees with the approach and draft positions being developed.

- A brief summary of the approaches and key draft positions being developed by the Working Group is set out below:

<u>Continuity of Care – 'Umbrella' Policy</u>

- The purpose of the draft 'umbrella' policy is to set out principles and expectations that apply broadly and underpin the suite of policies.

- The Working Group is drafting a set of principles that underpin the entire suite of policies and connects the content of the policies back to the values and duties found in the *Practice Guide*. Principles being contemplated focus on patients' best interests, communication and collaboration, public trust, physician competence, and participation in medical regulation.

- The draft policy being developed identifies, in a high level manner, the role that physicians, patient engagement, and technology can all play in facilitating continuity of care.

    - With respect to the physician's role, language is being drafted that identifies the importance of physicians seeing patient interactions with the health-care system as not discrete events, but rather as a set of interactions that require oversight and management over time.

    - With respect to patients, the Working Group felt it was important to recognize the important role that patients play in facilitating continuity of care. As such, the Working Group is drafting recommendations that physicians support patient engagement by, for example, helping patients understand their role and responsibility and how their actions can facilitate or disrupt continuity of care.

    - Finally, regarding technology, language is being drafted that encourages physicians to capitalize on advances in technology that may facilitate continuity of care. Importantly, the Working Group believes that the absence of a technological solution does not absolve physicians of their responsibilities with respect to continuity of care.

Availability and Coverage

- The purpose of this draft policy is to set out expectations for physicians regarding physician availability, after-hours coverage, and coverage during temporary absences.

- The Working Group does not intend to require individual physicians to personally provide on-demand and continuous (i.e., 24/7) access to care. Rather, the Working Group's goal is to require physicians to take meaningful steps towards improving their availability and facilitating access to coordinated care when physicians are unavailable. This had led to the development of a number of new expectations.

    - The Working Group is drafting an expectation that physicians have an office phone that is answered, that allows for voicemails to be left, and that has an accurate outgoing message.

    - To help improve patient access to care, expectations are being drafted to ensure patients with time-sensitive or urgent issues are being appropriately triaged. This includes, a recommendation that physicians consider implementing a same-day scheduling system or utilizing other physicians to facilitate access.

- Regarding after-hours coverage, the Working Group felt it was important that uncoordinated access to care and inappropriate usage of emergency rooms and walk-in clinics be minimized. To achieve this, language is being drafted that would require physicians providing care as part of a sustained physician-patient relationship to have a plan in place to coordinate care outside of regular operating hours.

    - The Working Group does not intend to prescribe what an after-hours plan looks like, but rather contemplates that the nature of the plan will vary depending on a variety of factors including time of day, needs of patients, and health professional and health system resources in the community.

- The draft policy will also address temporary absences from practice, including extended leaves of absence. This content was previously captured in the *Practice Management Considerations*.[3,4] The draft policy will set out an expectation that coverage arrangements be made for all temporary absences from practice. As with the expectations regarding after-hours coverage, the draft policy will not detail what the coverage arrangement will look like, but will recognize that coverage arrangements will depend on a variety of factors including e.g., length of absence, whether the absence is planned, needs of the patient, and health professional and health system resources in the community.

Test Results Management

- The purpose of this draft policy is to set out expectations for physicians regarding the ordering and management of all types of tests.

- Through its revisions, the Working Group intends to clarify that the scope of the policy applies to all tests, not just laboratory tests, and has focused on providing additional guidance regarding challenging elements of the test results management process. This includes, for example, tracking tests, communicating results to patients, receiving results in error, and patient engagement.

    - Regarding tracking tests, the Working Group is developing expectations that confirm what is in the current Test Results Management policy - that is, tests must be tracked for high risk patients. The policy will clarify what it means to track tests. In addition, the policy and/or FAQ will set out what this means operationally for physicians.

[3] The full policy title is: Practice Management Considerations for Physicians Who Cease to Practise, Take an Extended Leave of Absence or Close Their Practice Due to Relocation

[4] This policy is currently under review. A separate briefing note in the February 2018 Council materials gives an overview of this review and seeks permission to consult externally on a retitled "Closing a Medical Practice" draft policy.

- The Working Group will also be expanding on the current tracking provisions. In order to address a gap in the current policy, the Working Group is developing language to set out what physicians must do with respect to tracking tests for patients who are not high risk. The wording will provide that physicians must use their clinical judgement to determine whether tests must be tracked for these patients and the policy will include factors for the physician to consider when making this determination.

- The Working Group will be clarifying that physicians must use their professional judgment to determine how best to communicate test results and the policy will set out factors for physicians to consider in making this determination. In addition, the Working Group is developing language to clarify that physicians may have others communicate test results to patients.

- Given the issues we heard during the consultation with respect to 'no news is good news strategies', the Working Group is developing revisions to the current policy. Expectations are being developed to delineate the factors which a physician must consider when determining whether such a strategy is appropriate. As well, an expectation will be added which provides that patients must be informed of such a strategy and must be given the option to contact the physician's office to get the result.

- With respect to concerns that the current policy is not clear enough regarding physicians responsibilities relating to receiving results in error, the Working Group is developing language to clarify this issue.

- Expectations with respect to patient engagement are being developed by the Working Group. The policy will provide guidance to physicians on how to involve their patients in their own care related to tests and test results management. Importantly, and this is something we heard about in the consultation feedback, is that the policy will ask physicians to encourage patients to make themselves available to receive and/or discuss test results.

Transitions in Care

- The purpose of this draft policy is to set out expectations of physicians when patient care or an element of patient care is transferred between physicians or between physicians and other health-care providers.

- The Working Group has focused on setting out expectations regarding improved communication and coordination during hand-offs, hospital discharges, and the consultation process, as well as better supporting patients by keeping them informed about who is involved in their care and their respective roles.

- Expectations are being developed to help ensure patients know who is responsible for their care within multi-physician facilities and to help patients understand the roles and responsibilities of referring and consulting physicians involved in their care.

- Recognizing that breakdowns in care may occur during patient handovers in multi-physician facilities, the Working Group is drafting advice regarding best practices. This includes, for example, best practices with respect to real-time information exchange and utilizing a standard or systematic approach.

- Given the potential for stress during a hospital discharge, the Working Group is drafting language to help ensure that family and/or caregivers are actively involved in the discharge process and that a patient's discharge is supported by written reference materials, recognizing that the nature of these materials will vary depending on a variety of factors.

- The Working Group is developing language to ensure that discharge summaries are distributed in a timely manner, with a recommendation that this be done within 48 hours of discharge. In addition to a patient's primary care provider, the Working Group is looking at including language that would see physicians taking reasonable steps to identify others who would benefit from knowledge of the admission and sharing the discharge summary with them as well.

- Regarding the referral and consultation process, a number of expectations are being developed to improve this process. For example, language is being contemplated that would require consulting physicians to respond to a referral in a timely manner, urgently if necessary, and no later than 30 days from receipt. Regarding coordinating with the patient, the Working Group feels there is value in having the referring physician communicate the appointment date to the patient, but that consulting physicians should be responsible for communicating any supplementary information (e.g., preparatory information, administrative policies, etc.).

- The Working Group is also developing language to ensure consultation reports are sent in a timely manner and urgently if necessary. Additionally, and as with discharge summaries, draft language would require consulting physicians to send consultation reports to the patient's primary care provider and/or referring physician and to take reasonable steps to identify other health-care providers who would benefit from knowledge of the consultation.

Walk-in Clinics

- The purpose of this draft policy is to set out expectations of physicians providing care within a walk-in clinic practice setting.

- One of the core purposes of this draft policy is to apply existing expectations and standards of practice to the walk-in clinic environment. The aim being, in part, to help address issues the College has become aware of through our regulatory activities.

    - For example, draft language is being developed that would clarify how expectations relating to test-results management and appropriate follow-up apply in the walk-in clinic setting. This includes addressing whether it is appropriate or not to rely on a patient's primary care provider to provide follow-up care.

    - Similarly, draft language is being developed to articulate how expectations regarding being available to patients and other health-care providers apply in the walk-in clinic environment.

- The Working Group also intends to set expectations to help improve communication and coordination between walk-in clinics and primary care. For example, language is being drafted that would require physicians practicing in a walk-in clinic to provide the patient's primary care provider with a record of the encounter.

- The Working Group is also assessing how to manage and support orphan patients who regularly seek care from walk-in clinics. Language is currently being drafted that would encourage physicians practicing in a walk-in clinic to offer comprehensive primary care to patients who are unable to get a primary care provider but visit the same walk-in clinic for all their health-care needs. The draft language also recognizes that this may require coordinating with other physicians within the walk-in clinic and recognizes that a physician's scope of practice may not permit them to make this offer.

NEXT STEPS:

- An accompanying presentation will be made to Council at the February 2018 meeting in order to give Council the opportunity to have a discussion and weigh in on this work as the Working Group continues to develop and hone draft content.

- Similar discussion sessions are also being planned with ICRC and the Quality Assurance Committee.

- It is anticipated that the Working Group will be ready to bring draft policies forward to Council in May 2018, where they will seek Council's permission to consult on the draft policies externally.

- The Working Group is also considering hosting a discussion session with key external stakeholders during the consultation process. The goals of this session are to facilitate increased and meaningful engagement in this project and to ensure that the College's work is informed by the expertise that exists among these stakeholders.

DISCUSSION FOR COUNCIL:

- Discussion questions will be provided as part of the accompanying presentation.

Contact: Dr. Brenda Copps
Craig Roxborough, Ext. 339
Lynn Kirshin, Ext. 243

Date: February 2, 2018

FOR DECISION

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

February 2018

TOPIC: Governance Committee Report

FOR INFORMATION:

1. **New Public Member of Council**
2. **Committee Appointments**
3. **Current Committee Vacancies**

FOR DISCUSSION:

4. **Non-LGIC Public Members on Committees: Premises Inspection Committee (PIC) (focus on criteria)**
5. **Governance Review**

FOR DECISION:

6. **2019-2021 District Election Dates**
7. ***Committee Appointments for New Council Members (Placeholder)***

FOR INFORMATION:

1. New Public Member of Council

- Paul Malette of Toronto, Ontario was appointed to the CPSO Council by the Lieutenant Governor of Ontario for a three-year term (see Appendix A) on January 8, 2018.
- We are hopeful that the government will soon appoint two other public members of Council to fill the vacant positions.
- Additional information about College activity to attain the full complement of 15 qualified public members of Council including recent correspondence to the Minister of Health and Long-Term Care is contained in the Government Relations Report.

2. Committee Appointments

- At the Executive Committee meeting held on January 19, 2018, Mr. Paul Malette was appointed to the Discipline Committee.

- At the Executive Committee meeting held on January 22, 2018, Dr. El-Tantawy Attia *(PhD)* and Mr. Ron Pratt were appointed as non-Council public members to the Premises Inspection Committee. Both have served previously on the College Council. The rationale and criteria developed to inform these appointments is discussed later in this briefing note.

3. Current Committee Vacancies

- There are some committee vacancies for non-council physician specialists.
- The Governance Committee is actively recruiting for the positions identified in the chart below.
- Some of the positions are proving to be somewhat challenging to fill.
- By way of background, recruitment practices include the following:
    - Identifying pre-screened qualified physicians from the membership who have done work for the CPSO over the last three years;
    - Targeted outreach to specialty groups;
    - Reaching out to members who have expressed their interest in doing committee work to Council /committee members and staff;
    - Screening incoming applications from the general membership to match qualifications and skillset/specialty to vacant positions.
- While we strive to continuously refine and enhance our recruitment processes, Council and committee members are encouraged to review the list contained below of current vacancies for required specialties. In particular, please encourage qualified colleagues to apply for the positions.
    - Information about the committees and the time commitment is available on the College's Website: Committees and Time Commitment
- As part of making an application to participate on a College committee, candidates are asked to provide:
    - An e-mail or cover letter identifying the committee that they wish to apply for together with relevant experience that would make them suitable for the committee position;
    - A resume or CV;
    - For those with hospital appointments, applicants may also be asked to provide a reference letter from a Chief of Staff.
- Committee applications should be directed to Debbie McLaren, Governance Coordinator at:

  dmclaren@cpso.on.ca Debbie can also be reached at 416-967-2600, ext. 371, toll free, 1-800-268-7096, ext. 371.

2018 CPSO NON-COUNCIL COMMITTEE VACANCIES

Quantity	CPSO Committee	Non-council Member Committee Vacancy
1	ICR Committee	Cardiologist
1	ICR Committee	Geriatrician
1	ICR Committee	Ophthalmologist
1	ICR Committee	Plastic Surgeon
1	Patient Relations Committee	Physician (experience and knowledge of sexual abuse and boundary issue)
1	Premises Inspection Committee	Reproductive Endocrinology and Infertility (REI) Specialists
1	Premises Inspection Committee	Plastic Surgeon
1	Quality Assurance Committee	Internal Medicine - *General*
	Discipline Committee	***Require physicians with French language skills***
	Inquiries, Complaints and Reports Committee	***Require physicians with French language skills***

FOR DISCUSSION:

4. Non-LGIC Public Members on Committees: Premises Inspection Committee (PIC)

ISSUE:

- The College's public Council member resources are stretched. Recruiting public members who are not members of the College Council to serve on designated College committees is something Council has determined should be part of the College's strategy to manage its workload.
- PIC has had to cancel some 2018 panels and was in the position of having to cancel more because of a lack of availability of public Council members. PIC is required to have a public member participate on each panel. PIC public members do not have to be a member of the College Council.
- As a result of the time-sensitive and urgent needs of PIC, the Executive Committee approved, on the advice and recommendation of the Governance Committee, the concept of appointing non-LGIC public members who are former public members of Council to PIC according to specified criteria set out below.
    - Proven record of achievement while serving as a member of the College Council (contribution, dependability, quality of work)

  - Commitment to the public interest
  - Availability – meets needs of committee
  - Integrity
  - Capacity (able to perform work, manage technology**,** possesses necessary skillset to review, reflect on inspection reports)
  - Served on Council for the "maximum" years of eligibility
- The Governance Committee recommended the appointment of two former public members of Council, Dr. El-Tantawy Attia *(PhD)* and Mr. Ron Pratt who met the established criteria for appointment to PIC.
- The Executive Committee appointed Dr. El-Tantawy Attia *(PhD)* and Mr. Ron Pratt to PIC to ensure the Committee can continue its work. Both public members met the criteria and have participated in an interview process with Chairs.
- Reimbursement is at the member rate, consistent with remuneration of non-Council public members on the Patient Relations Committee.
- Further work needs to be done to develop an approach to non-LGIC public member appointments in the future for PIC and other committees. Council will consider these issues further at a future meeting.

Additional Background Information:

- The development of a broader process to recruit and retain public members who are not on the College Council to help manage the College workload is on the Governance Committee's to do list this year. Council expressed support for this approach in December, 2017.
- Growing complaints and discipline case-loads mean that public Council members must devote more time to ICR and Discipline Committee work because of quorum requirements (2 public members on DC panels and 1 on ICR panels).
- The College's public Council member resources are stretched and the risk of public member burnout is a growing concern.
- Other committees that rely on public Council member participation in their work are also having difficulty because of the need for these same public Council members to focus time on Discipline and ICR.
- As part of the Governance Committee's December 2017 report to Council, the idea of recruiting additional public members who are not members of Council to serve in designated committee positions where there is no legislative requirement to have a public member of Council serve on these committees was put forward. Council expressed support for the concept and approach.
- A move in this direction is seen as positive for a number of reasons. It would expand public involvement in the work of the College. It would also help focus precious public Council member resources in those areas where we are constrained by quorum requirements.
- Under the RHPA and the College By-laws, certain College committees and committee panels are required to have a certain number of LGIC public members. However, the following committees are not required to have LGIC public members:
  - Premises Inspection Committee (PIC)
  - Education Committee
  - Finance Committee
  - Outreach Committee
  - Patient Relations Committee
  - Quality Assurance Committee

- The two public members on the Patient Relations Committee (the chair and one other member of the committee) are not members of the College Council.
- A number of strategies have been developed to support and help respond to issues with the College's growing caseloads and issues with the public appointments process.

QUESTION FOR CONSIDERATION:

1. Council is asked to consider the criteria which have been developed to inform the appointment of former Council members to the Premises Inspection Committee.

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5. Governance Review

ISSUE:

- At its January 19th meeting, the Governance Committee considered its priorities for the next year, with a focus on one of the elements of the Corporate Plan – Regulatory Governance: Modernization.
- This proposed corporate initiative relates to the ongoing discussions about possible proposals relating to the Council's governance structure including: size of Council, competency based appointments, 50/50 public/member composition and separation between council and statutory committees.
- While Council has discussed this issue on several occasions over the past few years, it was the view of the Governance and Executive Committees that a more focused review should begin, prior to any strategic planning process.
- The purpose of this review is to build on the governance work completed by the College in 2017. This includes building on Council support for greater independence of the Discipline Committee (no overlap in membership between Council and Discipline Committee) and, support of a process and timeline to facilitate the election of a public member of Council as President. It is proposed that initial activity include the collection of information about existing governance models, best practices and work being done by other organizations, including CNO and AGRE.
- The Executive Committee decided that a combined Governance Committee/Executive Committee working group is well suited to conduct this work and engage and report to Council.
- Concrete objectives and a work plan will be developed to support this work.

QUESTION FOR CONSIDERATION:

1. Does Council support this direction?

FOR DECISION:

6. 2019 – 2021 District Election Dates

ISSUE:

- District Council Election dates for 2019 – 2021 are set out in the table below.

BACKGROUND:

- The College's General By-law sets out the framework for setting dates for the District Council Elections and corresponding aspects of the process.
- Council is required (as per By-law 12 (2)) to set the date for each election of members to the Council.

ELECTION DATES:

Year	Districts	Notice of Election	Deadline for Receipt of Nomination Papers	Election Date	Deadline for Request for Recount
		60 Days Before Election	*49 Days Before Election*	***Final Election Day***	*14 Days After Election*
2019	1, 2, 3, 4	Aug 16	Aug 27	**Oct 15**	Oct 29
2020	5, 10	Aug 14	Aug 25	**Oct 13**	Oct 27
2021	6, 7, 8, 9	Aug 13	Aug 24	**Oct 12**	Oct 26

QUESTION FOR CONSIDERATION:

1. Does Council approve the election dates?

7. Committee Appointments for New Council Members (Placeholder)

- The College is hopeful that two new public members of Council will be appointed by Government prior to the February meeting of Council. If new public members are appointed, Council will be asked to appoint the new public members to either Discipline or ICR Committees.

Contact: David Rouselle, Chair, Governance Committee
Marcia Cooper, ext. 546
Debbie McLaren, ext. 371
Louise Verity, ext. 466

Date: February 6, 2018

Attachments:
Appendix A: Order in Council for Paul Malette

Ontario

Executive Council of Ontario
Order in Council

On the recommendation of the undersigned, the Lieutenant Governor of Ontario, by and with the advice and concurrence of the Executive Council of Ontario, orders that:

Conseil exécutif de l'Ontario
Décret

Sur la recommandation de la personne soussignée, la lieutenante-gouverneure de l'Ontario, sur l'avis et avec le consentement du Conseil exécutif de l'Ontario, décrète ce qui suit:

PURSUANT TO clause 6(1)(b) of the *Medicine Act, 1991*,

Joseph Paul Malette of Toronto

be appointed as a part-time member of the Council of the College of Physicians and Surgeons of Ontario for a period of three years, effective January 5, 2018 or the date this Order in Council is made, whichever is later.

EN VERTU DE l'alinéa 6 (1) *b*) de la *Loi de1991 sur les médecins*,

Joseph Paul Malette de Toronto

O.C./Décret: 33/2018

est nommé au poste de membre à temps partiel du conseil de l'Ordre des médecins et chirurgiens de l'Ontario pour une durée de trois ans, à compter du 5 janvier 2018 ou de la date de la prise du présent décret, si elle est postérieure.

Recommended: Minister of Health and Long-Term Care
Recommandé par: le ministre de la Santé et des Soins de longue durée

Deb Matthews

Concurred: Chair of Cabinet
Appuyé par: Le président/la présidente du Conseil des ministres,

Approved and Ordered: JAN 0 8 2018
Approuvé et décrété le:

Lieutenant Governor
La lieutenante-gouverneure

Council Briefing Note - Supplementary

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

February 2018

TOPIC: Governance Committee Report – [Supplementary]

FOR DECISION:

7. Committee Appointments for new Council members

- **Mr. Mehdi Kanji**
- **Ms. Catherine Kerr**

FOR DECISION:

7. Committee Appointments for new Council members

- Two new public members, Ms. Catherine Kerr, Stevensville, Ontario and Mr. Mehdi Kanji, Richmond Hill, were appointed to Council on February 8, 2018 for a three-year term.
- Public members of Council are appointed to either the Discipline Committee or to the Inquiries, Complaints and Reports Committee.
- Council is asked to make the following the following committee appointments:
  - **Mr. Mehdi Kanji – Discipline Committee**
  - **Ms. Catherine Kerr – Inquiries, Complaints and Reports Committee**

DECISIONS FOR COUNCIL:

1. Appoint Mr. Mehdi Kanji to the Discipline Committee.
2. Appoint Ms. Catherine Kerr to the Inquiries, Complaints and Reports Committee.

Contact: David Rouselle, Chair, Governance Committee
Debbie McLaren, ext. 371
Louise Verity, ext. 466

Date: February 14, 2018

Attachments: **Appendix A:** Order in Council for Mr. Mehdi Kanji
Order in Council for Ms. Catherine Kerr

Appendix A

Ontario

Executive Council of Ontario
Order in Council

On the recommendation of the undersigned, the Lieutenant Governor of Ontario, by and with the advice and concurrence of the Executive Council of Ontario, orders that:

Conseil exécutif de l'Ontario
Décret

Sur la recommandation de la personne soussignée, la lieutenante-gouverneure de l'Ontario, sur l'avis et avec le consentement du Conseil exécutif de l'Ontario, décrète ce qui suit:

PURSUANT TO clause 6(1)(b) of the *Medicine Act, 1991*,

Mehdi Kanji of Richmond Hill

be appointed as a part-time member of the Council of the College of Physicians and Surgeons of Ontario for a period of three years, effective the date this Order in Council is made.

EN VERTU DE l'alinéa 6 (1) *b*) de la *Loi de1991 sur les médecins*,

Mehdi Kanji de Richmond Hill

O.C./Décret: 165/2018

est nommé au poste de membre à temps partiel du conseil de l'Ordre des médecins et chirurgiens de l'Ontario pour une durée fixe de trois ans à compter du jour de la prise du présent décret.

Recommended: Minister of Health and Long-Term Care
Recommandé par: le ministre de la Santé et des Soins de longue durée

Concurred: Chair of Cabinet
Appuyé par: Le président/la présidente du Conseil des ministres,

Approved and Ordered: FEB 08 2018
Approuvé et décrété le:

Administrator of the Government
L'administratrice du gouvernement

Ontario

Executive Council of Ontario
Order in Council

On the recommendation of the undersigned, the Lieutenant Governor of Ontario, by and with the advice and concurrence of the Executive Council of Ontario, orders that:

Conseil exécutif de l'Ontario
Décret

Sur la recommandation de la personne soussignée, la lieutenante-gouverneure de l'Ontario, sur l'avis et avec le consentement du Conseil exécutif de l'Ontario, décrète ce qui suit:

PURSUANT TO clause 6(1)(b) of the *Medicine Act, 1991*,

Catherine Kerr of Stevensville

be appointed as a part-time member of the Council of the College of Physicians and Surgeons of Ontario for a period of three years, effective the date this Order in Council is made.

EN VERTU DE l'alinéa 6 (1) b) de la *Loi de 1991 sur les médecins*,

Catherine Kerr de Stevensville

O.C./Décret: 166/2018

est nommée au poste de membre à temps partiel du Conseil de l'Ordre des médecins et chirurgiens de l'Ontario pour une durée fixe de trois ans à compter du jour de la prise du présent décret.

Recommended: Minister of Health and Long-Term Care
Recommandé par: le ministre de la Santé et des Soins de longue durée

Concurred: Chair of Cabinet
Appuyé par: Le président/la présidente du Conseil des ministres,

Approved and Ordered: FEB 08 2018
Approuvé et décrété le:

Administrator of the Government
L'administratrice du gouvernement

MEMBER TOPICS

No Meeting Materials

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Briefing Note

TOPIC: **Corporate Report and Dashboard – 2017 Final**

DATE: **February 2018 - For Information**

ISSUE:

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 focused on this framework targeted toward 4 high level priorities:

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

The CPSO is nearing the end of its current strategic plan, which extends until 2018. 2017 and 2018 will be interim reporting years as the organization transitions to new leadership and begins preparations for a new strategic plan.

The 2017 Corporate Plan guides the College's strategic and operational activities. Progress towards the goals set out in both the Strategic and Corporate Plans is reflected in the attached Corporate Report and Dashboard for 2017, attached at Appendix B.

The 2018 Corporate Plan, which will provide a foundation for strategic discussions in 2018, will be presented as part of the Registrar's Report. The Plan is designed to be an internal document that will support annual performance objectives for the Registrar and to enable monitoring of significant initiatives across all levels of the College. The 2018 plan has been improved to provide more specificity to the objectives/deliverables, and identify emerging/potential risks (that may require CPSO focus in future).

The plan aligns initiatives in four categories: Strategic (projects from Council's strategic priorities), Regulatory, Operations, and Risk. All of the initiatives represent a significant investment of staff time and dollars, and some will require commitment from staff and committees across the College (eg. Community health facilities). The 2018 Corporate Plan is an important document as the Council navigates several transitions at the Registrar/CEO level (current Registrar, Interim Registrar, new Registrar).

DECISION FOR COUNCIL: For information only

Contact: Rocco Gerace
Maureen Boon, ext 276

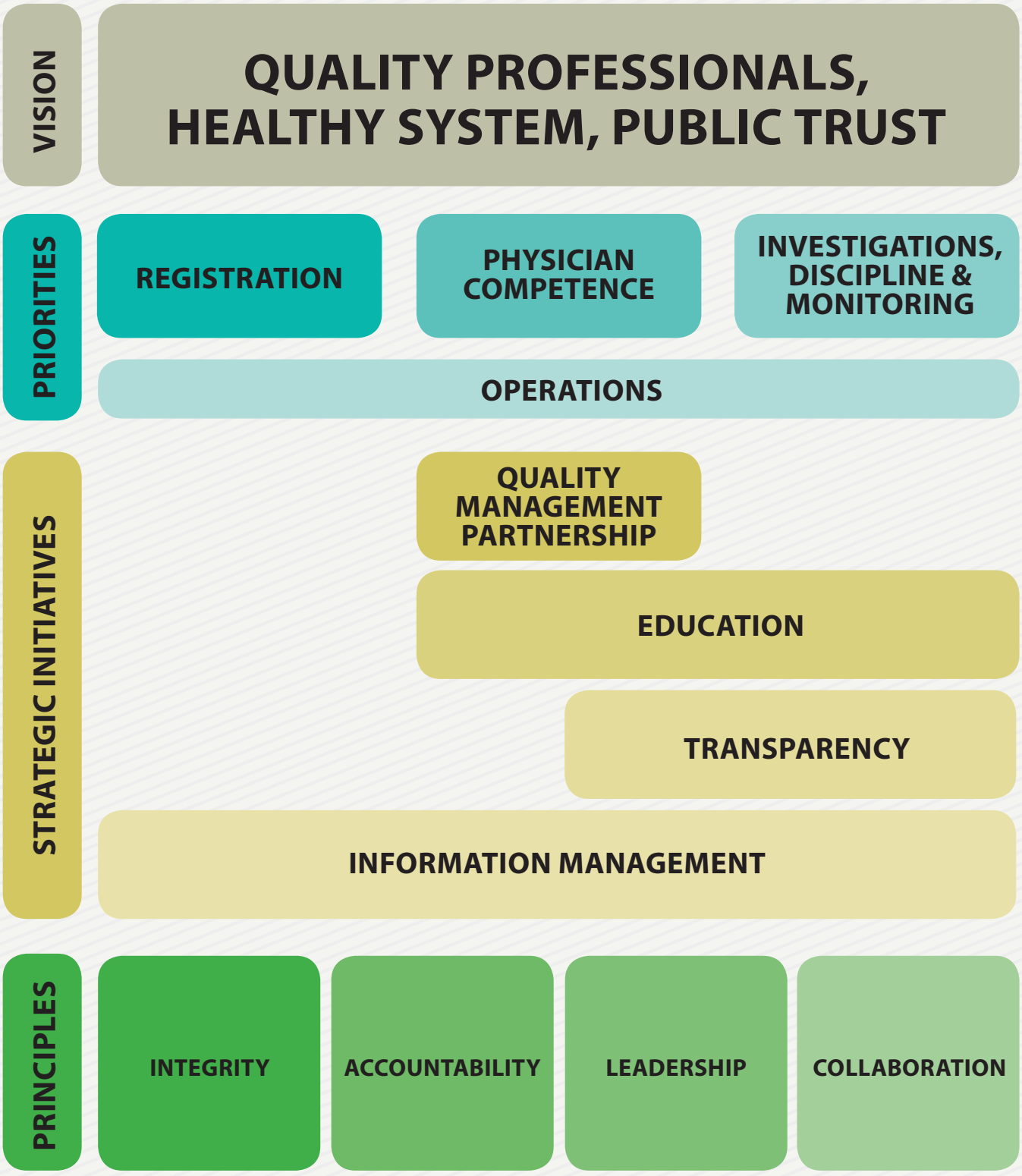
Date: February 8, 2018

Appendices:

A: Strategic Framework
B: Corporate Report and Dashboard – Final 2017
C: 2018 Corporate Plan

CPSO Strategic Framework 2015-2018

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO



Corporate Report – 2017 – Final

Strategic Initiatives	Objective(s)	Status
Quality Management Partnership	Consistent high quality in mammography, colonoscopy and pathology across the province Integrated performance standards at the provider, facility and system levels	Harmonization of QMP &CPSO processes underway Provider level reporting began fall 2017 Once complete, QMP will transition from a strategic initiative to a CPSO program
Education	Ensuring medical education related to the CPSO's regulatory activities is targeted, evidence-informed, and evaluated so that physicians are engaged in life-long learning and CPD	Education Strategy Drafted New member orientation initiative under development
Transparency	Improving transparency of process, outcome and member information Website improvements to FindaDoc and Premises Register	Evaluation report to be completed in 2018 Website improvements completed fall 2017 Transparency requirements incorporated into Protecting Patients Act
Data & Analytics	To develop quality data for analytics to support evidence-based decisions, College initiatives and operations and business	Data & Analytic strategic framework complete; implementation underway

Regulatory Initiatives	Objective(s)	Status
Facilities/Premises	Improved facilities oversight	The *Oversight of Health Facilities and Devices Act, 2017 (OHFDA)* passed in December 2017. When proclaimed, it will establish a single legislative framework for community health facilities. A transition team has been created to handle the issues that are expected to arise as a result of our new authority as an inspection body.
Investigations/Hearings/Monitoring	Process improvements Monitoring of Goudge recommendations & SATF response	Process improvements underway Protecting Patients Act (Bill 87) implementation underway
Registration	Modernization of registration regulation, including integration of pathways	Work on hold due to competing priorities.
Assessments	Every doctor assessed every 10 years (EDEX) Peer assessment redesign implementation	Initial assessments underway in some scopes for peer assessment redesign implementation. Linked to physician factors work.
RHPA Review (Protecting Patients Act)	To work with government to achieve best possible legislation relating to sexual abuse, transparency and committee structure	Protecting Patients Act (Bill 87) passed May 30, 2017. Implementation underway for sections currently in force. Regulations in development.

Risk Initiatives	Objective(s)	Status
Infection Control	Ensure risk level monitoring and processes in place to manage/minimize risk	Processes in place
Opioids	Improved ability to identify and respond to unsafe opioid prescribing Improved opioid prescribing	Most investigations concluded Opioids strategy framework implementation ongoing
Physician Factors	Understand the demographic, practice & environmental physician factors to inform effective programs & enhance quality practice	Pathways evaluation outcomes presented to Council in December 2017.
Regulatory Modernization (Governance)	Provide regulatory expertise to government to shape regulatory structure in 2017 and beyond.	Collaboration with AGRE on governance issues. See Governance Committee Report.

Dashboard – 2017 – Final

Strategic Priority	Objective	Measure/Target	Q1	Q2	Q3	Q4	Comments
Optimize Registration	Meets processing time for Registration Applicants	90% of applicants meet processing time of a) 3 wks b) 4 wks					Credentials Applications 4,233 of 4,234 applications is 99% Registration Committee Applications 1110 of 1143 applications is 97%
Assure/Enhance Physician Competence	Every physician assessed every 10 years (EDEX)	2600 assessments/year **NOTE**: this target has been adjusted to 2475 to redirect resources to peer redesign.					2,081 completed - 84% of adjusted target of 2,475
	Quality Management Partnership implementation: physicians receive information about quality	% of physicians in each program receiving quality reports 1 colonoscopy 2 mammography 3 pathology	No data available				2017/18 physician level colonoscopy quality management reports sent to 900 Endoscopists Nov 30, 2017
	Increase input in policy	130 responses/policy					Five policy consultations were undertaken in the final quarter of 2017: Medical Records (56 responses), Maintaining Appropriate Boundaries and Preventing Sexual Abuse (40 responses), Physician Services During Health Emergencies and Disasters (36 responses), Ensuring Competence (40 responses), Prescribing Drugs (10 responses received in 2017; consultation open until Feb 2 2018). The

Strategic Priority	Objective	Measure/Target	Q1	Q2	Q3	Q4	Comments
							average number of responses is 36. Total responses received in 2017: 593. Average number of responses/consultation in 2017: 66
	Existing policies[1] current/relevant	80% of policies have been reviewed within 5 years					80% of are either current (have been reviewed in the last 5 years) or under review.[2] Some policy reviews have been deferred to enable the Policy Department to respond to urgent or competing priorities of the College.
Optimize Investigations, Discipline and Monitoring	Reduce time for completion of high risk investigations	90% of high risk investigations completed in 243 days.					Jan 1 – Dec 31, 2017: 90% of high risk investigations were completed in an average of 231 days, (279 investigations involving 164 unique physicians).
	Schedule discipline hearings more quickly	Time from referral to hearing date is 1 year					Jan 1 – Dec 31, 2017: 90% of hearings (43) began on average, 366.1 days (12 months) from the NOH date.
	Reduce decision release time	Time from hearing date to decision release date 2 months for uncontested (UC)					Jan 1 – Dec 31, 2017: 90% of uncontested decisions (25) were released 38.8 days (1.3 months) from the last hearing date.

[1] Does not include registration policies
[2] Excludes registration policies

Strategic Priority	Objective	Measure/Target	Q1	Q2	Q3	Q4	Comments
		6 months for contested (C)					January 1 – December 31st, 2017: 90% of contested decisions (24) were released, 128.9 days (4.2 months) from the last hearing date.
Operational Excellence	Improve service level targets	85% live answer (PPAS, A&C)					A&C 27,428 of 33,293 = 82% live answer 46,575 of 52,937 = 88% live answer Combined **85%** = live answer
	Improve service level targets	10% call abandonment					A&C 1,505 calls abandoned = 5% PPAS 4,088 calls abandoned = 8% Combined calls abandoned = **7%**
	Media coverage	80-100% positive or neutral					In the 4th Quarter, the dashboard results for our media monitoring initiative are as follows for 285 stories measured: Positive: 59 (21%) Neutral: 159 (56%) Negative: 67 (23%)

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 **NOTE**: target has been adjusted to 2475 for Q3 and Q4.	Tracking to >= 2475	Tracking to 2300-2474	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 <=***243d*.**	90% High Risk investigations done ***244-256 d***.	90% High Risk investigations done in ***257d+***.
	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%

[R]Items include a specific identified risk.

Strategic

Initiative	Objectives	Deliverables – 2018[1]
1. Education	To support the CPSO's regulatory priorities so that Ontario physicians are engaged in life-long learning and continuing professional development.	1. Education Strategy Complete and Communicated 2. Begin implementation of Education Strategy a) Education data mapping complete by Q3 2018 b) New member orientation product development c) Remediation framework for opioid cases
2. Data & Analytics	To implement Data and Analytics Strategy to support evidence-based decisions, College initiatives, operations and business.	1. Create requirements and a framework document for a data and analytic repository; extract and clean routinely collected data for analytics 2. Provide a report to each department regarding its data assets and make suggestions to eliminate redundancies and streamline data collection & integration 3. Develop a data governance framework 4. Complete a project to routinely estimate the number and demographic composition of physician members over time
3. Transparency	1. Improving transparency of process, outcome and member information. 2. Website improvements to FindaDoc and Premises Register	1. Development of reports on effectiveness/outcomes as part of annual reporting for each regulatory process 2. Complete accessibility audit (AODA), and follow-up public site usability review 3. Implementation of improved public reporting relating to Facilities/Bill 160 and completion of outstanding transparency

[1] Unless specified, all deliverables will be completed by the end of 2018.

Initiative	Objectives	Deliverables – 2018[1]
		work.

Regulatory

Initiative	Objectives	Deliverables – 2018
1. **Facilities**	Implementation of oversight of community health facilities (CHF)	1. Work with MOH on regulations required to enact our role in CHF legislation (Bill 160), as well as governance and implementation. 2. Align program and processes with new CHF legislative requirements. **NOTE: This area has an additional identified risk relating to the size/scope of the implementation.**

Initiative	Objectives	Deliverables – 2018
2. Facilities - Quality Management Partnership	1. Increase the consistency in the quality of care provided across facilities. 2. Fulfill CPSO mandate to act in the public interest and to developing and maintaining professional competencies 3. Identification and provision of resources, tools and opportunities to support quality improvement for the Partnership's clinical stakeholders.	1. Harmonization of QMP & CPSO operational processes a) Complete 2018 funding agreement 2. Develop a plan to monitor pathology standards 3. Continue work on system consistency a) Revise, consult and implement standards identified by expert advisory panels. b) Work with Practice Assessment & Enhancement (PA&E) on any changes required based on CHF legislation regulations 4. Define public reporting and the roles of HQO, CPSO and CCO 5. Design and implement a strategy to facilitate engagement and promote QI skills and knowledge. 6. Develop an evaluation plan for Partnership operational improvements 7. Evaluate annual facility, regional and provincial reports (and physician reports in colonoscopy)

Initiative	Objectives	Deliverables – 2018
3. Investigations, Hearings and Monitoring	Improve investigative, monitoring and discipline processes	1) Process and Timeline Improvement: a. Regression analysis to assess changes in timelines related to individual investigative actions and overall time of investigation process resulting from changes in technology and staffing b. Modernize and enhance the hearings process (ie. possible use of digital audio recording (DAR). c. Complete analysis of Compliance Monitoring workload sustainability (Note: this relates to Workforce Planning). 2) Risk-based streaming of Investigations: a. Determine ability to identify level of concern and required attention of a new matter based on risk screen tool. b. Decide whether Physician & Public Advisory (PPAS) can take on specific low-risk complaints. If yes, develop plan and implement. 3) Committee resourcing: track availability of panel members/public members and impact on scheduling of Investigations, Complaints and Reports Committee (ICRC) and Discipline panels.

Initiative	Objectives	Deliverables – 2018
4. Bill 87 – Protecting Patients Act	1. Implementation 2. Improve regulatory processes. Leadership at Federation of Health Regulatory Colleges of Ontario (FHRCO) to ensure success.	1. Influence regulation development (i.e. sexual abuse related regulations, statutory committee related regulations), consistent with Bill 87 submissions. **2.** Secure FHRCO support for CPSO response to regulations **NOTE: This area has an additional identified financial risk relating to increased PRC funding.**
5. Registration	1. Modernization of Registration Regulation 2. Improve Registration Process	1. Complete an overview analysis of the current state of the registration regulation and risk to College of status quo. A recommendation to be made by June 2018 re whether to do further work and nature of work to be done. 2. Development of future process vision (e.g. moving away from a paper based registration system)
6. Assessments (Physician Factors)	To develop evidence-based assessment programs and to develop a broader model for physician assessment, based on risk and support factors	1. Create an overarching model for using data and evidence to support effective assessment programming 2. Phase in use of CPSO full member data to identify risks, based on factors analyses for priority cohorts (Factors) 3. Develop a new assessment for low risk matters based on evidence and create a plan to test its effectiveness 4. Continued roll out of peer re design assessments; evaluation complete and implementation of refinement based on evaluation 5. Use complaints recidivism study results to: a)better understand physicians with 7 or more complaints,

Initiative	Objectives	Deliverables – 2018
		b) develop a 'score' (risk profile) that identifies physicians at higher risk of recurrent complaints

Operations

Area	Objective	Deliverables - 2018
1. Corporate Planning	To develop an effective, transparent and sustainable internal planning process and annual Corporate Plans.	1. Establish a Corporate Planning Development Group to support all of the development and implementation work in 2018 *Group established by December 22, 2017* 2. Complete all deliverables in the terms of reference by December 31, 2018
2. Financial Integrity	1. Responsible management of financial resources in the short and long term 2. Identification of cost savings, efficiencies and potential revenue generating initiatives.	1. Develop the 2019 base budget – before new requests – that is 2% less than the 2018 base budget 2. Implement Council-approved recommendations from the Finance Committee, to modernize the physician compensation model for Council and Committee participation 3. Engage staff in the identification of cost savings and efficiency ideas, and use the Administrative & Purchasing Practice Review Working Group to prioritize ideas, effectively implement, and measure specific cost impact.

Area	Objective	Deliverables - 2018
3. Workplace Planning	Ensure we have sufficient and appropriate space for CPSO staff	Receive final workplace strategy report from Deloitte and develop implementation plan, that addresses short, medium and long term needs
4. Workforce Planning	Ensure human resource sustainability so that key regulatory functions are supported	Development of a workforce management plan to align resources to key regulatory processes a. Develop cross training, job shadowing and pooling programs to improve capacity across departments/divisions b. Review use of temporary replacement workers c. Develop and provide reports to help managers better understand their short and long term departmental staffing needs. **NOTE: This area has been identified as an additional risk given workload.**
5. Modernized Business Practices	Develop and implement a sustainable approach to continuously improve the efficiency and timeliness of regulatory processes	1. Development of Key Performance Indicators (KPIs) for each regulatory process 2. Develop a systematic, transparent approach to review and improvement of key regulatory processes. Work in 2018 will focus on investigations and legal. a) Improve management of investigation and compliance files in an electronic environment and facilitate the disclosure process. b) LEAN Legal review. 3. The 2019 budget will include additional analysis connecting financial reporting and budget requests to quantitative measures of volume and complexity in member-specific committees. 4. Member-specific committee annual reports will include

Area	Objective	Deliverables - 2018
		commentary on financial reporting and budget forecasts with respect to Committee activities. 5. Recommend a process for evaluation of the impact of committee decision-making on operations.

Risk

Initiative	Objectives	Deliverables – 2018
1. Opioids	1. Improve ability to identify and respond to inappropriate opioid prescribing 2. Facilitate safe/appropriate opioid prescribing 3. Protect patient access to care 4. Reduce risk to patients and the public.	1. Prescribing Drugs policy – full review 2. Complete an overarching model for using data and evidence to support effective opioid assessment programming using external and internal data inputs 3. Modify existing assessment process to identify/address prescribing issues 4. Communicate approach, regulatory results and best practices - Includes collaboration on delivery of educational opioid sessions for profession 5. Complete OneID integration to facilitate access to prescribing reports – Q2 2018 6. Narcotics Monitoring System (NMS) evaluation – results and recommendations for application to investigation work and future College programming

Initiative	Objectives	Deliverables – 2018
2. Regulatory Modernization: Governance	1. Governance proposals to ensure key regulatory functions are supported: a) Separate DC and Council b) Quorum Changes 2. Position CPSO for future by proposing a streamlined and purpose-driven governance structure.	1. Develop, advocate for and implement strategies to ensure regulatory work supported. For example: a) Appointment of a full complement of qualified public members b) Appoint new pool of public members to defined statutory committees c) New regulations/statutory change 2. With Council direction, develop good governance proposals for the future, potentially including the following: a) Reduction in size of council b) Competency based appointments (possible elimination of elections) c) 50/50 public/member committees d) Separation between council and statutory committees **NOTE: This area has an additional identified financial risk relating to Public Member Payment.**
3. Regulatory Modernization: Oversight/ Accountability	Develop strategy to anticipate and respond to proposals relating to oversight body and other oversight mechanisms	Discussion paper/analysis to incorporate key regulatory research/development and support strategic planning process

Emerging/Potential Risks

Staff leads will be responsible for monitoring these risks, reporting and making recommendations as necessary. All staff is responsible for identifying additional risks. List to be updated quarterly.

Risk	Type/Description	Potential Impact	Status
1. Physician Assistants	Organizational/Financial Risk Minister interested in regulatory model for PAs. Details not clear.	If MOH wants full regulation, significant operational, governance and program impact. If MOH content with enhancements to current model, impact is decreased.	Response to MOH by end of 2017; Q1 & Q2 of 2018 will determine next steps; influenced by election in June 2018
2. Physician Incorporation	Financial Risk Potential for federal government to dramatically alter the tax benefits of small business incorporations (including physician incorporation as part of planned income tax changes.	If physicians choose in large numbers not to incorporate, the CPSO loses a significant revenue stream.	Unclear Decision expected in 2018
3. Sexual Abuse	Public/ Organizational Risk Focus on DC cases relating to SA will continue. Risk is compounded by existing governance issues that may result in cancellation of high profile hearings.	A difficult DC decision, media coverage relating to SA stats, and/or the MOH consultant recommendations could result in direction to separate DC from the CPSO, which would be a significant undertaking.	MOH consultant recommendations on SA outstanding.

Risk	Type/Description	Potential Impact	Status
4. Digital Health	Organizational Risk Digital Health projects enabling physicians to connect to the EHR and access data about their own performance are starting to come to fruition.	As Digital Health becomes the norm, the CPSO may be required to make significant policy and program changes to reflect a new way of practicing. CPSO is also becoming involved in facilitating access to provincial assets in a number of ways.	Provincial projects at various stages of completion. Tipping point not yet clear.
5. Wettlaufer Inquiry	Organizational Risk Ministry inquiry into nurse murders at LTC homes could raise fundamental issues re regulatory oversight. This connects with the Regulatory Modernization (Oversight and Accountability) item above.	Recommendations could include enhanced oversight or other changes. If accepted by government, could be embedded into legislation.	Inquiry at beginning stages
6. Public Member Payment	Success in getting non-council public members on committees will have financial implications in terms of significant increased payments to public members.	Costs could be significant.	Unclear

INFORMATION ITEMS

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

February 2018

TOPIC: GOVERNMENT RELATIONS REPORT

FOR INFORMATION

Items:

1. Ontario's Political Environment
2. Issues of Interest
3. Interactions with Government

ONTARIO'S POLITICAL ENVIRONMENT:

Ontario PC Party

- The last number of weeks have been unprecedented in Ontario politics.
- Over the course of hours, allegations of sexual misconduct against PC leader Patrick Brown surfaced and these swiftly led to his resignation.
- On January 24th, CTV News was scheduled to air a report detailing allegations of sexual misconduct by two women from when Brown was a federal MP. In advance, Brown held a news conference calling the allegations "categorically untrue". Directly following the news conference, several senior PC staffers resigned and called for Brown to step down. Within hours, the PC Caucus echoed the staffers call for Brown to resign and by 1:30 a.m., Brown announced his resignation.
- Two days later, Vic Fedeli, PC Finance Critic and MPP for Nipissing, was elected Interim Leader of the PCs. Fedeli was mayor of North Bay from 2003 to 2010 and has been at Queen's Park since 2011.
- The PC Party Executive made a decision to hold a leadership race prior to the election. The date of the vote is scheduled for March 10.
- At the time this note was finalized on February 2nd, only three candidates had announced their intention to run: Doug Ford, Christine Elliott, and Caroline Mulroney. It is expected

that former public member of Council and former Postmedia chairman, Rod Phillips will also announce his intention to run for the leader's job.

- In the coming days we anticipate other candidates for leader will come forward.
- The deadline for filing nomination papers is February 16th. There is a registration fee of $75,000, a refundable $25,000 "compliance fee" to make sure candidates adhere to the rules and $25,000 fee for access to the party membership list. All candidates will have their backgrounds vetted by party officials.
- Although Fedeli is permitted to run, he announced that he would not and instead dedicate his time as interim leader to focus on addressing serious issues within the party in advance of the June election.
- Since Brown's resignation, the upheaval has continued. PC party president, Rick Dykstra stepped down from his role in the days following Brown's resignation. This occurred just hours before Maclean's magazine published a story alleging he had sexually assaulted a parliamentary staffer in Ottawa when he was an MP in 2014. Conservative leader Andrew Scheer has launched an independent investigation into Dykstra's federal campaign in 2015, following claims that party officials allowed Dykstra to stand as a candidate despite having known of this allegation.

Recent happenings for the Liberals

- The verdict in the trial of two of former premier Dalton McGuinty's two top aides – David Livingston and Laura Miller – was delivered on January 19th. Mr. Livingston was found guilty of illegally destroying documents related to the controversial government decision to cancel two gas plants before the 2011 election. Ms. Miller was found not guilty.
- The judge stated that Livingston was a sophisticated individual who knew exactly what he was doing when 20 hard drives were wiped in the Premier's office. A sentencing hearing is scheduled for February 26th.

The Ontario Legislature and the June Election

- The Legislature is scheduled to resume after a two month break on February 20, 2018. At most, the session will last ten weeks.
- The next provincial election is scheduled for June 7th and the last possible day for the election to be called is May 9th – less than a hundred days away.
- A number of prominent MPPs have also announced that they will not seek re-election in 2018. This includes Liberals Deb Matthews, Liz Sandals, Dave Levac, Glen Murray, and Brad Duguid and the longest serving female MPP in Ontario's history, PC Julia Munro, has also announced that she will retire from politics in 2018. NDP MPP Cheri DiNovo retired from politics at the beginning of January 2018.
- Following the planned departure of three veteran cabinet ministers, the Premier shuffled her cabinet on January 17th, advancing three backbenchers to Cabinet and giving five current ministers new roles.
- Notably, Advanced Education Minister Deb Matthews was replaced by Mitzie Hunter, Indira Naidoo-Harris takes over as Education Minister, Eleanor McMahon replaces Liz Sandals as Treasury Board President, and Steven Del Luca is replacing Brad Duguid as Economic

Development Minister. Brampton-Springdale MPP Harinder Malhi becomes the new Minister Responsible for the Status of Women.

- On February 1st, the Premier announced the appointment of the former Ministers noted above – Duguid, Matthews, and Sandals – to new Parliamentary Assistant (PA) roles. Duguid is now PA to the Minister of Intergovernmental Affairs (U.S. State Engagement), Matthews is the PA to the Premier, and Sandals is the PA to the Minister of Infrastructure. These appointments will ensure that the considerable expertise of these veteran MPPs is utilized in the lead up to the campaign.
- At this point, none of the political parties have nominated all of their 124 candidates for the 2018 election. The PCs are, however, the furthest ahead with approximately 100 candidates nominated, as of February 2nd. The Liberals have nominated about 70 candidates and the NDP 45.
- Given the events of the recent weeks, it is clear that the outcome in June's election is far from certain. It is conceivable that any one of the three parties might form the next Ontario government.

ISSUES OF INTEREST:

Bill 160, Strengthening Quality and Accountability for Patients Act, 2017

- The previous legislative session was active for the College due to the introduction and passage of *Bill 160, Strengthening Quality and Accountability for Patients Act, 2017*.
- *Bill 160, Strengthening Quality and Accountability for Patients Act, 2017* passed third reading and received Royal Assent on December 12, 2017, however it will not come into force until a day named by proclamation of the Lieutenant Governor. The latest information available suggests that proclamation will likely not occur until fall 2018 or winter 2019.
- As Council will recall, Bill 160 is a large omnibus health bill containing ten schedules.
- *Schedule 9 Oversight of Health Facilities and Devices Act, 2017* contains the government's plan for a single legislative framework for the Independent Health Facilities Program (IHFP), the Out-of-Hospital Premises Inspection Program (OHPIP) and energy applying and detecting medical devices (EADMDs). It is this schedule of the Bill that has been of particular interest to the College and was the focus of our submission to government.
- The College was generally very supportive of Schedule 9 of Bill 160 as it was largely consistent with our recommendations for a consolidated inspection regime and took steps to increase patient safety, transparency, and public reporting.
- However, the College's submission to government contained a number of amendments to ensure that the Bill met its objectives and that the proposed system was well-designed. The College actively participated in the legislative process and the majority of our amendments were accepted.
- College amendment recommendations that were adopted include the following:
    - Making the payment of the Inspecting Body fees a **condition** of issuance, transfer or renewal of a Community Health Facility license;

  - Allowing the Inspecting Body to establish and collect fees associated with administrative and overhead costs;
  - Allowing the Inspecting Body to post compliance and cessation orders;
  - Ensuring that the Inspecting Body can effectively serve notice on a licensee;
  - Clarifying the reporting structure and accountability between the Quality Advisor, the Inspecting Body and the licensee;
  - Ensuring that the "board of directors" or a committee of an Inspecting Body is protected from liability; and
  - Allow the posting of "personally identifiable information" and clarifying that it is personal health information that cannot be posted.
- In order for Schedule 9 to be proclaimed, dozens of regulations are required. The College is now actively engaged in a significant project with the Ministry to help facilitate program readiness as well as support the development of the regulations.

Physician Assistants

- At the December meeting of Council, information was provided about Minister Hoskins' request to the College to develop an approach to provide appropriate regulatory oversight for Physician Assistants.
- The Executive Committee approved a letter in December and this letter was sent the Minister of Health on December 22nd. The final letter is attached as **Appendix A**.
- Council will be kept apprised of further developments on this file.

Public Member Appointments

- Issues with the public appointments process and system and dated quorum requirements have been a long-standing problem for the College.
- Over the years, several solutions have been proposed to the government to alleviate or eliminate some of these problems.
- In December, the College was extremely concerned that we would have to postpone several discipline hearings in January because we would not be able to meet quorum requirements for public members.
- The possibility of postponing disciple panels poses a significant problem and a significant regulatory risk. Additionally, the College was aware that by the beginning of January 2018, three vacancies of public members were anticipated.
- There has been considerable conversation with government about public appointment issues and the need to ensure both a short and medium term solutions to the issues.
- The College's concerns are outlined in December 15, 2017 correspondence to the Minister of Health and Long-Term Care. That letter is attached as **Appendix B**.
- One public member was appointed in early January and two others are anticipated prior to the February meeting of Council.

INTERACTIONS WITH GOVERNMENT:

- The College is in contact with a variety of government decision-makers to ensure that they have accurate and up-to-date information about the College, our activities, and our role in protecting the public interest. We have regular interaction with the senior decision-makers and all political parties at Queen's Park.
- The College continues to work particularly closely with government decision-makers on a number of other areas of shared focus including medical assistance in dying, compensation of public members of council, the ongoing work to increase College transparency, and issues surrounding opioid and medication management.

Contact: Louise Verity, Ext. 466
Miriam Barna, Ext. 557

Date: February 2, 2018

Attachments:

Appendix A: December 22nd letter to Minister Hoskins re: Physicians Assistants

Appendix B: December 15th letter from Minister Hoskins re: Public Members of Council

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 22, 2017

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 in response to your request that the College work with the Ministry to identify a regulatory approach for physician assistants (PAs) and that we report back to you by the end of 2017.

This correspondence summarizes the action that we have taken to inform this response. It also identifies some proposed next steps.

The College and Ministry have met twice this fall to consider the request. Several resource documents were provided and reviewed to help inform our response. They consist of the following;

- Physician Assistants: A Jurisdictional Review from the Health Professions Regulatory Advisory Council, Health Professions Advisory Council, September, 2011.
- August 2012 Reports from the Health Professions Regulatory Council regarding regulation of Physician Assistants: Volume 1, The Health Profession Assistant: Consideration of the Physician Assistant Application for Regulation; Volume 2, The Health Profession Assistant: Consideration of the Physician Assistant Application for Regulation.
- Economic Analysis of Physician Assistants in Ontario: Literature Review and Feasibility Study from the Centre for Health Economics and Policy Analysis, McMaster, December, 2011.
- Conference Board of Canada Reports: Value of Physician Assistants, Understanding the Role of Physician Assistants Within Health Systems, June 2016; Gaining Efficiency, Increasing the Use of Physician Assistants in Canada, October 2016; Funding Models for Physician Assistants, Canadian and International Experiences, September 2017.
- The Physician Assistant Annual Narrative Report from the HealthForceOntario Marketing and Recruitment Agency, (April 1, 2016 to March 31, 2017).
- Canadian Association of Physician Assistants CanMEDS-PA 2015 Edition, (a competency framework for PA training).
- Other resources provided by the Health Workforce Policy Branch of the Ministry provided in support of the Physician Assistant Integration Working Group.

We have been informed that there are approximately 400 PAs practising in a variety of settings in Ontario including but not limited to family health teams, community health centres and hospital

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settings. PAs presently practise under the model of delegation which requires the supervision of a physician.

The College's *Delegation of Controlled Acts* policy sets expectations of physicians about when and how they may delegate controlled acts. The policy takes a principled approach, setting expectations for delegating any controlled act, to any recipient. It is applicable to PAs but also to many other potential recipients of delegation. Delegation can either take place through a direct order, specific to one patient, or through a medical directive which has more broad application. Responsibility for a delegated controlled act always remains with the delegating physician.

As part of our work to consider the request we have also considered available information that has come to the College's attention as part of the College's regulatory processes. This includes a small number of general inquiries and Discipline Committee decisions. There have been few discipline cases that pertain to delegation. While our information is limited to information received through general inquiries and as part of our complaints and investigative processes, we have not yet seen significant issues. That said, we do see an opportunity to develop additional resources and clarification in support of the PA role.

We believe that some of this can be achieved as part of the work with the Ministry's Physician Assistant Integration Working Group. Dan Faulkner, Deputy Registrar, a senior member of the College's leadership team is a member of the group. Part of the group's mandate is to define the role of PAs as a health-care provider and the work of this group is ongoing.

Given the ongoing discussion about PAs scope and role, work refining the PA funding model and ongoing questions as to how the work of PAs should be integrated into Ontario's health-care system more generally, the College recommends a measured approach to enhancing the accountability structure for PAs.

As part of the initial phase we suggest several strategies and activities including the following:

1. Two strategies to support and strengthen the accountability framework:
    a. The development of a resource to clarify the application of the Delegation policy to PAs. We want to ensure that application of the Delegation policy is easily accessible to the physicians and to PAs who work within the current delegation framework. The College will lead the development of this resource.
    b. The development of prototype medical directives specific to physician assistants. The Delegation policy does not provide specific templates for medical directives, but points to prototypes included in the *Emergency Department Medical Directives Implementation Kit*, jointly developed by the Ontario Hospital Association, the Ontario Medical Association and the Ministry of Health and Long-Term Care. We suggest that the Ministry Working Group take this on as the group has representation from

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practicing physician assistants, the Ontario Chapter of the Canadian Association of Physician Assistants (CAPA), and physicians involved in working with and training physician assistants, but also government representatives from the Health Workforce Branch, the Negotiations Branch, HealthForceOntario, LHINs along with the College. Such prototypes would bring greater specificity to how delegation to physician assistants should occur, and greater consistency in terms of how delegation is taking place in practice.

2. Continued participation by CPSO on the Physician Assistant Integration Working Group with a view to helping the group achieve its deliverables. We see these deliverables as necessary foundational work that will inform future discussion about regulation.

3. Collect timely and up-to-date information about where PAs are currently practicing and any delegated acts and activities.

   We have received from the resources provided, some information about where PAs are practicing and the range of their activities. Current data is required. The Ministry is best positioned to collect this information.

In closing, as you can appreciate, the College has actively focused over the past several months on implementation related issues relating to Bill 87. This work is very important and has been quite resource intensive. We have also worked in close collaboration with the Ministry on Bill 160 and anticipate that this work will also require significant attention and resources in the year ahead.

We anticipate further discussion with you and with the Ministry on these important issues and wish you the very best over the holiday season.

Yours truly,

S. C. Bodley MD, FRCPC
President

Rocco Gerace MD
Registrar

C:
Dr. Bob Bell, Deputy Minister, Ministry Health and Long-Term Care
Ms. Denise Cole, Assistant Deputy Minister, Health Workforce Planning & Regulatory Affairs Division
Ministry of Health and Long-Term Care

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THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 15, 2017

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,

Public Council Member Appointment Related Issues

We write to again express our concern and frustration with the public appointment (LGIC) system and to provide you with an urgent update on the impact of the ongoing problems which threaten the College of Physicians and Surgeons of Ontario's (College) ability to regulate the practice of medicine in the public interest. The matter requires your immediate attention.

Specifically, with the volume of cases currently scheduled before the College's Discipline Committee, and the number of available public members, the College is finding it extremely difficult to meet the statutory requirement to have two public members of Council on every discipline panel. This is raising the very real possibility that discipline hearings will have to be postponed because of the lack of government-appointed public members.

There are two elements to this problem. The first is the inability of the government to ensure that the College has its full complement of 15 active public members of Council. The second is that with the current volume of hearings, even if the College did have the full complement of public members, it is unlikely that the College could meet the statutory requirement for public members on all discipline hearings.

We rely and depend on government to appoint 15 **qualified** public members to the College Council who are able to provide a **minimum of 80 days of work (ideally more than 100) each year**. Public members make an essential contribution to College work and serve in leadership positions on the Council and its Committees.

As you are aware, the College has had longstanding concerns and problems with the public appointment process including unfilled vacancies, inappropriate appointments leading to early resignations, and the inadequacy of the per diem rates. We have detailed these concerns and proposed solutions over many years. Most recently, we asked for legislative change to address this problem in our submissions on Bill 87. The College has also worked diligently to resolve these issues with you and your office and senior staff from the Ministry.

Unfortunately, the problems created by an out-of-date and inadequately supported public appointment process have reached a crisis level and, the College may have to take the unprecedented step of

postponing several discipline hearings scheduled early in 2018 if it does not have two public members available for these hearings.

Our most pressing issue at the current time is the fact that as of January 4, 2018 we will be short three public members of Council. Government has been aware of the current and future vacancies for some time. As a result of the vacancies, the College may have no choice but to adjourn discipline hearings currently scheduled in January and February. This would result in delays to the hearings, which may cause further challenges for the College in its efforts to protect the public, and cause upset and disruption to the witnesses who are scheduled to testify.

Matters referred to the Discipline Committee are by nature the riskiest, most high profile cases. A significant proportion of current discipline cases relate to allegations of sexual abuse or sexual impropriety, some relate to allegations of disgraceful, dishonourable or unprofessional conduct and others relate to allegations of failing to maintain the standard of practice and/or incompetence. Notice of postponements, including the reason for them, will have to be made shortly.

We take our responsibility to support and protect patients from sexual abuse very seriously. It is inconceivable to us that with the government's stated focus on sexual abuse, the College may have to postpone sexual abuse hearings as a result of the government's lack of attention to the public appointments process.

By way of background, all public members of the College Council are appointed to the Discipline Committee or the Inquiries, Complaints and Resolutions Committee (ICRC). They cannot sit on both committees because of the need to avoid conflicts between the screening and adjudicative committees.

We further note that even with the appointment of 15 qualified public members of Council, we will continue to experience problems putting together discipline panels given current caseloads. There are currently 108 open discipline cases, up from 71 in 2015. While we write to you urgently because of the threat of hearings being postponed in January and February, we anticipate based on current volumes that the situation will be little improved in March, April and throughout the year, when attempts are made to find public members to sit on all the hearings currently scheduled before the Discipline Committee. While we are facing an urgent, short-term crisis at this moment, this is not a temporary problem – it is a systemic one. The current system and structure is simply unsustainable. More substantive regulatory or statutory change is urgently required.

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We also note that this increase in complaints and investigations has also had a very significant impact on the ICRC, the central screening committee. The ICRC workload for public members of Council is enormous.

Issues with the public appointments system and process require your immediate attention. The short term solution is for government to appoint three qualified and available public members to the College Council. The 2018 solution is to work with the College beginning in January to make regulatory or statutory change to expand the pool of individuals who are eligible to act as public members for the College on its Discipline Committee.

Yours truly,

SC Bodley MD, FRCPC
President

Rocco Gerace, MD
Registrar

C: Dr. Robert Bell, Deputy Minister of Health and Long-Term Care

Council Committee Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

February 2018

TOPIC: Policy Report

FOR INFORMATION

Updates:

1. Physician Administration of Edaravone
2. Blood Borne Viruses Policy: Housekeeping Amendments
3. Psychotherapy: Amendments to the Controlled Acts Regulation
4. MAID: Federal Regulation on Data Collection
5. Policy Consultation Update:
    I. Prescribing Drugs
6. Policy Status Table

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1. Physician Administration of Edaravone

Background:

- Edaravone is a medication prescribed to help slow the symptom progression of amyotrophic lateral sclerosis (ALS).
- It is currently only available in Korea, Japan and the United States. It is not available in Canada, and it is unclear whether the pharmaceutical company that manufactures Edaravone will make an application to Health Canada for formal approval.

- As Edaravone is not approved for use in Canada, physicians are not permitted to prescribe it except in the limited circumstances set out by Health Canada for unapproved drugs.[1]

- While not available in Canada, some patients have purchased Edaravone at their own personal expense from physicians abroad under Health Canada's Personal Importation Policy.

- Patients who import Edaravone must seek an authorized health care professional to administer it via intravenous infusion. Infusions must be administered on an ongoing basis for the symptom progression of ALS to be slowed.

Current issue:

- In the late Fall / Winter of 2017, the College was contacted by several physicians to inquire whether they were legally and professionally permitted to administer Edaravone that had been imported from outside Canada. It became clear at this time that there was significant interest and uncertainty among physicians and patients on this issue.

- In November, 2017, the College engaged in discussions with the Ministry of Health and Long-Term Care, Health Canada, and the College of Nurses of Ontario to confirm a mutual understanding of the key issues surrounding the administration of Edaravone, and to ensure alignment in our approaches and communications.

- In December, 2017, it was proposed that the College develop a brief, public statement to confirm the professional responsibilities of physicians who are considering administering or delegating the administration of Edaravone. This approach would be consistent with the approach taken by the College of Nurses of Ontario, which published a statement for nurses.

- It was also felt that in order to be appropriately responsive to this emerging issue and sensitive to the urgent need of patients, the development of the statement should be expedited. For this reason, a draft statement was presented for the Executive Committee's consideration and approval on December 14th, 2017.

- The draft statement was approved by the Executive Committee at that time. The draft statement indicates the following:

    - Physicians are not permitted to prescribe Edaravone;

[1] These circumstances include drugs that have been authorized by Health Canada for research purposes as part of a clinical trial or drugs that have been authorized for use under Health Canada's Special Access Programme.

- Physicians (and other authorized health care professionals) *are* legally permitted to administer Edaravone, provided that they have the necessary knowledge, skills and judgment to do so safely and effectively. This is consistent with the expectation of physicians when providing any treatment;

- Physicians are permitted to delegate the administration of Edaravone, in keeping with the College's Delegation of Controlled Acts policy; and

- Physicians are permitted to issue an initiating order to a Registered Nurse or Registered Practical Nurse to administer Edaravone.[2]

- The statement is posted on the College's website and a copy is can be found at **Appendix A**.

Next steps:

- CPSO staff will continue to monitor the issues surrounding the importation and administration of Edaravone, and Council will receive future updates as needed.

2. Blood Borne Viruses Policy: Housekeeping Amendments

- The College's Blood Borne Viruses (BBV) policy, approved by Council in December 2015, requires physicians to be tested for HIV and Hepatitis C every three years.

- The Annual Renewal Survey (ARS) contains a number of questions about BBVs and health.

- One of the BBV questions in the ARS for 2017 is as follows:

  "Are you infected with and/or have you had a positive blood test with respect to Hepatitis C?"

- During follow-up on the responses to the 2017 ARS BBV questions, staff realized that the question on the ARS set out above could be made clearer by specifying the main types of HCV tests which could have positive results for a physician.

- Dr. Bob Byrick (Chair of the previous BBV policy Working Group), Dr. Jim Wilson (Medical Advisor to the previous BBV policy Working Group) and Dr. Mary Vearncombe (Associate Microbiologist; Medical Director, Infection Prevention

[2] For more information, see the College of Nurses of Ontario's statement "Administering Edaravone".

and Control at Sunnybrook Health Sciences Centre)[3] discussed how to make the question on the ARS clearer.

- A decision was made to add the words "either HCV antibody or HCV RNA" at the end of the question to clarify that a positive HCV test result includes either a positive result for the HCV antibody or HCV RNA.

- The Annual Renewal Survey Questions Working Group considered the change proposed by the physicians noted above and agreed that this change should be made to this specific BBV question on the 2018 ARS.

- The question for the 2018 ARS now reads:

> "Are you infected with and/or have you had a positive blood test with respect to HIV or to Hepatitis C **including either HCV antibody or HCV RNA**?"

- Housekeeping amendments have been made to the current BBV policy so that it aligns with the wording that will be in the 2018 ARS. The revised policy has been posted to the College's website. Section C of the policy on Reporting Serological Status and Section D of the policy on Seropositive Physicians have been amended to clarify that testing positive for HCV includes testing positive for either HCV antibody or HCV RNA.

3. Psychotherapy: Proclamation of Controlled Act and Amendments to the Controlled Acts Regulation

- In April 2015, the *Psychotherapy Act* was proclaimed. This Act includes a definition of the controlled act of psychotherapy. The definition of the controlled act was also added to the *Regulated Health Professions Act* (RHPA). The definition of the controlled act of psychotherapy is:

> *Treating by means of psychotherapy technique, delivered through a psychotherapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning.*

- This definition attempts to limit the controlled act of psychotherapy to psychotherapy that treats an individual's **serious disorder** of thought, cognition, mood, emotional regulation, perception or memory that may **seriously impair**

[3] Dr. Vearncombe provided assistance to the BBV Policy Working Group during the policy review process. She has recently retired.

the individual's judgement, insight, behaviour, communication or social functioning.

- Thus, the definition draws a distinction between the controlled act of psychotherapy and "regular" psychotherapy which would be provided to individuals who do not fall within the above definition.

- 5 regulated health professions have been authorized the controlled act of psychotherapy: psychotherapists, physicians, nurses, occupational therapists, and psychologists. Social workers have also been authorized to perform the controlled act of psychotherapy.

- Although most of the provisions of the *Psychotherapy Act* were proclaimed in force in April 2015, the government delayed proclaiming the controlled act of psychotherapy that was contained in the RHPA.

- In December 2017, the government proclaimed the RHPA provision related to the controlled act of psychotherapy. At the same time, the Government also amended the exemption section of the Controlled Acts regulation under the RHPA.

- This amendment provides for a two-year transition period, from December 30, 2017 and December 31, 2019. During this time, individuals who provide psychotherapy services will have the opportunity to become registered with an appropriate regulatory college if they wish to continue to perform the controlled act of psychotherapy.

- An additional housekeeping amendment was made to allow social work and social service work students to perform the controlled act of psychotherapy under supervision, in the course of fulfilling requirements to become members of the profession. A similar provision exists for regulated health professions in the RHPA.

- The Ministry released a Bulletin about the "new psychotherapy requirements" on December 21, 2017.

Impact on Physicians:

- Proclamation of the controlled act and these amendments will not have any implications for physicians. Physicians will be able to perform the controlled act of psychotherapy and non-controlled act psychotherapy. As well, physicians will be able to use the title of psychotherapist.[4]

[4] Physicians can use the title psychotherapist but must comply with the conditions set out in the RHPA: must not describe himself or herself orally as a "psychotherapist" to any person unless the member also mentions the full name of the College where he or she is a member and identifies himself or herself as a

- The issues set out in this briefing note have not been a source of confusion or focus for the medical profession.

- Council will be kept informed of any developments with respect to these issues.

4. MAID: Federal Regulation on Data Collection

- As Council will recall, the federal legislation on MAID, and resulting changes to the *Criminal Code of Canada*, included a requirement that the Minister of Health make regulations respecting the provision, collection, use, and disposal of information for the purposes of monitoring medical assistance in dying (MAID).

- On December 16, 2017 the federal government released a draft of the *Monitoring of Medical Assistance in Dying Regulations* to fulfill this requirement and set a deadline of February 13, 2018 for stakeholders to provide feedback.

- The proposed Regulations establish a pan-Canadian approach to data collection and analysis relating to MAID that aims to allow Health Canada to build a picture of how the legislation is working and how eligibility criteria are being applied in practice.

- The proposed Regulations contemplate a reporting regime that is both complex and significant in terms of the amount of information collected. In particular, reporting obligations effectively aim to collect information pertaining to every stage and every element of the process (e.g., assessments of eligibility and changes in eligibility, referrals, withdrawal of requests, procedural requirements, and provision of MAID).

- Working with College President, Dr. Steve Bodley, a College submission has been developed in response to the proposed Regulations. The submission highlights areas where the College is supportive of the proposed Regulations and provides constructive feedback on key elements of the proposed Regulations. A brief overview of the key points contained in the submission is provided below:

member of that College or identifies himself or herself using the title restricted to those who are members of the health profession to which the member belongs and must not use the title “psychotherapist” in writing in a way that identifies the member as a psychotherapist on a name tag, business card or any document, unless the member sets out his or her full name in writing, immediately followed by at least one of the following, followed in turn by “psychotherapist”:

1. The full name of the College where he or she is a member.
2. The name of the health profession that the member practises.
3. The restricted title that the member may use under the health profession Act governing the member’s profession.

- The submission outlines the Colleges support for the objectives underlying the proposed Regulations. Namely, the development of a pan-Canadian approach to data collection and analysis relating to MAID. This will help ensure transparency and accountability in the system and will enable future decisions to be informed by evidence.

- The College is concerned that the burden of the reporting obligations will act as a disincentive to practitioner participation in MAID. By Health Canada's own estimation, it may take nearly an hour for a practitioner to fulfill their reporting obligations. Importantly, this does not include provincial reporting obligations, nor the time required to document the encounter in the medical record.

- It is very likely that instances of non-compliance with the *Criminal Code* will be identifiable in the data. However, the proposed Regulations are not explicit about the responsibility of Health Canada to disclose instances of non-compliance to the police and/or regulatory colleges. The College's submission recommends that the proposed Regulations be explicit in this regard.

- The submission expresses significant concern with the provision in proposed Regulations that requires physicians to report an estimation of by how much MAID has shortened a patient's life. This is inconsistent with provisions in the *Criminal Code* related to the 'reasonably foreseeable' death of patients. That provision explicitly states that practitioners are not required to provide an estimate of the patient's life-expectancy.

- Reporting obligations are triggered when a practitioner receives a written request for MAID. The submission indicates that the meaning of this term is unclear; it appears to be used differently in the regulations than in the *Criminal Code*. The College recommends that this be made more explicit in the proposed Regulations, but the submission also raises concerns that this will cause confusion, is not consistent with practice (i.e., initiating requests may be verbal), and will limit the scope of information collected by the reporting regime.

- Finally, the proposed Regulations only capture whether referrals are made due to institutional policies that prohibit MAID. As referrals can be made for a variety of reasons (e.g., clinical competence, conscientious objection), the submission recommends widening the scope of information being collected.

- Publication of the final regulation is expected in the summer of 2018, with the regulations coming into force in the late summer or early fall of 2018.

- Staff will continue to monitor development on this issue, and update the Executive Committee and Council accordingly.

5. Policy Consultation Update

I. Prescribing Drugs

- The College's Prescribing Drugs policy is currently under review. This policy sets out the College's expectations for all physicians who prescribe drugs or provide drug samples to patients. The policy also includes guidelines for the prevention of medication errors and the appropriate prescribing of narcotics and controlled substances, including opioids.

- As part of the policy review process, a preliminary external consultation was undertaken between December, 2017 and February, 2018.

- As of the Council submission date (February 2nd), the College has received a total of 84 responses to this consultation: 19 in a written format and 65 in the form of an online survey. Respondent demographics were 85% physicians, 1 % other healthcare professional, 8% members of the public, 2% who preferred not to say, and 4% organizations[5].

- All written feedback has been posted on the College's website, in keeping with regular consultation processes and posting guidelines. A report of the survey results will be available online following a careful review and analysis.

- While the feedback received to-date has touched on a wide range of topics, a few of the key themes that have emerged in the feedback are reported below:

  i. Public feedback has a significant focus on opioids

    - As was expected with the ongoing crisis of opioid abuse, misuse, and overdose, a significant proportion of public feedback relates to the prescribing of opioids.
    - Many patients and members of the public voiced concern around the College restricting the opioid prescribing of physicians under investigation. They note the significant strain that can be placed on a community when a prescriber is no longer able to provide a significant element of care to a large number of patients, especially in remote areas with few active prescribers.

[5] Organizational respondents included the Office of the Information and Privacy Commissioner of Ontario, the Professional Association of Residents of Ontario, and a chronic pain patient advocate.

- Patients are concerned that the policy is sending a signal to physicians that the College would like to limit the prescribing of opioids, and worry about the impact this may have on patients suffering from chronic pain.
- One patient questioned the evidence supporting the effectiveness of "treatment agreements" / "prescribing contracts". They suggest that they are ineffective at reducing abuse and/or diversion, and are instead abused by physicians to unilaterally terminate prescribing and/or care.

ii. Physician feedback has likewise focused on opioids

- While a number of physicians have noted that the policy provides helpful guidance with respect to the prescribing of opioids, others argue that it is overly prescriptive, and will have a "chilling effect" on appropriate prescribing.

iii. More clarity is needed around content of prescriptions

- Several respondents suggested that the current requirements for the content of prescriptions (e.g. date, prescriber name, patient name, etc.) are not comprehensive, and not aligned with the information pharmacists require to fill prescriptions.

iv. Additional guidance is needed for e-prescribing and prescribing via electronic systems

- A significant number of physician respondents requested that the policy include more guidance around the use of e-prescriptions and/or prescriptions automatically generated by Electronic Medical Records (EMRs).

v. Guidance requested for "off-label" prescribing

<u>Next steps:</u>

- All feedback received will be carefully reviewed by College staff and the Policy Working Group struck to undertake this review.

- When a draft policy has been developed, it will be presented, along with the full analysis of the feedback received, to the Executive Committee and Council for consideration.

6. Policy Status Table

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

- For further information about the status of any policy issue, please contact Andréa Foti, Manager, Policy, at extension 387.

DECISIONS/DISCUSSION FOR COUNCIL:

For information only

Contact: Andréa Foti, Ext. 387

Date: February 2, 2018

Appendices:

Appendix A: CPSO Statement – Physicians Administration of Edaravone
Appendix B: Policy Status Table.

Physician Administration of Edaravone

What is Edaravone?

Edaravone is an intravenous medication prescribed to help slow the symptom progression of amyotrophic lateral sclerosis (ALS or “Lou Gehrig’s disease”).

Currently, Edaravone is available in the United States, Japan, and Korea; however, it is not authorized for sale in Canada.

While not available in Canada, some patients have purchased Edaravone abroad and legally imported it under Health Canada’s Personal Importation Policy.[1] When Edaravone is legally imported, federal law does not prohibit authorized health professionals, including physicians and nurses, from administering it.

College Position

In keeping with the College’s mandate to serve and protect the public interest, we recognize the importance of ensuring that patients have safe access to new drug therapies, especially when there are limited treatment options available.

While Edaravone’s status as an unapproved drug restricts physicians from prescribing it, physicians are not restricted from administering Edaravone, provided that they have the necessary knowledge, skills, and judgment to do so safely and effectively. This expectation is no different than that which applies any time a physician provides a treatment to a patient.

In addition to administering Edaravone directly to a patient, physicians are also permitted to delegate the administration of Edaravone, in accordance with the College’s Delegation of Controlled Acts policy, or issue an initiating order to a Registered Nurse or Registered Practical Nurse to administer it. The College of Nurses of Ontario has recently released a statement to articulate the expectations of nurses with respect to the administration of Edaravone.

As with any other treatment or procedure, physicians must ensure that they meet the standard of care when administering Edaravone, and ensure that all other professional and legal duties are met when doing so, including obtaining informed consent, documenting consent in the patient’s record, and managing any adverse events that may arise.

Endnotes

[1] For further information on the personal importation of health products, see Health Canada's "Guidance Document on the Import Requirements for Health Products under the *Food and Drugs Act* and its Regulations" (GUI-0084).

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 competence in the area of practice they are returning to.	This policy is currently under review and being reviewed in tandem with the Changing Scope of Practice policy. The two current policies have been combined into a new draft policy entitled *Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice*. A consultation on the draft policy took place between September and November 2017. The draft policy has been revised in light of the feedback received and will be presented at the February meeting of Council for consideration for final approval.	2018
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 and being reviewed in tandem with the Re-entering Practice policy. The two current policies have been combined into a new draft policy entitled *Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice*. A consultation on the draft policy took place between September and November 2017. The draft policy has been revised in light of the	2018

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
		feedback received and will be presented at the February meeting of Council for consideration for final approval.	
Prescribing Drugs	This policy sets out the College's expectations of physicians who prescribe drugs or provide drug samples to patients.	This policy is currently under review. A Working Group has been struck to undertake this review and a preliminary consultation on the current policy has been undertaken. Further updates with respect to the status of this review will be provided at future meetings of Council.	2019
Maintaining Appropriate Boundaries and Preventing Sexual Abuse	This policy helps physicians understand and comply with the legislative provisions of the *Regulated Health Professions Act, 1991 (RHPA)* 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.	This policy is currently under review. The review will be informed by the College's Sexual Abuse Initiative, the Minister of Health and Long-Term Care's Task Force on the Prevention of Sexual Abuse of Patients, and Bill 87, the *Protecting Patients Act, 2017*. The initial stages of the review are underway and a preliminary consultation was held between September and December 2017. Further updates with respect to the status of this review will be provided at a future meeting.	2019
Practice Management Considerations for	This policy explains the practice management measures	This policy is currently under review. A draft policy entitled *Closing a Medical Practice* has	2018

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
Physicians Who Cease to Practise, Take an Extended Leave of Absence or Close Their Practice Due to Relocation	physicians should take when they cease to practise or will not be practising for an extended period of time.	been developed and will be presented for consideration to consult externally at the February 2018 meeting of Council. Further information can be found in a Briefing Note included in your Council materials.	
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. A draft policy was circulated for consultation following the September meeting of Council. The newly-titled *Public Health Emergencies* draft policy has been revised in light of the consultation feedback received. It will be presented for final approval at the February 2018 meeting of Council. Further information can be found in a Briefing Note included in your Council materials.	2018
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 *Continuity of Care* policy. For more information please refer to the Continuity of Care entry below.	2018

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
Continuity of Care	The College does not currently have a policy on *Continuity of Care*.	In May 2016, Council reviewed and discussed a *Continuity of Care Planning and Proposal* 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 *Test Results Management* policy. The Working Group is currently developing a 'suite' of draft policies. An update regarding this work is provided in a separate Briefing Note in the February 2018 Council Materials. Council will also have an opportunity to provide feedback on this work as part of a presentation and discussion session at this meeting.	2018
Confidentiality of Personal Health Information	This policy sets out physicians' legal and ethical obligations to protect the privacy and confidentiality of patients' personal health information.	This policy is currently under review. Initial stages of the review are underway and a preliminary consultation was held between May and July 2017. A working Group has been struck to assist with the policy review. Further updates with respect to the status of this review will be provided at a future meeting.	2019
Medical Records	This policy sets out the essentials of maintaining medical records.	This policy is currently under review. Initial stages of the review are underway and a	2019

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
		preliminary consultation was held between September and December 2017. A working group has been struck to assist with this review. Further updates with respect to the status of this review will be provided at a future meeting.	

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. The review of this policy has been deferred, due to competing priorities.
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. The review of this policy has been deferred, due to competing priorities.
Female Genital Cutting (Mutilation)	2016/17	This policy sets out physicians' obligations with respect to female genital cutting/mutilation. The review of this policy has been deferred, due to competing priorities.
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.
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 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.
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.

POLICY	TARGET FOR REVIEW	SUMMARY
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.
Anabolic Steroids, Substances and Methods Prohibited in Sport	2018/2019	The current policy articulates the College's expectations of physicians regarding the use of anabolic steroids and other substances and methods for the purpose of performance enhancement in sport (i.e., doping).
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 *Dialogue*, Volume 10, Issue 1, 2014.
Physicians' Relationships with Industry: Practice, Education and Research (formerly Conflict of Interest:	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

POLICY	TARGET FOR REVIEW	SUMMARY
Recruitment of Subjects for Research Studies and MDs Relations with Drug Companies)		September 2014 Meeting. The policy was posted on the College's website, and published in *Dialogue*, 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 *Human Rights Code*, 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.
Physician Treatment of Self, Family Members, or Others Close to Them (formerly Treating Self and Family	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.

POLICY	TARGET FOR REVIEW	SUMMARY
Members		
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.
Accepting New Patients	2022/23	This policy sets out the College's expectations of physicians when accepting new patients.
Ending the Physician-Patient Relationship	2022/23	This policy sets out the College's expectations of physicians when ending the physician-patient relationship.
Uninsured Services: Billing and Block Fees	2022/23	This policy articulates the College's expectations of physicians in relation to billing for uninsured services, including offering patients the option of paying for uninsured services by way of a block fee.

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

February 23, 2018

TOPIC: **Quality Management Partnership: Draft Progress Report on Quality in Colonoscopy, Mammography and Pathology**

FOR INFORMATION

ISSUE:

- This note informs Council of the Quality Management Partnership's (the Partnership) draft report on its progress to implement quality management programs for colonoscopy, mammography and pathology services.

BACKGROUND:

- The Partnership has a goal of improving public confidence through increased accountability and transparency. In support of this goal, in 2015 the Partnership released its inaugural report released "Building on Strong Foundations: Inaugural Report on Quality in Colonoscopy, Mammography and Pathology".
- This goal is aligned with the Patents First: Action Plan for Health Care (2015).
- The inaugural report showed that strong foundations for quality management programs (QMPs) already existed and that there were gaps to be filled in order to ensure consistent high quality care across the province for the three health service areas.
- This progress report builds on the inaugural report by providing a high-level update about the implementation of quality management programs (QMPs) for colonoscopy, mammography and pathology against these specific measures:

    - evidence-based standards, guidelines and indicators;
    - a clinical leadership structure of provincial, regional and facility leads;
    - quality reporting at the provincial, regional and physician levels, and;
    - resources, tools and opportunities to support quality improvement.

CURRENT STATUS:

- The primary audience for this progress report is the health system and our intended distribution list is comprised of stakeholders including associations such as the OHA, OMA (and pertinent sections), OAG (Ontario Association of Gastroenterologists), OAR (Ontario Association of Radiologists), and OAP (Ontario Association of Pathologists), and the MOHLTC amongst others.
- These are stakeholders the Partnership has included in past distributions of reports, many of which are participating in our governance tables.
- The report will also be made available on the Partnership's website (qmpontario.ca).
- In addition to reporting on specific measures, the progress report signals that public reporting is being developed with the Citizens Advisory Committee (a Partnership governance table) and system leaders, more specifically, HQO and the MOHLTC.

CONSIDERATIONS:

- The report utilizes non-identifiable, aggregate provincial data to highlight successes and challenges to implementation. It is important to note that data related to colonoscopy and pathology standards is self-reported and collected by the Partnership.
- Some of the colonoscopy standards are very similar to those of the OHPIP and data presented may appear to highlight inconsistencies with expectations of the OHP inspection program. These are a result of standards language not yet aligned between the Partnership and the OHPIP as well the self-report nature of the data. The Partnership is aware of these challenges and has inserted a note about these limitations in Table 5 of the progress report.
- As with the inaugural report, the progress report highlights that variation in each of the various existing quality programs continues. As a result, it is evident that some service providers will have had experience reviewing and understanding quality reports while for some this will be a new experience.
- The progress report highlights that key data is not available to OHPs meaning that some quality indicators, such as inadequate bowel preparation, cannot be included in quality management reports to OHPs. The Partnership continues to explore mechanisms to gather this data and provide complete reports to OHPs.
- This progress report provides an important focus on these service areas and supports the need for the Partnership QMPs.

NEXT STEPS:

- Concurrent to the review of this final draft document, the Partnership is targeting a February handoff of the progress report to CCO communications to design the document prior to electronic distribution before March 31, 2017.

This is for Information only.

Contact: Robin Reece ext. 396
Wade Hillier ext. 636

Date: February 23rd, 2018

Attachments:

Appendix A: Draft Progress Report on Quality in Colonoscopy, Mammography and Pathology

Appendix A

Advancing Quality: Progress on Key Priorities in Colonoscopy, Mammography and Pathology

Quality Management Partnership

2018

Message from the Partnership Executive

The Quality Management Partnership is working to ensure that all Ontarians have access to consistent, high-quality colonoscopy, mammography and pathology services. Working closely with our stakeholders, we have been implementing quality management programs (QMPs) in these three health service areas. A key component of the QMPs is quality reporting, which provides insights into the quality of care at multiple levels: across the province, and by region, facility and physician. Reporting information about performance provides a clearer view of quality across the system and helps identify areas for continuous quality improvement.

This report provides an overview of the quality of colonoscopy, mammography and pathology services in Ontario, based on select measures. It highlights the progress that has been made since QMP implementation began in January 2016. While quality improvements have been made, variation remains in some aspects of quality across the province. Working closely with our stakeholders to reduce this variation, the Partnership can contribute to achieving consistent, high-quality care wherever the care is provided.

The Partnership is committed to improving transparency in the healthcare system, ensuring greater accountability to the public and fostering engagement with key stakeholders, in alignment with Patients First: Action Plan for Health Care (2015). In the coming years, we will continue to enhance the information available publicly in a manner that is meaningful to those who use these three health services.

Achieving our shared goal of improving the quality of care provided to Ontarians requires the collective contributions of everyone involved, including healthcare providers, health system leaders and patients. We thank everyone for their efforts to date and look forward to continuing our work together.

Michael Sherar, PhD
President and CEO, Cancer Care Ontario

Dr. Rocco Gerace, MD
Registrar, College of Physicians and Surgeons of Ontario

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Introduction

Background

On March 28, 2013, the Ministry of Health and Long-Term Care announced the Quality Management Partnership (the Partnership), which brings together Cancer Care Ontario and the College of Physicians and Surgeons of Ontario (CPSO). Since then, the Partnership has been working closely with stakeholders to develop quality management programs (QMPs) for three health service areas: colonoscopy, mammography and pathology.

The Partnership established three goals for the QMPs:

- enhance the quality of care;
- increase the consistency in the quality of care provided across facilities; and
- improve public confidence by increasing accountability and transparency.

The QMPs were designed by three expert advisory panels chaired by three provincial clinical leads, one for each health service area. Panel members included physicians and other health professionals who practice in the health service area, administrators and patients/service users.[1] The panels' recommendations are detailed in the Partnership's report, Provincial Quality Management Programs for Colonoscopy, Mammography and Pathology in Ontario. A subsequent report, Building on Strong Foundations: Inaugural Report on Quality in Colonoscopy, Mammography and Pathology, provided summary information on:

- the health professionals and facilities that provide the three health services in Ontario;
- key provincial quality initiatives that currently exist in each health service area; and
- provincial performance, as measured by standards and indicators recommended by the expert advisory panels, where data are available.

The latter report referenced above showed that strong foundations for QMPs already exist in Ontario and also revealed gaps that need to be filled to ensure consistent, high-quality services across the province. The report detailed some of the progress that has been made in implementing QMPs in colonoscopy, mammography and pathology since the inaugural report was issued in 2015 and provides a high-level update on provincial performance for select measures.

Progress on Key Priorities

The Partnership identified four components of a QMP which it has been working to implement. The components are:

[1] Many people who have medical procedures – colonoscopy and mammography, in particular – are not sick and are doing so for routine screening purposes only, leading some to argue that "service users" is a more appropriate label than "patients." To address this issue, this report uses the terminology patients/service users to refer to people who use these health services.

- evidence-based standards, guidelines and indicators;
- a clinical leadership structure of provincial, regional and facility leads;
- quality reporting at the physician, facility, regional and provincial levels; and
- resources, tools and opportunities to support quality improvement.

QMPs must build on existing quality initiatives in order to be successfully implemented. Accordingly, each QMP has endorsed standards, indicators and guidelines that are recommended or implemented in Ontario and/or in other provincial, national or international programs or organizations. The Partnership works with key stakeholders to ensure that these best practice guidelines and standards are applied to all providers and facilities in Ontario.

The Partnership has established a clinical leadership structure for each of the three health service areas that consists of a network of clinical leads at the provincial, regional and facility levels who provide clinical guidance and oversight to the QMPs. To support their clinical leads, facilities designate QMP executive contacts, and hospitals also select administrative contacts. These contacts have operational accountability for quality within their organizations and assist facility leads by facilitating the implementation of standards and identified quality improvement initiatives.

The Partnership has developed and released reports in order to promote transparency and accountability in the healthcare system. For each health service area, the reports provide an overview of quality measured by select standards and indicators at the facility, regional and provincial levels. Reports are distributed to facility leads and administrative and executive contacts at facilities, as well as to regional clinical leads and administrators in regional cancer centres. Webcasts, teleconferences and written documentation are provided to support recipients in understanding their reports and using them to foster conversations about quality improvement in their facility and region. Physician-level reporting has been initiated for colonoscopy.

The Partnership has been developing resources to assist facility and regionals leads, as well as healthcare professionals and other personnel in facilities, in carrying out quality improvement initiatives. Examples include clinical and process toolkits, regional engagement plans, training on providing peer performance feedback, and an online learning management system (LearnQMP) to provide access to relevant resources, foster communities of practice and promote resource sharing. Further supports have been put in place for endoscopists who were receiving physician-level reports from the Partnership for the first time.

The Partnership has continued to engage patients/service users through a variety of channels such as the establishment of a Citizens' Advisory Committee. The committee provides guidance from the patient/service user's perspective on overall design and implementation of the QMPs and specific topics such as patient engagement, patient experience indicators and public reporting. Members of the Citizens' Advisory Committee participate in the three provincial quality committees that the Partnership has set up to provide the QMPs with advice and guidance.

The Partnership recognizes the importance of evaluation and evidence-based program design. As the QMPs are being implemented, evaluation of various activities has been carried out, and the learnings

have been used to improve and refine the Partnership's approach. For example, reports have been evaluated to assess, among other things, their reach and usability and were subsequently redesigned based on these findings. The evaluation of Partnership activities, and the Partnership's overall approach to quality and performance management, will be invaluable inputs that will inform future efforts.

Colonoscopy

Background

In Ontario, the majority of colonoscopies are performed by general surgeons and gastroenterologists. Colonoscopies are performed in hospitals and out-of-hospital premises (OHPs); in 2017, 168 facilities provided colonoscopy services in Ontario: 103 hospitals and 65 OHPs.

Progress on Key Priorities

CPSO's Out-of-Hospital Premises Inspection Program has embedded several of the Colonoscopy QMP's standards into its requirements for OHPs. In addition, the Colonoscopy QMP, the Gastrointestinal Endoscopy Quality Based Procedure, and ColonCancerCheck (the provincial colorectal screening program) have a number of standards and indicators in common. These three programs have aligned indicator methodologies, where appropriate, in order to ensure that reports developed by each initiative provide consistent information.

The clinical leadership structure for the Colonoscopy QMP has been established. To ensure alignment, the colonoscopy regional leads are responsible for supporting the Colonoscopy QMP, ColonCancerCheck and the Gastrointestinal Endoscopy Quality Based Procedure in their regions.

The Colonoscopy QMP first released reports at the facility, regional and provincial levels in 2016 to all facilities providing colonoscopy in Ontario. An evaluation of the reports showed that the majority of respondents found the reports useful in describing quality, and many used the reports to have conversations about quality. The evaluation also revealed that some stakeholders felt the amount of information in the reports could be overwhelming. To simplify the reports and help recipients focus their quality improvement efforts, a consultative process that included the QMP's Citizens' Advisory Committee and the Colonoscopy QMP Provincial Quality Committee was used to identify priority standards and indicators. Updated reports with more recent data, and with priority indicators and standards highlighted, were released in 2017.

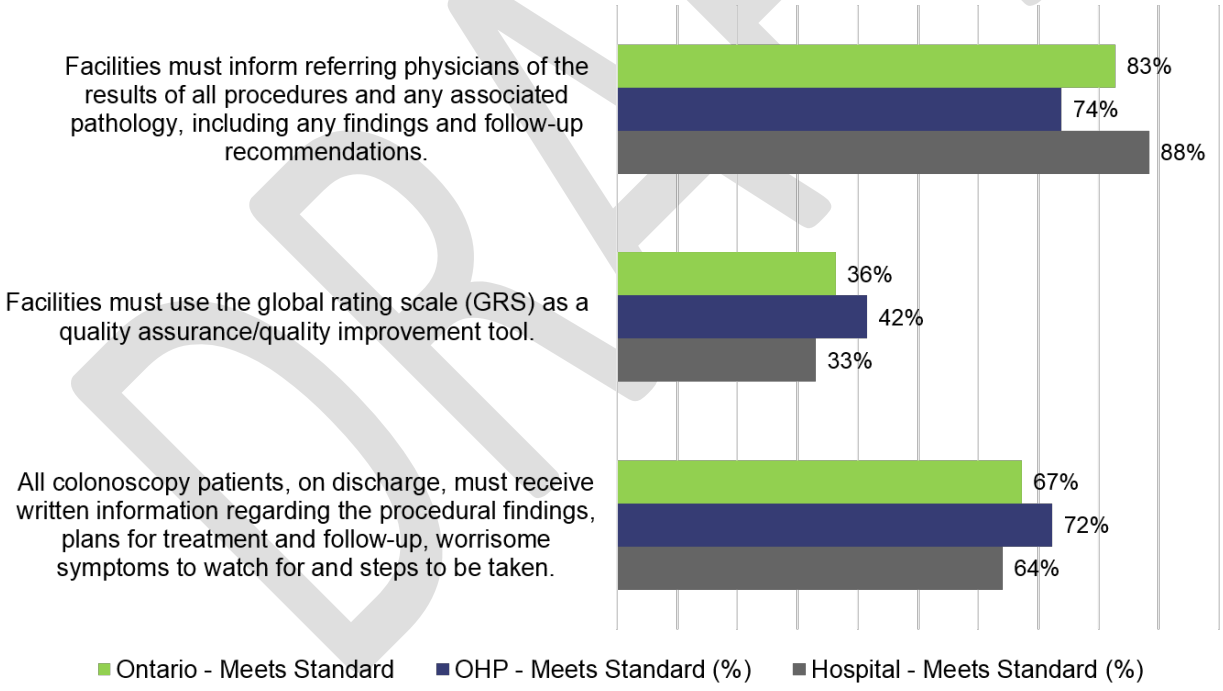
A key Partnership milestone was met when the Colonoscopy QMP released physician-level reports in 2017. The QMP reports build on Dr. Jill Tinmouth's randomized controlled trial examining the effectiveness of physician-level audit and feedback reporting in improving colonoscopy quality. The Partnership's release of physician reports is the first time in Ontario that all physicians in a health service area have received a report about their performance from a mandatory provincial program with an established performance management mandate. For the physician reports, this mandate was operationalized by focusing on processes to support physicians in improving their performance. Regional leads are available to all endoscopists to help them interpret their report. In addition, regional leads actively engage a subset of endoscopists who may benefit from discussing their report and work with them to develop a personal learning plan. Follow up will assess progress on the actions documented in the plan, and the entire approach will be evaluated as it rolls out.

Other colonoscopy-specific quality improvement supports include a resource package created to encourage consistent best practice in the performance of endoscopies and the operation of endoscopy facilities. The content was developed by a clinical working group using a systematic, evidence-informed process and includes guidelines for bowel preparation selection, pre- and post-procedure guidelines and checklists, and standardized discharge guidelines. The resource package is posted on the Partnership website, and relevant elements are referenced in documents that are included in the report release materials.

Key Report Findings

Figure A compares OHP and hospital adherence to three prioritized standards: informing referring physicians of all procedure results, using the global rating scale (GRS) and providing patients with written information at discharge. Overall, performance for the prioritized standards was mixed, with hospitals and OHPs performing similarly; lowest performance was reported for using the GRS. Compared to 2016, facilities performed slightly better on informing physicians of procedure results and using the GRS, and slightly worse on providing patients with written information on discharge (data not shown).

Figure A: Prioritized standards: OHP, hospital and Ontario adherence, 2017[2]



[2] Data are from a self-report facility survey for which the OHP response rate was 75% and the hospital response rate was 97%. The denominator for each standard is the total number of facilities (not the total number of survey respondents). As well, self-reported data are subject to respondent interpretation and assessment.

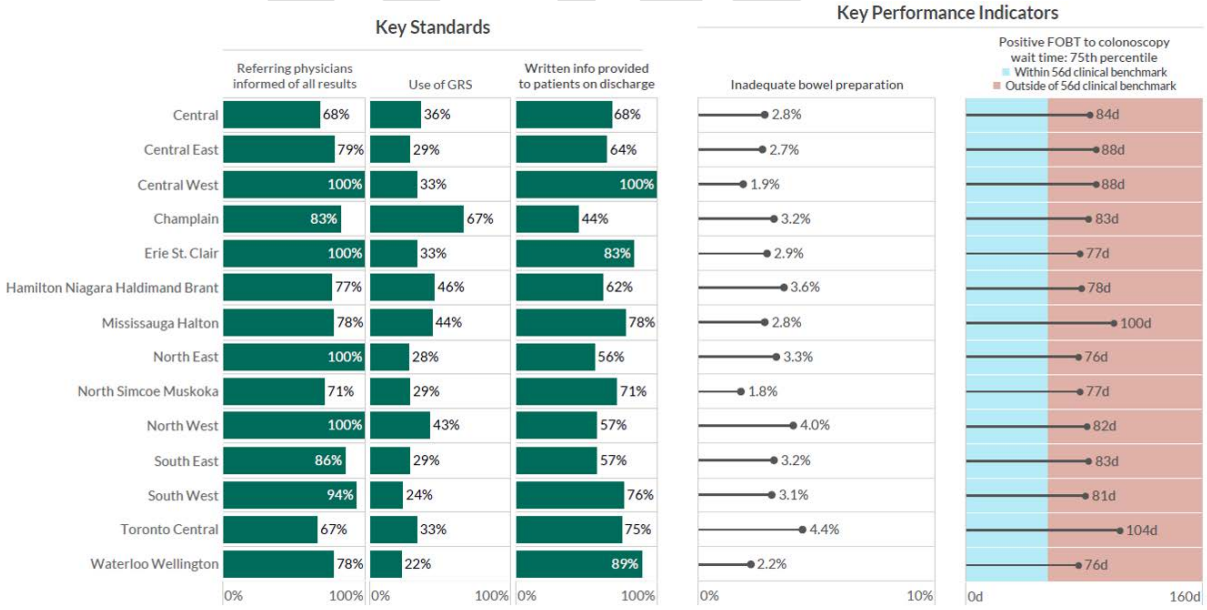
Figure B shows hospital and OHP performance for the two prioritized indicators: inadequate bowel preparation and wait times from positive fecal occult blood test (FOBT) to colonoscopy.[3] The figure shows that performance for these indicators was stable in 2015 compared to the previous year. At hospital level, the 75th percentile wait time from positive FOBT to colonoscopy ranges from 76 to 104 days, while inadequate bowel preparation ranges from 1.8% to 4.4% (data not shown).

Figure B: Prioritized indicators: OHP, hospital and Ontario performance

Positive FOBT to Colonoscopy Wait Time	75th Percentile (Days)	
	2014	2015
Hospital Total	79	83
OHP Total	63	68
Total	**75**	**78**
Inadequate Bowel Preparation	**Indicator Value (%)**	
	2015	**2016**
Hospital Total	3.3	3
OHP Total	--	--
Total	**3.3**	**3**

Figure C provides a regional summary of performance on the three prioritized standards (2017 data) and two prioritized indicators (2015 data), and shows that there is substantial regional variation in adherence and performance.

Figure C: Prioritized standards and indicators: regional summary



[3] Inadequate bowel preparation is only reported for hospitals because the data are sourced from the ColonCancerCheck Colonoscopy Interim Reporting Tool which is a hospital-based data collection tool.

Based on the selected standards and indicators shown here, endoscopy performance in Ontario is good. However, there are regional and facility variations that need to be addressed.

Mammography

Background

In Ontario, mammograms are performed by medical radiation technologists and interpreted by radiologists in hospitals and independent health facilities (IHFs). In 2017, 238 facilities provided mammography services in Ontario: 112 hospitals and 126 IHFs.

Progress on Key Priorities

The Mammography QMP continues to build on the excellent foundations for quality established by the Ontario Breast Screening Program (OBSP), as well as the CPSO's IHF Assessment Program and the Canadian Association of Radiology Mammography Accreditation Program (CAR MAP). The Mammography QMP recommends that all mammography facilities participate in the OBSP and made a number of other recommendations (e.g., that facilities be accredited by CAR MAP) that align with the OBSP and IHF assessment requirements. Like OBSP reports, Mammography QMP reports use established provincial, national and international indicators and targets.

The clinical leadership structure for the Mammography QMP has been established. To ensure alignment and reduce duplication, mammography regional clinical leads are responsible for supporting the Mammography QMP and the OBSP in their regions.

In 2016, the Mammography QMP released reports at the facility, regional and provincial levels that were sent to all facilities providing mammography in Ontario. Updated reports, with more recent data, were released in 2017. A recently completed evaluation found that there was good engagement with Mammography QMP reports, and that approximately half of respondents used the reports to engage in quality improvement activities in their facilities. However, the reports have some limitations. For example, the most robust dataset currently available for mammography reporting is obtained from the OBSP, and it only includes data on women who are screened in the program. To be able to report on all mammography and associated breast imaging, the Mammography QMP has been exploring how to expand data collection beyond the screening program. Data expansion of this scope is a complex undertaking that must be carefully planned and must proceed with stakeholder support. The Mammography QMP has been working with the OBSP to define data needs for both programs and to explore options for data collection modernization and expansion.

The Partnership led an evaluation to determine if Mammography QMP facility leads need additional training, support and/or resources to perform their roles. A project team worked with clinical experts to develop a list of activities that facility leads may be asked to perform and interviewed leads to find out whether they felt prepared to perform these activities. Most participants reported that they felt prepared to perform the activities and identified training and resource needs that could assist them. These findings have provided valuable guidance to the Partnership in developing resources to support facility leads in performing their role.

Key Report Findings

Figure D shows the percentage of OBSP screening mammograms that were identified as abnormal by radiologists in 2013 and 2014. The national target for this indicator is less than five percent for rescreens. Ten regions had an improved (lower) rate in 2014 compared to 2013. At a facility level, of the 129 facilities that had greater than 1,000 rescreens in both years,[4] 26 (20%) met the target in both 2013 and 2014 (data not shown). It is important to note that having abnormal calls higher than the target is not an Ontario-specific phenomenon; abnormal calls have been increasing in all Canadian jurisdictions and frequently exceed the target;[5] QMP will work with stakeholders to address this issue in the future. This important quality indicator should be considered in the context of the two other indicators shown here: positive predictive value and invasive cancer detection rate.

Figure D: Abnormal calls for OBSP facilities with greater than 1,000 rescreens, by Local Health Integrated Network (LHIN)

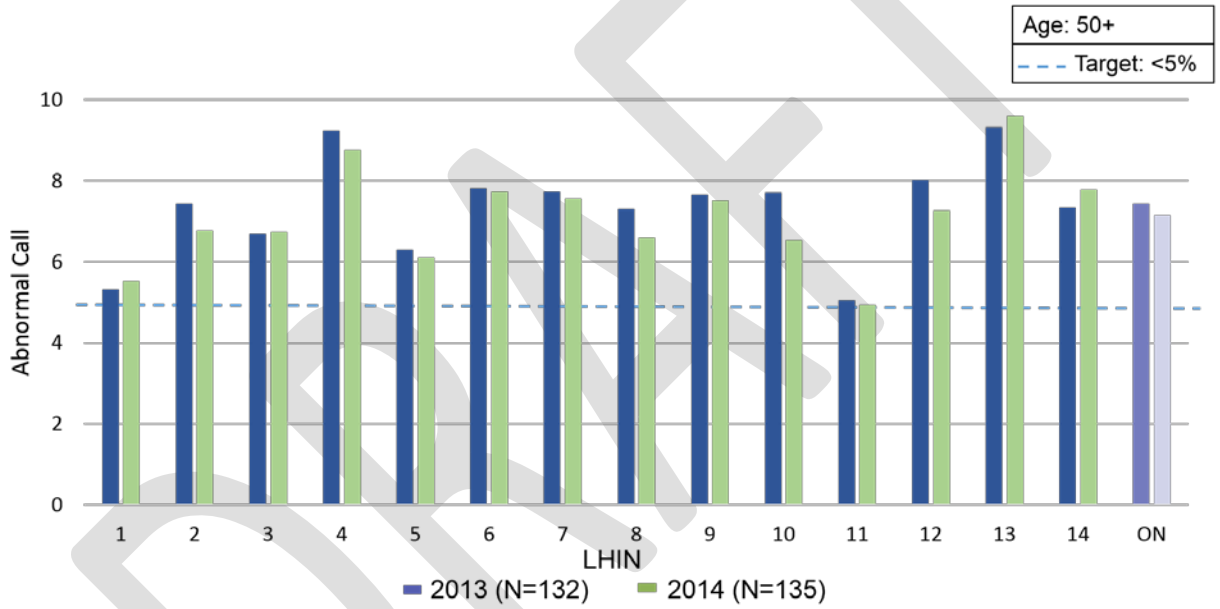


Figure E shows the positive predictive value, which is the percentage of OBSP screening mammograms with an abnormal result that were diagnosed with breast cancer (ductal carcinoma in situ or invasive breast cancer). The national target for this indicator is equal to or greater than six percent for rescreens. Most regions met the target, and the majority improved in 2014 compared to 2013. At a facility level, of the 129 facilities that had greater than 1,000 rescreens in both years, 75 (58%) met the target in 2013 and 2014 (data not shown). This indicator should be considered alongside the two other indicators shown here: abnormal calls and invasive cancer detection rate.

[4] Data are less reliable for volumes under 1,000.

[5] Canadian Partnership Against Cancer. Breast Cancer Screening in Canada: Monitoring and Evaluation of Quality Indicators - Results Report, January 2011 to December 2012. Toronto: Canadian Partnership Against Cancer; 2017.

Figure E: Positive predictive value for OBSP facilities with greater than 1,000 screens, by LHIN

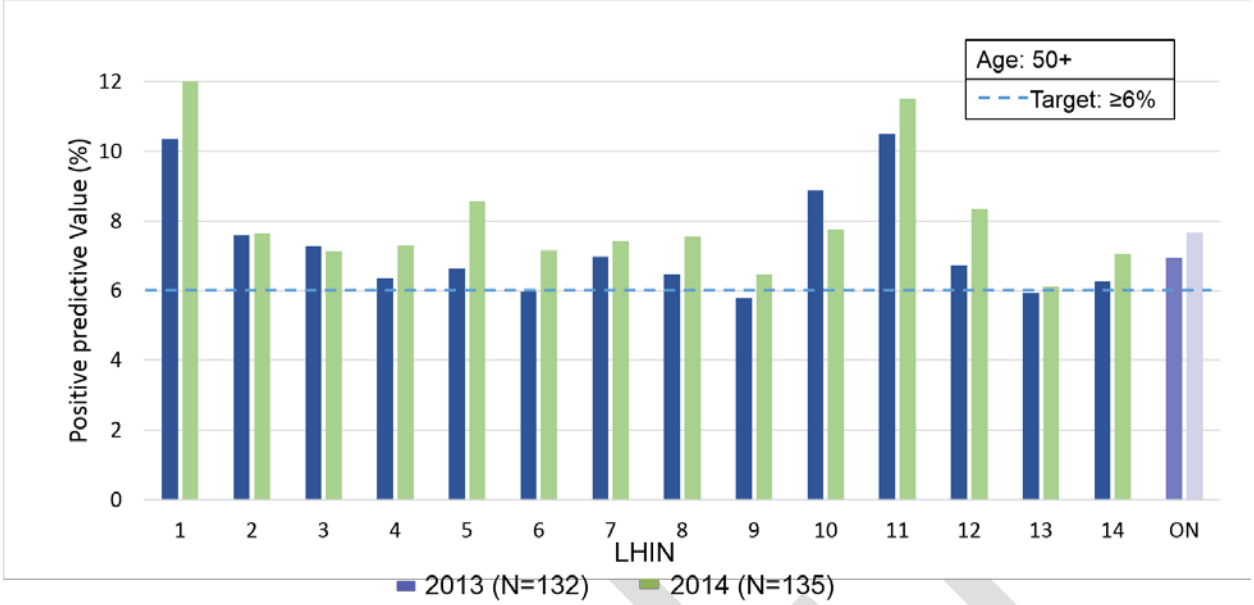
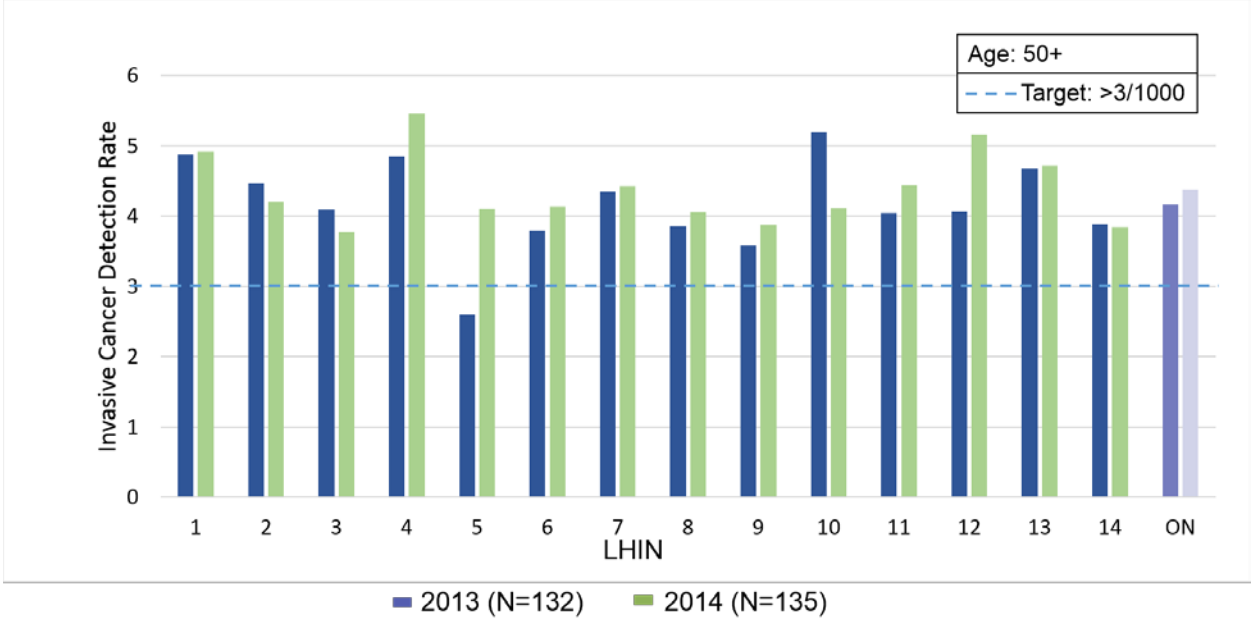


Figure F shows the rate of OBSP screening mammograms with an invasive screen-detected breast cancer per 1,000 mammograms. The national target for this indicator is greater than three per 1,000 rescreens. Most regions met the target, and the majority improved in 2014 compared to 2013. At a facility level, of the 129 facilities that had greater than 1,000 rescreens in both years, 82 (64%) met the target in both 2013 and 2014 (data not shown). This indicator should be looked at in the context of the two other indicators shown here: abnormal calls and positive predictive value.

Figure F: Invasive cancer detection rate (per 1,000 screens) for OBSP facilities with greater than 1,000 rescreens, by LHIN



These figures, taken together, show that the quality of screening mammography in Ontario is good and there are regional variations in outcomes.

Pathology

Background

The scope of the Pathology QMP is histopathology (i.e., surgical pathology), which involves the study of tissue samples for diagnostic purposes. In Ontario, diagnostic interpretation of tissue samples is done by anatomical and general pathologists in laboratories. In 2017, histopathology services were provided in 55 facilities: 50 hospitals, four community (private) laboratories and one university-based laboratory.

Progress on Key Priorities

One of the Pathology QMP's core goals is to standardize processes and decrease variability in interpretive pathology practices between laboratories, working closely with existing programs to ensure alignment across initiatives. For example, the Pathology QMP has recommended implementation of 10 prioritized standards that were based on the Standards2Quality Guidelines, developed by the Ontario Medical Association's Section on Laboratory Medicine and the Ontario Association of Pathologists, which detailed the best practice elements of a comprehensive quality management program. In addition, two working groups have been established. One group developed guidance information to assist laboratories in the operationalization of the standards, while the other is working to standardize indicator terminology, definitions and methodology. The Pathology QMP is also participating in an enterprise-wide initiative within Cancer Care Ontario to expand the use of pathology data to include non-cancer data, looking at feasibility, data governance and data quality.

The clinical leadership structure for pathology has been established. Pathology QMP regional leads were newly recruited and also have responsibilities at the facility level, as they are laboratory directors or delegated pathologists who have quality oversight as part of their portfolio.

In 2016, the Pathology QMP released reports at the facility, regional and provincial levels that were sent to all facilities providing surgical pathology in Ontario. These reports were based on self-reported survey data about compliance with the prioritized standards. An evaluation of the reports showed that the majority of respondents found them easy to understand, and many used the reports to contribute to quality improvement plans. Updated reports were released in 2017, and contained the same prioritized standards as the 2016 reports in order to allow comparison over time. The 2017 reports also highlighted self-reported barriers to implementation in facilities that did not have a standard in place. This information was collected in order to help facilities and the Pathology QMP to understand the obstacles facing laboratories in implementing standards.

Preliminary data on challenges related to the uptake of standards and sustainability were also collected, including information on laboratory information systems, decision and administrative support, and workload measurement. The results were not part of the formal 2017 QMP reports, but were summarized in the document *2017 Pathology Quality Management Program Report and Supplementary Data* and were shared with facilities in order to help clinical and administrative leads understand local and regional pressures. They are also being used by the Pathology QMP to learn more about the context in which pathology services are delivered in Ontario.

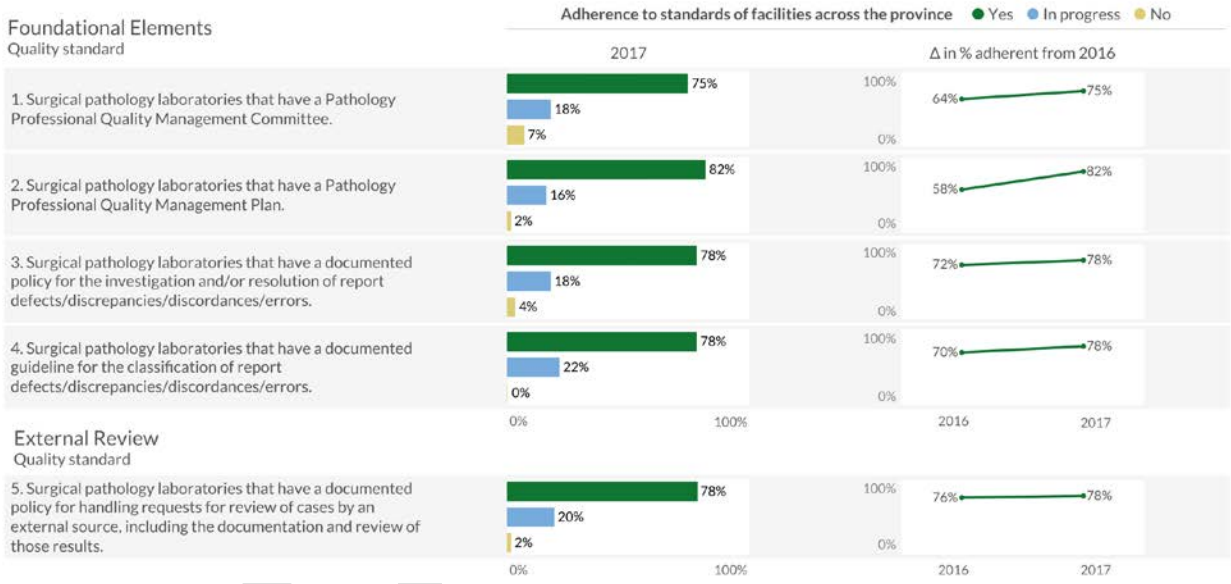
In 2016, the Pathology QMP developed and released a toolkit of resources to support implementation of the 10 prioritized standards. The toolkit included information taken from Standards2Quality, as well as samples of templates, policies and plans used in Ontario hospital laboratories and private community laboratories that have already adopted the standards. The toolkit, which is available on LearnQMP, was updated and re-released in June 2017. Other quality initiatives include recommendations about safety aspects of laboratory release of tissue to patients, which were made available to pathology QMP leads on LearnQMP. Recommendations about opportunities to streamline practices related to tissue handling were also completed.

Key Report Findings

The following figures highlight some of the findings from the 2016 and 2017 reports.

Figure G shows the proportion of Ontario facilities adherent to each of the 10 standards and how this has changed since 2016. There was an increase in self-reported adherence across all 10 standards in 2017.

Figure G: Adherence to prioritized standards, Ontario, 2017



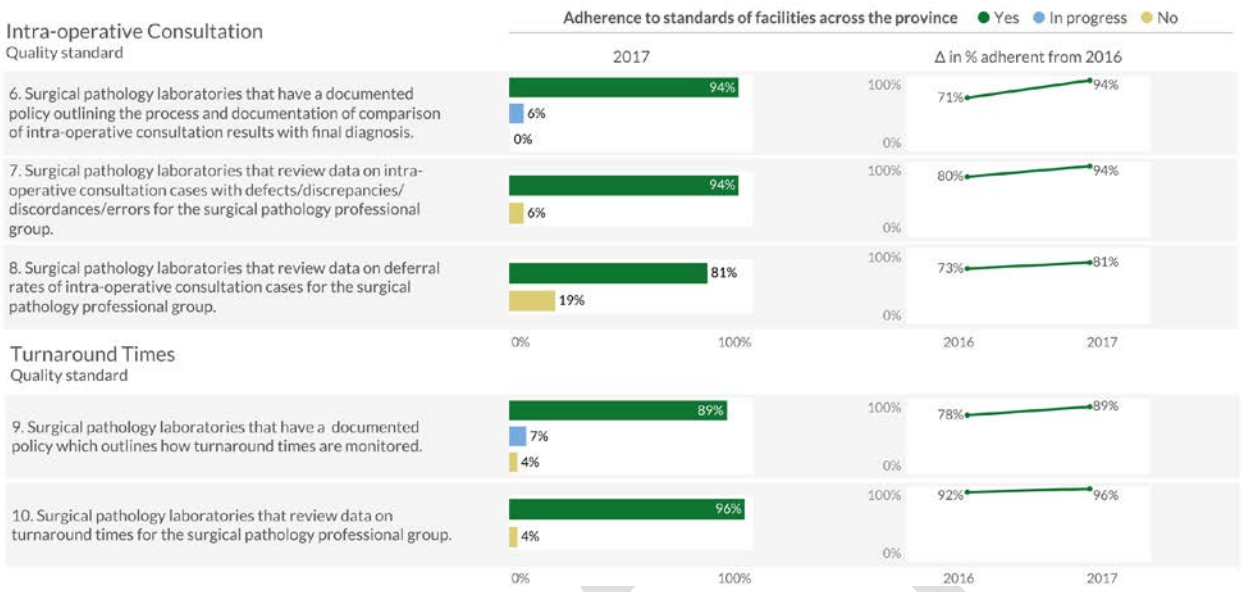
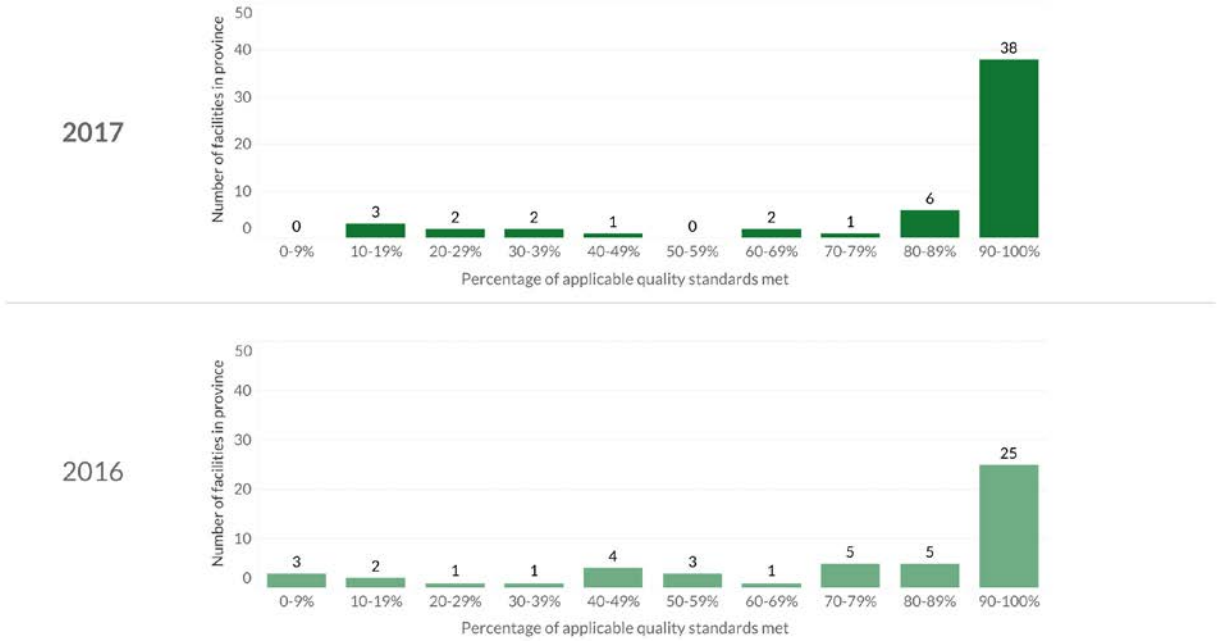


Figure H compares the percentage of overall adherence to the prioritized standards in 2016 and 2017. This figure shows that there has been progress since 2016.

Figure H: Percentage of prioritized standards met, Ontario, 2016 and 2017



These data show that the majority of pathology laboratories have internal processes in place to ensure high quality and are monitoring data for timeliness and intra-operative consultation discordance and deferral rates.

Looking Ahead

This report highlights some of the progress the Partnership has made in implementing QMPs for colonoscopy, mammography and pathology in Ontario. The Partnership would like to acknowledge that this progress would not have been possible without the active engagement of physicians and other health professionals who provide colonoscopy, mammography and pathology services; administrators and executives working in hospitals, IHFs and OHPs; and Cancer Care Ontario's Regional Cancer Program executives and staff. The Partnership would like to highlight that our progress also reflects, and builds upon, work that is ongoing at the local, regional and provincial levels across the healthcare system to improve performance and quality.

The QMPs are exploring how they can collaborate to move quality forward across health service areas. For example, the Colonoscopy and Pathology QMPs have been developing recommendations around polypectomy clinical history requirements and pathology reporting. The Mammography and Pathology QMPs have begun investigating how to improve breast radiology-pathology correlation through standardized reporting requirements.

Looking forward, the Partnership will continue to release reports for each QMP in order to show where progress is being made and where efforts need to be focused in order to further improve. The Partnership will continue to evaluate and improve reports, and develop tools and supports to assist facility and regionals leads, healthcare professionals and other personnel in facilities, to engage in quality improvement initiatives. Newly developed resources include physician and facility improvement plans and training for regional and facility leads in providing peer feedback. Resources like these will be especially useful as the Partnership moves to include physician-level reporting in all health service areas.

The Partnership is committed to public reporting in the future and is working with the Citizens' Advisory Committee and system leaders to develop plans to report publicly. The Citizens' Advisory Committee is actively engaged in identifying what is meaningful to report to the public, and will continue to co-develop the content and design of publicly reported information to ensure it is tailored to users' needs. Ongoing discussions with Health Quality Ontario and the Ministry of Health and Long-Term Care will help ensure an integrated approach to public reporting to ensure that the Partnership's publicly reported content can be accessed centrally by the public.

Thank you to everyone who is working with us to improve the consistency of care in colonoscopy, mammography and pathology. We look forward to continuing to work closely with you to achieve consistent, high-quality care in the three health service areas across the province.

This report was developed with the support of Ontario's Ministry of Health and Long-Term Care. The views expressed in this report are those of Cancer Care Ontario, the College of Physicians and Surgeons of Ontario and the Quality Management Partnership and do not necessarily reflect those of the Ministry of Health and Long-Term Care or the Government of Ontario.

Parts of this report are based on data and information provided by the Institute for Clinical Evaluative Sciences, which is funded by an annual grant from the Ministry of Health and Long-Term Care. The analyses, conclusions, opinions and statements expressed herein are those of the author(s), and not necessarily those of Institute for Clinical Evaluative Sciences and funding sources. No endorsement by the Institute for Clinical Evaluative Sciences or the Ministry of Health and Long-Term Care is intended or should be inferred.

Parts of this material are based on data and information compiled and provided by the Canadian Institute for Health Information. However, the analyses, conclusions, opinions and statements expressed herein are those of Cancer Care Ontario, the College of Physicians and Surgeons of Ontario and the Quality Management Partnership, and not necessarily those of Canadian Institute for Health Information.

Discipline Committee
Report of Completed Cases – February 2018

This report covers discipline cases completed (i.e., the written decision and reasons on finding and, if applicable, penalty have been released) between November 10, 2017 and February 2, 2018. The decisions are organized according to category, and then listed alphabetically by physician last name.

Sexual Abuse - 1 case

1. Dr. R. N. Morzaria

Name:	Dr. Rasiklal Narshidas Morzaria
Practice:	Pediatrics
Practice Location:	Scarborough
Hearing:	Uncontested Facts and Unopposed Penalty
Finding Decision Date:	September 11, 2017
Penalty/Written Decision Date:	November 10, 2017

Allegations and Findings

- Sexual abuse of a patient – **proved**
- Disgraceful, dishonourable, or unprofessional conduct – **proved**

Summary

Sexual Abuse of Patient A during Regular Office Appointments

Dr. Morzaria treated Patient A from the time Patient A was six years old until he was twelve.

When Patient A and his mother attended at Dr. Morzaria's office for appointments, Dr. Morzaria would often ask Patient A's mother to wait outside the examination room, claiming that Patient A was old enough to be seen alone. When alone with Patient A, Dr. Morzaria touched, rubbed/stroked and played with Patient A's penis. Dr. Morzaria would ask Patient A if it felt good, and tell him to come visit him on week-ends. When Patient A's mother was in the room, Dr. Morzaria would usually just check Patient A's genitals to follow up on a prior medical procedure.

At one appointment, while Patient A's mother was outside the examination room, Dr. Morzaria took his penis out of his pants and asked Patient A to suck it. Patient A refused, but was scared. Dr. Morzaria told Patient A he was an undercover cop and that if he told anyone what was happening, he and his family would spend the rest of their lives in jail, which made Patient A afraid to tell his parents.

Sexual Abuse of Patient A during Weekend Visits to Dr. Morzaria's Office

Dr. Morzaria would sometimes pick Patient A up at his home and drive him to the office on the weekends, when there were no staff members present. To arrange these visits, Dr. Morzaria would call the family home and speak to Patient A and his mother. Patient A's mother agreed to these outings, which Dr. Morzaria had offered on his own initiative, as Dr. Morzaria was a doctor and she trusted him. Patient A felt he had to go, because he believed Dr. Morzaria was an undercover cop.

During one weekend visit, Dr. Morzaria showed Patient A a magazine or a book with pictures of private parts and stroke Patient A's thigh. On other occasions, Dr. Morzaria made Patient A sit on his lap, and once, while Patient A was on his lap, he asked Patient A for a kiss. Patient A felt like he had no choice when Dr. Morzaria made him sit on his lap.

At one week-end visit, when Patient A's sibling was with him, Dr. Morzaria grabbed Patient A by his arm and tried to take him into another room. Dr. Morzaria did not let Patient A go until Patient A said he would scream. At another appointment, Patient A cried, and Dr. Morzaria took him home.

On the way to his office on weekend visits, Dr. Morzaria took Patient A to the drive-through at Burger King and bought him food. He told Patient A to keep his head down, and to say that he was Dr. Morzaria's grandson if asked. Dr. Morzaria promised Patient A a laptop and computer games for visiting him, and later gave Patient A and his family a computer and a laptop.

Patient A's Disclosure of the Abuse

At his last appointment, Patient A refused to allow Dr. Morzaria to examine him below the waist. After this appointment, Patient A's mother became suspicious and asked Patient A repeatedly about why he seemed to be acting differently with Dr. Morzaria. Shortly thereafter, Patient A disclosed to his mother that Dr. Morzaria had sexually abused him. Patient A and his mother terminated the doctor-patient relationship with Dr. Morzaria.

Dr. Morzaria's Interference with Police Investigation

Dr. Morzaria called Patient A's house after the matter was reported to the police, and tried to dissuade Patient A's mother from pursuing her complaint with threats of publicity for her family.

Disposition

On September 11, 2017, the Committee ordered and directed on the matter of penalty and costs that:

- the Registrar revoke Dr. Morzaria's certificate of registration effective immediately.
- Dr. Morzaria 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, in the amount of $16,060.00, within thirty (30) days of the date of this Order.
- Dr. Morzaria appear before the panel to be reprimanded.
- Dr. Morzaria pay costs to the College in the amount of $27,500.00, within thirty (30) days of the date of this Order.

Found Guilty of Offence Relevant to Suitability to Practise – 1 case

1. Dr. A.M. Galea

Name:	Dr. Anthony Michael Galea
Practice:	Sports Medicine
Practice Location:	Toronto
Hearing:	Agreed Facts and Contested Penalty
Finding Decision Date:	July 6, 2017
Penalty Decision Date:	December 6, 2017
Written Decision Date:	December 6, 2017

Allegations and Findings

- Found guilty of offence relevant to suitability to practise – **proved**
- Disgraceful, dishonourable and unprofessional conduct – **proved**

Summary

On July 6, 2011, Dr. Galea, a sports medicine physician, pleaded guilty and was convicted by the U.S District Court for the Western District of New York for introducing misbranded drugs into interstate commerce with intent to mislead an Agency.

Between February 2007 and September 2009, Dr. Galea lived and was a physician licensed to practise medicine in Ontario. He was not licensed to practise medicine in the United States. Dr. Galea operated a medical practice in Etobicoke known as the Institute of Sports Medicine Health and Wellness Centre (ISM).

Dr. Galea traveled from Canada to the United States on numerous occasions to treat patients there, knowing he was not licensed to practise anywhere in the United States. Sometimes Dr. Galea was accompanied by an ISM employee to assist him; sometimes he and the employee traveled separately and Dr. Galea met the employee in the United States; and on other occasions Dr. Galea traveled to the United States alone and treated patients in the United States without the employee being present.

Dr. Galea treated professional athletes in the United States, including players on National Football League and Major League Baseball teams.

On numerous occasions, Dr. Galea and the employee entered the United States at the Peace Bridge Port of Entry in Buffalo, New York. Other times, Dr. Galea flew from Toronto to various American cities. On some occasions, Dr. Galea traveled within the United States to different places to provide medical treatments to professional athletes.

When Dr. Galea and the employee traveled separately to the United States, the employee carried medical supplies in accordance with a checklist she prepared based on Dr. Galea's instructions, which included Nutropin, Actovegin, ATP, ginseng, Celebrex, IV tubing, a centrifuge, plasma kits, and sterile gloves.

Dr. Galea and the employee understood that if she was asked by U.S. border officers about the purpose for her entry into the United States with the medical supplies, she would respond that she was attending a medical conference where Dr. Galea would speak and demonstrate the use of medical supplies. Dr. Galea and the employee knew, however, that on the majority of the occasions they came to the United States, their only purpose for coming to the United States was to provide medical treatments to Dr. Galea's patients. Some of the medical supplies Dr. Galea and the employee brought into the United States for these treatments, including Nutropin and Actovegin, were misbranded drugs within the meaning of U.S. law.

The following is a list of treatments Dr. Galea provided to his patients while in the United States:

- Anti-inflammatory -IVs, i.e., intravenous treatments involving a mixture containing Actovegin (a substance derived from calf's blood), and Adenosine Triphosphate (ATP), Traumeel, magnesium, calcium, vitamins C, B- 1.00, B-6, and Glutathiome;
- Plasma Rich Platelet ("PRP") treatments, which involved extracting blood from patients, spinning the blood in a centrifuge to separate the plasma from the red blood cells, and re-injecting the plasma into the patients for the purpose of accelerating the healing process.
- Injections containing a mixture of substances including Actovegin, Traumeel, Vitamin B-12 and (in the case of chronic injuries) Zeel, as treatment for injured muscles; and
- Injections containing a mixture of substances including Nutropin, a human growth hormone (HGH) produced by recombinant DNA technology, Traumeel, Procaine, Zeel, and vitamin B-12 injected into the knee and given for the purpose of treating joint inflammation.

While in the United States, Dr. Galea also from time to time distributed and administered substances such as ATP for intramuscular injections. Items used for intramuscular injections were labeled in languages other than English.

Prescription items distributed by Dr. Galea, including Nutropin, did not bear the "RX only" symbol required by U.S. 1aw and U.S. Food and Drug Administration (FDA) regulations. Under U.S. law and FDA regulations, substances intended for use in the treatment of disease are "misbranded" if they are not approved by the FDA and labeled in the English language. The forms of Actovegin used as ingredients in the anti-inflammatory IVs and in the injections for injured muscles were not labeled in English but instead were labeled in German or Russian.

Nutropin was not approved by the FDA for the uses intended by Dr. Galea. Actovegin was not approved by the FDA for any use.

Dr. Galea administered medical treatments in the United States in such places as the homes of patients and in hotel rooms. The cost of the treatments, travel, lodging, and other expenses for Dr. Galea and the employee were charged to the patients. The amount Dr. Galea charged to the patients during the aforementioned time period was approximately $800,000.00. For the purposes of the Plea Agreement, Dr. Galea and the U.S. government agreed that the value of the substances provided to the patients which contained unapproved and/or misbranded substances exceeded $30,000.00 but did not exceed $70,000.00.

On or about August 27, 2009, Dr. Galea and the employee traveled to the United States separately. The employee entered the United States at the Peace Bridge and Dr. Galea traveled to the United States from Toronto by air. The purpose of Dr. Galea's entry into the United States was to provide medical treatments to several athletes.

On September 14, 2009, on Dr. Galea's instructions, the employee attempted to enter the United States at the Peace Bridge in Buffalo to meet Dr. Galea in Washington D.C., where Dr. Galea was to provide medical treatment to a professional athlete. Dr. Galea was flying directly from Toronto. The employee was referred to secondary inspection. During secondary inspection, the employee told an Officer from the Department of Homeland Security, Customs and Border Protection (CBP), that she was traveling to Washington, D.C. to attend a medical conference with her employer, Dr. Galea. The employee further stated to the CBP Officer that she had items intended for display at the medical conference. The employee made these statements pursuant to an understanding she had with Dr. Galea that she would falsely tell U.S. border personnel that she and Dr. Galea would be attending a medical conference in the United States. A duffle bag in her vehicle contained medical items including needles, over one hundred syringes, a medical centrifuge, numerous bottles, including a bottle of Nutropin and bottles of Actovegin, 20 vials and 76 ampoules of drugs not properly branded in contravention of U.S. Regulations, and a diagnostic ultrasound computer.

As a result of the above conduct, the employee was arrested and charged in the United States. The employee pleaded guilty in the United States District Court to making a false statement to a federal agent, and was convicted of a felony criminal offence. On July 25, 2011, she was sentenced to one year probation. She is unable to travel to the United States without permission.

On December 16, 2011, Dr. Galea was sentenced to time served, namely the day of his voluntary surrender to U.S. authorities, during which he had not been in detention, and supervised release for one year on the terms set out in the Judgment.

Disposition

On December 6, 2017, the Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Galea's certificate of registration for a period of nine (9) months, effective immediately.
- Dr. Galea appear before the Committee to be reprimanded within 60 days of the date of this Order.
- Dr. Galea pay to the College costs in the amount of $21,500.00 within 60 days of the date of this Order.

Disgraceful, Dishonourable, or Unprofessional Conduct - 5 cases

1. Dr. P.B. Cote

Name:	Dr. Peter Bernard Cote
Practice:	Family Medicine
Practice Location:	Thunder Bay
Hearing:	Agreed Facts and Joined Submission Penalty
Finding/Penalty Decision Date:	December 8, 2017
Written Decision Date:	January 3, 2018

Allegations and Findings

- Disgraceful, dishonourable, or unprofessional conduct – **proved**

Summary

Dr. Cote is a family medicine specialist who, during the relevant period of time, was practising in Manitouwadge, District of Thunder Bay. He graduated from McGill University's medical school in 1988 and was granted a certificate of registration authorizing independent practice from the College of Physicians and Surgeons of Ontario ("the College") in September 1990. Dr. Cote held hospital privileges at the Manitouwadge General Hospital.

<u>Physician Health Program</u>

On November 14, 2012, Dr. Cote entered into a 3-year monitoring contract with the Physician Health Program ("PHP") as resolution to an incapacity matter. On June 4, 2014, the College received a monitoring report from Dr. Cote's PHP Case Manager outlining concerns with respect to Dr. Cote's adherence to the contract, including one

missed urine screen; one positive urine screen and insufficient attendance with his treating clinician.

Undertaking with the College

This information led to Dr. Cote entering into an Undertaking with the College in November 2014, whereby he agreed that if he failed to comply with his PHP Contract "…such action may constitute a breach of this undertaking, and an act of professional misconduct."

On January 2, 2015, the College received the PHP's second annual report, stating that Dr. Cote had breached terms of his contract, including through supplementing prescription medicine with samples from his office when he ran out of his prescription medications.

Termination of PHP Contract

On June 18, 2015, information was received from the PHP that Dr. Cote failed to abide by the terms of his undertaking to this PHP, including missed appointments with his primary monitor on March 10 and April 13, 2015; no response to attempts to re-establish contact and failure to follow through with a referral to a therapist. Dr. Cote did not reach out to his family doctor or the PHP Clinical Coordinator when he experienced a reoccurrence of some of his mental health symptoms. Due to continued non-compliance with the PHP monitoring agreement, the PHP suspended and subsequently terminated Dr. Cote's contract.

Cease to Practice

On March 25, 2017, in the context of an incapacity investigation, Dr. Cote signed a Cease to Practice undertaking.

Disposition

On December 8, 2017, the Committee ordered and directed that:

- Dr. Cote appear before the panel to be reprimanded.
- Dr. Cote pay costs to the College in the amount of $5,500.00 within thirty (30) days of the date of this Order.

2. Dr. K.M. Kaveri Selvan

Name:	Dr. Kaveri Manian Kaveri Selvan
Practice:	General/Family Medicine
Practice Location:	Markham
Hearing:	Uncontested Facts and Joined Submission Penalty
Finding/Penalty Decision Date:	November 6, 2017
Written Decision Date:	December 20, 2017

Allegations and Findings

- Disgraceful, dishonourable, or unprofessional conduct – **proved**

Summary

Dr. Kaveri Selvan received his certificate of registration authorizing independent practice from the College of Physicians and Surgeons of Ontario ("the College") in February, 2011. Between August, 2011 and July 2012, he practised part-time at the Bur Oak Medical Centre ("BOMC").

Disgraceful, Dishonourable, or Unprofessional Conduct

In the late evening of November, 2012, Dr. Kaveri Selvan returned home from work to find out that a family member had unexpectedly left the family home with his two young children. Dr. Kaveri Selvan was advised that to secure the return of his children, he would need to bring a motion before family court and provide support for his position that the children should be placed in his care and custody.

The next day, Dr. Kaveri Selvan went to BOMC and showed the assistant on duty photographs on his phone of his family member's consultation report prepared by her treating specialist at the hospital. Dr. Kaveri Selvan asked if there was a copy of this report in the family member's BOMC chart. He was advised that the family member's chart did not contain a copy of the report.

Without her consent, Dr. Kaveri Selvan then requested the family member's records and signed his own name above the line that says "Signature of Patient" on the requisition form. The requisition was subsequently faxed to the hospital by BOMC.

Dr. Kaveri Selvan left BOMC with copies of some records from the family member's BOMC chart, containing her personal health information. He did not have the family member's consent to receive her records from the hospital or BOMC. He did not return to BOMC to retrieve copies of the hospital records that were the subject of the requisition he had signed.

On the same day, Dr. Kaveri Selvan also requested and received a copy of his family member's prescription history from the Bur Oak Discount Pharmacy without her consent.

On the following day, Dr. Kaveri Selvan filed an emergency motion in the family court seeking the return of his children and attached copies of the family member's medical records he received from BOMC and from the pharmacy. He did not have the consent of the family member to file these records with the court. He was not represented by a lawyer at the time. Dr. Kaveri Selvan was initially not successful in securing the return of his children, despite his motion and continued proceedings before the court.

Dr. Kaveri Selvan subsequently obtained a letter from BOMC, dated November 16, 2012, including information about his family member, which was written on BOMC's primary physician's letterhead, bearing the primary physician's stamp and what appeared to be the primary physician's signature. He did not have the consent of the family member to obtain this letter.

In the next two months, Dr. Kaveri Selvan brought a new motion before the court for the return of his children and included copies of the family member's medical and pharmacy records and a copy of the November 16, 2012 letter. He did not have the consent of the family member to file these records with the court.

Pursuant to court orders, custody of Dr. Kaveri Selvan's children alternated between Dr. Kaveri Selvan and the family member in 2013. In March, 2014, the court granted Dr. Kaveri temporary sole custody of the children. The court's order remains in force. While Dr. Kaveri's paramount concern at the time was the safety of his children, he acknowledges his actions should have respected the family member's privacy in her personal health information.

Disposition

On November 6, 2017, the Committee ordered and directed on the matter of penalty and costs that:

- The Registrar suspend Dr. Kaveri Selvan's certificate of registration for two (2) months, commencing December 1, 2017.
- Dr. Kaveri Selvan, at his own expense, participate in and successfully complete, within six (6) months of the date of this Order, the following program:
    - Individualized instruction in medical ethics satisfactory to the College, with an instructor selected by the College.
- Dr. Kaveri Selvan appear before the panel to be reprimanded.
- Dr. Kaveri Selvan pay costs to the College for a one day hearing in the amount of $5,500.00 within 30 days of the date of this Order.

3. Dr. T.R. Mayberry

Name:	Dr. Thomas Richard Mayberry
Practice:	Family Medicine
Practice Location:	Ingersoll
Hearing:	Agreed Facts and Joined Submission Penalty
Finding/Penalty Decision Date:	November 15, 2017
Written Decision Date:	December 12, 2017

Allegations and Findings

- Disgraceful, dishonourable, or unprofessional conduct – **proved**

Summary

Dr. Mayberry is a family physician practising in Ingersoll, Ontario. He received his certificate of registration authorizing independent practice from the College of Physicians and Surgeons of Ontario ("the College) in 1975 and holds privileges at the Alexandra Hospital, the Tillsonburg District Memorial Hospital and the Woodstock General Hospital.

On July 17, 2012, Dr. Mayberry signed an Undertaking, relinquishing his prescribing privileges with respect to narcotics, narcotic preparations, controlled drugs, and benzodiazepines.

2015 Prescribing of Alprazolam

The College obtained Narcotics Monitoring System ("NMS") data in relation to Dr. Mayberry for the period from May 22, 2014 to February 10, 2016 which revealed that two prescriptions for Alprazolam 0.5 mg, 90 tablets, were issued on April 9, 2015 and on September 29, 2015, respectively, to Patient A. The prescriptions were obtained from the pharmacy.

Dr. Mayberry breached his Undertaking with the College as Alprazolam is a Benzodiazepine, a category of drugs that Dr. Mayberry is prohibited from prescribing.

2015 Inquiries Complaints and Reports Committee ("ICRC") Caution

The facts in relation to penalty stated that in 2014, the College received Narcotics Monitoring System ("NMS") information which revealed that Dr. Mayberry had prescribed contrary to his undertaking on seven occasions, including the following substances: Morphine, Oxycodone, Pentazocine, Ativan, Tylenol 3, Adderall and Concerta.

On September 23, 2015, the ICRC considered the information and required Dr. Mayberry to attend the College to be cautioned in person with respect to this repeated prescribing of controlled substances in breach of his Undertaking with the College.

2016 Investigation

In response to the 2016 Investigation, Dr. Mayberry acknowledged that an error had occurred and that he was disappointed that the error occurred. There is no information with respect to any breaches of Dr. Mayberry's Undertaking between September 29, 2015 and the present.

Closure of Family Practice

Dr. Mayberry intends to close his family practice on December 1, 2017. Following that time, Dr. Mayberry intends to provide anesthetic services 2-3 times per week at a local hospital. He has found a physician to take over his family practice effective December 1, 2017.

Disposition

On November 15, 2017, the Committee ordered and directed that:

- the Registrar suspend Dr. Mayberry's Certificate of Registration for a two month period, effective December 1, 2017.
- the Registrar impose the following terms, conditions and limitations on Dr. Mayberry's Certificate of Registration:
  - Dr. Mayberry will successfully complete one-on-one instructions in medical ethics with an instructor approved by the College, at his own expense, within six months of the date of this Order.
- Dr. Mayberry appear before the panel to be reprimanded.
- Dr. Mayberry pay costs to the College in the amount of $5,500.00 within thirty (30) days of the date of this Order.

4. Dr. I.S. Rosenhek

Name:	Dr. Israel Shoel Rosenhek
Practice:	Cardiology
Practice Location:	Toronto
Hearing:	Uncontested Facts and Joined Submission Penalty
Finding/Penalty Decision Date:	October 11, 2017
Written Decision Date:	December 11, 2017

Allegations and Findings

- Disgraceful, dishonourable, or unprofessional conduct – **proved**
- Failure to maintain standards of practice of the profession – **withdrawn**
- Incompetence - **withdrawn**

Summary

Dr. Rosenhek is a cardiologist with a practice in Toronto, Ontario. Prior to 2016, he also had a practice in Windsor, Ontario.

2010 Discipline Committee Order

On November 8, 2010, the Discipline Committee found that Dr. Rosenhek had committed an act of professional misconduct in that he failed to maintain the standard of practice of the profession in cardiology between 2005 and 2007 in his care of multiple patients by:

- failing to appropriately manage cardiac risk factors, such as dyslipidemia, and to prescribe appropriate therapy to reduce such risk;
- failing to perform indicated investigations;
- failing to diagnose medical conditions appropriately and in a sufficiently timely manner;
- failing to appropriately monitor and/or ensure monitoring of complications of medications;
- failing to monitor and act upon test results in an appropriate and sufficiently timely manner;
- failing to engage in appropriate discharge planning for patients in the hospital, including failing to make appropriate and necessary arrangements for care and follow-up; and/or
- failing to maintain legible and sufficiently detailed records of his care and treatment of patients.

The Discipline Committee ordered that the Registrar impose the following terms, conditions and limitations on Dr. Rosenhek's certificate of registration for an indefinite period of time:

- Dr. Rosenhek shall practise only under the supervision of a Clinical Supervisor retained at his own expense and approved by the College, and will abide at his own expense by all recommendations of his supervisor with respect to his practice, including with respect to any practice improvements and/or ongoing professional development and/or education;
- If, at any time after 24 months have passed since the commencement of the clinical supervision of his practice, Dr. Rosenhek's clinical supervisor is of the opinion that Dr. Rosenhek is ready to practice without clinical supervision, such clinical supervision shall be discontinued only upon:
    - an assessment of Dr. Rosenhek's practice, undertaken by a College-appointed assessor at Dr. Rosenhek's expense, the results of which are satisfactory to the College; and
    - the approval of the College [emphasis add.

Terms of Clinical Supervision

As a result of the November 8, 2010 Discipline Committee Order, Dr. Rosenhek engaged a Clinical Supervisor, who undertook to act as Clinical Supervisor for Dr. Rosenhek, for the duration of at least 24 months. After 3 months of clinical supervision, the level of supervision could be varied at Clinical Supervisor' discretion and with the approval of the College, provided that clinical supervision continued for at least 24 months in total. The Clinical Supervisor agreed to submit a written report to the College on a monthly basis for the duration of the clinical supervision.

The Clinical Supervisor further agreed that at any time after 24 months, if he is of the opinion that Dr. Rosenhek is ready to practise without clinical supervision, he shall advise the College of this so that the College may arrange for a practice reassessment to be conducted by an assessor of its choice. In such a case, the clinical supervision was not to terminate unless and until: (a) the College receives, evaluates, and is satisfied by the results of the practice reassessment; and (b) the College provides its approval for the termination of clinical supervision of Dr. Rosenhek's practice.

Clinical Supervision and Breach of the 2010 Discipline Committee Order

The Clinical Supervisor provided the College with supervision reports during the period from January 14, 2011 to August 15, 2014.

On May 16, 2011, the Clinical Supervisor recommended that the number of patient charts reviewed per week be reduced from 10 to 5. The College agreed to this change on May 31, 2011. This was the only variation of the terms of Dr. Rosenhek's clinical supervision for which permission was sought from the College, and the only variation approved by the College.

On December 8, 2011 and on June 20, 2012 the College advised the Clinical Supervisor that his reports did not contain enough information to determine whether Dr. Rosenhek was practising within the standard of practice, and requested that his future reports contain more fulsome information.

On September 6, 2012, the Clinical Supervisor reported that Dr. Rosenhek has made tremendous improvements in his practice and that he is at the point to practise without clinical supervision. The College responded on October 15, 2012, indicating that pursuant to the Discipline Committee Order, the 24-month period of clinical supervision is calculated from the time the supervision commences, and, therefore, the earliest date on which Dr. Rosenhek's supervision could potentially end is on a date after November 2012.

On January 10 and April 11, 2013 respectively, the Clinical Supervisor reported that in his opinion the chart reviews could be eliminated and that he believes that it would be appropriate to end this ongoing review.

The College responded on June 13, 2013, indicating that pursuant to the Discipline Committee Order, the clinical supervision must continue until Dr. Rosenhek undergoes reassessment by the College and the discontinuation of the supervision is approved by the College following a review of the assessor's report. The College informed the Clinical Supervisor that the review was being arranged and that it could take six months to complete, during which time he was to provide supervision of Dr. Rosenhek's practice, until the College approves discontinuation of supervision.

The College was in correspondence with Dr. Rosenhek from July 2013 to March 2014 in an attempt to schedule practice reassessment. Dr. Rosenhek's practice reassessment proceeded in March 2014.

On April 9, 2014 and on April 11, 2014, the Clinical Supervisor reported to the College that he has provided clinical supervision of Dr. Rosenhek's practice since November 2010, and that it was his understanding that the supervision would last for 24 months, until November 2013. He indicated that he had no concerns with Dr. Rosenhek's practice, that there is no further value in continuing to do reviews of Dr. Rosenhek's records, and that he believes that he had completed his initial agreement with the College.

On April 9, 2014, the College wrote to the clinical supervisor, indicating that Dr. Rosenhek is expected to practise under supervision until his practice reassessment is completed, that Dr. Rosenhek is currently in the process of submitting the information required for the reassessment and to continue to provide supervision as per his undertaking until the reassessment is completed and the College communicates approval of its discontinuation. On July 30, 2014, the College wrote to the Clinical Supervisor to provide him with templates for his future reports and requesting that he completed and submitted the reports each month.

The Clinical Supervisor's last supervision report dated July 16, 2014 was received by the College on August 15, 2014. On August 25, 2014, the College wrote to the Clinical Supervisor requesting him to submit the August 2014 report, but no response was received.

Following the College's inquiry during the practice reassessment as to whether Dr. Rosenhek's practice is still under the clinical supervision as per the 2010 Discipline Committee's Order, Dr. Rosenhek's counsel informed the College on October 8, 2015 that the Clinical Supervisor had not received the College's letter of August 25, 2014 and that the Supervisor was of the understanding that no further reports were required of him, and that he advised Dr. Rosenhek that ongoing supervision was not required as he had fulfilled his undertaking. Dr. Rosenhek's counsel further indicated that the Clinical Supervisor now recognizes that he wrongly interpreted his obligations under his undertaking and that he regrets his error.

On October 3, 2017, Dr. Rosenhek advised the College that following the College's letter of September 15, 2015, he has sent copies of his patient charts to the Clinical Supervisor for the period from August 2014 to August 2015, and that he continued to periodically provide his records from September 2015 until approximately March 2016.

After July 2014, Dr. Rosenhek continued to practise medicine without supervision, in breach of the requirements in the 2010 Discipline Committee Order; he did not meet and did not follow-up with the Clinical Supervisor to determine if he was reviewing the patient charts that he resumed sending to the Supervisor after September 2015.

The College did not advise either the Clinical Supervisor or Dr. Rosenhek that supervision was no longer required. The College repeatedly advised the Clinical Supervisor that his clinical supervision of Dr. Rosenhek was to continue until he was advised by the College that it approved of the discontinuation of supervision. The College never approved the discontinuation of Dr. Rosenhek's supervision. Dr. Rosenhek did not attempt to confirm with the College whether his apparent understanding, or the Clinical Supervisor's apparent advice, that supervision was no longer required, were correct. Similarly, at no time did Dr. Rosenhek bring a motion to vary the terms of the 2010 Discipline Committee Order to permit him to return to unsupervised practice.

<u>Prior Dispositions by the Complaints Committee</u>

In November 2003, the Complaints Committee of the College required Dr. Rosenhek to attend at the College to be cautioned when aspects of his practice, and his response to a College complaint, were found to be concerning. Dr. Rosenhek was cautioned with regard to, among other things, the intemperate nature of his response to the patient complaint, the "threatening and intimidating tone" of which the Committee found to be "unnecessarily belligerent in the extreme".

In June 2004, the Complaints Committee of the College required Dr. Rosenhek to attend at the College to be cautioned regarding his professional communications.

In October 2006, the Complaints Committee of the College cautioned Dr. Rosenhek regarding his communications with patients and the importance of maintaining a professional and courteous demeanour.

In December 2008, the Complaints Committee of the College required Dr. Rosenhek to attend at the College to be cautioned regarding his professional attitude and demeanour in interacting with a patient, and the importance of understanding the fundamental nature of positive and effective communications with patients.

2013 Discipline Committee decision

On October 21, 2013, the Discipline Committee found that Dr. Rosenhek had 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 for:

- falsely representing himself as a member of the Royal College of Physicians and Surgeons of Canada and using the “FRCP(C)” designation when in fact he was not in good standing with the Royal College because of his failure to pay fees and his failure to report his continuing medical education hours pursuant to the Royal College’s Maintenance of Competence (“MOC”) program, between December 1986 when was removed from the register of Fellows in good standing with the Royal College because of his failure to pay annual dues and November 2008 when he paid his dues; and
- providing incomplete and inaccurate information to the Windsor Regional Hospital (where he held privileges) as part of its credentialing/re-appointment process regarding his compliance with a program of continuing medical education between 2006 and 2008.

As a result, Dr. Rosenhek was required to appear before the panel to be reprimanded, and to pay costs to the College.

March 23, 2016 Undertaking in lieu of s. 37 Order

On March 23, 2016 and on July 21, 2016 Dr. Rosenhek entered into interim undertakings with the College, which remained in effect until the date the Discipline Committee disposed of his discipline case.

Dr. Rosenhek undertook, among other things, to limit his practice to an initial maximum of the equivalent of two days per month, which limit was later raised to three days per month. He also agreed to practice under the supervision of a Clinical Supervisor acceptable to the College, who was required to meet with Dr. Rosenhek once per month to review at least ten patient charts from the equivalent of each full day of patient care

provided by Dr. Rosenhek, and to submit written reports to the College at least once every two months.

As a result of the interim undertakings, Dr. Rosenhek practised under the supervision of a different Clinical Supervisor, beginning March 23, 2016. In early 2017, the new Clinical Supervisor advised that he would be discontinuing his supervision of Dr. Rosenhek's practice as of April 30, 2017. Dr. Rosenhek was not able to locate a replacement supervisor. Dr. Rosenhek has not practiced medicine since May 1, 2017.

No concerns regarding Dr. Rosenhek's compliance with the interim undertakings have been identified by either the Clinical Supervisor or the College's compliance monitor.

October 11, 2017 Undertaking

Dr. Rosenhek has entered into an undertaking with the College, dated October 11, 2017, by which he has agreed, among other things, that he shall see a maximum of three patients per hour.

Disposition

On October 11, 2017, the Committee ordered and directed that:

- Registrar suspend Dr. Rosenhek's certificate of registration for a period of one (1) month commencing on October 12, 2017.
- Dr. Rosenhek appear before the panel to be reprimanded.
- Dr. Rosenhek pay costs to the College for a one day hearing in the amount of $5,500.00 within 30 days of the date of this Order.
- the results of this proceeding be included in the register.

5. Dr. T.H. Yu

Name:	Dr. Tsai Hsing Yu
Practice:	Family Medicine
Practice Location:	St. Catharines
Hearing:	Agreed Facts and Joined Submission Penalty
Finding/Penalty Decision Date:	November 24, 2017
Written Decision Date:	December 19, 2017

Allegations and Findings

- Disgraceful, dishonourable, or unprofessional conduct – **proved**

Summary

Dr. Yu is a family physician who graduated from medical school at Utkal University in India in 1976. He obtained a certificate of registration authorizing independent practice from the College of Physicians and Surgeons of Ontario (the "College") on April 4, 1984. Dr. Yu carries on a family and walk-in practice in St. Catharines, Ontario.

2016 Undertaking

On July 27, 2016, as a result of a College investigation, Dr. Yu entered into an Undertaking with the College. Pursuant to the 2016 Undertaking, Dr. Yu agreed not to issue new prescriptions or renew existing prescriptions for any narcotics, controlled or monitored drugs, or benzodiazepines or other targeted substances, with the exception of certain specified drugs which he is permitted to prescribe where clinically indicated.

Breach of the 2016 Undertaking

Between September and November 2016, inclusive, Dr. Yu renewed prescriptions for controlled substances for three patients on three occasions:

- In October 2016, Dr. Yu renewed a prescription for Sublinox for Patient A;
- In September 2016, Dr. Yu renewed a prescription for Lorazepam for Patient B; and
- In November 2016, Dr. Yu renewed a prescription for Lorazepam for Patient C.

Lorazepam and Sublinox (also known as zolpidem tartrate) are Class 1 Targeted Substances listed in the Benzodiazepines and Other Targeted Substances Regulations made under the *Controlled Drugs and Substances Act*. These substances are not among the specified drugs Dr. Yu is permitted to prescribe pursuant to his 2016 Undertaking. By authorizing these prescription renewals, Dr. Yu breached his 2016 Undertaking with the College.

Penalty

The following facts about Dr. Yu's history with the College were presented during the penalty portion of the hearing:

In 1994, as a result of a College investigation, Dr. Yu agreed to relinquish his prescribing privileges with respect to narcotics and controlled drugs pursuant to the provisions of the legislation in place at that time. A letter requesting voluntary termination of these privileges was sent to Health Canada early in 1995.

In 2009, Dr. Yu requested an amendment to his prescribing restriction. On February 11, 2011, Dr. Yu signed an undertaking with the College which modified his prescribing restriction ("2011 Undertaking"). Pursuant to the 2011 Undertaking, Dr. Yu

continued to be prohibited from prescribing narcotics and other targeted substances, but he was permitted to prescribe stimulants for the treatment of ADHD, long-acting narcotics for terminal patients, and Androgenic Steroid Replacement.

In December 2015, after receiving information regarding Dr. Yu's prescribing, the College commenced an investigation. In April 2016, a College investigator requested that Dr. Yu respond to the concern that he appeared to have breached his 2011 Undertaking by prescribing short-acting narcotics for patients who did not have a terminal diagnosis. In May 2016, Dr. Yu confirmed that he had prescribed short-acting narcotics to four patients who did not have a terminal diagnosis, contrary to the terms of his 2011 Undertaking. Dr. Yu indicated that he would consider entering into a new undertaking whereby he would not prescribe any narcotics or controlled drugs.

In July 2016, the Inquiries, Complaints and Reports Committee of the College ("ICRC") deferred the matter to permit negotiation of an undertaking with Dr. Yu, which he signed on July 27, 2016. On November 18, 2016, upon considering the results of the investigation, the ICRC decided to accept Dr. Yu's 2016 Undertaking. The ICRC also required Dr. Yu to attend the College to be cautioned in person regarding his failure to comply with his practice restrictions by breaching the 2011 Undertaking.

Disposition

On November 24, 2017, the Discipline Committee ordered and directed on the matter of penalty and costs that:

- The Registrar suspend Dr. Yu's certificate of registration for a three month period, to commence at 12:01 a.m. on December 1, 2017.
- Dr. Yu appear before the panel to be reprimanded.
- Dr. Yu pay costs to the College in the amount of $5,500.00 within thirty (30) days of the date this Order.