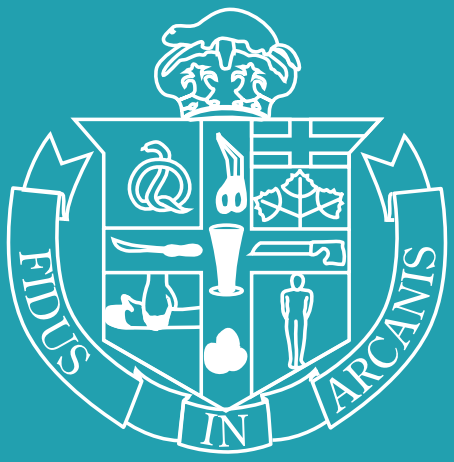
The College of Physicians and Surgeons of Ontario

Meeting of Council



December 5 and 6, 2019

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

NOTICE

OF

MEETING OF COUNCIL

A meeting of The College of Physicians and Surgeons of Ontario will take place on Thursday, December 5 and Friday, December 6, 2019 in the Council Chamber of the College, at 80 College Street, Toronto, Ontario.

The meeting will convene at 9:00 am on December 5, 2019.

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

November 19, 2019

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

MEETING OF COUNCIL

December 5 and 6, 2019

Council Chamber, 3rd Floor, 80 College Street, Toronto

December 5, 2019

CALL TO ORDER

9:00 **Group Photo**

9:15 **President's Announcements**

FOR INFORMATION

December 5, 2019

9:25 3. Registrar/CEO Report ..... *(no materials)*

10:15 BREAK

10:35 4. Strategic Plan Key Performance Indicators (Optimus).....157

- ***For Decision***

The College developed its strategic plan for 2020-2025. Optimus SBR has recommended some Key Performance Indicators to assist the College with measuring and reporting progress on the new strategic plan. Council is asked for approval of the proposed Key Performance Indicators.

11:20 5. Disclosure of Harm Policy 172

- ***For Decision***

The College's *Disclosure of Harm* policy is currently under review in accordance with the regular policy review cycle. A draft policy was circulated for external consultation over the summer and has now been revised to reflect the consultation feedback received. Council is asked whether the revised policy is approved as a policy of the College

COUNCIL AWARD PRESENTATION

11:35 6. Council Award Recipient: Dr. Michelle Hladunewich, Toronto 186

12:00 LUNCH BREAK

December 5, 2019

1:00 EDUCATION SESSION

7. Shared Learnings from a Governance Review..... *(no materials)*
Guest Presenter: Deanna L. Williams

Deanna Williams is the President of Dundee Consulting Group Ltd, a non-profit group consulting in governance, organization culture and change, strategic planning and negotiation, with expertise in professional and occupational regulation. Using a case example, Deanna will share learnings regarding governance best practices following a review of a health regulatory college that she conducted.

2:00 8. Boundary Violations – Revised Policy for Final Approval 188

- ***For Decision***

The College's current *Maintaining Appropriate Boundaries and Preventing Sexual Abuse* policy is under review. An updated and newly titled *Boundary Violations* policy was released for external consultation following the May 2019 meeting of Council. Council is provided with an overview of the revisions made in response to the feedback received and is asked whether the revised draft *Boundary Violations* policy can be approved as a policy of the College.

2:25 BREAK

2:45 9. Prescribing Drugs – Revised Policy for Final Approval 209

- ***For Decision***

The College's *Prescribing Drugs* policy is currently under review in accordance with the regular policy review cycle. An updated draft of the policy has been developed with the assistance of a Policy Working Group. The draft policy was circulated for external consultation over the summer and has now been revised to reflect the consultation feedback received. Council is asked whether the revised draft policy can be approved as a final policy of the College.

3:05 10. Motion to Go In Camera 229

ADJOURNMENT DAY 1

December 6, 2019

10:30 **President's Announcements**

10:35 11. **Report of the Finance and Audit Committee .....** *(materials will be posted Nov 26/19)*

- ***For Decision***
  - **Proposed by-law amendment to the General By-Law 1 – Signing Authorities**
  - **2020 Budget**
  - **Proposed by-law amendment – Fees**
  - **President's Stipend**
  - **Compensation Based on Scheduled Meeting Time**

The Finance and Audit Committee met on October 17, 2019 and is recommending to Council the approval of the above items.

10:45 12. **Member Topics.....** *(no materials)*

11:00 **BREAK**

11:20 13. **District Council Election Date for 2020 .....232**

- ***For Decision***

Following a recent review of the College's current Council elections process, there is an opportunity to improve the process by moving the elections from October to June. Council is asked to approve by-law amendments to enable the change in timing.

11:35 14. **2018-2019 Council Performance Assessment 234**

- ***For Discussion***

The Council completed the annual performance assessment for 2018-2019. Results from the assessment including strengths and opportunities for improvement will be shared with Council for discussion.

PRESIDENT'S TOPICS

11:45 15. **Presidential Address: Dr. Peeter Poldre**

12:05 16. **Induction of New President: Dr. Brenda Copps**

December 6, 2019

12:10 LUNCH BREAK

1:40 Closing Remarks

ADJOURNMENT DAY 2

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: **Council Meeting Minutes of September 20, 2019**

Date of Meeting: **December 5, 2019**

It is moved by _____,

and seconded by_____, that:

The Council accepts the minutes of the meeting of the Council held on September 20, 2019

or

The Council accepts the minutes of the meeting of the Council held on September 20, 2019 with the following corrections:

DRAFT PROCEEDINGS OF THE
MEETING OF COUNCIL OF
THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
September 20, 2019

Attendees:

Dr. Peeter Poldre (President)
Ms Hilary Alexander
Dr. Philip Berger (am only)
Mr. Shahid Chaudhry
Mr. Harry Erlichman
Dr. Michael Franklyn
Dr. Deborah Hellyer
Dr. Paul Hendry
Ms Catherine Kerr
Mr. John Langs
Dr. Haidar Mahmoud
Mr. Paul Malette
Ms Judy Mintz
Dr. Akbar Panju
Mr. Peter Pielsticker
Ms Joan Powell
Dr. John Rapin
Dr. Sarah Reid
Dr. Jerry Rosenblum
Dr. David Rouselle
Dr. Elizabeth Samson
Dr. Robert Smith
Ms Gerry Sparrow
Ms Christine Tebbutt
Dr. Andrew Turner

Non-voting Academic Representatives on Council Present:
Dr. Mary Bell, Dr. Terri Paul and Dr. Janet van Vlymen (by teleconference)

Regrets:
Dr. Brenda Copps, Ms Joan Fisk, Mr. Pierre Giroux, Dr. Rob Gratton, Mr. Mehdi Kanji, Ms Ellen Mary Mills, Dr. Judith Plante, Dr. Patrick Safieh, Dr. Scott Wooder

CALL TO ORDER

President's Announcements

Dr. Poldre called the meeting to order at 8:45 am and welcomed members and guests. He opened the meeting with a traditional land acknowledgement statement as a demonstration of recognition and respect for indigenous peoples.

Council Meeting Minutes of May 30-31, 2019

01-C-09-2019

It is moved by Dr. Jerry Rosenblum and seconded by Dr. Deborah Hellyer that:

The Council accepts the minutes of the meeting of the Council held on May 30-31, 2019.

CARRIED

Executive Committee's Report to Council, April-June 2019

The report was received with no comments.

REGISTRAR/CEO'S REPORT

Dr. Nancy Whitmore, the College's Registrar/CEO, reported on several key performance indicators. Progress is continuing in the complaints/discipline process timelines. Most notably, the time to resolve a complaint has decreased by 37% over a one-year period and the number of complaints managed through early resolution (ADR) has been reduced by 169% over the same one-year period. The time it takes to write an ICRC decision has been reduced from 26 weeks to five weeks. Regarding the College's discipline process, the time to release a discipline decision has been reduced by 51%. The College is committed to continue its work in improving its processes.

Dr. Whitmore also reported that the Quality Improvement pilot project has attracted 278 interested physicians who volunteered to participate. The project is now underway and will be complete by the end of 2019. She also reported on initiatives to more meaningfully engage with the public and physicians.

Dr. Whitmore also announced ***Dialogue*** will soon have a digital version. The first issue will be arriving in physicians' inboxes in the new year.

A copy of Dr. Whitmore's presentation is attached as **Appendix "A"** to these minutes.

PROTECTING PERSONAL HEALTH INFORMATION – DRAFT POLICY FOR CONSULTATION

02-C-09-2019

It is moved by Dr. Haidar Mahmoud and seconded by Ms Joan Powell that:

The College engage in the consultation process in respect of the draft policy "*Protecting Personal Health Information*" (a copy of which forms Appendix "B" to the minutes of this meeting).

CARRIED

MEDICAL RECORDS – DRAFT POLICIES FOR CONSULTATION

03-C-09-2019

It is moved by Dr. Jerry Rosenblum and seconded by Ms Hilary Alexander that:

The College engage in the consultation process in respect of the draft policies "Medical Records Stewardship" and "Medical Records Documentation" (a copy of which forms Appendix "C" and "D" to the minutes of this meeting).

CARRIED

CONTINUITY OF CARE – REVISED POLICIES FOR FINAL APPROVAL

04-C-09-2019

It is moved by Mr. Peter Pielsticker and seconded by Dr. Haidar Mahmoud that:

The Council approves:

(a) The policy "Availability and Coverage" (a copy of which forms Appendix "E" to the minutes of this meeting);

(b) The revised policy "Managing Tests", formerly titled "Test Results Management", (a copy of which forms Appendix "F" to the minutes of this meeting);

(c) The policy "Transitions in Care" (a copy of which forms Appendix "G" to the minutes of this meeting); and

(d) The policy "Walk-in Clinics" (a copy of which forms Appendix "H" to the minutes of this meeting).

CARRIED

CLOSING A MEDICAL PRACTICE – POLICY FOR FINAL APPROVAL

05-C-09-2019

It is moved by Dr. Haidar Mahmoud and seconded by Ms Catherine Kerr that:

The Council approves the revised policy "Closing a Medical Practice", formerly titled "Practice Management Considerations for Physicians Who Cease to Practise, Take an Extended Leave of Absence or Close Their Practice Due to Relocation", (a copy of which forms Appendix "I" to the minutes of this meeting).

CARRIED

COUNCIL AWARD PRESENTATION

Dr. Michael Franklyn presented the Council Award to Dr. Mark Spiller of Kirkland Lake, Ontario.

POLICY REDESIGN IMPLEMENTATION – BATCH 2

06-C-09-2019

It is moved by Dr. Robert Smith and seconded by Dr. Paul Hendry that:

The Council approves the following revised policies:

(a) "Dispensing Drugs" (a copy of which forms Appendix "J" to the minutes of this meeting);
(b) "Mandatory and Permissive Reporting" (a copy of which forms Appendix "K" to the minutes of this meeting);
(c) "Medical Expert: Reports and Testimony" (a copy of which forms Appendix "L" to the minutes of this meeting);
(d) "Physician Behaviour in the Professional Environment" (a copy of which forms Appendix "M" to the minutes of this meeting);
(e) "Physicians' Relationships with Industry: Practice, Education, and Research" (a copy of which forms Appendix "N" to the minutes of this meeting);
(f) "Physician Treatment of Self, Family Members, or Others Closer to Them" (a copy of which forms Appendix "O" to the minutes of this meeting);

CARRIED

PLANNING FOR AND PROVIDING QUALITY END-OF-LIFE CARE – POLICY CHANGES

07-C-09-2019

It is moved by Dr. Robert Smith and seconded by Dr. Deborah Hellyer that:

The Council approves the revised "Planning for and Providing Quality End-of-Life Care", (a copy of which forms Appendix "P" to the minutes of this meeting).

CARRIED

EFFECTIVE REFERRAL – POLICY CHANGES

08-C-09-2019

It is moved by Mr. John Langs and seconded by Dr. Andrew Turner that:

The Council approves:

(a) The revised policy "Medical Assistance in Dying" (a copy of which forms Appendix "Q" to the minutes of this meeting); and
(b) The revised policy "Professional Obligations and Human Rights", (a copy of which forms Appendix "R" to the minutes of this meeting)

CARRIED

CRIMINAL RECORD SCREENING – POLICY CHANGES

09-C-09-2019

It is moved by Ms Judy Mintz and seconded by Dr. Elizabeth Samson that:

The Council approves the revised policy "Criminal Record Search", formerly titled "Criminal Record Screening", (a copy of which forms Appendix "S" to the minutes of this meeting).

CARRIED

TRANSPARENCY: CHARGES AND FINDINGS OF GUILT FROM INTERNATIONAL JURISDICTIONS

10-C-09-2019

It is moved by Ms Hilary Alexander and seconded by Mr. Paul Malette that:

The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 125:

By-law No. 125

(1) Paragraph 49(1)19 of By-law No. 1 (the General By-law) is revoked and the following is substituted:

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

(i) a brief summary of the finding;

(ii) a brief summary of the sentence;

(iii) where the finding is under appeal, a notation that it is under appeal, until the appeal is finally disposed of; and

(iv) the dates of (i)-(iii), if known to the College.

(2) Paragraph 49(1)26 of the By-law No. 1 (the General By-law) is revoked and the following is substituted:

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

CARRIED

BY-LAW AMENDMENTS – HOUSEKEEPING MATTERS

11-C-09-2019

It is moved by Ms Judy Mintz and seconded by Dr. John Rapin that:

The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 128:

By-law No. 128

1. Section 11 of the General By-Law is revoked and the following is substituted:

11. The term of office of a member elected in a regular election is three years, starting at the first annual general meeting of the council held after the election and expiring at the annual general meeting of the council held after the election three years later.

2. Paragraph 18(1)(e) of the General By-Law is amended by deleting "or a ll" and replacing it with "to all".

3. Clause 28(2)(b)(i) of the General By-Law is revoked and the following is substituted:

(2) The council shall,

(b) annually appoint the Executive Member Representatives (as defined in subsection 39(1)) to the executive committee. The Executive Member Representatives shall be determined in accordance with the following:

(i) If one or both of the president-elect and the past president-to-be are not members of the College, or the then current president is unwilling or unable to serve on the executive committee as the past president in the following year, the council shall hold an election of nominees for the remaining number of physician councillor positions required in order to have a minimum of two physician councillors on the executive committee, as required by subsection 39(1);

CARRIED

GOVERNANCE MODERNIZATION

12-C-09-2019

It is moved by Mr. Shahid Chaudhry and seconded by Dr. Robert Smith that:

The Council of the College of Physicians and Surgeons of Ontario makes the following By-law

No. 129:

By-law No. 129

1. **Section 39 of the General By-Law is amended by revoking subsection 39(3) and replacing it with the following:**

   (3) In addition to the duties of the executive committee set out in section 30 of this by-law and section 12 (1) of the Health Professions Procedural Code under the *Regulated Health Professions Act*, the executive committee shall,

   (a) review the performance of the registrar and shall set the compensation of the registrar; and
   (b) oversee and assist College staff with the development and delivery of major communications, government relations, and outreach initiatives to the profession, the public and other stakeholders, consistent with the College's strategic plan.

2. **Subsection 39(4) of the General By-Law is amended by replacing the reference to "subsection (3)" with "subsection (3)(a)".**

3. **Section 41 of the General By-Law is amended by revoking "1 Council Award Selection Committee", "2 Education Committee", and "6 Outreach Committee".**

4. **Sections 41a, 42 and 47 of the General By-Law are revoked.**

CARRIED

13-C-09-2019

It is moved by Dr. David Rouselle and seconded by Dr. Andrew Turner that:

The Council of the College of Physicians and Surgeons of Ontario makes the By-law No. 130 (a copy of which forms Appendix "T" to the minutes of this meeting);

14-C-09-2019

It is moved by Mr. Peter Pielsticker and seconded by Dr. Paul Hendry that:

The motion 13-C-09-2019 regarding By-law No. 130 be amended by removing eligible practice requirements from the proposed bylaw, so the proposed bylaw reads as follows:

The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 130:

By-law No. 130

1. Section 11 of the General By-Law is amended by adding the following subsections (2) and (3):

(2) Subject to subsection 11(3), a member may not be a council member for more than a total of nine years, whether consecutively or non-consecutively.

(3) Transition. For a member whose most recent term of office on council commenced in 2017, 2018 or 2019, subsection 11(2) does not apply to the member for that term of office. If the member will have been a council member for more than a total of nine years by the end of that term of office, the member will not be eligible for election to the council for any additional terms.

2. Subsection 13(2) of the General By-Law is revoked and the following is substituted:

(2) A member is not eligible for election to the council who, if elected, would be unable to serve completely the three-year term prescribed by subsection 11(1) by reason of (a) the nine-consecutive-year term limit prescribed by subsection 5(2) of the Health Professions Procedural Code, or (b) the total nine-year term limit prescribed by subsection 11(2) of this by-law.

3. Subsection 24(3) of the General By-Law is revoked and the following is substituted:

(3) A member is eligible for appointment to the academic advisory committee if, on the date of the appointment,

(a) the member is on the academic staff of the faculty of medicine;

(b) the member is not in default of payment of any fee payable to the College;

(c) the member is not the subject of any disciplinary or incapacity proceeding;

(d) the member's certificate of registration has not been revoked or suspended in the six years preceding the appointment;

(e) the member's certificate of registration is not subject to a term, condition or limitation other than one prescribed by a regulation;

(f) the member is not a director or officer of the Ontario Medical Association, the Canadian Medical Protective Association, the Canadian Medical Association, or the Coalition of Family Physicians and Specialists of Ontario;

(g) the member does not hold a position which would cause the member, if appointed to the Academic Advisory Committee, to have a conflict of interest by

virtue of having competing fiduciary obligations to both the College and another organization; and

(h) the member is not ineligible for such appointment under subsection 37(5) or subsection 37(6)(a).

4. Section 25 of the General By-Law is revoked and the following is substituted:

25. A member shall be appointed to the academic advisory committee for a term of three years, from the first meeting of the council after his or her appointment when elected councillors take office until the third such meeting or until such earlier time as specified in the appointment, except that the term of office for a member appointed to the academic advisory committee prior to the 2019 annual general meeting of the council shall be one year.

5. Section 35 of the General By-Law is revoked and the following is substituted:

35. (1) The council may appoint a member of the College to a committee only if, on the date of the appointment,

(a) the member practises medicine in Ontario or resides in Ontario;

(b) the member is not in default of payment of any prescribed fees;

(c) the member is not the subject of any disciplinary or incapacity proceeding;

(d) the member's certificate of registration has not been revoked or suspended in the six years preceding the date of the appointment;

(e) the member's certificate of registration is not subject to a term, condition or limitation other than one prescribed by a regulation; and

(f) the member is not ineligible for such appointment under subsection 37(5) or subsection 37(6)(a).

(2) The council may appoint a person who is not a member of the College or a councillor to a committee. The council may appoint such a person to a committee only if, on the date of the appointment, the person is not ineligible for such appointment under subsection 37(5) or subsection 37(6)(b).

6. Section 37 of the General By-Law is revoked and the following is substituted:

37. (1) The term of office of a committee member starts when he or she is appointed or at such later time as the council specifies in the appointment.

(2) Except as provided in section 25 and in subsection 37(2.1), the term of office of a committee member automatically expires at the third annual general meeting

of the council which occurs after the appointment or at such earlier time as the council specifies in the appointment.

(2.1) The term of office of (a) each member of the Governance Committee and the Executive Committee, and (b) a member of a committee (other than the Governance Committee or the Executive Committee) appointed to the committee prior to the 2019 annual general meeting of the council, automatically expires at the annual general meeting of the council which occurs next after the appointment.

(3) Where one or more vacancies occur in the membership of a committee, the committee members remaining in office constitute the committee so long as their number is not fewer than the quorum prescribed by law or this by-law.

(4) The executive committee may and, if necessary for a committee to achieve its quorum, shall make appointments to fill any vacancies which occur in the membership of a committee.

(5) Subject to subsections 37(7) and 37(8), a person is not eligible for appointment to a committee if the person has been a member of that committee for a total of nine years or more, whether consecutively or non-consecutively.

(6) Subject to subsections 37(7) and 37(8),

(a) a member of the College is not eligible for appointment to a committee if the member has been a council member or a member of any one or more committees for a total of 18 years or more, whether consecutively or non-consecutively; and

(b) a person who is not a member of the College is not eligible for appointment to a committee if the person has been a member of any one or more committees for a total of 18 years or more, whether consecutively or non-consecutively.

For greater certainty, for purposes of calculating the 18 year total in subsection 37(6), any period of time spent on council and/or one or more committees concurrently counts as one period of time, and is not counted separately for council and each committee.

(7) Transition re Term Limits. Subsections 37(5) and 37(6) shall not be effective in respect of appointments to, and terms of office on, committees until the beginning of the annual general meeting of council held in 2020.

(8) Exceptional Circumstances. Despite subsections 24(3)(h), 35(1)(f), 35(2), 37(5) and 37(6), Council may appoint a member to a committee if council determines it is necessary to do so due to exceptional circumstances in order to ensure that the composition and quorum requirements for the committee can be met or that the committee can function properly and in a stable manner.

CARRIED

13-C-09-2019

It is moved by Dr. David Rouselle and seconded by Dr. Andrew Turner that:

The Council of the College of Physicians and Surgeons of Ontario makes By-law No. 130 as amended by motion 14-C-09-2019.

CARRIED

MEMBER TOPICS

Dr. Poldre introduced two medical learners invited to attend today's meeting as regular observers: Mr. Austin Yan, representing the Ontario Medical Students Association (OMSA) and Dr. Tracy Sarmiento, representing the Professional Association of Residents of Ontario (PARO). Going forward, representatives from OMSA and PARO will be invited to all College Council meetings.

GOVERNANCE COMMITTEE REPORT

15-C-09-2019

It is moved by Dr. Robert Smith and seconded by Ms Gerry Sparrow that:

The Council appoints the following committee members as Chairs, Co-Chairs or Vice Chairs of the following committees as of the close of the Annual General Meeting of Council in December 2019:

Discipline Committee:
Dr. Melinda Davie, Co-Chair
Dr. Eric Stanton, Co-Chair

Executive Committee:
Dr. Brenda Copps, Chair

Finance and Audit Committee:
Mr. Peter Pielsticker, Chair

Fitness to Practise Committee:
Dr. Deborah Hellyer, Chair
Governance Committee:
Dr. Peeter Poldre, Chair

Inquiries, Complaints and Reports Committee:
Dr. David Rouselle, Co-Chair, ICRC
Dr. Anil Chopra, Co-Chair, ICRC
Ms. Joan Fisk, Vice Chair, General Panels
Dr. Brian Burke, Co-Vice Chair, Settlement Panels
Ms. Joan Powell, Co-Vice Chair, Settlement Panels
Dr. Rob Gratton, Vice Chair, Obstetrical Panels
Dr. Andrew Hamilton, Vice Chair, Surgical Panels
Dr. Akbar Panju, Vice Chair, Internal Medicine Panels
Dr. Lesley Wiesenfeld, Vice Chair, Mental Health and Health Inquiry Panels
Dr. Judith Plante, Vice Chair, Family Practice Panels

Patient Relations Committee:
Ms. Lisa McCool-Philbin, Chair

Premises Inspection Committee:
Dr. Gillian Oliver, Chair

Quality Assurance Committee:
Dr. Hugh Kendall, Co-Chair
Dr. Deborah Robertson, Co-Chair

Registration Committee:
Dr. Akbar Panju, Chair

CARRIED

PENSION PLAN RESOLUTION

15-C-09-2019

It is moved by Mr. Paul Mallette and seconded by Dr. Jerry Rosenblum that:

WHEREAS the College of Physicians and Surgeons of Ontario (the "College") established the Employees' Retirement Savings Plan for The College of Physicians and Surgeons of Ontario, Registration No. 0951756 (the "Plan") effective January 1, 1986; and

WHEREAS Council of the College passed a resolution on May 31, 2019 relating to the Plan and the New DCPP (as defined below) but wishes to make certain changes to the resolution by replacing it with this resolution; and

WHEREAS pursuant to Section 13.01 of the Plan, the College reserves the right to amend and terminate the Plan; and

WHEREAS the College wishes to fully terminate the Plan effective September 30, 2019, or shortly thereafter, and replace it with a new defined contribution pension plan, the CPSO Retirement Savings Plan 2019 ("New DCPP"); and

WHEREAS the New DCPP will provide the same investment line up as is provided under the Plan as at date the Plan winds up, subject to any future amendments; and

WHEREAS the New DCPP will have a different contribution formula than that provided under the Plan as at date the Plan winds up, subject to any future amendments; and

WHEREAS the College, acting through its Council, wishes to delegate to the Executive Committee the necessary powers and duties to complete the wind-up of the Plan and to implement the New DCPP and to register the New DCPP with the applicable regulatory authorities; and

WHEREAS with the exception of the authority to determine the contribution formula under the New DCPP now and in the future, the College, acting through its Council also wishes to delegate to the Executive Committee the ability to determine all details in connection with the provisions, operation and administration of the New DCPP, including the power to adopt any subsequent compliance and plan design amendments that do not impact the contribution formula; and

WHEREAS employees hired on or after October 1, 2019 (or such later date as may be determined by the Executive Committee) will not be eligible to participate in the New DCPP and instead such employees will be eligible to participate in the Healthcare of Ontario Pension Plan ("HOOPP"); and

WHEREAS certain employees hired prior to October 1, 2019 (or such later date as may be determined by the Executive Committee) will have the option to participate in the New DCPP or HOOPP on or after such date.

NOW THEREFORE IT IS RESOLVED THAT:

1. **This resolution replaces and supersedes the resolution passed by Council on May 31, 2019 relating to the Plan and the New DCPP.**
2. **The Plan is fully terminated and wound-up with respect to members, former members and other persons entitled to payments under the Plan (collectively, "Members") effective September 30, 2019 or such later date as may be determined by the Executive Committee (the "Wind-up Date").**
3. **Contributions to the Plan shall be made with respect to service with the College up to and including the Wind-up Date.**
4. **The College shall notify the Members entitled to payments under the Plan in accordance with the provisions of the Ontario *Pension Benefits Act*.**
5. **Each Member shall have the required options provided to him regarding the payment of his benefit entitlement in accordance with the terms of the Plan, the Ontario *Pension Benefits Act* and the *Income Tax Act* (Canada).**
6. **A wind-up report for the Plan shall be prepared in accordance with the Ontario *Pension Benefits Act* and the regulations thereunder as may be required by the Financial Services Commission of Ontario (or its successor).**
7. **The following employees will have the option to participate in the New DCPP or HOOPP, subject to making an election as to which plan to join by August 30, 2019 or such later date as may be determined by the Executive Committee:**

a) **employees who were members of the Plan on September 30, 2019;**
b) **employees who were hired prior to October 1, 2019, were not enrolled as members of the Plan on September 30, 2019 but were eligible to be enrolled as members of the Plan on September 30;**

8. **The Executive Committee is authorized to:**
    a. **approve all decisions relating to the wind-up of the Plan, including but not limited to determining the date on which such wind-up is to occur in accordance with section 2 (above);**
    b. **approve all decisions relating to the New DCPP, including but not limited to the terms and conditions of the New DCPP (with the exception of the contribution formula); and**
    c. **approve all amendments to the New DCPP, as may be required or recommended, in the future in connection with compliance and plan design changes that do not affect the contribution formula.**

Effective October 1, 2019 or such later date as may be determined by the Executive Committee:

1. **The New DCPP will be established.**

2. **The New DCPP shall provide the same investment line-up as is provided under the Plan as at the Wind-up Date, subject to any future amendments.**

3. **The employee contribution formula under the New DCPP will be as follows:**
   - **5% of pensionable earnings**

4. **The employer contribution formula under the New DCPP will be as follows:**
   - **10% of pensionable earnings**

BE IT FURTHER RESOLVED THAT the College employees, as authorized by the College General By-law, are hereby authorized and directed to sign all documents and to perform any or all acts necessary or desirable to give effect to the foregoing resolution.

CARRIED

INFORMATION ITEMS

The following reports were received for information:

1. **Government Relations Report**
2. **2020 Council and Executive Committee Meeting Dates**
3. **Discipline Committee – Table of Completed Cases**
4. **Policy Report**

MOTION TO GO IN-CAMERA

16-C-09-2019

It is moved by Mr. John Langs and seconded by Dr. Elizabeth Samson that:

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

CARRIED

ADJOURNMENT

The meeting was adjourned at 4:03 pm.

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Dr. Peeter Poldre, President

_____

Ellen Spiegel, Recording Secretary

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 2019

TOPIC: Executive Committee's Report to Council
July - October 2019
In Accordance with Section 12 HPPC

FOR INFORMATION

August 13, 2019 Executive Committee Meeting

11. Proposed Changes to Funding for Therapy and Counselling Program – Direct Payment to Patients and Expanded Scope of Eligible Expenses

8-EX-Aug-2019 Upon a motion by Ellen Mary Mills and seconded by Steven Bodley and CARRIED, the Executive Committee directs that the Patient Relations Committee
(a) Allow reimbursement to a patient directly for therapy/counselling costs incurred,
(b) Allow eligible applicants to use the funds to pay for costs incurred in accessing therapy/counselling e.g. travel, childcare (will be evaluated on a case by case basis).

October 15, 2019 Executive Committee Meeting

9. New Defined Contribution Pension Plan, Plan Text

At its September meeting, Council approved a resolution to terminate the current DCPP and establish a New DCPP. At its meeting, The Executive Committee approved the Plan Text for the New Defined Contribution Pension Plan. The adoption of the Plan Text is necessary in order to be able to apply to the Canada Revenue Agency (CRA) and Financial Services Regulatory Authority of Ontario (FRSA) for registration of the new Defined Contribution Pension Plan.

3-EX-Oct-2019 Upon a motion by Peter Pielsticker, and seconded by Steven Bodley, and CARRIED, that:

WHEREAS the College of Physicians and Surgeons of Ontario (the "College") is establishing a new defined contribution pension plan, the CPSO Retirement Savings Plan 2019 (the "Plan") effective October 1, 2019; and

WHEREAS the Plan is a closed plan and it is being established solely for:

1. employees of the College who were participating in the Employees' Retirement Savings Plan for The College of Physicians and Surgeons of Ontario (the "Prior Plan") prior to October 1, 2019 and who elect to join the Plan by August 30, 2019;

2. employees of the College who were participating in the Prior Plan and who do not make an election to join either the Plan or the Healthcare of Ontario Pension Plan ("HOOPP") by August 30, 2019; and

3. employees of the College who were hired prior to October 1, 2019 and who were not participating in the Prior Plan but would be eligible to participate in the Prior Plan as at September 30, 2019 and who elect to join the Plan by August 30, 2019; and

WHEREAS the Prior Plan is being wound up effective September 30, 2019; and

WHEREAS pursuant to a resolution of the Council dated September 20, 2019, the Executive Committee has been given the necessary powers and duties to implement the new DCPP, and adoption of the Plan text is a necessary step for implementation; and

NOW THEREFORE IT IS RESOLVED THAT effective October 1, 2019, the Plan text is hereby adopted in the form annexed hereto.

11. Government Submission: Physician Assistants

The Executive Committee approved that a letter be sent to the Minister of Health that describes a possible model of CPSO regulation of Physician Assistants (PAs). Over the past number of years, the Ministry of Health has explored with the College different forms of oversight of PAs. Recently, the government asked the College to "refresh" a 2018 proposal for the regulation of PAs.

As with the 2018 proposal, the College proposes to create a new class for PAs and to preserve the role of PAs as physician-extenders, practising within the context of the physician-PA supervisory relationship. The response also suggests that the relatively unique nature of PA practice must be taken into account when designing an appropriate

regulatory framework for PAs, and that regulatory modernization should be part of the discussion as work on PA regulation moves ahead.

12. **5-EX-Oct-2019** Upon a motion by Akbar Panju, and seconded by Steven Bodley and CARRIED, the Executive Committee appoints Medical Advisors Dr. Ted Everson and Dr. Mary Manno to the ICR Committee.

Contact: Peeter Poldre, President
Lisa Brownstone, x 472

Date: November 18, 2019

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 2019

TOPIC: **GOVERNMENT RELATIONS REPORT**

FOR INFORMATION

1. Ontario's Political Environment
2. Issues of Interest

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1. ONTARIO'S POLITICAL ENVIRONMENT:

- The Legislature resumed for the fall session on October 28 and is scheduled to sit until December 12.
- The summer recess, which extended much later than usual, was exceptionally quiet. However, with the House back in session we have already seen significant uptick in activity.
- In particular, the government has passed new legislation limiting annual wage increases for public sector workers (unionized and non-unionized) to 1% when current contracts expire over the next three years. Aside from the Ontario Public Service, the bill affects staff at hospitals and long-terms care homes, as well as government agencies where the majority of directors or members are appointed by government.
- The Ontario government also continues to prioritize regulatory modernization and efficiency. This includes the recent introduction of new red tape reduction legislation to remove barriers to job creation and make it easier for citizens and businesses to interact with government.

2. ISSUES OF INTEREST:

Health System Transformation

- The government continues to champion health system transformation and to focus on the implementation of Ontario Health and the development of Ontario Health Teams (OHTs).
- To help move these priorities forward, the Ministry of Health underwent significant structural change in September, including the creation of new divisions responsible for Health Transformation, Ontario Health Teams, and Digital Health.
- Effective December 2, 2019, five provincial agencies – Cancer Care Ontario, Health Quality Ontario, eHealth, Health Shared Services Ontario, and HealthForceOntario – will begin

transferring into Ontario Health, while the 14 Local Health Integration Networks have been clustered into five interim and transitional geographic regions.

- In addition, the Minister of Health has announced that the first group of OHTs will be announced before end of November.
- Finally, the government has signaled that significant changes are coming to the state of digital health. This will include increased virtual care options, expanded access to online appointment booking, greater data access for patients, expanded access to patient record to health service providers, and better data integration and predictive analysis tools for health service providers.
- The first phase is to enable OHTs to collect, use and share information to allow for better patient care and outcomes, and we anticipate upcoming amendments to the *Personal Health Information Protection Act* to facilitate these changes.

Bill 138, the Plan to Build Ontario Together Act, 2019

- On November 6, 2019, the Minister of Finance introduced Bill 138 following the release of the Fall Economic Statement. Bill 138 proposes to amend, among other things, the *Health Insurance Act* (HIA) and the *Independent Health Facilities Act* (IHFA).
- The HIA changes primarily respond to plans laid out in the the 2019 Ontario Budget to protect OHIP against misuse, including steps to ensure that OHIP only pays for appropriate, delivered services and to better enable the government to recover funds when there are incorrect billings to OHIP.
    - Some of these changes were also recommended in a value-for-money audit of physician billing conducted by the Ontario Auditor General in 2016.
    - Reaction from the OMA to the OHIP changes has been fierce, with the organization strongly cautioning against a return to the pre-2005 system of auditing conducted by the Medical Review Committee (MRC), a former statutory Committee of the CPSO.
    - The systemic problems with the MRC and its processes were laid out in a comprehensive report by Justice Peter Cory.
- The IHFA changes are primarily designed to strengthen the transparency and accountability of independent health facilities (IHFs). This includes, among other things, provisions to strengthen the inspection process for IHFs and the powers of inspectors.
    - The changes also create a new regulation-making power that will enable the government to prescribe additional powers, functions, and duties of a governing, registering, or licensing body of a profession conducting assessments. (CPSO conducts assessments on behalf of the Ministry.)
- Internal work is underway to determine the impact of these changes on CPSO. Further information will be provided at the December Council meeting.

Public Appointments Update

- The College currently has a full complement of 15 public members of Council; however, the terms of seven public members will expire between the beginning of December 2019 and the end of February 2020.
- At time of writing, the Ministry has indicated that of these seven, one public member whose term is due to expire in December will not be reappointed, and another public member has separately advised that she will not be seeking reappointment to CPSO Council when their term expires in December.
- The Ministry has indicated that CPSO can expect the appointment of two new public member; however, the timing of these appointments is uncertain.
- CPSO staff have been in regular contact with the Ministry about the College's immediate public member appointment needs and the Ministry has committed to prioritizing them.
- The CPSO will also be facilitating a meeting between the Ministry's public appointments staff and College public members on December 5 to discuss challenges public members have been experiencing and identify potential solutions.

Red Tape Reduction, Governance Modernization, and Physician Assistants

- Red tape reduction and governance modernization have been areas of focus in our ongoing conversations with government. Overall, feedback on the CPSO's red tape recommendations, including governance modernization, have been positive.
- In addition, the College was asked by Ministry staff to re-examine the CPSO's April 2018 proposal regarding the regulation of physician assistants (PAs). Correspondence was prepared in response and approved by the Executive Committee in October (Appendix A).
- The response highlights the need for accompanying regulatory modernization to allow the CPSO to move ahead responsively and efficiently on emerging issues, including but not limited to the regulation of PAs.
    - The Minister announced at the Canadian Association of Physician Assistants conference on October 25 that the Ministry is reviewing the proposal.
- We anticipate further work to determine the Ministry's support for the proposed response and will provide Council with any additional information as it becomes available.

Contact: Laurie Cabanas, ext. 503
Heather Webb, ext. 753

Date: November 15, 2019
Attachment: Appendix A: Correspondence to the Minister of Health, October 21, 2019

Appendix A

CPSO

Trusted Doctors
Providing Great Care

October 21, 2019

The Honourable Christine Elliott, MPP
Deputy Premier and Minister of Health
5th Floor, College Park
777 Bay Street
Toronto, ON M7A 2J3

Dear Minister,

RE: Regulation of Physician Assistants

Thank you for the opportunity to provide you with perspectives from the College of Physicians and Surgeons of Ontario (CPSO) regarding the regulation of physician assistants ("PAs"). The CPSO has been in contact with the regulatory branch of the Ministry on this matter and is pleased to work with your team toward the objective of PA regulation.

Since non-military PAs were introduced in Ontario in 2006, the CPSO has provided feedback and a number of different proposals regarding the oversight of PAs, both to the Health Professions Regulatory Advisory Council and the Ministry. Having evaluated the merits of the various proposals over that time, it has been determined that a registry, particularly a voluntary one, is unlikely to achieve the level of oversight desired by government and other stakeholders.

At the same time, there continues to be a relatively small number of PAs in clinical practice in Ontario and we understand that the creation of a stand-alone health regulatory college is viewed to be impractical. We further understand that status for PAs as regulated health professionals is desired to address certain barriers that are perceived to limit them from providing care to the full extent of their abilities.

However, the status of PAs as regulated health professionals would be unique in Ontario for the key reason that PAs are only permitted to provide care under the supervision of a physician who oversees their clinical practice. Unlike regulated health professionals, PAs may not work independently; since their introduction in 2006, the primary oversight mechanism for PAs has been the supervisory relationship between the PA and the supervising physician(s).

This supervisory relationship is a key reason PAs are effective in their role on the health care team as physician-extenders, where their scope of practice to perform controlled acts flows entirely via delegation and is highly dependent on the individual PA-to-physician relationship. The relationship also brings a level of accountability that would not apply to the role of other regulated health professionals. In essence, PAs practice differently than other regulated health professionals and their regulation must be viewed through this lens.

Appendix A

Proposal to Create a New Class of Associate Member

Given this context, we suggest the creation of a new class of "associate member" for PAs under the *RHPA*, similar to the framework that has been adopted in Manitoba and New Brunswick. In our view, the creation of an associate member class for PAs will require a range of regulatory elements, including:

- a mandatory registry;
- title protection;
- entry to practice (registration) requirements;
- continuing professional development requirements;
- policy development relating to the practice of physicians in the context of their relationship with PAs; and
- professional liability protection.

However, given the distinct nature of PA practice as highlighted above, it is unnecessary in our view for the full investigation and disciplinary process for physicians to apply to PAs in all cases. It is proposed that the CPSO receive complaints regarding PA care and conduct, but be enabled to refer those complaints, where appropriate, to the supervising physician(s) for management. Pursuant to the College's *Delegation of Controlled Acts* policy, supervising physicians are already subject to extensive expectations regarding the oversight and assurance of the quality of care provided via delegation, including ensuring that there is ongoing monitoring and evaluation of the acts that are routinely delegated and periodic evaluation of the delegation process itself to ensure its safety and effectiveness.

We anticipate that resources and policies will need to be developed setting out expectations and guidance for supervising physicians around managing complaints against PAs. Where a PA is suspended or terminated from their employment as a result of a complaint or finding, it is anticipated that the supervising physician and the PA would be required to notify the CPSO so that the PA's standing on the register may be updated as a result.

This process will eliminate a layer of unnecessary regulatory oversight and promote the efficient management of complaints at the practice level. While the CPSO will necessarily continue to manage certain kinds of investigations – allegations of boundary violations and sexual abuse, concerns arising out of criminal charges, concerns arising from a pattern of non-compliance with College expectations, etc. – certain complaints will be triaged at an early stage for prompt resolution by the supervising physician(s).

These elements will require further development by the CPSO, assuming this proposal is supportable, but the CPSO will benefit from the experience of other Colleges and jurisdictions as we develop this activity.

Finally, physicians in Ontario currently pay an annual registration fee to support the costs of regulation. If incorporated as associate members of the CPSO, PAs will be expected to bear a similar fee, as well as additional costs associated with initial implementation barring financial contribution from another source.

Appendix A

Alignment with Regulatory Modernization

Implementing the proposal as described above will require legislative and regulatory changes, which we believe presents a greater opportunity to achieve regulatory modernization. As your government moves forward with health system transformation, the CPSO has been pleased to offer initial recommendations

to reduce red tape and achieve a more efficient regulatory structure for health regulatory colleges. This includes modernizing the structure of the CPSO's Council and providing the CPSO with the power to effect change through rules, rather than by regulation, on issues within its core mandate.

In our view, it is imperative that the regulatory framework governing the health professions modernize alongside the rest of the health care system in order for bodies like the CPSO to remain responsive and nimble in a rapidly evolving environment. Incorporating a new class of associate member highlights the need to simplify the time-consuming and cumbersome regulatory development process to better enable health regulatory colleges to effectively manage emerging issues. We look forward to further discussions with your team about how these two projects – regulation of PAs and overall regulatory simplification – can move forward together in a way that maximizes process efficiency and the modernization of the health regulatory college framework.

Next Steps

We look forward to your response to our proposal, as well as further discussions with the Ministry regarding implementation. If you have any questions or wish to discuss further, please contact Laurie Cabanas, Director of Governance and Policy (lcabanas@cpso.on.ca).

Yours truly,

Peeter Poldre, MD, EdD, FRCPC
President

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

c. Helen Angus, Deputy Minister of Health
Heather Watt, Chief of Staff, Minister of Health
Patrick Dicerni, Assistant Deputy Minister, Strategic Policy, Planning & French Language Services Division

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 2019

TOPIC: Policy Report

FOR INFORMATION

Updates:

1. Policy Consultation Update:

    I. *Medical Records Stewardship* and *Medical Records Documentation*
    II. *Protecting Personal Health Information*

2. Policy Status Table

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1. Policy Consultation Update

I. *Medical Records Stewardship* and *Medical Records Documentation*

- A consultation on the draft *Medical Records Stewardship* and *Medical Records Documentation* policies and accompanying *Advice to the Profession* documents began following September Council and will end on November 22, 2019.

- As of the Council submission deadline, the consultation received a total of 100 responses: 19 through written feedback and 81 via the online survey.[1] The majority of respondents were physicians.

- Overall respondents found the draft policies to be clear and comprehensive, the expectations to be reasonable, and respondents generally supported separating the medical records expectations into two draft policies.

[1] Organisational responses included: Information and Privacy Commissioner of Ontario (IPC) and Sustainable Consulting Group (Sconsulting.ca). Additional feedback from other key stakeholder organizations is anticipated before the submission deadline.

- Several physician respondents reported increased instances of physician burnout, which they attributed to documentation requirements and the use of EMRs.

- Common themes that emerged from the feedback are highlighted below:

Medical Records Stewardship

- The majority of survey respondents felt it was very important for physicians to use electronic medical records (EMRs) that meet privacy and security standards and that are interoperable with the broader health care system.

- The majority of survey respondents felt that the draft expectation requiring physicians to be proficient with their electronic record-keeping systems is reasonable.

Medical Records Documentation

- Respondents were somewhat divided about whether the expectations of the draft *Medical Records Documentation* policy are broadly applicable across specialties. Some respondents felt specialty specific guidance would be helpful and others felt that the broad principles of good documentation applied in all settings.

- Some physician respondents interpreted the draft expectations regarding the use of templates to be a general prohibition on their use and felt that this was unreasonable. Respondents expressed that as long as documentation represents the patient encounter, the use of templates should not be prohibited.

- Most survey respondents thought the draft expectations regarding documenting conversations with other health care providers were reasonable, though some physician respondents were concerned this could suppress collegial learning and collaboration or potentially open them up to medico-legal issues.

II. *Protecting Personal Health Information*

- A consultation on the draft *Protecting Personal Health Information* policy and accompanying *Advice to the Profession* document began following September Council and will end on November 22, 2019.

- As of the Council submission deadline, the consultation received a total of 25 responses: five through written feedback and 20 via the online consultation survey.[2] The majority of respondents were physicians.

[2] Organisational responses included: Information and Privacy Commissioner of Ontario (IPC) and Sustainable Consulting Group (Sconsulting.ca). Additional feedback from other key stakeholder organizations is anticipated before the submission deadline.

- Overall, feedback on the draft policy and draft *Advice* document was largely positive. The majority of survey respondents felt both draft documents were easy to understand and well organised.

- Specific feedback on certain provisions in the draft policy and draft *Advice* document made suggestions to promote clarity and comprehensiveness, which included:

    - revising the language of the expectations around obtaining consent from minors to more clearly explain when consent must be obtained and to clarify when patients under 16 years old can consent;

    - capturing further information about who is included within a patient's circle of care; and

    - amending the draft expectation requiring physicians to ensure that a colleague is using reasonable security safeguards, which was perceived as unreasonably onerous and potentially impeding timely communication between colleagues.

2. Policy Status Table

- The status of ongoing policy development and reviews, as well as target dates for completion, is presented for Council's information as **Appendix A**.

DECISIONS/DISCUSSION FOR COUNCIL:

For information only

Contact: Craig Roxborough, Ext. 339

Date: November 15, 2019

Appendices:

Appendix A: Policy Status Table

Policy Status Report – December 2019 Council

Table 1: Current Reviews

Policy	Launch	Stage of Policy Review Cycle					Target Comp.	Notes
		Prelim. Consult	Drafting	Approval to Consult	Revising Draft Policy	Final Approval		
Professional Responsibilities in Postgraduate Medical Education & Professional Responsibilities in Undergraduate Medical Education	Dec-19	✓					2021	A joint review is being undertaken to review and update each policy.
Medical Expert & Third Party Reports	Dec-19	✓					2021	A joint review is being undertaken to review and update each policy.
Advertising	May-19		✓				2020	A *new* policy is being developed to provide guidance on and set parameters within an existing legislative framework.
Complementary/ Alternative Medicine	Mar-19		✓				2020	
Delegation of Controlled Acts	Mar-19		✓				2020	
Disclosure of Harm	Sept-18					✓	2019	
Prescribing Drugs	Dec-17					✓	2019	
Maintaining Appropriate Boundaries and Preventing Sexual Abuse	Sept-17					✓	2019	The revised draft policy has been retitled: *Boundary Violations*
Medical Records	Sept-17				✓		2020	Two draft policies have been developed called: *Medical Records Stewardship* & *Medical Records Documentation*
Confidentiality of Personal Health Information	May-17				✓		2020	The draft policy has been retitled: *Protecting Personal Health Information*

Policy Status Report – December 2019 Council

Table 2: Policy Review Schedule

Policy	Target Review	Policy	Target Review
Female Genital Cutting (Mutilation)	2016/17	Physician Behaviour in the Professional Environment	2021/22
Dispensing Drugs	2016/17	Medical Assistance in Dying	2021/22
Mandatory and Permissive Reporting	2017/18[1]	Accepting New Patients	2022/23
Social Media – Appropriate Use by Physicians (Statement)	2018/19	Ending the Physician-Patient Relationship	2022/23
Providing Physician Services During Job Actions	2018/19	Uninsured Services: Billing and Block Fees	2022/23
Physicians' Relationships with Industry: Practice, Education and Research	2019/20	Ensuring Competence: Changing Scope of Practice and Re-entering Practice	2023/24
Telemedicine	2019/20	Public Health Emergencies	2023/24
Cannabis for Medical Purposes	2020/21	Closing a Medical Practice	2024/2025
Professional Obligations and Human Rights	2020/21	Availability and Coverage	2024/2025
Consent to Treatment	2020/21	Managing Tests	2024/2025
Planning for and Providing Quality End-of-Life Care	2020/21	Transitions in Care	2024/2025
Blood Borne Viruses	2021/22	Walk-in Clinics	2024/2025
Physician Treatment of Self, Family Members, or Others Close to Them	2021/22		

[1] A comprehensive update to this policy was completed as part of the Policy Redesign process. Council approved this updated version in September 2019.

Discipline Committee
Report of Completed Cases – December 2019 Council

This report covers discipline cases completed (i.e., the written decision and reasons on finding and, if applicable, penalty have been released) between August 30, 2019 and November 15, 2019. The decisions are organized according to category, and then listed alphabetically by physician last name.

Sexual Abuse – 3 cases

1. Dr. H. Hasnain

Name:	Dr. Haider Hasnain
Practice:	Family Medicine
Practice Location:	Windsor-Tecumseh
Hearing:	Allegations - Contested Penalty - Joint Submission
Finding/Written Decision Date:	January 17, 2019
Penalty Decision Date:	August 26, 2019
Written Penalty Decision Date:	October 4, 2019

Allegations and Findings

- sexual abuse of a patient - **proven**
- disgraceful, dishonourable or unprofessional conduct - **proven**

Summary

Dr. Hasnain is a 54-year-old family physician who received his certificate of registration authorizing independent practice in Ontario in 1992 and his specialist qualification in family medicine in 1994. His practice is located in the Windsor-Tecumseh area. Dr. Hasnain's CPSO number is 64959. During the relevant period, Dr. Hasnain practised out of the Tecumseh Community Care Centre ("the clinic"), providing service as a family physician at the clinic, including at the urgent-care clinic located in the same premises. Dr. Hasnain was the lessee for the clinic space.

The clinic operated on a shared chart system. All physicians treating a particular patient contributed to one global chart at the clinic. At the time, the charts were hand-written. In addition to Dr. Hasnain, who owned the clinic, four other physicians, Drs. B (a pediatrician), C, D and E, provided medical services to patients on a full-time basis. Two other physicians, Drs. F and G, provided medical services on a part-time basis.

Ms. Z is in her 50's. Between June 2008 and January 2009, Ms. Z was treated at the clinic by physicians other than Dr. Hasnain on several occasions for a variety of issues, including asthma, anxiety and concerns around a mammogram. The physicians include Drs. G, D, C and F.

On February 6, 2009, Ms. Z sought medical treatment at the clinic. She was initially seen by a nurse at the clinic who noted her observations of Ms. Z on the medical chart as follows: "pulse 60, increased lethargic, weight gain, depression, bp 106/60". Dr. Hasnain was working in the urgent care area of the clinic and he provided treatment to Ms. Z. Dr. Hasnain noted in the chart that Ms. Z missed her previous menstrual cycle and that she was not sexually active at all. Dr. Hasnain requisitioned a blood sample. That same day, a laboratory technician at the clinic drew a blood sample from Ms. Z.

The test results were faxed back to the clinic later that day. Dr. Hasnain submitted a claim to OHIP for an intermediate assessment. Hematology results suggested that Ms. Z's iron levels were slightly below normal. A nurse reviewed this information with Ms. Z the following day.

On February 10, 2009, Ms. Z was seen again by Dr. Hasnain. Dr. Hasnain noted in the patient chart that Ms. Z previously experienced constipation when taking iron pills. Dr. Hasnain prescribed six vials of 2 ml iron injections. Dr. Hasnain submitted a claim to OHIP for a minor assessment.

On February 19 and February 24, 2009, a nurse at the clinic administered two iron injections to Ms. Z, as previously directed by Dr. Hasnain and as recorded in the patient chart.

Ms. Z received medical treatment from Dr. G and other clinic physicians for various issues between February 2009 and May 2009. According to her patient chart, Ms. Z saw Dr. G on three occasions between February 2009 and April 2009 for gynecological issues including a pap smear and a referral to Dr. J, a specialist gynecologist. During March and April 2009, Ms. Z was treated by four other clinic physicians on four occasions for complaints including throat infections.

Sometime in May 2009, Ms. Z and Dr. Hasnain commenced a consensual sexual relationship. The relationship spanned from May 2009 to either December 2009 or January 2010 and included approximately 8-10 occasions of mutual oral sex and one occasion of sexual intercourse, as well as other sexual activity such as mutual sexual touching. All of the sexual interactions occurred in one room within the clinic, with the exception of one encounter that occurred elsewhere in the clinic. The final sexual encounter was the act of sexual intercourse that took place either in late December 2009 or early January 2010.

After the commencement of the sexual relationship with Dr. Hasnain, Ms. Z received treatment from Dr. G on August 23, 2009, for anxiety. Ms. Z was provided with a prescription for Celexa. Ms. Z also saw another clinic physician, Dr. E, on September 10, 2009, December 28, 2009, December 31, 2009 and January 8, 2010, regarding asthma and throat symptoms and back pain as set out in the patient chart.

Following the commencement of the sexual relationship in May 2009, Dr. Hasnain provided treatment to Ms. Z on three occasions in September 2009 and provided a prescription on one occasion in August 2009. The treatments provided in September 2009 were provided within the urgent care area of the clinic, at times when Dr. Hasnain was the only assigned physician.

On August 6, 2009, Ms. Z filled a prescription for a medication issued by Dr. Hasnain. There were no chart or OHIP entries related to this prescription.

On September 1, 2009, Dr. Hasnain provided treatment for Ms. Z, recorded as follows in her patient chart: “Bloodwork re alopecia, assessment, alopecia and get blood work results first.”

Ms. Z consented to the release of her most recent bloodwork results, which had been requisitioned by Dr. J, referred to above. On September 1, 2009, Medical Laboratories of Windsor forwarded the lab results, originally requested by Dr. J, to the clinic. After reviewing the results some time that night or the next day Dr. Hasnain wrote on the bottom of the fax coversheet from Medical Laboratories, “See Dr. G.” Dr. Hasnain submitted a claim to OHIP for a minor assessment.

On September 3, 2009, Ms. Z advised one of the nurses that she was experiencing “chest pains”. Dr. Hasnain was the only physician in the clinic at the time. Dr. Hasnain ordered an EKG. The results of the EKG revealed no abnormalities. Dr. Hasnain made the following notes on Ms. Z’s medical chart: “states history of arrhythmia and occurs a bit, and abdominal pain on and off, well and dizzy +++, observed no acute distress and assess well and EKG normal.” A claim was submitted to OHIP by Dr. Hasnain as a minor assessment.

On September 4, 2009, at approximately 11:39 a.m., a nurse wrote “f/u [follow up] re: bloodwork” in Ms. Z’s chart. Dr. Hasnain’s notes in Ms. Z’s medical chart states: “well, observed not acutely distressed and assess as well and second set of labwork ordered re alopecia and anemia.” A blood sample was drawn at the clinic on that day. Dr. Hasnain reviewed the results that night or the next day and wrote “let her know” on the results to advise the nurses to share the iron level results with Ms. Z. Dr. Hasnain submitted a claim to OHIP for a minor assessment.

Ms. Z commenced videotaping her encounters with Dr. Hasnain, including sexual encounters, as of June 5, 2009 without his knowledge. Ms. Z videotaped the medical encounters on September 1, 3 and 4, 2009. The videos of the appointments demonstrate that the appointments lasted the following lengths of time: appointment of September 1, 2009 - 1 minute and 46 seconds; appointment of September 3, 2009 - 1 minute and 10 seconds; appointment of September 4, 2009 - 2 minutes and 21 seconds.

Sexual Abuse of a Patient

For an act to fall within the meaning of “sexual abuse” as defined in the legislation, the Discipline Committee must find that the sexual relations occurred between a physician and a patient. As noted by the Ontario Court of Appeal in the case of Leering, “The disciplinary offence of sexual abuse is defined in the Code for the purpose of these proceedings as the concurrence of a sexual relationship and a health care professional-patient relationship. There is no further inquiry once those two factual determinations have been made.”

The Committee considered whether Ms. Z was a patient of Dr. Hasnain using the analytical approach adopted in the case law prior to legislative amendments coming into effect on May 1, 2018. This included a consideration of the factors outlined in the previous discipline case of Redhead to determine whether Ms Z was a patient of Dr. Hasnain's in the relevant time period. The Committee also considered whether Ms. Z was a patient of Dr. Hasnain by retrospectively applying the new definition of "patient" in the Health Professions Procedural Code (the Code) and the criteria in the new Patient Criteria Regulation. The Committee found that regardless of which approach is taken, a physician-patient relationship existed between Ms. Z and Dr. Hasnain and that it was established on February 6, 2009 and continued until at least September 4, 2009.

The Agreed Statement of Facts confirmed that the sexual relationship between Dr. Hasnain and Ms. Z commenced in May 2009 and extended into late December 2009 or early January 2010. The Agreed Statement of Facts confirmed that there was an ongoing sexual relationship when Dr. Hasnain wrote a prescription for Ms. Z in August 2009 and assessed Ms. Z and provided health care services to her on the three occasions in September 2009. The Committee found that the physician-patient relationship established in February 2009 continued until at least September 4, 2009 and that the sexual relationship between Dr. Hasnain and Ms. Z, which spanned the period May 2009 until late December 2009 or January 2010, was concurrent with the physician-patient relationship.

Therefore, the Committee found that the allegation of sexual abuse was proven.

Dishonourable, Disgraceful, or Unprofessional Conduct

The Committee found that Dr. Hasnain engaged in conduct or 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, by engaging in a sexual relationship with his patient.

Immediate Interim Suspension Order

Given the Committee's findings, the Committee made an immediate interim order suspending Dr. Hasnain's certificate of registration, until such time as the Committee makes its decision on penalty.

Disposition

On August 26, 2019, the Committee ordered that:

- The Registrar revoke Dr. Hasnain's certificate of registration effective immediately;
- Dr. Hasnain reimburse the College for funding provided to the patient 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, within sixty (60) days of the Order in the amount of $16,060.00;
- Dr. Hasnain appear before the panel to be reprimanded;

- Dr. Hasnain pay the College its costs of this proceeding in the amount of $20,550.00 within sixty (60) days from the date of the Order.

2. Dr. N. M. Phipps

Name:	Dr. Nigel Mark Phipps
Practice:	Family Medicine
Practice Location:	Georgetown
Hearing:	Admitted allegation of disgraceful, dishonourable or unprofessional conduct Contested allegation of sexual abuse Contested Penalty
Finding Decision Date:	August 27, 2019
Written Decision Date:	September 17, 2019
Penalty Decision Date:	September 17, 2019
Costs Decision Date:	October 11, 2019

Allegations and Findings

- sexual abuse of a patient - **proven**
- disgraceful, dishonourable or unprofessional conduct - **proven**

Summary

Dr. Phipps is a family physician. Dr. Phipps did not contest that the eleven individuals were his patients at the relevant times.

Sexual Abuse of Patients

During the period late August to early October 2014, Dr. Phipps showed one or more naked photographs of himself to eleven female patients during clinical visits. The women had been long-term patients of Dr. Phipps. They had trusted Dr. Phipps. In many instances, the women were shown a photograph in which Dr. Phipps's penis was erect or semi-erect. Often, he used the pretext of an apparently innocuous story from a golf trip he had taken more than two years before, when showing the photos. Some patients were shown naked photographs that had nothing to do with the golf trip and that Dr. Phipps took later at his home.

The Committee found that Dr. Phipps's conduct in showing one or more naked photographs of himself to each of eleven patients constitutes behaviour of a sexual nature towards a patient. The Committee therefore found that Dr. Phipps sexually abused each of the eleven patients.

The Committee found that Dr. Phipps was sexually aroused after showing the photos to two of the patients (Patients B and A). The Committee therefore found that Dr. Phipps

sexually abused Patient B and Patient A by becoming sexually aroused during his interactions with each of these patients.

Dr. Phipps acknowledged that he made comments to two patients to the effect that “I’ve seen yours, now you’ve seen mine” or “I’ve seen you naked, now you’ve seen me naked” (Patients C, I). In addition, Patient B testified that Dr. Phipps said to her as she was leaving, “Now you know more about me than most of my patients.” Further, Patient A testified that Dr. Phipps said to her, “Ain’t I well-endowed for a man my age?” after showing her the full-frontal photograph. The Committee found that each of these comments is a remark of a sexual nature and constitutes sexual abuse. Given the context in which each comment was made, specifically after Dr. Phipps had shown each patient a naked photograph of himself, the Committee found that an objective observer would conclude that each of these comments further sexualized the encounter with these four patients and constitutes sexual abuse.

Patient A testified that on the date of the visit when Dr. Phipps showed her his naked photograph, Dr. Phipps also examined her. She was seated on the examining table, Dr. Phipps stood facing her, leaned forward slightly, and pressed on her ribs with his right hand while lifting her top with his left hand. It was as he was leaning in that Patient A felt what she believed was an erection. She was adamant that it was Dr. Phipps’s erect penis that she felt. The Committee found that Dr. Phipps engaged in touching of a sexual nature of Patient A when he touched her leg with his erect penis during the physical examination conducted after he had shown her the full-frontal photograph.

Disgraceful, Dishonourable or Unprofessional Conduct

Dr. Phipps admitted that he 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.

Dr. Phipps showed naked photographs of himself to eleven patients, made remarks of a sexual nature to four patients, became sexually aroused during the encounters with two patients and touched one patient in a sexual manner. He engaged in this conduct with patients who had come to trust him over many years.

Trust is the cornerstone of the physician-patient relationship. When a patient seeks care from a physician, the patient trusts that the physician is a professional and will treat her in a professional manner. Physicians must establish and maintain appropriate professional boundaries with patients or the professional relationship is jeopardized and patients are at risk of great harm. Violations of such boundaries, particularly of a sexual nature, can engender in patients a loss of trust in the physician and in the health professions and feelings of betrayal, victimization, anger, shame and guilt. Sexualizing the relationship and sharing highly personal and private material represent a clear and profound breach of trust, and would be viewed by members of the profession as disgraceful, dishonourable and unprofessional conduct.

Dr. Phipps also showed naked photographs of himself to three staff members. Dr. Phipps was in a position of authority with respect to the staff at the clinic. His behaviour in sharing naked photographs of himself with clinic staff was wholly inappropriate and unacceptable. In the Committee's view, it rose well above the level of unacceptable into disgraceful, dishonourable and unprofessional conduct based on the highly personal and private nature of the material and the intent to embarrass. However, whether or not the staff were uncomfortable, shocked or otherwise adversely affected is not relevant; conduct need not be harmful to be unprofessional.

There are boundaries to physicians' behaviour towards patients, colleagues, coworkers and the public. Physicians are expected to strictly maintain those boundaries and if they do not do so, they should expect to be judged adversely. Boundaries in a physician's workplace are essential so as to provide an atmosphere of safety and respect for all. They help control and address issues of workplace harassment, workplace safety, and power imbalance in settings that are often fast-paced, intense, and stressful. Dr. Phipps' conduct crossed such boundaries and constitutes disgraceful, dishonourable, and unprofessional conduct. It cannot be tolerated.

The Committee accepted Dr. Phipps's admission and found that he committed an act of professional misconduct in that he has engaged in disgraceful, dishonourable and unprofessional conduct in relation to eleven patients and three clinic staff.

Disposition

On September 18, 2019, the Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Phipps's certificate of registration for a period of fourteen (14) months, commencing on October 1, 2019.
- The Registrar place the following terms, conditions and limitations on Dr. Phipps's certificate of registration:
    - Dr Phipps shall not engage in any professional encounters, in person or otherwise ("Professional Encounters"), with patients of any age, in any jurisdiction, unless the Professional Encounter takes place in the continuous presence and under the continuous observation of a monitor who is a regulated health professional acceptable to the College (the "Practice Monitor"). At all times, Dr. Phipps shall ensure that the Practice Monitor shall:
        - Remain in the examination room or consultation room at all times during all professional encounters with patients, even if another person is accompanying the patient;
        - Carefully observe all of his physical examinations with an unobstructed view of the examination;
        - Refrain from performing any other functions, except those required in the Practice Monitor's undertaking attached to the Order as Appendix

"A" (the "Practice Monitor's Undertaking"), while observing him in all his professional encounters with patients;

- Keep a patient log in the form attached as Appendix "B" to the Order of all the patients with whom Dr. Phipps has an in-person professional encounter in the Practice Monitor's presence (the "Log");

- Initial the corresponding entry in the records of each patient noted in the Log to confirm that the Practice Monitor was in the presence of Dr. Phipps at all times during in-person professional encounter;

- Submit the original Log to the College on a monthly basis; and
- Provide reports (as described in the Practice Monitor's Undertaking) to the College on at least a monthly basis.

- Dr. Phipps shall post a sign in each of his examination and consultations rooms that states: "Dr. Nigel Mark Phipps must not have professional encounters, in person or otherwise, with patients, unless in the continuous presence of and under the continuous observation of a practice monitor acceptable to the College of Physicians and Surgeons of Ontario. Dr. Phipps must not be alone with patients in any examination or consulting room. Further information may be found on the College website at www.cpso.on.ca;"
- Dr. Phipps shall continue therapy with a College-approved psychiatrist, who shall provide written reports to the College quarterly for two years and thereafter, every six months. Dr. Phipps shall meet with the psychiatrist as often as recommended by the psychiatrist;
- Dr. Phipps shall inform the College of each and every location where he practices, in any jurisdiction ("Practice Location(s)") within five days of commencing practice at that location; and
- Dr. Phipps shall be responsible for all costs associated with implementing the terms of the Order.
- Dr. Phipps shall reimburse the College funding under the program required under section 85.7 of the Code with respect to eleven patients, by posting an irrevocable letter of credit or other security acceptable to the College, within thirty days of the order in the amount of $176,660.00.
- Dr. Phipps attend before the panel to be reprimanded.

Costs

On October 11, 2019, the Committee ordered that Dr. Phipps pay costs in the amount of $32,270.00.

4. Dr. T. K. Young

Name:	Dr. Todd Kevin Young
Practice:	Family Medicine
Practice Location:	Springdale, Newfoundland
Hearing:	Uncontested Facts and Admission Penalty – Joint Submission
Finding/Penalty Decision Date:	July 23, 2019
Written Decision Date:	September 17, 2019

Allegations and Findings

- sexual abuse of a patient - **proven**
- disgraceful, dishonourable or unprofessional conduct - **proven**

Summary

Dr. Young has held a certificate of independent practice with the College of Physicians and Surgeons of Ontario since 2004. He also holds a certificate of registration with the College of Physicians and Surgeons of Newfoundland and Labrador. As of August 2009, he has practised as a family physician in Springdale, Newfoundland.

Patient A

Dr. Young was Patient A's family physician between August 2009 and February 2011. In addition to being Dr. Young's patient, Patient A was also employed at the hospital where Dr. Young worked.

While Patient A was a patient of Dr. Young's, Dr. Young engaged in a personal relationship with Patient A. He socialized with her at work in the doctor's lounge, in Dr. Young's office, and in the clinic, both during the day and after hours. They discussed matters of a personal nature, including that they were both having difficulties in their respective marriages. They exchanged personal cell phone numbers and would text each other throughout the day.

In February 2011, Dr. Young transferred Patient A's care to another family physician in order to pursue a romantic relationship with Patient A. After the termination of the physician-patient relationship, Dr. Young and Patient A continued to be work colleagues, and their relationship became romantic. Dr. Young and Patient A began dating in August 2011 and began having sexual intercourse in approximately late 2011/early 2012. Their relationship ended in approximately 2014.

In engaging in the conduct described above, Dr. Young 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.

Patient B

Dr. Young was Patient B's family physician between August 2009 and January 2014. In November 2013, Dr. Young and Patient B exchanged personal cell phone numbers. During a period of three months, while Patient B was a patient of Dr. Young's, Dr. Young engaged in a romantic relationship with Patient B, consisting of communications via text and over the telephone about personal matters, including Patient B's separation from her husband, and hugging and kissing on a couple of occasions.

In engaging in the conduct described at paragraph above, Dr. Young engaged in sexual abuse of Patient B, and 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.

College of Physicians and Surgeons of Newfoundland and Labrador

On November 26, 2015, Dr. Young appeared before the Adjudication Tribunal of the College of Physicians and Surgeons of Newfoundland and Labrador and pleaded guilty to an allegation that he had engaged in "conduct deserving of sanction", as defined in s. 39(c) of the *Medical Act, 2011*, SNL 2011, c. M-4.02. Under s. 39(c) of the *Medical Act, 2011*:

39. (c) "conduct deserving of sanction" includes:

(i) **professional misconduct,**
(ii) professional incompetence,
(iii) conduct unbecoming a medical practitioner,
(iv) incapacity or unfitness to engage in the practice of medicine, and
(v) acting in breach of this Act, the regulations or the code of ethics adopted under section 15 [emphasis added].

Dr. Young pleaded guilty to engaging in conduct deserving of sanction with respect to his conduct towards Patients A and B, as set out above.

For reasons released December 15, 2018, the Adjudication Tribunal of the College of Physicians and Surgeons of Newfoundland and Labrador found Dr. Young "guilty of conduct deserving of sanction in relation to his personal and sexual relationship with Patient A with whom he had a doctor/patient relationship, and in relation to his inappropriate kissing and hugging with patient B with whom he had a doctor/patient relationship".

Dr. Young's Discipline History

Dr. Young has no prior discipline history.

Disposition

On July 23, 2019, the Discipline Committee ordered that:

- The Registrar suspend Dr. Young's certificate of registration for six (6) months.
- Dr. Young attend before the panel to be reprimanded.
- Dr. Young pay costs to the College in the amount of $6,000.00 within 30 days of the date of the Order.

Failed to Maintain the Standard of Practice of the Profession – 4 cases

1. Dr. E. D. Armogan

Name:	Dr. Edward Davindra Armogan
Practice:	Family Medicine
Practice Location:	London
Hearing:	Agreed Statement of Facts and Admission Penalty – Joint Submission
Finding/Penalty Decision Date:	August 14, 2019
Written Decision Date:	September 24, 2019

Allegations and Findings

- failed to maintain standard of practice of the profession - **proven**
- disgraceful, dishonourable or unprofessional conduct – **proven**
- incompetence - **withdrawn**

Summary

Dr. Armogan is a family physician who received his certificate of registration authorizing independent practice from the College of Physicians and Surgeons of Ontario ("the College") in June 1990.

At the relevant time, Dr. Armogan practised family medicine in London, Ontario. A significant portion of his practice has focused on providing general practitioner psychotherapy and treatment to patients with psychological disorders. The remaining portion of his practice is general family medicine for patients. Dr. Armogan also maintains a cosmetic medicine practice which is not the subject of this matter.

Dr. Armogan signed an undertaking on April 27, 2015 (the "2015 Undertaking"). Among other things, Dr. Armogan agreed to undergo clinical supervision of his prescribing of opioids and other controlled medications. As a result, Dr. Armogan engaged in clinical supervision with Dr. Rashmi Bhalla from June 8, 2015 to August 17, 2016.

During supervision, Dr. Bhalla identified concerns about Dr. Armogan's prescribing of stimulants for treatment of attention deficit hyperactivity disorder ("ADHD") in adults. As a result of the concerns raised by Dr. Bhalla, Dr. Armogan entered into a supplemental undertaking on May 13, 2016 (the "2016 Supplemental Undertaking").

The 2016 Supplemental Undertaking specified that Dr. Armogan was not to prescribe stimulant medication to adults for augmentation in the treatment of depression or for the treatment of adult ADHD unless the medication was first prescribed by a psychiatrist.

Data obtained by the College from the provincial Narcotics Monitoring System ("NMS") showed that on several occasions Dr. Armogan breached the 2016 Supplemental Undertaking, by initiating or re-initiating prescriptions for stimulants for adult patients for the treatment of ADHD without ensuring the medication was first prescribed by a psychiatrist.

In general, Dr. Armogan's breaches of his 2016 Supplemental Undertaking comprised of the following circumstances:

a) Matters in which Dr. Armogan re-initiated prescribing of stimulants to adult patients without a psychiatrist having written the first prescription or having completed a consultation prior to Dr. Armogan's prescribing;
b) Matters in which Dr. Armogan initiated prescribing of stimulants after having obtained a consultation with a psychiatrist, but where the psychiatrist had not written the first prescription and in some cases had not endorsed a current ADHD diagnosis or initiation of stimulant prescribing at this time; and
c) Matters in which Dr. Armogan initiated prescribing of stimulants based on information from the patient that the patient had been prescribed stimulants for ADHD in the past, but where Dr. Armogan did not ensure that the information was correct and/or did not ensure the currency of any first prescription written by a psychiatrist.

Standard of Practice

Dr. Armogan's 2015 Undertaking required him to undergo a reassessment of his family practice after completion of a period of clinical supervision. Dr. Joy Weisbloom was retained to conduct the reassessment. She reviewed fifteen patient records and interviewed Dr. Armogan.

As concluded by Dr. Weisbloom, Dr. Armogan failed to maintain the standard of practice of the profession in eleven of the fifteen patient charts reviewed, including with respect to appropriate prescribing of stimulants and narcotics, conduct of and response to urine drug screens, and medical record-keeping.

Dr. Weisbloom did find that Dr. Armogan had made positive changes since she first assessed his practice in 2014 prior to his entering into the 2015 Undertaking, and that it was evident he cared about his patients and was endeavouring to improve his practice to provide better care. She noted that the major deficiencies had been addressed and shown improvements.

Clinical Supervision and Cooperation with the College

Dr. Armogan cooperated with the College Compliance Case Manager's requests for information regarding prescriptions for specific patients. After the Compliance Case Manager drew the College's compliance concerns to Dr. Armogan's attention, no new compliance concerns arose.

Pending the discipline hearing, Dr. Armogan voluntarily agreed to abide by an interim undertaking to the College requiring, among other things, that his practice be under clinical supervision.

As a result of this interim undertaking, Dr. Armogan's practice has been under the clinical supervision of Dr. Shelendra Joshi since August 2018. Among other things, Dr. Joshi undertook to review with Dr. Armogan every patient chart regarding each patient to whom Dr. Armogan prescribes any narcotic drugs, narcotic preparations, controlled drugs, benzodiazepines and other targeted substances, and/or all other monitored drugs to ensure that assessment, clinical examination, risk assessment for addiction and ongoing management and follow-up is appropriate.

Dr. Joshi's report of May 26, 2019 notes among other things that:

- Dr. Armogan's prescribing of controlled substances was reasonable in dose and amounts dispensed.
- Dr. Armogan has become more diligent regarding updating the medication lists in his cumulative patient profiles. His documentation for prescribing opioids has been meeting the standard of practice required.
- Dr. Armogan has been abiding by the terms of his restrictions regarding prescribing of stimulants for ADHD.

Relevant History with the College

In October 2010, Dr. Armogan was required by the Inquiries, Complaints and Reports Committee ("ICRC") to attend at the College to be cautioned regarding the assessment and management of anxiety, depression and ADHD and, specifically, what is required to assess these conditions before prescribing potentially dangerous combinations of medications.

In 2015, the ICRC accepted Dr. Armogan's 2015 Undertaking in resolution of a public complaint regarding his care of a patient and a broader investigation into his prescribing to pediatric patients.

In the 2015 Undertaking, Dr. Armogan agreed to a restriction on his prescribing stimulants to patients under the age of 18 without prior approval of a consulting psychiatrist. This restriction remains in effect and is not in issue in the present matter. No concerns have arisen to date regarding Dr. Armogan's compliance with this restriction.

In addition to engaging in the remediation and clinical supervision required by his 2015 Undertaking, 2016 Supplemental Undertaking and interim undertaking pending the present discipline hearing, Dr. Armogan voluntarily attended the Safe Opioid Prescribing Course at the University of Toronto, which he completed on December 7, 2018.

Disposition

On May 13, 2019, the Discipline Committee ordered and directed that:

- Dr. Armogan attend before the panel to be reprimanded
- The Registrar suspend Dr. Armogan's certificate of registration for a period of two months, commencing from August 15, 2019 at 12:01 a.m.
- The Registrar place the following terms, conditions and limitations on Dr. Armogan's certificate of registration:

  (i) Dr. Armogan shall comply with the College Policy on "*Practice Management Considerations for Physicians Who Cease to Practise, Take an Extended Leave of Absence or Close Their Practice Due to Relocation*", in respect of the suspension of his certificate of registration.

  (ii) Dr. Armogan shall not prescribe stimulant medication to patients who are 18 years of age or older, unless the medication has been first prescribed by a psychiatrist, as documented in a consultation letter from the psychiatrist to be maintained by Dr. Armogan in the patient's chart. For greater certainty, and without restricting the foregoing, if a patient of Dr. Armogan who is 18 years of age or older was previously prescribed stimulant medication, but such prescribing has been discontinued or the medication has not been taken for the past three or more months, Dr. Armogan shall not prescribe stimulant medication to the patient unless a psychiatrist first assesses the patient and initiates a new prescription, as documented in a consultation letter to be maintained by Dr. Armogan in the patient's chart.

  (iii) Dr. Armogan shall participate in and successfully complete, within six months of the date of the Order, individualized instruction in medical ethics satisfactory to the College, with an instructor approved by the College, who shall provide a summative report to the College including his or her conclusion about whether Dr. Armogan successfully completed the instruction.

  (iv) Dr. Armogan shall consent to the College providing any information the College has that led to the circumstances of the Order and any information arising from the monitoring of his compliance with the Order to any person who requires this information to facilitate his completion of the individualized instruction in medical ethics.

  (v) Dr. Armogan shall keep a log of all prescriptions for Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines and Other Targeted Substances and All Other Monitored Drugs, which will include at least the following information:

    (a) the date of the appointment;
    (b) the name of the patient and chart/file number;
    (c) the name of the medication prescribed, dose, direction, number of tablets to be dispensed and frequency;
    (d) the clinical indication;

- (e) whether the prescription is for a new medication and/or different dose or frequency than currently prescribed to the patient (Y/N);
- (f) Dr. Armogan's signature;
- (g) the date of the Clinical Supervisor's review (if applicable, as set out below); and
- (h) the Clinical Supervisor's signature (if applicable, as set out below).

(vi) Dr. Armogan shall keep a copy of all prescriptions he writes for Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines and Other Targeted Substances and All Other Monitored Drugs, in the corresponding patient chart.

(vii) Upon the conclusion of the suspension of Dr. Armogan's certificate of registration, Dr. Armogan shall practise under the guidance of a clinical supervisor acceptable to the College (the "Clinical Supervisor") for three months, on the terms set out below

(viii) Dr. Armogan shall cooperate fully with the Clinical Supervision and abide by all recommendations of his Clinical Supervisor including, but not limited to, any recommended practice improvements and professional development.

(ix) Dr. Armogan shall review with his Clinical Supervisor every patient for whom he has prescribed any Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines and Other Targeted Substances and/or All Other Monitored Drugs to ensure that assessment, clinical examination, risk assessment for addiction and ongoing management and follow up is appropriate.

(x) Dr. Armogan shall ensure that his Clinical Supervisor confirms their review of his patient care with him by signing the Prescribing Log and the patient chart in question within two weeks of Dr. Armogan issuing any prescription for Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines and Other Targeted Substances and/or All Other Monitored Drugs.

(xi) Dr. Armogan shall ensure that Schedule "F" to the Order is signed and delivered to the College by an approved Clinical Supervisor prior to the conclusion of the suspension of his certificate of registration.

(xii) If a person who has given an undertaking in Schedule "F" to the Order is unable or unwilling to fulfill its provisions, Dr. Armogan shall, within fourteen (14) days of receiving notice of the same, ensure that he has delivered to the College an executed undertaking in the same form from a similarly qualified person who is acceptable to the College.

(xiii) If Dr. Armogan is unable to obtain a Clinical Supervisor on the terms set out, he will cease prescribing Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines and Other Targeted Substances and/or All Other Monitored Drugs until he has obtained a Clinical Supervisor acceptable to the College, and this will constitute a term, condition, or limitation on his certificate of registration.

(xiv) Dr. Armogan shall consent to the disclosure by the Clinical Supervisor to the College, and by the College to the Clinical Supervisor, of all information the Clinical Supervisor or the College deems necessary or desirable in order to fulfill the Clinical Supervisor's undertaking and to monitor Dr. Armogan's compliance with the Order. This shall include, without limitation, providing the Clinical Supervisor with any reports of any assessments of or prior clinical supervision of Dr. Armogan's practice in the College's possession.

(xv) Approximately six months after the Clinical Supervision above has ceased, Dr. Armogan will submit to a reassessment (the "Reassessment") of his family practice, including but not limited to his prescribing of Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines and Other Targeted Substances and All Other Monitored Drugs, by an assessor or assessors selected by the College (the "Assessor(s)"). The Reassessment may include chart reviews, direct observation of Dr. Armogan's care, interviews with colleagues and co-workers, feedback from patients and any other tools deemed necessary by the College. The results of the Reassessment will be reported to the College and may form the basis of further action by the College.

(xvi) Dr. Armogan shall cooperate fully with the Reassessment and with the Assessor(s). Dr. Armogan shall consent to the disclosure among the Clinical Supervisor, the College, and the Assessor(s) of all information any of them deems necessary or desirable to complete the Reassessment and to monitor Dr. Armogan's compliance with the Order. This shall include, without limitation, providing the Assessor(s) with any reports of any assessments of or clinical supervision of Dr. Armogan's practice in the College's possession

(xvii) If it deems the Reassessment satisfactory, the Inquiries, Complaints and Reports Committee of the College may direct that any or all of the terms, conditions and limitations on Dr. Armogan's certificate of registration be lifted.

(xviii) Dr. Armogan shall cooperate with unannounced inspections of his office practice and patient charts for the purpose of monitoring and enforcing his compliance with the terms of the Order.

(xix) Dr. Armogan shall inform the College of each and every location where he practices, including but not limited to hospitals(s), clinic(s) and office(s), in any jurisdiction, within 10 days of the Order. Going forward, he shall inform the College of any and all new Practice Locations in any jurisdiction five days in advance of commencing practice at that location.

(xx) Dr. Armogan shall give his irrevocable consent to the College to make enquiries of the Ontario Health Insurance Plan ("OHIP"), the Drug Program Services Branch, the Narcotics Monitoring System ("NMS") implemented under the Narcotics Safety and Awareness Act, 2010 and/or any person or institution who may have relevant information, in order for the College to monitor his compliance with the provisions of the Order.

(xxi)Dr. Armogan shall be responsible for any and all costs associated with implementing the terms of the Order.

- Dr. Armogan pay costs to the College in the amount of $6,000 within thirty (30) days of the date of the Order.

2. Dr. T.Y. Hurmatov

Name:	Dr. Tetyana Yaremivna Hurmatov
Practice:	Family Medicine
Practice Location:	St. Catharines
Hearing:	Agreed Statement of Facts and Admission Penalty – Joint Submission
Finding/Penalty Decision Date:	July 22, 2019
Written Decision Date:	September 16, 2019

Allegations and Findings

- failed to maintain standard of practice of the profession - **proven**
- disgraceful, dishonourable or unprofessional conduct – **proven**
- incompetence - **withdrawn**

Summary

Dr. Hurmatov is 41 years old, and practices family medicine in St. Catharines, Ontario. She received her certificate of registration authorizing independent practice from the College in 2010.

Information from the Narcotics Monitoring System

In October 2016, the College received information from the Ministry of Health and Long-Term Care's Narcotics Monitoring System regarding Dr. Hurmatov's prescribing of controlled drugs, including narcotics, from January 1, 2015 to December 31, 2015 (the "NMS data"). The NMS data indicated that Dr. Hurmatov had been identified as a physician who, in 2015, had eight or more patients receiving at least 650 oral morphine equivalents ("OMEs") per day, and who had issued at least one prescription exceeding 20,000 OMEs.

Investigation of Dr. Hurmatov's Practice

The College retained Dr. Andrew Grant to opine on Dr. Hurmatov's prescribing of controlled substances, with a specific focus on the use of opioids for non-cancer pain. Dr. Grant identified a number of issues with Dr. Hurmatov's opioid prescribing:

a) Dr. Hurmatov prescribed a high-dose opioid to a patient attempting to get pregnant;
b) Dr. Hurmatov provided a patient with dosing instructions for use of high-dose long-acting opioids on an as-needed ("PRN") basis, leading to large dose fluctuations with no gradual titration upwards;

c) Patients self-escalated their opioid doses, contrary to signed opioid contracts which stated that patients were only to take opioids at the doses prescribed by Dr. Hurmatov. Although Dr. Hurmatov did warn some patients not to self-escalate their dose, in some other cases Dr. Hurmatov's responded by increasing the dose of prescribed opioid to the amount that the patient had achieved by self-escalation;
d) Dr. Hurmatov's poor interpretation of urine drug screen results. In six cases, Dr. Hurmatov continued prescribing high dose opiates in the setting of urine drug screen results that were significantly abnormal and that potentially indicated drug addiction and/or diversion;
e) Dr. Hurmatov concurrently prescribed large dose immediate release opioids in addition to large dose controlled release opioids, indicating a lack of knowledge about the appropriate use and dosing of short acting opioids;
f) In three cases, Dr. Hurmatov rotated patients' opioids at high doses, without reducing the morphine equivalent dose of the new opioid to account for lack of tolerance;
g) There was poor tracking of patients' opioid renewal dates, inappropriate early refills, and lack of oversight with respect to patients' accumulation of surplus high dose opioids;
h) Dr. Hurmatov frequently used controlled release opioids at a shorter dosing interval than recommended (i.e. with TID or QID dosing);
i) Dr. Hurmatov co-prescribed benzodiazepines with high dose opioids; and
j) Dr. Hurmatov rapidly escalated patients' doses of controlled release opioids.

The College also retained Dr. Linda Klapwyk to provide an opinion as to Dr. Hurmatov's prescribing practices, other than with respect to her opioid prescribing. Dr. Klapwyk expressed a number of concerns with respect to Dr. Hurmatov's prescribing:

a) Concomitant prescribing of benzodiazepines with high-dose opioids, which may result in profound sedation, respiratory depression, coma, and death, and which should very rarely be prescribed together;
b) Prescribing of benzodiazepines in high doses and for long periods of time;
c) Combining central nervous system depressants such as anticonvulsants, antipsychotics, hypnotics, and skeletal muscle relaxants with opioids;
d) Inappropriate prescribing of stimulants to address complaints of fatigue and sedation in patients to whom central nervous system depressants had also been prescribed;
e) Prescribing Olanzapine, an atypical antipsychotic indicated for schizophrenia or bipolar disorder, for sleep in a patient who was overmedicated, at risk for respiratory depression, and did not have an indication for an olanzapine prescription other than sedation as there was no documentation of schizophrenia or bipolar disorder;
f) Failure to reduce patients' prescriptions for sedatives despite documentation of side-effects or harm such as sedation, fatigue, and impaired cognition.

Self-prescribing and Self-Treatment

Between 2011 and 2017, Dr. Hurmatov wrote numerous prescriptions in her name and the name of her clinic for her own use and/or which she used and treated herself, between approximately 2011 and 2017, including for narcotics and controlled substances:

a) Dr. Hurmatov started herself on Cipralex 10mg in January 2011;
b) In the fall of 2011, Dr. Hurmatov injected herself with Juvederm hydrate. She obtained the filler over the Internet from Ireland. She developed facial edema and neck swelling, which she self-treated with Prednisone, subsequent injections of Kenalog and Hyaluronidase, Lasix, antibiotics, Percocet, and Tylenol #1. Dr. Hurmatov developed adrenal insufficiency with Cushingoid appearance due to self-administering cortisone injections;
c) In December 2011, Dr. Hurmatov was started on Pristiq 50mg per day by another physician. Dr. Hurmatov increased the Pristiq to 100mg on her own, and later lowered it back down to 50 mg;
d) In January 2012, Dr. Hurmatov started herself on Temazepam and Atenolol;
e) In March 2012, Dr. Hurmatov began self-prescribing Dilaudid 2 mg. She sourced the Dilaudid, an opioid, from tablets returned by a patient. She also gave herself Xylocaine occipital nerve blocks;
f) In June 2013 and April 2014, Dr. Hurmatov took Nootropil that she had ordered online, to help relax and as a memory aid;
g) In March 2014, Dr. Hurmatov had some sleep problems which she attempted to self-treat by taking extra amounts of Clonazepam;
h) By 2017, Dr. Hurmatov had been prescribed Cymbalta 30 mg and Zopiclone 7.5 mg by another physician. She increased the Cymbalta to 60 mg and the Zopiclone to 15 mg without a physician's approval;
i) In June 2017, the College received information from the NMS that Dr. Hurmatov prescribed benzodiazepines to herself between March 2013 and April 2017, issuing approximately 29 prescriptions, most commonly of lorazepam (30 1-mg tablets)
j) In addition to writing herself prescriptions for benzodiazepines as set out above, Dr. Hurmatov also self-prescribed eight other medications between January 2015 and February 2017, including CAP Prometrium, TAB Apo-Sumatriptan, TAB Apo-Eletriptan, Estrogel and Cytomel.

Dr. Hurmatov's self-prescribing took place in the context of depression and anxiety. Since February 2018, Dr. Hurmatov has been under the treatment of a physician, and there have been no further issues with self-prescribing.

Treatment of Family Members

Between 2011 and 2017, Dr. Hurmatov wrote prescriptions for five family members. This included:

- a total of five prescriptions to Family Member A, issued in 2011, 2013, 2015, and 2016, for TAB Dexedrine, CAP Tamiflu, CAP Apo-Minocycline, TAB Apo-Indapamide, and GM Fucidin Cream 2%;
- a total of three prescriptions to Family Member B, in 2014 and 2016 for ML Apo-Amoxi Oral Susp and DOS Omnaris;
- one prescription to Family Member C in 2013 for CAP Tamiflu;
- a total of six prescriptions to Family Member D, issued in 2012, 2015, 2016 and 2017 for POW Pms-Azithromycin; ML Sandoz-Azithromycin; ML Apo-Amoxi Oral Susp (Sugar Free); and ML Apo-Amoxi Oral Susp; and
- a total of 52 prescriptions to Family Member E, issued in 2013, 2014, 2015, 2016, and 2017 for medications including, TAB Apo-Cefprozil, CAP Tamiflu, STR Oracle Test Strips,TAB Co-Rizatroptan ODT, TAB Pms-Metodopramide, WAF Maxalt RPD, DOS Nitrolingual Pumpspray, DOS Ventolin HFA 100mcg,TAB Apo-Valacyclovir, CAP Apo-Amoxi, TAB Apo-Escitalopram,TAB Mylan-Ciprofloxacin, CAP Mylan-Minocycline,TAB Mylan-Ciprofloxacin, GM Anusol-HC Ointment, CAP Apo-Amoxl, TAB Apo-Atenol, GM Anusol-HC Ointment, ML Apo-Olopantadine, TAB-Mylan-Baclofen,TAB Apo-Metoprolol, TAB Novo-Rabeprazole EC, CAP Creon 25, TAB Pms-Ciprofloxacin XL, TAB Novo-Lexin, GM Taro-Mometasone 0.1%, GM Ketoderm Cream 2%, TAB Novo-Semide, CAP Xenical, TAB Teva-Almotriptan, CAP Apo-Amoxi, TAB Glucobay, TAB Apo-Metformin, GM Fucidin Cream 2%,TAB Mylan-Baclofen, ML Ratio-Ectosone Scalp Lotion 0.1%, TAB Apo-Baclofen 20mg, Apo-Amoxi, TAB Apo-Amoxi Clav, TAB Novo-Sucralate, TAB Pantoprazole Magnesium, TAB Acto-Clarithromycin XL, DOS Apo-Ciclesonide,TAB Apo- Baclofen, CAP Creon 25, TAB Apo-Bisoprolol, CAP Xenical, GM Anusol-HC Ointment, CAP Apo-Hydroxyzine, and ML Ciprodex Otic Soln.

Dr. Hurmatov did not maintain patient charts for the family members to whom she prescribed and treated. Dr. Hurmatov did not bill OHIP for prescribing to and treating her family members. Dr. Hurmatov engaged in this treatment of her family members during a period when she had depression and anxiety, and in the context of a difficult family dynamic. Since November 2017, Dr. Hurmatov's family members have been exclusively under the care of an unrelated family physician.

College Undertaking

On July 16, 2019, Dr. Hurmatov entered into an undertaking with the College by which, among other things, she permanently agreed, effective July 22, 2019, not to issue new prescriptions or renew existing prescriptions for or administer any of the following substances: narcotic drugs, narcotic preparations, controlled drugs, benzodiazepines and other targeted substances, and monitored drugs.

Disposition

The Discipline Committee ordered that:

- Dr. Hurmatov attend before the panel to be reprimanded.

- The Registrar suspend Dr. Hurmatov's certificate of registration for a period of three (3) months, commencing from July 23, 2019, at 12:01 a.m.
- The Registrar place the following terms, conditions and limitations on Dr. Hurmatov's certificate of registration:
    - Dr. Hurmatov will participate in the PROBE Ethics & Boundaries Program offered by the Centre for Personalized Education for Professionals, by receiving a passing evaluation or grade, without any condition or qualification. Dr. Hurmatov will complete the PROBE program within 6 months of the date of the Order, and will provide proof to the College of her completion, including proof of registration and attendance and participant assessment reports, within one month of completing it.
- Dr. Hurmatov pay costs to the College in the amount of $6,000.00 within thirty (30) days from the date of the Order.

3. Dr. B.M. Hyde

Name:	Dr. Byron Marshall Hyde
Practice:	General Practice
Practice Location:	Ottawa
Hearing:	Agreed Statement of Facts on Liability Penalty – Joint Submission
Finding/Penalty Decision Date:	August 14, 2019
Written Decision Date:	October 2, 2019

Allegations and Findings

- failed to maintain standard of practice of the profession - **proven**
- disgraceful, dishonourable or unprofessional conduct – **proven**
- incompetence - **withdrawn**

Summary

Until July 9, 2019, Dr. Hyde was a general practitioner in Ottawa, Ontario. He held a certificate of independent practice with the College of Physicians and Surgeons of Ontario since 1968.

Failure to Maintain the Standard of Practice of the Profession

The College retained an expert to provide an opinion with respect to Dr. Hyde's care and treatment of patients. In his reports, the expert opined that:

I. Dr. Hyde failed to maintain the standard of practice with respect to his medical record-keeping in that:
    a. His patient charts are not clearly written, are disorganized and often lack an easily identifiable patient record;

b. He fails to maintain chronological SOAP notes or other clearly delineated summaries of patients' investigations and medical condition(s), such as a Cumulative Patient Profile, and does not include pertinent positive or negative findings, rationale for ordering investigations or discussions with patients about the results;
c. Dr. Hyde uses unprofessional language in his charts to describe his patients;

II. Dr. Hyde states that he practices "complex disease management" primarily involving Myalgic Encephalomyelitis and Chronic Fatigue Syndrome, which is outside the conventionally-recognized scope of general or primary care practice;
III. Dr. Hyde takes diagnostic approaches that are not supported or corroborated by conventional practice, and orders investigations the results of which are nonspecific and yield no discernible constructive findings;
IV. Dr. Hyde failed to follow currently accepted guidelines for the detection of prostate cancer, including in ordering PSA testing;
V. Dr. Hyde lacked knowledge of opioid or benzodiazepine treatment contracts, despite prescribing long-term benzodiazepines to patients;
VI. Dr. Hyde lacked knowledge as to whether or not his electronic correspondence and patient files are encrypted or stored in a secure fashion, despite the fact that he purported to conduct an extensive telemedicine practice from Italy for several months each year.

The College retained another expert to provide an opinion specifically with respect to Dr. Hyde's psychotherapy practice. In his reports, the expert opined that:

I. Dr. Hyde failed to record what is required of a practitioner providing psychotherapy, such as a mental status exam, diagnosis, his psychotherapeutic treatment plans, his interventions and the patient's response to treatment;
II. In one case, where Dr. Hyde billed OHIP for providing psychotherapy 49 times between 2006 and 2016, the expert found only one adequate psychotherapy note;
III. In five cases, the expert could find no evidence in the charts that Dr. Hyde performed any psychotherapy, despite Dr. Hyde's numerous billings between 2005 and 2016.
IV. In one case, Dr. Hyde prescribed addictive medications and opioids, including Dilaudid, quietapine, clonazepam, and hydromorphone, without documenting the patient's progress, and how the psychotherapy he was providing was assisting the patient. He failed to properly monitor the patient for risk of addiction, overdose and suicide. This displayed a lack of judgment.

Dr. Hyde's inappropriate care and treatment of his employee

Individual B was employed by Dr. Hyde. While Individual B was Dr. Hyde's employee, Dr. Hyde:

I. prescribed medication to Individual B on six occasions, including a prescription for a tricyclic antidepressant; and

II. billed OHIP for providing treatment to Individual B on eight occasions, including for psychotherapy on seven of those occasions, between April 2009 and August 2010.

Despite prescribing to Individual B, and billing OHIP for treating Individual B, Dr. Hyde did not maintain a patient chart for Individual B.

Unprofessional communications, boundary violations, and conflict of interest

Dr. Hyde is the founder of a charitable foundation. Dr. Hyde wrote newsletters for his charitable foundation, which he mailed to the patients in his medical practice. In these newsletters, Dr. Hyde provided his personal opinions that the compensation of physicians in Canada is inadequate, complained about the College's requirements of physicians, solicited patients to make donations to his charitable foundation, and disclosed inappropriate personal information about himself and of his patients.

Patient A was a patient of Dr. Hyde's between approximately 2008 and 2014. In appointments with Patient A, Dr. Hyde disclosed his and other patients' health information, questioned the competency of other physicians, and complained about physicians' remuneration and about the College, including the College's record-keeping requirements.

Block Fee for Uninsured Services

When Patient A first became a patient of Dr. Hyde's, Dr. Hyde charged her $1,500, purportedly as a block fee for services that are not covered by OHIP. In doing so, Dr. Hyde failed to comply with the OHIP Schedule of Benefits, and the College's policy on Block Fees and Uninsured Services by:

I. improperly charging Patient A a block fee charged to cover the constituent elements of one or more insured services;
II. failing to provide her with the alternative of paying for each service individually at the time that it was provided; and
III. failing to offer the block fee in writing indicating the services that were and were not covered by the block fee and failed to provide her with a copy of the policy to ensure that she was fully informed of her payment options.

Delay in Responding to Request for Patient Chart and Inappropriate Fee

In September 2013, Patient A's lawyer wrote to Dr. Hyde requesting a copy of her chart, which Patient A was required to produce for the purpose of motor vehicle litigation, enclosing a direction authorizing Dr. Hyde to release it to the lawyer.

Patient A did not obtain any portion of her chart from Dr. Hyde until July 2014, despite having made multiple requests for it both directly to Dr. Hyde and to his secretary, and despite attending at Dr. Hyde's office numerous times specifically for this purpose.

In July 2014, Dr. Hyde's assistant informed Patient A that her chart was available to be picked up, and that the fee would be $825. Dr. Hyde's first invoice to Patient A, indicated that the $825 fee was for "medical-legal work". When Patient A raised a concern with Dr. Hyde that his fee was excessive, and that she had not requested that he do any medical-legal work, he provided a revised invoice indicating that he had charged her $825 "to organize all patient data into a comprehensive chart and copy the entire file at the request of [Patient A]'s lawyer", and that this had taken him four hours.

Dr. Hyde entered into an undertaking to the College on July 5, 2019, by which he agreed to resign from the College, and not to apply or re-apply for registration as a physician to practise medicine in Ontario or any other jurisdiction, effective July 9, 2019.

Disposition

The Discipline Committee ordered that:
- Dr. Hyde attend before the panel to be reprimanded.
- Dr. Hyde pay costs to the College in the amount of $10,370.00 within thirty (30) days from the date of the Order.

4. Dr. E.J. Smith

Name:	Dr. Edward James Smith
Practice:	Family Medicine
Practice Location:	Ottawa
Hearing:	Agreed Statement of Facts and Admission Contested Penalty
Finding/Penalty Decision Date:	July 12, 2019
Written Decision Date:	October 4, 2019

Allegations and Findings

- failed to maintain standard of practice of the profession - **proven**
- disgraceful, dishonourable or unprofessional conduct – **proven**
- incompetence - **withdrawn**

Summary

Dr. Smith is a 63-year-old physician practicing medicine in Ottawa.

Disgraceful, dishonourable or unprofessional conduct

In 2010, the College's Out-of-Hospital Premises Inspection Program (OHPIP) was created by Regulation 114/94 to the Medicine Act. All members had 60 days to notify OHPIP if they were performing the procedures outlined in the Regulation. Dr. Smith wrote to the College providing a list of procedures he performed in his family practice. Based on his list of procedures, Dr. Smith fell within the ambit of the program and was

required to comply with OHPIP Standards. He was informed that his premises would have to be inspected and would have to be approved as an Out-of-Hospital premises (OHP). Shortly after being notified of this requirement, Dr. Smith communicated with College staff and advised them that he was not in fact providing any OHP procedures to his patients and that no inspection was required. Based on information provided by Dr. Smith, no inspection was ever conducted and his office was not approved as an OHP. In 2016, the College received information that another physician was performing OHP interventional pain management procedures in Dr. Smith's office. This information triggered a College investigation, during which it was determined that, despite what he had told the OHPIP, Dr. Smith was in fact himself performing OHP interventional pain management procedures. OHPIP conducted an inspection that disclosed multiple deficiencies in Dr. Smith's unapproved premises, including a failure to meet general physical standards, failure to meet medication standards and failure to meet staffing requirements, all of which are mandated in OHPIP Standards.

OHIP data established that Dr. Smith billed OHIP for OHPIP procedures between 2011 and 2017.

Failure to maintain the Standard of Practice

The College''s expert outlined multiple deficiencies in Dr. Smith's practice. Providing OHP procedures in an unapproved setting is an unsafe practice, particularly in light of the multiple deficiencies identified in the OHPIP inspection. The expert also concluded that Dr. Smith displayed a lack of judgment and knowledge in performing high-risk OHP procedure in an unapproved setting, without adequate staffing, equipment and adequate means or expertise to treat potential life-threatening complications.

Disposition

The Discipline Committee ordered that:

- The Registrar suspend Dr. Smith's certificate of registration for a period of seven months, to commence on the date of the order;
- The Registrar place the following terms, conditions and limitations on Dr. Smith's certificate of registration:
    - Dr. Smith shall comply with College Policy #2-07 "Practice Management Considerations for Physicians Who Cease to Practice, Take an Extended Leave of Absence or Close Their Practice Due to Relocation".
    - Dr. Smith will successfully complete the PROBE course in ethics and professionalism at his own expense, within 6 months of the date of the Order, or any alternative course in ethics and professionalism approved by the College. Dr. Smith will agree to abide by any recommendations of the PROBE program and provide proof of completion to the College.
    - Dr. Smith shall appear before the Committee to be reprimanded;
    - Dr. Smith pay to the College costs in the amount of $10,370.00 within 30 days of the date of the Order.

Appeal

On October 10, 2019, Dr. Smith appealed the penalty decision of the Discipline Committee to the Superior Court of Justice (Divisional Court). Pursuant to section 25.4(5) of the Health Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professions Act, 1991*, the penalty decision of the Discipline Committee remains in effect despite the appeal.

Found Guilty of Offence Relevant to Suitability to Practise – 1 case

1. Dr. T. J. Barnard

Name:	Dr. Thomas Joseph Barnard
Practice:	Family and Emergency Medicine
Practice Location:	Windsor
Hearing:	Agreed Statement of Facts Penalty – Joint Submission
Finding/Penalty Decision Date:	July 23, 2019
Written Decision Date:	September 17, 2019

Allegations and Findings

- found guilty of offence relevant to suitability to practise - **proven**
- disgraceful, dishonourable or unprofessional conduct – **proven**

Summary

Dr. Barnard is a 70-year-old family physician practising in Windsor. He received his certificate of registration authorizing independent practice from the College of Physicians and Surgeons of Ontario (College) in July 1980. He was certified by the College of Family Physicians of Canada as a specialist in Family Medicine in July 1982, and as a specialist in Family Medicine (Emergency Medicine) in November 1984.

On January 20, 2017, Dr. Barnard signed a voluntary Undertaking with the College. The Undertaking was part of the resolution of a discipline proceeding, which involved allegations regarding, among other things, Dr. Barnard's clinical care and prescribing practices. Pursuant to this Undertaking, Dr. Barnard agreed to cease practising family medicine and to limit his practice to the provision of cosmetic, aesthetic, and nutritional and lifestyle services. Dr. Barnard provided these services at a medical spa that he owned, the Fresh Medical Spa, in Windsor, Ontario.

Disgraceful, Dishonourable or Unprofessional Conduct Re: Breach of Discipline Committee Order

Pursuant to the Undertaking referenced above, as of March 17, 2017, Dr. Barnard's practice was restricted to aesthetic and cosmetic services and nutritional counselling. The Undertaking specified eleven services that he was permitted to provide. These included "injections of Botox for the reduction of wrinkles and superficial deformities"; and "injection of dermal fillers to replace lost volume and to correct deformities and scarring".

By Order of the Discipline Committee, dated February 13, 2017, Dr. Barnard was suspended from practising medicine for a period of four months, commencing on March

17, 2017. On account of his suspension, Dr. Barnard arranged for a nurse to attend Fresh Medical Spa to provide cosmetic injections during this period. He also contacted a physician colleague to act as a medical supervisor and oversee the nurse. The colleague agreed, in principle, to act as the medical supervisor to the nurse during Dr. Barnard's suspension. Dr. Barnard's initial telephone call was the only contact anyone at Fresh Medical Spa had with the proposed medical supervisor regarding supervision.

In late March 2017, the College learned that a nurse was scheduled to attend Fresh Medical Spa on April 5, 2017 for the purpose of performing cosmetic injections. On April 5, 2017, two Compliance Case Managers from the College attended Fresh Medical Spa unannounced. The nurse was present and had performed 10 injections over approximately two hours. Staff members of Fresh Medical Spa informed the Compliance Case Managers that the nurse was being overseen by the proposed medical supervisor, and that she was to contact him directly with any questions or concerns regarding the injections.

On the same day, the Compliance Case Managers interviewed the proposed medical supervisor. He confirmed that he had not been contacted to arrange for consultations with patients or to review the procedures recommended by the nurse before they were performed. He was entirely unaware that the nurse was attending Fresh Medical Spa and performing injections on that day. Consequently, the nurse performed injections without the oversight of a medical supervisor.

The College retained a cosmetic dermatologist, Dr. Nowell Solish, to review the issues around supervision and delegation during Dr. Barnard's suspension. Dr. Solish reviewed eleven charts of patients who attended at Fresh Medical Spa, as well as transcripts of interviews with the nurse and the proposed medical supervisor. He found no evidence that any patients were seen or reviewed by any physician in charge, and no evidence that any treatments or doses had been properly delegated to the nurse.

In his report Dr. Solish opined that, due to his suspension, Dr. Barnard could not be the physician in charge to either perform or delegate the injections. As such, a new physician-patient relationship with a physician other than Dr. Barnard was required for the purpose of assessing and delegating the injections. He further opined that "although Dr. Barnard requested that [the proposed medical supervisor] cover him during his suspension that no proper plan was in place. It appears that [the proposed medical supervisor] was not aware patients were being treated under his care and what his responsibilities were. It also appears that [the nurse] was not aware of these circumstances."

Along with his report, Dr. Solish provided an addendum, dated November 28, 2017. In the addendum, Dr. Solish describes concerning practices by Dr. Barnard that he noted during his chart review, namely, injecting Botox that was brought in by a patient from home, injecting Botox after its date of expiration, and storing partial filler for future use instead of using fully on a single patient or discarding.

Convicted of an Offence Relevant to his Suitability to Practise

In 2009, the Ministry of Health and Long-Term Care (MOHLTC) notified the Ontario Provincial Police (OPP) regarding Dr. Barnard's billing practices. According to the MOHLTC, Dr. Barnard had been billing a very significant number of time-based services (i.e., psychotherapy and counselling), which require direct patient contact for a prescribed period of time, pursuant to the Ontario Health Insurance Plan (OHIP) Schedule of Benefits. As a result, the OPP monitored Dr. Barnard's billing activity for a three-day period: November 17 – 19, 2009. That monitoring revealed that Dr. Barnard billed the following amounts:

i. November 17, 2009: Dr. Barnard billed for 42.7 hours of time-based services. He was paid $5,690.55 for that day;
ii. November 18, 2009: Dr. Barnard billed for 36.97 hours of time-based services. He was paid $4,974.90 for that day; and
iii. November 19, 2009: Dr. Barnard billed for 32.23 hours of time-based services. He was paid $4,309.20 for that day.

Dr. Barnard also billed for other, non-time-based services on those days.

As a result of the above information, the OPP conducted an investigation of all Dr. Barnard's billing for a period of 33 months. The OPP investigation determined that between April 1, 2007 and December 29, 2009, Dr. Barnard claimed 15 – 19 hours of time-based services per day on 57 days. He claimed more than 19 hours of time-based services per day on 323 days. His total billings for the 380 days where he billed in excess of 15 hours between April 1, 2007 and December 29, 2009 were approximately $1.3 million.

As a result of the investigation, on May 27, 2010, Dr. Barnard was arrested by the OPP and charged with two counts of fraud over $5,000 under section 380(1) of the Criminal Code of Canada. He was released on a Promise to Appear and an Undertaking.

The OPP investigation, however, continued and revealed that between December 31, 2009 and September 9, 2010, Dr. Barnard submitted the following claims for time-based billing services:

i. On 6 days during this period, Dr. Barnard billed between 15 – 19 hours of time-based services per day. He billed $13,360 for those 6 days.
ii. On 28 days during this period, Dr. Barnard billed between 19 – 24 hours of time-based services per day. He billed $80,156 for those 28 days.
iii. On 138 days during this period, Dr. Barnard billed more than 24 hours of time-based services per day. He billed $595,034 for those 138 days.

Even after being charged on May 27, 2010, Dr. Barnard continued his improper billing practices. He was subsequently charged with two additional counts of fraud over $5,000 on November 30, 2010.

The College learned of the criminal fraud charges through articles that appeared in the Windsor Star newspaper, and from the OPP. The MOHLTC also contacted the College to advise of their ongoing concerns regarding Dr. Barnard's billing of time-based K-Prefix codes and assessment fee codes which occurred after the first set of charges were laid. Dr. Barnard did not notify the College of these criminal charges, as he was required to do.

On May 31, 2017, all criminal fraud charges were withdrawn and Dr. Barnard pleaded guilty to one count of knowingly obtaining or attempting to obtain payments for an insured service that he was not entitled to obtain contrary to section 43(1) of the Ontario Health Insurance Act.

Prior to the Ontario Court of Justice Proceedings on May 31, 2017, Dr. Barnard had signed an Undertaking with the College which prohibited him from billing OHIP and from providing any insured services to patients. Justice of the Peace A. Renaud was advised of this Undertaking during the joint submissions on sentencing. The Court imposed a global restitution fee of $600,000, of which Dr. Barnard had already paid $350,000, as well as a fine totalling $10,000. Dr. Barnard paid the remaining $250,000 of restitution and the fine by June 9, 2017.

Disgraceful, Dishonourable or Unprofessional Conduct Re: Medical Post Comment

On February 13, 2017, a hearing regarding Dr. Barnard was held before the Discipline Committee of the College. At the hearing, Dr. Barnard admitted that he failed to maintain the standard of practice of the profession in his care and treatment of 55 patients. He also pleaded no contest, and the Discipline Committee made the finding, that he engaged in disgraceful, dishonourable and unprofessional conduct with respect to two patients.

The following day, the Windsor Star published a news story regarding Dr. Barnard's hearing at the College. The story referenced some of the evidence presented by the College at the hearing, including evidence related to a patient who had been prescribed narcotics by Dr. Barnard and who died of an overdose.

The Windsor Star article was circulated by the Medical Post via an e-newsletter on February 15, 2017. Shortly after it was circulated, a reader posted a comment on the news story that referenced Dr. Barnard's "legacy of overprescribing". Dr. Barnard posted a comment online in response to the reader's comment. Dr. Barnard's comment could be viewed by all healthcare providers across Canada who subscribed to the Medical Post at the time.

On February 16, 2017, the College learned of the comment posted by Dr. Barnard and immediately advised him that it viewed the post as containing highly confidential and personal information of a former patient and that this was a breach of patient privacy. Dr. Barnard was directed by the College to remove all references to confidential

information that came to his attention in the course of providing care to patients, present or past.

On February 21, 2017, Dr. Barnard's comment was edited to remove all information regarding the patient. The comment was nevertheless viewable in the original version for six days.

Prior Discipline History

2017 Discipline Hearing

On February 13, 2017, the Discipline Committee found that Dr. Barnard had failed to maintain the standard of practice of the profession in relation to his patient care and prescribing practices with respect to 55 patients. The Discipline Committee also found that Dr. Barnard engaged in disgraceful, dishonourable and unprofessional conduct in the manner in which he terminated two patients from his practice; cancelled one patient's specialist consultation; and failed to notify that patient of the cancellation.

The Discipline Committee issued a reprimand, suspended Dr. Barnard from practice for a period of four months, and placed significant restrictions on his scope of practice and prescribing practices, among other things. The penalty reflected the Undertaking that Dr. Barnard had entered into on January 20, 2017, prior to the discipline hearing, by which he had agreed, among other things, that, effective March 17, 2017, he would no longer practise family medicine and would no longer bill the Ontario Health Insurance Plan.

2006 Discipline Hearing

On January 9, 2007, the Discipline Committee of the College released its Decision and Reasons for Decision in respect of a discipline proceeding regarding Dr. Barnard that was held on November 28, 2006. A Supplementary Decision and Reasons for Decision was released on July 3, 2007. At the 2006 discipline proceeding, Dr. Barnard was found to have 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, in relation to the manner in which he implemented block fees for uninsured services in his family practice.

The Discipline Committee issued a suspension for a period of one month and ordered Dr. Barnard to pay costs to the College. In addition, Dr. Barnard was required to comply with numerous conditions in relation to administrating block fees, and to cooperate with inspections of his practice for a period of nine months following the suspension.

Prior Public Complaints History

The College received and investigated several complaints regarding Dr. Barnard in the period between 2001 to 2017, described below:

- Public Complaint (2017): This complaint related to Dr. Barnard's advertising practices. The Inquiries, Complaints and Reports Committee ("ICRC") issued advice to Dr. Barnard to ensure that he complies with the advertising regulations.

- Public Complaint (2016): This patient complained about Dr. Barnard's care and conduct with respect to the patient's newly diagnosed lymphoma. The ICRC ordered Dr. Barnard to attend at the College for a verbal caution.

- Public Complaint (2016): This patient complained about Dr. Barnard's communications. The ICRC advised Dr. Barnard regarding patient communication and the termination of the physician-patient relationship.

- Public Complaint (2008): These patients complained about Dr. Barnard's termination of them as patients, his reported disclosure of confidential information and his failure to properly administer his office in that he failed to return the patients' block fees when he dismissed them from his practice. The Complaints Committee cautioned Dr. Barnard about the importance of following the College's guidelines when ending the physician-patient relationship.

- Public Complaint (2001): This complaint concerned the clinical care provided to a child. Prior to the Complaints Committee's disposition, the complainants stated that they had reached a financial settlement with the Centre that Dr. Barnard had been associated with and they no longer wished to pursue their complaint. The Complaints Committee referred this matter to the Quality Assurance Committee.

- Public Complaint (2001): This complaint also concerned the clinical care provided to a young child. The complainant, the patient's mother, withdrew her complaint prior to the Complaints Committee's disposition. The Complaints Committee referred this matter to the Quality Assurance Committee.

The College also conducted a Registrar's investigation into Dr. Barnard's compliance with an Undertaking he signed with the College:

- Registrar's Investigation (2016): This investigation examined whether Dr. Barnard had breached his interim Undertaking with the College not to prescribe narcotics or controlled substances while the College completed investigations into his practice, including his prescribing practices. Dr. Barnard signed the Undertaking on November 9, 2014. On February 15, 2015, the Ministry of Health and Long-Term Care's Narcotic Monitoring System provided the College with data indicating that 1,527 prescriptions for narcotics and controlled substances had been issued in Dr. Barnard's name between November 9, 2014 and January 20, 2015. The ICRC advised Dr.

Barnard that a physician who has relinquished prescribing privileges must be aware of the drug he is prescribing and be careful not to prescribe in breach of his Undertaking.

Undertaking to the College

Dr. Barnard entered into an Undertaking with the College on June 18, 2019, resigning his certificate of registration and agreeing never to apply or re-apply for registration as a physician in Ontario.

Disposition

On July 23, 2019, the Committee ordered that:

- Dr. Barnard attend before the panel to be reprimanded.
- Dr. Barnard pay costs to the College in the amount of $6,000.00 within thirty (30) days of the date of the Order.

Disgraceful, Dishonourable or Unprofessional Conduct – 4 Cases

1. Dr. G. P. Dempsey

Name:	Dr. Gerald Paul Dempsey
Practice:	Pediatrics
Practice Location:	Belleville
Hearing:	Agreed Statement of Facts and Admission Penalty – Joint Submission
Finding/Penalty Decision Date:	September 4, 2019
Written Decision Date:	October 9, 2019

Allegations and Findings

- disgraceful, dishonourable or unprofessional conduct – **proven**

Summary

Dr. Gerald Paul Dempsey ("Dr. Dempsey") is a 53 year-old paediatrician who received his certificate of registration authorizing independent practice from the College of Physicians and Surgeons of Ontario ("the College") on February 21, 1996.

At the relevant time, Dr. Dempsey practised at a clinic in Belleville, Ontario. In 2007, Dr. Dempsey purchased a building located at 100 Station Street, Belleville, with the intention of establishing a multi-service pediatric and family facility with his pediatric clinic as the anchor. Dr. Dempsey has advised the College that he undertook significant renovation of the premises, which involved taking on significant debt. He operated his clinic until 2017. On March 20, 2017, his construction lender locked the doors at 100 Station Street and initiated foreclosure proceedings. Dr. Dempsey advised the College that he was unable to meet his financial obligations to his lender as two of his tenants had stopped paying rent.

Disgraceful, Dishonourable or Unprofessional Conduct

a) Closure of Office and Registrar's Investigation

In May 2017, the College began to receive complaints from the parents of Dr. Dempsey's patients, who were not able to contact Dr. Dempsey or access their children's medical records. The College also received information from the Chief of Staff at Quinte Health Care that the hospital was receiving calls from concerned patients regarding Dr. Dempsey's office closure. The College commenced a Registrar's Investigation regarding Dr. Dempsey closing his office without notice to his patients and without facilitating access to their medical records.

On May 4, 2017, in response to e-mails from the College's Patient and Physician Advisory Service regarding the information it had received about his office closure, Dr.

Dempsey contacted the College and advised that his mortgage financier had locked him out of his building. Dr. Dempsey advised that he was working with the bank and that it appeared that he would be able to re-open his clinic soon. Dr. Dempsey advised the College that he had posted, on the clinic's Facebook page, the temporary closure. College staff advised Dr. Dempsey that he may wish to consider posting a sign on the clinic door, update his telephone greeting, and update any websites he may have regarding the closure. Dr. Dempsey advised that he would consider these options if he ran into a similar situation in the future. Dr. Dempsey advised that all patient records would be with the patients' family doctors, as he is a consulting paediatrician and he sends reports to patients' family physicians after every visit. Dr. Dempsey also advised that patients could e-mail their medical record requests to him.

Dr. Dempsey obtained a new fax number sometime in May 2017. Dr. Dempsey advised the College on June 21, 2017 that he was looking at ready-to-use clinic space in Belleville and expected to be back in practice "very quickly." On August 28, 2017, Dr. Dempsey advised the College that he had resumed seeing patients at another physician's office in Belleville. Dr. Dempsey subsequently determined that the space was not suitable for his practice and stopped seeing patients at that location. Dr. Dempsey did not re-open his clinic or secure a new practice location of his own in the Belleville area.

Dr. Dempsey provided a fax number to the investigator for patients to request their medical records. The fax number was posted on the College's public website in July 2017. Dr. Dempsey advised the College in November 2017 that he had received a number of faxed requests for medical records, to which he had responded.

In late 2017 and early 2018, Dr. Dempsey worked some shifts at a paediatric clinic network in Toronto. In early January 2018, Dr. Dempsey was offered a position at a Toronto clinic network, where he now practises.

b) DOCUdavit Solutions

On November 17, 2017, Dr. Dempsey advised the College that he was contracting with DOCUdavit Solutions for storage of his medical records and management of patient record requests. On November 29, 2017, the College requested permission from Dr. Dempsey to post the DOCUdavit service information on the College website. Dr. Dempsey replied on November 30, advising that he was waiting for the DOCUdavit portal to be ready before advising the College to post the information on its website.

On January 4, 2018, the College investigator received an email from a College staff member advising that staff had contacted DOCUdavit and that DOCUdavit advised that it had no records for Dr. Dempsey.

On January 5, 2018, the College emailed Dr. Dempsey and advised that DOCUdavit had told the College that they were not providing services on his behalf. Dr. Dempsey advised that he would be negotiating the contract with DOCUdavit on January 8, 2018.

On January 30, 2018, the College received a phone call from DOCUdavit Solutions indicating that it had received numerous calls regarding Dr. Dempsey's medical records,

and confirming that DOCUdavit did not have a signed contract with Dr. Dempsey and was not currently storing any of Dr. Dempsey's medical records.

Dr. Dempsey ultimately retained DOCUdavit to process medical record requests in January 2019, after this matter had been referred to the Discipline Committee. As of August 6, 2019, six patients of Dr. Dempsey's had requested charts from DOCUdavit.

c) Patient Complaints

In the months following the closure of his office in May 2017, the College received seven public complaints from parents of Dr. Dempsey's patients who complained that Dr. Dempsey had closed his office without notice to them and that they were unable to obtain their children's medical records from Dr. Dempsey.

Throughout this time period, Dr. Dempsey corresponded frequently with the College investigator.

d) Ms A's Complaint

On May 29, 2017, the College received a complaint from Ms A regarding her inability to reach Dr. Dempsey and gain access to her daughter's medical record. Ms A advised that she had tried calling and attending Dr. Dempsey's office to obtain the records but had been unable to do so. Ms A advised that her daughter had been seeing Dr. Dempsey regularly for a year, and had many tests and scans done, but her family physician was not copied on any reports, so she needed her daughter's file from Dr. Dempsey.

On June 1, 2017, the College investigator called Dr. Dempsey advising him of the complaint from Ms A. According to Dr. Dempsey, the only report that was not provided to Ms A's daughter's family physician was a Children's Treatment Centre Report which stated that there were no outstanding issues. Dr. Dempsey offered to email the report to Ms A. On June 2, 2017, Ms A advised the College that she did not require a copy of the Children's Treatment Centre Report, but that she wanted to keep the file open to see if Dr. Dempsey re-opened his practice, as she wanted her daughter to remain a patient of Dr. Dempsey.

On July 24, 2018, the College investigator called Ms A to follow up regarding whether she had received her daughter's medical record or if she had heard from Dr. Dempsey. Ms A advised that she was interested in obtaining the entire medical record and that she had not heard from Dr. Dempsey regarding the medical record or Dr. Dempsey's whereabouts. Ms A never received a complete medical record from Dr. Dempsey.

e) Ms. B's Complaint

On August 3, 2017, the College received a complaint from Ms B, whose son was a patient of Dr. Dempsey's. Ms B was concerned that Dr. Dempsey closed his office without notice. Ms B's son has a unique medical condition. Ms B had requested her son's medical records on June 15 and July 7, 2017 for review by a new paediatrician. As she had not heard back from Dr. Dempsey, she complained to the College. Ms B

advised that her request was urgent, as her son had not been able to see a paediatrician since January 2017.

On August 4, 2017, the College investigator notified Dr. Dempsey of Ms B's complaint. Dr. Dempsey responded to the investigator's email the same day, stating that he believed that the medical records had already been sent or if not, they would be mailed out.

By email dated August 28, 2017, Dr. Dempsey confirmed that he sent the medical records to Ms B by registered mail and that they were signed for. Ms B confirmed to the College that she received the medical records by mail.

f) Ms C's Complaint

On October 27, 2017, the College received a complaint from Ms C regarding her inability to reach Dr. Dempsey in order to obtain her daughter's medical records. Ms C expressed concern that Dr. Dempsey closed his office without notifying his patients. Ms C advised that she had called and e-mailed to request the records, but had been unable to obtain them from Dr. Dempsey. Ms C advised that her request for Dr. Dempsey's records for her daughter was urgent as her daughter had recently received a life-threatening diagnosis.

On November 7, 2017, Dr. Dempsey was notified of Ms C's complaint and the urgency of the request.

On November 21, 2017, Ms C followed up with the College, as she had not received the medical records or heard from Dr. Dempsey.

On November 27, 2017, Dr. Dempsey provided a tracking number for the medical records request. The investigator provided the tracking number to Ms C.

On November 30, 2017, Ms C contacted the College again, advising that she had received the electronic records provided by Dr. Dempsey, but that not all of her daughter's records were in the electronic record. Ms C requested the complete paper records from Dr. Dempsey. This was not provided by Dr. Dempsey.

On December 11, 2017, Dr. Dempsey responded by advising that he did not have a paper chart for Ms C's daughter, and advised that Ms C's daughter may have seen one of two other paediatricians who had previously practised in his office, and that if she had, then Dr. Dempsey did not have access to those records. Dr. Dempsey also advised that if he had seen Ms C's daughter at Quinte Health Care, then those records would have to be requested from the hospital.

On December 14, 2017, Ms C clarified that her daughter had not seen either of the two physicians identified by Dr. Dempsey.

g) Ms D's Complaint

On November 3, 2017, the College received a complaint from Ms D regarding her inability to schedule any appointments with Dr. Dempsey for her son. Ms D also

indicated that she had sent a letter to a fax number that was provided to her to request her son's medical records, but the medical records had not been forwarded to her son's new paediatrician. Ms D advised that her son has a heart condition and requires regular consultations with a paediatrician.

On November 13, 2017, Dr. Dempsey was notified of Ms D's complaint. The investigator also sent an email to Ms D, requesting that Ms D advise the College if Dr. Dempsey provided the medical records. Dr. Dempsey responded on November 17, 2017, advising that he would provide the registered mail tracking number for the records.

On November 20, 2017, the College received an email from Ms D confirming that her son's new paediatrician had not yet received the medical records from Dr. Dempsey. On December 19, 2017, the College received an email from Ms D indicating that she had received the medical records on a USB stick in the mail from Dr. Dempsey.

h) Ms E's Complaint

On October 26, 2017, Ms E faxed Dr. Dempsey, using the fax number provided by Dr. Dempsey that was posted on the College's website, to request her son's medical records. No response was received from Dr. Dempsey, despite his having received the fax.

On December 7, 2017, the College received a complaint letter from Ms E, expressing her concern that Dr. Dempsey closed his office without letting anyone know and that she had been unable to obtain her son's medical records from Dr. Dempsey despite calling, e-mailing and faxing Dr. Dempsey to request the records.

On January 9, 2018, the investigator called Ms E and advised that the College had notified Dr. Dempsey regarding the complaint and would be communicating with Dr. Dempsey to assist in the release of the medical record. Ms E explained that her son has mild autism and that obtaining testing, such as blood work, was difficult for him. She wanted to obtain her son's medical records from Dr. Dempsey to avoid having repeat blood work done. The same day, the investigator sent an email to Dr. Dempsey regarding Ms E's request for records and requesting that he expedite the request. Dr. Dempsey responded to the e-mail on January 12, 2018, advising that he would be couriering the medical records to Ms E and would provide the tracking number to the College.

On February 11, 2018, the College received an email from Ms E indicating that she still had not received the medical records from Dr. Dempsey and had not heard from Dr. Dempsey regarding her request.

On February 12, 2018, the investigator emailed Dr. Dempsey to advise that Ms E had not received the medical record and inquired whether Dr. Dempsey had sent the record as he had previously advised. Dr. Dempsey responded, requesting that the investigator "clarify this request" and provide him with information about Ms E. The investigator provided Ms E's contact information to Dr. Dempsey on February15, 2018, and

reiterated her request for the medical records. The investigator also provided Ms E's telephone number and suggested that Dr. Dempsey call Ms E regarding her request.

On March 15, 2018, Ms E advised the College by email that she had still not received her son's medical records. On March 15, 2018, the College also received a voicemail from Ms E expressing frustration with Dr. Dempsey as she still had not heard from him or received the records.

On March 15, 2018, the investigator attempted to contact Dr. Dempsey using the contact information provided by Dr. Dempsey to the College. The cell phone number on file provided a message that the customer could not be reached and Dr. Dempsey's home telephone number was no longer in service. The investigator sent a text message to Dr. Dempsey's dedicated text line regarding Ms E's request.

On March 20, 2018, Dr. Dempsey responded to the email exchange of March 15, 2018, which had been forwarded to him, advising that he had thought that the request was from a different patient with a similar name to Ms E, and had sent that patient their medical records. In order to rectify the error, Dr. Dempsey advised that he would courier Ms E's son's records to Ms E the following day.

On March 23, 2018, the College received a telephone call from Ms E indicating that she had received the medical record.

i) Ms F's Complaint

On April 16, 2018, the College received a complaint from Ms F, indicating that Dr. Dempsey had closed his office and retained her childrens' medical records. She advised that she had been unable to obtain the records by faxing a request to the number provided by Dr. Dempsey and posted on the College's website, as the fax did not transmit.

On April 30, 2018, the investigator called Ms F and indicated that she would email Dr. Dempsey to facilitate the transfer of records. The investigator emailed Dr. Dempsey the same day to notify him of Ms F's complaint and request that he provide the medical records to Ms F.

The investigator sent a follow-up email to Dr. Dempsey on May 10, 2018, inquiring about the status of Ms F's request. Dr. Dempsey never responded to either of the investigator's emails regarding Ms F's request.

On August 2, 2018, after the allegations had been referred to the Discipline Committee, the investigator called Ms F to obtain a mailing address to send the ICRC's Decision and Reasons. During the call, Ms F confirmed that she still had not received the medical records of her four children from Dr. Dempsey.

j) Ms G's Complaint

On July 30, 2018, the College received a complaint from Ms G, expressing concerns that Dr. Dempsey had suddenly left town, and that she had been unable to obtain her

son's medical records from Dr. Dempsey, despite her efforts, for over a year. Ms G advised that her son has developmental delays, and that due to Dr. Dempsey's sudden absence, he had to start over with another paediatrician, which was made more difficult by the inability to obtain Dr. Dempsey's medical records. Ms G advised that her family physician had faxed the number provided by Dr. Dempsey several times, but had received no response. Ms G also tried calling a phone number provided by her family physician where Dr. Dempsey's records were supposed to be, but was told that they did not have the records.

The College notified Dr. Dempsey of Ms G's complaint on August 17, 2018. On September 25, 2018, Ms G contacted the investigator by telephone and advised that she had heard nothing to date from Dr. Dempsey and had not received a copy of her son's medical record.

On January 30, 2019, Counsel for Dr. Dempsey advised the College that Ms G's son's medical record had been provided to her through DOCUdavit.

Dr. Dempsey's History with the College

On May 10, 2007, the Discipline Committee found that Dr. Dempsey had engaged in disgraceful, dishonourable or unprofessional conduct. Dr. Dempsey admitted the allegation.

Dr. Dempsey admitted that between 1998 and 1999, and between 2001 and 2004, he entered into sexual and romantic relationships with the mothers of two of his patients while continuing to provide care and treatment to the patients.

The Discipline Committee ordered that Dr. Dempsey be reprimanded and that the results of the proceeding be recorded in the register.

Disposition

The Discipline Committee ordered that:

- The Registrar suspend Dr. Dempsey's certificate of registration for a period of two (2) months, commencing from September 5, 2019 at 12:01 a.m.
- The Registrar place the following terms, conditions and limitations on Dr. Dempsey's certificate of registration:
    - Dr. Dempsey shall comply with the College Policy #2-07 "Practice Management Considerations for Physicians Who Cease to Practise, Take an Extended Leave of Absence or Close Their Practice Due to Relocation";
    - Dr. Dempsey will participate in the PROBE Ethics & Boundaries Program offered by the Centre for Personalized Education for Professionals, by receiving a passing evaluation or grade, without any condition or qualification. Dr. Dempsey will complete the PROBE program within 6 months of the date of the Order, and will provide proof to the College of his completion, including proof of registration and attendance and participant assessment reports, within one (1) month of completing it;

  - Dr. Dempsey will, within two (2) weeks of the date of the Order, provide proof to the College that he has contracted with a third-party provider to process patient medical record requests and will for the next three (3) years, provide proof to the College every six (6) months that the arrangement remains in good standing.
  - Dr. Dempsey will maintain a log of requests for medical records, which will indicate when such requests were made and when they were fulfilled, and which will be provided to the College upon request;

- Dr. Dempsey attend before the panel to be reprimanded.
- Dr. Dempsey pay costs to the College in the amount of $6,000 within 60 days of the date of the Order

2. Dr. R.A. Kunynetz

Name:	Dr. Rodion Andrew Kunynetz
Practice:	Dermatology
Practice Location:	Barrie
Hearing:	Uncontested Facts and Plea of No Contest Penalty – Joint Submission
Finding/Penalty Decision Date:	September 13, 2019
Written Decision Date:	September 24, 2019

Allegations and Findings

- disgraceful, dishonourable or unprofessional conduct – **proven**
- sexual abuse – **withdrawn**
- sexual impropriety– **withdrawn**

Summary

Dr. Kunynetz received his medical degree from the University of Toronto in 1977 and completed his residency at the University of Ottawa. He was certified as a dermatologist by the Royal College of Physicians and Surgeons in 1982. For many years, he acted as an assessor in dermatology for the College of Physicians and Surgeons of Ontario. Dr. Kunynetz carried on private practice in dermatology in the Barrie community from 1983 onwards. He serviced patients not only in the Barrie and Simcoe County area, but also from Collingwood, Midland, Penetanguishene, North Bay and Sudbury.

At the relevant times, Dr. Kunynetz maintained a very busy office practice. He generally saw 65 to 70 OHIP patients per day, as well as 12-15 patients per day participating in clinical trials. He typically worked from 7:15 a.m. until 6 or 6:30 p.m. Patients typically experienced long waits in the waiting room before seeing the doctor. Accordingly, Dr. Kunynetz had a very busy practice with a large number of patients he saw daily. He developed an abrupt communication style in the course of examining patients.

Dr. Kunynetz does not contest that, in respect of multiple patients, he engaged in disgraceful, dishonourable or unprofessional conduct in that he moved or removed their clothing, in the course of clinical examinations, without providing adequate warning or explanation of what he was doing, and without obtaining adequate consent from the patients. The conduct included pulling up patients' shirts, moving brassieres and underwear. As a result of this conduct, Dr. Kunynetz's patients were left feeling upset and uncomfortable.

Dr. Kunynetz admits that, at the time of the misconduct in question, he had previously been provided with material from the College as a result of another patient complaint, emphasizing the importance of explaining to a patient ahead of time the nature and reason for any portion of a physical examination, particularly if the actions are relevant to, or involve, sensitive parts of the body. Dr. Kunynetz received the material from the College in 2009. Four of the eight patient encounters occurred following his receipt of the material.

- the plea of no contest pertains to eight patients, seen in different appointments between 1996 and 2015;
- Each of the patients was referred to Dr. Kunynetz for the examination of skin lesions (including mole checks for certain patients), which necessitated a dermatological examination of their skin. The patients were aware that their skin was to be examined;
- In the course of clinical examinations of the patients, Dr. Kunynetz moved clothing to visualize and examine their skin. Dr. Kunynetz had a medical reason to examine the skin underneath the clothing;
- Dr. Kunynetz does not contest that, prior to moving patients' clothing, he should have provided a more adequate explanation as to the nature of the examinations and how he intended to conduct them, to avoid any surprise, misunderstanding or patient distress, and to ensure adequate consent.

Dr. Kunynetz has already been the subject of a lengthy College discipline hearing which addressed, amongst other things, allegations of moving clothing without adequate warning, allegations that are similar to the facts in this case.

The Prior Hearing – 2015 Notice of Hearing

In July 2015, the Inquiries, Complaints and Reports Committee ("ICRC") referred allegations of sexual abuse with respect to four patients to the Discipline Committee. The principle allegation, in relation to two patients, was that Dr. Kunynetz had engaged in sexual abuse by rubbing or pressing his genitals against them during dermatology examinations. The 2015 Notice of Hearing also alleged that Dr. Kunynetz had engaged in sexual abuse by inappropriately touching a third patient's breasts. Finally, the Notice of Hearing alleged sexual abuse or disgraceful, dishonourable or unprofessional conduct, for three of the four patients, in failing to provide appropriate privacy to patients, and in moving clothing without adequate warning and consent.

In September 2015, the ICRC referred an additional allegation of breach of an interim order to the Discipline Committee. The ICRC imposed an interim suspension of Dr.

Kunynetz's certificate of registration effective October 1, 2015. Dr. Kunynetz remained suspended on an interim basis during the liability and penalty phases of the hearing, i.e. from October 1, 2015 through to February 20, 2018.

The liability hearing on all of the above-described allegations proceeded over 37 days from January 6, 2016 through to July 12, 2016.

With respect to the eight patients described in the current case, two testified as similar fact witnesses at the first discipline hearing and gave evidence regarding (among other things) how Dr. Kunynetz moved their clothing during skin examinations. At the time of the first hearing, all of the current complainants had complained to the College. The complaints of the current complainants were ultimately referred to discipline in Notice of Hearing dated April 28th and December 18th, 2017.

The Discipline Committee released its reasons on March 21, 2017. The panel dismissed all of the allegations of sexual abuse, with the exception of a finding that Dr. Kunynetz had engaged in sexual abuse of one patient by touching her breasts during the course of a dermatological examination. The panel also found that Dr. Kunynetz engaged in disgraceful, dishonourable or unprofessional conduct by moving patients' clothing without adequate warning or explanation and by allowing his abdomen to touch two patients. Finally, the panel found that Dr. Kunynetz breached an interim order of the ICRC.

With respect to the allegations of moving patients' clothing, the Discipline Committee found as follows:

> Dr. Kunynetz said that he commonly moved or shifted items of clothing such as bra straps to view the skin beneath, or lifted clothing that obscured a portion of the skin that needed to be inspected. He said that he usually gave the patient a reason for this, but he also admitted that his explanations were brief and often occurred during the displacement of clothing. The Committee concludes that the removal of clothing occurred during the process of a clinical examination, and that Dr. Kunynetz was justified in needing to examine the skin underneath the clothing. Thus, the context in which this occurred was not one in which "viewed in the light of all the circumstances, the sexual or carnal content of the assault (or actions) was visible to a reasonable observer." Thus, Dr. Kunynetz's actions do not meet the test articulated by the Supreme Court of Canada in R. v Chase (1087) 2 S.C.R. 293 with respect to sexual assault. The Committee finds that Dr. Kunynetz's actions in moving clothing does not constitute behaviour of a sexual nature and is therefore not sexual abuse.
>
> The material that had been provided to Dr. Kunynetz by the College investigator emphasized the importance of explaining to a patient ahead of time the nature and reason for any portion of a physical examination. While this may not constitute formal seeking of consent in the way in which this term is usually used, the process of explanation demands that the physician take reasonable steps to ensure that the patient comprehends why something is being done, particularly if

> the actions are relevant to, or involve, sensitive parts of the body. This was clearly not done before the shifting of clothing performed by Dr. Kunynetz.
>
> The Committee finds that the absence of adequate warning or explanation to Patients A and D by Dr. Kunynetz before moving or removing their clothing, constitutes conduct that would be reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The penalty hearing proceeded over four days in July and August, 2017. In reasons released on February 20, 2018, the Discipline Committee revoked Dr. Kunynetz's certificate of registration. The Discipline Committee found that the mandatory revocation provisions of the Health Professions Procedural Code applied retrospectively to the finding of sexual abuse.

Dr. Kunynetz appealed the findings and penalty to the Divisional Court. In a judgment dated July 23, 2019, the Divisional Court quashed the sexual abuse finding made by the Discipline Committee and quashed the finding of disgraceful, dishonourable or unprofessional conduct based on Dr. Kunynetz allowing his abdomen to touch patients. The Divisional Court upheld the Discipline Committee's finding of disgraceful, dishonourable or unprofessional conduct in moving patients' clothing without adequate warning or explanation as well as the finding that Dr. Kunynetz breached the interim order.

In the circumstances, the Divisional Court did not refer the matter back to the Discipline Committee for a further hearing on penalty, but instead quashed the revocation order and the reprimand, and held that no further suspension should be imposed, noting that Dr. Kunynetz had been vindicated of all of the serious allegations. The Court reasoned as follows:

> [153] As indicated above, the Court is dismissing the allegation of sexual abuse of Patient B and dismissing the finding of professional misconduct with respect to Patients C and D. The usual remedy, when an appeal of a decision of an administrative decision maker is granted, is to remit the matter to the decision maker for re-determination of the issue of liability or for re-determination of penalty of the remaining findings. That respects the legislative policy to leave such decisions to the administrative body.
>
> [154] The following are unique circumstances of this case that warrant the unusual remedy set out below:
>
> (a) The Notice of Hearing originated in July 2015 which is four years ago. Assuming the same five members are available, sending it back for a fresh penalty hearing on the remaining findings will likely take at least six months. Sending it back for a fresh liability hearing before a new panel on the allegations involving Patient B will likely take much longer. The single allegation involving Patient B occurred in August 2008, eleven years ago.
> (b) The Appellant, the College, the complainants and the public all share an interest in finality. It would be unfair to the witnesses to have to participate

in another hearing on the merits of the allegation of sexual abuse with respect to Patient B, particularly because she made the original complaint in 2008 and since then has been involved in both the College proceedings and the criminal proceedings. The evidence of witnesses has likely deteriorated over that lengthy period and, as a result, the prospects of the College providing "clear, convincing and cogent evidence" are dim.

(c) The Appellant was under suspension from October 1, 2015 to February 20, 2018 when the penalty decision was released. Since then he has been subject to the revocation order. The period of suspension of almost 28 months and the 17-month period of revocation totals 45 months. We consider it unlikely that a penalty greater than 28 months or 45 months will be imposed with respect to the remaining findings of removal of clothing without warning or consent and two breaches of an interim order.

(d) Other than the original complaint from Patient B, the Appellant had no prior record of discipline which is a mitigating factor in assessing penalty.

(e) In her evidence during the hearing as to penalty, the Appellant's wife described the enormous toll that the proceeding had had on the Appellant personally and professionally as well as on her and their children. She described the press reports as a "constant bombardment of ugliness". In the end, the Appellant has been vindicated of all of the serious allegations. He and his family ought to be able to see a light at the end of the tunnel.

(f) The College has a vested interest in sustaining the "usual remedy" that matters of liability and penalty are sent back. The outcome of substitution in this case is exceptional.

(g) The College has a vested interest in sustaining the "usual remedy" that matters of liability and penalty are sent.

As set out in the judgment of the Divisional Court, Dr. Kunynetz was suspended for approximately 28 months under former s.37 of the Health Professions Procedural Code and was also subject to a period of revocation for 17 months, for a total of 45 months.

Current Interim Suspension Order

Although the Order of the Divisional Court reinstated Dr. Kunynetz's certificate of registration as of July 23, 2019, Dr. Kunynetz remained subject to an interim suspension of his certificate of registration, imposed by the ICRC on June 8, 2017, under section 25.4 of the Code, in respect of this hearing.

Remedial Work Undertaken by Dr. Kunynetz

In June 2016, Dr. Kunynetz completed the Understanding Boundaries and Managing Risks Inherent in Doctor-Patient Relationships course at Western University.

Disposition

The Discipline Committee ordered that:

- Dr. Kunynetz attend before the panel to be reprimanded.

- Dr. Kunynetz pay costs to the College in the amount of $6,000.00 within thirty (30) days of the date of the Order

3. Dr. B. A. Shamess

Name:	Dr. Brian Allen Shamess
Practice:	General Practice
Practice Location:	Sault Ste. Marie
Hearing:	Uncontested Facts and Plea of No Contest Contested Penalty
Finding/Penalty Decision Date:	June 11, 2019
Written Decision Date:	September 24, 2019

Allegations and Findings

- disgraceful, dishonourable or unprofessional conduct – **proven**
- sexual abuse - **withdrawn**

Summary

On July 24, 2011, Dr. Shames conducted a track mark examination regarding Patient A. Patient A stated that Dr. Shamess had examined her inappropriately at this examination.

The Committee found that the track mark examination of July 14, 2011 was clinically indicated. Dr. Shamess had good reason to suspect injectable drug use, based on Patient A's history. He was acting judiciously, professionally, and in the interests of his patient in examining her for evidence of injectable drug abuse. The Committee found that he requested and received consent from Patient A in this regard.

However, the Committee found that Dr. Shamess's actions (even on his own evidence of what occurred) during the course of the track mark examination, left Patient A feeling exposed, violated, and distressed. The Committee accepted Patient A's evidence as to how she felt following the examination.

With respect to her belief that her privacy had been violated during the track mark examination, the Committee found that Patient A was credible in her evidence. Unlike her evidence with respect to the details of the examination, her evidence as to how she felt about the examination did not materially change when she subsequently complained to multiple individuals that Dr. Shamess had examined her improperly, including to Dr. Shamess himself and nursing staff at his office. Further, Dr. Shamess accepted that she had been upset, and arranged a long session with Patient A to explore her concerns. Despite serious problems with Patient A's credibility in other areas, the Committee found that her evidence that she felt violated and exposed by the manner in which the track mark examination was conducted was persuasive.

Dr. Shamess had a professional obligation to conduct this examination in a way that was more respectful of Patient A's privacy. Alternatives would have included having a female nurse perform the examination, having a chaperone present with him in his office while the examination was being conducted, and offering Patient A draping or a gown. Dr. Shamess's actions were insensitive and disrespectful to Patient A. The Committee found that the membership would reasonably regard his conduct in this regard as unprofessional

The Committee therefore found the allegation of disgraceful, dishonourable, or unprofessional conduct is proven, with respect to this incident regarding Patient A.

Disposition

On July 5, 2019, the Discipline Committee ordered that:
- Dr. Shamess appear before the panel to be reprimanded.
- Dr. Shamess pay the College its costs of this proceeding in the amount of $5,090.00 within 30 days from the date of the Order.

Appeal

On July 9, 2019, Dr. Shamess appealed the decisions of the Discipline Committee on finding of June 11, 2019 and penalty of July 5, 2019. Pursuant to ss.25(1) of the *Statutory Powers Procedure Act*, the decision of the Discipline Committee is stayed pending the outcome of the appeal.

3. Dr. B.C. Thicke

Name:	Dr. Brian Christopher Thicke
Practice:	Independent Practice
Practice Location:	Brampton
Hearing:	Uncontested Facts and Plea of No Contest, Joint Penalty
Finding /Penalty Decision Date:	October 8, 2019
Written Decision Date:	November 6, 2019

Allegations and Findings

- sexual abuse of a patient - **withdrawn**
- disgraceful, dishonourable or unprofessional conduct - **proven**

Summary

Dr. Thicke is a 90-year-old physician who practiced family medicine. He received his certificate of registration in 1956.

Between approximately 1965 and 2018, Dr. Thicke practiced at Peel Village Medical located at 28 Rambler Drive in Brampton ("Peel Village Medical"). In addition to his family medicine practice, Dr. Thicke was a designated Civil Aviation Medical Examiner. He conducted civil aviation medical examinations for pilots and medical examinations for flight attendants. Between 1965 and 2018, Dr. Thicke held hospital privileges at William Osler Health System.

Undertaking with the College

On January 23, 2018, Dr. Thicke entered into an undertaking in lieu of an Order under s.25.4 of the Health Professions Procedural Code to have a practice monitor present for all patient encounters. Dr. Thicke did not obtain a practice monitor and ceased practicing. His certificate of registration expired on August 16, 2018.

DISGRACEFUL, DISHONOURABLE OR UNPROFESSIONAL CONDUCT

Patient A (Ms Fruitman)

In the 1990s, Patient A was in the process of obtaining a private pilot's licence and was required to undergo a civil aviation medical examination. She saw Dr. Thicke for a civil aviation medical examination at Peel Village Medical on June 28, 1993. She was in her mid-twenties at the time.

At the end of the June 28, 1993, examination, Dr. Thicke told Patient A to get back on the examination table as he wanted to conduct a breast examination. Patient A was surprised and asked why a breast examination was necessary in the context of a civil aviation medical. Dr. Thicke asked Patient A whether she was questioning his judgment. Dr. Thicke then conducted a breast examination on Patient A.

Prior to conducting the breast examination, Dr. Thicke failed to:

- Explain to Patient A the rationale for the exam and what the exam would involve;
- Obtain Patient A's informed consent before proceeding with the exam;
- Provide Patient A with privacy to undress; and
- Provide Patient A with proper draping or a gown.

Dr. Thicke's conduct had a long-lasting impact on Patient A and she continues to feel extremely distressed.

Patient B

In the late 1990s, Patient B was in the process of obtaining employment as a flight attendant with an airline. She was twenty-two (22) years old at the time. The airline required her to undergo a medical examination to complete the hiring process. It referred Patient B to Dr. Thicke. Patient B saw Dr. Thicke at his office at Peel Village Medical on one occasion in the late 1990s for the medical examination. During the

appointment, Dr. Thicke used unprofessional and inappropriate language by telling her he needed to check her “boobs”.

Prior to conducting the breast examination, Dr. Thicke failed to:

- Explain to Patient B the rationale for the exam and what the exam would involve;
- Obtain Patient B’s informed consent before proceeding with the exam; and
- Provide Patient B with proper draping or a gown.

As a result of Dr. Thicke’s conduct, Patient B felt that the examination was “weird”. The airline is now defunct. Records indicating the specific date of Patient B’s appointment with Dr. Thicke are not available.

Patient C

In the 1980s, Dr. Thicke conducted life insurance medical assessments for Sun Life Insurance. Patient C was twenty-seven (27) years old and was in the process of obtaining life insurance. The insurance company referred Patient C to Dr. Thicke for the medical assessment.

Patient C saw Dr. Thicke in June 1983 at his office at Peel Village Medical. At the beginning of the appointment, Dr. Thicke asked Patient C to remove all of her clothing, including her bra, leaving on only her underwear. Dr. Thicke left the examination room and returned once Patient C was undressed. Patient C felt embarrassed and uncomfortable as she was not provided with any draping or a gown to cover herself, leaving her breasts fully exposed.

Prior to conducting the breast examination, Dr. Thicke failed to:

- Explain to Patient C the rationale for the exam and what the exam would involve;
- Obtain Patient C’s informed consent before proceeding with the exam; and
- Provide Patient C with proper draping or a gown.

As a result of Dr. Thicke’s conduct, Patient C left the appointment feeling very upset.

Patient D

Dr. Thicke was Patient D’s family physician between approximately 1966 and 1992. Patient D attended medical appointments at Dr. Thicke’s office at Peel Village Medical.

Beginning in her teenage years, Patient D saw Dr. Thicke for physical examinations which included several breast examinations and internal examinations. On these occasions, Patient D undressed completely and wore a gown tying at the back. Prior to each breast examination, without providing any warning or explanation, Dr. Thicke pulled down Patient D’s gown from the front off her shoulders, exposing her breasts. Patient D felt exposed and uncomfortable.

Prior to conducting the breast examinations, Dr. Thicke failed to:

- Explain to Patient D the rationale for the exam and what the exam would involve; and
- Obtain Patient D's informed consent before proceeding with the exam.

At one appointment, date unknown, when Patient D was approximately 15 or 16 years old, Dr. Thicke failed to show appropriate sensitivity while he was conducting a Pap test and commented, "Aren't you a healthy-looking young lady?". Patient D was a young teenager and this was her first Pap test. Patient D was disturbed by the comment. As a result of Dr. Thicke's conduct, Patient D felt upset and uncomfortable.

Patient E

In approximately 1996, Patient E was in the process of obtaining employment as a flight attendant with an airline. She was in her twenties at the time. The airline required her to undergo a medical examination to complete the hiring process. It referred Patient E to Dr. Thicke. Patient E saw Dr. Thicke on one occasion at Peel Village Medical for the examination.

During the medical appointment, Dr. Thicke asked Patient E to remove her shirt. She remained in her bra and pants. Dr. Thicke remained in the room while Patient E undressed and did not provide her privacy. He did not offer Patient E a gown or drape.

Dr. Thicke conducted a breast examination on Patient E. Prior to conducting the breast examination, Dr. Thicke failed to:

- Advise Patient E that he was going to conduct a breast examination;
- Explain to Patient E the rationale for the exam and what the exam would involve;
- Obtain Patient E's informed consent before proceeding;
- Provide Patient E with privacy to undress; and
- Provide Patient E with proper draping or a gown.

As a result of Dr. Thicke's conduct, Patient E felt confused and upset. The airline is now defunct. Records indicating the specific date of Patient E's appointment with Dr. Thicke are not available.

Patient F

Patient F was a patient of Dr. Thicke between approximately 1965 to 1980. She saw Dr. Thicke at his office at Peel Village Medical.
When Patient F was approximately eighteen (18) or nineteen (19) years old, she attended an appointment with Dr. Thicke to obtain a birth control prescription. At this appointment, Dr. Thicke conducted a physical examination of Patient F which included a breast exam and internal exam. This was Patient F's first physical examination. Dr.

Thicke told Patient F to undress completely and put on a gown. He did not provide her privacy to undress and Patient F felt exposed and uncomfortable.
During the appointment, Dr. Thicke used unprofessional and inappropriate language with Patient F by telling her that he was first going to examine her “boobies”. Dr. Thicke then conducted a breast examination on Patient F.
Prior to conducting the breast examination, Dr. Thicke failed to:

- Explain to Patient F the rationale for the exam and what the exam would involve; and
- Obtain Patient F’s informed consent before proceeding with the exam.

Prior to conducting the internal examination, Dr. Thicke failed to:

- Explain to Patient F the rationale for the exam and what the exam would involve; and
- Obtain Patient F’s informed consent before proceeding with the exam.

At the end of the appointment, Dr. Thicke provided Patient F a prescription for birth control and made an unprofessional and inappropriate comment stating that the prescription was not a “licence for promiscuity”. As a result of Dr. Thicke’s conduct, Patient F continues to feel embarrassed and ashamed.

Patient G

Dr. Thicke was Patient G’s family physician between approximately 1992 and 2017. Patient G attended medical appointments at Dr. Thicke’s office at Peel Village Medical. During appointments with Patient G, Dr. Thicke made rude, inappropriate and unprofessional comments to her as follows:

- Dr. Thicke commented on Patient G’s appearance and called her ugly; and
- Dr. Thicke made insensitive and demeaning comments about Patient G’s deceased mother and her mother’s finances.

In addition, while taking Patient G’s blood pressure, Dr. Thicke failed to take sufficient care to maintain Patient G’s privacy and spatial boundaries. As a result, on several occasions, Dr. Thicke’s hand and arm brushed against the side of Patient G’s breast. As a result of Dr. Thicke’s conduct, Patient G felt very nervous and anxious during appointments.

Patient H (Ms Golubovich)

In May 2005, Patient H was in the process of obtaining employment as a flight attendant with an airline. She was twenty-five (25) years old at the time. The airline required her to undergo a medical examination to complete the hiring process. Patient H was referred to Dr. Thicke by the airline. She saw Dr. Thicke on May 30, 2005 at Peel Village Medical.

During the medical appointment, Dr. Thicke told Patient H that he needed to examine her heart with a stethoscope. She sat on the examining table and unbuttoned the top two buttons of her shirt. Without providing any explanation or obtaining informed consent, Dr. Thicke unbuttoned two more buttons of Patient H shirt and displaced her shirt and bra strap. As a part of the examination, he then placed his stethoscope and hand underneath her bra strap to listen to her heart. Patient H felt Dr. Thicke's hand on her nipple and breast. Dr. Thicke failed to show appropriate sensitivity by allowing his hand to rest on her nipple and breast without any explanation. Patient H was troubled by Dr. Thicke's conduct.

Patient I

In the mid-1980s Patient I was a private pilot. To obtain her private pilot's licence, she was required to undergo a civil aviation medical examination. Her flying club recommended Dr. Thicke to its members. Patient I saw Dr. Thicke on one occasion sometime in approximately 1985 at Peel Village Medical.

Dr. Thicke conducted a civil aviation medical examination of Patient I. At some point towards the end of the appointment, Dr. Thicke conducted a breast examination on Patient I. Prior to conducting the breast examination, Dr. Thicke failed to:

- Explain to Patient I the rationale for the exam and what the exam would involve; and
- Obtain Patient I's informed consent before proceeding with the exam.

As a result of Dr. Thicke's conduct, Patient I was shocked and upset.

Patient J

Patient J and her husband were members of a flying club and Patient J wanted to obtain a private pilot's licence. To obtain her private pilot's licence, she was required to undergo a civil aviation medical examination. The flying club recommended Dr. Thicke to its members. Patient J saw Dr. Thicke on one occasion in September 1987 at Peel Village Medical for the medical examination. She was thirty-seven (37) years old.

Dr. Thicke conducted a civil aviation medical examination of Patient J. At some point towards the end of the appointment, without any warning or explanation, Dr. Thicke displaced Patient J's clothing and conducted a breast examination on Patient J. Patient J was not expecting a breast examination. Prior to conducting the breast examination, Dr. Thicke failed to:

- Advise Patient J that he was going to conduct the examination;
- Explain to Patient J the rationale for the exam and what the exam would involve;
- Obtain Patient J's informed consent before proceeding; and
- Provide Patient J with proper draping or a gown.

As a result of Dr. Thicke's conduct, Patient J felt shocked and extremely confused.

Patient K

Patient K was a patient of Dr. Thicke in approximately 1984 and 1985. Patient K attended medical appointments at Dr. Thicke's office at Peel Village Medical.

During several medical appointments, Dr. Thicke made inappropriate and unprofessional comments about Patient K's appearance and her figure. Patient K found these comments very odd and this made her uncomfortable. At Patient K's last medical appointment, Dr. Thicke made an inappropriate and unprofessional comment to Patient K about the importance of getting her "boobies" checked.

As a result of Dr. Thicke's conduct, Patient K was very upset and never returned to see Dr. Thicke again.

Complainant L (Ms Thorpe)

Between 1975 and 1978, Complainant L was employed as a nurse at the Peel Memorial Hospital in Brampton. She was twenty-three (23) years old. Dr. Thicke held privileges at Peel Memorial Hospital during that time. Complainant L was a colleague of Dr. Thicke and periodically saw him at the hospital.

On a date in approximately 1977, Complainant L was working a nursing shift in the hospital. She was assigned to work in the nursery and was asked to bottle-feed a baby. During her shift in the nursery, Complainant L was seated on a chair behind a partition wall with a baby in her arms, bottle-feeding the baby. She was alone in the nursery. Dr. Thicke unexpectedly approached her. Complainant L does not recall whether Dr. Thicke greeted her or whether she had any conversation with Dr. Thicke. Dr. Thicke, while standing in front of Complainant L, slid his hand into her uniform and grabbed and squeezed her left breast. He then left. Complainant L was startled and in disbelief.

She immediately reported the incident to the head nurse and subsequently to the Director of Nursing at the hospital.

Patient M

In 2004, Patient M was in the process of obtaining employment as a flight attendant with an airline. She was twenty-six (26) years old at the time. The airline required her to undergo a medical examination to complete the hiring process. Patient M was referred to Dr. Thicke by the airline. Patient M saw Dr. Thicke on one occasion in April 2004 at his office at Peel Village Medical for the examination.

At the beginning of the examination, Dr. Thicke asked Patient M to remove her shirt. Her bra and pants remained on. Dr. Thicke remained in the room while Patient M undressed. He did not provide her with privacy. He did not offer or provide Patient M with any draping or a gown.

Patient M sat on the examination table and Dr. Thicke told her he was going to check her heartbeat with a stethoscope. Without warning or explanation, Dr. Thicke moved Patient M's bra with his hand. This resulted in Patient M feeling exposed and uncomfortable. Dr. Thicke then placed the stethoscope on Patient M's chest to listen to her heartbeat. Patient M felt Dr. Thicke's hand on her breast and nipple. Dr. Thicke failed to show appropriate sensitivity by allowing his hand to rest on Patient M's breast and nipple without any explanation

Dr. Thicke made an inappropriate and unprofessional comment about Patient H's appearance by stating, "why are all of you girls from Montreal so pretty". As a result of Dr. Thicke's conduct, Patient H felt extremely upset.

Patient N

In 2005, Patient N was in the process of obtaining employment as a flight attendant with an airline. The airline required her to undergo a medical examination to complete the hiring process. Patient N was referred to Dr. Thicke by the airline. Patient N saw Dr. Thicke on one occasion in approximately the spring of 2005 at his office at Peel Village Medical.

During the medical appointment, Dr. Thicke conducted a breast examination. Prior to conducting the breast examination, Dr. Thicke failed to:

- Advise Patient N that he was going to conduct a breast examination;
- Explain to Patient N the rationale for the exam and what the exam would involve;
- Obtain Patient N's informed consent before proceeding with the exam; and
- Provide Patient N with proper draping or a gown.

As a result of Dr. Thicke's conduct, Patient N felt very confused about the breast examination.

Patient O

Dr. Thicke was Patient O's family physician between approximately 1967 and 1987. Patient O attended medical appointments at Dr. Thicke's office at Peel Village Medical.

On a date in approximately 1982, Patient O saw Dr. Thicke for a medical appointment. She was approximately fifteen (15) years old at the time. Months earlier, Patient O had sustained a fall that had resulted in a persistent bump on her right buttocks. Her mother was concerned that the bump was cancerous and wanted Patient O to get it examined. Patient O attended the appointment on her own.

During the appointment, Patient O told Dr. Thicke of her concerns about the bump on her buttocks. Dr. Thicke asked Patient O to lower her pants and underwear so he could examine the bump. He remained in the room when Patient O undressed and did not provide her privacy. He did not offer or provide her with any draping or a gown. While

Patient O was standing, Dr. Thicke examined the bump on her buttocks and made an inappropriate and unprofessional comment about Patient O being overweight, calling her a “fat ass” and suggesting that if she lost weight the bump would probably go away.

Patient O had ongoing weight issues during that time and felt ridiculed by Dr. Thicke.

Undertaking

Dr. Thicke entered into an undertaking to the College on October 8, 2019, by which he agreed not to apply or re-apply for registration as a physician to practise medicine in Ontario or any other jurisdiction, effective immediately.

Dr. Thicke’s Discipline History

Dr. Thicke has no prior history with the Discipline Committee.

Disposition

On October 8, 2019, the Discipline Committee ordered that:
- Dr. Thicke attend before the panel to be reprimanded.
- Dr. Thicke pay costs to the College in the amount of $10,370.00 within thirty (30) days of the date of the Order.

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 2019

TOPIC: INTERVENTIONAL PAIN MANAGEMENT CHANGE OF SCOPE

FOR INFORMATION

SUMMARY:

- At its meetings of October 15 and November 12, 2019, the Executive Committee considered the College's management of change of scope (COS) applications in respect of interventional pain management (IPM).

- The Executive Committee noted that when the College began its interventional pain COS process, there was no specific educational program for this area of practice.

- The 2011 CPSO COS process for IPM was an interim measure awaiting the development of external academic training in IPM, which now exists.

- The Executive Committee is of the view that external academic programs are the appropriate educational avenues for those wanting to practice in the area of interventional pain management in future.

- The Committee therefore approved the following actions of the College in respect of IPM COS, which are being implemented:

    - New applications requesting consideration to engage in IPM to be placed on hold.

    - A communication sent to the Medical Directors of all the Out of Hospital Premises that report performing IPM procedures, advising them that the College has recently begun reviewing its IPM COS program and has therefore placed new applications on hold.

- The 76 physicians currently engaged in the COS process (at varying stages of training/supervision and/or awaiting assessment) will be assessed by a smaller group of assessors.

- For future applicants who plan to pursue a COS in IPM the College will look to previous practice experience in IPM and expect most to have completed an *accredited academic pain program*.

FOR INFORMATION

Contact: Sheila Laredo, Ext. 387
Angela Carol, Ext 288
Samantha Tulipano, Ext 709

Council Briefing Note

December 2019

TOPIC: Annual Committee Reports

FOR INFORMATION

ISSUE:

- Every year, each Committee submits an annual report to Council highlighting the key activities and accomplishments that took place over the course of the year.

BACKGROUND

- The past year was one of significant change for many of the College's Committees.

- As part of the College's work on governance modernization, the Governance Committee conducted a review of all committees and identified opportunities for improvement and streamlining to better serve the College.

- Overall, the Committees accomplished a great deal of work. The College appreciates that this work could not have been accomplished without the time, commitment and valuable contributions from all the Committee members and Committee support staff.

Contact: Laurie Cabanas, ext. 503

Date: November 15, 2019

Attachments:

Appendix A: Discipline Committee
Appendix B: Education Committee
Appendix C: Executive Committee
Appendix D: Governance Committee
Appendix E: Inquiries, Complaints and Reports Committee
Appendix F: Outreach Committee
Appendix G: Patients Relations Committee

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Discipline Committee
Annual Report 2019

MANDATE

The Discipline Committee is an independent adjudicative committee within the College structure that conducts public hearings regarding allegations of an Ontario physician's professional misconduct or incompetence. The hearing panel must decide the facts and legal issues in dispute and provide a written decision and reasons for its decision to the College, the physician and the complainant. The decisions of the Committee are subject to review by the courts.

In keeping with Council's strategic priority to optimize the discipline process, the Discipline Committee's objectives are aimed at the effectiveness and efficiency of the discipline process, while ensuring fairness.

Fairness, transparency and accountability are core values of the discipline process. To further these values and Council's strategic priority, the objectives of the Discipline Committee are to:

- Provide orientation and specialized education to committee members;
- Review committee processes, practices and procedures to improve the timeliness and efficiency of hearings, while ensuring fairness;
- Improve timeliness and enhance the quality of committee decisions;
- Improve transparency and communication of committee activities and decisions;
- Demonstrate financial accountability.

YEAR IN REVIEW

Orientation and Specialized Education Sessions

In 2019, the Discipline Committee delivered the following training sessions:

- New Member Orientation (January 17 and 21, 2019)
- Chairing Case Conferences / Hearings (May 23, 2019)
- Decision Writing (September 24, 2019)

Business Meetings

The Discipline Committee also employs biannual business meetings to provide education on hearing topics, policies and practices of the Committee and the College and the decisions of other committees, tribunals and courts. As well, the Committee reviews its performance against the hearings and decision key performance indicators and its rules of procedure. Business meetings were held on June 24 and October 22, 2019.

Committee Practice and Procedure

In June 2019, the Committee focused on the fundamentals of administrative law, practice and procedure. In October 2019, Dr. Mike Condra, Adjunct Professor, Department of Psychology, Queen's University, presented on Compassion Fatigue and Professional Burnout: The Essentials. Also, the Committee approved for implementation a Practice Direction for the Scheduling of Two Half Day Hearings on the Same Day, and amendments to Rule 2 of its Rules of Procedure to facilitate electronic filing of materials and to Rule 6 to require case discussion between the parties prior to a pre-hearing conference.

Case Rounds

A standing item at Discipline Committee business meetings is case rounds to discuss court cases, cases from other colleges and appropriate Discipline Committee cases (appeal waived or appeal period expired) that raise learning points or practice and procedure before or within the Committee.

Processes, Practices and Timelines

The Discipline Committee reviews continually its processes, practices and timelines.

The stages of the discipline process are:

- Referral of the matter by the Inquiries, Complaints and Reports Committee
- Reciprocal Disclosure (for cases referred as of August 1, 2016)
- Pre-hearing processes, including case management conferences and pre-hearing conferences
- Resolution resulting in withdrawal or an uncontested hearing
- Hearing
- Written Decision and Reasons for Decision

The Discipline Committee manages each case from the time of referral to decision.

Caseload

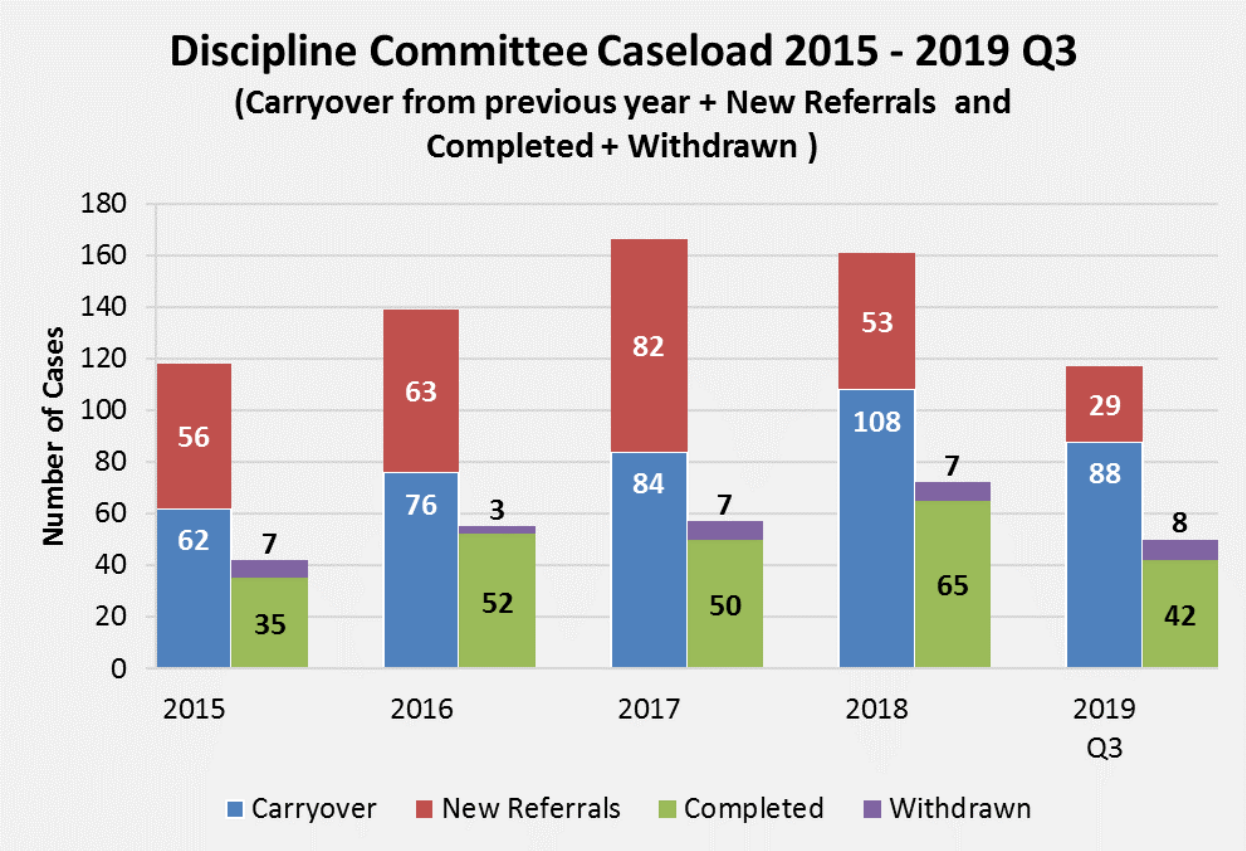
As of 2019 Q3:

- the discipline caseload was 67;
- there were 29 referrals; and
- the Committee has completed 42 cases.

Also, the College withdrew all allegations in eight cases. In two of those cases, the physician was revoked on another matter. In three cases, the physician signed an undertaking to resign and not

to reapply. In three cases, the College achieved an alternate resolution of the matter in the public interest.

The following chart reflects the caseload from 2015 to 2019 Q3, including carryover from the previous year, and the number of referrals, completed cases, and withdrawn cases.



As of September 30, 2019
There was 1 case in 2013, 2 cases in 2014, and 1 case in 2017 that did not proceed because the physician died. There was one case that the Divisional Court had returned for a penalty hearing and in 2018, the Court of Appeal granted the physician's appeal and restored the Committee's penalty decision.

Managing the Caseload

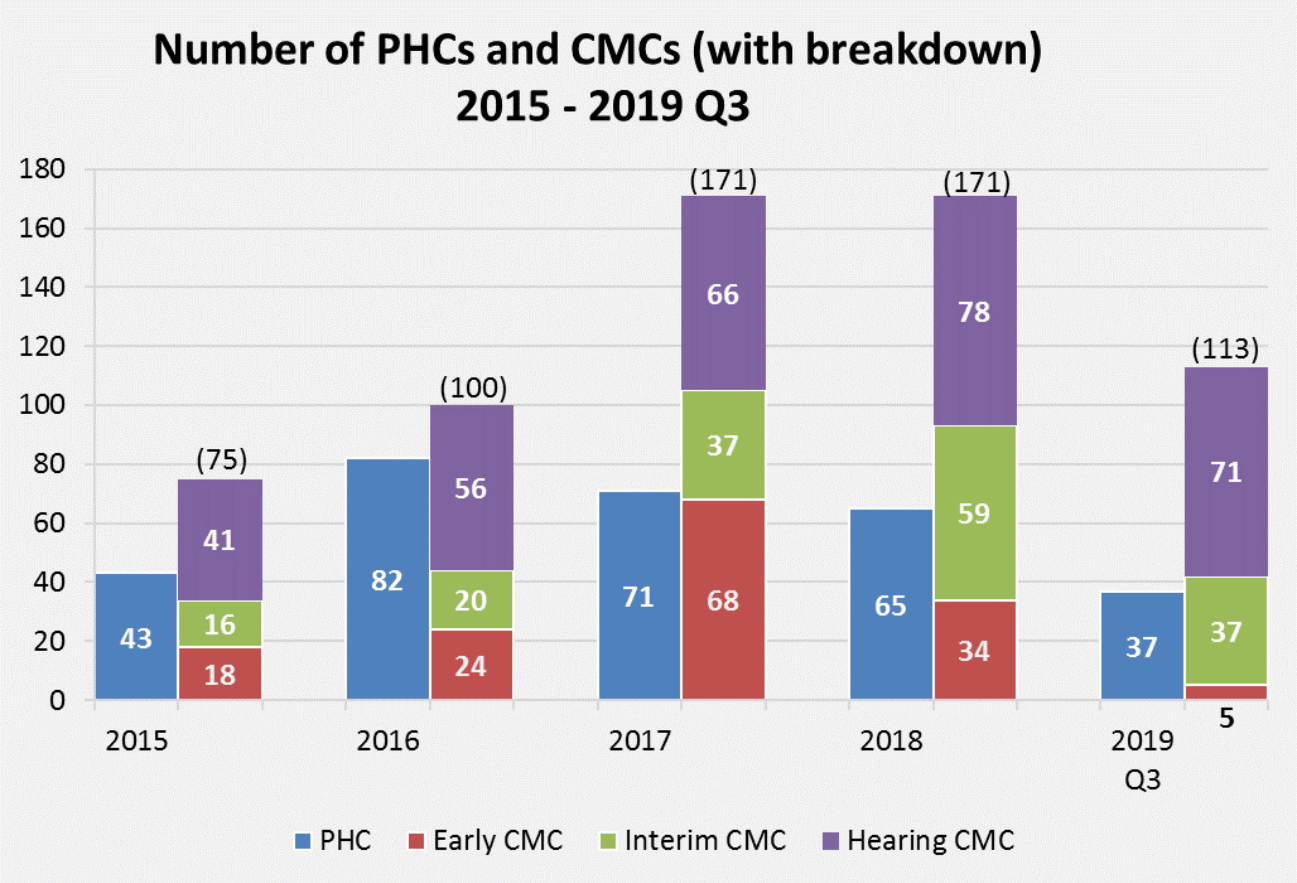
In managing its cases, the Committee must balance process efficiency, effectiveness and fairness. Recognizing that there will always be a percentage of cases that for legitimate reasons take longer to commence and complete, the Committee's aim is to eliminate *unreasonable* delay in the hearings process and, in doing so, to reduce case time span.

The Discipline Committee conducts pre-hearing conferences and case management conferences to manage cases in accordance with its Practice Direction on Case Management, which was implemented in January 2014.

Pre-hearing conferences (PHCs) have both a case resolution function, to narrow issues and negotiate potential settlements, and a case management function, including the scheduling of hearing dates.

Three types of Case Management Conferences (CMCs) have primarily a case management function. Early CMCs facilitate the scheduling of PHCs. Interim CMCs provide periodic oversight based on the needs of the case. Hearing CMCs identify any new issues prior to a multiple-day hearing and ensure an adequate number of hearing days/efficient use of hearing time and aid in scheduling penalty hearing dates.

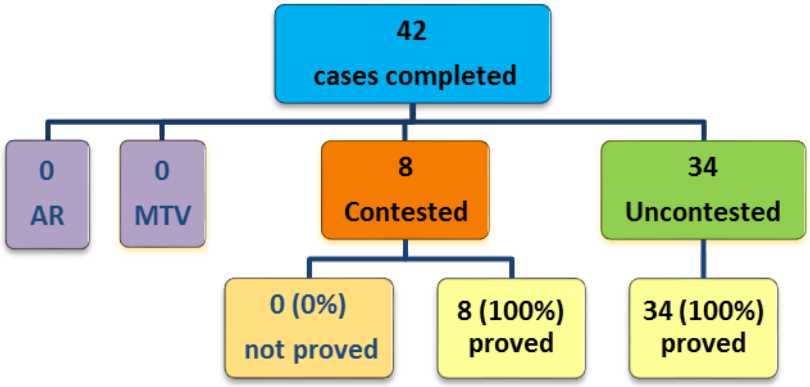
The following table provides the number of PHCs and CMCs, with a breakdown per CMC type, from 2015 to 2019 Q3.



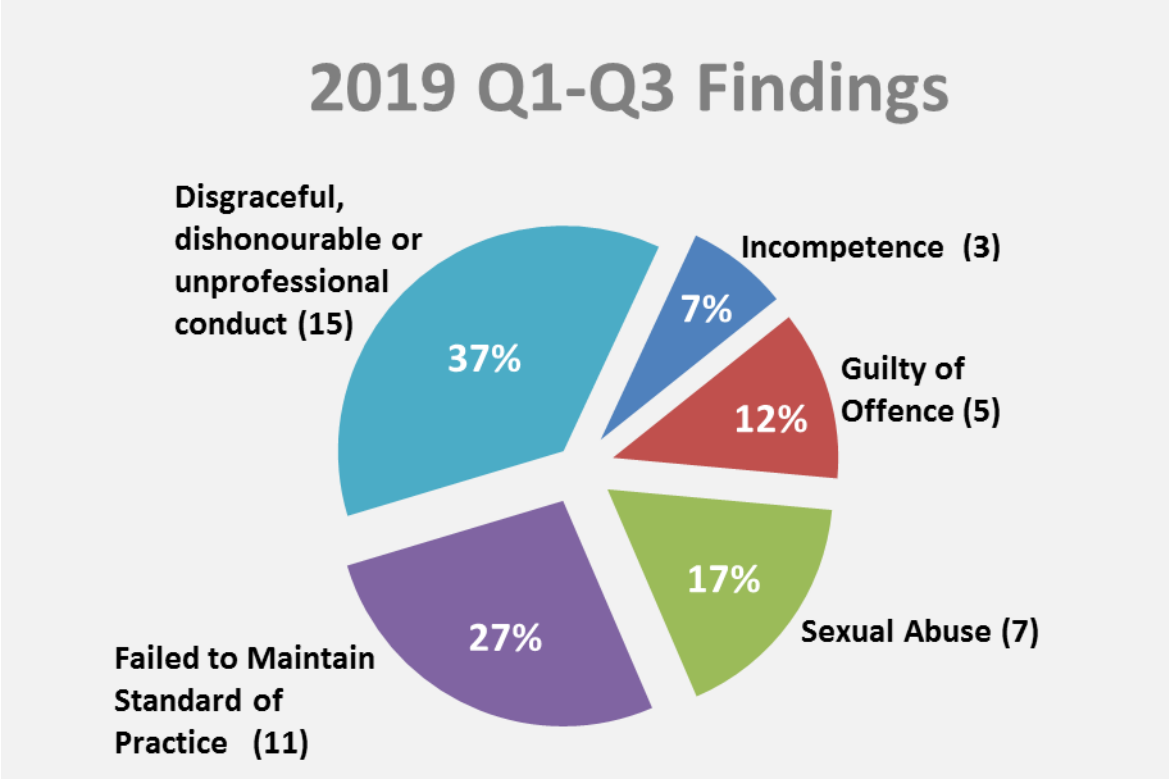
As of September 30, 2019

Conducting Timely Hearings

The Discipline Committee also manages its caseload by conducting hearings of the cases referred to it. As of 2019Q3, the Committee completed 42 cases in 41 hearings (2 cases completed in one hearing) of allegations of professional misconduct and/or incompetence.

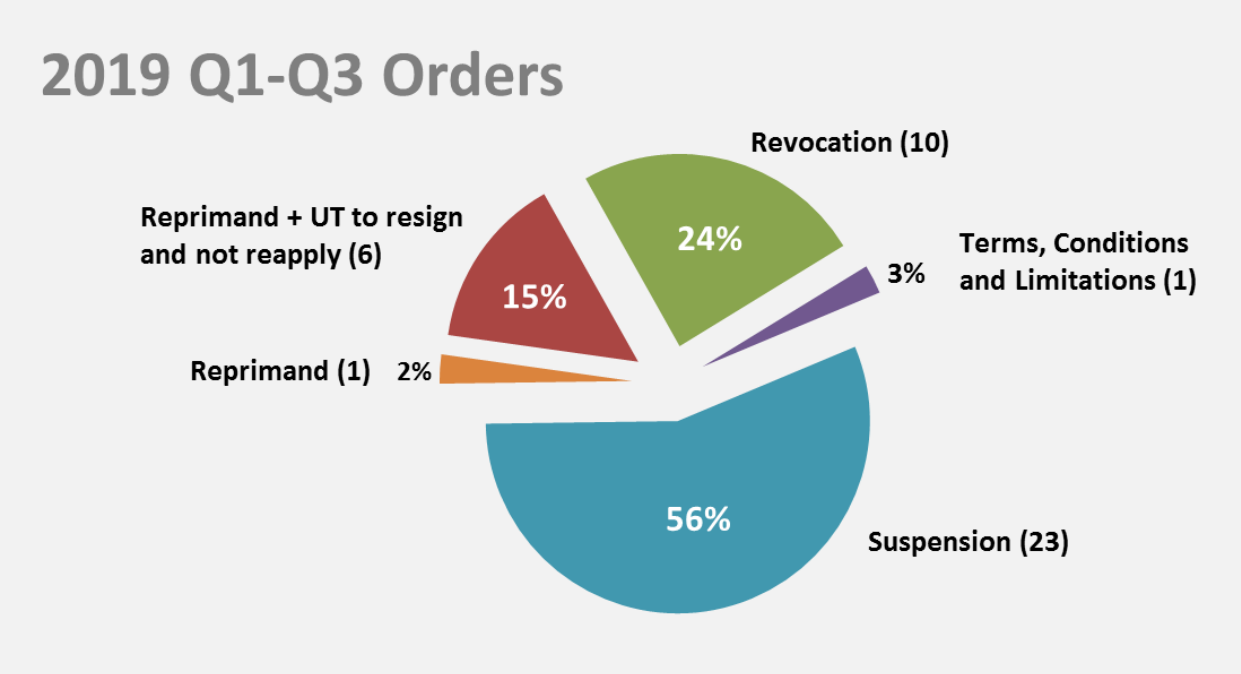


The following depicts the percentage and types of findings as of 2019Q3 (42 cases in 41 hearings).



As of September 30, 2019

The following depicts the orders of the Committee as of 2019Q3 (42 cases in 41 hearings). An Order of the Discipline Committee may have one or multiple components. For example, the Committee may order revocation and a reprimand, or a suspension, the imposition of terms, conditions and limitation and a reprimand. The following is based on the most serious component of the Order in each case:



Finding	Revocation	Suspension	TCL	Reprimand + UT	Reprimand
Sexual Abuse	4	2		1	
Incompetence	2			1	
Failed to Maintain Standard of Practice	1	7	1	2	
Guilty of Offence	3	1		1	
DDU		13		1	1

As of September 30, 2019
Note: *2 of the 42 proved cases were joined into one hearing and therefore the chart shows 41 penalties.*

Timeliness and Quality of Decisions and Reasons for Decision

Key Performance Indicators for Decisions

The 2019 key performance indicators for decision are for:

- 90% of written decisions and reasons in *uncontested cases* to be released within eight weeks of the last hearing date; and
- 90% of written decisions and reasons in *contested cases* to be released within twelve weeks of the last hearing date.

As of 2019 Q3, the Discipline Committee met its key performance indicators for decisions in uncontested and contested cases.

Appeals

To date in 2019, seven appeals were determined. The Committee's decisions were upheld in five cases and overturned, in part, in two cases.

On September 14, 2018, in *Taylor v. CPSO*, the Divisional Court had dismissed the physician's appeal regarding finding and penalty, and on January 7, 2019, the Court of Appeal dismissed a motion for leave to appeal. On October 3, 2018, in *Hill v. CPSO*, the Divisional Court had dismissed the physician's appeal regarding finding and penalty and on March 15, 2019, the Court of Appeal dismissed a motion for leave to appeal. On June 26, 2019, the Divisional Court dismissed the physician's appeal regarding finding and penalty on multiple issues in *Doyle v. CPSO*. On January 28, 2019, in *Otto v. CPSO*, the Divisional Court dismissed for delay the physician's appeal regarding penalty. On June 18, 2019, Dr. Horri abandoned his appeal of the Committee's decision of March 29, 2019 regarding redetermination of penalty.

On July 23, 2019, in *Kunynetz v. CPSO*, the Court quashed the finding of sexual abuse of a patient and the finding of disgraceful, dishonourable or unprofessional conduct based on the physician allowing his abdomen to contact the body of two patients; the Court upheld the findings of disgraceful, dishonourable or unprofessional conduct based on the physician moving or removing clothing in the absence of adequate warning or explanation in respect of two patients and regarding breaching an order requiring a practice monitor for patients on two occasions. The Divisional Court quashed the penalty decision of revocation, a reprimand, reimbursement of the fund for therapy and hearing costs, and ordered a suspension from October 1, 2015 (the date of Dr. Kunynetz's interim suspension) to the date of the release of the Divisional Court's decision, i.e., July 23, 2019.

On July 19, 2019, in *Lee v. CPSO*, the Divisional Court upheld the Committee's decision on finding, however, granted the appeal of its penalty decision and returned the matter of penalty for rehearing; the Court of Appeal denied the College's motion for leave to appeal the decision of the Divisional Court on November 1, 2019.

Three appeals are awaiting determination - two appeals to the Divisional Court and one physician motion for leave to appeal the Divisional Court's decision to the Court of Appeal.

Transparency of Committee Activities and Decisions

Decisions

The Discipline Committee posts hearing dates, case status (whether a case is adjourned or a decision is under reserve) and its findings and orders on the College's website under Doctor Search. The decisions are also posted on the LexisNexis and Carswells legal databases and on CanLII, a free publicly accessible legal database managed by the Federation of Law Societies of Canada.

Committee Financial Accountability

The Discipline Committee tracks its costs and expenditures. Discipline hearing costs are directly related to the number, length and complexity of hearings.

Paid Hearing Days and Late Cancelled Days

As of 2019 Q3, a number of cases that were scheduled for multiple day hearings resolved to take place in one day or adjourned, resulting in a reduced number of hearing days.

Paid hearing days (PHD) = Days used + Days not used but paid (due to late cancellation). The number of paid hearing days (PHD) for 2015 to 2019 Q3 was as follows:

Year	2015	2016	2017	2018	2019Q3
PHD	210	232	208	148	83

Late cancellation costs are incurred due to late resolution (less than 10 business days' notice of hearing commencement) or adjournment of cases or early completion of hearings. The number of late cancelled days (LCD) for 2015 to 2019 Q3 was:

Year	2015	2016	2017	2018	2019Q3
LCD	92	75	74	35	25

Reducing the number of late cancelled days is a goal of case management, although not entirely in the Committee's control. For example, in 2014, late cancelled days were reduced to 28. In 2015, late cancelled days increased due to the late settlement of four cases and the withdrawal, dismissal and loss of hearing days, respectively, in three cases in which patients did not wish to attend to testify. The number of late cancelled days decreased significantly in 2018 and 2019.

Scheduling Two Half Day Hearings in One Day

In June of 2018, the Discipline Committee implemented a practice to schedule two half-day hearings in one day for eligible cases. Advantages of this practice include: timely justice, as cases

move through the process more quickly; efficient use of hearing days and committee member resources, as two cases are completed in one day and the same panel hears both cases; the potential incentive to resolve cases as the College has sought costs of $6,000 for a half-day hearing rather than the tariff rate of $10,370; and, costs recovery and savings. From the Committee perspective, the recovery of costs of two half day hearings at $6,000 for each hearing is higher than recovery at the daily tariff rate. However, this must be balanced with the additional cost to the Committee of panel member preparation time for advanced review of materials, which is required for matters to complete within a half day. Overall cost savings are anticipated as two hearings are dealt with in one day and more cases may resolve to a half day.

Costs

Council policy is that the usual amount of costs sought by the College in appropriate discipline cases would be in accordance with the Discipline Committee tariff for one day of hearing. On March 3, 3019, Council increased the costs tariff from $10,180 to $10,370 per day. The referring committee retains the discretion to change the amount sought in specific cases. As of 2019 Q3, the Discipline Committee has ordered $410,830 in costs payable to the College.

LOOKING AHEAD TO 2020

In accordance with the strategic plan, the Committee will continue to focus on ways to improve the effectiveness and efficiency of the discipline process while ensuring fairness, including ways to achieve earlier settlement. The Committee is continually reviewing its governance strategies including its training and education cycle and its recruitment and succession planning to ensure adequate resources in light of the caseload and potential statutory changes to committee and panel composition requirements. This will include enhancing capacity and diversity through recruitment and training experienced members in the role of case management conference and pre-hearing conference chair.

We commend our Committee members who have dedicated significant time and effort to the hearing schedule. The Committee would like to thank the Hearings Office staff and the Independent Legal Counsel team for their outstanding work in assisting the Committee to fulfil its mandate and for their support throughout the year.

Respectfully submitted,

Dr. Melinda Davie
Co- Chair, Discipline Committee

Dr. Eric Stanton
Co-Chair, Discipline Committee

Appendix B

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Education Committee
Annual Report 2019

MANDATE

The Education Committee's mandate and objectives, as defined in by-law are to:

- review and make recommendations to Council respecting matters of undergraduate and postgraduate medical education in Ontario;
- establish mechanisms to enhance continuing professional development by College members including:
    - systematically tracking College-observed trends of needs in physician education;
    - advocating for these needs to be met by external educational providers; and
    - endorsing methods for measuring outcomes of educational interventions by the College.
- approve, monitor and/or evaluate methods for use by the College, which may include the following:
    - assessment methods and tools for competence and performance;
    - programs to promote and enhance professionalism; and
    - supervision roles.

YEAR IN REVIEW

In 2019, the Education Committee engaged in and provided feedback on CPSO initiatives pertaining to medical education (undergraduate, postgraduate and physicians in practice), continuing professional development (CPD), and physician assessment. In addition, the Education Committee has played a key advisory role in shaping CPSO educational initiatives, including the New Member Orientation and the Quality Improvement program.

CPSO Educational Initiatives

The Committee engaged in further shaping and refining of educational initiatives of the CPSO.

<u>New Member Orientation and the Quality Improvement Toolbox</u>

The Committee provided feedback on the content of the New Member Orientation project. Specifically, the Committee members provided considerations for the ordering of the modules and policies that should be highlighted. The Committee received an overview of the Practice Profile, Self-Guided Chart Review and Data-Driven QI tools.

<u>QI/QA Model</u>

The Committee received an update on the development of the Quality Improvement/Quality Assurance model and made a number of observations for consideration. These included the importance of framing the use of data in a way that would be helpful to physicians, including the

utilization of coaching and mentoring; opportunities for the College to collaborate with its external partners; the importance of the program focusing on patient safety; and the incentive of CPD credits for participating in the QI activities.

Practice Improvement Plans: Self-Assessment in a Quality Improvement/Quality Assurance Context

The Committee provided input into the development of the global Practice Improvement Plans (PIPs) as a component of the Quality Improvement/Quality Assurance model, touching on the use of CanMEDS 2015 as an organizing framework, accessibility of data for practising physicians, and the role of coaching.

Undergraduate Student (UGME) and Postgraduate (PGME) Engagement

CPSO Outreach Activities

The Committee received a presentation on CPSO's outreach activities to the medical schools and medical students. The Committee discussed how to better engage the Academic Representatives in outreach activities to students and faculty to help disseminate College information to medical schools. Recommendations included: extending the practice of the PARO presentation at Council to the OMSA representatives; collaborating with the CMPA; developing topics that are relevant to medical students; collaborating with medical programs to implement the professionalism modules into curriculums of the Faculties of Medicine.

Continuing Professional Development (CPD)

CPSO Course Recognition

The Committee decided to end the course recognition process for the Medical Record Keeping course offered by the University of Toronto and the Understanding Boundaries offered by Western. Over time, the College has cultivated strong relationships with members of both faculties and regularly collaborates with both universities on program content. In addition, these programs undergo a formal accreditation cycle through CFPC and RCPSC which ensures rigor.

OTHER ACTIVITIES

Governance Modernization Review of Standing Committees

This year has been one of significant change from a governance perspective. As part of CPSO's governance modernization work, the Governance Committee consulted with members of the Education Committee regarding the mandate, structure and membership of Standing Committees. Based on the governance review, it was determined that the Education Committee had some overlap in mandate and responsibilities with other Standing Committees. In addition, the mandate

of the Education Committee was not as strongly aligned to CPSO's strategic plan as it was in the past.

At the September meeting, Council approved by-law amendments to remove the Education Committee as a Standing Committee and have it move forward as an advisory group, which would enable more flexibility and agility to accomplish objectives. The Education Advisory Group had its first meeting in November and will continue to support CPSO in its work related to the education of medical students, residents and physicians at various stages of their career.

Respectfully submitted,

Akbar Panju,
Chair, Education Committee

Appendix C

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Executive Committee Annual Report 2019

MANDATE

The Executive Committee has 2 main functions:

1. Under section 12 (1) of the *Regulated Health Professions Act*, between meetings of Council, the Executive Committee has almost all the powers of the Council with respect to any matter that, in the Committee's opinion, requires immediate attention. The only power it does not have is to make, amend or revoke a regulation or by-law.

2. To ensure that the work of the College is able to proceed between Council meetings, the Executive Committee also guides the response to significant issues. Executive Committee gives direction to staff about what may be required before the matter is ready to go to Council. In addition, the Executive Committee makes recommendations to Council as to outcome.

YEAR IN REVIEW

The Executive Committee held 10 meetings in 2019.

Executive Committee Update: A summary of Executive Committee's deliberations and direction circulated to all Council members after each Executive Committee meeting.

Executive Committee Liaison: Executive Committee members contact each Council member to ensure that Council members understand what was considered and have access to further information.

Executive Committee's Reports to Council: The Executive Committee provides quarterly reports to Council in accordance with Section 12 of the Health Professions Procedural Code.

Governance Modernization

As part of CPSO's governance modernization work, Council approved the removal of three standing committees: Outreach, Council Award Selection and Education. The Executive Committee incorporated the responsibilities of the Outreach Committee into its mandate, which include but are not limited to:

- Working with the Communications area to help develop major communications and outreach initiatives to the profession and public
- Assisting in the development of major communication and government relations strategies
- Developing plans to deliver on each of the communications and outreach related components of the strategic plan.

Other issues within the governance modernization work that the Executive Committee discussed include term limits, length of appointments, succession planning, eligible practice requirements and Council elections.

Strategic Plan

Building on the work done in early 2019, CPSO contracted Optimus SBR to develop key performance indicators (KPIs) that will be used to measure progress on the 2020-2025 Strategic Plan. The Executive Committee had an opportunity to provide input into the development of the KPIs as well as a stakeholder engagement framework.

Policies

The Executive Committee reviewed and discussed a number of policies over the course of the year, including:

Final Approval

- Continuity of Care Policies
- Closing a Medical Practice
- Policy Redesign, incl. updates to Planning for and Providing Quality End of Life Care, Professional Obligations and Human Rights, Medical Assistance in Dying
- Disclosure of Harm (pending Council approval)
- Boundary Violations (pending Council approval)
- Prescribing Drugs (pending Council approval)

Drafts for Consultation

- Medical Records Stewardship & Medical Records Documentation
- Protecting Personal Health Information

Performance Evaluation of the CEO and Registrar

One of the primary functions of Council is to evaluate the performance of the CEO/Registrar on an annual basis. This year, the Executive Committee retained an external consultant to conduct a more robust evaluation of the CEO/Registrar's performance, including interviews with key external stakeholders and a formal opportunity for Council members to provide input.

OTHER ACTIVITIES

The Executive Committee discusses and responds to other issues as they emerge, including but not limited to:

- Renewal of the Council Award Program

- Regulation of Physician Assistants
- Regulatory Modernization
- Interventional Pain Management Change of Scope Program

Respectfully submitted,

Peeter Poldre,
Chair, Executive Committee

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Governance Committee
Annual Report 2019

MANDATE

The Governance Committee is a standing committee of the College of Physicians and Surgeons of Ontario (CPSO), operational in nature, with its mandate and composition set out in the General By-Law. The Governance Committee is responsible for overseeing and making recommendations to Council to enhance the CPSO's governance structure.

There is literature to demonstrate the benefits of following good governance practices, including sound strategic planning and better risk management.

YEAR IN REVIEW

In early 2019, the Governance Committee developed a work plan based on recommendations from the 2018 Annual Report. Areas of focus for the 2019 Governance Committee Work Plan include:

Governance Modernization - Legislative Governance Changes

At its December 2018 meeting, Council approved the following recommendations of the Governance Review Working Group:

- Increase public member representation so there are equal numbers of physician and public members on the Council;
- Reduce the size of the Council from 34 to between 12 – 16 members;
- Eliminate overlap between Council and statutory committee membership;
- Implement a competency-based selection process;
- Implement a hybrid selection model for physician members;
- Provide equal compensation for physician and public members of the Council; and
- Retain the option of appointing an Executive Committee.

A letter outlining these recommended legislative changes was sent to the Minister on January 25, 2019, which followed a similar letter sent by the College of Nurses of Ontario (CNO) earlier in the

year. The CPSO continues to advocate for these changes, in collaboration with the CNO, Federation of Health Regulatory Colleges of Ontario (FHRCO) and the Citizen Advisory Group (CAG). It is possible that government could use its authority either to enact regulations under its current regulation-making authority or to propose new legislation. Updates from the Ministry's office and CAG are noted below.

The CPSO has had productive meetings with the Deputy Minister Helen Angus, Assistant Deputy Minister Patrick Dicerni, as well as contacts through the Premier's Office, where our red tape and governance modernization recommendations continue to be well-received. As we work to keep these recommendations on the agenda with decision-makers through 2019, we anticipate providing Council with a fulsome government relations update in December.

The CAG was asked to consider the CPSO's proposed process for appointing members to the Council. The CAG was presented with a comprehensive overview of the proposed changes regarding size, composition, and a competency-based selection process. Overall, CAG members were supportive of the proposed changes, noting that they appeared to be sound, effective and efficient, and an improvement over the current process. Members were particularly pleased with the move to a more transparent process and expansion of the diversity of professional experience (medical and other professional skills) on the board. Several members made strong arguments for having individuals with "lived patient experience" on the board. The CAG was also asked to consider the hybrid model for selecting board members. Most members were not in favor of this model, as in their view, it added an unnecessary additional level of complexity for little gain. There was concern that the inclusion of an election component would weaken the ability to attain a diverse, competency-based board and not serve the public interest.

Governance Modernization - Non-Legislative Governance Changes

Over the last several months, the Governance Committee has been engaged in modernization work with the goal of incorporating good governance practices and better aligning the CPSO's work with its 2020-2025 Strategic Plan. Council approved a series of by-law amendments recommended by the Governance Committee related to four areas:

Removal of Three Standing Committees

The Council Awards Selection and Education Committees were removed as standing committees and will continue as Advisory Groups. The Outreach Committee was removed as a standing committee and its core mandate was incorporated into the mandate of the Executive Committee.

Term Limits

A 9-year term limit will be applied for Council members (excluding Lieutenant Governor In-Council appointed members) and members of any one Committee, whether those years are

consecutive or non-consecutive. An 18-year limit would be applied for individuals who have participated in any combination of Committees or Council, whether those years are consecutive or non-consecutive. The term limits will come into effect in December 2020.

Committee Appointments

The length of Committee appointments has been lengthened from 1 year to up to 3 years effective December 2019 (excluding Executive, Governance and Finance & Audit Committees which will remain at 1 year. Depending on succession planning and Committee needs as well as Committee member availability, 1, 2- and 3-year appointments may be proposed for existing Committee members.

Exceptional Circumstances

Creation of an "exceptional circumstances" provision could apply in instances where a Committee requires the extension of an appointment for a member that exceeds the applicable term limit. It has been clearly communicated that where committees may experience significant challenges with either recruitment or expertise, the exceptional circumstances provision is available to bridge the gap until the Committee can find a solution. The use of this provision is available for Committees to use not only during the transition period, but into the future as well.

Stability and effective functioning of the Committees during this time of change is a key priority. To enable a seamless transition, the Governance Committee recognizes that additional time may be required to support the application of term limits effectively on appointments and reappointments for all committees. This can be facilitated by the Exceptional Circumstances provision that has been included in the by-law amendments. The provision allows some flexibility in ensuring that mentorship and knowledge transfer occurs successfully between seasoned and newer members. Implementation Plans for each committee have been developed and there will be a staged approach to facilitate smooth implementation of the changes and minimize disruption to Committees.

The Governance Committee is committed to making sure that Committee members felt that the transition process was fair and compassionate with active engagement from Committee Chairs. There are also plans in place to convene with Committee Chairs in January 2020 to discuss members transitioning off in December 2020.

Council was also presented with an "eligible practice" criteria recommendation which was premised on the fact that the majority of Committee work reasonably requires current or recent medical practice experience and knowledge. It is the view of the Governance Committee that most of the Council felt that this recommendation required further exploration and so it was not approved at the September meeting. The Committee will continue to examine the definition and how it can best be applied to enhance Council and Committee effectiveness.

Nominations

Making recommendations regarding Chair and Committee appointments are a focus for the Governance Committee each year. Committee appointments are made on an annual basis and the Governance Committee oversees the recruitment and screening processes for these positions. Ultimately, all appointments and are made by Council.

Committee membership renewal and succession planning are important drivers in the nominations process. Finding the right balance between bringing in new, qualified Committee members and retaining expertise is important.

This year has been a transitional year for Committees. At the beginning of the year, there were 13 Committees. Council passed by-laws at the September Council meeting that reduced the number of standing committees to 10. Among the 10 Committees, there are 204 positions, Council members serve on 68 of these Committee member positions. 136 positions are filled by Committee members who are not on Council. Of these 136 non-Council committee positions, 132 are filled by physicians and 4 are filled by members of the public.

Non-Council Committee Appointments

Considering the governance modernization work underway, this year's recruitment process proactively considered the skills and qualifications required to execute the Committees' respective mandates effectively. In total, there were 47 applications for 19 vacancies which is a marked improvement compared to previous years. Various recruitment strategies were used during the call for applications. Additionally, there was a concerted effort to enhance the diversity in each Committee with respect to geography, specialty, gender, ethnicity and language (i.e. French and other languages).

Moving forward, the Governance Team will continue to liaise with Committee support staff to ensure recruitment is not conducted within one specific timeframe, but regularly throughout the year.

The Governance Committee continues to look for ways to appoint a greater proportion of Council members and public members to College Committees. Existing quorum requirements require Council member participation on some statutory committees, namely the Discipline Committee and Inquiries, Complaints and Reports panels. These requirements are particularly onerous for public members who must provide between 100 and 120 days of work on Council and Committees each year. Separation between the Council and statutory committees is considered a best practice and is something that CPSO is striving to achieve. Council and statutory committees have very different roles (oversight/strategic role for the Council vs. adjudicative for statutory committees). Separation in membership from the board will enhance the integrity and

independence of the board and statutory committees as well as help strengthen public confidence in the regulatory system. This separation seems inevitable, and we continue to work towards this objective by improving our practices of allocating physician Council members on Committees based on their interest and availability to commit.

Public Member Appointments

CPSO relies and depends on the government to appoint 15 qualified public members to the Council. Current practice is where a reappointment is endorsed by the Committee, the Committee Chair has typically undertaken the responsibility of signing a letter to the Minister recommending the reappointment of the public member. The specific content of these letters varies from appointee to appointee, but typically describes the member's record of service on Council, including service on Committees and working groups, as well as the date that the member's term will be expiring. It also includes a statement of recommendation or endorsement on behalf of the Committee and the College which is often based on subjective information. Governance Committee support staff then deliver the recommendation letter and the Reappointment Information Form to the Minister of Health and the Ministry's Agency Liaison and Public Appointments Unit (ALPAU) within four months of the term expiry.

CPSO looks forward to legislative change that adopts a competency-based model, where members collectively demonstrate the experience, knowledge, skills, and character needed for effective regulatory governance. In the meantime, the Governance Committee explored with the ALPAU's support, a change in approach to recommendation letters that would continue to meet the Ministry's information needs. The proposed approach is to no longer consider whether to endorse public members' reappointments on a case-by-case basis as part of regular committee business. Instead, a letter which appends a model for Council members of a health regulatory college (competencies and attributes identified for CNO's future board) will form the basis of letters sent to the Minister about upcoming term expiries going forward. The Governance Committee will continue to explore this proposed approach.

Charting the Way for a Public Member President

By-law amendments and new provisions are in place to support the election of a Council President who is a public member. These efforts were initiated at the May Council meeting and continued at the December 2018 Council meeting when Council approved by-law amendments to support opening the President and Vice-President positions to public members on Council.

Enhancement of Orientation and Education Program

Over the past year, the Governance Committee has reviewed the 2019 onboarding activities for new members with the goal of better understanding the specific learning needs of new Council members. The Annual Education Day, which was held in February last year, was focused on the

legislative framework, strategic priorities, overview on the role of Council members and specific Committee orientation. In March 2020, we welcome the opportunity to host Annual Education Day for Council and Committee members.

With respect to continuing education, because there was a focus on the governance modernization work, a number of speakers came to discuss relevant topics. Learnings from the review indicate a desire among members to:

- Engage in just-in-time learning
- Learn using various formats and modes of delivery (i.e. in person, webinar, virtual)
- Have customized learning based on their background, skills, experience and interests
- Align learning with the strategic plan and current priorities for Council

The mentorship program for new Council members was well received this year and is an effective way of fostering relationship building as well as facilitating knowledge transfer. A special thank you to our Council members who have served as mentors in 2019: Mr. Pierre Giroux, Ms. Joan Powell, Dr. Andrew Turner, Dr. Judith Plante, Mr. Harry Erlichman, Mr. John Langs and Ms. Joan Fisk.

Council Performance Assessment

The Governance Committee continues to oversee the Council Performance Assessment process which helps to inform and drive continuous improvement. Introduced in 2004, the CPSO's annual Council Performance Assessment was intended to inform and support ongoing development and continuous improvement. The purpose of the process is to determine how effective the Council was in achieving its strategic objectives as well as identify opportunities to enhance the performance of Council and Council members moving forward.

This year, Council members completed an enhanced Council Performance Assessment that explores fundamental aspects of a Council's performance including:

- How well has the Council met its strategic objectives;
- How well has the Council conducted itself;
- Feedback regarding the Council President;
- How well Council Members perform generally; and
- How well individual Council members feel they performed.

The electronic survey was completed online, and Governance Committee staff analyze and interpret the results. As in previous years, individual responses remain anonymous and aggregated information was consolidated, shared and discussed at the December Council meeting.

This year, the Governance Committee also introduced a new evaluation tool that measures the effectiveness and member satisfaction with each Governance, Executive and Council meeting.

Evaluation results are reviewed by staff, Chairs and the President, with a discussion about actions that can be taken to address issues raised. This tool will help to build accountability and transparency within Committees, facilitate continuous improvement and enhance Committee member experience.

OTHER ACTIVITIES

The CPSO welcomed new leadership in the Governance and Policy area, Laurie Cabanas (Director of Governance & Policy), who, in a short time at CPSO, has clearly demonstrated her effectiveness in governance by making improvements to current practices that are meaningful and impactful. She has also made significant inroads through her ability to influence and activate others through personal advocacy, vision and drive, her change management leadership and her strategic approach to implementing best governance practices.

Looking Ahead to 2020

While 2019 has been a year of change and transition, 2020 will be a significant year for building and enhancing governance practices and processes. CPSO will continue to advocate for much needed regulatory modernization in collaboration with our system partners, which will allow us to strengthen our role in governance. The Governance Committee looks forward to providing ongoing updates regarding work with other health regulators that share a common goal of delivering best-in-class structural and governance reform.

Committee Acknowledgments

The Governance Committee would like to acknowledge Dr. Steven Bodley for his contributions this past year as the Chair of the Governance Committee. The challenges and successes of ongoing governance modernization have been easier to manage based on his wise counsel and patient advice throughout the various stages of respective initiatives. As we look back on the year's accomplishments, the Committee's achievements were made possible with him at the helm.

Respectfully submitted,

Dr. Steven Bodley
Chair, Governance Committee

Appendix E

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Inquiries Complaints and Reports Committee

Annual Report

2019

MANDATE

The Inquiries, Complaints and Reports Committee (ICRC) is a statutory Committee of the College, formed on June 4, 2009, under Ontario's *Health System Improvements Act, 2007*. The ICRC has jurisdiction over all College investigations, of which there are three kinds:

- Complaints investigations
- Registrar's investigations
- Incapacity investigations

ICRC COMPOSITION

The entire ICRC is currently (November 2019) composed of 67 members.

The members may be physicians who are members of Council, physicians who are non -Council members, staff physicians, or public members of Council. The ICRC currently has seven public members.

Quorum consists of three panel members, at least one of whom must be a public member of Council.

ICRC Review and Disposition Authority

Review

The ICRC may consider a variety of factors when reviewing any investigation, including:

- facts of the case
- number and seriousness of care and/or conduct concerns at issue
- standard of care expected of practitioners
- whether the physician is practicing within his or her area of expertise
- physician's response to the investigation
- insight and self-identification of areas for improvement and changes to practice
- physician's apparent capacity for remediation
- physician's investigative and disciplinary history
- expert opinions obtained in the course of the investigation
- other documentary and witness information.

Dispositions

The ICRC may, following a complaints or Registrar's investigation:

- refer allegations of professional misconduct and/or incompetence to the Discipline Committee
- require a physician to appear in person to be cautioned before an ICRC panel
- refer a complaints or Registrar's investigation for incapacity proceedings

- require the physician to complete a specified continuing education or remediation program (SCERP); the ICRC no longer has the power to refer any clinical information to the College's Quality Assurance (QA) Committee
- take any action not inconsistent with the legislation (including "no action," "advice," "direct or accept remedial agreements and/or undertakings," etc.)

Where a physician recognizes that engaging in remedial training or entering into a relevant practice restriction may be needed in order to address concerns that are under investigation, the ICRC will consider whether it is appropriate to dispose of the investigation in whole or in part by accepting an undertaking by the physician. An undertaking is a professional commitment by the physician to complete certain elements within a specific timeframe or to abide by certain practice restrictions, with monitoring by the CPSO to ensure protection of the public.

There are a variety of factors that impact the number of ICRC referrals to the Discipline Committee from year to year. The ICRC considers whether there is a reasonable prospect of successful prosecution prior to referring a matter to the Discipline Committee. This is heavily dependent on the evidence available in the particular case. In addition, the ICRC will take public protection into account, including whether the physician has offered other measures which will protect future patients (such as an undertaking to resign or to restrict the physician's practice).

The ICRC may, during an incapacity inquiry, require the physician to participate in health examinations or assessments.

The ICRC may, following the completion of the incapacity inquiry, refer the matter of the physician's capacity to the Fitness to Practice Committee, if appropriate and if the matter has not been addressed through an undertaking with the College or a monitoring agreement with the Physician Health Program.

The Ontario Legislature passed the *Protecting Patients Act*, *2017*, in May 2017. It conferred on the ICRC the power, at any time following the receipt of a complaint or following the appointment of an investigator, to make an interim order directing the Registrar to suspend, or to impose terms, conditions or limitations on, a physician's certificate of registration if the ICRC is of the opinion that the conduct of the physician exposes or is likely to expose *his or her patients to harm or injury*.

In March 2018, a new process was implemented in Section 25.3 (1) allowing a complaint to be withdrawn at any time. The Registrar (or designate) will review the request, applying a risk analysis. If the Registrar (or designate) denies withdrawal of the complaint, the matter may come to ICRC for further direction.

<u>Process Changes to ICRC in 2019</u>

In 2019 the ICRC made significant improvements to its decision release times. The average timeline for a decision to be written and released to the parties in the period from January to September 2018 was 16.5 weeks. In the period of January to September 2019 the timeline was reduced to 7.1 weeks. The work of ICRC has been focused on ensuring timely conclusion of investigations and decision delivery to both

members and complainants. ICRC continues to strive to strike a balance between an effective, complete investigation through to a reasonable ICRC decision while maximizing efficiencies and appropriate use of resources.

In addition, the Investigations and Resolutions division has embraced the legislative provisions for alternative dispute resolution (ADR) to message the College's new approach in resolving disputes in a meaningful manner with consent of the parties. The implications for ICRC may be considerable reduction in matters to ICRC in 2020.

Of note, process changes within ICRC that were implemented in 2019:

- decreased listing time for panels on an ongoing basis in 2019 (from 6 weeks to 3 weeks);
- increased frequency of various types of panel meetings;
- a new decision template with a simplified format to reduce decision drafting time;
- introduced a new type of ICRC panel, the "hybrid panel" to address low level and medium risk matters on a regular, weekly basis;
- increased regular general panels with specialists assigned to some to handle low level risk, surgical and obstetrics/gynecology complaints in timely manner;
- a move to an electronic process to support caution materials;
- increased use of teleconferences for panels and zoom video conferencing was introduced (in 2020 continue with videoconferences however will switch to Skype for business); and
- introduction of Individual Education Plan (IEP) form to be completed by panel members to direct staff to appropriate remedial education for subject physicians.

CORE ACTIVITIES

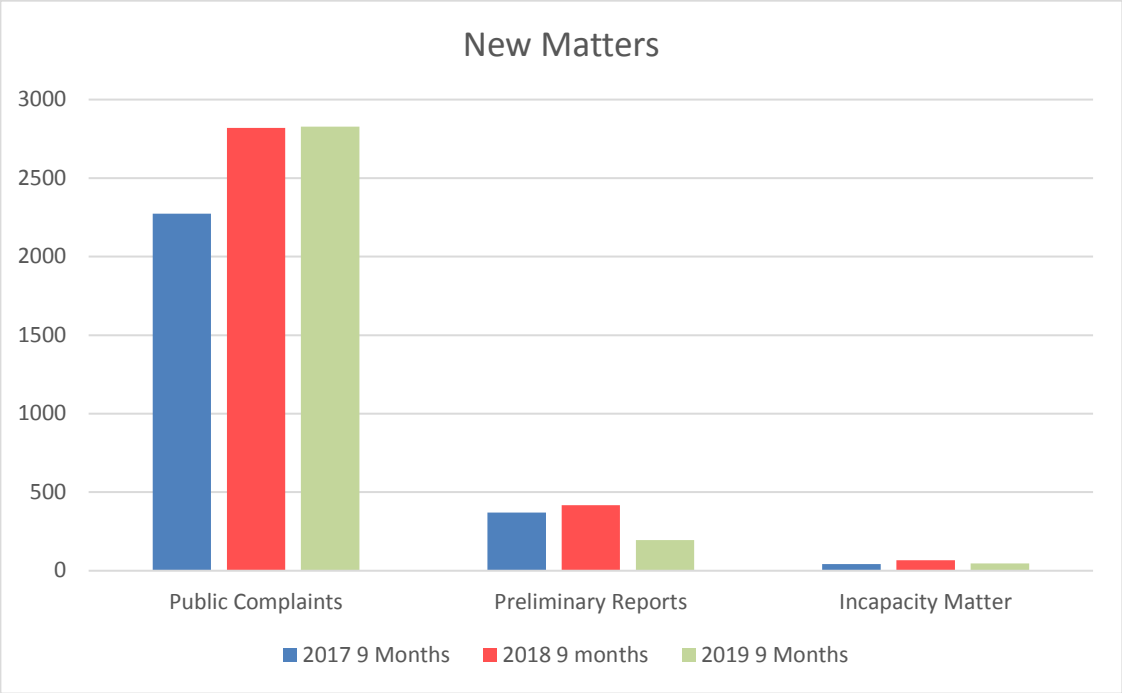
Panel Meeting Types and Formats

The ICRC meets in a variety of different panel types, including:

- general panels
- specialty panels, including:
  - Surgical Panel
  - Obstetrical Panel
  - Mental Health Panel
  - Family Practice Panel
  - Internal Medicine Panel
  - Prescribing – formerly Narcotics Monitoring System (NMS) – Panel
- standing weekly teleconferences
- ad hoc teleconferences
- hybrid panels for abbreviated investigations or low risk matters
- incapacity (or "health") inquiry panels
- settlement panels
- caution in person panels
- business/policy meetings
- quarterly leadership team meetings

New Matters January 1 - September 30, 2019

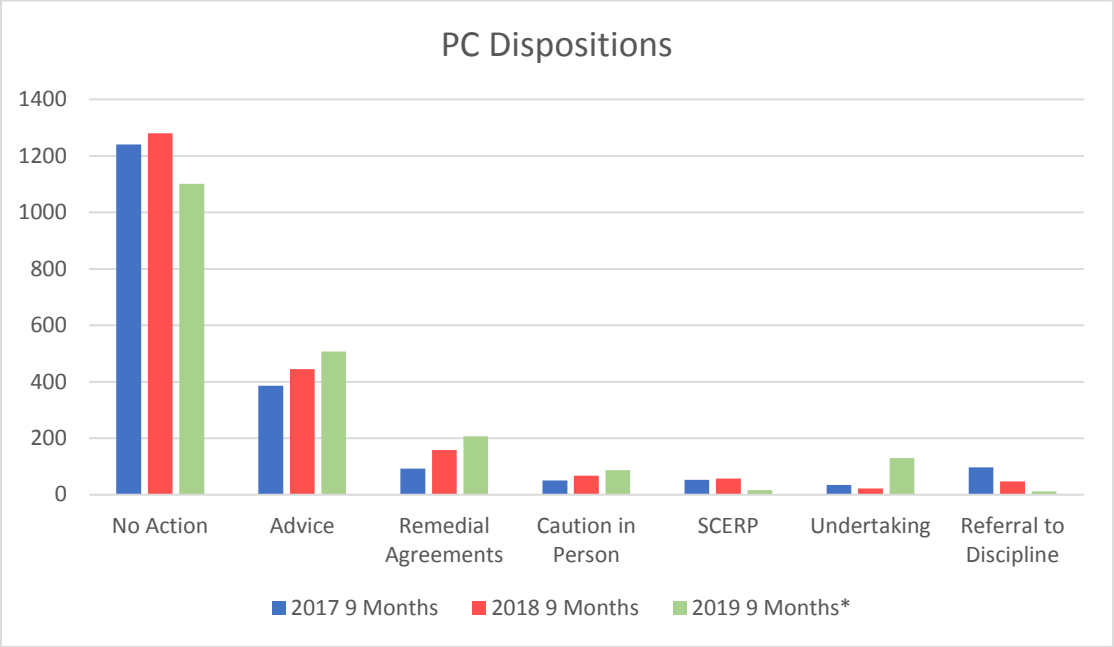
	2017 9 months	2018 9 months	2019 9 months	% Change from 2018
Public Complaints	2273	2820	2828	0%
Preliminary Reports	371	417	195	-53%
Incapacity Matters	42	66	46	-30%
TOTAL	**2686**	**3303**	**3069**	**-7%**



Intake and Closures January 1-September 30, 2019

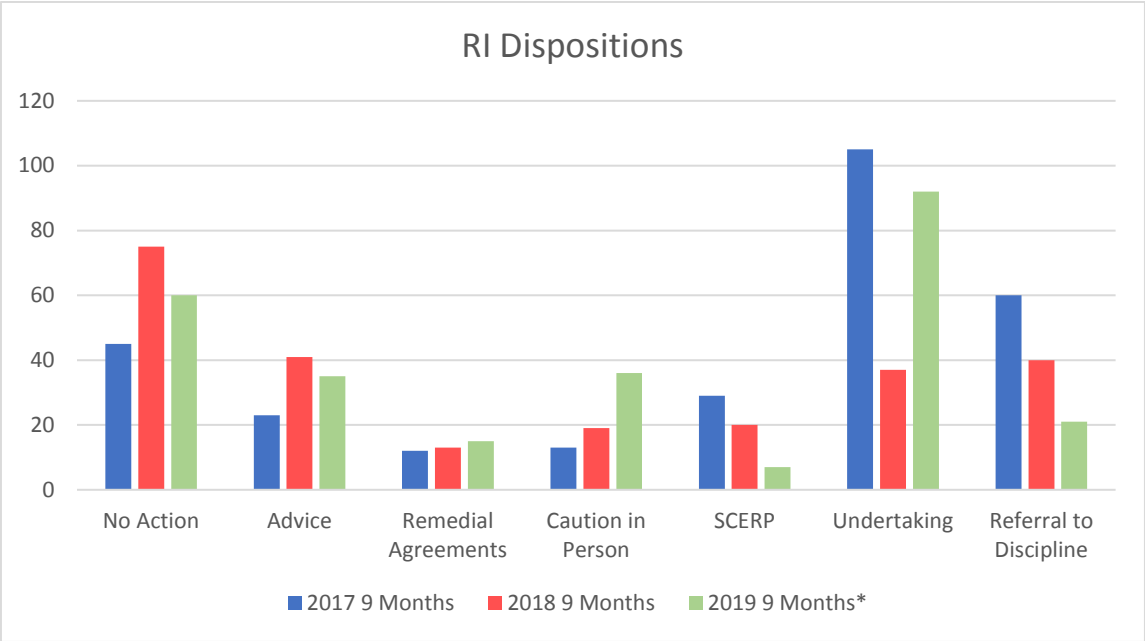
Intake and Closures

	2017 9 months	2018 9 months	2019 9months	% Change from
Early Resolution Files	446	547	1207	121%
Withdrawals	*NA*	*130*	*333*	156%
Did Not Meet Threshold	*NA*	*166*	*662*	299%
ADR	*NA*	*NA*	*208*	
Pre-RI Closures (RPGs Declined)	155	186	175	-6%
Pre-Incapacity Closures	28	21	20	-5%



Public Complaints

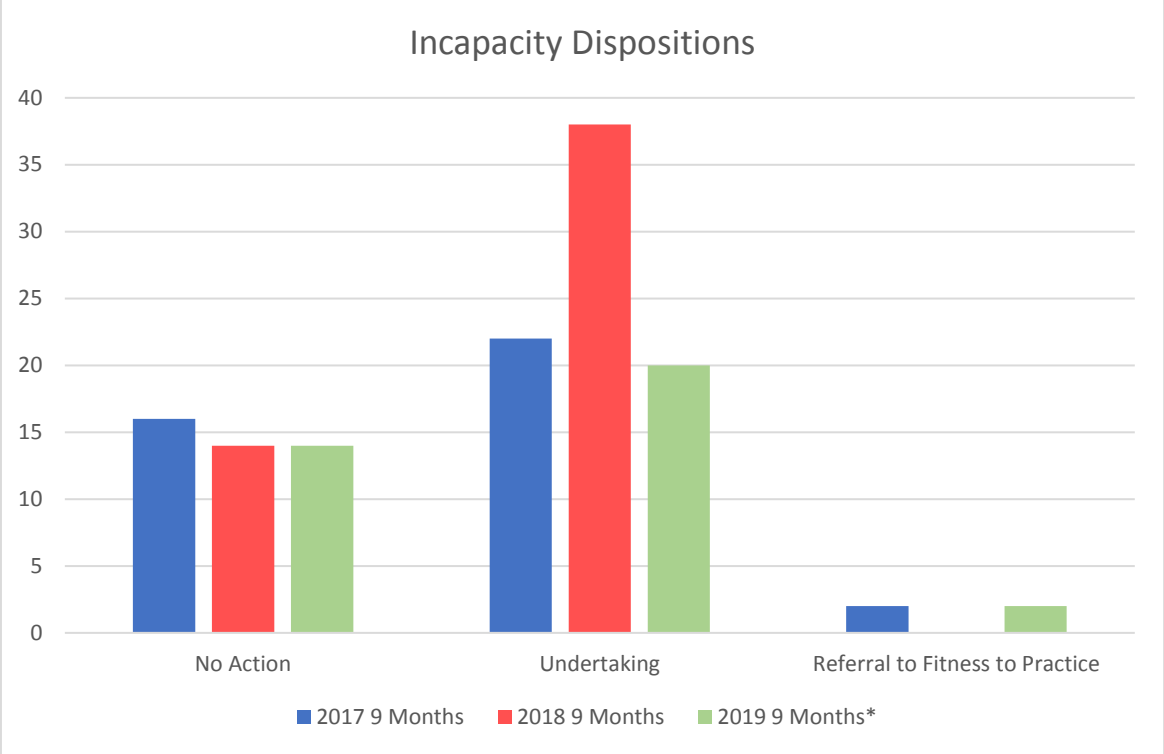
	2017 9 months	2018 9 months	2019 9 months	% Change from 2018
No Action	1240	1280	1101	-14%
Advice	386	445	507	14%
Remedial Agreements	92	158	207	31%
Caution in Person	51	67	87	30%
SCERP	53	57	17	-70%
Undertaking	35	22	130	491%
Referral to Discipline	97	47	12	-74%
Total	**1954**	**2076**	**2061**	**-1%**



Registrar's Investigations

	2017 9 months	2018 9 months	2019 9months	*% Change from 2018*
No Action	*45*	*75*	*60*	*-20%*
Advice	*23*	*41*	*35*	*-15%*
Remedial Agreement	*12*	*13*	*15*	*15%*
Caution in Person	*13*	*19*	*36*	*89%*
SCERP	*29*	*20*	*7*	*-65%*
Undertaking	*105*	*37*	*92*	*149%*
Referred to Discipline Committee	*60*	*40*	*21*	*-48%*
Total	***287***	***245***	***266***	***9%***

RPGs Declined by Quarter		
Q1	Q2	Q3
71	62	34



Incapacity Investigations

	2017 9 months	2018 9 months	2019 9 months	% Change from 2018
No Action	16	14	14	0%
Undertaking	22	38	20	-47%
Referred to Fitness to Practice	2	0	2	
Total	**40**	**52**	**36**	**-31%**

Decision Release

The ICRC continued in 2019 to fulfill its statutory mandate to release written decisions and reasons, as required under the *Health Professions Procedural Code*.

Decision Release

	Jan 1-September 30 2018			Jan 1-September 30 2019		
Disposed Matters	**Decisions Drafted**	**Avg. Decision Release (weeks)**	**Decision Release (90th Percentile - weeks)**	**Decisions Drafted**	**Avg. Decision Release (weeks)**	**Decision Release (90th Percentile - weeks)**
	2369	16.5	24.6	3040	7.1	12.7

Decision timelines

	Jan 1-September 30 2018		Jan 1-September 30 2019				
Disposed Matters	**# of Investigations**	**Ave. file open days**	**# of Investigations**	**Ave. file open days**	**90th Percentile (days)**	**% change in # of Investigations 2018-2019**	**%change in avg. timeline 2018-2019**
Public Complaints							
Intake	547	69.4	1207	42.1	85	121%	-39%
ICRC Decisions	2076	256.9	2061	251	446	-1%	-2%
Registrar's Investigations							
Closures/Resolutions	186		175	149.3	319.7	-6%	
ICRC Decisions	245	568	266	721.8	1158.3	9%	27%
Incapacity Investigations							
Closures/Resolutions	21		20	1006.9	1084.3	-5%	
ICRC Decisions	52	242	36	291.9	457.8	-31%	21%

Reviews by the Health Professions Appeal and Review Board

Most of the ICRC's *public complaints* decisions are subject to review, on request of either the complainant or the physician, to the Health Professions Appeal and Review Board ("HPARB", or the "Board"). S. 25.4 orders may only be reviewed by the Court.

Upon holding a review, the Board may confirm the Committee's original decision, make recommendations to the Committee, or require the Committee to do anything the Committee could have done at the first instance.

The Board, consisting of non-medical members, reviews ICRC decisions with a view to both the adequacy of ICRC investigations and the reasonableness of the decisions.

Of note, the Board releases its review of ICRC decisions approximately 12 to 18 months after a party has appealed the ICRC decision. Therefore, the data below does not reflect HPARB decisions from appeals of ICRC's 2019 decisions as these returns often reflect ICRC decisions that were issued 1-2 years prior. It is anticipated that HPARB decisions from appeals of 2019 ICRC decisions will be released by HPARB in 2020.

ICRC Committee members discuss matters returned by HPARB at the semi-annual business/policy meetings, to highlight trends and to inform future decision-making. Typically, there is some variation from year to year in the percentage of ICRC decisions appealed to HPARB.

HPARB Statistics

	2018	Jan 1 - September 2019
ICRC Appealable Decisions Issued in that Calendar Year	3188	3235
Total HPARB Reviews Completed in that Calendar year	338 (12%)	235 (7%)
Total number of HPARB returns Received in that Calendar year	31 (8%)	25 (11%)
Total HPARB Decisions Upheld	357 (92%)	210 (89%)
Total Number of HPARB Reviews requested in that Calendar Year for ICRC Decisions Issued in that Calendar Year	505 (16%)	427 (13%)
	2018	**Jan 1 - September 2019**
Appeals requested by Complainant for Decisions issued by the ICRC in that Calendar Year	404/505 (80%)	400/427 (94%)
Appeals requested by Respondent for Decisions Issued by the ICRC in that Calendar Year	101/505 (20%)	27/427 (6%)

Committee Financial Accountability

ICRC costs pertain mostly to preparation and attendance at meetings. There are also lesser costs associated with travel time and travel expenses. ICRC conducts many panels via teleconference or videoconferencing, resulting in a reduction of travel costs. ICRC members are provided with guidance in preparation costs for panels which continues to improve consistency and predictability in costs and ensures accountability.

ICRC turned multiple in-person panel meetings into teleconferences to eliminate costs associated with travel time and travel expenses. On average ICRC has up to 25-30 panels a month. 20%-25% are usually in person in order to accommodate caution meetings. 75% - 80% are run via teleconferencing or videoconferencing to save travel time and expenses. Members do appreciate the flexibility for panel members participating in this format. ICRC strikes an appropriate balance as it continues to schedule regular in-person meetings to allow members face-to-face interactions.

ICRC also moved to having fewer members on some of the newly added general and specialty panels that are held via teleconference which contributed to some savings in attendance costs. ICRC operates fully

electronically using Microsoft Sharepoint and for this reason no costs are incurred relating to couriering materials or USBs, photocopying or printing of ICRC materials. ICRC submissions are also being prepared with hyperlinks and bookmarks within the document to allow for easier navigation of the investigative file in order to assist in reducing preparation time.

ICRC member Education and Training

The ICRC Leadership Team continues to identify opportunities for Committee member education, with the goal of enhancing consistency and reasonableness of committee decisions.

In February 2019, an education training session for Chairs/Vice Chairs and Alternates was held. Topics included a legal overview of the legislation around Section 75 investigations and the implications for ICRC, guidelines for supervision and a proposal to standardize supervision requirements, the ADR process, use of physician histories, principles of procedural fairness that included group work with cases studies, introduction of a new decision template and public summary template as well as HPARB updates.

In June 2019, the leadership team met and worked on case scenarios using the new decision template. The decision administrators attended this educational session and presented some draft decisions crafted from the new members notes. Other topics at this session included Undertakings and Cautions, IEP process, the new QI/QA approach and a FMRAC and HPARB overview included the decision on *Montour v. Health Professions Appeal and Review Board.*

The ICRC panel members regularly incorporate educational sessions into the Committee's semi-annual business meetings. At its spring business meeting, the committee received training on sexual abuse complaints which included breakout sessions for group discussions. A presentation on video conferencing led by an ICRC Coordinator and a presentation on Avoiding CPSO Complaints from the Vice Chair of the Internal Medicine panel were also topics at this meeting. At the fall business meeting, recent developments in judicial reviews were presented by the CPSO senior counsel. Other topics presented included the introduction to the new complaints director, an update of remediation planning, HPARB trends, the draft medical records policy, the governance modernization plan and the usage of the new members notes template on panels. The ICRC is also regularly provided with relevant publications of Grey Areas Newsletters (administrative law updates) from *Steinecke, Maciura, LeBlanc.*

Staff Support

The members of the ICRC wish to thank staff for their excellent work in assisting the Committee to implement operations and fulfill its mandate.

Respectfully submitted,

Dr. David Rouselle
Chair, Inquiries, Complaints and Reports
Committee

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Outreach Committee

Annual Report

2019

MANDATE

The Outreach Committee was a College standing committee and the mandate of the committee was set out in the General By-Laws. The Outreach Committee works with staff to help develop major communications and outreach initiatives to the profession and public. It also assists in the development of major communication and government relations strategies. In addition, it develops plans to deliver on each of the communications and outreach related components of the strategic direction.

YEAR IN REVIEW

The Outreach Committee had two meetings in 2019 and worked with staff to accomplish the following activities:

- Review communications (including social and traditional media activities) and outreach initiatives for the profession and the public;
- Discuss plans to deliver on each of the communications and outreach-related components of the College's strategic plan.
- Review and consider public and patient engagement initiatives and related components of the College's strategic plan

The Committee is supported by the Communications & Media Division and the Policy Department.

Areas of Focus

Committee attention and focus over the past year has included the following:

- Media monitoring and measurement
- Continued review and feedback on the College's social media strategy
- The College's membership/public outreach strategy
- Ongoing work to enhance engagement of with the public and profession in College work (with an emphasis on policy activity)
- Government relations

Following is a high-level overview that summarizes activity in each of these areas.

<u>Communications Modernization</u>

A new approach to communication has been implemented to support CPSO's transformational changes in the right-touch regulation approach investigations and other core regulatory processes, and to modernize and enhance our communications products and activities.

The two primary components of the strategy include:

1. Relationship building and influence: a focus on public/patients, the profession, the media, government and internal audiences; and

2. Modernizing communications products: In particular, launching a new CPSO website, intranet for staff and modernizing Dialogue with a new design and electronic version of the magazine.

Communications/Social Media

In 2019, the College continued to build its social media audience across its four key platforms: Twitter, Facebook and LinkedIn, as well as launch a new presence, on the popular social media site Instagram. These platforms now have a total combined audience of nearly 9,000 users.

CPSO continues to hold regular social media campaigns for various provincial, national and global Health Awareness Days, such as Patient Safety Awareness Week, International Women's Day, Doctor's Day, etc., and for all open policy consultations as well as important policy changes (e.g. *Continuity of Care*). These tools are used to promote job openings, issues and articles of *Dialogue* and other College publications, and to provide real-time customer service to physician members, patients and the general public via replies on private and public channels on each of the platforms.

Each platform has its own diverse sets of audiences, and each audience group is multi-diverse in terms of demographics, political views and opinions on our policies and programs. CPSO actively tries to reach out to more of the patient-centric and public-centric groups on each platform, improve partnership with health stakeholders, and foster positive relationships with healthcare institutions, other regulators and Ontario health partners. We are doing so by creating special campaigns to enhance our customer service efforts on social media, by promoting the Patient Help Centre webpage through videos, images, and interactive Instagram campaigns, such as IG Story polls and quizzes.

These are our primary target audiences on each platform, based on followers and those who engage with our content:

- Twitter: Members, Patients/Patient Advocates, Healthcare & Regulatory Partners.
- Facebook: Mostly Patients, Applicants & International Inquirers.
- Instagram: Mostly Healthcare & Regulatory Partners, CPSO Staff, Medical Students & Residents.
- LinkedIn: CPSO Staff, Healthcare Professionals & Job Seekers.

Digital Dialogue

Work on developing eDialogue began in the summer of 2019 and will be ready to launch on January 20, 2020. The website will launch concurrently with the delivery of the first issue of print *Dialogue* in 2020, containing identical content and the following features:

- A WordPress foundation that meets AODA compliance requirements;
- An assortment of carefully curated articles from 2019;
- Detailed reporting analytics to indicate website and article performance;
- Easy sharing to social sites, such as Twitter, LinkedIn and Facebook;
- A responsive website that is mobile-, tablet- and desktop/laptop-friendly;
- A "reading time" prompt indicating the length of time to read an article;
- An overall look and feel consistent with the recently redesigned CPSO website and print *Dialogue*; and
- Dynamic content rich with images, and hyperlinks to resources and helpful information for physicians.

eDialogue will be hosted on CPSO servers and supported by both IT and Communications. At launch, the website address (URL) for eDialogue will be www.cpsodialogue.ca.

Membership/Public Outreach

Outreach activities provide an excellent opportunity to influence and educate several key audiences, including members of the public, medical students, residents, CPSO members and other health care stakeholders. At the time of this report, CPSO representatives completed 50 outreach engagements with physicians, students, the public and other stakeholders. To date, there have been:

- 5 public outreach sessions;
- 2 patient engagement sessions with local PFAC's;
- 1 international delegation (South Korea);
- 4 resident education sessions;
- 9 medical student events;
- 7 events with other health care stakeholders; and
- 22 meetings with the membership

Right-touch Regulation, QI/QA, and Continuity of Care continue to garner significant attention and have been the focus of many outreach events.

Public and Patient Engagement

The College's public engagement program underwent a transformation in 2019 with the approval of a new strategic plan and the adoption of 'Meaningful Engagement' as a strategic priority. Work that has been historically undertaken to obtain public perspectives and feedback on regulatory issues, was formally organized and expanded into a new framework to support enhanced engagement on a go-forward basis. Early work on patient and public engagement best practices was conducted with review and input from the Outreach Committee, eventually forming the foundation of the implementation plan that was put in place to achieve the College's new strategic priority.

Most notably, the College became the Chair of the Citizen Advisory Group (CAG) in 2019, managing the CAG on behalf of a partnership of 18 health regulators in Ontario in order to support and advance the inclusion of the patient and caregiver voice in the regulatory environment. The College also co-sponsored multiple in-person meetings of the CAG in order to solicit feedback on issues such as issues such as governance modernization, patient engagement, and physician advertising practices. Finally, public opinion polling was also conducted in 2019 to engage with the public and understand their perspectives and expectations in relation to the following policy reviews: Advertising, Boundary Violations, and Disclosure of Harm.

Government Relations Activities

The College's government relations activities in 2019 were largely influenced by the election of the PC government in June 2018, which continues to introduce new policy priorities to the health care system. This year, the College has focused on continuing to build relationships with key decision-makers in the PC government, including outreach to, and meetings with, elected and non-elected decision-makers.

Through this activity, the College is ensuring that decision-makers are aware of the College's mandate and that appropriate processes are in place to facilitate effective communication with key officials and staff.

The College is also continuing to bring forward key organizational priorities, including:

- legislative change to support governance modernization;
- red tape reduction recommendations to improve organizational efficiency;
- ongoing advocacy regarding the appointment and government support of public members of Council; and

- internal work refocusing on core regulatory functions and complaints processes.

This work was supported by two submissions to the Minister of Health requesting the government's help to modernize the *Medicine Act* and *Regulated Health Professions Act* in order to achieve governance reform and regulatory modernization. The College also responded to a request from the Minister to revisit earlier work on the potential regulation of physician assistants.

Finally, the College had the opportunity to engage at early stages with decision-makers on key government priorities, including modernization of Ontario's privacy legislation and reform of the auto insurance medical assessment process.

OTHER ACTIVITIES

Governance Modernization Review of Standing Committees

This year has been productive for the Outreach Committee and one of significant change from a governance perspective. As part of CPSO's governance modernization work, the Governance Committee consulted with members of the Outreach Committee regarding the mandate, structure and membership of Standing Committees. Based on the governance review, it was determined that the Outreach Committee had some overlap in mandate and responsibilities with other Standing Committees, which presented an opportunity to streamline functions.

At the September meeting, Council approved by-law amendments to remove the Outreach Committee as a Standing Committee and have the Executive Committee incorporate the engagement and outreach functions into its mandate moving forward.

Respectfully submitted,

Jerry Rosenblum
Chair, Outreach Committee

Appendix G

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Patient Relations Committee

Annual Report 2019

MANDATE

The Patient Relations Committee (PRC) is a statutory committee of Council. The *Regulated Health Professions Act, 1991 (RHPA)* requires all regulatory colleges to have a patient relations program that includes measures for preventing and dealing with sexual abuse of patients by members.

The PRC is responsible, under Section 85.7 of the Health Professions Procedural Code under the *RHPA* (the Code), for administering a program to provide funding for therapy and counselling for persons alleging that they have been sexual abused by physicians. The PRC is also responsible for advising Council with respect to the patient relations program, as necessary.

COMMITTEE COMPOSITION

The PRC is currently composed of four physician non-Council members and two public non-Council members.[1,2] The majority of PRC members have experience in the areas of mental health, psychotherapy, or psychiatry as well as knowledge of sexual abuse issues. The Committee is supported by the Policy Department.

YEAR IN REVIEW

Administering Funding for Therapy and Counselling

The PRC makes two determinations upon receipt of a funding application: whether the applicant is eligible for funding, and if so, the amount of funding that should be awarded. The eligibility criteria are set out in the Code[3] and Ontario Regulation 114/94 under the *Medicine Act*, *1991*.[4]

Ontario regulation 50/94[5] under the *RHPA* states that the maximum amount for funding is the amount that OHIP would pay for 200 half-hour sessions of individual out-patient psychotherapy with a psychiatrist – this amount is currently $16,060. Typically, the PRC awards eligible applicants the maximum amount of funding allowed by regulation.

The PRC determines on a case-by-case basis what constitutes 'therapy or counselling. Given the considerable amount of choice the Code affords eligible patients in selecting a therapist/counsellor, the PRC has funded a range of therapies, including some therapists/counsellors who are not regulated health professionals. Eligible patients are advised of the implications associated with selecting an

[1] One physician member and one public member of the Committee will be resigning at the end of the year; however, appointments to replace them will be made at the December Council meeting.
[2] A physician who is the subject of an application for funding for therapy and counselling may also be the subject of concurrent or future complaints or discipline matters, therefore only non-council members are appointed to this committee in order to avoid any apprehension of bias or conflict issues that could arise.
[3] Section 85.7(4).
[4] Section 42(2).
[5] Section 1(a).

unregulated therapist/counsellor and must confirm that they understand the therapist/counsellor would not be subject to regulatory oversight. Ultimately, the legislation entitles eligible patients to select the therapist/counsellor that best meets their needs.

RECENT CHANGES TO PROGRAM

The Committee's work in reviewing applications for funding for therapy and counselling has increased, especially given the new eligibility criteria[6] which was set out in Bill 87 (the *Protecting Patients Act*, 2017), so new approaches to streamlining the Committee's decision-making processes have been implemented.

Applicants recently identified two areas of concern which the PRC considered and responded to by changing the way the funding program is administered. Specifically, payment for costs to access therapy and counselling and direct payments to patients.

The benefits of paying for costs associated with facilitating access to therapy, e.g., transportation, childcare costs, etc. means that patients will likely experience fewer barriers to accessing the therapy/counselling and receiving the therapy they need to heal from sexual abuse. There have been several requests for payment of these type of expenses since the funding for therapy and counselling program has been in existence.

Paying a patient directly instead of requiring a therapist to complete and submit a form in order to invoice the College will alleviate the privacy concerns of some eligible applicants. When therapists invoice the College, eligible applicants need to disclose that they have been awarded funding through the College's funding for therapy and counselling program. This results in an obligation to disclose the abuse experience, including in circumstances beyond traditional talk therapy (e.g. massage therapy, yoga, chiropractic care).

The process that operationalizes direct payments to the patient is modelled on workplace insurance programs. Staff take steps to confirm that the receipt/invoice is valid, and patients must confirm that the practitioner is not a family member.

These changes are consistent with the College's advocacy work with Government on these issues.

Statistics

Since 1994, 262 applications have been approved, and 21 applications have been denied.[7] The total amount awarded over this period is $3,574,875.00. The total amount paid out to date is $1,720,844.62.

[6] A person is eligible if it is alleged in a complaint or report that the person was sexually abused by a member while a patient.

[7] The PRC typically denies applications because either there isn't a physician-patient relationship (e.g. applicant is a family friend or employee of the physician) or there isn't sufficient evidence to support a reasonable belief that

The monies are paid out as applicants use therapy and counselling. Some patients may not use the full award, and some may use it at different intervals over a period of time. Applicants have 5 years to use their funding. The following chart summarizes the funding for therapy and counselling that has been approved and used over the last ten years:

The trend is that there has been an increase in the number of applications in recent years. As part of this, applications considered under the new eligibility criteria comprised 43% of the applications received in 2019. The College continues to make concerted efforts to improve accessibility of the

	2019 (Jan-Oct)	2018	2017	2016	2015	2014	2013	2012	2011	2010	2009
Applications Reviewed	40	35[8]	25[9]	22[10]	13[11]	5	4	8	5	5	5
Applications Approved	40	33	23	16	10	4	3	8	4	5	4
Funding Approved	$642,400	$529,980	$369,380	$256,960	$160,060	$64,240	$48,180	$128,480	$63,120	$71,740	$56,800
Money Paid Out	$234,765	$152,324	$147,737	$102,712	$76,998	$47,572	$77,494	$51,978	$33,475	$51,870	$29,676

funding for therapy and counselling program on the College's website and improving direct communication to potential applicants.

OTHER ACTIVITIES

In 2019, the PRC focused primarily on funding for therapy and counselling applications and making the changes set out above with respect to the administration of the program. However, the Chair of the PRC is also the Working Group Chair for the College's *Maintaining Appropriate Boundaries and Preventing Sexual Abuse* policy review and the PRC assisted in the review by providing its advice and content expertise.

Looking forward to 2020, the PRC will work to find further efficiencies in the funding for therapy and counselling program in order to enable the Committee to consider issues relating to broader educational/engagement activities, succession planning, and the implementation of the new governance changes.

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the applicant was sexually abused while they were a patient (e.g. little information about the allegations, alleged touching is determined to be non-sexual, or no records to confirm there was a physician-patient relationship).

[8] Two of these applications were denied.

[9] Two of these applications were denied.

[10] One of these applications was deferred (was later approved in November 2017) and five of these applications were denied.

[11] One of these applications was deferred (and remains deferred as of November 2019).

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Premises Inspection Committee

Annual Report 2019

MANDATE

The Premises Inspection Committee (PIC) shall administer and govern the College's premises inspection program in accordance with Part XI of Ontario Regulation 114/94. The duties of PIC shall include, but is not limited to:

- Ensuring appropriate individuals are appointed to perform inspections or re-inspections as authorized by Ontario Regulation 114/94;
- Ensuring adequate inspections and re-inspections are undertaken and completed in a timely way using appropriate tools and mechanisms;
- Reviewing premises inspection reports and other material referred to in Ontario Regulation 114/94 and determining whether premises pass, pass with conditions or fail an inspection;
- Specifying the conditions that shall attach to each "pass with conditions" or "fail";
- Delivering written reports as required under Ontario Regulation 114/94;
- Establishing or approving costs of inspections and re-inspections and ensuring the member or members performing the procedures on the premises are invoiced for those costs; and
- Reviewing adverse event reports from premises.

YEAR IN REVIEW

The Out-of-Hospital Premises Inspection Program (OHPIP) is overseen by the PIC. Procedures performed in OHPs include, but are not limited to cosmetic surgery, endoscopy, hair transplantation and interventional pain management that are performed using specified types of anesthesia (e.g. general anesthesia, sedation, most types of regional anesthesia and, in some cases, local anesthesia).

Committee membership attempts to reflect the breadth of inspection-assessment activities that occur in out-of-hospital (OHP) settings. Members on PIC practice in areas such as anesthesia, interventional pain, obstetrics/gynecology, plastic/cosmetic surgery, and general surgery. For the 2019 program year, there will have been 17 individual committee panels to review inspection assessment reports, 3 adverse event subcommittee meetings, as well as three 3 business meetings to give overall direction to the program.

The PIC's key activities and milestones are outlined below.

<u>Facility and Assessment Standards</u>

With the goal of modernizing and using a "Right touch" approach for the Out-of-Hospital Premises Inspection Program (OHPIP) and Independent Health Facilities Program (IHFP), the Committee has supported the development of a core set of facility and assessment standards that would apply to both OHPIP and IHFP, without the requirement for legislative change.

Program staff reviewed all standard documentation related to both OHPIP and IHFP assessment programs, resulting in a set of core standards that will be applicable to all facilities/premises. The revised standards were developed with input from a working group comprised of representatives from both programs and were presented to the PIC for feedback.

Furthermore, these facility standards have been referred to key stakeholders for consultation and feedback. It is anticipated that the core standards with the assessment standards will be piloted in the spring of 2020.

Committee Financial Accountability

All PIC panel meetings and adverse events subcommittee meetings are conducted via teleconference. There are 3 day-long business meetings per year conducted in person. Program staff have also decreased costs by distributing electronic agenda materials, thus eliminating the cost of USB drives and couriers.

The quorum for Committee meetings is determined in the College by-laws: three members, including one public member. When planning meetings, four members are scheduled due to potential conflicts of interest and ensuring quorum if a member becomes unavailable.

In 2019, several initiatives are ongoing to improve overall committee efficiency:

- Reducing the number of low risk items brought to the Committee for review
- Evidence of compliance with Program standards can be determined at the program level with support from a College Medical Advisor (MA)

Since this initiative began program staff have reduced the amount of low risk assessment items presented to the committee by 50%. This included new premises site inspections, changes in equipment, relocation of facilities, withdrawals from the program, renovations and response to decision reports. These efficiencies have resulted in decreasing both the number of panel meetings required annually and the time commitment for the members.

OTHER ACTIVITIES

Annual Assessment Cost and Invoices

As part of the OHP program, annual assessment costs are reviewed every 5 years. The College evaluated these costs with Grant Thornton, LLB this past year. Program staff will review recommendations made by Grant Thornton and will reassess the impact to annual program fees. An immediate change to the annual assessment costs will be to align the invoicing to facilities with the CPSO fiscal year. There will also be alignment with annual invoicing between the OHPIP and IHFP.

Ongoing Collaboration with Public Health Ontario

CPSO is involved in a variety of initiatives with system stakeholders to improve infection prevention and control (IPAC) practices among physicians, as well as develop consistent approaches to managing IPAC lapses in out-of-hospital premises. This work supports PIC as IPAC recommendations are a frequent issue in inspection-assessment reports reviewed by the committee. PIC continues to be involved with conducting joint IPAC inspection-assessments with regional public health units across the province.

Education

Education opportunities and presentations at conferences/meetings have been undertaken to continue communication with the membership and other stakeholders about the OHP program and work of the PIC. In the past year, program staff were represented at Assessor Network Group meetings. Moving forward, we are planning a combined OHP/IHF education day for fall of 2020. Furthermore, we will be revamping production of the newsletter which is sent to medical directors and ensuring a commitment to more frequent communication with Medical Directors.

Respectfully Submitted,

Dr. Dennis Pitt
Chair, Premises Inspection
Committee

Appendix I

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Quality Assurance Committee Annual Report 2019

MANDATE

Under the *Regulated Health Professions Act*, *1991,* the Quality Assurance Committee (QAC) is mandated to administer the Quality Assurance (QA) Program. The QA Program fosters continuing competence among members, assesses individual members' knowledge, skill and judgment and monitors members' participation and compliance with the QA Program. The QAC supports the College's commitment to the public that physicians are engaged in continuous quality improvement.

The QA Program includes but is not limited to:

- Self, peer and practice assessments
- A mechanism for the College to monitor members' participation in, and compliance with, the quality assurance program
- Continuing education or professional development designed to:
  - promote continuing competence and quality improvement among the members;
  - address changes in practice environments; and
  - incorporate standards of practice, advances in technology, changes made to entry to practice competencies and other relevant issues at the discretion of Council.

YEAR IN REVIEW

This year, the QAC's work focused on two key areas:

<u>Assure and enhance physician competence</u>

The objectives of this priority include:

- The adoption of Right-Touch Regulation as one of the foundational principles at the College provided an opportunity for the QAC to consider the redesign of our approach to quality assurance and to develop initiatives aimed at quality improvement (QI);
- Creating processes that better allow us to assess the extent to which College programs improve physician practice; and
- Ensuring policies improve quality of care/safety.

As noted in previous annual reports, the Analytics, Data and Decision Support (ADDS) department has been working on redesign protocols/tools used for peer assessment. Under the direction of a dedicated ADDS staff lead, the following outputs were accomplished this year:

- There are 10 handbooks and assessment tools publicly available on the CPSO website;
- As of November 2019, 483 assessments have been conducted using the new Peer Redesign protocols/tools.

ADDs and Quality in Practice program staff developed a QI and QA model including a suite of self-directed QI tools as part of modernizing our approach to ensure physician quality. Based on the evidence that identifies risk and support factors to physician practice the ADDs program

developed three tools (Practice Profile, Self-Guided Chart Review; and Data Driven QI). These online tools provide information and resources to physicians specific to their practice. All three tools were pilot tested in April/May 2019 with a cohort of physicians who participated by completing the three QI activities provided their feedback.

A fourth tool, New Member Orientation (NMO) was also developed to provide new and current members with information about the role of the College. The NMO tool will be available to new applicants and existing members in 2020. In the second quarter of 2019, a Learning Management System (LMS) was under development which will permit physicians with online access to the practice improvement tools and resources.

Some highlights of the program include:

- Beginning in September 2019, 263 family physicians agreed to participate in the pilot of the QI/QA Program currently under development, exceeding our target of recruiting 250 participants.
- This involved each physician completing all three of the newly developed QI tools, submission of a practice improvement plan and participate in coaching by a Medical Advisor, as required.
- A robust project plan continues to be executed in order to meet the anticipated launch of the Program in the first quarter of 2020.
- Full implementation of the QI/QA Program will include 1,300 physicians.
- QA staff continued with the peer assessment of physicians who are 70 and 70+ in 2019, as well as methadone, change of scope and registration assessments.

Committee Financial Accountability

Starting in 2016, in an effort to reduce costs, Council directed staff and committee chairs to include financial reporting and budget forecasts in the annual reports from member-specific committees, and to consider the use of technology and to be more fiscally-minded. Building on the momentum from last year, staff implemented a process to monitor member-specific issues (MSI) caseload volumes 6-8 weeks in advance of a scheduled meeting to assess the feasibility of converting an in-person meeting to a teleconference if no interviews were scheduled.

For 2019, multiple meetings were rescheduled due to small caseloads and cases were subsequently reassigned to existing meetings resulting in cost savings. In addition, three in-person meetings were converted to teleconferences resulting in an additional cost saving removing the requirement for Committee members to travel into the College.

OTHER ACTIVITIES

QAC Education Sessions

The QAC has begun to use a portion of their business meetings for educational purposes. This year, with the final transition of the Methadone Specialty-Panel into QAC, the members decided to learn more about addiction medicine and the opioid crisis. Members of the former Methadone Panel provided presentations including impacts of addiction in Northern Ontario, and Emergency Safe Supply. These education sessions also offered the opportunity to invite external guest speakers with expertise in the area of addiction medicine. Given the presence of safer supply opioid practices in Ontario, this education was viewed as timely and relevant.

QAC Working Group

Formed in late 2015, this subset of QAC members meets monthly to review peer and practice assessments and to provide feedback and advice on a variety of staff initiatives in advance of presentations to the larger QAC. The working group has developed significant expertise in supporting staff in their work and in the efficient review of new tools, and new initiatives such as the QI/QA project. It is anticipated that the working group will continue to meet every other month for the 2020 assessment year.

Process Improvements – New Interview Format

The QAC has continued to be involved in streamlining processes to improve the efficiency of meetings and to continue to improve consistency in decision-making. Led by the Quality in Practice Decision Administrators, a new interview format guide was developed to support members in making consistent decisions and to focus more on educational supports through in-person interviews. Medical Advisors will play a critical role in the new process by providing physicians with an opportunity to address the QAC's concerns in a more supportive way through discussion. The program has recently introduced this new format in the 3rd quarter of the year. This new format is currently under review and feedback will be brought back to the QAC in the second quarter of 2020.

QAC Member Interviews

Committee co-chairs are speaking directly with all members of the QAC annually to review Committee members' goals, and to give and receive feedback on each member's work on the Committee. All members were contacted in the first half of 2019.

Respectfully submitted,

Dr. Hugh Kendall
Co-Chair, Quality Assurance Committee

Dr. Deborah Robertson
Co-Chair, Quality Assurance Committee

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Registration Committee
Annual Report 2019

MANDATE

The Registration Committee's mandate is described in the *Health Professions Procedural Code*, to consider applications for a certificate of registration to practice medicine in Ontario of individuals who, in the opinion of the Registrar, do not fulfill the registration requirements, prescribed in the Regulation.

When an individual applies to the College for registration, the Registrar has the following two options:

1. Register the applicant; or
2. Refer the application to the Registration Committee for its consideration.

The referral to the Registration Committee may be made for the following reasons:

- The applicant does not fulfill the registration requirements (examinations) set out in the Regulation; or
- The Registrar has doubts on reasonable grounds whether the applicant fulfills the non-exemptible requirements in the Regulation (requirements that pertain to conduct, character and competence).

Additionally, the Registration Committee is responsible for the development of policies and programs on issues pertaining to granting of certificates of registration to practice medicine in Ontario.

The Registration Committee is guided by the strategic direction established by Council. The Committee is committed to reducing barriers to registration for qualified individuals by facilitating the development of new registration policies that are fair and objective, while maintaining the registration standard in Ontario.

The Registration Committee continues to collaborate with external stakeholders to identify alternative ways to evaluate the competence and performance of physicians. External stakeholders include provincial medical licensing authorities across Canada, Royal College of Physicians and Surgeons of Canada, College of Family Physicians of Canada, Medical Council of Canada, Ontario medical schools, Ministry of Health and Long-Term Care, and Health Force Ontario.

YEAR IN REVIEW

Review of Applications

The Registration Committee, after considering an application, may make an Order directing the Registrar to issue a certificate of registration prescribed in the Regulation, to issue a certificate of registration with terms, conditions and limitations, or to refuse to issue a certificate of registration.

When the Registration Committee makes an Order to refuse the applicant's request, it must give written reasons for its decision. An applicant, who is dissatisfied with the Registration Committee decision may appeal the decision to the Health Professions Appeal and Review Board (HPARB) and may request a written review or an oral hearing.

If the applicant or the Registration Committee is dissatisfied with the Order of the HPARB, either party may appeal the HPARB Order to the Divisional Court of Ontario.

Volume of Applications

At the end of 2018, the Registration Committee issued the Registrar a set of directives which provide that, if an applicant has satisfied all other requirements for registration, the Registrar no longer forms reasonable grounds to refer these applications to the Committee for approval. What this means is that several policies no longer require review and approval by the Registration Committee, provided the applicants 1) meet all other requirements for issuance of a certificate of registration and 2) have no additional (Section 2) issues presenting.

Since instituting the directives, the College has seen a 20% reduction in matters going to the Registration Committee. The implementation of the directives has also resulted in a faster processing time for applicants and overall better customer service experience.

Committee Efficiencies

The Committee and staff continue to look for ways to increase efficiency without compromising quality. With changes to the administrative processes and procedures, the Committee and staff have been successful in managing increasing caseloads without increasing the Committee in-person meeting days.

How we did it:

- Adopting a "Right Touch Regulation" philosophy;
- Instituting the "Directives" which reduced matters being referred to the Registration Committee by 20%.;

- Harmonizing the review of applications seeking consideration under the College's "Ensuring Competence: Changing Scope of Practice and/or Re-Entering Practice.
- Interim Panel meetings were held by teleconference to expedite cases and help maintain an appropriate workload.
- Re-organizing meeting agendas to cover complex cases first, increasing the efficiency of the meeting and a better utilization of time
- Continuing to utilize a panel-based approach to Committee meetings. Ensuring that a mixture of both new and seasoned members attend the meetings to ensure cross training and appropriate succession planning.

Timeliness of Review of Applications and Issuance of Decisions

We continue to monitor and report on the amount of time taken to review applications for licensure. Performance on this metric has remained on-target throughout the year.

HPARB APPEALS

There were 5 appeals initiated with 1 being withdrawn and 4 appeals outstanding from previous years with no disposition.

Registration Committee Goals and Objectives

At the beginning of 2019, the Registration Committee agreed to a set of goals and objectives for this year. The following provides an update:

Objective #1: Remove barriers to registration for qualified individuals – creating and maintaining mechanisms to enable registration of individuals who may not fulfill the requirements outlined in the Regulation, while maintaining the registration standard.

- The registration data for 2019 shows that for the 14th year in a row there has been an increase in the number of certificates of registration being issued by the College and this is a direct result of the policies approved by Council.
- The Registration Committee continues to review the registration policies on an on-going basis to determine if the policies are still relevant and if further changes are warranted.
- As a result of this review, the Registration Committee recommended the following:
    - Directives were issued to the Registrar regarding certain registration requirements which, if fully satisfied would allow the Registrar to issue certificates of registration without requiring the Registration Committee's review.
    - In conjunction with the approval of the Directives, changes were made to the following policies to bring them in-line with the direction:

  - Alternatives to Degrees in Medicine from Schools Listed in the World Directory of Medical Schools Published by the World Health Organization Policy
  - One year Canadian Practice Experience Exemption Policy
  - Canadian Citizenship/Permanent Resident Status Exemption Policy
  - Haiti/Uganda/McMaster Exchange Electives
  - Pre-Entry Assessment Program Exemption (PEAP) Policy
  - Postgraduate Term for Clinical Fellows
  - Recognition of Certification Without Examination Issued by the CFPC
- The Registration Committee also recommended, and Council approved, changes to the College Policy "The Postgraduate Education Term for Clinical Fellows" permitting an extension of the term to a maximum of 5 years, provided that the fellow continues in the same discipline (or sub-discipline) and at the same institution, without requiring review and approval by the Registration Committee.

Objective # 2: Provide evaluation of applications for registration in a timely manner

- There continues to be a process in place to ensure continuous improvement and monitoring of timely decisions;
- Interim "Panel meetings" (teleconferences) enable expedited review of cases that are urgent and/or are not complex in nature.
- Directives have not only reduced the number of matters being referred to the Registration Committee but have also created efficiencies in the process resulting in reduced time in application processing.

Objective #3: Improve web-based registration

- The College is participating, through FMRAC, in the development of an online national application process for Independent Practice Certificates. The Application for Medical Registration (AMR) was launched in October 2018 to first time applicants in Ontario, applying for Independent Practice. In April 2019, AMR was expanded to include Final Year Residents who were completing training in Ontario and seeking to apply for Independent Practice. To-date the College has received 633 applications through AMR.
- The CPSO website has been updated to reflect the new process and timelines to ensure transparency and facilitate better understanding of Registration and the Registration Committee's process.
- Additionally, this year the following published application resources have been updated:
  - Comprehensive fee guidelines;
  - Guide to Acceptable Criminal Records Checks;
  - Study Plan Guidelines and Corresponding Resources/Courses;
  - Application General Guidelines/FAQ document;

  - Schedule of Requirements for applications;
  - Change of Scope Application
  - Re-Entering Practice Application;
- With respect to the assessment processes, registration specific assessment tools were added to the CPSO website relevant to Registration Assessments specifically to less commonly encountered disciplines (e.g., diagnostic imaging).
- All the website enhancements have resulted in increased transparency specifically regarding requirements/processes and protocols.

Objective # 4**:** Proactively regulate the profession

- The Registration Committee continues to be active in its participation in the development of National Standards for Licensure.
- In 2018, the Applications and Credentials department was subject to a full assessment by the Office of the Fairness Commissioner (OFC). The review resulted in the College being deemed compliant with our registration mandate, of being fair, objective, impartial and transparent.
- In early 2019 Registration Compliance activities were re-aligned within Applications and Credentials to ensure a more efficient and robust monitoring of registration terms, conditions and limitations.

UPDATE ON OTHER ACTIVITIES

The adoption of a right touch philosophy has led to significant improvements/efficiencies in the Registration Committee's processes. A cornerstone of right touch regulation is the belief that regulation should be utilized only when necessary – and should aim to be proportionate, consistent, targeted, transparent, accountable, and agile. Utilizing this lens, the Committee approved and employs the "Directives" with great success, realizing both efficiencies in Committee and Staff time, and enhancing the overall customer service experience.

We continue to look at ways in which the Committee can employ right touch regulation and anticipate enhancements in our process in the year to come.

Respectfully submitted,

Akbar Panju
Chair, Registration
Committee

Registrar/CEO Report

No meeting materials

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: Strategic Plan Key Performance Indicators (KPIs)

Date of Meeting: December 5 or 6, 2019

It is moved by_____,

and seconded by_____, that:

The Council adopts the following Key Performance Indicators (KPIs) to measure and report progress on the 2020-2025 Strategic Plan:

1. Complaints completed within 150 days
2. Complaints responded to within 2 business days
3. Time from referral to Discipline Committee to first hearing
4. Investigations that are resolved through early resolution process
5. Physicians selected for age-targeted assessment
6. Physicians who engaged in the QI program
7. Engagement meetings conducted with public and patients
8. Engagement meetings conducted with the profession
9. Engagements completed by Council members
10. Collaborations with health system organizations
11. Process improvements per employee

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Briefing Note

December 2019

TOPIC: **Strategic Plan Key Performance Indicators**

FOR DECISION

ISSUE:

- In the short time ahead, the College of Physicians and Surgeons of Ontario (CPSO) will begin executing on its 2020-2025 Strategic Plan and to ensure that the CPSO Council can measure progress on the plan, a set of Key Performance Indicators (KPIs) are required.

- Council is being asked to approve the proposed KPIs (Appendix A) that have been developed by Optimus SBR, the consulting firm that supported the strategic planning process in early 2019.

BACKGROUND:

- Building on the work done over the past year to develop the 2020-2025 Strategic Plan, Council requested Optimus SBR to assist with the next phase of work which is to develop the KPIs that will be used to measure and report progress on the strategic plan.

- Optimus SBR undertook a multi-pronged approach to identify relevant and meaningful KPIs, which included:
    - a review of data and reports that currently exist in relation to the 5 dimensions of the 2020-2025 Strategic Plan;
    - interviews with key leaders within CPSO;
    - validation sessions with senior leaders within CPSO; and
    - input from the Executive Committee

- Based on Optimus SBR's approach, the following 11 KPIs are being presented to Council for approval:

1. Complaints completed within 150 days
2. Complaints responded to within 2 business days
3. Time from referral to Discipline Committee to first hearing
4. Investigations that are resolved through early resolution process
5. Physicians selected for age-targeted assessment

6. Physicians who engaged in the QI program
7. Engagement meetings conducted with public and patients
8. Engagement meetings conducted with the profession
9. Engagements completed by Council members
10. Collaborations with health system organizations
11. Process improvements per employee

- Additional Measure: Surplus/Deficit (*note: this financially related metric will also be reported, however, is not directly tied to a Strategic Plan pillar*)

FOR DECISION:

1. Does Council approve the adoption of the KPIs presented by Optimus SBR to measure and report progress on the 2020-2025 Strategic Plan?

Contact: Laurie Cabanas, ext. 503

Date: November 18, 2019

Attachment:
Appendix A: Key Performance Indicator (KPI) Development to Support CPSO's Strategic Vision

Appendix A

December Council Pre-Reading Material

Key Performance Indicator Development to Support CPSO's Strategic Vision

December 5th, 2019

Purpose of this Document

- Through interviews and a working session with CPSO leadership, Optimus SBR supported development of Strategic Plan KPIs to measure progress of CPSO's 2020 – 2025 Plan
- This document contains KPIs for each of CPSO's strategic pillars to measure progress on the strategic plan
- The KPIs in this document have been reviewed by the Executive Committee and approved to be presented at Council
- The end of this document contains a set of common questions and answers in relation to the process of developing these KPIs and how they will be used

KPI Development Overview

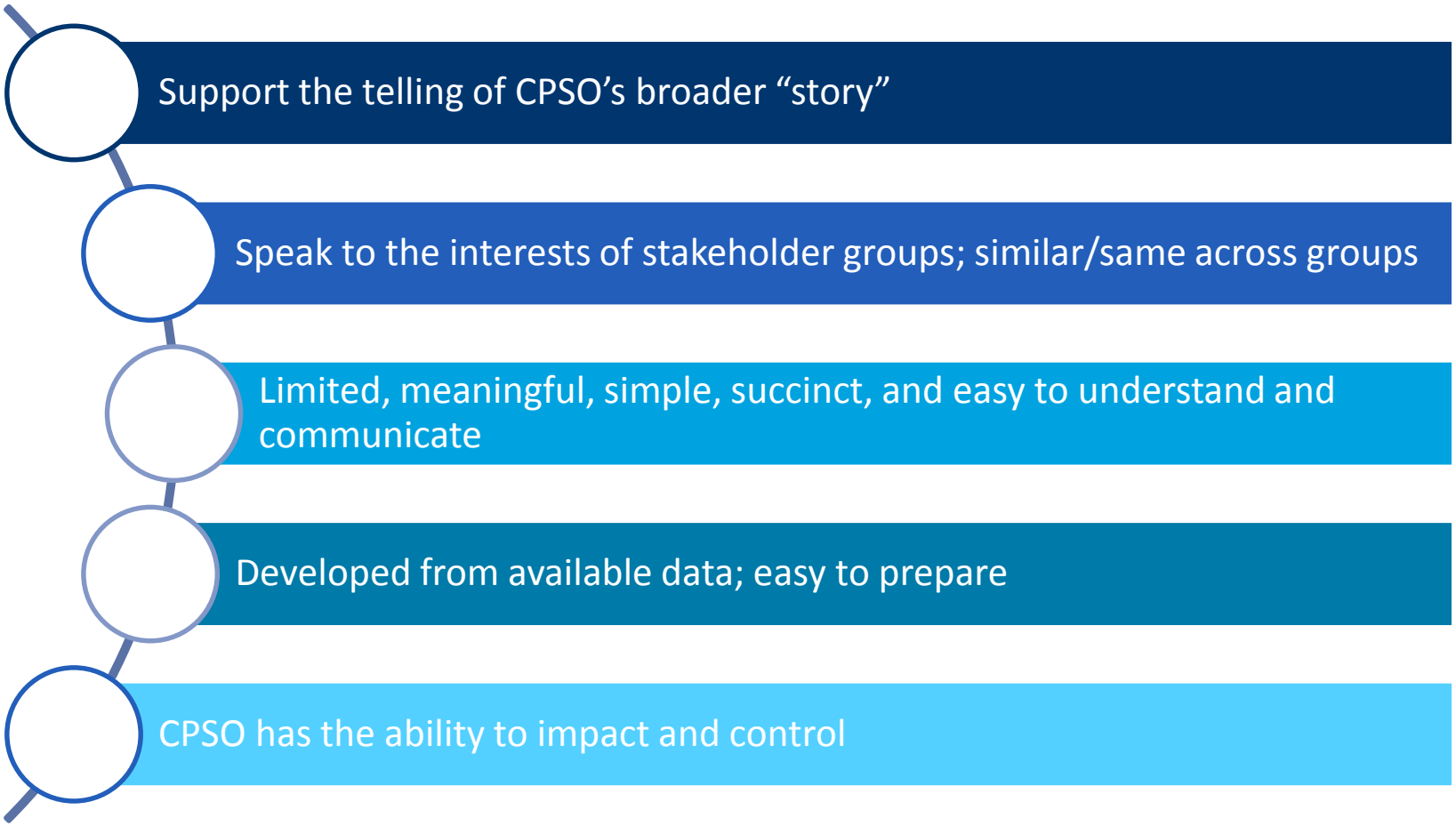
- CPSO's Strategic Plan for 2020 through 2025 includes the following strategic priorities:

- The draft Key Performance Indicators (KPIs) provided in the following slides are Strategic Plan KPIs designed to demonstrate progress against these strategic priorities
- The KPIs will be reported to Council, the public/patients, physicians, and other stakeholders
- The draft KPIs were developed through the following process:

- Information on current KPIs and available data was reviewed
- Ideas for potential KPIs were collected
- A long list of potential KPIs developed by Optimus SBR was discussed and refined
- KPIs were drafted based on working session discussions and Executive Committee input

Strategic Plan KPI Development Guiding Principles

The following guiding principles were used to develop the draft KPIs.



Key Performance Indicators

Strategic Pillar and Objectives	Draft KPI	Rationale for Inclusion
Right Touch Regulation		
▪ Apply a proportionate, consistent, targeted, transparent, accountable, and agile approach to all aspects of medical regulation ▪ Continually measure, monitor and report on our progress towards more effective regulation ▪ Work to align legislation with right-touch regulation	▪ **Complaints completed within 150 days** [80th percentile completed within 150 days] ▪ **Complaints responded to within 2 business days** [Percentage] ▪ **Time from referral to Discipline Committee to first hearing** [Median days] ▪ **Investigations that are resolved through early resolution process** [Percentage]	▪ Shows responsiveness to concerns of public and physicians ▪ Puts focus on ensuring appropriate timelines for complaint and disciplinary processes ▪ Highlights that CPSO is applying a right-touch approach

Key Performance Indicators

Strategic Pillar and Objectives	Draft KPI	Rationale for Inclusion
Quality Care		
▪ Use evidence to evaluate risk and address the greatest concerns for patient care ▪ Guide and support doctors throughout their careers ▪ Respond to emerging trends and new technologies	▪ **Physicians selected for age-targeted assessment** – Target 500 [Number] ▪ **Physicians who engaged in the QI program** – Target 1,300 physicians [Number]	▪ Highlights the degree to which physicians are participating in CPSO improvement programs

Key Performance Indicators

Strategic Pillar and Objectives	Draft KPI	Rationale for Inclusion
Meaningful Engagement		
▪ Purposefully involve patients, the public and physicians to inform College decisions ▪ Build awareness of our role, mandate, and processes through clear and accessible communication	▪ **Engagement meetings conducted with public and patients** (Citizen Advisory Group, Patient Advisory Group, etc.) – Target minimum 1 per month [Number] ▪ **Engagement meetings conducted with the profession** (Hospitals, physicians, etc.) – Target minimum 1 per month [Number] ▪ **Engagements completed by Council members** [Number] (note: in relation to, but outside of, the above KPIs, CPSO will also be tracking the number of people engaged)	▪ Shows commitment to continued engagement with the public and physicians ▪ Highlights that those governing and those leading CPSO understand the perspectives of the public they serve and physicians CPSO regulates

Key Performance Indicators

Strategic Pillar and Objectives	Draft KPI	Rationale for Inclusion
System Collaboration		
▪ Develop open and collaborative relationships that support a connected health system ▪ Promote inter-professional collaboration and share best practices	▪ **Collaborations with health system organizations** - Target 8 collaborations per year with no less than 1 for each organization/category [Number] *(organizations/categories: OMA, CMPA, government, health system infrastructure, other regulators)*	▪ Demonstrates that CPSO is actively collaborating with health system organizations to solve health system challenges

Key Performance Indicators

Strategic Pillar and Objectives	Draft KPI	Rationale for Inclusion
Continuous Improvement		
▪ Foster a culture of continuous improvement and openness to change ▪ Modernize all aspects of our work to fulfill our mission	▪ **Process improvements per employee -** Target 350 per year measured at the organizational level [Number]	▪ Shows that CPSO is actively identifying problems to solve and proactively creating solutions
Financial (not a strategic pillar)		
▪ n/a	▪ Surplus/Deficit	▪ Financially-minded individuals will likely want a proxy of CPSO's financial sustainability; Financial statements are also provided in CPSO's annual report

Summary of Draft KPIs

Right Touch Regulation	**1. Complaints completed within 150 days** **2. Complaints responded to within 2 business days** **3. Time from referral to Discipline Committee to first hearing** **4. Investigations that are resolved through early resolution process**
Quality Care	**5. Physicians selected for age-targeted assessment** **6. Physicians who engaged in the QI program**
Meaningful Engagement	**7. Engagement meetings conducted with public and patients** **8. Engagement meetings conducted with the profession** **9. Engagements completed by Council members**
System Collaboration	**10. Collaborations with health system organizations**
Continuous Improvement	**11. Process improvements per employee**

Financial	Surplus/Deficit

Q&A

The following are common questions in relation to KPI development. Answers have been provided to support Council's understanding of the KPI development process.

- Q: What is the right number of KPIs?
  - A: *The number of KPIs needs to be limited to bring strategic focus. Organizations should look to have no more than 10 KPIs*
- Q: Will these KPIs be the only metrics Council will see in the future?
  - A: *No. Council will continue to receive additional metrics to continue to inform it of CPSO's progress. These KPIs are to measure progress on the Strategic Plan*
- Q: Some of the KPIs appear to be operational. Are they truly KPIs?
  - A: *KPIs ideally measure the outcomes or impact that an organization is achieving. In reality, outcomes are difficult to measure and often aren't sufficiently within an organization's control or data may not be available to measure. Therefore proxies are needed and the best proxies may be somewhat operational in nature. Developing KPIs requires balancing several factors to decide on the best measure of success. Guiding principles were used to identify the factors that need to be balanced*
- Q: What does "median days" mean?
  - A: The median is the middle number in a set or string of numbers. "Averages" can be distorted by a few very high or low numbers and so using the middle (or median) number helps to avoid this distortion.

Q&A

The following are common questions in relation to KPI development. Answers have been provided to support Council's understanding of the KPI development process.

- Q: How do you determine whether a percentage or number is used?
  - A: *KPIs should be meaningful. Depending on what is being measured it can be more meaningful to interpretation to use a percentage or number. Often a number is used when a clear numerical target is established, while a percentage may be used when a clear numerical target is not available or established. There can be exceptions to this*
- Q: For what time period will the KPIs be used for?
  - A: *The KPIs are aligned with areas where CPSO wants to make progress and impact. A KPI becomes less relevant as progress is made and the goal is achieved. At this point the metric should continue to be measured to ensure sustained change, however, it no longer needs to remain a core KPI and may be replaced with another KPI relating to where progress needs to be made next. It is anticipated that the KPIs will be reviewed approximately every year to determine if they need to be refreshed*
- Q: Is more explanation of the KPIs needed for the public to understand them?
  - A: *Yes. There will need to be language included with the KPIs that provides context and describes what the KPI means. **How** the KPIs are communicated is separate from **which** KPIs to select. It is envisioned that the KPIs will be placed on CPSO's website and viewers could click into different levels of detail and explanation depending on their understanding of CPSO's work.*

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: Disclosure of Harm Policy

Date of Meeting: December 5 or 6, 2019

It is moved by_____,

and seconded by_____, that:

The Council approves the revised policy “Disclosure of Harm”, (a copy of which forms Appendix “ ” to the minutes of this meeting).

Council Briefing Note

December 2019

TOPIC: Disclosure of Harm – Revised Policy for Final Approval

FOR DECISION

ISSUE:

- In May 2019, Council released the draft *Disclosure of Harm* policy for external consultation. The draft policy has been revised in light of the feedback received through the consultation.

- Council is provided with an overview of the changes and is asked whether the revised draft *Disclosure of Harm* policy can be approved as a policy of the College.

BACKGROUND:

- The current *Disclosure of Harm* policy was approved by Council in 2010. The current review launched in mid-2018 and is supported by Angela Carol (Medical Advisor) and Carolyn Silver (Legal Counsel), with advisory assistance from Judith Plante (Council Member).

- Following extensive research[1] and a preliminary consultation held in the fall of 2018,[2] a draft *Disclosure of Harm* policy was developed and approved for external consultation by Council in May 2019. The accompanying *Advice to the Profession* document was also released at this time.

- 84 responses were received as part of the consultation.[3] Broadly speaking, stakeholders expressed support for the draft policy, with a large majority of respondents agreeing that it was easy to understand and well organized.

- The scope and weight of the draft policy's core expectations were also well supported by feedback. This finding was reiterated by the results of public polling conducted over the summer of 2019 on key questions about physicians' disclosure obligations.

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[1] Research included a review of statistical information about matters before the Inquiries, Complaints, and Reports Committee, feedback from the College's Public and Physician Advisory Service, scholarly articles, research papers, jurisdictional examples from Canadian and international medical regulatory authorities, and information from organizations like the CMPA and the Canadian Patient Safety Institute.

[2] Council received an overview of the preliminary consultation feedback in the December 2017 Policy Report.

[3] 11 written responses and 73 survey responses.

- All feedback received through the consultation has been posted on the consultation-specific page of the College's website, along with a comprehensive report of the survey results. An overview of the feedback was provided to Council in the September 2019 Policy Report.

CURRENT STATUS:

- A revised draft policy has been developed (**Appendix A**) and updates were made to the *Advice* document (**Appendix B**) in response to feedback from the general consultation.

A. Revised Draft *Disclosure of Harm* Policy

- The revised draft *Disclosure of Harm* policy retains the spirit and intention of the expectations in the draft policy.

- Changes to the draft policy, in response to feedback received through the consultation, are primarily aimed at enhancing the clarity and specificity of the policy's expectations. An overview of the specific substantive changes is provided below.

Terminology and Definitions

- Changes have been made to the terminology in the draft to:

    - expand upon or clarify key terms (e.g., "apology", "disclosure", "no-harm");
    - specifically direct readers to examples for each type of incident included in the *Advice* document; and
    - align terms and definitions to promote consistency within and outside the organization (e.g. "Most Responsible Physician (MRP)", "postgraduate trainee").

To Whom, When, and What to Disclose

- The draft policy included a requirement that physicians disclose to the patient's estate trustee, administrator of the estate, and substitute decision-maker (SDM) in situations where the patient had died. In response to feedback from the Canadian Medical Protective Association (CMPA), the SDM has been removed from this list to align with the regime for disclosing critical incidents under *Public Hospitals Act* regulation and the requirements of the *Personal Health Information Protection Act* (provision 5).

- The draft policy included a requirement that physicians disclose additional relevant information over time as it becomes available. Addressing feedback from the College of Physicians and Surgeons of Alberta to clarify the need for a timely response, this has been

amended to require that additional relevant information be provided "as soon as possible once it becomes available" (provision 7).

- In response to survey feedback, the list of information that must be provided as part of the disclosure discussion was updated to include "any steps the patient can take to monitor for potential consequences or similar incidents", and "who the patient may contact for further information" (provision 8).

Who Must Disclose

- The draft policy anchored disclosure expectations to the MRP where there are multiple physicians involved in a patient's care. In response to Ontario Medical Association (OMA) feedback that determining the MRP outside the hospital setting is not always clear, the revised draft policy anchors the expectations to the physicians "directly involved in the patient's care at the time of the incident" to provide better clarity (provision 11).

Role and Obligations of Postgraduate Trainees

- In response to feedback from the OMA and the Professional Association of Residents of Ontario (PARO), the expectations regarding the role of postgraduate trainees have been updated to clarify their obligations and involvement in the disclosure process. This includes clarification that:

    - trainees must inform the MRP and clinical preceptor in a timely manner of all harmful, no-harm, and near miss incidents (provision 13); and
    - the MRP must encourage the trainee's involvement in the disclosure process, to the extent the MRP considers appropriate in the circumstances (provision 14).

Documentation

- The revised draft more clearly sets out the kind of information that must be captured in the patient's medical record, in order to respond to feedback from PARO requesting more guidance around the level of detail to include (provision 15).

Role and Obligations of Subsequent Physicians

- The expectations regarding the role of subsequent physicians have also been updated to make their obligations more explicit. The revised expectation states that the subsequent physician is required to:

    - discuss the matter with the previous physician, where possible; and

- where appropriate, ensure that disclosure takes place at the first reasonable opportunity (provision 16).

- The expectation also clarifies that subsequent physicians may be required to disclose the incident, to the extent that they have appropriate knowledge about the incident to do so.

B. Draft *Advice to the Profession* Document

- The revised draft *Advice* document (**Appendix B**) includes additional content as requested through the general consultation, including:

  - clearer and more examples of harmful, no-harm, and near miss incidents;
  - additional guidance about how to identify no-harm incidents; and
  - clarification about the relationship between the policy's expectations and the critical incident regime under the *Public Hospitals Act* regulation.

NEXT STEPS:

- Should Council approve the revised draft policy, it will be announced in *Dialogue* and will replace the current *Disclosure of Harm* policy on the College's website.

DECISION FOR COUNCIL:

1. Does Council approve the revised draft *Disclosure of Harm* policy as a policy of the College?

Contact: Heather Webb, ext. 753
Date: November 15, 2019

Attachments:

Appendix A: Revised Draft *Disclosure of Harm* Policy
Appendix B: *Advice to the Profession: Disclosure of Harm*

Appendix A

Disclosure of Harm

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

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

Definitions

Apology: an expression of sympathy or regret; a statement that one is sorry for what has happened.[1]

Disclosure: the acknowledgement and discussion of a harmful incident, no-harm incident, or near miss incident with the patient, substitute decision-maker, and/or estate trustee, as the case may be.

Harm: an outcome that negatively affects a patient's health or quality of life. Harm may or may not relate to material risks discussed during the informed consent process.

Harmful incident: an incident that has resulted in harm to the patient (also known as an "adverse event"). For specific examples, please see the *Advice to the Profession* document.

No-harm incident: an incident with the potential for harm that reached the patient, but no discernible or clinically apparent harm has resulted. For specific examples, please see the *Advice to the Profession* document.

Near miss incident: an incident with the potential for harm that did not reach the patient due to timely intervention or good fortune (also known as a "close call"). For specific examples, please see the *Advice to the Profession* document.

[1] In Ontario, the law states that an apology does not constitute an admission of fault or liability by the person making the apology. Further, apologies made for harm that occurs during treatment cannot be used as evidence of liability against a physician in a civil proceeding, administrative proceeding, or arbitration. Please see the *Advice to the Profession* document [hyperlink] for more information.

Appendix A

Policy

Obligation to disclose[2]

1. Physicians **must** ensure that harmful incidents are disclosed.[3]

2. Physicians **must** ensure that no-harm incidents are disclosed.[4]

3. Physicians **must** consider whether to disclose near miss incidents, taking into account whether:

    a. the patient is aware of the incident and an explanation will reduce concern and promote trust;
    b. the patient should be educated to monitor for future similar incidents; and
    c. a reasonable person in the patient's position would want to know about the incident.

To whom to disclose

4. Physicians **must** disclose directly to the patient or, where the patient is incapable with respect to the treatment, to the patient's substitute decision-maker.

5. If the patient has died, the physician **must** disclose to the patient's estate trustee (or, if there is no estate trustee, the person who has assumed responsibility for the administration of the patient's estate).

When to disclose

6. Physicians **must** disclose as soon as possible after the incident occurs.

7. Disclosure is an ongoing obligation, and physicians **must** disclose additional relevant information as soon as possible once it becomes available.

What to disclose

8. As part of disclosure, physicians **must** communicate the following information:

    a. the facts of what occurred and a description of the cause(s) of the incident;
    b. any consequences for the patient, as they become known;

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[2] For further information regarding the conduct of effective disclosure discussions, physicians may wish to consult the CMPA's *Disclosing harm from healthcare delivery: Open and honest communication with patients*.

[3] Physicians who work in hospitals or other health care facilities may be subject to additional disclosure requirements as established by their particular institution, as well as the requirements of Regulation 965, made under the *Public Hospitals Act*, relating to the disclosure of "critical incidents."

[4] No-harm incidents require disclosure because harm may manifest in the future and may therefore require monitoring. Please see the *Advice to the Profession* document [hyperlink] for more information.

c. actions that have already been taken and those that are recommended to address any actual or potential consequences to the patient, including any steps the patient can take to monitor for potential consequences or similar incidents, as well as options for follow-up care;
d. actions being taken, if any, to avoid or reduce the risk of the incident recurring; and
e. who the patient may contact for further information.

9. Physicians **must** consider whether an apology is appropriate, taking into consideration the nature of the incident and the consequences of the incident for the patient.[5]

Who must disclose

10. Where a sole physician is directly involved in the patient's care at the time of the incident, that physician **must** disclose.

11. Where multiple physicians are directly involved in the patient's care at the time of the incident, the physicians **must**:

    a. assess who is the most appropriate physician to disclose; and
    b. ensure that disclosure occurs, regardless of who conducts the disclosure.

12. Physicians **must** use their professional judgment in determining whether to include in the disclosure, as appropriate, other health care providers involved in the patient's care, someone trained in the disclosure process, and/or someone with particular expertise in the patient's condition.

Postgraduate trainees

13. Postgraduate trainees **must** inform the Most Responsible Physician (MRP)[6] and their clinical preceptor in a timely manner of any harmful, no-harm, or near miss incidents.

14. In the interest of professionalism and ongoing education, MRPs **must** encourage the postgraduate trainees' active involvement in the disclosure process to the extent the MRP determines is appropriate in the circumstances.[7]

Documentation

15. Physicians who disclose an incident **must** capture the following in the patient's medical record:

    a. the facts of what occurred;

[5] See *Advice to the Profession: Disclosure of Harm* [hyperlink] for further information regarding apologies.
[6] The MRP is the physician who has primary responsibility for managing the medical care of a patient at a specific point in time.
[7] What will be appropriate in the circumstances will vary according to the situation. In some cases, it may be appropriate for the trainee to conduct the disclosure discussion independently; in others, it may not be appropriate for the trainee to be present.

b. a description of the cause(s) of the incident; and
c. the relevant details of all discussions and communications with the patient relating to disclosure of the incident.

Subsequent physicians

16. Where a subsequent physician has reason to believe that an incident warranting disclosure has not in fact been disclosed, they **must**:

a. discuss the matter with the previous physician, where it is possible to do so; and
b. where appropriate, ensure that disclosure takes place at the first reasonable opportunity, which may require the subsequent physician to disclose the incident to the extent that they have the appropriate knowledge about the incident to do so.

Appendix B

Advice to the Profession: Disclosure of Harm

Advice to the Profession companion documents are intended to provide physicians with additional information and general advice in order to support their understanding and implementation of the expectations set out in policies. They may also identify some additional best practices regarding specific practice issues.

Despite the best efforts of health professionals, the delivery of medical care can sometimes result in unexpected outcomes and expose a patient to harm or potential harm. Harm is not always preventable, nor is it necessarily an indicator of substandard care, but its impact can deeply affect patients and their families.

Physicians may also be significantly impacted when their patients experience negative health care outcomes. Physicians sometimes feel ill-equipped to disclose and discuss the harm that has occurred with patients and families, and may also struggle to find the support they need to conduct these conversations effectively.[1]

This document is intended to help physicians interpret their disclosure obligations as set out in the *Disclosure of Harm* [hyperlink] policy and provide guidance around how these obligations may be effectively discharged.

Why disclose? Legal and ethical imperatives

Physicians have a legal duty to disclose errors made in the course of medical treatment. The courts have also found that where a medical error is not fully disclosed, the non-disclosure can negate the patient's ability to provide valid consent for subsequent treatment.[2]

The professional expectations set out in the policy build upon these legal obligations. The expectations reflect the underlying principle that full disclosure helps foster openness, transparency, and good communication in the delivery of medical treatment. These are integral to promoting patient autonomy and maintaining trust, both in the physician-patient relationship and the medical profession generally.

Physicians and other health care practitioners may feel that disclosure could decrease trust in the profession and increase the likelihood of litigation. However, research suggests that an open, honest

[1] Canadian Patient Safety Institute, *Canadian Disclosure Guidelines: Being Open with Patients and Families* (2011) p. 16.

[2] *Gerula v. Flores*, 1995 CanLII 1096 (ONCA). Physicians who work in hospitals or other health care facilities may be subject to additional disclosure requirements as established by their particular institution, as well as the requirements of Regulation 965, made under the *Public Hospitals Act*, relating to the disclosure of "critical incidents."

disclosure discussion – including an apology, where appropriate – can have a positive impact on patient trust and reduce the risk of litigation.[3]

Finally, on a practical level, disclosure can help physicians and health care institutions prevent future incidents, thereby improving overall quality of care and patient safety outcomes. Disclosure also ensures that the patient can access, and make informed decisions about, timely and appropriate interventions that may be required as a result of an unexpected health care outcome.

What incidents must be disclosed?

In considering what kinds of incidents must be disclosed, remember that the purpose of disclosure is not to attribute blame. Rather, disclosure aims to provide patients with a full understanding of all aspects of their health care, as well as the information they need to make autonomous, informed medical decisions.

Harm to patients may arise in a number of ways, including through:

- the natural progression of the patient's medical condition;
- a recognized risk inherent to the investigation or treatment; and
- events or circumstances, such as individual or systemic failures, that resulted in unnecessary harm to the patient (also known as "patient safety incidents").

The cause of harm is often complex and may arise out of two or more of the above contributing factors. However, the policy expectations and this advice document are primarily meant to help physicians navigate disclosure discussions in situations where something has gone wrong with a patient's care, rather than situations where the patient's condition worsens due to a progressive illness.

1) Harmful incidents

A "harmful incident" is an incident that led to patient harm. Patients expect, and are entitled to know about, any harm they have experienced. Physicians must disclose *all* incidents that have resulted in harm to the patient, no matter the cause. These situations are also sometimes known as "adverse events." For example:

- The wrong unit of blood was infused and the patient died from a haemolytic reaction.
- A patient with a known allergy to penicillin is administered penicillin and suffers an allergic reaction.
- A cancer patient was inadvertently administered too much opioid medication, and requires an opioid antagonist and temporary respiratory support.

[3] Gerald B. Robertson and Justice Ellen I. Picard, *Legal Liability of Doctors and Hospitals in Canada*, 5th Ed. (2017), p. 263; American Academic of Pediatrics, "Policy Statement: Disclosure of Adverse Events in Pediatrics" (December 2016) *Pediatrics*, 138:6.

2) *No-harm incidents*

A "no-harm incident" is a situation where an incident with the potential for harm has reached the patient, even though the patient has not experienced any immediate, discernible, or clinically apparent harmful effects. For example:

- A patient is mistakenly administered the wrong vaccine.
- A patient with a known allergy to penicillin is administered cephalosporin, but there is no allergic reaction.
- A relevant finding in the body of a laboratory report is missed, although there had been no clinically apparent effect on the patient's health at the time the mistake was discovered.

In determining whether an incident is a no-harm incident, it is useful to recall and apply the definition of "harm" set out in the policy. In other words:

- does the incident have the potential to negatively affect the patient's health or quality of life; and
- did the incident reach the patient?

If the answer to both these questions is yes, the incident is a no-harm incident and must be disclosed.

No-harm incidents must be disclosed to patients because of the potential that harm might manifest in the future.[4] Where a potentially harmful incident has reached a patient, there must be certainty about whether harm has occurred, and this certainty can only be achieved by discussing the incident with the patient. Acknowledgment of the incident will also allow the patient, family, and health care team to monitor and potentially intervene to prevent potential future harm.

Moreover, disclosure may be necessary to the informed consent process to ensure that the patient can make fully informed decisions with respect to any subsequent treatment.

3) *Near miss incidents*

A "near miss incident" is a potentially harmful incident that did not reach the patient due to timely intervention or good fortune. These are also known as "close calls." For example:

- The wrong unit of blood was issued to a patient but the error was detected before the infusion began.
- A medication error is made – for example, the prescription does not match the discharge summary order or a patient with a similar name is almost dispensed another patient's medication – but the error is caught by the pharmacist prior to dispensing to the patient.
- The wrong site is prepared for surgery but the mistake is found while completing the pre-operative checklist.

[4] *Disclosing harm from healthcare delivery: Open and honest communication with patients*, Canadian Medical Protective Association (2015).

Physicians must consider whether a near miss needs to be disclosed to the patient, using their professional judgment in the specific clinical context, taking into account the factors set out in the policy.

Alignment with the "critical incident" regime

Physicians working in hospitals will be familiar with the regulation under the *Public Hospitals Act*[5] that requires the disclosure of "critical incidents". A critical incident is defined by the regulation as any unintended event that occurs in the hospital that:

- results in death or serious disability, injury, or harm to the patient; and
- does not result primarily from the patient's underlying medical condition or from a known risk inherent in providing the treatment.

The scope of incidents that fall under the *Disclosure of Harm* policy is therefore broader than those included in the definition of critical incident, which applies to only a subset of "harmful incidents."

Physicians involved in the review of critical incidents pursuant to the *Quality of Care Information Protection Act, 2016* (QCIPA)[6] may have questions about how the QCIPA process could affect their disclosure obligations. You may find additional guidance on these issues through the Ontario Hospital Association.

Disclosure as an ongoing obligation

Disclosure is an ongoing obligation, which means that physicians must disclose relevant information as soon as possible when it becomes available. Full disclosure may therefore require a series of discussions, depending on the nature and complexity of the incident, and taking into account the time it could take for harm to develop following the incident.

The nature of the information disclosed will depend on how much time has passed since the incident occurred, the stage of the investigation, and the condition of the patient. For example, at an early stage, physicians might choose to focus on the circumstances that caused the incident and any immediate implications for the patient's treatment plan, with a commitment to follow up once further investigation occurs or more facts are discovered. At all stages, it is important for physicians to communicate only what is known and to avoid speculation.

Subsequent physicians are also subject to disclosure obligations. Where you are concerned that an incident warranting disclosure has not been disclosed, you must discuss the matter with the previous physician. A constructive and respectful discussion may help clarify the particular facts and circumstances of the incident, the evolution of the case, and the obligations of the previous physician around disclosure. If you continue to have concern about the clinical care or outcome, consider working with the previous physician in a sensitive manner to create a plan for disclosure. It will be helpful for you

[5] R.R.O. 1990, Reg. 965.

[6] S.O. 2016, c. 6, Sched. 2.

to document your conversations with the other physician. Ultimately, you may be responsible for disclosure to the extent that you have sufficient knowledge about the incident to do so.

The role of apologies

A full and sincere apology may contribute to a successful disclosure discussion.[7] Such an apology can be greatly appreciated by patients and their family, and can assist in promoting trust and reducing litigation risk.[8] Patients also say that the manner in which an apology is delivered can be extremely important; the most effective apologies demonstrate sincerity, empathy, and genuine concern for the patient's well-being.[9] Apologies should therefore be tailored in each individual circumstance, avoiding a formulaic approach.

Physicians sometimes hesitate to apologize to patients because of concern about legal implications. It is important to note that an apology is not an admission of legal liability, nor does it absolve physicians of harm that has occurred or shield them from a finding of liability in the future.

Physicians have identified a number of additional barriers to an apology, including a lack of training and self-confidence in conducting the disclosure discussion effectively. It is common, in the context of a difficult disclosure conversation, to feel uncertain about what to say to patients and their families, and the confidence required to conduct these conversations effectively is often obtained through practice and training. You may wish to access further educational resources and materials regarding the delivery of apologies (and disclosure generally), including the Canadian Patient Safety Institute' s *Canadian Disclosure Guidelines: Being Open with Patients and Families* and the Canadian Medical Protective Association's *Disclosing harm from healthcare delivery: Open and honest communication with patients*.

Additional tips

The following tips and guidance may be helpful in thinking about disclosure and apologies:

- Try to reassure the patient or substitute decision-maker that you will do everything you can to address their concerns.
- Outline a plan for prompt and thorough intervention to mitigate the harm.
- Consider whether it would be appropriate to transfer the patient to the care of another physician and make the patient aware of any changes to their health care team.
- Consider the patient's cultural and ethnic identity, as well as their language of choice, and enable access to family and/or interpretive support where possible.
- Convey sincerity through tone of voice, body language, gestures, and facial expression.
- Consider contacting the CMPA and/or the CPSO's Physician Advisory Service for advice prior to proceeding with disclosure.

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[7] McLennan et al., "Apologies in medicine: Legal protection is not enough" (2015) *CMAJ*, 187(5), p. E157; Wolk et al., "Institutional disclosure: Promise and problems" (2014) *Journal of Healthcare Risk Management*, 33:3, p. 30.
[8] Levinson et al., "Disclosure of Medical Error" (2016) *JAMA*, 316:7, p. 765; American Academic of Pediatrics.
[9] McLennan et al, p. E157; Wolk et al., p. 30.

Council Briefing Note

December 2019

TOPIC: COUNCIL AWARD RECIPIENT

FOR INFORMATION

ISSUE:

At the December meeting of Council, **Dr. Michelle Hladunewich** 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

CURRENT STATUS:

Ellen Mary Mills will present the award.

DECISION FOR COUNCIL:

No decisions required.

Contact: Tracey Sobers, Ext. 402
Date: November 13, 2019

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

EDUCATION SESSION

Shared Learnings from a Governance Review

Guest Presenter: Deanna L. Williams

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: Boundary Violations – Revised Policy for Final Approval

Date of Meeting: December 5, 2019

It is moved by_____,

and seconded by_____, that:

The Council approves the revised policy “Boundary Violations”, formerly titled “Maintaining Appropriate Boundaries and Preventing Sexual Abuse”, (a copy of which forms Appendix “ ” to the minutes of this meeting).

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 2019

TOPIC: Boundary Violations – Revised Policy for Final Approval

FOR DECISION

ISSUE:

- The College's *Maintaining Appropriate Boundaries and Preventing Sexual Abuse* policy is under review.
- An updated and newly titled *Boundary Violations* policy and Advice to the Profession: Maintaining Appropriate Boundaries document (*Advice*) were released for external consultation following the May 2019 meeting of Council.
- Council is provided with an overview of the revisions made in response to the feedback received and is asked whether the revised draft *Boundary Violations* policy (attached as **Appendix A**) can be approved as a policy of the College.

BACKGROUND:

- The current *Maintaining Boundaries and Preventing Sexual Abuse* policy was last reviewed and approved by Council in 2008, with minor housekeeping amendments made in 2017 and 2018 in order to respond to legislative changes.
- A Working Group was struck to undertake the policy review process. The members of the Working Group are Ms. Lisa McCool-Philbin (Chair of the Working Group), Dr. Peeter Poldre, Ms. Gerry Sparrow, and Dr. Carol Leet and Dr. Barbara Lent (non-Council members). The Working Group is also supported by Alice Cranker (Legal Counsel) and Dr. Peter Prendergast (Medical Advisor). Dr. Keith Hay (Medical Advisor) also reviewed the draft policy and *Advice*, providing feedback from the perspective of a rural physician.
- Following extensive research including a literature review, jurisdictional research, internal data collection and a review of relevant legislation and case law, as well as a preliminary consultation, a draft *Boundary Violations* policy was developed and approved for external consultation by Council in May 2019. The *Advice to the Profession* document was also

released at this time. 117 consultation responses were received and a summary of the feedback was provided at September Council in the Policy Report.

- Broadly speaking, stakeholders expressed support for the draft policy. A large majority of respondents found the draft policy to be easy to understand, well organized, and clearly written. As well, a large majority of respondents found the draft policy to be comprehensive.

- All stakeholder feedback was posted publicly on the consultation-specific page of the College's website and a comprehensive report of the survey results is available on the consultation page.

CURRENT STATUS:

- In response to the consultation feedback, a revised draft policy was developed, and updates were made to the *Advice* document (**Appendix B**).

A. Revised Draft Policy

- The revised draft policy generally maintains the expectations set out in the consultation draft; however, some revisions have been made and the most pertinent ones are set out below.

Consent before Examinations

- In response to feedback, including from the Canadian Medical Protective Association and the Ontario Trial Lawyers Association, an expectation was added to the revised policy which requires physicians to obtain consent before proceeding with an examination of a patient.

    - Although the *Health Care Consent Act* links the requirement for consent to when a physician provides treatment, it is open to the College to set out a broader expectation for physicians.

    - The *Advice* document provides additional information about how this expectation can be discharged. In particular, that the process is not meant to be burdensome and can include a concise explanation of what the exam will entail in order to promote patient understanding.

Third Party Attendance at Examinations

- Overall, the draft expectation that physicians offer patients a third party was well received. Some physicians, in particular those who work in emergency department settings, were

concerned that the requirement is impractical, but some members of the public thought that more physicians should have at least a nurse present in the examination room for intimate examinations.

- Notwithstanding this general support, the following revisions were made:

    - The policy was clarified in relation to what must occur when a physician does not have a third party available or there is disagreement as to whom the third party is (i.e. delay, reschedule or refer to another physician if the examination is not urgent and explain the risks of delaying the examination if the examination is urgently needed). As well, the *Advice* addresses what to do in clinical settings such as an emergency department.
    - New expectations were added in response to OMA feedback regarding physicians who want to have a third party present and how to manage patient refusals.
    - The policy was revised to add a provision which states that the expectation with respect to third parties applies regardless of the gender of the physician and/or patient to address feedback from a few individual respondents and the OMA.

<u>Sexual Relations with Patients after the Physician-Patient Relationship has Ended</u>

- The draft policy specifies that if a physician has provided psychotherapy that is more than minor or insubstantial, the period of time of a physician-patient relationship is extended to 5 years after the individual ceased to be the physician's patient. This wording reflects a proposed regulation which was approved by Council in May 2018.

- Some consultation respondents asked for clarification as to what psychotherapy that is more than minor or insubstantial means. The *Advice* document provides clarification and states that it is important for physicians to use their professional judgment when determining whether psychotherapy is minor or insubstantial. Factors that physicians can consider in making this determination include the nature of issues discussed and the period of time for which the psychotherapy was provided.

<u>Non-Sexual Boundaries</u>

- While the majority of consultation respondents agreed with the draft expectations regarding non-sexual boundary issues, some physicians said that the expectations would be very difficult for physicians who practise in small or rural communities and were unfair.

- The expectations with respect to non-sexual boundaries have been maintained in the revised draft policy as the Working Group is of the view that these are important expectations and the expectations are consistent to those set out by other medical regulators. As well, non-sexual boundary violations may lead to sexual boundary violations.

- The *Advice* document acknowledges that patients will be part of a physician's social network in some circumstances and the expectation is that physicians will manage these dual relationships appropriately.

B. Revised Draft Advice to the Profession: Maintaining Appropriate Boundaries

- As Council is aware, companion *Advice* documents provide context, rationale, and answers to frequently asked questions.

- In addition to the revisions or additions highlighted above, the following changes were also made in response to feedback received in the consultation, including adding FAQs about:
    - the consequences for physicians who sexually abuse patients (in chart form to reflect Council feedback),
    - what to do in situations of inappropriate patient-initiated contact,
    - communication with patients, including on social media, and
    - mandatory reporting.

NEXT STEPS:

- Should Council approve the revised draft policy, it will be announced in *Dialogue* and will replace the current *Maintaining Appropriate Boundaries and Preventing Sexual Abuse* policy on the College website.

DECISION FOR COUNCIL:

1. Does Council approve the revised *Boundary Violations* draft policy as a policy of the College?

Contact: Lynn Kirshin, Ext. 243
Date: November 15, 2019

Attachments:

Appendix A: Revised Draft Boundary Violations Policy
Appendix B: Revised Advice to the Profession: Maintaining Appropriate Boundaries

Boundary Violations

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

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

Definitions

Boundary: Defines the limit of a safe and effective professional relationship between a physician and a patient. There are both sexual boundaries and non-sexual boundaries within a physician-patient relationship.

Boundary Violation: Occurs when a physician does not establish and/or maintain the limits of a professional relationship with their patient.

Patient: In general, a factual inquiry must be made to determine whether a physician-patient relationship exists, and when it ends. The longer the physician-patient relationship and the more dependency involved, the longer the relationship will endure.

However, for the purposes of the sexual abuse provisions of the *Health Professions Procedural Code* (*HPPC*), a person is a physician's patient if there is direct interaction and **any** of the following conditions are met:

- the physician has charged or received payment from the person (or a third party on behalf of the person) for a health care service provided by the physician,
- the physician has contributed to a health record or file for the person,
- the person has consented to the health care service recommended by the physician, or
- the physician prescribed the person a drug for which a prescription is needed.[1,2]

[1] O. Reg. 260/18 under the *Regulated Health Professions Act, 1991,* S.O. 1991, c.18 (*RHPA*).

[2] A person is not a physician's patient if **all** of the following conditions are met:

- There is a sexual relationship between the person and the physician at the time the health care service is provided to the person;
- The health care service provided by the physician to the person was done due to an emergency or was minor in nature; and
- The physician has taken reasonable steps to transfer the person's care, or there is no reasonable opportunity to transfer care. (O. Reg. 260/18 under the *RHPA*)

In addition, the physician-patient relationship endures for one year from the date on which the person ceased to be the physician's patient.[3]

Sexual Abuse: The *HPPC* defines sexual abuse as follows:

- sexual intercourse or other forms of physical sexual relations between a physician and their patient;
- touching, of a sexual nature, of a patient by their physician; or
- behaviour or remarks of a sexual nature by a physician towards their patient. [4]

Policy

1. Physicians **must** establish and maintain appropriate boundaries with their patients.

Sexual Boundary Violations

2. Physicians **must not** engage in sexual relations with a patient, touch a patient in a sexual manner or engage in behaviour or make remarks of a sexual nature towards a patient.[5]

3. To help ensure sexual boundaries are maintained and that sexual boundary violations do not occur, physicians **must**:

    a. **Not** make any sexual comments or advances towards a patient.
    b. **Not** respond sexually to any form of sexual advance made by a patient.
    c. Explain to patients in advance, the scope and rationale of any examination, treatment or procedure and if asking questions regarding sexual matters why they are being asked.
    d. Obtain consent before proceeding with an examination.[6]
    e. Only touch a patient's breasts, genitals or anus when it is medically appropriate, and use appropriate examination techniques when doing so.
    f. Use gloves when performing pelvic, genital, perineal, perianal, or rectal examinations.
    g. Show sensitivity and respect for a patient's privacy and comfort by:

        i. Providing privacy when patients dress or undress.

[3] Section 1(6) of the *HPPC*, Schedule 2, to the *RHPA*.

[4] Touching, behaviour or remarks of a clinical nature appropriate to the service provided do not constitute sexual abuse (Subsections 1(3) and (4) of the *HPPC*). It is an act of professional misconduct for a physician to sexually abuse a patient (Section 51(1), paragraph (b.1) of the *HPPC).*

[5] Such activity constitutes sexual abuse under the *HPPC*.

[6] For more information about obtaining consent, please see the *Advice to the Profession: Maintaining Appropriate Boundaries (Advice)* document.

ii. Providing patients with a gown or drape during the physical examination or procedure if clothing needs to be removed, and only exposing the area specifically related to the physical examination or procedure.
iii. Ensuring that the gown or draping adequately covers the area of the patient's body that is not actively under examination.
iv. During an examination, only assisting patients with the adjustment or removal of clothing or draping if the patient agrees or requests the physician to do so.

h. **Not** ask or make comments about a patient's sexual history, behaviour or performance except where the information is relevant to the provision of care.
i. **Not** make any comments regarding their own sex life, sexual preferences or fantasies.
j. **Not** socialize or communicate with a patient for the purpose of pursuing a sexual relationship.
k. Use their professional judgment when using touch for comforting purposes. Supportive words or discussion may be preferable to avoid misinterpretation.

Third Party Attendance at Intimate Examinations

5. Regardless of the gender of the physician and/or the patient, physicians **must** give patients the option of having a third party present during an intimate examination[7], including bringing their own third party if the physician does not have one.

6. If the patient wants a third party present during an intimate examination, and a third party is unavailable or there is no agreement on who the third party should be, physicians **must**:

a. Give patients the option to delay or reschedule the examination or be referred to another physician if the examination is not urgently needed, or

b. Explain the risks of delaying the examination if the examination is urgently needed.

7. Physicians also have the option to request the presence of a third party during an intimate examination. If doing so, physicians **must** explain to the patient who the third party is. If the patient declines, physicians **must** consider whether to proceed with the examination based on the best interests of the patient, including whether the examination is urgently required.

Sexual Relations after the Physician-Patient Relationship has Ended

8. Under the *HPPC, e*ngaging in any of the following within one year after the date upon which an individual ceased to be the physician's patient will constitute sexual abuse:

[7] Intimate exam includes breast, pelvic, genital, perineal, perianal and rectal examinations of patients.

a. sexual relations with a patient, and/or

b. sexual behaviour or making remarks of a sexual nature towards their patient.[8]

Therefore, physicians **must not** engage in sexual relations with a patient or engage in sexual behaviour or make remarks of a sexual nature towards their patient during this time period.

9. Where psychotherapy that is more than minor or insubstantial[9] has been provided, physicians **must not** engage in sexual relations or engage in sexual behaviour or make remarks of a sexual nature towards their patient for a minimum of five years after the date upon which the individual ceased to be the physician's patient.[10]

10. Even after the one or five year time period has passed, it may still be inappropriate for a physician to engage in sexual relations with a former patient.[11] Prior to engaging in sexual relations with a former patient, a physician **must** consider the following factors:

- the length and intensity of the former professional relationship,
- the nature of the patient's clinical problem,
- the type of clinical care provided by the physician,
- the extent to which the patient has confided personal or private information to the physician, and
- the vulnerability the patient had in the physician-patient relationship.

Sexual Relations between Physicians and Persons Closely Associated with Patients[12]

11. It may be inappropriate for a physician to engage in sexual relations with a person closely associated with a patient. A physician may be found to have committed an act of

[8] Subsections 1(3) and (6) of the *HPPC*, Schedule 2, to the *RHPA*. The *HPPC* provides for mandatory revocation for specific acts of sexual abuse including sexual intercourse. For a complete list, see *Advice*.

[9] Please see *Advice* for more information about what is considered minor or insubstantial psychotherapy.

[10] Physicians may be found to have committed disgraceful, dishonourable or unprofessional conduct if they engage in sexual relations with a patient in these circumstances. The Courts have found that certain physician-patient relationships may endure subsequent to the end of the formal relationship, for example, in the case of a long-standing psychotherapeutic relationship.

[11] See footnote 10.

[12] Individuals who possess one or more of the following features:

- They are responsible for the patient's welfare and hold decision-making power on behalf of the patient.
- They are emotionally close to the patient. Their participation in the clinical encounter, more often than not, matters a great deal to the patient.
- The physician interacts and communicates with them about the patient's condition on a regular basis, and is in a position to offer information, advice and emotional support.

Examples of such individuals include but are not limited to, patients' spouses or partners, parents, guardians, substitute decision-makers and persons who hold powers of attorney for personal care.

professional misconduct if they do so. [13] Prior to engaging in sexual relations with a person closely associated with a patient, a physician **must** consider the following factors:

- the nature of the patient's clinical problem,
- the type of clinical care provided by the physician,
- the length and intensity of the professional relationship between the physician and the patient,
- the degree of emotional dependence the individual associated with the patient has on the physician, and
- the degree to which the patient is reliant on the person closely associated with them.

Mandatory Duty to Report Sexual Abuse[14]

12. Physicians **must** make a report in writing to the Registrar of the College to whom an alleged abuser belongs, if:

    a. they have reasonable grounds[15], obtained in the course of practising the profession, to believe that another member of the same or a different regulated health college has sexually abused a patient; and/or

    b. they have reasonable grounds to believe that a member of a regulated health college practising in the facility has sexually abused a patient.

Non-Sexual Boundaries

13. Physicians' obligations to establish and maintain appropriate boundaries with patients are not limited to sexual interactions. Physicians **must** establish and maintain appropriate boundaries with patients at all times, including with respect to social or financial/business matters and **must not** exploit the power imbalance inherent in the physician-patient relationship.

14. Physicians **must** consider the impact on the physician-patient relationship and on other patients in their practice when engaging with a patient in a non-clinical context (social or financial/business relationships).

For further information about maintaining appropriate boundaries, please see the Advice to the Profession: Maintaining Appropriate Boundaries document (link to document will be provided).

[13] Allegations of professional misconduct could be made under the following grounds: act or omission relevant to the practice of medicine that, having regard to all of the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional and/or conduct unbecoming a physician (Section 1(1), paragraphs 33 and 34 of the *Medicine Act, Professional Misconduct Regulation).*

[14] Sections 85.1 to 85.6 of the *HPPC*.

[15] Please see *Advice* for more information about what reasonable grounds means.

Advice to the Profession: Maintaining Appropriate Boundaries

Advice to the Profession companion documents are intended to provide physicians with additional information and general advice in order to support their understanding and implementation of the expectations set out in policies. They may also identify some additional best practices regarding specific practice issues.

The *Boundary Violations* policy sets out expectations for physicians with respect to establishing and maintaining boundaries. This document is intended to help physicians interpret their obligations as set out in the policy and provide guidance around how these obligations may be effectively discharged.

Background

There is an inherent power imbalance within the physician-patient relationship which is a result of a number of factors:

- A patient depends on the physician's knowledge and training to help them with their health issues.
- A patient shares highly personal information with the physician that they rarely share with others.
- The clinical situation often requires that the physician conduct physical examinations that are of a sensitive nature.
- A patient's vulnerability is heightened when they are unwell, worried or undressed.

As such, a physician must only act in the patient's best interests and must take responsibility for establishing and maintaining boundaries within a physician-patient relationship.

If physicians do not do this, individual patients may be harmed and the public's trust in the medical profession may be eroded.

Frequently Asked Questions about Sexual Boundary Violations

27 **What are the consequences to physicians for sexually abusing a patient?**

Physician Conduct	Penalty	Reapplication
Sexual intercourse with a patient	Revocation of certificate of registration	No earlier than 5 years from date of revocation
Genital to genital, genital to anal, oral to genital, or oral to anal contact;	Revocation of certificate of registration	No earlier than 5 years from date of revocation
Masturbation of a physician by, or in the presence of, the patient; masturbation of the patient by a physician; encouraging the patient to masturbate in the presence of a physician.	Revocation of certificate of registration	No earlier than 5 years from date of revocation
Touching of a sexual nature of the patient's genitals, anus, breast or buttocks.	Revocation of certificate of registration	No earlier than 5 years from date of revocation
All other instances of sexual abuse e.g., behaviour or remarks of a sexual nature by a physician towards their patient.	The Discipline Committee is required to, at a minimum, reprimand the physician and order a suspension of their certificate of registration. In these instances, the Committee has the power to order revocation of the physician's certificate, although such revocation is not mandatory.	No earlier than 5 years from date of revocation
Physician has been found guilty of professional misconduct by the governing body of another health profession in Ontario, or by the governing body of a health profession in a jurisdiction other than Ontario and the misconduct includes or consists of the specific acts of sexual abuse described above.	Revocation of certificate of registration	No earlier than one year from date of revocation

Physician has been found guilty of an offence that is relevant to the member's suitability to practise and the offence is prescribed in a regulation made under clause 43 (1) (v) of the *Regulated Health Professions Act, 1991*.	Revocation of certificate of registration	No earlier than one year from date of revocation

What if my patient agrees to a sexual relationship?

Under the *RHPA* sexual contact with a patient is considered sexual abuse even if a patient has agreed to a sexual relationship. This is because of the power imbalance inherent in the physician-patient relationship.

What do I do in situations of uninitiated patient contact?

If a patient initiates inappropriate contact with you, for example, repeated personal emails or texts, you will need to re-establish the professional boundary between you and your patient. It is good practice to document the uninitiated interaction or contact and how you responded to it in the patient's medical record. If the patient's behaviour persists, it may be appropriate to terminate the physician-patient relationship in accordance with the College's Ending the Physician-Patient Relationship policy.

What is the difference between a boundary crossing and a boundary violation?

Boundary violations occur when a physician does not establish and/or maintain the limits of a professional relationship with a patient. The *Boundary Violations* policy sets out firm expectations for physicians to comply with in order to ensure that boundaries are not violated. Boundary violations occur when these expectations are not complied with. Such violations are exploitative.

Boundary crossings are different than violations in that they are minor deviations from traditional therapeutic activity that are non-exploitative and are often undertaken to enhance the clinical encounter. For example, accepting a small gift from a patient or holding of the hand of a grieving patient. While these actions may be well-intentioned, it is important for physicians to consider what these actions can mean to patients and their impact on the physician-patient relationship or on other patients in their practice. Repeated boundary crossings may often lead to a boundary violation.

Communication with Patients

How do I obtain consent before examining my patient?

Prior to examining your patient, explain what you will be doing and why in a concise and easily understood manner. Then you can ask, "is this okay?". Getting consent from your patient for an examination should not be burdensome or time-consuming and will ensure your patient knows what to expect during their appointment with you. Consent can be implied and would not necessarily have to be documented in the patient's medical record.

How can I incorporate trauma-informed care into my practice?

Trauma-informed care is defined as practices that promote a culture of safety, empowerment, and healing. A medical office or hospital can be a difficult experience for someone who has experienced trauma, particularly for childhood sexual abuse survivors. It is important to recognize how common trauma is and to understand that any patient may have experienced serious trauma. Physicians can assume that a patient may have this history and act accordingly. For example, explaining why the exam needs to be performed, telling patients that if they need a physician to stop the exam, that they can tell them so and letting patients bring a trusted friend or family member into the examination room with them.

Can I use touch for comforting purposes?

The policy states a physician must use their professional judgment to determine when to use touch for comforting purposes. In using their professional judgment, there are a number of factors that physicians can consider including, how long the individual has been their patient, that the patient may have experienced trauma, and why the patient may need comforting touch. A physician may also want to consider asking a patient if it is okay to hug them or touch them in a comforting manner. These steps align with the provision of trauma-informed care.

Can I communicate with my patients on Social Media?

Physicians are expected to comply with all of their existing professional expectations, including those set out in relevant legislation, codes of ethics, and College policies, when engaging in the use of social media platforms and technologies.

As set out in the policy, making comments of a sexual nature towards a patient is considered sexual abuse under the *RHPA* and this would apply equally to comments of a sexual nature made to a patient on social media.

In communicating to my patients, can I disclose information about myself?

Self-disclosure can be a challenging area to navigate. It is important for physicians to use their professional judgment when disclosing personal information to patients, considering factors such as the nature of the information being disclosed, the length and nature of the physician-patient relationship, and the purpose of self-disclosure.

Third Parties at Examinations

The *Boundary Violations* policy outlines what the College expects of a physician who is not able to provide a third party for their patient when conducting an intimate examination.

A physician may want to consider informing patients (through their administrative staff or themselves) when booking appointments that they are not able to offer a third party, but if the patient would like to have a third party present they may bring their own third party, e.g., a family member or a friend to the appointment. Having a sign posted in a physician's office about third-party attendance at intimate examinations does not satisfy the requirement.

What if I am not able to provide a third party for my patient?

In limited clinical settings, such as an emergency department, an intimate examination may not be as foreseeable as it would in a different setting (e.g., a scheduled pelvic examination) and it may be more difficult to find an available third party. In these circumstances, where the patient does not have an available third party who has accompanied them, a physician could explain to the patient that a third party may be obtained but it could take some time for this to happen. If the examination is not urgent, the patient can then decide whether they want to wait until the third party can attend.

What should I document in relation to third parties?

When a third party is declined by a patient, it may be worthwhile for physicians to document the decision in the patient's medical record.

If a third party is present, physicians may want to document whether the third party has been provided by the physician or the patient.

Privacy

How can I provide privacy for my patients?

As stated in the *Boundary Violations* policy, physicians must provide privacy when a patient undresses and dresses. This can be achieved by having an appropriate place for a patient to

undress and dress out of view of anyone, including the physician, e.g., a separate examination room where a patient can change or having a suitable curtain between the physician and the patient. Merely turning around and facing away from a patient without a curtain is not acceptable.

Sexual Relationships with Former Patients and Others Close to Patients

Why might it not be appropriate for a physician to have sexual relations with a patient even after the physician-patient relationship has ended?

At all times, a physician has an ethical obligation not to exploit the trust, knowledge and dependence that develops during the physician-patient relationship for the physician's personal advantage. This dependence does not disappear once the physician-patient relationship has ended – the power imbalance can persist after a person ceases to be a physician's patient.

As such, for the purposes of sexual abuse, the *RHPA* treats the physician-patient relationship as continuing one year past the last physician-patient encounter. It is also the College's position that if psychotherapy that is more than minor or insubstantial was provided by a physician, that physician must not engage in sexual relations with a patient for at least five years after the date of the last physician-patient encounter.

Prior to engaging in sexual contact, physicians are advised to verify that they have not provided treatment to the individual within the prior year or the previous five year period if they have provided psychotherapy to the individual. Even after these time periods have elapsed, sexual relations may be considered professional misconduct.

A physician who is considering having sexual relations with a former patient must use their professional judgment, acting cautiously as they consider the potentially complex issues relating to trust, power dynamics and any transference concerns. As well, it is important for a physician to explain to a former patient the dynamics of a physician-patient relationship and the boundaries applicable to that relationship.

Where a physician is in doubt as to whether the physician-patient relationship has ended, they should refrain from any relationship with the patient until they seek advice, for example, from legal counsel.

What does minor or insubstantial psychotherapy mean?

It is important for physicians to use their professional judgment when determining whether psychotherapy is minor or insubstantial. Factors that physicians can consider in making this determination include the nature of issues discussed and the time period over which the psychotherapy was provided.

Why might it not be appropriate for a physician have a sexual relationship with a person closely associated with a patient?

Sexual relations between physicians and individuals who are closely associated with a physician's patients may also raise concerns about breach of trust and power imbalance, and may be considered professional misconduct.

In addition to the risk of exploitation, sexual relations between a physician and a person closely associated with a patient can detract from the goal of furthering the patient's best interests. It has the potential of affecting the physician's objectivity and the closely associated person's decisions with respect to the health care provided to the patient.

Mandatory Reporting

What does 'reasonable grounds' mean in the expectation for physicians to report sexual abuse?

Courts have described the test as a "reasonable probability" or a "reasonable belief". This is a low threshold; however, it is a higher threshold than a mere suspicion and a lower threshold than proof on a balance of probabilities.

For example, in most circumstances, where a patient tells you that they have experienced sexual abuse by another physician, this would need to be reported to the College. Additional corroborative evidence is not required and you should not attempt to investigate the patient's allegations.

Frequently Asked Questions about Non-Sexual Boundary Violations

How do non-sexual boundary violations impact the physician-patient relationship?

Non-sexual boundary violations can occur when a physician has a social relationship and/or a financial/business relationship with a patient.

It is important for physicians to be aware of the increased risk associated with managing a dual relationship with a patient, including the potential for compromised professional judgment and/or unreasonable patient expectations. The following activities *may* have the potential to cause harm particularly when the physician uses the knowledge and trust gained from the physician-patient relationship.

Social relationships can include the following activities:

- Giving or receiving inappropriate or elaborate gifts;
- Asking patients directly, or searching other sources, for private information that has no relevance to the clinical issue;
- Asking patients to join faith communities or personal causes; or
- Engaging in leisure activities with a patient.

Financial/business relationships can include the following activities:

- Lending to/borrowing money from patients,
- Entering into a business relationship with a patient, or
- Soliciting patients to make donations to charities or political parties.

What should I do when my patients are part of my social network?

The College does not prohibit physicians and patients from interacting within the same social network. In fact, we recognize that this is a reality of practice for many physicians. For example, in small communities and in religious, language and ethnic communities, physicians will be invited to, or engaged in, social events and activities with patients.

We understand that these issues can be challenging for physicians; however, as set out in the answer above, physicians need to manage the increased risks associated with having a dual relationship with a patient. For example, it is best practice for professional issues to be discussed in the physician's office.

The College's Physician Treatment of Self, Family Members, or Others Close to Them policy also contains important information with respect to this issue.

Resources

The information below provides additional guidance for physicians with respect to maintaining appropriate boundaries and avoiding sexual abuse complaints.

Dialogue Articles

Dialogue, the College's quarterly publication for members, regularly addresses themes or issues relating to boundary violations, including sexual abuse. While some expectations may have changed since these articles were published, they contain helpful advice. Some examples are linked below:

- Practice Points, Issue 4 2018
- Bill 87 – Protecting Patients Act, Issue 1, 2017
- Mandatory Reporting for Sexual Abuse, Issue 4, 2016

Discipline Committee Findings

Past findings of the College's Discipline Committee can also be instructive as to what behaviours have resulted in findings of sexual abuse and/or disgraceful, dishonourable or unprofessional conduct.

The lists below are not exhaustive and the Discipline Committee would examine the facts of a specific case to see whether the conduct amounts sexual abuse or disgraceful, dishonourable or unprofessional conduct.

The Discipline Committee has made findings of sexual abuse in situations which include the following conduct:

- Remarks of a sexual nature to a patient including comments sexualizing the patient's appearance where there is no therapeutic value in the remarks,
- Stroking a patient's buttocks as they were leaving an appointment,
- Sexual touching while the patient was under anesthetic, and
- Kissing a patient.

Additionally, the Discipline Committee has determined that the following types of behaviour amounted to disgraceful, dishonourable or unprofessional conduct.

- Borrowing money from a patient;
- When providing counselling: hugging and providing a kiss on the cheek, meeting outside of the office on three occasions including at a restaurant;
- Failing to provide adequate explanation and obtaining informed consent prior to and during a sensitive examination
- Failing to provide adequate coverage for an examination resulting in unwanted exposure;

- Repeated, unwanted touching of nursing colleagues; and
- Engaging in a sexual relationship with a patient too soon after the termination of the doctor-patient relationship.

CPSO's Professionalism and Practice Program

How a doctor delivers care is just as important as the care provided. To that end, the CPSO has partnered with medical schools across Ontario to develop modules on key professionalism topics. These modules include PowerPoint presentations, and case studies ground in real life issues and trends seen by the CPSO. They are also grounded in relevant frameworks, such as CanMEDs. We encourage medical students — and anyone else interested in medical professionalism —to visit the Professionalism and Practice area on our website and to download the Boundaries and Sexual Abuse Module.

Canadian Medical Protective Association

The CMPA is a national organization and provides broad advice about a number of medico-legal issues. For Ontario specific information physicians are advised to look at the CPSO policy and advice document regarding boundary issues. However, the CMPA has a number of resources on the issues generally that physicians may find helpful.

For example:

Recognizing Boundary Issues

Is it Time to Rethink Your Use of Chaperones?

Good Practice Guide: Respecting Boundaries

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: Prescribing Drugs Policy

Date of Meeting: December 5, 2019

It is moved by_____,

and seconded by_____, that:

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

Council Briefing Note

December 2019

TOPIC: Prescribing Drugs – Revised Policy for Final Approval

FOR DECISION

ISSUE:

- In May 2019, Council released the draft *Prescribing Drugs* policy for a 60-day external consultation. The draft policy has now been revised in light of the feedback received.

- Council is provided with an overview of the changes to the draft policy and is asked whether the revised draft *Prescribing Drugs* policy can be approved as a policy of the College.

BACKGROUND:

- The College's current *Prescribing Drugs* policy was last reviewed and approved by Council in December 2012 (with minor housekeeping amendments undertaken in 2016 and 2017[1]).

- This policy is now under review as part of the College's normal policy review cycle.

- A Policy Working Group has been struck to undertake this review, consisting of Dr. Scott Wooder (Working Group Chair), Dr. Steven Bodley, Dr. Janet Van Vlymen, and Pierre Giroux. The Working Group is also supported by Jessica Amey (Legal Counsel) and Dr. Angela Carol (Medical Advisor).

- As per the usual policy review process, an updated draft of the policy was developed following extensive preliminary research[2], external public consultation[3], and Working Group discussion. This updated draft policy was approved for external consultation by Council in May 2019.

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[1] These amendments were made in response to issues arising from the emerging "opioid" crisis.

[2] E.g., a review of scholarly articles; research papers; relevant decisions of the Inquiries, Complaints, and Reports Committee (ICRC); feedback obtained from the College's Physician and Public Advisory Service (PPAS); and an international jurisdictional review.

[3] Council received an overview of the preliminary consultation feedback in the Feb 2018 Policy Report.

CURRENT STATUS:

- The external consultation on the draft policy generated 130 responses.[4] As a general observation, the draft policy was well received by the College's external stakeholders.

- In keeping with regular consultation processes and posting guidelines, all written feedback can be viewed on the College's website and a report summarizing the results of the online survey can be viewed here.

A. Revised Draft *Prescribing Drugs* Policy

- Following careful consideration of the feedback received, a revised draft *Prescribing Drugs* policy has been developed by the policy Working Group (**Appendix A**).

- Additionally, the Working Group has elected to draft an accompanying *Advice to the Profession* document which articulates advice and provides elaboration with respect to the policy's expectations (**Appendix B**).

- While the proposed revisions to the draft policy are primarily aimed at enhancing clarity, an overview of three key policy decisions is provided below.

"Safer supply" opioid prescribing

- The Policy Working Group has had an opportunity to consider the issue of "safer supply" opioid prescribing[5] and has sought to reflect the key issues arising from this practice in the revised draft policy (e.g., reflecting the heightened risk of diversion).

- In doing so, the Working Group has sought to avoid setting out expectations that are specific to safer supply, and instead have articulated general principles of good practice that can apply equally to *any* narcotic or controlled substance.

- The Working Group's approach was informed by public comments made by Dr. Sheila Laredo on the topic of safer supply prescribing, internal discussion within the Working Group, and consultation with practitioners (including practitioners who practice safer supply prescribing and those who who have expressed concern about the unintended consequences of safer supply).

[4] This included 33 written responses and 97 responses to our online survey.
[5] "Safer supply" opioid prescribing is grounded in principles of harm reduction and involves the direct delivery (prescribing) of prescription opioids to individuals experiencing opioid use disorder. The goal of "safer supply" is to provide patients with an alternative to the toxic illicit supply of opioids available on the street.

- While not explicitly referencing safer supply, relevant sections of the draft policy have been expanded to provide additional guidance (e.g., provisions 32 and 33 of the revised draft policy).

- More substantive and explicit *advice* regarding safer supply opioid prescribing has been added to the *Advice to the Profession* document. This advice is specific to safer supply and is strongly rooted in the policy's general expectations for prescribing narcotics and controlled substances.

- As safer supply prescribing is an evolving area of clinical practice, staff are committed to the continued monitoring of this issue and will respond to new developments as needed.

Accessing patients' digital prescription histories

- The consultation draft of the *Prescribing Drugs* policy contained a requirement for physicians to "review a patient's digital prescription history" (e.g. the Digital Health Drug Repository [DHDR]) when prescribing opioids for chronic pain.

    - This requirement was the result of a public commitment made by the College in 2016 and was based in part on an understanding that widespread access to electronic sources of prescribing data was imminent.
    - In the three years that have followed this public commitment, physician access to electronic data repositories has remained limited, and this requirement has been the subject of ongoing criticism from physicians as well as the Ontario Medical Association.

- In response to this criticism, and in recognition that physician-access to electronic prescribing data is still limited, the Working Group has elected to remove this requirement.

- Instead, advice has been added to the accompanying *Advice to the Profession* document which provides additional detail regarding accessing electronic resources where possible (e.g., the DHDR).

- As electronic access to prescription data is an evolving area, staff will continue to monitor this issue and update the advice to the profession document as needed.

Considering the patient's ability to pay

- Several physician respondents to the external consultation, as well as some members of Council, have requested that the revised draft policy include expectations around the issue of drug costs (e.g., a reminder or encouragement to physicians to consider the ability of their patients to afford the drugs being prescribed).

- Following careful deliberation, the Working Group elected to address this issue in the accompanying *Advice to the Profession* document (**Appendix B**), rather than the policy itself; however, staff will continue to explore options to support physicians in making prescribing decisions that are informed about the cost of drugs.

B. Draft *Advice to the Profession* Document

- As noted, the draft *Advice to the Profession* document (**Appendix B**) includes additional content to support physicians in meeting their professional obligations in key practice areas, including:
    - "safer supply" opioid prescribing,
    - accessing patients' electronic prescription histories,
    - considering prescription drug costs,
    - the use of prescribing contracts (also known as "treatment agreements"),
    - reporting adverse drug reactions or medication incidents, and
    - prescription drug disposal.

NEXT STEPS:

- Should Council approve the revised draft policy, it will be announced in *Dialogue* and posted on the College's website as a final policy of the College.

DECISION FOR COUNCIL:

1. Does Council approve the revised draft *Prescribing Drugs* policy as a policy of the College?

Contact: Cameron Thompson, ext. 246
Date: November 15, 2019

Attachments:

Appendix A: Revised Draft *Prescribing Drugs* Policy

Appendix B: Draft *Advice to the Profession: Prescribing Drugs* Document

Prescribing Drugs – Draft Policy

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

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

Policy

1. Physicians **must** comply with the requirements for prescribing that are set out in this policy, as well those contained in any other relevant College policies[1] and legislation[2].

Before Prescribing

2. Physicians **must** only prescribe a drug if they have the knowledge, skill, and judgment to do so safely and effectively.[3]

3. Before prescribing a drug, physicians **must**:

   a) undertake an appropriate clinical assessment of the patient (limited exceptions are set out in provisions 4 and 5 of this policy);[4]
   b) make a diagnosis or differential diagnosis and/or have a clinical indication based on the clinical assessment and any other relevant information;
   c) consider the risks and benefits of prescribing the chosen drug, including the combined risks and benefits when prescribing multiple drugs and the risks and benefits when providing long-term prescriptions; and
   d) obtain valid consent.[5]

[1] Other relevant policies include (among others): Cannabis for Medical Purposes, Confidentiality of Personal Health Information, Consent to Treatment, Medical Records, and Telemedicine.

[2] Relevant legislation includes, but may not be limited to: the *Food and Drugs Act*, R.S.C, 1985, c. F-27 (hereinafter *FDA*); the *Controlled Drugs and Substances Act*, S.C. 1996, c. 19 (hereinafter *CDSA*); the *Narcotics Safety and Awareness Act*, 2010, S.O. 2010, c. 22 (hereinafter *NSAA*); and the *Drug and Pharmacies Regulation Act*, R.S.O.1990, c. H.4 (hereinafter *DPRA*).

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

[4] An appropriate clinical assessment includes an appropriate patient history as well as any other necessary examinations or investigations.

Relying on an Assessment Undertaken by Someone Else / Prescribing with no Prior Assessment

4. Physicians are permitted to prescribe on the basis of an assessment conducted by someone else.[6] When doing so, physicians **must**:

    a) have reasonable grounds to believe that the person who conducted the assessment had the appropriate knowledge, skill, and judgment to do so;[7] and
    b) evaluate the assessment and judge it to be appropriate.

5. If no prior assessment of the patient has been undertaken, physicians **must** only prescribe:

    a) for the sexual partner of a patient with a sexually transmitted infection who would not otherwise receive treatment and where there is a risk of further transmission;
    b) prophylaxis as part of a public health program operated under the authority of a Medical Officer of Health; and/or
    c) post-exposure prophylaxis for a health-care professional following potential exposure to a blood borne virus.

Content of Prescriptions

6. Physicians **must** ensure that written prescriptions are legible.

7. Physicians **must** ensure that the following information is included on every written or electronic prescription:

    a) the prescribing physician's printed name, signature[8] (or electronic signature), and CPSO registration number[9];

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[5] For more information on consent, please refer to the College's Consent to Treatment policy. [6] The prescribing physician is ultimately responsible for how they use the assessment information, regardless of who conducted the assessment.

[6] The prescribing physician is ultimately responsible for how they use the assessment information, regardless of who conducted the assessment.

[7] In most circumstances, this will require that the physician know the person conducting the assessment and be aware of their qualifications and training. In some limited circumstances, such as large health institutional settings, the physician may be able to rely upon knowledge of the institution's practices to satisfy him or herself that the person conducting the assessment has the appropriate knowledge, skill, and judgment.

[8] Signatures must be authentic and unaltered. Electronic signatures may be acceptable if they meet the requirements of the Ontario College of Pharmacists. For more information, see the Ontario College of Pharmacists' website: http://www.ocpinfo.com/regulations-standards/policies-guidelines/unique-identifiers/.

[9] The *NSAA* requires physicians to include their CPSO registration number on all prescriptions for monitored drugs. See Section 2 of the *NSAA* for the definition of "monitored drug." For a complete list of monitored drugs, see the Ministry of Health and Long-Term Care's website: http://health.gov.on.ca/en/pro/programs/drugs/monitored_productlist.aspx.

b) the prescribing physician's practice address;
c) the patient's name;
d) the name of the drug;
e) the drug strength and quantity;
f) the directions for use;
g) the full date the prescription was issued (day, month, and year);
h) refill instructions, if any;
i) if the prescription is for a monitored drug[10], an identifying number for the patient[11] (unless certain conditions set out in regulation are met)[12];
j) if the prescription is for a fentanyl patch, additional requirements apply (these are set out in provision 36 and 37 of this policy); and
k) any additional information required by law.

8. Physicians **must** use their professional judgment to determine whether it is necessary to include any additional information on the prescription (e.g., the patient's weight where this information would affect dosage or the patient's date of birth where this information would assist in confirming the patient's identity).

The College is aware that some patients face financial difficulties that limit their ability to afford the drugs prescribed to them. For more information about prescribing drugs in a way that reflects the patient's ability to pay, please see the College's *Advice to the Profession: Prescribing Drugs* document.

Authorizing and Transmitting Prescriptions

9. When providing prescriptions, physicians **must** authorize each prescription in one of three ways: with a written signature, electronically, or verbally[13].

a) When authorizing prescriptions electronically, physicians **must** authorize the prescription themselves. Physicians **must not** permit other members of staff to authorize a prescription unless there is a direct order or medical directive in place, and if

[10] See Section 2 of the *NSAA* for the definition of "monitored drug." For a complete list of monitored drugs, see the Ministry of Health and Long-Term Care's website at: http://health.gov.on.ca/en/pro/programs/drugs/monitored_productlist.aspx.
[11] For example, a Health Card number. See the full list of approved forms of identification here: http://www.health.gov.on.ca/en/public/programs/drugs/ons/publicnotice/identification_list.aspx.
[12] See Sections 3 and 6 of the *General*, O. Reg., 381/11, enacted under the *NSAA*.
[13] There are some limitations on the use of verbal prescriptions (for example, narcotics cannot be authorized verbally). Physicians can contact the pharmacist if they are uncertain about whether a particular prescription is permitted. The Ontario College of Pharmacists (OCP) created a summary of federal and provincial laws governing prescription requirements which can be found here: http://www.ocpinfo.com/library/practice-related/download/Prescription%20Regulation%20Summary%20Chart%20(Summary%20of%20Laws).pdf.

so, there **must** be a mechanism within the system to identify who authorized the prescription and under what authority.

10. Regardless of the method of transmission, physicians **must** ensure that patient privacy and confidentiality are protected.[14]

Duplicate Prescriptions

11. Physicians **must not** create duplicate copies of a prescription except for the purposes of retaining a copy in the patient's medical record or to replace a lost or damaged prescription.

12. If physicians wish to provide a copy of the prescription to their patients for information purposes, physicians **must** provide this information in a format that does not resemble a prescription (e.g. a written summary).

Respecting Patient Choice When Choosing a Pharmacy

13. Physicians **must** respect the patient's choice of pharmacy.

14. Physicians **must not** attempt to influence the patient's choice of pharmacy unless doing so is in the patient's best interest and does not create a conflict of interest for the physician.

Communicating with Pharmacists

15. Physicians **must** respond in a timely manner when contacted by a pharmacist or other health-care provider involved in the care of a patient. The timeliness of the communication will depend on a variety of factors, including the degree to which a delay may impact patient safety.

Documentation

16. In addition to complying with the general requirements for medical records[15], physicians **must** specifically document all relevant information regarding the drugs they prescribe. Physicians **must** do this by either retaining a copy of the prescription in the patient's medical record or by specifically documenting the information contained in the prescription (as set out in provision 7, a-k of this policy).

[14] Obligations with respect to the security of personal health information are set out in Sections 12 and 13 of *PHIPA*. For more information on the security of faxed prescriptions, see the Information and Privacy Commissioner of Ontario's "Guidelines on Facsimile Transmission Security".

[15] Sections 18-21 of the *Medicine Act, General Regulation*. For full details of the requirements concerning medical records, see the College's Medical Records policy.

17. Physicians **must** also document the type of prescription it is (e.g. verbal, handwritten, or electronic) and comply with any applicable requirements for the documentation of patient consent, as set out in the College's Consent to Treatment policy.

Monitoring Drug Therapy

18. Physicians **must** ensure that appropriate monitoring protocols are in place as-needed to identify emerging risks or complications arising from the drugs they prescribe.

19. Physicians **must** inform patients of:

    a) the follow-up care required to monitor whether changes to the prescription are necessary; and
    b) the patient's role in safe medication use and monitoring effectiveness.

20. If patients do not comply with an agreed-upon plan for prescription monitoring, physicians **must** consider whether continued prescribing is safe and appropriate by weighing the risks of continuing prescribing against the risks of discontinuing prescribing.

21. If, in the physician's judgment, drug therapy is not effective or the risks outweigh the benefits, physicians **must** consider discontinuing the prescription.[16]

22. Whenever possible, physicians **must** only discontinue prescribing following discussion with the patient.

Prescription Refills (also known as Repeats or Renewals)

23. Physicians **must** review all requests to refill a prescription and authorize any refills provided unless these tasks are delegated to staff[17] or the person authorizing the refill is a regulated health professional with the authority to prescribe.

24. Physicians **must** ensure that all requests for refills and all authorized refills are documented in the patient's medical record.

25. Physicians **must** ensure that procedures are in place to monitor the ongoing appropriateness of the drug when prescribing refills (e.g., by conducting periodic re-assessments).

[16] Specific expectations for discontinuing narcotics and controlled substances are set out in provisions 34 – 35 of this policy.

[17] If physicians are delegating this responsibility to staff, they **must** do so in accordance with the College's Delegation of Controlled Acts policy.

26. Physicians **must not** adopt blanket "no refill" policies.[18] While some physicians may rarely, if ever, write prescriptions with refills, physicians **must** decide whether or not to prescribe refills on a case-by-case basis, with consideration for the circumstances of each patient.

Redistributing Returned Drugs

27. Because the integrity of the drugs cannot be ensured, physicians **must not** redistribute drugs that have been returned by a patient.

28. Physicians **must** dispose of returned drugs in a safe and secure manner.[19]

Drugs That Have Not Been Approved for Use in Canada ('Unapproved Drugs')

29. Physicians **must not** prescribe drugs that have not been approved for use in Canada (i.e., drugs for which Health Canada has not issued a Notice of Compliance) except in the limited circumstances permitted by Health Canada.[20]

Distributing Drugs without a Prescription (e.g. Drug Samples)

30. When providing drugs to patients without a formal prescription[21] (e.g. drug samples), physicians **must** continue to meet all of the relevant requirements that apply to prescribing generally, including those related to patient assessment, documentation, and prescription monitoring.

31. When providing drugs to patients without a prescription, physicians **must** ensure that no form of material gain is obtained for the physician or for the practice with which they are associated (this includes selling or trading).

Narcotics and Controlled Substances

[18] A blanket "no-refill policy" means that a physician will not authorize refills for any patient, for any drug, in any circumstances. A blanket no-refill policy is an arbitrary, inflexible position that prevents physicians from exercising independent clinical judgment that takes into account the circumstances of the individual patient. This approach is not consistent with patient-centered care and has no clinical basis.

[19] For more information about the safe disposal of drugs, please see the College's *Advice to the Profession: Prescribing Drugs* document.

[20] For more information, see Health Canada's Notice of Compliance webpage: https://www.canada.ca/en/health-canada/services/drugs-health-products/drug-products/notice-compliance/database.html. There are two circumstances when access to an unapproved drug can be obtained for patient use: the first is when drugs have been authorized by Health Canada for research purposes as part of a clinical trial and the second is when drugs have been authorized under Health Canada's Special Access Programme.

[21] Small amounts of drugs are sometimes provided to patients without a formal prescription for the immediate treatment of acute symptoms or to evaluate the clinical effectiveness of the treatment.

Narcotics and controlled substances[22] can help support the safe, effective, and compassionate treatment of many conditions, including acute or chronic pain and addiction. When prescribing these drugs; however, special consideration is necessary given that they are susceptible to diversion, misuse, and/or abuse, and many carry a risk of dependence and overdose.

Before Prescribing Narcotics and Controlled Substances

32. Before initiating a prescription for a narcotic or controlled substance (or continuing a prescription initiated by another prescriber), physicians **must**:

    a) consider whether the narcotic or controlled substance is the most appropriate choice for the patient;
    b) if prescribing opioids for chronic pain, physicians **must** document in the patient's medical record that there are no appropriate or reasonably available alternatives;
    c) consider the potential risks associated with prescribing, and take reasonable steps to mitigate those risks, consistent with any relevant practice standards, quality standards, and clinical practice guidelines;[23]
        i. Where these do not exist (e.g., in areas of medicine that are less developed), physicians **must** consider any available indirect evidence, clinical trials, evidence-based research or consensus recommendations, and general best practices;
    d) review any previous interventions the patient has undergone and develop a comprehensive treatment plan that includes:
        i. realistic treatment goals;
        ii. a plan for discontinuing prescribing should the risks outweigh the benefits;
        iii. a plan for minimizing risks and unintended consequences (e.g. diversion); and
        iv. a plan for managing withdrawal, where applicable;

[22] For the purposes of this policy, "Narcotics and Controlled Substances" includes Narcotic Drugs, Narcotics Preparations, and Benzodiazepines and Other Targeted Substances as defined in the Regulations made under the *CDSA,* Controlled Drugs as defined in the Regulations made under the *FDA*, and Monitored Drugs as defined in the *NSAA*. Examples include narcotic analgesics (e.g. Tylenol 3 and OxyNEO), methadone, and non-narcotic controlled drugs such as methylphenidate (e.g. Ritalin), benzodiazepines (e.g. Valium), and barbiturates (e.g. phenobarbital).[23] With respect to the prescribing of opioids for chronic non-cancer pain, relevant guidelines and standards include the 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain, the Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain, and any applicable Quality Standards developed by Health Quality Ontario. Relevant guidelines for the clinical management of opioid use disorder include, among others: the CRISM National Guideline for the Clinical Management of Opioid Use Disorder, the British Columbia Centre for Substance Use: A Guideline for the Management of Opioids Use Disorder, and National Guidelines on the Treatment of Opioid Use Disorder.

[23] With respect to the prescribing of opioids for chronic non-cancer pain, relevant guidelines and standards include the 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain, the Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain, and any applicable Quality Standards developed by Health Quality Ontario. Relevant guidelines for the clinical management of opioid use disorder include, among others: the CRISM National Guideline for the Clinical Management of Opioid Use Disorder, the British Columbia Centre for Substance Use: A Guideline for the Management of Opioids Use Disorder, and National Guidelines on the Treatment of Opioid Use Disorder.

e) take reasonable steps to review the patient's prescription history as it relates to narcotics and controlled substances (e.g., by contacting the patient's other treating physicians or by reviewing electronic sources of information regarding the patient's prescription history, where available[24]); and
f) obtain valid consent as required by applicable legislation[25] and the College's Consent to Treatment policy;
    i. when prescribing narcotics and controlled substances, physicians **must** inform patients of the risks and harms associated with the drug being prescribed, including any risk of dependence, addiction, withdrawal, diversion, and overdose.

When Prescribing Narcotics and Controlled Substances

33. When prescribing narcotics or controlled substances (or continuing a prescription initiated by another prescriber) physicians **must**:

    a) meet the general requirements for prescribing that are set out in this policy, as well as any other relevant policies and/or legislation;
    b) consider any relevant practice standards, quality standards, and clinical practice guidelines, and apply them as appropriate;
        i. where these resources do not exist (e.g., in areas of medicine that are less developed), physicians **must** consider any available indirect evidence, clinical trials, evidence-based research or consensus recommendations, and general best practices;[26] and
    c) inform patients of how to safely secure, store, and dispose of any unused medication (especially in circumstances where locked storage is considered critical, such as prescription opioids and methadone).

Tapering and Discontinuing Narcotics and Controlled Substances

34. Physicians **must not** taper patients inappropriately or arbitrarily. Physicians are reminded that it is not always possible or appropriate to taper below a specific dose, nor is it usually appropriate to suddenly or rapidly taper prescriptions.

35. When tapering or discontinuing narcotics and controlled substances, physicians **must**:

[24] For more information about accessing patient's electronic prescription histories, please see the College's companion *Advice to the Profession: Prescribing Drugs* document.
[25] Applicable legislation includes the *Health Care Consent Act, 1996* (HCCA).
[26] With respect to the prescribing of opioids for chronic non-cancer pain, relevant guidelines and standards include the 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain, the Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain, and any applicable Quality Standards developed by Health Quality Ontario. Relevant guidelines for the clinical management of opioid use disorder include the CRISM National Guideline for the Clinical Management of Opioid Use Disorder.

a) proceed with consideration for the safety and well-being of the patient;
b) consider and apply, as appropriate, relevant practice standards, quality standards, and clinical practice guidelines;[27]
c) explain to the patient the rationale for tapering or discontinuation, and provide an opportunity for discussion;
d) discuss a strategy to treat withdrawal symptoms, where applicable;
e) whenever possible, make decisions with respect to tapering or discontinuation in collaboration with the patient; and
f) carefully document decision-making and any discussions with the patient.

Prescribing Fentanyl Patches

36. When prescribing fentanyl patches, physicians **must** include the following additional information on every prescription:[28]

    a) the name and address of the pharmacy where the patient has chosen to fill the prescription; and
    b) a notation that it is the patient's first prescription for fentanyl patches when the following conditions are met: 1) the physician has not previously prescribed fentanyl patches to that patient, and 2) the physician is reasonably satisfied[29] that the patient has not previously obtained a prescription for fentanyl from another prescriber.

37. Physicians **must** also notify the pharmacy directly. Notification is automatically achieved if the prescription is faxed directly to the pharmacy; however, if the prescription is provided to the patient directly then physicians **must** notify the pharmacy separately (e.g. via telephone).

"No Narcotics" Prescribing Policies

While some physicians may rarely, if ever, prescribe narcotics or controlled substances in practice[30], arbitrarily refusing to prescribe these drugs without consideration for the circumstances of each patient may lead to inadequate patient care.

[27] With respect to the prescribing of opioids for chronic non-cancer pain, relevant guidelines and standards include the 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain, the Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain, and any applicable Quality Standards developed by Health Quality Ontario. Relevant guidelines for the clinical management of opioid use disorder include the CRISM National Guideline for the Clinical Management of Opioid Use Disorder.

[28] *Safeguarding our Communities Act, 2015*. Physicians can find more information about their obligations under the Act in the College's "Patch-for-Patch Fentanyl Return Program: Fact Sheet", which is a companion to the College's Prescribing Drugs policy.

[29] A physician may be reasonably satisfied based on his or her discussions with the patient as well as any other information available to the physician.

[30] For example, because the physician practices in an emergency room setting and feels unable to provide necessary follow-up care and monitoring.

38. Unless the prescribing of narcotics and controlled substances falls outside of the physician's scope of practice or clinical competence[31], or the physician has a restriction imposed by the College prohibiting prescribing, physicians:

    a) **must not** adopt a blanket policy[32] refusing to prescribe narcotics and controlled substances, and
    b) **must** make prescribing decisions on a case-by-case basis with consideration for each patient.

Reporting the Loss or Theft of Narcotics or Controlled Substances

39. Physicians **must** report the loss or theft of narcotics and/or controlled substances from their possession to the Office of Controlled Substances, Federal Minister of Health[33], within 10 days.[34]

Drug Storage

40. Where physicians stock narcotics and controlled substances, they **must** be securely and appropriately stored in the office to prevent theft/loss.

[31] Physicians with primary care practices are reminded that given their broad scope of practice, there are few occasions where scope of practice would be an appropriate ground to refuse to prescribe all narcotics and controlled substances.

[32] A blanket "no prescribing" policy means that a physician will not prescribe narcotics or controlled substances for any patient in any circumstances. A blanket "no-prescribing" policy is an arbitrary, inflexible position that prevents physicians from exercising independent clinical judgment that takes into account the circumstances of the individual patient.

[33] https://www.canada.ca/en/health-canada/corporate/contact-us/office-controlled-substances.html

[34] Section 55(g) of the *CDSA*, *Narcotic Control Regulations*; Sections 7(1) and 61(2) of the *Benzodiazepines and Other Targeted Substances Regulations*, S.O.R./2000-217, enacted under the *CDSA*. These obligations are also set out in the College's Mandatory and Permissive Reporting policy.

Advice to the Profession: Prescribing Drugs

Advice to the Profession companion documents are intended to provide physicians with additional information and general advice in order to support their understanding and implementation of the expectations set out in policies. They may also identify some additional best practices regarding specific practice issues.

While prescribing drugs is a standard component of most physicians' practices, it is also a complex area of clinical care that requires appropriate knowledge, skill, and professional judgment.

This document is intended to help physicians interpret their obligations as set out in the *Prescribing Drugs* policy and to provide guidance for how these obligations can be effectively discharged. This document also seeks to provide physicians with practical advice for addressing common issues that arise in practice.

"Safer supply" opioid prescribing

"Safer supply" opioid prescribing is an emerging area of clinical practice that is grounded in the principles of harm reduction[1]. It refers to the direct delivery (prescribing) of prescription opioids to opioid-addicted patients as an alternative to the toxic street supply of illicit opioids.

While it can take many forms, safer supply opioid prescribing usually involves the prescribing of hydromorphone tablets that are consumed by patients without direct supervision by a health care professional.

While the College is generally supportive of harm reduction strategies, it is essential that these strategies minimize the risk of harm and not introduce unintended consequences that may negatively impact patients or the public. The need for caution is heightened in the absence of clinical practice guidelines or strong clinical evidence demonstrating the risks and benefits of a particular approach.

If considering safer supply opioid prescribing, physicians are reminded of the following expectations of the current *Prescribing Drugs* policy:

- practise within the limits of your clinical competence and/or scope of practice;

[1] "Harm reduction" refers to evidence-based, patient-centred approaches to care that seek to reduce the health and social harms associated with addiction and substance use but do not necessarily require people who use substances to abstain from them.

- demonstrate sound clinical judgment, taking into account the individual needs of each patient;
- consider and apply relevant practice standards, quality standards, and clinical practice guidelines, where they exist;
- where relevant practice standards, quality standards, and clinical practice guidelines do not exist, or in areas of medicine that are less developed, consider the best available indirect evidence, including clinical trials and evidence-based research to help inform consensus protocols or best practices;
- review previous interventions the patient has undergone; and
- explore the development of a comprehensive treatment plan that can help the patient while minimizing risks and unintended consequences (e.g., the risk of diversion).

Physicians are further reminded that the importance of careful documentation increases as care departs from recommended guidelines and/or moves into areas of medicine that are less developed.

Accessing patients' electronic prescription histories

The *Prescribing Drugs* policy requires that, prior to initiating a prescription for a narcotic or controlled substance, physicians **must** take reasonable steps to review the patient's prescription history (provision # 32, e).

As an example, the policy suggests (but does not require) that this could include reviewing electronic sources of information regarding the patient's prescription history (e.g., via provincial prescribing databases), where these are available.

The College is aware that many physicians do not currently have access to provincial clinical data repositories at the point of care; however, this reality is beginning to change: physicians in many parts of Ontario are now able to access valuable information about their patient's prescription histories electronically via the Digital Health Drug Repository (DHDR).

The DHDR supports authorized healthcare providers' secure electronic access to a patient's available drug and pharmacy service information, enabling prescribers to develop the best possible medication history at the point of care.

Information available via the DHDR currently includes:

- over eight years of information about dispensed publicly-funded drugs;
- over eight years of information about publicly-funded pharmacy services (e.g., Meds-Check program; influenza vaccinations); and
- over six years of information regarding all dispensed monitored drugs, including narcotics and controlled substances (when the approved identification used was a valid Ontario Health number).

The DHDR is currently available through two provincial clinical viewers:

1) ClinicalConnect[2] in **South West Ontario**, and
2) ConnectingOntario[3] in the **Greater Toronto Area** and **Northern** and **Eastern Ontario**.

For more information about the DHDR, including information on how to access these systems, please see the Digital Health Drug Repository Fact Sheet:
https://www.ehealthontario.on.ca/images/uploads/pages/documents/Medication_Records.pdf

The College will continue to monitor the landscape for new electronic sources of information regarding patient's prescription histories and will update this Advice Document to support safe and effective prescribing.

Considering prescription drug costs

Available research shows that a failure to consider prescription drugs costs at the point of care can have a variety of unintended negative consequences, including that:

- many prescriptions go unfilled because the patient is unable to afford them;
- many patients do not take their medications as prescribed due to cost; and
- high prescription drug costs are associated with increased clinic, emergency room visits, and hospitalizations.

For this reason, physicians may wish to consider on a proactive basis:

- the cost of the drugs they prescribe, and
- whether there is a therapeutically equivalent alternative that is available at a lower price.

This analysis will be particularly important when a physician has reason to believe that their patient may struggle to afford or be unable to pay for the drug being prescribed.

The College is aware that physicians do not currently have convenient or up-to-date access to information regarding the cost of prescription drugs. As resources become available to support physicians in considering prescription drugs, the College will seek to make these resources available.

[2] Clinical connect is a secure, web-based portal that gives health care providers real-time access to the patients' electronic medical information from all acute care hospitals, Local Health Integration Networks' (LHIN) Home and Community Care Services, and Regional Cancer Programs in South West Ontario, in addition to various provincial clinical data repositories.

[3] The Connecting Ontario Clinical Viewer is a secure, web-based portal that provides real-time access to digital health records including dispensed medications, laboratory results, hospital visits, Local Health Integration Networks' (LHIN) Home and Community Care Services, mental health care information, and diagnostic imaging reports and images.

Prescription treatment agreements (e.g., "narcotics prescribing contracts")

Prescription treatment agreements (sometimes called narcotics prescribing contracts) are formal and explicit written agreements between physicians and patients that delineate mutual expectations for continued prescribing.

Treatment agreements are usually employed to help promote compliance with an agreed-upon set of conditions for the continued prescribing of drugs with a potential for abuse, misuse, and diversion, such as prescription opioids.

As the proposed benefits of treatment agreements are limited by low-quality evidence, they are not currently required or endorsed by the CPSO nor are they recommended by the 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain; however, physicians may use them in keeping with their own professional judgment.

Where physicians elect to use treatment agreements in support of safe and effective prescribing, best practice would suggest using them as an educational tool, rather than a punitive one. In this way, treatment agreements may help to ensure that patients understand the circumstances in which they will or will not receive a prescription, while avoiding creating a power imbalance that could undermine the physician-patient relationship.

Reporting adverse drug reactions or medication incidents[4]

Physicians can help support the ongoing evaluation of prescription drug safety by reporting adverse drug reactions[5], suspected adverse drug reactions, and medication incidents[6] to the relevant organizations, especially those that are:

- unexpected, regardless of their severity;
- serious,[7] whether expected or not; and
- related to recently marketed health products (on the market for less than five years).

[4] In addition to reporting any adverse drug reactions or medication incidents, physicians can find additional requirements for reporting (as applicable) in the College's Disclosure of Harm policy.

[5] Adverse drug reactions are unwanted effects that happen when drugs are used under normal conditions. Adverse drug reactions are also called side effects. Adverse drug reactions are not medication incidents. Unlike a medication incident, an adverse drug reaction generally doesn't involve a mistake and typically can't be prevented.

[6] A medication incident is a mistake with medication, or a problem that could cause a mistake with medication. 'Medication error' is another name for one kind of medication incident. Medication incidents include obvious things like receiving the wrong medication or dose, but might also include problems like a confusing label that might lead to someone receiving the wrong medication.

[7] Health Canada's *Adverse Reaction Information* webpage describes a serious adverse drug reaction as one that requires in-patient hospitalization or prolongation of existing hospitalization, causes congenital malformation, results in persistent or significant disability or incapacity, is life-threatening or results in death. Adverse reactions that require significant medical intervention to prevent one of these listed outcomes are also considered to be serious.

Physicians can report adverse drug reactions to Health Canada's Vigilance Program at http://www.hc-sc.gc.ca/dhp-mps/medeff/vigilance-eng.php and medication incidents through the Institute for Safe Medication Practices Canada: https://www.ismp-canada.org/err_report.htm.

Physicians can also encourage their patients to report any medication incidents at http://www.safemedicationuse.ca.

Prescription drug disposal

Because most community pharmacies have procedures in place to safely dispose of patient returned medications (also called post-consumer waste), it is generally best practice for physicians to direct patients to their local pharmacy to return unused medication.

In circumstances where a physician takes possession of the patient's drugs directly or is in possession of any other types of medications (e.g., unused or expired medication samples), physicians can contact a drug disposal company to set up their own contract for safe disposal. Physicians may further consider arranging for the disposal of unused/expired/returned drug samples directly through the pharmaceutical representative or company that has provided them.

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: **In Camera Motion**

Date of Meeting: **December 5, 2019**

It is moved by_____,

and seconded by_____, that:

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

Report of the Finance and Audit Committee

Materials will be posted on November 26, 2019

Member Topics

No meeting materials

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: **By-law Amendments – election date**

Date of Meeting: **December __, 2019**

It is moved by _____,

and seconded by _____, that:

The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 133:

By-law No. 133

1. Section 12 of the General By-law is revoked and the following is substituted:

Election Date

12. (1) A regular election shall be held in,

(a) May or June 2020, and in every third year after that for Districts 5 and 10;

(b) May or June 2021, and in every third year after that for Districts 6, 7, 8 and 9; and

(c) May or June 2022, and in every third year after that for Districts 1, 2, 3 and 4.

(2) Subject to subsection (1), the council shall set the date for each election of members to the council.

Explanatory Note: - This by-law does not need to be circulated to the profession.

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: **2020 District Election Dates**

Date of Meeting: December

It is moved by_____,

and seconded by_____, that:

the Council approves the 2020 district election date set out below:

Districts 5 and 10: June 9, 2020

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: **By-law Amendment – election recounts**

Date of Meeting: **December 6, 2019**

It is moved by_____,

and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario proposes to make the following By-law No. 134, after circulation to stakeholders:

By-law No. 134

(1) Section 21 of the General By-law is revoked and the following is substituted:

Recounts

21. (1) A candidate may require a recount by giving a written request to the registrar no more than three business days after the date of an election and paying a fee of $500.

(2) The registrar shall hold the recount no more than thirty days after receiving the request.

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

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 2019

TOPIC: District Council Election Date

FOR DECISION

ISSUE:

- As part of continuous improvement and in an effort to reflect leading governance practices, Council is being asked to consider moving the timing of the College of Physicians and Surgeons of Ontario district Council elections from the Fall to the Spring.

BACKGROUND:

- The College's General By-law sets out timelines for the district Council elections and corresponding aspects of the process. Council had set the dates for the 2020 and 2021 district Council elections in February 2018.

- For the past number of years, elections have taken place in October and Council terms begin at the December Council meeting.

- Based on the observations over the past few years, this has resulted in a number of challenges:

    - To meet the timeframe of an October election, the nomination process must take place over the summer months when many members take vacation. We expect this may be resulting in fewer nominations submitted - in the case of the past few years, several acclamations in districts;

    - Incoming Council members have very little time to receive proper orientation before assuming their Council roles in December; and

    - There is a 14-day period in which any candidate may request a recount; this means the elections results are not official until closer to the end of October which leaves little time for incoming Council members to rearrange schedules and make arrangements to be available for the first Council meeting as well as Committee meetings.

- Following a review of this year's district Council election process, staff identified two opportunities to improve the process:

- Consider moving the elections to the Spring which would provide ample time for valuable orientation activities as well as rearranging schedules to accommodate Council and Committee meetings

- Shorten the 14-day period to request a recount to three business days, which would enable earlier communication of the official results (it is also important to note that since the introduction of electronic voting, there have not been any requests for a recount)

- Should the election be held in the Spring next year, the proposed dates for 2020 would be as follows:

Districts	Notice of Election	Deadline for Receipt of Nomination Papers	Distribution of On-line Ballot	Deadline for Voting
	60 Days Before Election	*49 Days Before Election*	*21 Days Before Election*	***Final Election Day***
5, 10	April 10	April 21	May 19	**June 9**

NEXT STEPS:

- Pending Council approval to move the Council elections to the Spring, the General By-law would be amended to enable this change beginning in 2020. The 2021 date for district Council elections will be considered and adjusted at a later date, likely after the 2020 elections are held.

- Pending Council approval to shorten the period to request a recount from 14 days to three business days, the proposed General By-Law amendment would need to be circulated to the profession and would come back to Council in March for final approval.

DECISIONS FOR COUNCIL:

- Does Council approve the proposed by-law amendments to move the district Council elections to the spring beginning in 2020?

- If so, does Council approve the proposed District Council Election dates for 2020?

- Does Council approve circulation of proposed by-law amendments to shorten the period to request a recount from 14 days to three business days?

CONTACT: Laurie Cabanas ext. 503

DATE: November 29, 2019

Council Briefing Note

December 2019

TOPIC: **2018-2019 Council Performance Assessment**

FOR DISCUSSION

ISSUE:

- Reflective of good governance practices, the College of Physicians and Surgeons of Ontario (CPSO) Council conducts an annual performance assessment to support ongoing development and continuous improvement of its governance.

- Council members recently completed the 2018-2019 Council Performance Assessment (Appendix A) and a summary of the results are being shared with Council members for discussion.

BACKGROUND:

- The CPSO Council has been conducting annual performance assessments since 2004 and has used the results to identify areas of improvement.

- This year, we enhanced the CPSO Council performance assessment to evaluate the following areas:
    - How well the Council met its strategic objectives
    - How well the Council conducted itself
    - Feedback regarding the Council President
    - How well Council members performed overall
    - How well individual Council members felt they contributed

- The performance assessment also gives Council members an opportunity to share qualitative comments after each section and suggest questions to include in future assessments.

- All Council members were invited to complete the performance assessment using an online tool.

- To encourage open and honest feedback, Council members were made aware that individual responses would remain anonymous and aggregated information would be reported.

- The results of the 2018-2019 Council Performance Assessment will be shared with Council and will inform the Governance Committee's work plan for 2019-2020.

FOR DISCUSSION:

1. What feedback do Council members have regarding the evaluation tool and process used to assess Council performance for 2018-2019?

2. What reflections do Council members wish to share regarding the results of the 2018-2019 Council Performance Assessment?

3. How can the Council Performance Assessment process be improved for next year?

Contact: Laurie Cabanas, ext. 503
Suzanne Mascarenhas, ext. 843

Date: November 18, 2019

Attachment:
Appendix A: 2018-2019 Council Performance Assessment

Council Performance Assessment 2018-2019

	Strongly Disagree			Strongly Agree
Has Council Met Its Strategic Objectives?				
1. Council is adequately involved in the process of developing the Strategic Plan.	1	2	3	4
2. Council ensures that the organization engages relevant stakeholders when considering strategic planning and advances in medical regulation.	1	2	3	4
3. The current Strategic Plan provides a clear set of relevant and realistic goals and strategic directions to the organization.	1	2	3	4
4. Council regularly monitors and evaluates progress towards strategic goals and directions	1	2	3	4
5. Council effectively oversees the development of the annual budget and financial plans for the organization	1	2	3	4
6. There is an effective process to inform Council about significant risk issues in a timely manner.	1	2	3	4
7. Council ensures that the organization communicates its performance and plans to its key stakeholders in an effective and transparent fashion.	1	2	3	4
How Does Council Conduct Itself?				
8. Council acts in the best interest of the public at all times.	1	2	3	4
9. Council understands and performs its governance role and allows management to handle operational issues.	1	2	3	4
10. Council meetings are well planned so that necessary Council business can be conducted.	1	2	3	4
11. Council balances its time well between considering future issues and dealing with current governance matters.	1	2	3	4
12. Council allocates time and resources effectively between important issues and those of lesser importance.	1	2	3	4
13. Council effectively uses evaluation tools to identify opportunities to make modifications in its governance processes.	1	2	3	4
14. Council uses in-camera sessions appropriately.	1	2	3	4
15. Council meeting materials are distributed to members with adequate time to prepare.	1	2	3	4
16. Council materials are sufficiently informative so that Council members can participate in discussions and make decisions.	1	2	3	4
How Effective is the President?				
17. The President facilitates the meetings effectively (i.e. starts and finishes on time, meets objectives).	1	2	3	4

APPENDIX A – COUNCIL PERFORMANCE ASSESSMENT

	Strongly Disagree			Strongly Agree
18. The President gains consensus in a respectful and engaging manner.	1	2	3	4
19. The President ensures that all members have an opportunity to voice his/her opinions during the meeting.	1	2	3	4
20. The President is skilled at managing different points of view and manages dissent well.	1	2	3	4
21. The President knows how to be direct with individual Council members when their behaviour needs to change.	1	2	3	4
22. The President demonstrates good listening skills and summarizes discussion points well in order to facilitate decision- making.	1	2	3	4
How Do the majority of Council Members Perform?				
23. Most Council members actively participate in important Council discussions.	1	2	3	4
24. Most Council members are open to and encourage different points of view.	1	2	3	4
25. Most Council members are collaborative and effective in making decisions by consensus.	1	2	3	4
26. Most Council members ask constructive questions and express their views in a respectful manner.	1	2	3	4
27. Most Council members respect the confidentiality of in-camera discussions.	1	2	3	4
28. Most Council members have sufficient diversity of skills, experience and backgrounds for good governance.	1	2	3	4
29. New Council members receive adequate orientation to prepare them to contribute effectively to the Council.	1	2	3	4
30. Council members receive frequent continuing education and training.	1	2	3	4
How Do I Perform as a Council Member?				
31. I am familiar with and follow the College's by-laws, governance practices and policies.	1	2	3	4
32. I read the minutes, reports and other materials in advance of our Council meetings so that I can actively participate in discussion and decision- making.	1	2	3	4
33. I frequently encourage other Council members to express their opinions.	1	2	3	4
34. I maintain the confidentiality of Council discussions as indicated.	1	2	3	4
35. When I have a different opinion than the majority, I raise it.	1	2	3	4
36. I stay informed about issues relevant to our mission and vision and bring information to the attention of the Council.	1	2	3	4

37. What are 2 strengths of the Council?

38. What are 2 areas of improvement for the Council?
39. The 2018-2019 Council Performance Assessment has been revised since last year. Do you have any suggested questions or ideas for improving the Council Performance Assessment for next year?

Should you wish to provide your name after completion of the survey, it is optional.

Council Motion

Motion Title: 2019-2020 Committee Nominations

Date of Meeting: December ___ 2019

It is moved by_____,

and seconded by_____, that:

The Council appoints the following people to the following committees for the terms indicated below:

Discipline Committee:

PHYSICIAN COUNCIL MEMBERS:	
Dr. Philip Berger	1 year
Dr. Michael Franklyn	1 year
Dr. Deborah Hellyer	1 year
Dr. Paul Hendry	1 year
Dr. Peeter Poldre	1 year
Dr. Ian Preyra	1 year
Dr. John Rapin	1 year
Dr. Robert (Bob) Smith	1 year
Dr. Andrew Turner	1 year
PUBLIC MEMBERS OF COUNCIL:	
Mr. Pierre Giroux	1 year
Mr. Mehdi Kanji	1 year
Mr. John Langs	1 year
Mr. Paul Malette	1 year
Ms. Ellen Mary Mills	1 year
Mr. Peter Pielsticker	1 year
Ms. Gerry Sparrow	1 year

Ms. Christine Tebbutt	1 year
NON-COUNCIL PHYSICIAN MEMBERS:	
Dr. Ida Ackerman	1 year
Dr. Heather-Ann Badalato	3 years
Dr. Steven Bodley	1 year
Dr. Pamela Chart	1 year
Dr. Carole Clapperton	1 year
Dr. Melinda Davie	1 year
Dr. Paul Garfinkel	1 year
Dr. Kristen Hallett	1 year
Dr. Stephen Hucker	1 year
Dr. William L.M. King	1 year
Dr. Barbara Lent	1 year
Dr. Bill McCready	1 year
Dr. Veronica Mohr	1 year
Dr. Joanne Nicholson	1 year
Dr. Terri Paul	1 year
Dr. Dennis Pitt	1 year
Dr. Robert Sheppard	1 year
Dr. Eric Stanton	1 year
Dr. Yvonne Verbeeten	1 year
Dr. James Watters	1 year
Dr. Susanna Yanivker	1 year

Finance and Audit Committee:

PHYSICIAN COUNCIL MEMBERS:	
Dr. Brenda Copps	1 year
Dr. Rob Gratton	1 year
Dr. Akbar Panju	1 year
PUBLIC MEMBERS OF COUNCIL:	
Mr. Harry Erlichman	1 year
Mr. Pierre Giroux	1 year
Mr. Peter Pielsticker	1 year
NON-COUNCIL PHYSICIAN MEMBER:	
Dr. Thomas Bertoia	1 year

Fitness to Practise Committee:

PHYSICIAN COUNCIL MEMBER:	
Dr. Deborah Hellyer	1 year
PUBLIC MEMBERS OF COUNCIL:	
Mr. John Langs	1 year
Ms. Christine Tebbutt	1 year
NON-COUNCIL PHYSICIAN MEMBERS:	
Dr. Steven Bodley	1 year
Dr. Pamela Chart	1 year
Dr. Carole Clapperton	1 year

Dr. Melinda Davie	1 year
Dr. Paul Garfinkel	1 year
Dr. Stephen Hucker	1 year
Dr. Barbara Lent	1 year
Dr. Bill McCready	1 year
Dr. Dennis Pitt	1 year
Dr. Robert Sheppard	1 year
Dr. Eric Stanton	1 year
Dr. James Watters	1 year

Governance Committee:

PHYSICIAN COUNCIL MEMBERS:	
Dr. Brenda Copps	1 year
Dr. Akbar Panju	1 year
Dr. Peeter Poldre	1 year
XXX-Physician Member of Council	1 year
PUBLIC MEMBERS OF COUNCIL:	
XXX-Public Member of Council	1 year
XXX-Public Member of Council	1 year

Inquiries, Complaints and Reports Committee:

PHYSICIAN COUNCIL MEMBERS:	
Dr. Rob Gratton	1 year
Dr. Haidar Mahmoud	1 year
Dr. Akbar Panju	1 year
Dr. Judith Plante	1 year
Dr. Jerry Rosenblum	1 year
Dr. David Rouselle	1 year
PUBLIC MEMBERS OF COUNCIL:	
Mr. Shahid Chaudhry	1 year
Mr. Harry Erlichman	1 year
Ms. Joan Fisk	1 year
Ms. Catherine Kerr	1 year
Ms. Judy Mintz	1 year
NON-COUNCIL PHYSICIAN MEMBERS:	
Dr. Haig Basmajian	1 year
Dr. George Beiko	1 year
Dr. Mary Jane Bell	1 year
Dr. Brian Burke	1 year
Dr. Bob Byrick	1 year
Dr. Anil Chopra	1 year
Dr. Paula Cleiman	3 years
Dr. Nazim Damji	1 year
Dr. Naveen Dayal	1 year

Dr. Mary Jean Duncan	1 year
Dr. Gil Faclier	1 year
Dr. Thomas Faulds	1 year
Dr. Daniel Greben	1 year
Dr. Andrew Hamilton	1 year
Dr. Christine Harrison	1 year
Dr. Elaine Herer	1 year
Dr. Robert Hollenberg	1 year
Dr. John Jeffrey	1 year
Dr. Carol Leet	1 year
Dr. Edith Linkenheil	1 year
Dr. Jane Lougheed	1 year
Dr. Edward Margolin	1 year
Dr. Dale Mercer	1 year
Dr. Robert Myers	1 year
Dr. Anita Rachlis	1 year
Dr. Val Rachlis	1 year
Dr. Michael Rogelstad	1 year
Dr. Dori Seccareccia	1 year
Dr. Lynne Thurling	1 year
Dr. Anne Walsh	1 year
Dr. Donald Wasylenki	1 year
Dr. Stephen White	1 year
Dr. Stephen Whittaker	1 year
Dr. Lesley Wiesenfeld	1 year
PHYSICIAN MEDICAL ADVISORS:	
Dr. Angela Carol	1 year
Dr. Ben Chen	1 year
Dr. Ted Everson	1 year
Dr. Keith Hay	1 year
Dr. Mary Manno	1 year
Dr. Peter Prendergast	1 year
Dr. Nathan Roth	1 year
Dr. Michael Szul	1 year
Dr. Jim Wilson	1 year

Patient Relations Committee:

NON-COUNCIL PHYSICIAN MEMBERS:	
Dr. Rajiv Bhatla	1 year
Dr. Heather Sylvester	1 year
Dr. Angela Wang	1 year
Dr. Diane Whitney	3 years
NON-LGIC PUBLIC MEMBERS:	
Ms. Lisa McCool-Philbin	1 year

Premises Inspection Committee:

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PHYSICIAN COUNCIL MEMBERS:	
Dr. Jerry Rosenblum	1 year
Dr. Andrew Turner	1 year
PUBLIC MEMBERS OF COUNCIL:	
Mr. Peter Pielsticker	1 year
NON-COUNCIL PHYSICIAN MEMBERS:	
Dr. Timea Belej-Rak	3 years
Dr. Steven Bodley	1 year
Dr. Andrew Browning	1 year
Dr. Patrick Davison	1 year
Dr. Bill Dixon	1 year
Dr. Marjorie Dixon	1 year
Dr. Mark Mensour	1 year
Dr. Gillian Oliver	1 year
Dr. Holli-Ellen Schlosser	1 year
Dr. Robert Smyth	3 years
Dr. James Watson	1 year
Dr. Ted Xenodemetropoulos	1 year
NON-LGIC PUBLIC MEMBERS:	
Dr. El-Tantawy Attia, PhD	1 year
Mr. Ron Pratt	1 year

Quality Assurance Committee:

PHYSICIAN COUNCIL MEMBERS:	
Dr. Michael Franklyn	1 year
Dr. Deborah Hellyer	1 year
Dr. Sarah Reid	1 year
Dr. Patrick Safieh	1 year
Dr. Robert (Bob) Smith	1 year
PUBLIC MEMBERS OF COUNCIL:	
Mr. John Langs	1 year
Mr. Paul Malette	1 year
Ms. Ellen Mary Mills	1 year
Mr. Peter Pielsticker	1 year
NON-COUNCIL PHYSICIAN MEMBERS:	
Dr. Steven Bodley	1 year
Dr. Lisa Bromley	1 year
Dr. Jacques Dostaler	1 year
Dr. Miriam Ghali Eskander	1 year
Dr. Hugh Kendall	1 year
Dr. Ken Lee	1 year
Dr. Meredith MacKenzie	1 year
Dr. Deborah Robertson	1 year
Dr. Ashraf Sefin	1 year
Dr. Tina Tao	1 year

Dr. Smiley Tsao	1 year
Dr. Janet van Vlymen	1 year

Registration Committee:

PHYSICIAN COUNCIL MEMBERS:	
Dr. Akbar Panju	1 year
Dr. Judith Plante	1 year
PUBLIC MEMBERS OF COUNCIL:	
Mr. Harry Erlichman	1 year
Mr. Pierre Giroux	1 year
NON-COUNCIL PHYSICIAN MEMBERS:	
Dr. Bob Byrick	1 year
Dr. Barbara Lent	1 year
Dr. Kim Turner	1 year

Council Briefing Note

December 2019

TOPIC: Governance Committee Report

FOR DECISION:
Nominations:
1. **2019-2020 Governance Committee Election**
2. **Committee Membership Appointments for 2019-2020**

FOR INFORMATION:
3. **Completion of Annual Declaration of Adherence Form**

FOR DECISION:

Nominations:

1. 2019- 2020 Governance Committee Election

ISSUE:

- There will be an election for one physician member and two public members for the 2019-2020 Governance Committee (if more than one physician member is nominated and more than 2 public members are nominated).
- Two nominations have been received for one physician member position:
    - Dr. Haidar Mahmoud
    - Dr. Jerry Rosenblum
- Two nominations have been received for two public member positions:
    - Mr. Mehdi Kanji
    - Mr. John Langs
- Nomination Statements are included in *Appendix A*.

DECISION FOR COUNCIL:

1. Vote, if applicable, for elected positions for 2019-2020 Governance Committee; 1 physician member and 2 public members on the Council. If applicable, appoint acclaimed nominees to the Governance Committee.

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2. Committee Membership Appointments for 2019-2020

- The Governance Committee is responsible for recruiting committee members and for making nomination recommendations for committee and chair positions.
- The Governance Committee has made recommendations for committee appointments/reappointments for the 2019-2020 Council term*. (Appendix B)*
- For 2019-2020 committee appointments, the Governance Committee recommends 3-year committee appointments for newly appointed non-council committee members and 1-year committee appointments for all other committee members to efficiently phase in 2020 committee succession plans.
- The proposed committee membership rosters *(Appendix B)* consider a number of factors including skills, expertise, as well as committee membership succession planning; recognizing the 9-year term limit (9 years on any one committee and 18 years for Council and committees combined), approved by Council at its September meeting.
- The Chair of the Governance Committee and members of the governance team have met with committees and committee support staff to ensure that every committee can meet statutory requirements and other obligations set out in the College's governing legislation and by-laws.
- Recruitment for non-Council members to fill expected 2019-2020 committee vacancies took place over the summer months.
- As a result, the Governance Committee selected qualified non-Council members to be interviewed by relevant committee Chairs. Particular attention is taken to avoid candidates with potential apprehension of bias and conflicts.
- Non-council members who are recommended by the Chairs and the Governance Committee for committee appointment are presented to Council on the proposed rosters for committee appointment.
- Interviews with selected committee candidates are ongoing. It is anticipated that there may be further recommendations for 2019-2020 committee appointments.

DECISION FOR COUNCIL:

1. Election of nominated committee members to committees as set out in *Appendix B*.

FOR INFORMATION:

3. Completion of Annual Declaration of Adherence Form for 2019-2020

- Council members are asked to read, sign and submit your completed annual *Declaration of Adherence Form* for 2019-2020. Please provide staff with your completed *Declaration of Adherence Form* by the adjournment of the Council meeting on December 6, 2019.
- The purpose of signing the annual Declaration of Adherence Form is to ensure that all members of Council understand and adhere to our legislative obligations and respect the by-laws and policies applicable to the Council including the following:
    - Statement on Public Interest
    - Council Code of Conduct
    - Conflict of interest Policy
    - Impartiality in Decision-Making Policy
    - Confidentiality Policy
    - Role Description of a College Council Member
- The relevant governance policies and General By-Law are provided as an electronic link on the *Declaration of Adherence Form (Appendix C)*.

For Completion:

1. All Council members are asked to print, sign and submit their annual Declaration of Adherence Form *(Appendix C)* at the December Council meeting.

Contact: Steven Bodley, Chair, Governance Committee
Laurie Cabanas, ext. 503
Debbie McLaren, ext. 371
Marcia Cooper, ext. 546

Date: November 15, 2019

Attachments:

Appendix A: Memo re: Nomination/Election Process for 2019-2020 Governance Committee Vote at Council meeting; includes Nomination Statements for: Dr. Haidar Mahmoud, Dr. Jerry Rosenblum, Mr. Mehdi Kanji and Mr. John Langs
Appendix B: Proposed 2019-2020 Committee Membership Roster
Appendix C: 2019-2020 Declaration of Adherence Form

Appendix A

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

MEMORANDUM

To: All Council Members

From: Dr. Steven Bodley, Chair, Governance Committee

Date: **October 23, 2019**

Subject: **Nomination/Election Process for vote at the December Council Meeting for elected positions on the 2019-2020 Governance Committee**

At the upcoming Council meeting in December, there will be a process for selecting the three elected positions on the 2019-2020 Governance Committee.

The three elected positions are: one physician member on Council who is not a member of the Executive Committee, and two public members on Council who are not members of the Executive Committee.

The *General By-Law 44-(3)* states the mandate of the Governance Committee:
44-(3) The Governance Committee shall,

(a) monitor the governance process adopted by the Council and report annually to the Council on the extent to which the governance process is being followed;
(b) consider and, if considered advisable, recommend to the Council changes to the governance process;
(c) ensure nominations for the office of president and vice-president
(d) make recommendations to the Council regarding the members and chairs of committees; and
(e) make recommendations to the Council regarding any other officers, officials or other people acting on behalf of the College.

Please refer to the Governance Process Manual for role descriptions and key behavioural competencies that are necessary to fill the positions.

All Council members who wish to be nominated for an elected position on the Governance Committee are invited to submit a brief **Nomination Statement.** The **Nomination Statement** will include brief biographical information and a CPSO photo, or alternatively, you may submit your own photo. Nomination Statements will be circulated to all Council members prior to the December Council meeting and will be included in the Governance Committee Report to Council.

Nomination Statements will assist Council members to identify candidates who are running for election, and provide more information regarding a candidate's background, qualifications and reasons for running for a Governance Committee position.

In addition, to the **Nomination Statement**, a completed ***Nomination Form*** is due on the first day of the Council meeting to validate Council's support of candidates. Each nomination requires the signatures of a nominator, a seconder, and the agreement of the nominee. All voting members of Council are eligible to nominate or second a candidate's nomination. A Council contact list will be provided for you to facilitate your communication with Council members.

If you wish to be nominated for a 2019-2020 Governance Committee position, please contact Debbie McLaren, dmclaren@cpso.on.ca to obtain a Nomination Statement template.

For your reference, a list of the current composition of the 2019 Governance Committee, a list of the proposed non-elected 2019-2020 Governance Committee members, as per the General By-Law, and a list of the 2019-2020 Executive Committee membership are attached.

1. **The deadline for submission of your completed Nomination Statement is Friday, November 8, 2019 at 5:00 p.m.**
2. **The deadline to submit your completed *Nomination Form* is Thursday, December 5, 2019, prior to the commencement of the Council meeting.**
3. **The vote (if applicable) will take place at the Council meeting on Friday, December 6, 2019.**

Election Process:

1. If there is more than one nomination for the position of physician member and/or more than two nominations for the positions of public member on the Governance Committee, a vote will take place at the December Council meeting.

2. Each nominee will have the opportunity to address Council, if they wish, for a maximum of two minutes about his/her candidacy for the position before the vote takes place. Audio/visual presentations will not be accepted.

3. 2019-2020 Council members will vote for Governance Committee positions.

If you have any questions regarding the nomination process, please contact Debbie McLaren, dmclaren@cpso.on.ca or 416-967-2600, ext. 371/1-800-268-7096, ext. 371).

Thank you,

S.C. Bodley, MD, FRCPC
Chair, Governance Committee

att.

2019 (current) Governance Committee:	**Proposed 2019-2020 Governance Committee:**
Dr. Steven Bodley, (Past President), Chair ♦×	Dr. Peeter Poldre, (Past President), Chair ♦×
Dr. Peeter Poldre, (President) ♦	Dr. Brenda Copps, (President)♦
Dr. Brenda Copps, (Vice President) ♦	Dr. Akbar Panju, (Vice President)♦
Dr. Jerry Rosenblum, (has served for 2 years)	Physician member of Council (voted by Council)*
Mr. John Langs, (has served for 3 years)	Public member of Council (voted by Council)*
Ms. Joan Powell, (has served for 2 years, 9 months)	Public member of Council (voted by Council)*

♦The Governance Committee is composed of, the president, the vice-president and a past president as per the *General By-Law 44.-(1)(a)*

*A physician member of Council and two public members of Council who are appointed by Council at the annual meeting, and are not members of the Executive Committee as per the *General By-Law 44.-(1)(b) and 44.-(1)(c)*

*A past president chairs the Governance Committee as per the *General By-Law, 44(2)*

2019-2020 Executive Committee:
(appointed by Council at the May 2019 Council meeting)

(Physician member and two public members (below) who will be members on the 2019-2020 Executive Committee are not eligible for the 2019-2020 Governance Committee)

Dr. Brenda Copps, (President)
Dr. Akbar Panju, (Vice President)
Dr. Judith Plante, (Physician Member)
Ms. Ellen Mary Mills, (Public Member)
Mr. Peter Pielsticker, (Public Member)
Dr. Peeter Poldre, (Past President)

Governance Committee
Nomination Form for Physician Members

I, _____ am willing to be
Print name here

nominated as a Physician Member on the Governance Committee.

Signed by: _____ _____
Signature of Nominee ***Date***

Nominated by: _____ _____
Signature ***Date***

Seconded by: _____ _____
Signature ***Date***

Governance Committee
Nomination Form for Public Members

I, _____ am willing to be
Print name here

nominated as a Public Member on the Governance Committee.

Signed by: _____ _____
Signature of Nominee ***Date***

Nominated by: _____ _____
Signature ***Date***

Seconded by: _____ _____
Signature ***Date***

NOMINATION STATEMENT
CANDIDATE FOR PUBLIC MEMBER, GOVERNANCE COMMITTEE

MR. MEHDI KANJI

Public Member of Council
Richmond Hill, Ontario

Occupation:
Principle, MK Consulting (current)
Project Director, Courthouse Development Projects (retired)

Appointed Council Terms:
2018 – 2021

CPSO Committees and Other CPSO Work:

Discipline Committee:	2018-2019

NOMINATION STATEMENT:

Although I am new to the College, I have been immersed into the business of the College, especially through my involvement on the Discipline Committee, that I have found both rewarding and challenging.

I have spent my professional career in the public sector with the Ontario Government in several ministries (including the Ministry of Health and Long Term Care). I have held various management and leadership positions in human resources management, policy development, stakeholder management, labour relations, and in public/private partnerships in infrastructure development leading professionals and projects with focus on team collaboration and high quality deliverables.

I believe I can make a significant contribution to the Governance Committee with my diversity of experiences and competencies as the College moves forward with its journey on governance review.

I would very much appreciate your support for my nomination on the Governance Committee for the coming year.

NOMINATION STATEMENT
CANDIDATE FOR PUBLIC MEMBER, GOVERNANCE COMMITTEE

MR. JOHN LANGS

Public Member of Council
Toronto, Ontario

Occupation: Lawyer

Appointed Council Terms:
2014 – 2017
2017 – 2020

CPSO Committees and Other CPSO Work:

Discipline Committee:	2014 - 2019
Fitness to Practise Committee:	2018 - 2019
Governance Committee	2016 - 2019
Outreach Committee:	2015 - 2019
Quality Assurance Committee:	2014 - 2019
Policy Working Group : *Accepting New Patients / Ending the Physician-Patient Relationship*	2015 - 2017
Policy Working Group: *Protecting Personal Health Information*	2018 - present

NOMINATION STATEMENT:

Again, I am asking for your support for my nomination to the Governance Committee.

As noted above, I was first elected to the Committee in 2016. Since that time, the College has been responding to both internal and external forces, has both anticipated and been fully engaged in the modernization process related to Regulated Professions.

To the extent that the change can be implemented without amendments to our governing legislation, changes are well underway. The timing of the required changes to our governing legislation is unknown and not within our control. However, if, and when, such changes are enacted, the Committee will be in an excellent position to respond to carry out it's modernization strategy.

I would welcome the opportunity to continue serving on the Governance Committee using my experience over the past few years, as well as my experience having served on several Governance Committees of other organizations.

NOMINATION STATEMENT
CANDIDATE FOR PHYSICIAN MEMBER, GOVERNANCE COMMITTEE

DR. HAIDAR MAHMOUD

District 10 Representative
Toronto, Ontario

Principal Area of Practice or Specialty:
Obstetrics and Gynecology

Elected Council Terms:
2014-2017
2017-2020

CPSO Committees and Other CPSO Work:

Inquiries, Complaints and Reports Committee:	2014 - 2019
Peer Assessor:	2004 - 2014 (as non-Council member)

NOMINATION STATEMENT:

As a District 10 Council member, I am exceptionally committed to the Council, ensuring the provision of the highest quality service.

My ICRC involvement developed my communication and leadership, as I critically engaged with policy and governance issues. As a safeguard, the ICRC allows the highest calibre of provided service, ensuring physicians and the public are protected and treated fairly. The implemented policies reflect the best interests of the physician community.

Education and betterment are crucial to stay ahead of any changes. The debate surrounding medically assisted death was a pivotal moment, allowing me to contribute to the development of healthcare, crucially engaging in governance and policy making. My Masters Certification on Patient Safety and Quality Assurance positioned me to ensure that we keep striving towards excellence.

Along with my experiences as Departmental Chief, I will bring real and achievable goals by properly planning successful program implementation, maintaining the standard of practice. My commitment to the CPSO's values will allow me to continue providing the highest quality services that will meet the needs of the public and our members as they develop, as I serve on the Governance Committee.

NOMINATION STATEMENT
CANDIDATE FOR PHYSICIAN MEMBER, GOVERNANCE COMMITTEE

DR. JERRY ROSENBLUM

District 3 Representative
Waterloo, Ontario

Principal Area of Practice or Specialty:
Anesthesiology

Elected Council Terms:
2013-2016
2016-2019
2019-2022

CPSO Committees and Other CPSO Work:

Finance and Audit Committee	2014 – 2018
Governance Committee	2017 -- 2019
Inquiries, Complaints and Reports Committee	2013 – 2019 2010 – 2013 (as non-council member)
Outreach Committee	2014 – 2019
Premises Inspection Committee	2017 – 2019
Patient Relations Committee	1996 – 2000 (as non-council member)
Peer Assessor	2004 – 2010 (as non-council member)
Policy Review Working Group: *Medical Records*	2018 – present

NOMINATION STATEMENT:

The Governance Committee is currently in the process of governance reform. Much but not all of the non-legislative changes have been approved by Council. The legislative changes we have proposed to government are still being studied by the MOH, and once accepted, will have to be implemented by the CPSO. There remains much work to be done.

I am asking for re-election to the Governance Committee for another year, and I believe I am still uniquely qualified to sit on this committee. Continuity in membership is crucial to ensure this process is completed. My previous two terms has given me the knowledge and experience to contribute effectively on this and other governance issues.

As well I am entering my seventh year on Council, and continue to sit on ICRC and PIC. I have previously served on Outreach (one year as chair) and Finance, and have been a peer assessor for many years. My organizational, communication and analytic skills, and my passion for governance make me an ideal candidate for this position. I have proven to be capable of meeting the challenges ahead.

It will be an honour and privilege to continue to serve on the Governance Committee in 2020.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
PROPOSED 2019-2020 Committee Membership *Rev. 2019-11/25*

Appendix B

DISCIPLINE COMMITTEE:

PHYSICIAN COUNCIL MEMBERS:	
Dr. Philip Berger	
Dr. Michael Franklyn	
Dr. Deborah Hellyer	
Dr. Paul Hendry	
Dr. Peeter Poldre	
Dr. Ian Preyra	
Dr. John Rapin	
Dr. Robert (Bob) Smith	
Dr. Andrew Turner	

PUBLIC MEMBERS OF COUNCIL:	
Mr. Pierre Giroux	
Mr. Mehdi Kanji	
Mr. John Langs	
Mr. Paul Malette	
Ms. Ellen Mary Mills	
Mr. Peter Pielsticker	
Ms. Gerry Sparrow	
Ms. Christine Tebbutt	

NON-COUNCIL PHYSICIAN MEMBERS:	
Dr. Ida Ackerman	
Dr. Heather-Ann Badalato	*3-year appointment*
Dr. Steven Bodley	
Dr. Pamela Chart	
Dr. Carole Clapperton	
Dr. Melinda Davie	Co-chair
Dr. Paul Garfinkel	
Dr. Kristen Hallett	
Dr. Stephen Hucker	
Dr. William L.M. King	
Dr. Barbara Lent	
Dr. Bill McCready	
Dr. Veronica Mohr	
Dr. Joanne Nicholson	
Dr. Terri Paul	
Dr. Dennis Pitt	
Dr. Robert Sheppard	
Dr. Eric Stanton	Co-chair

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
PROPOSED 2019-2020 COMMITTEE MEMBERSHIP

NON-COUNCIL PHYSICIAN MEMBERS: (continued)
Dr. Yvonne Verbeeten
Dr. James Watters
Dr. Susanna Yanivker

EXECUTIVE COMMITTEE:

PHYSICIAN COUNCIL MEMBERS:	
Dr. Brenda Copps	President, Chair
Dr. Akbar Panju	Vice President
Dr. Judith Plante	
Dr. Peeter Poldre	Past President
PUBLIC MEMBERS OF COUNCIL:	
Ms. Ellen Mary Mills	
Mr. Peter Pielsticker	

FINANCE and AUDIT COMMITTEE:

PHYSICIAN COUNCIL MEMBERS:	
Dr. Brenda Copps	
Dr. Rob Gratton	
Dr. Akbar Panju	
PUBLIC MEMBERS OF COUNCIL:	
Mr. Harry Erlichman	
Mr. Pierre Giroux	
Mr. Peter Pielsticker	Chair
NON-COUNCIL PHYSICIAN MEMBER:	
Dr. Thomas Bertoia	

FITNESS TO PRACTISE COMMITTEE:

PHYSICIAN COUNCIL MEMBER:	
Dr. Deborah Hellyer	Chair
PUBLIC MEMBERS OF COUNCIL:	
Mr. John Langs	
Ms. Christine Tebbutt	

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
PROPOSED 2019-2020 COMMITTEE MEMBERSHIP

NON-COUNCIL PHYSICIAN MEMBERS:
Dr. Steven Bodley
Dr. Pamela Chart
Dr. Carole Clapperton
Dr. Melinda Davie
Dr. Paul Garfinkel
Dr. Stephen Hucker
Dr. Barbara Lent
Dr. Bill McCready
Dr. Dennis Pitt
Dr. Robert Sheppard
Dr. Eric Stanton
Dr. James Watters

GOVERNANCE COMMITTEE:

PHYSICIAN COUNCIL MEMBERS:	
Dr. Brenda Copps	
Dr. Akbar Panju	
Dr. Peeter Poldre	Chair
Physician Member of Council	*To be elected by Council at Dec AGM*
PUBLIC MEMBERS OF COUNCIL:	
Public Member of Council	*To be elected by Council at Dec AGM*
Public Member of Council	*To be elected by Council at Dec AGM*

INQUIRIES, COMPLAINTS AND REPORTS COMMITTEE:

PHYSICIAN COUNCIL MEMBERS:	
Dr. Rob Gratton	Vice Chair, Obstetrical Panels
Dr. Haidar Mahmoud	
Dr. Akbar Panju	Vice Chair, Internal Medicine Panels
Dr. Judith Plante	Vice Chair, Family Practice Panels
Dr. Jerry Rosenblum	
Dr. David Rouselle	Co-Chair

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
PROPOSED 2019-2020 COMMITTEE MEMBERSHIP

PUBLIC MEMBERS OF COUNCIL:	
Mr. Shahid Chaudhry	
Mr. Harry Erlichman	
Ms. Joan Fisk	Vice Chair, General Panels
Ms. Catherine Kerr	
Ms. Judy Mintz	

NON-COUNCIL PHYSICIAN MEMBERS:	
Dr. Haig Basmajian	
Dr. George Beiko	
Dr. Mary Jane Bell	
Dr. Brian Burke	Co-Vice Chair, Settlement Panels
Dr. Bob Byrick	
Dr. Anil Chopra	Co-Chair
Dr. Paula Cleiman	*3-year appointment*
Dr. Nazim Damji	
Dr. Naveen Dayal	
Dr. Mary Jean Duncan	
Dr. Gil Faclier	
Dr. Thomas Faulds	
Dr. Daniel Greben	
Dr. Andrew Hamilton	Vice Chair, Surgical Panels
Dr. Christine Harrison	
Dr. Elaine Herer	
Dr. Robert Hollenberg	
Dr. John Jeffrey	
Dr. Carol Leet	
Dr. Edith Linkenheil	
Dr. Jane Lougheed	
Dr. Edward Margolin	
Dr. Dale Mercer	
Dr. Robert Myers	
Dr. Anita Rachlis	
Dr. Val Rachlis	
Dr. Michael Rogelstad	
Dr. Dori Seccareccia	
Dr. Lynne Thurling	
Dr. Anne Walsh	
Dr. Donald Wasylenki	
Dr. Stephen White	

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
PROPOSED 2019-2020 COMMITTEE MEMBERSHIP

NON-COUNCIL PHYSICIAN MEMBERS: (continued)	
Dr. Stephen Whittaker	
Dr. Lesley Wiesenfeld	Vice Chair, Mental Health & Health Inquiry Panel
PHYSICIAN MEDICAL ADVISORS: (CPSO Staff)	
Dr. Angela Carol	
Dr. Ben Chen	
Dr. Ted Everson	
Dr. Keith Hay	
Dr. Mary Manno	
Dr. Peter Prendergast	
Dr. Nathan Roth	
Dr. Michael Szul	
Dr. Jim Wilson	

PATIENT RELATIONS COMMITTEE:

NON-COUNCIL PHYSICIAN MEMBERS:	
Dr. Rajiv Bhatla	
Dr. Heather Sylvester	
Dr. Angela Wang	
Dr. Diane Whitney	*3-year appointment*
NON-LGIC PUBLIC MEMBERS:	
Ms. Lisa McCool-Philbin	Chair

PREMISES INSPECTION COMMITTEE:

PHYSICIAN COUNCIL MEMBERS:	
Dr. Jerry Rosenblum	
Dr. Andrew Turner	
PUBLIC MEMBERS OF COUNCIL:	
Mr. Peter Pielsticker	
NON-COUNCIL PHYSICIAN MEMBERS:	
Dr. Timea Belej-Rak	*3-year appointment*
Dr. Steven Bodley	
Dr. Andrew Browning	
Dr. Patrick Davison	
Dr. Bill Dixon	

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
PROPOSED 2019-2020 COMMITTEE MEMBERSHIP

NON-COUNCIL PHYSICIAN MEMBERS: (continued)	
Dr. Marjorie Dixon	
Dr. Mark Mensour	
Dr. Gillian Oliver	Chair
Dr. Holli-Ellen Schlosser	
Dr. Robert Smyth	*3-year appointment*
Dr. James Watson	
Dr. Ted Xenodemetropoulos	
NON-LGIC PUBLIC MEMBERS:	
Dr. El-Tantawy Attia, PhD	
Mr. Ron Pratt	

QUALITY ASSURANCE COMMITTEE:

PHYSICIAN COUNCIL MEMBERS:
Dr. Michael Franklyn
Dr. Deborah Hellyer
Dr. Sarah Reid
Dr. Patrick Safieh
Dr. Robert (Bob) Smith

PUBLIC MEMBERS OF COUNCIL:
Mr. John Langs
Mr. Paul Malette
Ms. Ellen Mary Mills
Mr. Peter Pielsticker

NON-COUNCIL PHYSICIAN MEMBERS:	
Dr. Steven Bodley	
Dr. Lisa Bromley	
Dr. Jacques Dostaler	
Dr. Miriam Ghali Eskander	
Dr. Hugh Kendall	Co-chair
Dr. Ken Lee	
Dr. Meredith MacKenzie	
Dr. Deborah Robertson	Co-chair
Dr. Ashraf Sefin	
Dr. Tina Tao	
Dr. Smiley Tsao	
Dr. Janet van Vlymen	

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
PROPOSED 2019-2020 COMMITTEE MEMBERSHIP

REGISTRATION COMMITTEE:

PHYSICIAN COUNCIL MEMBERS:	
Dr. Akbar Panju	**Chair**
Dr. Judith Plante	
PUBLIC MEMBERS OF COUNCIL:	
Mr. Harry Erlichman	
Mr. Pierre Giroux	
NON-COUNCIL PHYSICIAN MEMBERS:	
Dr. Bob Byrick	
Dr. Barbara Lent	
Dr. Kim Turner	

Please submit your completed *Declaration of Adherence Form* at the Council meeting on December 5 and 6, 2019 to Council Administration Staff.

Appendix C

Declaration of Adherence Form for Members of Council - 2019-2020

I acknowledge that, as a **member of Council** of the College of Physicians and Surgeons of Ontario:

I have read and am familiar with the College's By-laws General By-Law and governance policies. Governance Process Manual [1]

- I stand in a fiduciary relationship to the College.
- I am bound to adhere to and respect the By-laws and policies applicable to the Council, including without limitation, the following:

- Statement on Public Interest
- Council Code of Conduct
- Conflict of Interest Policy
- Impartiality in Decision Making Policy
- Confidentiality Policy
- Role Description of College Council Member
-
- I am aware of the obligations imposed upon me by Sections 36 (1) (a) through 36 (1) (k) of the *Regulated Health Professions Act, 1991*.
- I have also read Section 40 (2) of the *Regulated Health Professions Act*, 1991, a copy of which is attached to this undertaking, and understand that it is an offence, carrying a maximum fine on conviction for a first offence of $25,000.00, and a fine of not more than $50,000 for a second or subsequent offence to contravene subsection 36 (1) of the *Regulated Health Professions Act, 1991*. I understand that this means in addition to any action the College or others may take against me, I could be convicted of an offence if I communicate confidential information in contravention of subsection 36 (1) of the *Regulated Health Professions Act, 1991*, and if convicted, I may be required to pay a fine of up to $25,000.00 (for a first offence), and a fine of not more than $50,000 for a second or subsequent offence.

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

Signature: _____

Print Name: _____

Date: _____

[1] See Governance Process Manual, pages 58-76 for governance policies listed, and pages 9-12 for Role Description of a College Council Member.

Council Briefing Note

December 2019

TOPIC: Governance Modernization

FOR INFORMATION/DISCUSSION

ISSUE:

- This briefing note outlines:
    1) The status of the work of legislative and non-legislative changes to modernize the CPSO's governance structures and practices.
    2) By-Law Amendments – Term Limits and Exceptional Circumstances Provision
    3) Eligibility Practice Criteria – Update
    4) College Advisory Groups - Update

FOR INFORMATION:

Legislative Governance Changes

- At its December 2018 meeting, Council approved the following recommendations of the Governance Review Working Group:

    - Increase public member representation so there are equal numbers of physician and public members on the board;
    - Reduce the size of the board from 34 to between 12 – 16 members;
    - Eliminate overlap between board and statutory committee membership;
    - Implement a competency-based board selection process;
    - Implement a hybrid selection model for physician members;
    - Provide equal compensation for physician and public members of the board; and
    - Retain the option of appointing an Executive Committee.

- The CPSO sent a letter outlining these recommended legislative changes to the Minister on January 25, 2019, which followed a similar letter sent by College of Nurses. The CPSO

continues to advocate for these changes in collaboration with the College of Nurses of Ontario (CNO), Federation of Health Regulatory Colleges of Ontario (FHRCO) and the Citizen Advisory Group (CAG). It is possible that the current government could use its authority either to enact regulations under its current regulation-making authority or to propose new legislation. Below are current updates from the Ministry's office and CAG.

- The College has had productive meetings with the Deputy Minister Helen Angus, ADM Patrick Dicerni, as well as contacts through the Premier's Office where our red tape and governance modernization recommendations continue to be well-received. As we work to keep these recommendations on the agenda with decision-makers through the fall, we anticipate providing Council with a fulsome government relations update in December.

- In May 2019, CAG was asked to consider the College's proposed process for appointing members to the CPSO Council. The CAG was presented with a comprehensive overview of the proposed changes as regards to board size, composition, and a competency-based selection process. Overall, CAG members were supportive of the proposed changes, noting that they appeared to be sound, effective and efficient, and an improvement over the current process. Members were particularly pleased with the move to a more transparent process and expansion of the diversity of professional experience (medical and other professional skills) on the board. Several members made strong arguments for having individuals with 'lived patient experience' on the board.

- The CAG was asked also asked to consider the hybrid model for selecting board members. Most members were not in favor of this model as, in their view, it added an unnecessary additional layer of complexity for little gain. There was concern that the inclusion of an election component would weaken the ability to attain a diverse, competency-based board, and not serve the public interest.

<u>Non-Legislative Governance Changes</u>

- Appendix A tracks progress on Council-approved non-legislative governance changes that were recommended by Council in December 2018 and tabled with the Governance Committee in February 2019.

FOR DISCUSSION

By-Law Amendments – Term Limits and Exceptional Circumstances Provision

- In September 2019, Council approved the following changes which impact various Committees within the CPSO.

By Law Amendment	Implementation Date
Lengthen Committee appointments to up to 3 years (with the exception of Executive, Governance and Finance & Audit Committees)	December 2019
Apply the following term limits to Council and Committee members (excludes LGIC public members): - 9-yr limit on Council - 9-yr limit on any one Committee - 18-yr limit on Council and all Committees combined	December 2020
Exceptional Circumstances Provision To ensure that Committees and Council are not destabilized by the changes, the Council approved a provision to allow a member's appointment to exceed applicable term limits in situations that would significantly impact the stability or effective functioning of a Committee	Immediate

- While the eligible practice criteria proposed by-law amendment was discussed, Council felt that it required further exploration, so it was not approved at the September meeting. The Committee will continue to examine the definition of 'eligible practice' and how it can best be applied to enhance Council and Committee effectiveness.

- Prior to, and following the Council meeting, the Governance Team used a variety of communication strategies to share information about changes to the appointments and reappointments process as they relate to the by-law amendments. These include but are not limited to:

    - attending various Committee business meetings to speak to by-law amendments and address questions from Committee members
    - providing support and advice to Committee support staff including templates and assisting with co-designing Committee implementation plans.

- Although the application of term limits will take effect next year, Committee support staff proactively identified who will be impacted, recognizing that there needs to be mentoring and effective knowledge transfer to ensure continuity during the transition period.

- It has been clearly communicated that where Committees may experience significant challenges with either recruitment or expertise, the Exceptional Circumstances provision is available to bridge the gap until the Committee can find a solution. The use of this provision is available for Committees to use not only during the transition period, but into the future as well.

- The Governance Committee Chair emailed all Chairs and Co-Chairs in mid-September advising of the governance modernization recommendations, while emphasizing:

    - The need for Chairs/Co-Chairs to communicate with respective Non-Council Committee members about proposed changes;
    - The impact of changes may vary by Committee and Committee support staff have developed customized implementation plans for future discussions with Chairs (including discussions about succession planning and the effective functioning of Committees during the transition); and
    - The recruitment process could provide a pool of qualified candidates for Council and Committee to support succession planning.

- Members who have performance issues or have indicated that they would like to transition off for personal reasons, should not be reappointed and that it would be appropriate for the Chair to have a conversation with the member to provide the feedback and arrive at a mutual decision to transition off the Committee.

NEXT STEPS:

The Governance Team continues to work closely with the Chair of the Governance Committee and Committee support staff to:

- Communicate changes and refine succession plans with the Chair/Co-Chairs of respective committees to enable a seamless transition;
- Develop resources and processes for:
    - seeking exceptional circumstances;
    - clarifying expectations of Committee Chairs and Committee members; and
    - mentoring and facilitating knowledge transfer between seasoned and newer members.

FOR INFORMATION:

College Advisory Groups

- At its September meeting Council approved by-law amendments to remove the Council Award Selection and Education Committees as standing committees. Both will continue as Advisory Groups (Council Award Selection Advisory Group and Education Advisory Group). In preparation for upcoming Advisory Group meetings in November, Terms of Reference were developed for both groups with a clear and concise mandate, updated responsibilities and similar member composition as when they were standing committees.

- In developing the Terms of Reference, consideration was given to some of the other ad hoc groups that exist within the organization, such as:

    - Policy Working Groups, which have been convened from time to time to oversee many policy reviews, particularly those dealing with more controversial or difficult issues. Unique Working Groups would be comprised for individual reviews. The Working Group's role is to consider research, feedback and other sources of information in order to provide direction on how policies should be revised or what expectations should be developed. These activities would take place over a number of in-person and/or teleconference meetings and require the review of materials in advance of the meeting. The products of the Working Group would then be presented to the Executive Committee and Council for consideration and approval, with members of the Working Group acting as stewards of the products.

    - Policy Redesign Working Group, which was convened to oversee and provide direction in relation to the Policy Redesign Process.

    - Policy Review Working Group, which is essentially the Policy Redesign Working Group repurposed. With the policy redesign work completed, members are participating in a pilot project to conduct an evaluation of having a single, consolidated Policy Review Working Group that provides feedback and direction on multiple policy reviews that are underway. The product of the Working Group will again be presented to the Executive Committee and Council for consideration and approval, with members of the Working Group acting as stewards of the products. If the pilot project is successful, the intention is to seek Council's endorsement of this approach and to more formally delineate composition, eligibility criteria, and succession planning.

- Because these Working Groups require significant time commitments and engagement in the content, along with responsibility for stewarding the policies through the approvals process, members have been compensated at the normal rate for their time.

- The two new Advisory Groups will be compensated as well to ensure consistency among ad hoc groups.

Contact: Laurie Cabanas, ext. 503
Suzanne Mascarenhas, ext. 843

Date: November 14, 2019

Attachments:

Appendix A: Non-Legislative Changes – Progress to-date

Appendix A

Table 1: Non-legislative governance changes

Recommendations Council Meeting – December 2018	Rationale	Actions/Implications Early 2019	December 2019 Progress
1) Board Member Orientation and Education **a.** Enhance board orientation and education to reinforce and support role and focus of Council		The goals of the new 2019 Orientation and Education program are to: 1) Provide orientation/education on an ongoing basis; 2) Consolidate materials so it is always accessible; 3) Separate orientation and education and tailor it based on member experience; and 4) Provide education on specific issues.	The 2020 Orientation and Education program focuses on goals outlined in 2019 and a framework has been developed with short- and long-term deliverables. The program continues to be enhanced with the following considerations: • Engaging President and Governance Committee in ensuring effectiveness; • Timing content and delivery to align with key milestones for Council; • Delivering bite-size learning throughout the year rather than information overload; • Ensuring variety in format, content and presenters; • Canvasing Council members for knowledge gaps and education needs; • Seeking feedback from new Council members to adapt and adjust content as needed; and • Providing orientation to technology, devices or other software required for Council.

Recommendations Council Meeting – December 2018	Rationale	Actions/Implications Early 2019	December 2019 Progress
b. Build competencies of current board members to align with research re. board effectiveness.	Consistent with move to competency-based boards.		Phased approach through governance modernization
(2, 3 and 4) **Avoid putting new physician council members on statutory committees. If they are needed on a statutory committee to fulfill a quorum requirement put them on DC, instead of ICR.**	• Separation of statutory committees and the board seems inevitable. Implementing this now will help with workload and enable us to change the membership of committees.	-Sarah Reid (new physician member) has been appointed to Education Committee. -Hilary Alexander (new public member) has been appointed to ICRC -Christine Tebbutt (new public member) has been appointed to DC and FTP -This cannot be implemented until we have new physician council members -Council members to focus on board, board committees (GC, Finance&Audit, Executive) and DC/ICR. -Move away from appointing Council members to any other committees. -Transition existing Council members off other committees. -Increased focus on populating statutory committees with non-Council members. This will require increased focus on recruitment. **<u>Question for consideration</u>**: Should this recommendation also include a plan to gradually reduce the number of professional members on statutory committees, where it is possible to do so?	-Ian Preyra (new physician member) has been appointed to the Discipline Committee. -New Council members are requested to provide their Committee interest and the Governance Committee will be advised as such.

Recommendations Council Meeting – December 2018	Rationale	Actions/Implications Early 2019	December 2019 Progress
5) Policy Working Group Structure • Consider policy working group structure and whether working groups could be consolidated into a single working group or committee with a mandate to support and contribute to policy development and review.	• Policy working group structure contributes to delays (5 working groups currently comprised of busy Council members).	• Current proposal to create a small policy WG to oversee the policy redesign project. • Existing policy WGs will continue. • Once policy redesign is complete, process and structure to be evaluated.	• The Policy Redesign Working Group was convened to oversee and provide direction in relation to the Policy Redesign Process. With that work completed, the Working Group has been repurposed (and renamed) in order to conduct an evaluation of having a single, consolidated Policy Review Working Group that provides feedback and direction on *multiple* policy reviews that are underway.
6) Operating* (Standing) Committees Review ***Note: (Operating Committees will be reflected as "Standing" Committees in future communication)***	• This will free up members to focus on/be available for statutory committees where there are quorum requirements.	• Review the mandates of by-law committees. • Consider decreasing the number of committees overall.	• Removal of Education, Council Award Selection and Outreach Standing Committees • Creation of Education Advisory Committee and Council Award and Selection Advisory Committee with TORs • Mandate of Outreach Committee incorporated into Executive Committee
7) Focus on Diversity • Recruitment targets for committees to ensure we have members that are representative of the broader population • Build cultural competence of board members	• Diversity in board membership is a best practice that has been found to promote innovation. • Improvements can be made to	• Begin with a breakdown of an analysis of Council diversity. Compare to other organizations, general population and targets in other sectors. • Develop a plan to recruit for under-represented characteristics.	• This year's focus on recruitment of Non-Council Committee members was strongly enhanced and focused predominantly on diversity and an emphasis on role qualifications and

Recommendations Council Meeting – December 2018	Rationale	Actions/Implications Early 2019	December 2019 Progress
• Consider ways in which technological advancements could promote flexibility in scheduling and allow members to take part in meetings remotely.	the current composition of Council with respect to age, career stage, gender and cultural diversity, to ensure the board is reflective of the population.	• Council/committee meeting modernization discussions are underway.	time commitments on respective committees • New technology at the College will promote member flexibility in virtual meeting attendance and promote flexibility in scheduling

Council Briefing Note

December 2019

TOPIC: Council Orientation and Education

FOR INFORMATION

ISSUE:

- This briefing note provides Council members with the 2020 Council Orientation and Education Overview *(Appendix A).*

CONSIDERATIONS:

- Our 2020 overview will focus on Council key milestones and responsibilities and potential education topics will align with our strategic plan and ongoing governance modernization work. Just-in-time learning continues to be a reigning mentality of today's world and continues to be functional for College-specific issues at various times in the year.

- In reviewing best practices, there are several considerations that will be ongoing as the College updates its current program:

    - Engaging President and Governance Committee in ensuring effectiveness;
    - Timing content and delivery to align with key milestones for Council;
    - Delivering bite-size learning throughout the year rather than information overload;
    - Ensuring variety in format, content and presenters;
    - Canvasing Council members for knowledge gaps and education needs;
    - Seeking feedback from new Council members to adjust content as needed; and
    - Providing orientation to technology or software required for Council.

FOR INFORMATION: 2020 Council Orientation and Education Overview

Contact: Laurie Cabanas, ext. 503
Suzanne Mascarenhas, ext. 843

Date: November 14, 2019

Attachment:
Appendix A: 2020 Council Orientation and Education Overview

Appendix A

2020 Council Orientation and Education Overview

	January/February	March/April	May/June	September/October	November/December
Council Key Milestones and Responsibilities	• *Proposed: Provide notice for Council Elections* • Onboard new Council members and Committee members • Discuss transitions for members leaving	• *Proposed: Nominations for Council Elections*	• *Proposed: Council Elections*	• *Proposed: New Council Member Orientation*	• Appoint new Council members • Conduct Council performance assessment • Conduct Registrar performance assessment
Proposed Deliverables	• Orientation for Council and Committee members • Training Session for Committee Chairs	• Education Day • Council Meeting • Orientation for Public Members	• Council Retreat • Council Meeting	• Council Meeting • Proposed: Orientation for new Council and Committee members	• Council Meeting
Potential Educational Topics	• Council Roles and Responsibilities • Effective Stakeholder Engagement	• Governance Modernization • Select a topic suggested by Council members	• Risk Management • Partnering with Patients	• Performance Management of CEO and Council	• Setting Goals/Learning from Failure • Select a topic suggested by Council members