CPSO

Meeting of Council

December 3 & 4, 2020

CPSO

NOTICE

OF

MEETING OF COUNCIL

A virtual meeting of the College of Physicians and Surgeons of Ontario (CPSO) will take place on Thursday, December 3 and Friday, December 4, 2020. Due to the current pandemic situation, an in-person meeting at a physical location will not be held.

The meeting will be conducted by remote communication and streamed live. Members of the public who wish to observe the meeting can register on CPSO's website using the online registration. Instructions for accessing the meeting will be sent to those who register.

The meeting will convene at 9:00 am on December 3, 2020.

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

Council Meeting Agenda

December 3-4, 2020

THURSDAY, DECEMBER 3, 2020

Item	Time	Topic and Objective(s)	Purpose	Page Number
1	9:00am	**Call to Order and Welcoming Remarks** (B. Copps) • Welcome Council members and guests, conduct roll call and declare any conflicts of interest • Introduce staff who are joining the meeting	Discussion	**N/A**
2	9:35am	**Consent Agenda** (B. Copps) **2.1 Approve Council meeting agenda** **2.2 Approve minutes from Council held September 10 and 11, 2020** **2.3 Items for information:** • Executive Committee Report • Discipline Committee Report • Government Relations Report • Policy Report • Annual Committee Reports	 Approval Approval Information	 **7** **9** **21** **22** **28** **32** **48**
3	9:40am	**CEO/Registrar's Report** (N. Whitmore)	Discussion	**N/A**
4	10:25am	**President's Report** (B. Copps) • Update on key initiatives including the Continuity of Care Guide for Patients and Caregivers	Discussion	**80**
*	10:40am	**NUTRITION BREAK**		
5	11:00am	**Policy Review Kick-off – Professional Obligations and Human Rights, Medical Assistance in Dying and Planning for and Providing Quality End-of-Life Care** (C. Roxborough, M. Cabrero Gauley, L. Kirshin) • Engage early in CPSO's process to review and update the three subject policies *Council members will need to have access to their CPSO e-mail account to participate*	Discussion	**102**

Item	Time	Topic and Objective(s)	Purpose	Page Number
6	12:15pm	**Motion to Go in Camera**	Decision	112
*	12:15pm	**LUNCH**		
*	1:15pm	**IN CAMERA**		
7	2:00pm	**Budget 2021** (P. Pielsticker) • Discuss the Finance and Audit Committee recommendations to Council in December • Present a proposed by-law amendment to the fees for approval	Decision	113
8	2:15pm	**Member Topics**	Discussion	N/A
*	2:25pm	**NUTRITION BREAK**		
9	2:45pm	**eLearning Program Overview** (L. Rinke-Vanderwoude/D. Bowlby) • Review and discuss the outline the proposed eLearning Program for prospective Council and Committee members	Decision	127
10	3:00pm	**Declaration of Adherence** (L. Rinke-Vanderwoude/M. Cooper) • Consider for approval the proposed changes to the Declaration of Adherence	Decision	141
11	3:40pm	**Registration Pathways** (S. Tulipano) • Consider for approval the proposed changes to the Alternatives Pathways to Registration policies	Decision	197
12	4:15pm	**COUNCIL AWARD PRESENTATION** (P. Berger) • Celebrate the achievements of Dr. Najma Ahmed from Toronto		213
13	4:30pm	**Motion to Go in Camera** (B. Copps)	Decision	214
14	4:35pm	**Adjournment Day 1** (B. Copps)	N/A	N/A
*	4:40 pm	**IN CAMERA**		

FRIDAY, DECEMBER 4, 2020

Item	Time	Topic and Objective(s)	Purpose	Page
15	**9:00am**	**Call to Order** (B. Copps) • Participate in roll call and declare any conflicts of interest	Discussion	**N/A**
16	**9:10am**	**Guest Presentation: Diversity, Equity and Inclusion** (Dr. Javeed Sukhera) • Learn some foundational concepts about diversity, equity and inclusion and its importance to CPSO's mandate		
*	**10:40am**	**NUTRITION BREAK**		
17	**11:00am**	**Skills and Diversity Matrix** (L. Cabanas) • Provide feedback on the skills and diversity matrix that has been developed to enhance diversity on Council and Committees	Discussion	**217**
18	**11:15am**	**Key Performance Indicators for 2021** (N. Whitmore) • Discuss and consider proposed Key Performance Indicators for 2021	Decision	**221**
*	**12:00pm**	**LUNCH**		
19	**1:00pm**	**Complementary and Alternative Medicine Policy** (J. van Vlymen) • Discuss draft policy and consider its release for external consultation	Decision	**239**
20	**1:30pm**	**Council Elections** (L. Cabanas, M. Cooper) 1. District Election Dates for 2021 2. Eligibility Criteria 3. Nominations Review Process	 Decision Decision Discussion	 **261** **263** ***Materials to follow***
*	**2:20pm**	**NUTRITION BREAK**		
21	**2:40pm**	**Advertising – Revised Policy for Final Approval** (L. Miljan) • Council is asked to approve the revised Advertising policy as a policy of the College	Decision	**273**
22	**3:10pm**	**Committee Mentoring Program** (S. Mascarenhas, D. Bowlby) • Review and consider approving the new mentoring program for committee members	Decision	**291**

Item	Time	Topic and Objective(s)	Purpose	Page
23	**3:25pm**	**Governance Committee Report** (P. Poldre) 1. Governance Committee Election 2. Request for Exceptional Circumstances 3. 2021-2022 Chair Appointments 4. Committee Appointment(s) *Council members will need to have access to their CPSO e-mail account to participate*	Decision	**321** **327** *#3 & #4 Materials to follow*
24	**3:55pm**	**President's Items** (B. Copps) 1. Acknowledge Outgoing Council Members (20 min) 2. Presidential Address (10 min) 3. Induction of New President (5 min) 4. Welcome Incoming Council Members (15 min)	Discussion	**N/A**
*	**4:45pm**	**Adjournment Day 2** (B. Copps) • Reminder that the next meeting is scheduled for March 4-5, 2021	Discussion	**N/A**
*	**4:50pm**	**Meeting Reflection Session** (B. Copps) • Share observations about the effectiveness of the meeting and engagement of Council members	Discussion	**N/A**

Council Motion

Motion Title: Council Meeting Consent Agenda

Date of Meeting: December 3, 2020

It is moved by_____,

and seconded by_____, that:

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

- The Council meeting agenda for December 3-4, 2020
- The minutes from Council held September 10-11, 2020
- Items for information:
    - Executive Committee Report
    - Discipline Committee Report
    - Government Relations Report
    - Policy Report
    - Committee Annual Reports

or

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

- The Council meeting agenda for December 3-4, 2020
- The minutes from Council held September 10-11, 2020
- Items for information:
    - Executive Committee Report
    - Discipline Committee Report
    - Government Relations Report
    - Policy Report
    - Committee Annual Reports

With the following corrections:

September 10, 2020

Attendees:

Dr. Brenda Copps (President)
Dr. Philip Berger
Mr. Shahid Chaudhry
Mr. Jose Cordeiro
Ms. Joan Fisk
Dr. Michael Franklyn
Mr. Murthy Ghandikota
Mr. Pierre Giroux
Dr. Rob Gratton
Dr. Deborah Hellyer
Dr. Paul Hendry
Ms. Nadia Joseph
Mr. Mehdi Kanji
Ms. Catherine Kerr
Dr. Haidar Mahmoud
Mr. Paul Malette
Dr. Lydia Miljan, PhD
Mr. Peter Pielsticker
Dr. Judith Plante
Dr. Peeter Poldre
Dr. Ian Preyra
Dr. John Rapin
Dr. Sarah Reid
Dr. Jerry Rosenblum
Dr. David Rouselle
Dr. Patrick Safieh
Dr. Elizabeth Samson
Dr. Robert A. Smith
Dr. Andrew Turner
Dr. Janet van Vlymen
Ms. Shannon Weber

Non-Voting Academic Representatives on Council Present:
Dr. Mary Bell, Dr. Terri Paul and Dr. Karen Saperson

1. Call to Order and Welcoming Remarks

Dr. Brenda Copps called the meeting to order at 12:00 p.m. and welcomed members of Council and guests to the virtual Council meeting. B. Copps then gave a traditional land acknowledgement statement as a demonstration of recognition and respect for Indigenous peoples. B. Copps reminded attendees of the new strategic plan for 2020-2025.

2. Consent Agenda

01-C-09-2020

It is moved by P. Safieh, and seconded by D. Hellyer, that:

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

- The Council meeting agenda for September 10-11, 2020
- The minutes from Council held May 28, 2020
- Items for information:
  - Discipline Committee Report
  - Diversity, Equity and Inclusion Initiative
  - Executive Committee Report
  - Government Relations Report

- Policy Report
- Office of Chief Forensic Pathologist
- Reserve Fund Policy

CARRIED

3. Quality Improvement Program

02-C-09-2020

It is moved by S. Chaudhry and seconded by J. Fisk that:

1. The Council approves the Quality Improvement Program to continue proceeding as described by staff and in alignment with what was outlined when Council approved the 2020-2025 Strategic Plan.

2. The Council confirms it will continue to maintain oversight of the Quality Improvement Program and monitor outcomes through the reporting of Key Performance Indicators on a regular basis.

CARRIED

4. Staff Introductions

L. Cabanas, Director of Governance and Policy introduced members of the senior management team and other key staff in the meeting.

5. Registrar's Report

Dr. Nancy Whitmore, Registrar, presented her report on the progress that is being made on key CPSO initiatives. Dr. Whitmore shared updates about the CPSO's quality improvement program, engagement activities with the public and profession, system collaborations, and other updates.

N. Whitmore noted that there are an unprecedented number of physicians running for the upcoming elections for Districts 5 and 10, which closes on September 29.

There were several process improvement updates, including:

- The launching of Solis, the new member portal, on September 14, over five weekly phases;
- Vault, the in-house document management system, was launched for the Policy and Communications departments on August 31. The rest of the College will launch over the next few months;
- The College exceeded the target for process improvements;
- Regarding complaints and investigations

  - The number of ongoing cases has dropped by 70% since the start of 2018; the number of complaints over 365 days has fallen by 92% in the last 18 months;
  - Around 45% of files are resolved through early resolution including alternate dispute resolution (ADR) - there has been positive feedback from participants in ADR;
  - The time to contact a complainant has decreased (from 21 days in 2018 to 2 days);
  - Time to complete complaints has decreased;
- Regarding Discipline Committee cases
  - David Wright is joining in mid-November as Chair and will run the Hearings Office;
  - The time to disclosure has dropped since 2019;
  - 16 of 19 decisions released this year have been made earlier than the benchmark of 13 weeks;
  - 18 virtual hearings were conducted during the pandemic.

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

6. President's Report

B. Copps provided some key updates to Council.

Some members expressed a desire for more engagement and participation in discussions about key issues. The Telemedicine policy undergoing review will be discussed later today for Council's input at an earlier stage in the process.

B. Copps noted that a new staff member is being hired to assist public members of Council in terms of remuneration and engagement with the Ministry.

B. Copps said goodbye to two public members, Mr. John Langs and Ms. Ellen Mary Mills whose appointment terms ended. She welcomed Ms. Shannon Weber who was recently appointed by the Minister of Health.

She congratulated Nathalie Novak, Chief Transformation Officer and the entire Transformation Office on the launch of Vault, the document management system. Solis will launch on September 14, 2020.

There is an upcoming virtual meeting with Ms. Cathy Fooks, the new Patient Ombudsman, who has a mandate to help improve the quality of care and supports people receive in hospitals, long-term care homes and in their own homes through home and community care.

7. Governance Committee Report

P. Poldre, Chair of the Governance Committee, introduced the following items:

7.1 Committee Chair/Vice-Chair Model

03-C-09-2020

It is moved by J. Fisk and seconded by M. Kanji, that:

The Council approves the Committee Chair/Vice-Chair model, for which each Committee will have a Chair and a Vice-Chair appointed from among members of the Committee, with a 2-year term for each position, such model to become effective as of the close of the Annual General Meeting of Council in December 2020.

CARRIED

7.2 Election of 2020-2021 Academic Representatives on Council

04-C-09-2020

It is moved by P. Safieh, and seconded by R. Smith, that:

Council accepts the recommended slate of 2020-2021 voting academic representatives:

- Dr. Janet van Vlymen, (Queen's University)
- Dr. Paul Hendry, (University of Ottawa)
- Dr. Roy Kirkpatrick (Northern Ontario School of Medicine)

CARRIED

7.3 2020-2021 Chair Appointments

05-C-09-2020

It is moved by P. Pielsticker, and seconded by S. Chaudhry, that:

The Council appoints the following committee members as Chairs, Acting Chair and Specialty Chairs of the following committees as of the close of the Annual General Meeting of Council in December 2020:

Committee	Proposed Chair for 2021	Term (years)
Executive	Dr. Judith Plante	1
Finance & Audit	Dr. Thomas Bertoia (N/C)	2
Fitness to Practise	Dr. Deborah Hellyer	2
Governance	Dr. Brenda Copps	1
Inquiries, Complaints and Reports	Dr. Anil Chopra (N/C) **Proposed 2021 Specialty Chairs**	2

Committee	Proposed Chair for 2021	Term (years)
	Dr. Brian Burke, (N/C) Settlement	2
	Ms. Joan Fisk, General	2
	Dr. Rob Gratton, Obstetrical	2
	Dr. Andrew Hamilton, (N/C) Surgical	2
	Dr. Thomas Faulds, (N/C) Family Practise	2
	Dr. Anita Rachlis, (N/C) Internal Medicine	2
	Dr. Lesley Wiesenfeld, (N/C) Mental Health & HIP	2
Patient Relations	Ms. Sharon Rogers, (N/C)	2
Premises Inspection	Dr. Gillian Oliver, (N/C)	2
Quality Assurance	Dr. Janet van Vlymen	2
Registration	Dr. Barbara Lent, (N/C), Acting Chair	1

CARRIED

7.4 Request for Exceptional Circumstances

J. Rosenblum declared a conflict for this item and left the meeting until the next agenda item.

06-C-09-2020

It is moved by P. Safieh, and seconded by L. Miljan, that:

The Council approves, in principle, that the exceptional circumstances clause in Section 37(8) of the General By-law be applied in respect of the following member of the Inquiries, Complaints and Reports Committee when the member's appointment expires at the Annual General Meeting of Council in December 2020:

Inquiries, Complaints and Reports Committee
Dr. Jerry Rosenblum

CARRIED

J. Rosenblum returned to the meeting.

7.5 Committee Appointment

P. Poldre reminded Council that Dr. Trevor Bardell was appointed to to the Inquiries, Complaints and Reports Committee at the June 23, 2020 Executive Committee Meeting and Ms. Shannon Weber was appointed as a public member of Council on August 13, 2020 for one year.

8. Overview of Policy Process

Craig Roxborough, Manager of Policy, reviewed the policy development and review process and the role of Council in the process.

9. Telemedicine Policy Review Kick-off

Tanya Terzis, Policy Analyst, gave an overview of the current Telemedicine policy and discussed the upcoming review and update of the policy. Council discussed their experiences of providing or receiving virtual care and thoughts on key issues to focus on during the review.

10. Members' Topics

There were no topics contributed from Council members for the meeting.

In absence of any items to discuss, B. Copps welcomed Dr. Brendan Lew from the Professional Association of Residents of Ontario to share an update on relevant initiatives underway at his organization.

11. Council Award Presentation

Dr. David Rouselle, Council Member, presented the Council Award to Dr. Stephanie Milone and Dr. Stephen Milone of Orangeville.

Adjournment Day 1

B. Copps adjourned the meeting at 4:40 pm.

September 11, 2020

Attendees:

Dr. Brenda Copps (President)
Dr. Philip Berger
Mr. Shahid Chaudhry
Mr. Jose Cordeiro
Ms. Joan Fisk
Dr. Michael Franklyn
Mr. Murthy Ghandikota
Mr. Pierre Giroux
Dr. Rob Gratton
Dr. Deborah Hellyer
Dr. Paul Hendry
Ms. Nadia Joseph
Mr. Mehdi Kanji
Ms. Catherine Kerr
Dr. Haidar Mahmoud
Mr. Paul Malette
Dr. Lydia Miljan, PhD
Mr. Peter Pielsticker
Dr. Judith Plante
Dr. Peeter Poldre
Dr. Ian Preyra
Dr. John Rapin
Dr. Sarah Reid
Dr. Jerry Rosenblum
Dr. David Rouselle
Dr. Patrick Safieh
Dr. Elizabeth Samson
Dr. Robert A. Smith
Dr. Andrew Turner
Dr. Janet Van Vlymen
Ms. Shannon Weber

Non-Voting Academic Representatives on Council Present:

Dr. Mary Bell, Dr. Terri Paul and Dr. Karen Saperson

12. Call to Order

Dr. Brenda Copps called the meeting to order at 9:00 am and welcomed members of Council and guests to the second day of the virtual Council meeting.

B. Copps introduced Ushma Purohit, the current President-Elect of the Ontario Medical Students Association (OMSA) to provide an update on relevant initiatives underway at her organization.

13. Guest Presentation: Physician Burnout

Dr. Ken Milne is the Chief of Staff at South Huron Hospital Association and Adjunct Professor in the Department of Medicine and Department of Family Medicine at the Schulich School of Medicine and Dentistry. Dr. Milne engaged Council members in a dynamic presentation about the various system factors that contribute to the problem of physician burnout and shared some strategies to address it.

14. Third Party Medical Reports

07-C-09-2020

It is moved by I. Preyra, and seconded by L. Miljan, that:

The College engage in the consultation process in respect of the draft policy "Third Party Medical Reports" (a copy of which forms **Appendix "B"** to the minutes of this meeting).

CARRIED

15. Executive Committee Elections

B. Copps introduced P. Poldre to facilitate elections for 2020-2021 Executive Committee.

There was no election for any position on the Executive Committee; all members were acclaimed. Each of Dr. Judith Plante (President for the 2021 Council term), Dr. Janet van Vlymen (Vice President), Dr. Robert Gratton, Ms. Joan Fisk, and Mr. Peter Pielsticker made brief remarks.

P. Poldre noted that Ms. Ellen Mary Mils was not reappointed to Council. In order to fill the current vacancy, he asked Council to appoint Ms. Fisk to the Executive Committee commencing immediately rather than in December when her term was expected to begin.

08-C-09-2020

It is moved by P. Pielsticker and seconded by S. Chaudhry, that:

The Council approves Ms. Joan Fisk's term as Executive Member Representative on Executive Committee to start immediately.

CARRIED

09-C-09-2020

It is moved by D. Hellyer, and seconded by L. Miljan, that:

The Council appoints Dr. Judith Plante (as President), Dr. Janet van Vlymen (as Vice President), Dr. Robert Gratton (as Executive Member Representative), Ms. Joan Fisk (as Executive Member Representative), Mr. Peter Pielsticker (as Executive Member Representative), and Dr. Brenda Copps (as Past President), to the Executive Committee for the year that commences with the adjournment of the annual general meeting of Council in December 2020, except that Joan Fisk's term of office will commence immediately.

CARRIED

16. Delegation of Controlled Acts

10-C-09-2020

It is moved by J. Fisk, and seconded by L. Miljan, that:

The College engage in the consultation process in respect of the draft policy "Delegation of Controlled Acts" (a copy of which forms **Appendix "C"** to the minutes of this meeting).

CARRIED

17. Council Award Presentation

Dr. Andrew Turner, Council Member, presented the Council Award to Dr. Nicole Laferriere of Thunder Bay, Ontario.

18. Motion to Go In Camera

11-C-09-2020

It is moved by P. Safieh, and seconded by J. Rosenblum, that:

The Council exclude the public from the part of the meeting immediately after the open meeting of Council adjourns, under clauses 7(2)(b) of the Health Professions Procedural Code.

CARRIED

19. CPSO Presidential Compensation

B. Copps and J. Plante declared conflicts and left the meeting for this item.

12-C-09-2020

It is moved by S. Chaudhry, and seconded by I. Preyra, that:

The President's annual stipend be increased to $45,000 effective for the 2020 CPSO year and for the policy to be reviewed on a three-year cycle.

It is moved by P. Safieh and seconded by R. Smith, that the motion be amended as follows:

The President's annual stipend be increased to $45,000 subject to annual cost of living increases, effective for the 2020 CPSO year and for the policy to be reviewed on a three-year cycle

The amended motion carried.

CARRIED

B. Copps and J. Plante returned to the meeting.

20. Application of Blood Borne Viruses Policy to Emergency Medicine Physicians

13-C-09-2020

It is moved by D. Hellyer, and seconded by S. Chaudhry, that:

Council approves the revised "Blood Borne Viruses" policy, (a copy of which forms **Appendix "D"** to the minutes of this meeting) as a policy of the College.

CARRIED

21. Reduced Membership Fees for Parental Leaves

14-C-09-2020

It is moved by P. Pielsticker, and seconded by J. Rosenblum, that:

Council approves in principle, a reduction in membership fee for members taking parental leave effective June 1st, 2021.

CARRIED

22. By-Law Amendments to Reflect Solis Processes

Nathalie Novak, Chief Transformation Officer, presented by-law amendments to facilitate the implementation of Solis that were circulated to the profession and have come back to Council for approval.

15-C-09-2020

It is moved by M. Kanji, and seconded by R. Gratton, that:

The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 137:

By-law No. 137

(1) Subsection 51(3) of By-law No. 1 (the General By-law) is revoked and the following is substituted:

(3) The College may from time to time request information from its members. In response to each such request, each member shall accurately and fully provide the College with the information requested using the Member Portal (as defined in subsection 51(8)), or such other form or method specified by the College, by the due date set by the College. A request for member information may include (but is not limited to) the following:

(a) his or her home address;
(b) an e-mail address for communications from the College and the address of all locations at which the member practices medicine;
(c) a description or confirmation of the services and clinical activities provided at all locations at which the member engages in medical practice;
(d) the names, business addresses and telephone numbers of the member's associates and partners;
(e) information required to be maintained on the register of the College;
(f) information respecting the member's participation in continuing professional development and other professional training;
(g) the types of privileges held at each hospital at which a member holds privileges;
(h) information that relates to the professional characteristics and activities of the member that may assist the College in carrying out its objects, including but not limited to:
    (i) information that relates to the member's health;
    (ii) information about actions taken by other regulatory authorities and hospitals in respect of the member;
    (iii) information related to civil lawsuits involving the member;
    (iv) information relating to criminal arrest(s) and charge(s); and
    (v) information relating to offences.

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

(2) Subsection 51(7) of By-law No. 1 (the General By-law) is revoked and the following is substituted:

(7) Upon request of the College, a member shall provide to the College, in writing or electronically as specified by the College, acceptable documentation confirming completion of continuing professional development programs in which the member has participated during a specified period of time.

(3) The following is added as Subsection 51(8) of By-law No. 1 (the General By-law):

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

And that The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 138:

By-law No. 138

(1) Section 13 of By-law No. 2 (the Fees and Remuneration By-law) is revoked and the following is substituted:

FAILURE TO PROVIDE INFORMATION

13. The College may charge a member a fee of $50 for each notice it sends to the member for his or her failure to provide by the due date or, where there is no due date specified, within 30 days of a College written or electronic request in a form approved by the Registrar, any information that the College is required or authorized to request and receive from the member.

CARRIED

23. Enterprise System Release 1 Preview

The team from Deloitte provided a sneak peak of Solis in advance of the launch on September 14th, 2020.

24. Professional Responsibilities in Medical Education

16-C-09-2020

It is moved by J. Fisk, and seconded by E. Samson, that:

The College engage in the consultation process in respect of the draft policy "Professional Responsibilities in Medical Education" (a copy of which forms **Appendix "E"** to the minutes of this meeting).

CARRIED

Adjournment Day 2

B. Copps adjourned the meeting at 3:25 pm.

_____
Dr. Brenda Copps, President

_____
Alexandra Wong, Recording Secretary

CPSO

Council Briefing Note

December 2020

TOPIC: Executive Committee Report

FOR INFORMATION

3-EX-October-2020 Upon a motion by P. Poldre and seconded by J. Fisk and **CARRIED**, the Executive Committee rescinds the following three statements:
Mifegymiso; Naloxone; and Physician Administration of Edaravone.

Contact: Brenda Copps, President
Lisa Brownstone, Chief Legal Officer

Date: November 16, 2020

CPSO

Council Briefing Note

December 2020

TOPIC: Discipline Committee Report of Completed Cases – August 22, 2020 to November 20, 2020

FOR INFORMATION

ISSUE:

This report covers the 9 discipline cases completed (i.e., the written decision and reasons on finding and, if applicable, penalty have been released) between August 22, 2020 to November 20, 2020.

BACKGROUND:

The report consists of two tables:

- **Table 1**, setting out in order of decision release date the findings from each case, where applicable (i.e., excluding decisions on penalty only). Note, many decisions include more than one finding.

- **Table 2**, setting out in order of decision release date the penalty from each case, where applicable (i.e., excluding decisions where penalty will be the subject of separate hearing, yet to be held).

In the second column of each table, hyperlinks are provided to the physician's public register profile from the College's website.

- The Committee's decision is available for viewing from the physician's public register profile on the College's website. It contains the full text Discipline Committee's decision and reasons document.

- If you experience any difficulty opening a hyperlink, please use "Control-click" or right click on the blue text and select "open hyperlink".

- Physicians' names in the first column of each table are hyperlinked to let you

navigate back and forth from the liability findings in Table 1 to the penalty findings in Table 2, for each physician.

SUMMARY:

In the period reported, the Discipline Committee released 9 decisions and reasons (D&Rs)

- 5 D&Rs set out findings on liability and the Committee's penalty order
- 3 D&Rs set out findings on liability and a penalty hearing is to be scheduled
- 1 D&Rs set out the Committee's penalty order (cases where findings were made previously)

In the 6 D&Rs that included a penalty order, the Committee's orders included:

- 6 reprimands
- 4 suspensions
- 5 impositions of Terms, Conditions or Limitations on the physician's Certificate of Registration
- 1 revocation (Please note that the decision to which this applies is under appeal.)

The Committee imposed a costs order on the physician in 6 D&Rs.

DECISION FOR COUNCIL:

- This item is for information

Contact: Dionne Woodward, Counsel - Hearings Policy and Publications
David Wright, Tribunal Director

Date: November 24, 2020

TABLE 1: DISCIPLINE DECISIONS
FINDINGS (August 22, 2020 to November 22, 2020)

TCL = Term, Condition or Limitation; and DDU = Disgraceful, Dishonorable, or Unprofessional

PHYSICIAN NAME (Click the Hyperlink to see Table 2 for Penalty Details)	DECISION Release Date and Link to CPSO Public Profile	FINDINGS							
		With Penalty or Both	Sexual Abuse	Incompetence	Found guilty of offence relevant to practice	Failing to maintain the standard of Practice	DDU	Conduct Unbe-oming	Contravened a TCL on Certificate of Registration
Jha, Neilank Kumar	Sept. 2, 2020	Finding Only			✓				
Nahas, Richard	Sept. 10, 2020	Both					✓		
Attallah, Gabriel Nicola	Sept. 10, 2020	Penalty Only							
Miller, Robert Barry	Sept. 21, 2020	Both					✓		
Jugenburg, Martin	Sept 24, 2020	Finding Only					✓		

Gale, George Douglas	October 5, 2020	Both				✓			
Taliano, John Patrick	October 22, 2020	Findings Only		✓			✓		
Michael, Essam Samy Naguib	November 18, 2020	Both			✓		✓		
Shapiro, Solomon Marc	November 18, 2020	Both				✓	✓		

TABLE 2: DISCIPLINE DECISIONS
PENALTIES (August 22, 2020 to November 22, 2020)

Physician Name (Click the Hyperlink to Return to Table 1 For Findings)	**Revocation**	**Suspension/ Length**	**Reprimand**	**TERM, CONDITION, LIMITATION**			**Costs/ Comment**
				Clinical supervision	**Prescribing restrictions**	**Other**	
Jha, Neilank Kumar							Penalty hearing to be scheduled
Nahas, Richard		✓ **2 months**	✓			✓	Costs: $6000.00
Attallah, Gabriel Nicola	✓		✓				Costs: $124,440.00 (Decision is under appeal; penalty is stayed in the interim.)
Miller, Robert Barry		✓ **3 months**	✓			✓	Costs: $10, 370.00
Jugenburg, Martin							Penalty hearing to be scheduled

Physician Name (Click the Hyperlink to Return to Table 1 For Findings)	**Revocation**	**Suspension/ Length**	**Reprimand**	**TERM, CONDITION, LIMITATION**			
				Clinical supervision	**Prescribing restrictions**	**Other**	**Costs/ Comment**
Gale, George Douglas			✓	✓			Costs: $6000.00
Taliano, John Patrick							Penalty hearing to be scheduled Immediate interim suspension under Section 51(4.2) of the Code.
Michael, Essam Samy Naguib		✓ **1 month**	✓			✓	Costs:$6000.00
Shapiro, Solomon Marc		✓ **6 months**	✓	✓			Costs:$6000.00

Council Briefing Note

December 2020

TOPIC: Government Relations Report

FOR INFORMATION

1. Ontario's Political Environment
2. Interactions with Government

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1. ONTARIO'S POLITICAL ENVIRONMENT

- The fall legislative session is scheduled to wrap up for its winter break on December 10 – with a planned return on February 16, 2021.
- The arrival of the second wave of COVID-19, and growing case numbers throughout the fall, have kept the focus at Queen's Park squarely on the pandemic and questions about the government's preparedness.
- With 18 months to the next provincial election (scheduled for June 2, 2022), the Ford government is in a challenging position as it seeks to define a legacy outside of the COVID-19 pandemic while also responding to the immense challenges posed by the pandemic.
- The government unveiled its 2020 budget on November 5, 2020.
    - Unlike the 2019 Provincial Budget, which was aimed to return the province back to fiscal balance, the 2020 Budget makes significant investments to address the impacts of COVID-19. This leaves Ontario with its highest-ever deficit of $38.5 billion.
    - The Budget details more than $187 billion in spending this year, of which $30 billion is pandemic-related spending.
    - Ontario's health budget is up by $15.2 billion this year when counting the additional spending announced last spring ($7.7 billion) and the additional funding set out in the Budget ($7.5 billion). The increased funds are allocated to hospitals, temporary wage increases for personal support workers and direct support workers, building new long-term care beds, among other initiatives.

- Bill 229 Support and Recover from COVID-19 Act (Budget Measures) is the Legislation that accompanied the 2020 Budget and is an omnibus bill that amends 44 Acts.
    - Schedule 33 is of particular interest to CPSO and its work on governance modernization. This schedule amends the *Ontario College of Teachers Act, 1996* and makes significant changes to the Ontario College of Teacher's governance structure including the elimination of Council elections.
    - Among the changes, the Bill shrinks the Council size from 37 (23 elected and 14 appointed by the Lieutenant Governor in Council) to 18 (9 appointed by Council and 9 appointed by the Lieutenant Governor in Council).
    - The Bill also sets terms limits for both Council and Committee members.
    - The Bill establishes a Selection and Nominating Sub-committee, composed of members from the Council appointed by the Council.
    - The new sub-committee's duties include reviewing and assessing all applications of persons who have applied to Council and preparing a list of nominees who may be appointed to the Council and statutory or regulatory committees. The Lieutenant Governor in Council may also consider the persons on the list of nominees prepared by the sub-committee. In preparing a list of nominees for each case, the Selection and Nominating Sub-committee will consider any criteria prescribed by the regulations.
    - The Bill also establishes stricter provisions and penalties around sexual misconduct and expands the College's sexual abuse prevention program.
    - Finally, it sets out a transitional period and creates the role of Transition Supervisory Officer.
- Two other notable government Bills have been introduced this session.
- *Bill 218, Supporting Ontario's Recovery and Municipal Elections Act*, contains one schedule of interest to CPSO.
    - Schedule 1, would ensure liability protection for *any person*—meaning any individual, corporation, or other entity, including the Crown in right of Ontario—who have made a "good faith effort" to follow federal, provincial, or municipal laws as well as public health guidance related to COVID-19 and were not grossly negligent. The proposed liability protection will be retroactive to March 17, 2020.
    - At the time this note was written, the Bill was expected to pass on or soon after November 16, 2020.
- The government has also introduced *Bill 213, Better for People, Smarter for Business Act* – an omnibus bill that amends 29 Acts.
    - Bill 213 is part of the government's efforts for red tape reduction and economic recovery. However, also included in the bill are schedules that would grant university status or expanded degree-granting powers to three

private, religious postsecondary institutions – most notably and controversially, Charles McVety's Canadian Christian College and School of Graduate Theological Studies.
    - McVety was an outspoken opponent of the Wynne government's changes to Ontario's sex education curriculum and is a vocal supporter of the Premier.
    - The government is facing mounting pressure to reverse course on granting McVety's school university status, not only from the opposition parties, but also from post-secondary stakeholders, broader human rights groups, and from within the PC Caucus.
    - At the time this note was written, the Bill was currently stalled in Second Reading and it was unclear whether or how the government will respond to these criticisms.
- On Federal business, two by-elections were held on October 26.
    - The Liberals were able to defend two of their strongholds in Toronto.
    - Toronto Centre was carried by Marci Ien, where she won with over 42 percent of the vote. New Green Party Leader, Annamie Paul ran in Toronto Centre and finished second with 33 percent of the vote.
    - York Centre saw a close race between Liberal candidate Ya'ara Saks and Conservative Julius Tiangson, with Saks winning with just an additional 700 votes.

2. INTERACTIONS WITH GOVERNMENT:

- CPSO continues to work with government on the regulation of physician assistants. Council will be provided with an update on this file at the December Council meeting.
- CPSO staff have increased its interactions with the Minister's Office in an effort to strengthen its advocacy for improvements in the public appointments process and ensure streamlined communication between CPSO and both the political and civil service areas of government.
- The usual pace of MPP meetings has slowed down due to COVID-19, however staff have been working to ensure important information is proactively shared with government and that we remain responsive to any inquiries or concerns.

Contact: Miriam Barna, Senior Government Relations Advisor

Laurie Cabanas, Director of Governance and Policy
Danna Aranda, Government Relations Coordinator

Date: November 13, 2020

CPSO

Council Briefing Note

December 2020

TOPIC: Policy Report

FOR INFORMATION

UPDATES:

1. Rescission of the following three CPSO statements:

    I. *Mifegymiso*;
    II. *Naloxone*; and
    III. *Physician Administration of Edaravone*

2. Policy Consultation Update:

    I. *Delegation of Controlled Acts*
    II. *Professional Responsibilities in Medical Education*
    III. *Third Party Medical Reports*
    IV. *Telemedicine*

3. Medical Assistance in Dying – Bill C-7 Update

4. Policy Status Table

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1. Rescission of three CPSO statements:

- As part of the commitment to right-touch regulation, an evaluation of the *Mifegymiso*, *Naloxone,* and *Physician Administration of Edaravone* (hereinafter, *Edaravone*) statements was carried out in order to assess whether revisions were needed or if they could be rescinded.

- The evaluation process revealed that the factors motivating CPSO to develop these statements do not exist anymore and so the statements could be rescinded.

- The Executive Committee agreed and directed that the statements be rescinded at its October 2020 meeting.[1]

- Council is provided with an overview of the rationale for rescinding each statement below.

I. ***Mifegymiso***

- The *Mifegymiso* statement was developed in March 2017 in response to concerns that access to Mifegymiso – a two-drug combination that provides a non-surgical option for early abortion – could be impaired because of confusion surrounding the drug's prescribing, dispensing and administering process.

- Since then, the external landscape has changed dramatically. The dispensing and administering process for Mifegymiso is now in line with other medications, and the myriad requirements that had to be satisfied before physicians could prescribe Mifegymiso have also been relaxed or eliminated altogether.

- As a result of these updates, confusion about Mifegymiso has been dispelled, access to the drug has improved, and the statement no longer serves its original purpose.

II. ***Naloxone***

- When the *Naloxone* statement was developed in February 2016, Naloxone – a highly effective drug that can reverse the respiratory depression associated with an opioid overdose – was available by prescription only.

- Since then, Naloxone has become available across the province without a prescription. A variety of government programs have also increased the availability of Naloxone at no cost to Ontarians.

[1] The *Mifegymiso* and *Edaravone* statements were approved by the Executive Committee. Council approved the publication of the *Naloxone* statement, but it went forward only incidentally, as part of a broader package of work related to opioids. In light of this, and given CPSO's lean approach and the findings of the evaluation process, the Executive Committee was of the opinion that it could approve all three rescissions.

- As a result of these changes, the barriers that existed when the *Naloxone* statement was developed have been addressed and the statement no longer serves its original purpose.

III. ***Edaravone***

- The *Edaravone* statement was initially developed in December 2017, when Edaravone – an intravenous medication used to help slow the symptom progression of amyotrophic lateral sclerosis (ALS) – was not approved for sale in Canada.

- The *Edaravone* statement was developed to clarify that even though Edaravone's status as an "unapproved drug" restricted physicians from prescribing it, physicians were legally permitted to administer the drug in the event patients imported it into Canada.

- Since then, Health Canada approved Edaravone for sale in Canada for the treatment of ALS. As a result, there is no longer any confusion about whether physicians in Ontario are permitted to administer (and/or prescribe) the drug, and the statement no longer serves its original purpose.

2. Policy Consultation Update:

I. *Delegation of Controlled Acts*

- In September 2020, Council approved the draft *Delegation of Controlled Acts* policy and *Advice* document for public consultation.

- Notice of the consultation was sent to the membership and external stakeholders, including those representing or advocating for the interests of diverse and/or vulnerable groups, and was also promoted through the CPSO's website and social media platforms.

- As of the Council submission deadline, the consultation received 116 responses: 8 through written feedback and 108 via the online survey.[2] The majority of respondents were physicians.

- Overall, feedback for the draft policy was largely positive. Respondents described the draft policy as clear and reasonable and a majority of survey respondents agreed that the draft policy clarifies when and how to delegate appropriately.

- Respondents were generally supportive of the draft expectations including those pertaining to delegating in the patient's best interest, ongoing delegation, consent to treatment, and supervision and support of delegates. In particular:

    - A majority of respondents agreed that the patient best interest framework in the draft policy (e.g., only delegating when it is safe, effective, and ethical to do so) is reasonable and helpful in determining whether delegation is appropriate.

    - A majority of respondents strongly agreed that the draft expectations regarding ongoing delegation were reasonable, in particular ensuring that patients are informed of who the delegating physician is and that the patient may speak with them if they wish and that physicians must re-assess patients in certain circumstances.

        - A few respondents questioned the feasibility and practicality of these expectations in the context of community paramedicine.

    - A majority of respondents agreed that consent should be obtained for any treatments that are delegated, and not the delegation itself, while there were some respondents who expressed that consent for the delegation should be obtained as well.

        - Respondents who expressed support stated that it would be impractical or impossible to obtain consent for the delegation itself while others expressed that if delegation is to be done in the patient's best interest and with transparency then consent should be required for the delegation as well.

[2] Organizational responses included: Huron County Paramedic Service and Information; Privacy Commissioner of Ontario (IPC); and weinject.

- A majority of respondents agreed that the draft policy includes the right factors for assessing risk when determining the appropriate level of supervision and support of a delegate. A majority of respondents also agreed that:

    - there are instances where it would be appropriate to supervise without being onsite;
    - there are instances where in-person supervision is necessary; and
    - being available by phone and able to attend in-person, if necessary, can also be sufficient for the purposes of supervision.

- All feedback is currently being reviewed in detail and will help inform revisions to the draft policy.

II. *Professional Responsibilities in Medical Education*

- In September 2020, Council approved the draft *Professional Responsibilities in Medical Education* policy and *Advice* document for public consultation.

- Notice of the consultation was sent to the membership and external stakeholders, including those representing or advocating for the interests of diverse and/or vulnerable groups, and was also promoted through the CPSO's website and social media platforms.

- As of the Council submission deadline, the consultation received 113 responses: 27 through written feedback and 86 via the online survey.[3] The majority of respondents were physicians.

- Overall, the majority of the feedback received was supportive of many of the expectations in the draft policy.

- The vast majority of survey respondents strongly agreed that the draft expectations related to professional relationships and boundaries between most responsible physicians (MRPs)/supervisors and medical students/trainees were reasonable.

[3] Organizational responses included: Faculty of the Department of Medicine at the University of Ottawa; Office of the Information and Privacy Commissioner of Ontario (IPC); Professional Association of Residents of Ontario (PARO); and Society for Canadians Studying Medicine Abroad (SOCASMA).

- Some respondents suggested that there might be privacy and confidentiality concerns with disclosing private information around pre-existing relationships.

- There was also strong support for the draft expectations around prohibiting violence, harassment, or intimidation in the learning environment and the vast majority of survey respondents found these draft expectations to be reasonable.

    - Some respondents thought that the draft policy could include more information (i.e., steps and processes) on reporting instances of disruptive behaviour.

- Some respondents had concerns about the draft expectations outlining when express consent must be obtained for medical student/trainee observation and participation in patient care.

    - Some physician and academic respondents were concerned the draft expectations would impose barriers to care and disrupt learning environments.

    - At the same time, many respondents (primarily members of the public) supported and highlighted the need to respect patient autonomy and choice.

    - CPSO staff has met with the undergraduate and postgraduate deans of medical education as well as CPSO's Education Advisory Group to discuss this issue and how to move forward.

- Some respondents believed the draft expectations around availability and supervision would require constant on-site supervision from supervisors/most responsible physicians.

- Other suggestions included clarifying language and definitions in the policy.

- All feedback is currently being reviewed in detail and will help inform revisions to the draft policy.

III. ***Third Party Medical Reports***

- In September 2020, Council approved the draft *Third Party Medical Reports* policy and *Advice* document for public consultation.

- Notice of the consultation was sent to the membership and external stakeholders, including those representing or advocating for the interests of diverse and/or vulnerable groups, and was also promoted through CPSO's website and social media platforms.

- As of the Council submission deadline, the consultation received 79 responses: 14 through written feedback and 65 via the online survey.[4] The majority of respondents were physicians.

- Online survey respondents found the draft policy clearly written and easy to understand, and feedback around the draft expectations was largely supportive:

    - The majority of respondents agreed that the draft title is appropriate and captures what the title is about (independent medical examinations, third party medical reports, and testimony).

    - While the majority of respondents agreed it is reasonable to require that physicians take reasonable steps to obtain and review all relevant clinical information and opinions relating to the subject that could impact their statements and/or opinions, some respondents felt the onus should not be on the physician to do this.

    - Most respondents strongly agreed it is reasonable to require that physicians clearly identify who assisted them in conducting independent medical examinations (IMEs) and who contributed to the third party medical report (TPMR).

    - Views regarding timelines varied, with some preferring no timelines, some preferring shorter or longer timelines, and general consensus that any of the specific options available (e.g., 30, 45, 60 days) were all reasonable.

- Some respondents were concerned with the draft expectations requiring that physicians have an active certificate of registration and be actively practicing

[4] Organizational respondents included: Canadian Medical Protective Association (CMPA); Insurance Bureau of Canada (IBC); Office of the Information and Privacy Commissioner of Ontario (IPC); and Professional Association of Residents of Ontario (PARO).

(within the past two years) within the scope of practice and area of expertise to accept a request to conduct an IME or act as a medical expert.

  - Some respondents felt an active certificate of registration should not be required for medical expert work as the admissibility and weight of their evidence is determined by the courts.

  - While the majority of survey respondents agreed that the draft active practice requirement was reasonable and highlighted the importance of recent clinical experience, some respondents felt this was an inappropriate restriction against competent and knowledgeable retired physicians.

- Some respondents provided specific suggestions on how to revise the draft policy to ensure it accurately reflects the range of different roles that physicians play and the various legal requirements that apply (i.e., case law, privacy law, court rules, etc.).

- All feedback is currently being reviewed in detail and will help inform revisions to the draft policy.

IV. ***Telemedicine***

Policy Review Kick-off at Council

- The *Telemedicine* policy review officially kicked off at September Council with an interactive presentation and discussion amongst Council members to inform the strategic direction of the review.

  - Council was presented with an overview of the current *Telemedicine* policy, the current virtual care landscape in light of the COVID-19 pandemic, and discussion questions meant to get a sense of Council's experiences with virtual care, views on the advantages and risks that need to be managed, and issues the profession might be looking for guidance on.

  - Feedback included the importance of setting out considerations for the appropriateness of virtual care, practicing across borders, and issues related to consent.

Consultation Feedback

- A public consultation on the current policy was launched after September Council.

- The consultation garnered a total of 209 responses: 13 through written feedback and 196 via the online survey.[5] The majority of respondents were physicians.

- Both patient and physician survey respondents reported positive experiences with virtual care and a majority would like to continue using it after the pandemic.

- Notwithstanding the many advantages identified (e.g., improved access, convenience, and safety during a public health crisis) respondents identified key challenges to both providing and receiving virtual care, including equitable access, technical and connectivity issues, and providing virtual care across borders.

- Overall, survey respondents thought the current *Telemedicine* policy is clearly written and easy to understand, but physician respondents did request practical guidance around a few key issues, including:

    - The limitations of virtual care (when it is and is not appropriate to provide care virtually);

    - How to comply with privacy and security requirements, including the platforms that comply with privacy and security requirements;

    - Issues related to licensing and practising across jurisdictions (both providing care while out of province and providing care to patients that are out of province); and

    - Issues related to billing and liability.

Virtual Care Symposium

- In addition to the usual consultation activities, as part of CPSO's commitment to meaningful engagement, Dr. Copps hosted a 'Virtual Care Symposium' in late October 2020 that brought together diverse physicians, patients, and caregivers to discuss their experiences with virtual care. This virtual event piloted a new approach to engagement and was intended to understand what a quality virtual care encounter looks like from both perspectives.

[5] Organizational respondents included: Ontario Medical Association (OMA) and the OMA Section on Rheumatology and the Ontario Rheumatology Association (ORA).

- The discussion resulted in substantive perspective sharing between physicians, patients, and caregivers and agreement on many of the key points and themes that emerged, including:
    - Challenges around accessibility and the digital divide;
    - The need for a regulatory framework that is flexible in determining but includes guidance on real limits to the appropriateness of virtual care;
    - Considering consent and security provisions that reduce barriers to access and respect both patient autonomy and the specific care being provided; and
    - The recognition that virtual care is best used as a complement to, rather than a replacement of, in person care.
- Overall, feedback about the Symposium was overwhelmingly positive and participants strongly agreed that having patients, caregivers and physicians come together to talk about virtual care was a valuable experience.
- All feedback from the consultation and engagement activities is currently being reviewed in detail and will help inform revisions to the current policy.

3. Medical Assistance in Dying – Bill C-7 Update

- In September 2019, the Superior Court of Quebec struck down one of the eligibility requirements for accessing medical assistance in dying (MAID) in Canada, namely, the requirement that a person's natural death be reasonably foreseeable.
- While the Court decision only applies in Quebec, the federal government has committed to changing the law at the federal level and introduced Bill C-7[6] to amend the MAID provisions in the *Criminal Code* in February and October 2020.
- Council was provided with an overview of Bill C-7 at its meeting in March 2020 and that exact Bill was reintroduced unchanged in October 2020.

[6] The development of Bill C-7 was informed by a public consultation and Federal Ministers' Roundtable on MAID held in January 2020.

Overview of Bill C-7

- The existing eligibility criteria for MAID will be retained, but the requirement for a person to have a "grievous and irremediable medical condition" will be amended to expressly exclude persons suffering solely from mental illness, and the requirement for a reasonably foreseeable natural death will be removed as an eligibility criterion, but will instead be used as a factor to determine which procedural safeguards apply.

- For individuals whose death is reasonably foreseeable, the Bill contemplates retaining most of the procedural safeguards, but easing some.

    - This includes removing the requirement for a 10-day reflection period between the date of the signed written request and when the person receives MAID, and granting individuals the ability to enter into an agreement that would permit MAID to be provided should they lose capacity.

- For individuals whose death is not reasonably foreseeable, the Bill contemplates expanding the procedural safeguards that need to be met.

    - This includes instituting a 90-day reflection period, requiring one of the assessors of eligibility to be a specialist in the patient's medical condition, and making additional efforts to ensure patients are aware of and have considered their alternative treatment options.

- Some of the procedural safeguards for all deaths will be eased, including:

    - The requirement will be to only have one independent witness (not two) sign the person's written request for MAID, and the independent witness can now be a paid professional personal or health care worker, provided that they are not the practitioner doing the eligibility assessment and/or providing MAID.

- Additionally, the Bill contemplates enabling those who are receiving the self-administered version of MAID[7] to enter into an agreement waiving their final consent should a back-up clinician-administered MAID be necessary.

[7] Regardless of whether or not their natural death is reasonably foreseeable.

- The Bill also introduces new reporting requirements for practitioners who have conducted preliminary eligibility assessments to make a report to Health Canada, even in the absence of a written request.

Next Steps

- Should Bill C-7 pass, revisions to CPSO's MAID policy will be required to reflect the new legal framework for MAID.

- The Bill is progressing through the legislative process and it appears as though it may pass before the December 18, 2020 deadline.

- CPSO staff will continue to closely monitor its progress and are drafting revisions to CPSO's MAID policy to reflect Bill C-7 and any amendments that are made prior to adoption. When Bill C-7 is being finalized, the Executive Committee will be asked to approve the updated policy so it can be in effect shortly after Bill C-7 passes.

4. Policy Status Table

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

- For further information about the status of any policy issue, please contact Craig Roxborough, Manager, Policy, at extension 339.

DECISION FOR COUNCIL:

1. This item is for information only.

Contact: Craig Roxborough, Ext. 339

Date: November 13, 2020

Attachments:

Appendix A: Policy Status Table

Table 1: Current Reviews

Policy	Launch	Stage of Policy Review Cycle						Target Comp.	Notes
		Prelim. Consult	Drafting	Approval to Consult	Consult on Draft Policy	Revising Draft Policy	Final Approval		
Professional Obligations and Human Rights	Dec-20	✓						**2022**	A review is underway to review and update the policy.
Medical Assistance in Dying	Dec-20	✓						**2022**	A review is underway to review and update the policy.
Planning for and Providing Quality End-of-Life Care	Dec-20	✓						**2022**	A review is underway to review and update the policy.
Telemedicine	Sep-20	✓						**2022**	A review is underway to review and update the policy.
Social Media: Appropriate Use by Physicians (Statement)	Apr-20		✓					**2021**	A review is underway to review and update the statement.
Statements & Positions Redesign	Jan-20		✓					**2021**	All CPSO *Statements & Positions* are being evaluated for relevance and currency.
Professional Responsibilities in Postgraduate Medical Education & ***Undergraduate Medical Education***	Dec-19					✓		**2021**	The current policies have been combined into a new draft policy titled *Professional Responsibilities in Medical Education.*
Medical Expert & ***Third Party Reports***	Dec-19					✓		**2021**	The current policies have been combined into a new draft policy titled *Third Party Medical Reports.*
Advertising	May-19					✓		**2020**	A *new* draft policy has been developed, consistent with existing legislation.
Complementary / Alternative Medicine	Mar-19			✓				**2022**	The draft policy has been retitled: *Complementary and Alternative Medicine.*

Delegation of Controlled Acts	Mar-19					✓		**2021**	Consultation feedback is being reviewed and will inform a revised draft policy.

Table 2: Policy Review Schedule

Policy	Target Review	Policy	Target Review
Female Genital Cutting (Mutilation)	2016/17	*Ensuring Competence: Changing Scope of Practice and Re-entering Practice*	2023/24
Dispensing Drugs	2016/17	*Public Health Emergencies*	2023/24
Mandatory and Permissive Reporting	2017/18[1]	*Closing a Medical Practice*	2024/25
Providing Physician Services During Job Actions	2018/19	*Availability and Coverage*	2024/25
Physicians' Relationships with Industry: Practice, Education and Research	2019/20	*Managing Tests*	2024/25
Cannabis for Medical Purposes	2020/21	*Transitions in Care*	2024/25
Consent to Treatment	2020/21	*Walk-in Clinics*	2024/25
Blood Borne Viruses	2021/22	*Disclosure of Harm*	2024/25
Physician Treatment of Self, Family Members, or Others Close to Them	2021/22	*Prescribing Drugs*	2024/25
Physician Behaviour in the Professional Environment	2021/22	*Boundary Violations*	2024/25
Accepting New Patients	2022/23	*Medical Records Documentation*	2025/26
Ending the Physician-Patient Relationship	2022/23	*Medical Records Management*	2025/26

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

Uninsured Services: Billing and Block Fees	2022/23	***Confidentiality of Personal Health Information***	2025/26

CPSO

Annual Committee Reports 2020

Discipline Committee

Committee Mandate

The Discipline Committee is an independent adjudicative committee 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. The hearing panel provides written decisions and reasons for its decision to CPSO, the physician and the complainant. Written decisions are also available to the broader membership and the public via the CPSO website and "Dialogue". The decisions of the Discipline Committee are subject to review by the courts.

In keeping with CPSO and Council's principles, the Discipline Committee remains committed to being respectful and responsive to the stakeholders that appear before it. In addition, the Discipline Committee remains committed to continuous improvement to ensure effective and efficient discipline processes that are fair, proportional, transparent and accountable.

Committee Members

Dr. Ida Ackerman
Dr. Heather-Ann Badalato
Dr. Steven Bodley
Dr. Philip Berger
Dr. Pamela Chart
Dr. Carole Clapperton (January to December)
Mr. Jose Cordeiro
Dr. Melinda Davie, Co-chair
Dr. Michael Franklyn
Dr. Paul Garfinkel
Mr. Peirre Giroux
Dr. Kristen Hallett
Dr. Deborah Hellyer
Dr. Paul Hendry
Dr. Stephen Hucker
Mr. Mehdi Kanji
Dr. Allan Kaplan
Dr. William L. M. King (January to December)
Dr. Barbara Lent (January to December)
Dr. Bill McCready (January to December)
Mr. Paul Malette
Ms. Ellen Mary Mills (January to September)
Dr. Veronica Mohr
Dr. Joanne Nicholson
Dr. Terri Paul
Mr. Peter Pielsticker
Dr. Dennis Pitt
Dr. Peeter Poldre
Dr. Ian Preyra
Dr. John Rapin
Ms. Linda Robbins
Dr. Robert Sheppard
Dr. Robert Smith (January to December)
Ms. Geraldine Sparrow (January to February)
Dr. Eric Stanton, Co-chair
Ms. Christine Tebbutt (to December 31, 2019)
Dr. Andrew Turner
Dr. Yvonne Verbeeten
Dr. James Watters
Dr. Susanna Yanivker

We thank those members whose terms are ending in 2020. Your dedication, commitment and contribution to the Discipline Committee, over the years of your service, has been valued and greatly appreciated.

Key Accomplishments

To protect the health and safety of those involved in hearings, the Discipline Committee's adjudicative process in-person hearings were suspended in March 2020. A key accomplishment of the Discipline Committee was its ability to adapt to electronic processes to maintain core functions during the COVID-19 pandemic. Notably, all Discipline Committee business was converted from in-person to virtual sessions and the Discipline Committee considered only electronic submissions. Though briefly impacted by these changes, the public's access to hearings was quickly restored to ensure the open and transparent hearing process as mandated.

The Discipline Committee continued it usual practice of:

Pre-Hearing and Case Management Conferences (with a designated Chair) to:

- reduce unreasonable delays in the hearings process, case time spans, and/or late cancellation of hearing days;
- help to narrow issues and to further resolution discussions, where possible, for the settlement of some or all the allegations before the Discipline Committee;
- assess a case's progress towards timely hearing dates with an adequate number of hearing days to ensure efficient use of hearing sessions time; and
- maintain budget conscious processes both in being conducted virtually, but also by reducing lengthy hearings and/or late hearing day cancellation fees.

Bi-Annual Business Meetings and Education/Training Sessions for:

- education, review of practice and procedure, consideration of relevant cases and case law (i.e. administrative or court cases, CPSO or other Regulatory College decisions and/or appeal court rulings); and
- orientation and education sessions for new members, pre-hearing/case management conference Chairs and Hearing Panel Chairs; and deliberation and decision writing.

During the Discipline Committee's business and education/training sessions, there is a review of the Discipline Committee's key performance indicators. The focus remains on efforts to enhance efficiencies and timeliness throughout the hearing stages and in the timely release of reasons for Decision.

As with all hearing activity, the education and training sessions were conducted virtually. In addition, and for the first time, all Committee members (not just designated Chairs or Writers) were invited to attend all training sessions. This new approach was consistent with the aim of enhancing mentorship and succession planning, particularly considering the governance term limits. The feedback from session attendees was overwhelmingly positive.

Looking Ahead to 2021

We commend our Discipline Committee members who have dedicated significant time, attention, and effort to carrying out the hearing schedule during a time of change and uncertainty. The Discipline Committee would like to thank the Hearings Office staff and the Independent Legal Counsel team for their outstanding work in assisting the Discipline Committee in fulfilling its mandate throughout the year.

We extend appreciation to the Discipline Committee membership, Independent Legal Counsel, College staff and all other stakeholders for their patience and participation as the virtual hearing processes were implemented and continuously enhanced.

Looking ahead, the Discipline Committee will continue to review the rules of procedures and common practices in the quest for ongoing improvement. The virtual hearing process provides many opportunities for the future of hearings, even post-pandemic. The Discipline Committee will carefully consider how to best incorporate virtual hearings into usual business practice to ensure ongoing stakeholder access, hearing efficiency, timeliness and cost-effectiveness.

Lastly, the Discipline Committee welcomes Mr. David Wright as Tribunal Director and Chair of the Discipline Committee. Mr. Wright brings his experience as the Former Chair of the Law Society Tribunal and will lead the Discipline Committee's ongoing efforts to improve the quality, efficiency, transparency and timeliness of its work.

Respectfully submitted,

Dr. Melinda Davie
Co-Chair, Discipline Committee

Dr. Eric Stanton
Co-Chair, Discipline Committee

Executive Committee

Committee Mandate

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.

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. The 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.

Committee Members

Dr. Brenda Copps, President and Chair
Ms. Joan Fisk (September to December)
Ms. Ellen Mary Mills (January to August)
Mr. Peter Pielsticker
Dr. Akbar Panju, Vice-Chair (January to February)
Dr. Judith Plante, Vice-Chair (February to December)
Dr. Peeter Poldre, Past Chair
Dr. Janet van Vlymen (March to December)

We thank those members whose terms are ending in 2020. Your dedication, commitment and contribution to the Executive Committee, over the years of your service, has been valued and greatly appreciated.

Key Accomplishments

Reflective of good governance practices, the Executive Committee developed and approved a Terms of Reference. The Terms of Reference will be used to clarify Committee member expectations and can be used to inform discussions about the Committee's effectiveness over the past year.

The Executive Committee also developed the key performance indicators (KPIs) to monitor and measure progress on the 2020-2025 Strategic Plan. The KPIs are reported on at every Executive Committee meeting as well as at every Council meeting.

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

- Rescinding of three statements: Mifegymiso; Naloxone; and Physician Administration of Edaravone
- Medical Records Stewardship and Medical Records Documentation
- Protecting Personal Health Information
- Application of Blood Borne Viruses Policy to Emergency Medicine Physicians
- Specialist Recognition Criteria in Ontario
- Redesigned Registration Policies:
  - Acceptable Qualifying Examinations Policy
  - Alternative to the MCCQE 2 Examination Policy
  - Recognition of Certification without Examination Issued by CFPC Policy
  - Restricted Exam Eligible Policy
- Alternative Pathways to Registration
- Academic Registration Policy

The following policies are being sent to December Council for approval to consult with the profession, stakeholders and patients/families and caregivers:

- Third Party Medical Reports
- Advertising
- Delegation of Controlled Acts (August/2020)
- Complementary and Alternative Medicine

Looking Ahead to 2021

The Executive Committee is motivated to build on the successes from this year and continue the momentum into 2021. The following activities are expected to continue into next year:

- Executive Committee supports the Registrar moving forward potential changes to the structure and operations related to Discipline
- Regulation of Physician Assistants
- Regulatory modernization
- Executive Committee Meeting Reflection Session (is to provide a forum for Executive Committee Members to promote a positive culture of self-reflection after the Executive Committee meeting has ended)

Respectfully submitted

Dr. Brenda Copps, President
Chair, Executive Committee

Finance and Audit Committee

Committee Mandate

The Committee monitors, evaluates, advises and makes recommendations, in accordance with their terms of reference, on the financial affairs and positions of the College. These include the annual budget, investment policy, banking of College funds, external audit, risk management, internal control functions, pension plans and the financial reporting and accounting control policies and practices of the College. The Committee also perform other duties as the Council may delegate or direct from time to time. The Finance and Audit Committee is part of the Transformation Office supporting the CPSO infrastructure and is tied to Continuous Improvement as a pillar in the Strategic Plan.

Committee Members

Dr. Thomas Bertoia
Dr. Brenda Copps
Mr. Pierre Giroux
Dr. Rob Gratton
Mr. Peter Pielsticker, Chair
Dr. Judith Plante

We thank those members whose terms are ending in 2020. Your dedication, commitment and contribution to the Finance and Audit Committee, over the years of your service, has been valued and greatly appreciated.

The Finance and Audit Committee convened four times in 2020: January 23 (Orientation/Education), March 26 (annual financial meeting), August 11 and October 15 (focus on the budget for the next year).

The Finance and Audit Committee reviews:

- its work plan at each of these meetings to ensure that it remains appropriate and on target;
- financial statements and variance analysis to confirm budget tracking; and
  any educational needs for the Committee.

In addition to these responsibilities the Finance and Audit Committee reviews any other financial issues.

Over the past year, the Committee reviewed the following topics:

- January 23, 2020 (Orientation)
    - InsuranceCoverage – HIROC provided a detailed overview.
    - Space– Reviewed the Toronto office market.

- March 26, 2020 (Audit)
    - Auditor's Report and Year-end Financial Statement – The Auditors said the statements were impeccable.
    - Internal Controls – No recommendations for improvement.
    - Enterprise System for the College – An update was given.
    - Budget Objectives for 2021 – No anticipation for increased fees.

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

- August 11, 2020
    - President's Stipend – Reviewed and a new amount recommended.
    - Reduced Annual Fee for Parental Leave – Was discussed and recommended.
    - Reserve Fund Policy – Was adopted and recommended.
    - Solis Update – Was discussed.
    - Investment Policy – Reviewed and recommended.

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

- October 15, 2020 (Budget)
    - 2021 Budget – No fee increase for the third year was recommended. Staff numbers have changed from 403 to 395. No increases to staff numbers in the last this year. Staffing costs have decreased by $1,232,656
    - Cyber Attack – Update was provided on the recent unsuccessful attack on CPSO.
    - Investment Options – Three proposals were discussed one was dismissed.
    - Compensation Plan – The organization's new compensation plan was presented.

Further details on a number of these items follow.

2021 Budget

The College is accountable for a $72.5 million budget, and regularly demonstrates – through detailed reports to the Finance and Audit Committee, Council, physicians and the public – fiscal accountability, optimal resource use and delivery of effective and efficient programs.

Revenue is predicted to be $76.6 million. The surplus before new requests is $4.82 million and after new requests the surplus expected to be $843,000. Requests for new items including an increase to the per diem, staff salary increases and related costs, and depreciation on capital items, leaving a modest surplus of .01% of the total budget.

2021 Budget		
Revenues	$76,612,883	
Base Budget (Expenses)	$72,523,161	
New Requests		
Per Diems & HST		$163,621
Salary & related benefits		$775,792
Staffing Requests		$0
Other New Requests (PAs, Depreciation, virtual working support)		$2,307,313
Total New Requests		$3,246,726
Surplus (Deficit)		**$842,996**

Investments

In March of 2015, Council approved the recommendation of the Finance and Audit Committee to move the longer-term investments from the current asset mix of approximately 75% fixed income and 25% equities to a five-year GIC ladder. The College is looking at the reinvestment of $50 million in maturing GICs in November 2020.

As each of the investments came due it was invested to coincide with the maturity of the five-year GIC in November 2020.

In keeping with Council's decision in March 2015 and based on the College's Investment Policy, the $50 million will be reinvested in a ladder approach. The Finance and Audit Committee reviewed options from three organizations:

TD Asset Management
National Bank
CIBC

After careful consideration, the Finance and Audit Committee narrowed it down to National Bank and CIBC.

Infrastructure

CPSO's investment in workplace strategy focused on getting users mobile, by securing a 0% lease with Lenovo to migrate users from a discontinued Windows 7 Desktop to a more modern Windows 10 laptops that included a docking bay and additional monitors. This has allowed users the mobility needed to work remotely and be agile, especially during the COVID-19 pandemic. We had to strategize

moving our services into the cloud where the foundation of Azure was built to migrate to our old email exchange, other services for Office 365 and to build the fundamentals for Solis\Vault platforms. This will also include the future F&O system.

By moving to the cloud, CPSO security has also been increased by using MFA (Multi-Factor Authentication), which mitigates the risk of cyber attacks on the old legacy systems and file structures. We continue to migrate and adapt to newer technology to allow CPSO to secure and host our membership data.

Looking Ahead to 2021

The Finance Department is looking forward to the implementation of the Finance and Operations system. This will lead to more efficiencies and a reduction on the reliance of paper.

Respectfully submitted,

Mr. Peter Pielsticker
Chair, Finance and Audit Committee

Fitness to Practice Committee

Committee Mandate

The Fitness to Practice Committee is an independent adjudicative committee that conducts hearings regarding whether an Ontario physician's health (capacity to practice) impacts in areas of public interest.

The Fitness to Practice Committee is rarely engaged due to the commendable efforts towards early intervention and resolution of physician health concerns. One avenue of resolution is achieved when a physician engages with the Ontario Medical Association's Physician Health Program. Among its many services, this Program provides formal health monitoring to assist physicians in their treatment and recovery.

Committee Members

Dr. Steven Bodley
Dr. Pamela Chart
Dr. Carole Clapperton
Dr. Melinda Davie
Dr. Paul Garfinkel
Dr. Deborah Hellyer, Chair
Dr. Stephen Hucker
Dr. Barbara Lent
Dr. Bill McCready
Dr. Dennis Pitt
Dr. Robert Sheppard
Dr. Eric Stanton
Dr. James Watters

We thank those members whose terms are ending in 2020. Your dedication, commitment and contribution to the Fitness to Practice Committee, over the years of your service, has been valued and greatly appreciated.

Key Accomplishments

Though Fitness to Practice hearings are rare, Committee members are cross appointed to the Discipline Committee. As such, the general practice of business meetings, education/training and continuous process reviews are maintained. This ensures that the Fitness to Practice Committee maintains its commitment to being respectful and responsive to the stakeholders that appear before it; and committed to continuous improvement to ensure effective and efficient Fitness to Practice processes that are fair, proportional, and accountable.

Looking Ahead to 2021

The Fitness to Practice Committee welcomes Dr. Watters as Vice Chair of the Committee.

Respectfully submitted,

Dr. Deborah Hellyer
Chair, Fitness to Practice Committee

Governance Committee

Committee Mandate

The Governance Committee monitors the governance processes adopted by Council and reports annually to the Council on the extent to which the governance processes are being followed. In addition, it:

- recommends to Council changes to the governance process as the Governance Committee considers advisable;
- ensures nominations for the office of President and Vice-President;
- makes recommendations to the Council regarding the members and Chairs of committees; and
- makes recommendations to the Council regarding any other officers, officials or other people acting on behalf of the College [General By-law, s. 44(3)]

Committee Members

Dr. Brenda Copps
Dr. Judith Plante
Dr. Peeter Poldre, Chair
Dr. Jerry Rosenblum
Mr. Mehdi Kanji

We thank those members whose terms are ending in 2020. Your dedication, commitment and contribution to the Governance Committee, over the years of your service, has been valued and greatly appreciated.

Key Accomplishments

In 2020, the Governance Committee developed a work plan based on recommendations from the 2019 Annual Report. Areas of focus for the 2020 Governance Committee included:

Legislative and Regulatory Reform

Governance Modernization

Governance Education

Good Governance Practices

Right Touch Regulation

Governance Modernization

The Committee continues to advocate for legislative and regulatory reform to modernize CPSO's governance structure and processes. This advocacy has included:

- Conversations with various levels of government to discuss opportunities for legislative and regulatory reform.
- The development of a skills and diversity matrix that can be used as part of CPSO's efforts to identify public members with the required skills, competencies and availability to contribute to CPSO work.

Continuous Improvement, Quality Care

Legislative Changes

Numerous conversations about the importance of good governance modernization have occurred over the last number of months with all levels of government. CPSO has put forward a proposal to government with requests to:

- Provide a broader range of Council and public members;
- Allow for the eventual reduction in the size of Council;
- Allow for composition and quorum requirements for statutory committees to be set by regulation; and
- Allow for a competency-based selection process for both professional and public members of Council.

Non-Legislative Changes

A major priority for CPSO is modernizing and strengthening its governance structures and processes. Whilst there is anticipation for changes in legislative and regulatory reform, CPSO is making efforts to focus Council members on Committees where they are required for quorum.

- In September 2019, Council approved by-law amendments to introduce term limits on CPSO Committees beginning in December 2020. CPSO staff have been implementing the succession plans over the past several months in preparation for Committee members transitioning off this year.
- A recruitment was launched in mid-July for Non-Council Committee members to fill 10 vacancies, of which there were 88 applications. A focus on diversity was mandated by the Committee for this year's recruitment.
- To ensure that Committees across the College continue to function effectively as many Committee members transition off, a working group was established by the Governance Committee to develop a Committee Mentoring Program. Implementation of the Program will commence in early 2021.

- As part of succession planning, staff has developed a prototype for Committee appointment information for every Council and Committee member in order to keep track of term appointments. Requirements have been gathered and will eventually feed into the Solis/Vault Project moving forward.

Governance Education

The Committee continues to enhance the current governance education opportunities provided to Council members and Committee members where appropriate.

- In February 2020, Committee Chairs participated in a facilitated workshop designed to enhance the performance of Committees. Feedback from the session was very positive. A second session was held in in November with a focus on providing Chairs and Vice-Chairs with the tools and knowledge to provide excellent leadership to committee members and enhance performance during and after meetings.
- Education Day was held in March this year and provided Council and Committee members with a refresher on foundational governance principles and expectations of Council and Committee members. Approximately 80 Council and Committee members attended. A virtual half-day Education Day was also organized in September.
- Dr. Javeed Sukhera (Physician Educator Activist and Child and Adolescent Psychiatry) was a speaker at a Governance Committee meeting and will be at December Council to discuss some foundational concepts as they relate to diversity, equity and inclusion and share some considerations based on research and his experience as a physician.
- Under the direction of the Governance Committee, CPSO began developing a new eLearning Program for prospective elected physician Council members, new Committee members and newly appointed public members.

Meaningful Engagement

District Elections

The Committee strengthened the Council elections process to encourage applications from knowledgeable and diverse physicians who possess the competencies required to be an effective Council member.

- CPSO received an unprecedented number of candidates (10 in District 5 for 2 positions and 22 in District 10 for 4 positions).
- Enhancements to the current elections process include:
  - Improved application process for candidates that better informs them about the College and the role of a Council member.
  - A redesigned, interactive resource to replace the current Governance Process Manual
  - Revised Declaration of Adherence form and associated policies
  - Raised awareness of the Council elections among some underrepresented populations through greater outreach

Tools, Resources and Processes

The Committee continues to develop tools, resources and processes to support Council and Committees with implementing good governance practices.

- Process improvements as evidenced in Council meeting evaluation results are ongoing based on the 2019 Council Performance Assessment.
- Staff have successfully developed and approved a Terms of Reference for 7 of 10 Committees. Each Committee will have at a minimum, a draft Terms of Reference by the end of 2020.
- The Committee reviewed and revised the Committee Satisfaction and Interest Survey and associated processes were reviewed and an electronic survey was developed, yielding a 100% response rate and helpful information.
- As recommended by the Committee, Council approved the implementation of a Chair/ Vice-Chair model to facilitate succession planning and consistency across CPSO Committees. The Committee introduced a Chair and Vice-Chair Roles and Responsibilities including core competences.
- Self-Assessments for Council and Committees will be completed at the end of 2020 in support of enhancing performance.
- A new Committee Mentoring Program was developed to support and enhance succession planning between seasoned and newer members of all Committees across the organization.

Looking Ahead to 2021

2020 was a significant year for building and enhancing CPSO's governance practices and processes through the COVID-19 pandemic. The Governance Committee has also been a champion of CPSO's advocacy efforts in support of regulatory modernization.

In 2021, the Governance Committee will build on its work to strengthen diversity on Council and Committees and will be examining how it can better apply the diversity and equity lens to its governance processes and structures. Governance education and enhanced training for Committee Chairs and Vice-Chairs will also be a priority for CPSO and will be a prominent component of the Governance Committee's work plan.

Respectfully submitted,

Dr. Peeter Poldre, Past President
Chair, Governance Committee

Inquiries, Complaints and Reports Committee

Committee 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

Committee Members

For majority of 2020 the ICRC was composed of 50 members. The members are a mix of the following: physicians who are members of Council; physicians who are non-Council members; and public members of Council. Quorum for ICRC consists of three panel members, at least one of whom is a public member of Council.

Dr. Trevor Bardell
Dr. Haig Basmajian
Dr. George Beiko
Dr. Mary Jane Bell
Dr. Thomas Bertoia
Dr. Brian Burke
Dr. Robert Byrick
Mr. Shahid Chaudhry
Dr. Anil Chopra, Co-chair
Dr. Paula Cleiman
Dr. Nazim Damji
Dr. Naveen Dayal
Dr. Mary Jean Duncan
Dr. Gil Faclier
Dr. Thomas Faulds
Ms. Joan Fisk
Mr. Murthy Ghandikota
Dr. Robert Gratton
Dr. Daniel Greben
Dr. Andrew Hamilton
Dr. Christine Harrison
Dr. Elaine Herer
Dr. Robert Hollenberg
Dr. John Jeffrey
Dr. Lara Kent
Ms. Catherine Kerr
Dr. Carol Leet
Dr. Edith Linkenheil
Dr. Jane Lougheed
Dr. Haidar Mahmoud
Dr. Edward Margolin
Dr. Dale Mercer
Dr. Lydia Miljan, PhD
Dr. Robert Myers
Dr. Judith Plante
Dr. Anita Rachlis
Dr. Val Rachlis
Dr. Michael Rogelstad
Dr. Jerry Rosenblum
Dr. David Rouselle, Co-chair
Dr. Elizabeth Samson
Dr. Karen Saperson
Dr. Dori Seccareccia
Dr. Lynne Thurling
Dr. Anne Walsh
Dr. Donald Wasylenki
Dr. Brian Watada
Dr. Stephen Whittaker
Dr. Lesley Wiesenfeld

We thank those members whose terms are ending in 2020. Your dedication, commitment and contribution to the Inquiries, Complaints and Reports Committee, over the years of your service, has been valued and greatly appreciated.

Key Accomplishments

Over the past year, the ICRC, with the assistance of the Investigations and Resolutions staff, have identified, measured and monitored improvements to the processes and outcomes of the Committee. The Committee, which has been supportive of modernizing its work over the years, was pushed to embrace a virtual space in which to work, as the COVID pandemic unfolded in early 2020. The Committee demonstrated its ability to change and adapt when all panel meetings shifted from in-person and teleconference meetings to the Skype and Microsoft Teams platforms. In April, this transition went beyond panel meetings to include the addition of Verbal Cautions on the Skype platform.

Frequent, focused and shorter panel meetings, combined with the positive uptake of early resolution options (i.e. Alternate Dispute Resolution [ADR], threshold & withdrawal) have allowed the Committee to tackle the complex cases, many of which require more preparation time and result in detailed dispositions, such as undertakings. Complex cases require the focused attention of the Committee members who not only review and adjudicate on the investigative materials, but also consider and weigh the advice of the legal and medical advisor teams.

The frequent meetings have allowed for investigative matters to be listed and adjudicated in a timely manner. Decision writers have been able to focus their attention on fewer cases, drafting and completing decisions within four to six weeks. Over the course of 2020, approximately 80% of public complaints were completed within 164 days; this is the first time the ICRC has been able to complete investigations in a timely manner, that is just shy of the legislated timeframe of 150 days. The ICRC's commitment to and application of the principles of Right Touch Regulation, along with the effective use of Alternate Dispute Resolution (ADR) have contributed to the Committee's ability to close cases in a timely manner. Streaming low level public complaints to the early resolution I&R Team has allowed the Committees to focus on moderate to high risk matters.

The Committee continued to make updates to the decision template used by Committee members in SharePoint to record their deliberative notes and to communicate with other members of the panel prior to a meeting. The deliberative notes are also used by the Decision Writers to assist with drafting the Committee decisions, both pre and post meeting; the well-structured and utilized decision template has assisted the decision writers with extracting the important pieces of information needed for drafting the decisions.

The Committee also introduced the Guide of Outcome Dispositions; a tool meant to assist new Committee members with their deliberations and outcome assessments. Over the course of 2020, the ICRC continued to identify gaps and needs of its members and then respond to those needs by providing various tools and supports.

Mentorship & Training for New Members

Throughout this past year, in collaboration with the Governance Committee and staff, the ICRC implemented a mentorship initiative for new Committee members. The initiative involved pairing an experienced Committee member with an incoming member for support. The mentorship is in addition to a set orientation program delivered by several College staff experts. The mentor assists the new member by shadowing him/her at the first assigned panel(s), reviewing cases, discussing processes and convening to address any questions or learning gaps. The mentorship relationship is flexible, but ideally is set for the first nine to twelve months; it is intended to meet the learning needs of the new Committee member with real time guidance and feedback. Both mentees and mentors have provided overwhelmingly positive feedback to date on this new initiative; data will continue to be collected and presented as the program progresses, with revisions made to the mentorship program as is required.

As part of the orientation for new Committee members and continuous training for existing members, a select group of ICRC members (<2 years on ICRC) received targeted legal training on the following topics:

- The role of causation
- The relationship between the ICRC and the Discipline Committee
- Independent decision-making/statutory roles
- Deliberative privilege
- Conflict of interest
- The roles of settlement & prescribing panels

ICRC Training and Education for Members

The ICRC Leadership Team, in collaboration with I&R leadership staff, identified learning and training needs of the Committee throughout the year. In February, the ICRC Leadership team, consisting of Co-chairs, Vice Chairs and alternate Chairs, received an education session focused on leadership topics such as, establishing meeting norms and being an effective chair. At this meeting the Leadership Team was introduced to the draft Terms of Reference (TOR), an initiative from the Governance Committee; the TOR have helped to align the ICRC with all other Committees.

The two Committee Business meetings held in April and October provided focused knowledge translation and training provided by College staff from various departments on several topics including these examples:

- Standardized Supervision
- Judicial review and Administrative law updates
- Deliberative privilege and maintaining the record
- Declaring a conflict of interest
- Omitting Panel Member Names from ICRC Decisions
- How complaints are investigated
- Review of guidelines for:
  - Efficient Panel Meetings
  - Posting Notes of SharePoint
  - Use of the Risk Assessment Tool
  - Dispositions for Complaints and Registrar's investigations

Looking Ahead to 2021

The Committee will likely continue to hold panel meetings virtually on the Microsoft Teams platform for the first half of 2021. The new year will also see the adoption of the College's New Solis System Platform, which is scheduled for release to the Committee in July of 2021.

Succession planning will continue to be a focus in the following year. The Committee will also continue to foster a core group of experienced members who understand legal processes, College policies and the governing legislation, while further enhancing the mentorship, training, education and recruitment needs.

Respectfully submitted,

Dr. David Rouselle
Co-Chair, Inquiries, Complaints and Reports Committee

Dr. Anil Chopra
Co-Chair, Inquiries, Complaints and Reports Committee

Patient Relations Committee

Committee Mandate

The Patient Relations Committee 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 Patient Relations Committee 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 Patient Relations Committee is also responsible for advising Council with respect to the patient relations program, as necessary.

By administering the funding for therapy and counselling program, the Patient Relations Committee not only assists patients in getting the help they need, but in doing so is also making an important statement about the College's commitment to supporting these patients. Through this fund, the College recognizes the harm caused when physicians sexually abuse their patients.

Committee Members

Dr. Rajiv Bhatla
Ms. Lisa McCool-Philbin, Chair
Ms. Sharon Rogers
Dr. Heather Sylvester
Dr. Angela Wang
Dr. Diane Whitney

We thank those members whose terms are ending in 2020. Your dedication, commitment and contribution to the Patient Relations Committee, over the years of your service, has been valued and greatly appreciated.

Key Accomplishments

Funding for Therapy and Counselling

In 2020, the PRC focused primarily on reviewing funding for therapy and counselling applications. Between January and October 2020, the Committee reviewed and approved 27 applications for funding for therapy and counselling, awarding $433,620 to the approved applicants.[1,2] During this time period,

[1] *The eligibility criteria are set out in the Code (85.7(4)) and Ontario Regulation 114/94 under the Medicine Act, 1991 (Section 42(2)).*

[2] *Ontario regulation 50/94 (Section 1(a)) 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 $17,030. Typically, the Patient Relations Committee awards eligible applicants the maximum amount of funding allowed by regulation.*

$173,391.70 was paid out to approved applicants. This amount includes monies awarded to applicants approved in years prior to 2020. Monies are paid out as applicants use therapy and counselling. Some patients may not use the full award or even any of it, and some may use it at different intervals over a period of time. Applicants have five years to use their funding.

Council was informed in the last Annual Report that the Patient Relations Committee decided to allow approved applicants to use their funding to pay for costs associated with facilitating access to therapy and counselling e.g., transportation and childcare costs. Since this program decision was made, several individuals have received reimbursement for travel to get to a therapist as well as childcare costs. If these costs had not been paid these individuals would not have been able to access the needed therapy. The recent decision by the Patient Relations Committee to pay approved applicants directly when they have paid out of pocket instead of requiring a therapist to complete and submit a form to invoice the College has also been very beneficial to these individuals as well. Both of these steps were taken following feedback from approved applicants, supporting the College's key performance indicator relating to meaningful engagement.

The College continues to make concerted efforts to improve the accessibility of the funding for therapy and counselling program on the College's website as well as improving direct communication to potential applicants. Application forms are available online (or they can be mailed out at various points during the intake and complaints process), there is a comprehensive FAQ about the funding for therapy and counselling program, as well as a list of community resources for victims of sexual abuse on the College's website, all of which supports the College's KPI regarding meaningful engagement.

In addition, this year the invoicing of submitted receipts was streamlined, supporting the College's key performance indicator relating to continuous improvement.

Education

When time permitted, the Patient Relations Committee was able to learn more about other areas and processes of the College. This year, the Committee had educational sessions on Compliance Monitoring and Legal Counsel presented on the threshold for imposing interim suspensions by the Inquiries, Complaints and Reports Committee. Before the end of 2020, the Committee will also be learning about QA/QI at the College as well as the College's Committee Structure and where the Patient Relations Committee fits. Patient Relations Committee members have also been active participants in broader committee training and education, including governance training and the College's Annual Education Day.

As all Committees have done, the Patient Relations Committee updated their Terms of Reference this year. This included additions to capture the Committee's interest in educating and advising Council with respect to broader sexual abuse issues that arise and preventative measures, as necessary and recommending new initiatives to Council regarding the College's patient relations program concerning sexual abuse, as appropriate.

Succession Planning

A succession plan was developed for the new public member who joined the Committee last year and was assuming the role of Chair of the Patient Relations Committee by the end of her first year on the Committee. The plan included mentoring by the current Chair as well as chairing most of the meetings in 2020.

Looking Ahead to 2021

The Committee has gleaned a number of insights from their review of funding for therapy and counselling applications. Over the past year the Committee has seen applications from patients alleging sexual abuse by physicians with long histories of progressive complaints/boundary issues and physicians who sexually abused a number of individuals. This is an area in which the Committee intends to do further research and will identify ways to share their learnings and perspectives with Council.

The Patient Relations Committee will continue to build on the efficiencies that have been recently implemented. As part of the Committee's commitment to continuous improvement, it is looking at developing a framework that helps assess ad-hoc/novel requests for funding in order to foster consistency. The Patient Relations Committee will continue to identify ways to respond to applicant/approved applicant feedback, and use found time to do educational and meaningful engagement activities.

Respectfully submitted,

Ms. Lisa McCool-Philbin
Chair, Patient Relations Committee

Premises Inspection Committee

Committee Mandate

The Premises Inspection Committee (PIC) oversees the Out-of-Hospital Premises Inspection Program (OHPIP). The program captures procedures performed with the use of parenteral sedation, general anesthesia or regional anesthesia (except for a digital nerve block). Some procedures commonly performed in an OHP include, but are not limited to, cosmetic surgery, endoscopy, hair transplantation and adult chronic pain management.

The role of PIC is to administer and govern the College's premises inspection program in accordance with Part XI of Ontario Regulation 114/94. The duties of PIC include, but are not limited to:

- Review premises inspection reports and other related materials
- Decide if a premise passes, passes with conditions or fails an inspection;
- Specify the conditions for each premise that passes with conditions or fails an inspection;
- Provide written reports to premises that are inspected;
- Review adverse event reported by individual premises
- Enforce OHPIP standards.

Committee Members

Dr. El-Tantawy Attia, PhD
Dr. Tamia Belej-Rak
Dr. Steven Bodley
Dr. Andrew Browning
Dr. Patrick Davison
Dr. Marjorie Dixon
Dr. William Dixon
Dr. Mark Mensour
Dr. Gillian Oliver, Chair
Mr. Peter Pielsticker
Mr. Ron Pratt
Dr. Jerry Rosenblum
Dr. Holli Schlosser
Dr. Robert Smyth
Dr. Andrew Turner
Dr. James Watson
Dr. Ted Xenodemetropoulos

We thank those members whose terms are ending in 2020. Your dedication, commitment and contribution to the Premises Inspection Committee, over the years of your service, has been valued and greatly appreciated.

Key Accomplishments

This past year saw the OHP inspection program sidetracked by COVID-19 and the programs response to the pandemic, which resulted in several inspections being put on hold. In the early months of the pandemic, OHPs were closed, as per the directive of the Ontario Government. All inspections were ceased during the period of lockdown in the province. Following the Government issuing Directive #2, which allowed OHPs to reopen, program staff collaborated with Public Health Ontario (PHO) to develop expectations related to premises operating with appropriate COVID precautions. The precautions outlined expectations regarding social distancing within a clinic, sterilization of surface areas between patients, proper use of personal protect equipment, and other relevant infection prevention practices. The COVID-19 precautions were sent to all OHP Medical Directors and were available on the CPSO and PHO websites. Since the release of Directive #2, OHP inspections have resumed, with completed inspections proceeding to PIC.

All inspections that were previously placed on hold have been initiated; the program is slowly catching up to the targeted number of inspections slated for completion in 2020.

The pandemic also forced the inspection program to make changes to how and when inspections are conducted. If the assessor(s) are required to be on site for either stage of the inspection, then arrangements are made to have the assessor complete the inspection on a day when minimal patients are scheduled. Medical charts and premises documents (such as policies, etc.) are requested in advance and received by the College staff, thus minimizing the assessor's time at and contact with the premises.

When possible, arrangements are made for remote (virtual) assessments to follow up on inspection recommendations/requirements, such as renovations, in a Level 1 premises; level 1 premises use single use items only, these facilities do not use sterilization for reprocessing.

Looking Ahead to 2021

- January 2021 is the beginning of the next five-year cycle, which presents the opportunity to review and revise the current OHPIP Standards
- Further process changes and efficiencies are anticipated with the roll out of the Solis and Vault enterprise systems in July 2021

Respectfully submitted,

Dr. G.D. Oliver
Chair, Premises Inspection Committee

Quality Assurance Committee

Committee Mandate

Under the Regulated Health Professions Act, 1991, the Quality Assurance Committee (QAC) is mandated to administer the Quality Assurance Program. This fosters continuing competence among members, assesses individual members' knowledge, skill and judgment, and monitors members' participation and compliance with the Quality Assurance program. The QAC supports the College's commitment to the public that physicians are engaged in continuous quality improvement.

As CPSO refined and launched its Quality Improvement Program earlier this year, it was an opportunity to clarify how Quality Improvement intersects with Quality Assurance. While Quality Improvement is under the oversight of Council and sits outside of the Quality Assurance process, the QAC supports the College's commitment to the public that physicians are engaged in continuous quality improvement.

The Quality Assurance 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.

Committee Members

Dr. Steven Bodley
Dr. Lisa Bromley
Dr. Jacques Dostaler
Dr. Michael Franklyn
Dr. Miriam Ghali Eskander
Dr. Deborah Hellyer
Dr. Hugh Kendall (Jan-Oct 2020)
Dr. Kenneth Lee
Mr. Paul Malette
Dr. Meredith MacKenzie
Mr. Peter Pielsticker
Dr. Sarah Reid
Dr. Deborah Robertson
Dr. Patrick Safieh
Dr. Ashraf Sefin
Dr. Robert Smith
Dr. Tina Tao
Dr. Smiley Tsao
Dr. Janet van Vlymen, Chair

We thank those members whose terms are ending in 2020. Your dedication, commitment and contribution to the Quality Assurance Committee, over the years of your service, has been valued and greatly appreciated.

Key Accomplishments

Key accomplishments included the adoption of right-touch regulation as one of the foundational principles. This new approach provided an opportunity for the QAC to consider the redesign of its processes, which permits new approaches to the Quality Assurance Program, and to develop and understand future initiatives aimed at quality improvement.

During this past year, the QAC has added another option to its Opportunity to Address decision-making process by providing members with the opportunity to address the Committee's concerns through one-on-one discussions with CPSO Medical Advisors. In 2020, there have been 13 referrals for physicians to speak with a Medical Advisor. Medical Advisors prepare a memo to the QAC regarding their interaction with the physician. Of the 13 Medical Advisor cases reviewed, 12 of the 13 resulted in a No Further Action decision by the QAC. The remaining one physician was provided the opportunity to sign an undertaking to undergo an Individualized Education Program with a follow-up reassessment once the elements of the program were complete. As a result of this new option, the QAC has significantly reduced the number of interviews of physicians. In 2020, the Committee had a total of five interviews that were scheduled.

COVID-19 resulted in a suspension of peer and practice assessments for a period of three months (March – June) during the height of the pandemic. In June the peer and practice assessments were reinstated utilizing different approaches to the traditional on-site peer assessments. The Assessor Network Leads were consulted on how components of an in-person assessment could be completed remotely in order to reduce the risk for both the subject physician and the assessor. Staff worked to develop a remote assessment process for those physicians who had an EMR system, and offering physicians who were still using paper charts the option of either having an on-site assessment with appropriate personal and protecting equipment in place and/or submitting charts for scanning to the CPSO for assessor review. We are continuing to work with our assessors and subject physicians in light of the second wave of COVID-19. We are aiming to have our assessments completed by the end of the year.

The overall number of Member Specific Information meetings in 2020 was reduced from every two weeks to monthly while maintaining productivity. These meetings are being held virtually and as a result we have reduced overall program costs. If there are assessments that identify serious clinical issues, there is the capability to arrange an ad-hoc panel meeting between the regular scheduled Member Specific Information meeting to deal with these types of cases.

Looking Ahead to 2021

There have been some significant challenges with the QAC in 2020 which resulted in the Co-Chairs stepping down from their role with one Co-Chair resigning from the Committee.

Council approved changes to the governance structure of all CPSO Committees in September which shifts away from a Co-Chair model to a Chair/Vice-Chair model. This governance structure is more reflective of leading practices, enables better succession planning and facilitates mentoring within the Committees. As we move forward in 2021, the new Chair and Vice Chair will be working with CPSO staff and members of the QAC to foster better communication, stability and trust.

The Committee will continue to use a portion of their business meetings for educational purposes. As a result of concerns raised in 2020, some new initiatives have been put on hold, however they are anticipated to resume next year.

In 2021, the QAC will:

- be introduced to the process of removing the option of in-person interviews from their decision options.
- work with our policy and QA program staff to consult on policies concerning the prescribing of Opiate Agonist Treatment and Safe Supply in order to guide physicians who are considering these treatment options for opioid addiction and better access for patients who are seeking treatment.
- finalize a Terms of Reference for the Committee which will clarify the roles, responsibilities and expectations of Committee members and facilitate the Committee's annual self-assessment process.

In the coming months, the Chair will continue to speak with all members of the QAC to review the Committee members' goals, and identify strategies to enhance the effectiveness of Committee overall.

Respectfully submitted,

Dr. Janet van Vlymen, Incoming Vice-President
Chair, Quality Assurance Committee

Registration Committee

Committee Mandate

The Registration Committee's mandate, described in the Health Professions Procedural Code, is 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 developing 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.

Committee Members

Dr. Bob Byrick
Mr. Pierre Giroux
Dr. Barbara Lent
Mr. Paul Malette
Dr. Judith Plante, Chair
Dr. Kim Turner

We thank those members whose terms are ending in 2020. Your dedication, commitment and contribution to the Registration Committee, over the years of your service, has been valued and greatly appreciated.

Key Accomplishments

Right-Touch Regulation

In 2020 the Registration Committee was faced with some unique challenges. The COVID-19 pandemic required the Committee to respond to an emerging crisis that had direct impact on physician resources and required the Committee's swift response.

As soon as the College learned that the CFPC, RCPSC and MCC exams were being postponed, the Registration Committee worked to find ways that the College could mitigate impact while still operating within our overarching legislative framework.

The Registration Committee met in mid-March and agreed to modify the existing "Restricted Certificates of Registration Policy for Exam Eligible Candidates" for 2020 Final Year Residents who were unable to sit the examinations due to COVID-19.

The modified policy included expediting registration of qualified candidates, reducing application requirements, modifying expectations around supervision, and exempting this group from a subsequent application fee

Additionally, the Committee approved the Imposition of Terms Conditions and Limitations Proposed by the Registrar for "Restricted Certificates of Registration for 2020 Final Year Residents who are Exam Eligible Candidates During the COVID-19 crisis," allowing applicants to be issued without requiring Registration Committee review as long as they met the prescribed requirements.

The certificates were issued for a period of six months with the expectation that candidates would be able to sit the postponed examinations in the fall.

In October, upon hearing that examinations were again being postponed due to COVID-19, and in support of candidates who expressed safety concerns with sitting an in-person exam while COVID cases were on the rise, the Committee approved extension of the Restricted certificates until June 30, 2021.

Throughout the COVID-19 pandemic, the Registration Committee has been committed to acting as a flexible, enabling Committee with the goal of ensuring there are minimal to no impacts on health care human resources while ensuring safe care for the public.

This reflects the Committee's core objective – to remove barriers to registration for qualified individuals – creating and maintaining mechanisms to enable registration of individuals who may not fulfill the requirements outlined in the Regulation, but who are capable of practicing at the standard expected of an Ontario physician.

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.

System Collaboration

The Registration Committee continues to work closely with several stakeholders including the medical schools, certifying bodies and resident organizations to ensure it is proactively regulating the profession.

Continuous Improvement

In July, the College's New Member Orientation (NMO) launched as a credentialing requirement for all newly registered members. The NMO consists of e-learning modules designed to assist new registrants in understanding regulatory requirements and expectations of members. It sets out the roles and responsibilities as self-regulated professionals and provides an overview of the College. Topics include professionalism, College policies, and expectations, particularly around boundary violations and the prevention of sexual abuse.

Web-based registration improvements

This September, the College's online Enterprise System, Solis, launched. Solis provides, among many other benefits, an online portal to applicants and members for electronic submission of applications with a real-time view to application status.

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 we have created the following published application resources:

- Frequently Asked Questions documents for supervisors and clinical fellows; and
- Registration Policy Guides.

All the website enhancements have resulted in increased transparency, specifically regarding requirements/processes and protocols.

Education Initiatives

This year, in addition to circulating relevant articles of interest and discussing decision review and outcomes, the Committee participated in an educational session on "Unconscious Bias" and inclusion.

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.

Fiscal Accountability

The Registration Committee continued 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.

Additionally, as of March, the Registration Committee transitioned strictly to a virtual meeting platform which has led to increased cost savings.

Looking Ahead to 2021

A guiding principle of Right-Touch Regulation is the belief that regulation should be utilized only when necessary and aim to be proportionate, consistent, targeted, transparent, accountable, and agile.

This year's unique challenges have highlighted the Committee's ability to be nimble, fair, proactive and innovative. The Committee has approved and employed 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. Additionally, in 2021 we anticipate continuing to explore educational opportunities in equity, diversity and inclusion.

In accordance with the College's strategic plan, the Committee will continue to focus on ways to improve efficiency of the Registration Committee process – and ensuring a process that is fair, transparent, impartial and objective.

Respectfully submitted,

Dr. Judith Plante, MDCM, CCFP, FCFP
Incoming President
Chair, Registration Committee

CEO/REGISTRAR'S REPORT

(No materials)

CPSO

Council Briefing Note

December 2020

TOPIC: Continuity of Care Guide for Patients and Caregivers

FOR INFORMATION

ISSUE:

- During the development of the *Continuity of Care* policies, a commitment was made to recognize, capture, and support the important and growing role patients play in facilitating continuity of care by developing a resource that would help engage them in their care and complement the efforts of physicians.

- Using a 'co-design' strategy, CPSO staff and members of the Citizen Advisory Group have now finalized the *Continuity of Care Guide for Patients and Caregivers* (the "Guide"). Council is provided with an overview of the development of this resource and an outline of next steps.

BACKGROUND:

- Beginning in the Spring of 2016, a policy review and development process was undertaken to address continuity of care issues. This culminated in the approval of four *Continuity of Care* policies in the Fall of 2019 that address: *Availability and Coverage*; *Managing Tests*; *Transitions in Care*; and *Walk-in Clinics*.

    - This review and development process included extensive research, consultation and engagement, including with members of the public and patients through public opinion polling and focus groups with the Citizen Advisory Group.

- During the review, it became clear that while physicians are key facilitators of continuity of care, there are limits to what any individual physician can do to ensure continuity of care.

  - Notably, there are often health system-level factors that are beyond the control or influence of individual physicians that impact continuity of care; and
  - Patients have an important and growing role to play in facilitating continuity of care, as actions they take may contribute to or help prevent breakdowns in continuity of care.

- As a result, patient engagement in their own care was identified as a key mechanism for facilitating continuity of care that could complement efforts made by physicians in compliance with the expectations set out in the *Continuity of Care* policies.

- To support this engagement, CPSO committed to developing a resource for patients that would help them understand the role they can play in facilitating continuity of care by outlining some of the actions they can take.

CURRENT STATUS:

- While initially the focus of this work was on patients, the important role caregivers play in supporting patients and facilitating continuity of care became obvious from the outset and so the scope of the project was quickly adapted.

- In keeping with CPSO's commitment to meaningful engagement and recognizing that this resource was being developed for and to help patients and caregivers, a 'co-design' model of content creation was adopted. This meant working collaboratively and iteratively with patients and caregivers as *partners* in the creation of the resource, giving them as much control over what was said and how it was said as possible.

- The Guide (attached as **Appendix A**) was developed over the course of many months and multiple interactions with members of the Citizen Advisory Group. While CPSO staff were responsible for developing materials and supporting decision-making, our focus was on making sure the content was accurate from a policy perspective and that the content reflected the feedback and direction of the Citizen Advisory Group.

  - The project launched with a virtual focus group with a small but engaged group of patients and caregivers in order to: explore the policies; identify expectations that they felt were most relevant or important for patients and

caregivers to know about; and to identify the kinds of actions patients and caregivers can take and the supports they need to undertake these actions.

- Responding to direction from the focus group, all members of the Citizen Advisory Group were then invited to provide stories or personal reflections on times where they felt engaged in their care in order to include illustrative examples in the Guide.

- On the basis of the feedback and direction obtained in the initial focus group, a draft version of the Guide was developed and then reviewed by members of the Citizen Advisory Group through an externally facilitated virtual meeting with the express intention of validating the resource and the learnings of previous engagement activities. Members reviewed each section of the Guide in detail, to ensure it reflected the direction previously provided and to determine whether the information and guidance provided resonated with them and would be helpful for other patients and caregivers.

- After the Citizen Advisory Group's exuberant endorsement of the content, with minor revisions throughout, the Guide was finalized and is now ready for publication. The format of the Guide is to look thematically at components of the four policies, explaining to patients and caregivers what expectations have been set out for physicians, and then outlining steps they can take to engage themselves in their care.

NEXT STEPS:

- The Guide is currently being prepared for publication on CPSO's website. CPSO's and the Citizen Advisory Group's goal is to make the Guide accessible and to distribute it as widely as possible.

    - To support this objective, a communications plan is being developed that includes: translating the Guide into priority languages; distributing it to key and diverse stakeholder groups; promoting it through our communication tools (i.e., social media, Patient Compass, etc.); and engaging the various patient and caregiver networks we have built relationships with to support distribution.

DECISION FOR COUNCIL:

1. This item is for information

Contacts: Dr. Brenda Copps
Craig Roxborough, ext. 339
Michelle Cabrero Gauley, ext. 439

Date: November 13, 2020

Attachments:

Appendix A: *Continuity of Care Guide for Patients and Caregivers*

CPSO

Serving the people of Ontario through effective regulation of medical doctors

Continuity of Care

Guide for Patients and Caregivers

**This guide was co-designed by College of Physicians and Surgeons of Ontario (CPSO) and the Citizen Advisory Group (CAG).*

CPSO is the organization who serves the public interest by regulating doctors in Ontario. This means CPSO is responsible for licensing doctors and has a legislated mandate to continuously improve the quality of care provided by doctors. CPSO is who you would contact if you have any questions or concerns about a doctor.

CAG helps bring the patient voice and perspective to healthcare regulation in Ontario. CAG members are patients and caregivers who provide essential feedback on topics such as professional rules, standards of practice, policies, strategic priorities and communications directed at the public. Their voice helps to support health regulators work in protecting the public interest.

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What is it like to be a patient in Ontario?

As a patient, you likely seek care from a number of different health-care providers in a number of different settings. For example, you may have a family doctor, but also see specialists for specific issues. You may also occasionally see a chiropractor or massage therapist, and you may pick up your prescriptions from one or more pharmacies. You may seek care from walk-in clinics and the emergency room, and may even have to stay at the hospital for a period of time.

Your health-care information is not captured in one place. Each health-care provider keeps their own records about the care they provide you, but that information isn't necessarily shared between all the health-care providers you see.

Did you know…?

You can ask your health-care providers if there is a local electronic health record you can access.

While there isn't a province-wide electronic health record that patients have access to yet, some regions or organizations have local electronic health records and patients may even have access to them.

For example, MyChart is an online website where patients can create and manage their own personal health information. Patients have access to clinic visit notes, radiology (e.g., x-rays or ultrasounds), labs, etc. from participating hospitals.

Because health-care providers are not all connected and information does not always move seamlessly through the health-care system, information sometimes falls through these cracks, which can have bad outcomes for patients. See the story of Greg Price in Alberta for a very tragic example of how a patient fell through the cracks.

What is continuity of care?

Continuity of care can mean many things, but often it refers to patients experiencing their care as being connected and coordinated as they move between health-care providers and through the health-care system.

CONTINUITY OF CARE MEANS:

- Knowing when and where to seek care;
- Having a family doctor (or primary care provider) and primarily seeing them for any care you need so they can provide you with complete care;
- Only using walk-in clinics or emergency rooms when you really have to;
- Having your information shared between all your health-care providers so they have the whole picture and can better care for you;
- Understanding what role each health-care provider has in your care;
- Making sure test results or referrals to other heath-care providers are not lost or delayed; and;
- Making sure your transitions between parts of the health-care system are smooth.

You can help support the continuity of your care by working in partnership with your health-care providers and **playing an active role in your care**.

What is CPSO's role in continuity of care?

CPSO sets expectations for doctors through documents called "policies". CPSO has policies on a number of different issues related to the practice of medicine. CPSO has recently developed the following four *Continuity of Care* policies:

POLICY	WHAT'S IT ABOUT
1) *Availability and Coverage*	• Having access to your doctor and knowing when and where to go if they are out of the office.
2) *Managing Tests*	• Making sure test results don't get lost or delayed.
3) *Transitions in Care*	• Knowing what role each health-care provider is playing in your care and making sure any transfers to new health-care providers or settings are smooth.
4) *Walk-in Clinics*	• Knowing what you can expect from walk-in clinics and the limitations of using one instead of having and seeing a family doctor.

CPSO recognizes that there are limits to what we or any individual doctor can do to ensure continuity of care is provided. For example, we only regulate doctors so we can't set expectations for other health-care providers, and there are things in the health-care system that the CPSO and individual doctors can't control. CPSO policies try to address some of the problems that lead to breakdowns in care without expecting that doctors will be responsible for fixing everything in the system.

Why was the *Continuity of Care Guide for Patients and Caregivers* developed?

Patients and caregivers play an increasingly important role in helping support continuity of care and their actions can help prevent breakdowns in care. Patients and caregivers who are engaged and have the right information and tools they need to navigate the health-care system can help prevent patients from falling through the cracks.

What is in the *Continuity of Care Guide for Patients and Caregivers*?

In each section of this *Guide*, there is a description of the issue, a list of responsibilities doctors have, and a list of things you (patients and caregivers) can do to help support continuity of care.

The "you" in this document is often speaking to patients, but we know caregivers play a very important role in patient care, and we expect caregivers will see themselves in the "you" when reading this. As such, both patients and caregivers can do any of the things listed in the "what you can do" sections throughout the *Guide*.

1) Communicating with your doctor

It is important for you and other health-care providers (e.g., pharmacists) to be able to communicate with your doctor. Doctors' offices cannot be open 24/7 to take calls. But your doctor's office is required to give you and others who are involved in your care the chance to communicate with them.

WHAT YOU CAN EXPECT FROM YOUR DOCTOR	WHAT YOU CAN DO
→ **During regular business hours, you will be able to call your doctor's office and either someone will answer, or you will be able to leave a voicemail.** → **Your doctor will communicate with and/or provide information to other health-care providers (e.g., specialist, pharmacist, etc.) who are caring for you.**	→ Ask if your doctor is available to communicate by email, text, instant messaging, portal, etc. o If so, this will give you another way to communicate with them during business hours. → If the doctor has multiple ways to communicate with them (e.g., phone, email, etc.), tell them which way you prefer to communicate with them (e.g., by phone because you don't have email). → Ask what to expect in terms of response times when communicating with the doctor's office (e.g., you can expect a call back within x hours, email is only monitored during business hours and you can expect a reply within x hours, etc.).

2. Booking appointments with your doctor

Seeing your own doctor when possible helps with continuity of care. When your doctor can't fit you in, you may have to seek care elsewhere (e.g., walk-in clinic or emergency room).

WHAT YOU CAN EXPECT FROM YOUR DOCTOR	WHAT YOU CAN DO
→ **Your doctor has to create some space in their schedule for patients with time-sensitive or urgent issues so they can get an appointment.** → **This means you do not have to seek care elsewhere (e.g., a walk-in clinic or an emergency room) for these issues.**	→ When possible and appropriate, wait to see your doctor instead of going to a walk-in clinic or emergency room. → When possible, try to plan ahead and make appointments with your doctor for things you can predict (e.g., yearly physicals, regular prescriptions that need to refilled every 3 months, etc.). o This will help your doctor plan for the predictable while leaving some space in their schedule to address the unpredictable (e.g., urgent or time-sensitive issues).

What caregivers are saying…

"I am the primary caregiver for my loved one and I make all of their appointments and communicate with the doctor on their behalf. We spoke to the doctor about my role as the patient's caregiver so they know I am able to do this on the patient's behalf, and the office expects my calls and presence at their appointments."

3. When your doctor is not available…

Doctors cannot be available 24/7. Your doctor may not be available when their office is closed for the day and/or weekend, or when they are away from the office for an extended time (e.g., on vacation).

Even if your doctor is unavailable in these circumstances, they still have some responsibilities to you.

WHAT YOU CAN EXPECT FROM YOUR DOCTOR	WHAT YOU CAN DO
→ **Your doctor will let you know when and where to go for care when their office is closed for the day and/or weekend, to help you navigate your options.** → **Test results that require immediate attention will be communicated to you 24/7.** → **Your doctor will make arrangements when they are away from the office (e.g., on vacation) to make sure you get the care you need in response to test results or specialist reports.** → **Your doctor will try to make arrangements with other health-care providers to cover your care when they are away from the office (e.g., on vacation), but may point you to a walk-in clinic or the emergency room if they are not able to do so.**	→ Ask your doctor what signs or symptoms you should watch out for, and when and where you should seek care outside regular office hours. → Check if your doctor has after-hours or weekend coverage before seeking care elsewhere. → Make sure your doctor has your up-to-date contact information in case they need to contact you urgently about a test result. → If you are waiting for test results or a specialist's report and haven't heard anything, contact your doctor's office to inquire about the status. → Check if your doctor has another health-care provider covering for them while they are away from the office before seeking care elsewhere. → Consider asking another health-care provider (e.g., pharmacist) that is caring for you whether they can assist with any relevant issues (e.g., prescription refills). → Write down important information about your health including a list of medications you are on so that if you go to a walk-in clinic or emergency room, you can share that information with the health-care provider you see. → If you seek care elsewhere (e.g., from Telehealth, a walk-in clinic, emergency room, etc.), tell your doctor about it.

What caregivers are saying…

"I keep the little slip of paper I get from the pharmacist when I fill a prescription. This has a list of all the medications that I have received from that pharmacy. I am a caregiver for some of my family members and friends, and I tell them to keep this list so we can bring it to their appointments. That way, the health-care provider we see will have the patient's medication list."

Templates for your health summary and medication list

To help you write down important information about your health, see **Appendix A** for a template you can print, fill out, and bring to any new health-care provider you see.

To help you make a **medication list**, see Medication Lists and Tools for letter and wallet size templates you can print, fill out, and bring to any new-health provider you see.

Questions to ask your doctor

To help you understand when and where to go for care when your doctor is unavailable, ask your doctor:

1. Which specific signs or symptoms should I look out for (e.g., blood pressure, temperature, feeling faint or dizzy, swelling, etc.)?
2. How urgently should I get care if I experience these signs or symptoms (e.g., wait until your office reopens in the morning or call 911)?
3. Where should I get care if I experience these signs or symptoms (e.g., walk-in clinic or emergency room)?

4. Ordering tests and tracking results

Your doctor orders tests to help them to monitor your health-care needs and identify any concerning issues. Your safety can be compromised when you don't do a test your doctor orders or your test results are missed or delayed.

WHAT YOU CAN EXPECT FROM YOUR DOCTOR	WHAT YOU CAN DO
→ **Your doctor will explain why a test is being ordered, how quickly it needs to be done, and the instructions you need to follow (e.g., to fast before the test) and the importance of doing so.** → **Your doctor will have a system in place to manage test results. This will help make sure test results are not missed or delayed.**	→ Ask what test is being ordered and why, and how quickly the test needs to be done. → Before you go for the test, make sure you have, understand, and follow the test requisition form instructions. If the instructions are unclear, ask for clarification. → Do the test in a timely manner, especially if it is urgent. → Tell your doctor if you are anxious about the test. → If someone other than your family doctor is ordering a test, ask them to copy your family doctor on the test requisition (if you have one). This will keep your family doctor informed about the tests that are being ordered for you.

5. Communicating and following-up on test results

The results of any test you do is information you are entitled to. How and when you get it will depend on the result, your circumstances, and the need for follow-up care.

Your doctor will review your test results and determine what, if any, action is needed to address the results. This helps ensure you receive the care you need.

WHAT YOU CAN EXPECT FROM YOUR DOCTOR	WHAT YOU CAN DO
→ **Your doctor will communicate any test results that require immediate attention to you in a timely manner, but may hold off on other results until your next appointment.** → **Your doctor will tell you:** o **Whether or not they are using a 'no news is good news' strategy; and** o **That you have the option to personally contact the office or to make an appointment to come into the office to hear the test results.** → **If you have any questions about the test results, your doctor will be available to respond, even if they rely on others to communicate test results.** → **Your doctor will take any necessary action in response to test results that require immediate attention.** o **How quickly this care is provided to you will depend on how serious the test results are.**	→ Check if your doctor will use a 'no news is good news' strategy. → Ask the lab or diagnostic facility if there is a way to get or access the test results (e.g., a patient portal). → Tell your doctor if your condition worsens at any point in time after the test is ordered. → If you like, you could contact your doctor's office to ask about your test results, or to make an appointment to come into the office to hear about your test results (even if the doctor is using a 'no news is good news' strategy). → If you do an important test, follow-up with the doctor who ordered it if you haven't been contacted about the results. → Ask your doctor any questions you have about what the test results mean, and what the next steps are. → If a test has to be reordered, ask why. → Confirm who will be responsible for providing any care that is required (e.g., the doctor who ordered the test, a specialist, etc.). → Tell your doctor if you continue to feel unwell after taking the test and/or receiving the test results.

Did you know…?

You can ask your doctor or the lab you visit if you can access your test results.

Some labs or diagnostic facilities in Ontario provide patients with access to their test results.

For example, My Results is free and secure service that allows you to access LifeLabs test results online. Most results are available within 24—48 hours.

Please note that some labs or diagnostic facilities may charge a fee for this service, and not all test results may be available through a patient portal.

What patients are saying...

"I took time off work so I could get a test my doctor ordered. I showed up at the lab and they said I had to fast for 8 hours in order to prepare for the test. That meant I couldn't get the test done and had to return another day. Now whenever I get a test requisition, I ask the doctor or lab what I need to do in order to prepare for the test."

6. Staying at a hospital (or other health-care setting)

There may be many different health-care providers who are caring for you when you are admitted to a hospital or other health-care setting (e.g., rehabilitation facility) at any given time. For example, you may be seen by a team of doctors, nurses, physiotherapists, etc.

You need to know who is in charge of your care so you know who to go to for questions and concerns.

WHAT YOU CAN EXPECT IN THE HOSPITAL (OR OTHER HEALTH-CARE SETTING)	WHAT YOU CAN DO
→ **When care is provided by a team of changing individuals, your doctor or others on their team will keep you informed about who is in charge of your care (i.e., the most responsible provider).** → **When another health-care provider is assuming responsibility for your care (e.g., is in now in charge), your doctor will make sure the health-care provider has complete and up-to-date information about you.** → **This means the health-care provider who is now in charge will have the information they need to continue caring for you, but they may still double check the information with you when they see you.**	→ Ask each health-care provider to identify themselves to you and explain what their role is. → Check any information boards in your room that say who is in charge of your care and if you are unsure if they are up-to-date, ask. → Ask other health-care providers involved in your care for help with any questions or concerns you have. → If you still have questions or concerns, raise them with the person in charge of your care.

What caregivers are saying...

"There was an information board in my daughter's hospital room, but it was blank. I asked the health-care providers who were caring for my daughter to write their names on the board and I prompted them to update the information board daily. This helped me keep track of who was caring for my daughter and it helped me build rapport with the health-care providers when I could call them by name. I also put my contact information on the board so everyone knew how to get in touch with me when I wasn't there in the room with her."

7. Going home from the hospital

Moving from one health-care setting to another sometimes leads to a breakdown in continuity of care. To help avoid these breakdowns, specific steps are needed to equip you and any health-care provider assuming responsibility for your care with the right information.

It is important for you to understand what going home from the hospital will be like, and what, if any, follow-up is needed.

WHAT YOU CAN EXPECT WHEN LEAVING THE HOSPITAL[1]	WHAT YOU CAN DO
→ **Before you leave the hospital, your doctor (or a member of the health-care team) will talk to you about important information like:** o **Risks or complications (e.g., problems) you could have;** o **Signs and symptoms to watch out for;** o **Who to contact and where to go if you need help; and** o **What follow-up care is needed (including any appointments that have been or need to be booked).** → **Your doctor will try to involve your family and/or caregivers in the discussion about leaving the hospital if that is what you want and agree to.** → **Your doctor will consider whether or not providing written reference materials will help during this discussion.** → **Your doctor will send a discharge summary (summary of care provided to you in hospital) to the health-care provider who will be responsible for your care once you leave the hospital (usually your family doctor).**	→ Ask to have your family and/or caregiver involved in the discussion about leaving the hospital if you think this would help you. → Tell your doctor (or member of the health-care team) if you are concerned about needing time to prepare to go home and would like to have this discussion early (not just before you leave). → Ask if there are any community resources available to help support the move and what role, if any, your family doctor can play (if you have one). → Ask questions about the information you get and clarify whether any follow-up is necessary. → Ask who to contact if you have any questions or concerns after you go home. → Write down important information, confirm you have it right, or ask the doctor (or member of the health-care team) to write it down for you so you can refer back to it. → Ask other health-care providers involved in your care for help with any questions or concerns you have.

[1] *When you are admitted as an inpatient and are being discharged. This wouldn't apply if you visited the emergency room and are leaving without being admitted as an inpatient.*

Patient and caregiver resource

To help you write down important information when you are going home from the hospital, see **Appendix B** for a template you can print and fill out at the hospital.

For more information about going home from the hospital, see the Ontario Health Quality Guide.

What caregivers are saying…

"As a caregiver, with an extensive health-care background, I am empowered in the true definition of this word. Therefore as a caregiver for my mother many years ago I was able to navigate the system and understand the transition process and advocate for my mother. For caregivers in general, I am not sure they feel empowered, i.e., knowledgeable enough to manage the system."

"Patients don't always have a family member or caregiver with them when they are transferred from one health-care setting to another (e.g., from long-term care to hospital). It is especially important for these patients to have a 'travelling file' that can go with them, so health-care providers have relevant information about the patient, and the patient's family and caregiver can access important information about their loved one."

8. When specialist care is needed

Sometimes issues come up that your family doctor is not able to manage and so they will make a referral to a specialist. A specialist may be involved for just a short period of time, helping your family doctor to understand your needs, or they may play an active role in your care for a long time.

Like going home from the hospital, referrals involve moving from one part of the health-care system to another and so breakdowns can occur. For example, a referral might get missed or delayed and you may not understand who you will hear from and when, or what role the specialist will play in your care.

WHAT YOU CAN EXPECT WHEN SPECIALIST CARE IS NEEDED	WHAT YOU CAN DO
→ **When your doctor refers you to a specialist, they will communicate their role to you (e.g., I don't know how to treat this condition, so I'm going to send you to specialist. If your condition worsens before your specialist appointment, let me know).** → **The specialist will also communicate their role to you (e.g., I will treat this specific condition, but you need to see your family doctor for any other issues that come up).** → **If your referral is urgent, your doctor will tell you to follow-up if you haven't heard back from anyone and will track the referral themselves to make sure the specialist gets it and you get the care you need.** → **The specialist will let your doctor know within 14 days of receiving the referral whether they can see you or not, and when. This will help your doctor figure out if the timing is right.**	→ Ask your doctor who is referring you to a specialist: o What their role will be; o Which specialist you are being referred to (or if you have a specific specialist in mind, communicate your preference); o What you are being referred for; and o When you can expect to hear about an appointment with the specialist. → Contact your doctor who is referring you to a specialist: o If you have not heard anything from the specialist when you were expected to; and o If you have any concerns about your health (e.g., you are feeling worse). → Contact the specialist if you need to change the appointment date or time. → Write down any questions you have for the specialist and bring them to your appointment.

→ **The specialist will contact you directly if and when they can see you, and will coordinate directly with you if you need to reschedule the appointment.** → **The specialist will report back to your doctor within 30 days of completing their assessment (although this might take a couple of visits) and will keep your doctor informed if they start providing ongoing care you.**	→ Bring any relevant information (e.g., medication list, test results, etc.) to your appointment. → Go to the appointment with the specialist.

What patients are saying…

"I was suffering from a rare condition and my family doctor had a hard time finding a specialist to refer me to. I did some research, made a list of specialists who treat my condition, and gave this list to my family doctor. This helped my family doctor find a specialist they could refer me to. I felt good about taking an active role in my care and working with my family doctor to find someone who can help me."

9. Going to a walk-in clinic

Walk-in clinics play an important role in our health-care system by helping patients access care when they need it and in a convenient manner. Because this care happens outside of established relationships patients have with their family doctors, there could be breakdowns in the continuity of their care. This is why it is important for patients to have and see their family doctor, when possible.

When you go to a walk-in clinic, it is important for information about the visit to be shared with your family doctor (if you have one), and for the walk-in clinic doctor to provide any appropriate follow-up necessary. This would help make sure you get the care you need.

WHAT YOU CAN EXPECT FROM DOCTORS IN WALK-IN CLINICS	WHAT YOU CAN DO
→ **When appropriate, doctors will talk to you about the benefits of having and seeing a family doctor.** → **Doctors will tell you if the care you need is not suitable for a walk-in clinic and will help you know where to go next.** → **Doctors providing care in walk-in clinics are held to the same standard as doctors in other settings.**	→ When you arrive, confirm they are able to address your concern. → If the walk-in clinic doesn't provide the service you came for, ask where you can go to get the service. → Write down important information about your health including a list of medications you are on so you can share that information with the walk-in clinic doctor. → If you would like your family doctor to know about the walk-in clinic visit, ask the walk-in clinic to send a report to your family doctor.

o **This means they will follow-up on any tests they order or referrals they make.** → **Doctors will report back to your family doctor (if you have one) if you ask or it's needed in order to protect your safety.** → **Doctors may involve you in this process if they can't send the information directly (e.g., if they don't have your family doctor's correct contact information).**	→ Take notes on what happened at the walk-in clinic visit and share them with your family doctor (if you have one), or keep them in your "file" and bring them to the next health-care provider you see.

Did you know…?

Family doctor offices in Ontario have different practice models. Some work by themselves, but many work with other doctors and/or health-care providers in group practices that often have after-hours care. Depending on the types of services you need, you may want to try to choose a family doctor based on what type of services they provide.

For example, if you can only go to the doctor after-hours, you may want to look for a family doctor that provides after-hours coverage. If you want to see a variety of health care professionals in one office, you may want to look for a family health team.

To explore which health care services are near you (e.g., community health centres, family health teams, etc.), you can visit the Ontario government's Health Care Options website.

For help finding a family doctor or nurse practitioner (both provide primary care and are who you would make an appointment with when you have a new, non-emergency health concern), you can use the Ontario government's Health Care Connect service.

Templates for your health summary and medication lists

To help you write down important information about your health, see **Appendix A** for a template you can print, fill out, and bring to the walk-in clinic.

To help you make a **medication list**, see Medication Lists and Tools for letter and wallet size templates you can print, fill out, and bring to the walk-in clinic.

What patients are saying…

"I don't have a family doctor so I created a 'file' with all my medical information (including a list of prescriptions) and bring that information with me whenever I visit a walk-in clinic. I add to the 'file' after each visit to the walk-in clinic so I have a complete history of medical issues and the care I received in my 'file'."

"If my family doctor is not available, I go to a walk-in clinic but I visit the same one every time. This allows me to have a similar relationship with the walk-in clinic doctor as I have with my family doctor (they get to know me). Also, this means my health records are just in two offices, instead of multiple places across the city. I prepare for my visit at the walk-in clinic the same way I prepare for a visit with my family doctor: I make notes on what I want to discuss during the appointment, and I take notes during the appointment so I don't forget any important information."

"I don't know why walk-in clinics have such a bad rap. They provide good services in my opinion. I've had nothing but good experiences at the walk-in clinic near my place."

If you have any questions or concerns…

Navigating the health-care system can be challenging, especially when you or your loved one is not feeling well. If you have questions or concerns, please raise them with your family doctor or health-care provider that is treating you, or with someone in the health-care setting (e.g., hospital) you are in.

Most health-care settings (e.g., hospital) will have patient relations or advocacy staff who are there to help you navigate your options. You can also contact the Patient Ombudsman, the organization that facilitates resolutions and investigates complaints involving health-care organizations in Ontario, at 1-888-321-0339.

If you have questions or concerns about a doctor, including concerns about them not meeting their responsibilities to you as described in this *Guide*, you can contact the CPSO's Patient Help Centre at 416-967-2603 or 1-800-268-7096, ext. 603 or feedback@cpso.on.ca.

Appendix A: Your Health Summary

PATIENT INFORMATION:

Name: _____

Phone number: _____ Sex: _____ Birthdate: _____

Address: _____

EMERGENCY CONTACT INFOMATION		PHONE NUMBER
CONTACT #1		
CONTACT #2		

DISEASES/CONDITONS (e.g., Asthma, Cancer, Depression, Diabetes, High Blood Pressure, etc.)	START DATE	END DATE	COMMENTS

FAMILY MEDICAL HISTORY
(including Genetic History)

_____

_____

_____

SOCIAL HISTORY
(e.g., smoking, alcohol and/or drug use, etc.)

_____

_____

_____

ALLERGIES AND DRUG INTOLERANCES (name of food, drug, etc.)	REACTION (e.g., rash, hives, anaphylaxis, etc.)

NAME OF MEDICATION	DOSE	AMOUNT	HOW OFTEN AND WHEN	DATES (started, changed or stopped)	COMMENTS

PREVIOUS ACCIDENTS/SURGERIES	DATES	LOCATION	COMMENTS

MAJOR INVESTIGATIONS (i.e., Tests, such as MRI, CAT scan, biopsy, etc.)	DATES	LOCATION	COMMENTS

YOUR HEALTH-CARE PROVIDERS *(including Specialists)*

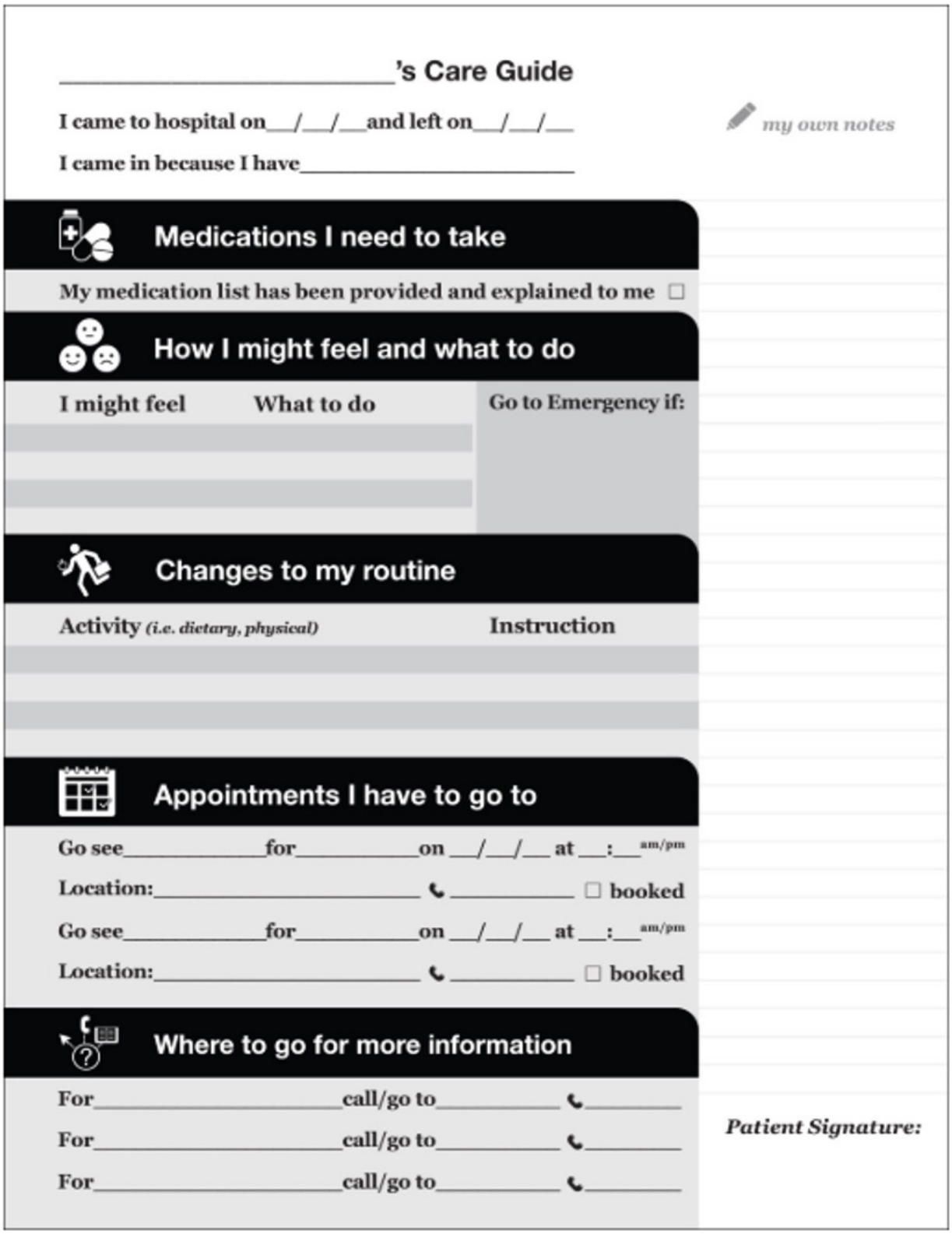
Name: _____ Phone number: _____

Comments: _____

Name: _____ Phone number: _____

Comments: _____

Appendix B: Your Hospital Discharge Information



_____'s Care Guide

I came to hospital on__/__/__and left on__/__/__

I came in because I have_____

my own notes

Medications I need to take

My medication list has been provided and explained to me ☐

How I might feel and what to do

I might feel	What to do	Go to Emergency if:

Changes to my routine

Activity *(i.e. dietary, physical)*	Instruction

Appointments I have to go to

Go see_____for_____on __/__/__ at __:__ am/pm

Location:_____ _____ ☐ booked

Go see_____for_____on __/__/__ at __:__ am/pm

Location:_____ _____ ☐ booked

Where to go for more information

For_____call/go to_____ _____

For_____call/go to_____ _____

For_____call/go to_____ _____

Patient Signature:

http://uhnopenlab.ca/project/pods/

CPSO

Council Briefing Note

December 2020

TOPIC: **Policy Review Kick-Off – *Professional Obligations and Human Rights*, *Medical Assistance in Dying,* and *Planning for and Providing Quality End-of-Life Care***

FOR DISCUSSION

ISSUE:

- The College's *Professional Obligations and Human Rights*, *Medical Assistance in Dying*, and *Planning for and Providing Quality End-of-Life Care* policy reviews are set to be launched following the December 2020 Council Meeting.

- In an effort to increase Council's engagement in the policy review process, Council is being asked for feedback at this early stage to help shape and inform the direction of the review.

- Council is provided with an overview of the current policies, the key issues that are anticipated to be the focus of each review, and questions aimed at engaging Council in a preliminary discussion on these issues.

BACKGROUND:

- Council was provided with detailed histories on each of these policy files at its September 2019 meeting where it considered amendments to each policy (see the materials starting at page 219). What follows is just a brief overview of each policy.

Professional Obligations and Human Rights

- Last reviewed in 2014-2015, the policy sets out physicians' legal and professional obligations under the Ontario *Human Rights Code* along with professional

expectations that address instances where physicians limit the services they provide for reasons of conscience or religion. This includes:

  - Providing health services without discrimination when, for example, accepting new patients, providing services to existing patients, and ending the physician-patient relationship;

  - Taking reasonable steps to accommodate the needs of patients where a disability or personal circumstances may limit their access to care;

  - Respecting patient dignity and diversity by refraining from expressing personal or moral judgments about patients; and

  - Ensuring patients have access to care by providing them with information about all clinical options available to them and providing an effective referral in instances where physicians do not provide those services for reasons of conscience or religion.

- The introduction of the effective referral requirement was a significant focus of the last review. Council deliberately sought to respect physicians right to limit the services they provide for reasons of conscience or religion, while balancing this with patient's right to access care.

  - After significant consideration of the available research and feedback, Council sought to achieve this balance by setting an expectation that required physicians in these instances to take positive action to connect patients with a non-objecting, available, and accessible physician, other health-care professional, or agency.

  - In coming to this decision, options such as a self-referral (i.e., leaving it to patients to make the connection themselves) and a full transfer of care were considered and rejected on the basis that they were perceived as either insufficient, patient abandonment, and/or an expression of moral judgment.

- The effective referral requirement was then unsuccessfully challenged by the Christian Medical and Dental Society at both the Ontario Superior Court and the Ontario Court of Appeal.

- Following our successful defense of the position, Council made minor amendments to the policy in September 2019. These amendments focused on addressing

specific areas of confusion flowing from the terminology used to describe the requirement and highlighting the plurality of options available to physicians in discharging these obligations in the companion *Advice to the Profession* resource.

- Notwithstanding these amendments, confusion has persisted, and some stakeholders have continued to express their discontent with the expectation.

Medical Assistance in Dying

- In June 2016, the legal framework for accessing medical assistance in dying (MAID) was enacted through legislative amendments to the *Criminal Code*. In response, the College developed the current *Medical Assistance in Dying* policy to help physicians understand their legal obligations and to set out professional expectations for issues not addressed in the legislation.

- Most notably, a determination needed to be made regarding whether the effective referral requirement from the *Professional Obligations and Human Rights* policy would apply in the MAID context.

    - In particular, whether the same or a different approach was warranted given the gravity of this immense societal change and the nature of MAID itself.

    - Ultimately Council decided to retain a single expectation that applied across all health services physicians might refuse to provide for reasons of conscience or religion and explicitly applied it in the context of MAID. It was felt that the effective referral requirement was essential to ensuring that vulnerable patients were able to access this legally available health service, while minimally imposing on physicians who objected to this practice.

- The consultation activities relating to the policy development process focused almost exclusively on the effective referral requirement.

    - Many stakeholders and advocates have called the effective referral the “gold standard” in terms of ensuring access to care, and public opinion polling showed very strong and broad support for the requirement among the public.

    - In contrast, many members of the public and some physicians or physician-led organizations felt the expectation forced physicians to be complicit in the provision of MAID, violating their oath to “do no harm”.

- Subsequent to its approval, the policy was similarly challenged as part of the Christian Medical and Dental Society's unsuccessful legal challenge, and the same revisions that were made to the *Professional Obligations and Human Rights* policy in 2019, highlighted above, were made to this policy as well.

Planning for and Providing Quality End-of-Life Care

- The policy was last reviewed and updated in 2013-2015 and followed on the heels of the landmark *Rasouli* decision where the Supreme Court of Canada determined that, in Ontario, consent was required to withdraw life-sustaining treatments such as mechanical ventilation.
- The policy focuses on a number of issues including effective communication, advance care planning, improving access to palliative care, and providing quality end-of-life care. However, much of the policy review and consultation activities focused on issues relating to the provision of potentially life-sustaining and life-saving treatments and, in particular, the writing of no-CPR orders.

    - During the review process, the Health Professions Appeal and Review Board (HPARB) directed the College to update its policy and require consent to be obtained prior to writing a no-CPR order. This direction was based on an interpretation and application of the *Rasouli* decision in the context of no-CPR orders but had not yet been tested in the Courts.

    - The prospect of establishing a consent requirement in accordance with this direction generated significant concern and criticism from members of the critical care and palliative care specialties, along with bioethicists embedded in hospital environments.

    - Council ultimately sought to strike a balance that supported and respected both physician professional judgement and patient autonomy and a diversity of patient values regarding important end-of-life decisions.

    - To achieve this balance, Council decided not to require consent to be obtained prior to writing a no-CPR order, but did decide to prohibit unilateral decision-making regarding the writing of a no-CPR order, in particular, where there is disagreement and conflict resolution is underway.

    - Minor amendments were made by Council in 2016 to clarify that there is no expectation to provide CPR while conflict resolution is underway if the

patient's condition prevented the physiologic goals of CPR from being achieved.

- A subsequent Court decision specified that consent is not required to write a no-CPR order and that there is no obligation to provide CPR when doing so is outside the standard of care. This decision required amending the policy in September 2019. The amendments aimed to respect patient autonomy by continuing to prohibit unilateral decision-making regarding the writing of the no-CPR order, while broadening physicians' ability to exercise professional judgment regarding in the moment decisions about whether to provide CPR.

- The amendments were viewed positively by many, but ongoing feedback suggests there continue to be concerns regarding the practical implementation of these expectations as well as criticism that the College did not fully align the policy with the Court decision which can be viewed as permitting the writing of a no-CPR order even where there is disagreement.

CURRENT STATUS:

1. Anticipated Issues

- By all indications these policy reviews are liable to generate significant and potentially polarizing engagement. Additionally, while there are many important issues addressed in each of the policies, it is anticipated that much of the external facing activity and engagement will be relatively narrow in focus.

- With respect to the *Professional Obligations and Human Rights* and *Medical Assistance in Dying* policies, it is anticipated that the effective referral requirement will be the focus of the consultation and engagement activities.

  - In keeping with historical precedents, we anticipate that physicians who have a conscientious objection to various procedures and members of the public who oppose these procedures will be vocal in expressing their concern.

    - The prospect of the eligibility criteria being expanded by pending legislation (see the Policy Report in these materials for more information on Bill C-7) is liable to amplify and renew these concerns.

- In contrast, proponents of the expectation who view it as the “gold standard” are liable to re-express this support and urge the College to uphold or even strengthen the current position, especially in light of the recent Court decisions upholding this position. It is also anticipated that broader public support will continue to be strong as evidenced by past public opinion polling.

- With respect to the *Medical Assistance in Dying* policy more broadly, it is anticipated that the profession will be seeking continued guidance on existing challenges and new aspects of the pending and expanded legal framework.

    - Legal terms such as “grievous and irremediable” and “reasonably foreseeable natural death” have historically caused confusion in the medical community.

    - The pending legislation adds additional complexity by requiring physicians to more meaningfully distinguish between natural deaths that are reasonably foreseeable and those that are not, to ensure compliance with different sets of procedural safeguards.

- With respect to the *Planning for and Providing Quality End-of-Life Care* policy it is anticipated that there will be a nearly singular focus on the expectations for physicians when writing no-CPR orders.

    - Regular engagement with members of the critical care specialty and bioethicists embedded in hospitals indicates a readiness to be consulted, with an aim to outline concerns and support amending the provisions to better address practical challenges and align with the minimum requirements identified by the Court.

2. Council Engagement and Discussion

- The expectations aimed at balancing divergent rights and values in each of these policies directly engage with the core values of medical professionalism and the College’s public interest mandate.

  - The current policy expectations seek to ensure access to care and respect for differing values among the most vulnerable, while simultaneously striving to set expectations that are workable in practice and respect physicians' professional judgment and rights.

- Before the policy reviews get underway in earnest, Council is asked to reflect on the existing policy expectations and the College's commitment to implementing targeted expectations that are proportionate to risk, while promoting equity in terms of access to care and respect for a diversity of values or perspectives.

  - Notably, given the preliminary stages of the review, there is much to still learn and hear as part of the policy review process which may shape or inform Council's subsequent decision-making.

  - As a result, Council is not being asked to make a determination regarding whether and how the expectations should be updated, but rather to provide initial thoughts and identify particular areas of focus or consideration to help inform the next steps of the review.

- To support this reflection process, Council Members will be divided into three group during the meeting to discuss key questions in relation to one of the three policies before returning to a debrief and larger format discussion at the main meeting.

Breakout Room #1 – Professional Obligations and Human Rights

- More than any other College policy, the principles of equity, diversity, and inclusion are central to the *Professional Obligations and Human Rights* policy. In particular, the policy aims to ensure that health care services are provided in a manner that is free from discrimination and judgment, and that access to care is not compromised as a result of a physicians exercising their right to freedom of religion or conscience.

- Council Members are asked to consider the following questions:

  1. Beyond compliance with the Ontario *Human Rights Code*, what does respect for equity, diversity, and inclusion look like from the perspective of medical professionalism?

  2. What expectations are needed to ensure health care services are provided in a manner that is free from discrimination and judgment?

3. What actions are needed by physicians to ensure that access to care is not compromised when they limit the services they provide for reasons of conscience or religion?

Breakout Room #2 – Medical Assistance in Dying

- The changing legal status of MAID in Canada resulted in a seismic shift in society. Physicians, as one of the professions legally authorized to participate in the process, have become inevitably entangled in the balancing of rights and values that flowed from entitling Canadians to access a health-care service that is morally contentious. The courts and government have both consistently recognized the need to balance physician rights to freedom of religion and conscience with patient's right to access care, but have ultimately left it to regulatory Colleges to strike this balance.

- Council Members are asked to consider the following questions:

    1. Patients seeking MAID are likely to be among the most vulnerable and in need of support. On the other hand, physicians objecting to MAID are liable to have very strong objections. How do we reconcile this?

    2. There are many services that physicians may conscientiously object to providing. How would setting different expectations for different services impact physicians and patients? Would it create uncertainty regarding what is expected? Would it risk compromising access?

    3. What actions do physicians need to take to ensure that access to MAID is not compromised when they limit the services they provide for reasons of conscience or religion?

Breakout Room #3 – Planning for and Providing Quality End-of-Life Care

- The prioritization of patient autonomy in the *Rasouli* decision even in instances where the care being provided is no longer clinically indicated created uncertainty in other areas of medicine. Most notably, in instances where potentially life-saving care (e.g., CPR) was being withheld where the patient's values and beliefs might insist all attempts be made to keep them alive regardless of their probability of success or quality of life. Notwithstanding the additional clarity recently provided by the Court regarding physicians' legal obligations, the decision reflects an assessment of the standard of care at the time of the case and may not align with the expectations of the public.

- Council Members are asked to consider the following questions:

    1. What does respect for equity, diversity, and inclusion look like when there is divergence between the prevailing medical view and the perspective of the patient on a fundamental decision such as whether or not to provide CPR?

    2. How can disagreement in decisions regarding potentially life-saving treatments be negotiated without unilaterally imposing one perspective on another's?

    3. Does medical professionalism and respect for a diversity of perspectives warrant taking steps over and above the minimum legal requirements?

NEXT STEPS:

- In keeping with the College's commitment to meaningful engagement and system collaboration, significant consultation and engagement activities will be undertaken as part of the early phases of the policy review process. This includes, but is not limited to:

    - An extended 4-month consultation period;

    - Public opinion polling to update historical results regarding Ontarians attitudes and expectations in each of these contexts;

    - Focus groups with the Citizen Advisory Group to engage patients and caregivers in the nuance of the balancing act each policy aims to strike;

- Effort to increase diversity of perspective in these processes by reaching out to organizations representing marginalized or vulnerable populations to overcome barriers that have historically limited their participation in our process; and

- Outreach and engagement efforts with organizations representing physicians most directly impacted by the expectations set out in each policy.

DISCUSSION FOR COUNCIL:

- The discussion questions for each policy are outlined above.

Contact: Craig Roxborough, Ext. 339
Michelle Cabrero Gauley, Ext. 439
Lynn Kirshin, Ext. 243

Date: November 16, 2020

CPSO

Council Motion

Motion Title: **In-Camera Motion**

Date of Meeting: December 3, 2020

It is moved by_____,

and seconded by_____, that:

The Council exclude the public from the part of the meeting immediately following the lunch break, under clause 7(2)(b) of the Health Professions Procedural Code.

Council Motion

Motion Title: **Budget Approval for 2021**

Date of Meeting: **December _____, 2020**

It is moved by_____,

and seconded by_____, that:

Council approve the “Budget for 2021” (a copy of which forms Appendix “ ” to the minutes of this meeting) authorizing expenditures for the benefit of the College during the year 2021.

Council Motion

Motion Title: **Fees By-law Amendment – Council and Committee Remuneration**

Date of Meeting: **December ___, 2020**

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. 139:

By-law No. 139

(1) Paragraph 20(3) of By-Law No. 2 (the Fees and Remuneration By-Law) is revoked and the following is substituted, effective January 1, 2021:

(3) The amount payable to members of the council and a committee is, subject to subsections (4) and (8),

(a) for attendance at, and preparation for, meetings to transact College business, $522 per half day, and

(b) for transacting College committee business by telephone or electronic means of which minutes are taken, the corresponding hourly rate for one hour and then the corresponding half hour rate for the half hour or major part thereof after the first hour.

CPSO

Council Briefing Note

December 2020

TOPIC: Budget for 2021

FOR DECISION

ISSUE:

The Finance and Audit Committee met on October 15, 2020 and is recommending the following 2021 Budget be presented to Council for approval.

BACKGROUND:

The College is accountable for a $72.5M budget, and regularly demonstrates – through detailed reports to the Finance and Audit Committee and Council – fiscal accountability, optimal resource use and delivery of effective and efficient programs.

Revenue is predicted to be $76.6M. The surplus before new requests is $4.82M and after new requests the surplus will $843K. Requests for new items such as an increase to the per diem, staff salary increases and related costs, and Physician Assistant regulation, leaving a modest surplus of .01% of the total budget.

2021 Budget		
Revenues	$76,612,883	
Base Budget (Expenses)	$72,523,161	
New Requests		
Per Diems & HST		$163,621
Salary & related benefits		$775,792
Staffing Requests		$0
Other New Requests (PAs, Depreciation)		$2,307,313
Total New Requests		$3,246,726
Surplus (Deficit)		**$842,996**

The Finance and Audit Committee approved the following motions:

It was moved by Mr. Giroux, seconded by Dr. Bertoia, and CARRIED, that the Finance & Audit Committee recommends to Council that the budget for 2021 be approved as presented.

It was moved by Dr. Gratton, seconded by Dr. Bertoia, and CARRIED, that the Finance & Audit Committee recommends to Council that per diems be increased by 2.5% effective January 1, 2021.

Over the last seven years, we have had an average increase of 1.4% and no increase for the past three years.

DECISION FOR COUNCIL:

Does Council approve the motions as detailed above?

Contact: Peter Pielsticker, Chair Finance and Audit Committee
Nathalie Novak, Chief Transformation Officer
Douglas Anderson, Corporate Services Officer
Leslee Frampton, Manager Finance

Date: November 2, 2020

Attachments: Appendix A: 2021 Budget

APPENDIX A

Statement of Operations Input Template

College of Physicians and Surgeons of Ontario

	ACTUALS			BUDGET					FORECAST	
	ACTUALS 2017	ACTUALS 2018	ACTUALS 2019	BUDGET 2020	NUMBERS	FEES	BUDGET 2021	% INCREASE OVER 2020 BUDGET	FORECAST FOR 2019	DIFFERENCE
REVENUE NET OF CRCC'S										
MEMBERSHIP FEES										
Independent Practice										
3110 - Renewal Independent Prac Lic - First 5 months	53,641,622	57,305,026	60,059,038	61,442,919	35,739	1,725	25,687,406		61,399,956	(35,712,550)
3110 - Renewal Independent Prac Lic - Last 7 months					36,468	1,725	36,695,925	2%		36,695,925
3111 - New Independent Practice Lic	2,817,923	3,020,001	3,309,918	3,199,875	1,816	1,725	3,132,600	-2%	3,132,825	(225)
3465 - Credit Card Service Charges	(1,335,698)	(1,513,182)	(1,521,195)	(1,504,707)			(1,510,572)	0%	(1,345,053)	(165,518)
3120 - Renewal - Postgraduate Cert.	1,216,943	1,467,374	1,559,697	1,531,455	2,873	345	991,185	-35%	1,641,271	(650,086)
3121 - New Post Graduate Certificate	698,503	728,186	766,524	750,375	2,214	345	763,830	2%	764,002	(172)
3198 - Mem Fee - IP - Late Penalty	256,662	336,705	178,723	401,548			403,626	1%	1,102	402,524
TOTAL MEMBERSHIP FEES	**57,295,956**	**61,344,111**	**64,352,704**	**65,821,464**			**66,164,000**	**1%**	**65,594,103**	**569,898**
APPLICATION FEES										
General										
3210 - App Fee - New IPL Rate	1,856,535	2,227,858	2,116,375	2,029,635	2,221	1,035	2,298,735	13%	2,298,379	356
3280 - App Fee - SD	8,520	5,230	5,195	6,632			6,315	-5%	30,725	(24,410)
3212 - App Fee - IP - 3&3	0	0	237,535	249,435	122	1,035	126,270	-49%	126,157	113
3245 - App Fee - IP - Exp Review	62,246	94,830	124,718	78,538			109,774	40%	57,352	52,422
3255 - App - SD - Exp Review	647	335	690	491			513	4%	1,725	(1,213)
3220 - App Fee - PG - Int Elect (McM)	1,120,749	1,317,766	1,009,076	1,135,913	2,348	431	1,012,575	-11%	1,012,258	317
3230 - App Fee - CF - s.12 PEAP Exmt	46,271	39,869	37,950	42,455			41,363	-3%	23,894	17,469
3240 - App Fee - EL - Can/US	0	0	330,163	315,675	367	431	158,269	-50%	158,040	229
3250 - App Fee - PG - Exp Review	58,056	106,608	123,224	82,332			114,916	40%	60,713	54,203
3325 - RMS Svc - CPC	576,000	644,692	657,675			0	0	0%	263,304	(263,304)
3326 - CPC - Paid by Hospital	7,450	3,675	4,500			0	0	0%	692	(692)
Certificates of Incorporation									-	-
3340 - App Fee - CoA - New	434,700	398,367	412,750	400,000	1,043	400	417,200	4%	417,108	92
3341 - App Fee - CoA - Renew	3,486,275	3,568,110	3,639,925	3,568,075	20,389	175	3,568,075	0%	2,877,304	690,771
TOTAL APPLICATION FEES	**7,657,450**	**8,407,339**	**8,699,775**	**7,909,181**			**7,854,004**	**-1%**	**7,327,651**	**526,353**
OTHER										
Miscellaneous Services										
3305 - Embassy Letters	15,770	12,655	9,620	0		0	0	-100%	3,663	(3,663)
3310 - RMS Svc - Diploma	19,575	18,750	26,625			0	0	0%	10,243	(10,243)
3990 - Miscellaneous	13,296	37,230	34,747	25,585			28,425	11%	76,932	(48,507)
3825 - Survivor Fund Charge Backs	16,952	1,355	0						-	-
3830 - Discipline Costs Recovered	260,124	589,792	610,458	650,000	455,000		455,000	-30%	481,800	(26,800)
3835 - Court Costs Awarded	97,250	38,000	32,500						-	-
3880 - Prior Year Items	-33,751	108,847	145,266	29,771			73,454	147%	263,533	(190,080)
Investment Income									-	-
3520 - Investments - Long Term	686,421	732,493	2,797,036	848,000	1,038,000		1,038,000	22%	3,442,646	(2,404,646)
3530 - Bank Account Interest	479,071	892,534	1,219,884	1,350,000	1,000,000		1,000,000	-26%	877,621	122,379
TOTAL OTHER	**1,554,708**	**2,431,657**	**4,876,136**	**2,903,356**			**2,594,878**	**-11%**	**5,156,438**	**(2,561,559)**
TOTAL REVENUE (BEFORE CRCC'S)	**66,508,113**	**72,183,106**	**77,928,615**	**76,634,001**			**76,612,883**	**0%**	**78,078,192**	**(1,465,309)**
EXPENDITURES NET OF CRCC'S										
Registrar Division	2,436,289	1,829,442	2,908,039	1,469,869			1,999,114	36%	1,706,294	292,821
Chief Medical Advisor Division			2,757,832	3,581,342			3,210,616	-10%	3,436,384	(225,768)

Quality Management Division	7,990,215	8,970,314	6,582,175	7,106,711	5,841,999	-18%	4,269,055	1,572,945
Registration & Membership Services Division	4,713,646	4,826,339	4,816,222	5,200,566	4,226,020	-19%	4,584,810	(358,790)
Communications & Media Division	2,431,209	3,029,699	1,921,124	1,790,233	1,527,354	-15%	1,728,603	(201,249)
Transformation Office Division	14,813,782	14,936,524	20,053,911	23,184,148	22,779,980	-2%	27,969,122	(5,189,142)
Legal Office Division	4,931,400	4,912,920	4,909,346	5,482,782	5,575,996	2%	5,739,917	(163,921)
Complaints Division	24,813,605	24,511,833	23,078,260	24,302,215	23,295,982	-4%	20,507,603	2,788,379
Governance & Policy Division	2,577,431	3,300,830	3,368,682	3,514,590	4,066,100	16%	3,428,992	637,108
TOTAL EXPENDITURES (BEFORE CRCC`S)	**64,707,577**	**66,317,901**	**70,395,591**	**75,632,456**	**72,523,161**	**-4%**	**73,370,778**	**(847,616)**
EXCESS REVENUE OVER EXPENDITURES (BEFORE CRCC`S)	**1,800,536**	**5,865,205**	**7,533,024**	**1,001,545**	**4,089,722**		**4,707,414**	**(617,692)**

CAPITAL AND NEW REQUESTS

ADDED:

Increase in Membership Fee (i.e. 7 months of the New Year at the increased rate)	36,468	0	-

LESS:

Per diem rate increase - Operating	153,634
HST increase (Due to per diem rate increase) - Operating	9,986
COLA	390,013
Salary Increases	235,626
Benefit increase due to change in salaries - Operating	90,092
Pension increase (Due to salary increase) - Operating	60,061
New Requests - PA Regulation (7090)	1,000,000
New Reqeusts - F & O licences ($100K) + Solis ($750K) (7280)	850,000
New Requests - Furniture for home offices (8000)	365,000
New Requests - New call centre (7080)	50,000
New Requests - Depreciation and software for iPads, monitors and AppleCare (7270)	42,313
TOTAL NET SURPLUS/(DEFICIT)	**842,996**

EXPENDITURES BY ACCOUNT (BEFORE CRCC'S)

College of Phys. & Surgs. Ont

Cost Centre

Reporting as of: Jun, 2020

	ACTUALS			BUDGET					
	ACTUALS 2017	ACTUALS 2018	ACTUALS 2019	BUDGET 2020	BUDGET 2021	FORECAST FOR 2020	DIFFERENCE TO FORECAST	CHANGE FROM PY BUDGET $	CHANGE FROM PY BUDGET %
COMMITTEE COSTS									
Attendance	2,906,976	2,993,767	2,286,359	2,616,649	2,786,144	1,619,695	1,166,449	169,495	6%
Preparation Time	2,740,301	2,557,228	2,300,227	2,376,448	2,648,992	1,826,349	822,643	272,543	11%
Decision Writing	690,424	881,652	611,481	434,860	820,998	549,026	271,972	386,138	89%
Expert/Peer Opinions	1,827,805	1,293,652	774,158	886,335		-	-	(886,335)	-100%
Assessors	-	1,296		0		-	-	(0)	-100%
Travel Time	1,292,712	1,476,785	871,599	823,599	840,468	296,480	543,988	16,869	2%
HST on Per Diems	560,252	571,283	427,021	473,242	461,279	259,751	201,528	(11,963)	-3%
Legal Fees	1,956,780	1,083,157	981,253	1,261,290	1,238,829	1,530,872	(292,043)	(22,461)	-2%
Audit Fees	44,526	55,597	62,498	45,000	45,000	-	45,000	-	0%
Catering	233,848	366,735	225,985	351,896	260,400	117,650	142,750	(91,496)	-26%
Meals and Accommodations	304,734	370,939	255,041	297,648	271,674	157,634	114,040	(25,974)	-9%
Travel Expenses	610,772	667,397	481,169	487,900	473,690	210,776	262,915	(14,210)	-3%
Witness Expenses	40,429	24,895	45,442	41,000	55,000	75,011	(20,011)	14,000	34%
TOTAL COMMITTEE COSTS	**13,209,559**	**12,344,384**	**9,322,233**	**10,095,869**	**9,902,474**	**6,565,959**	**3,336,515**	**(193,394)**	**-2%**
STAFFING COSTS									
Salaries	33,771,156	35,580,341	37,973,035	38,654,700	37,575,646	37,263,049	312,597	(1,079,054)	-3%
Part Time Help	206,846	117,867	237,241	119,400	76,400	70,095	6,305	(43,000)	-36%
Benefits	4,380,323	4,763,133	5,406,604	5,637,278	5,465,893	5,446,919	18,974	(171,384)	-3%
Pension	3,213,787	3,336,753	4,044,850	3,872,197	3,807,262	4,085,757	(278,495)	(64,935)	-2%
Personnel Consultants	301,915	331,298	360,097	244,000	299,000	625,812	(326,812)	55,000	23%
Placement	237,940	25,681	24,380	150,000	55,000	485	54,515	(95,000)	-63%
Training and Conferences	497,357	527,490	572,149	899,998	1,068,960	256,449	812,511	168,962	19%
Employee Engagement	183,265	220,737	285,935	292,032	288,788	191,485	97,303	(3,244)	-1%
TOTAL STAFFING COSTS	**42,792,589**	**44,903,299**	**48,904,292**	**49,869,605**	**48,636,949**	**47,759,536**	**877,413**	**(1,232,656)**	**-2%**
DEPARTMENT COSTS									
Consultant Fees	1,682,397	1,165,335	3,849,566	7,052,137	5,631,230	14,294,947	(8,663,717)	(1,420,907)	-20%
Software Costs	363,809	366,598	875,862	1,539,260	1,386,242	1,882,420	(496,178)	(153,018)	-10%
Office Supplies	307,298	288,144	242,016	255,580	157,500	97,489	60,011	(98,080)	-38%
Equipment Leasing	10,796	28,664	65,674	30,500	50,000	239,460	(189,460)	19,500	64%
Equipment Maintenance	55,711	36,431	15,089	38,918	56,360	5,212	51,148	17,442	45%
Miscellaneous	104,878	183,442	90,502	173,532	57,700	224,717	(167,017)	(115,832)	-67%
Photocopying	348,567	339,884	279,907	315,420	272,650	237,510	35,140	(42,770)	-14%
Printing	22,828	4,492	8,537	5,250	6,100	3,923	2,177	850	16%
Member's Dialogue	339,522	340,363	388,540	360,000	320,000	141,041	178,959	(40,000)	-11%
Postage	275,355	253,801	201,715	211,900	123,955	79,801	44,154	(87,945)	-42%
Courier	65,038	39,696	31,430	35,546	44,100	18,499	25,601	8,554	24%
Telephone	322,313	316,159	271,337	306,950	313,610	193,264	120,346	6,660	2%
Reporting and Transcripts	453,629	326,489	311,878	383,863	464,597	248,710	215,887	80,734	21%
Professional Fees - Staff	91,324	106,944	139,656	177,680	180,145	145,038	35,107	2,465	1%
FMRAC Fees	490,620	433,900	445,616	460,000	460,000	454,528	5,472	-	0%
Publications and Subscriptions	193,784	181,367	206,111	226,640	150,220	166,726	(16,506)	(76,420)	-34%
Travel and Other	232,420	319,719	235,502	284,631	286,711	194,344	92,367	2,080	1%
Grants	94,000	54,000	140,297	120,000	74,000	-	74,000	(46,000)	-38%
Survivors Fund	140,223	952,836	391,089	100,000	75,000	234,635	(159,635)	(25,000)	-25%

Offsite Storage Fees	188,552	199,941	205,831	189,200	190,600	186,452	4,148	1,400	1%
Bad Debt Expense	47,648	69,417	280,206			23,257	(23,257)	-	0%
TOTAL DEPARTMENT COSTS	**5,830,710**	**6,007,620**	**8,676,359**	**12,267,007**	**10,300,720**	**15,508,244**	**(5,207,524)**	**(1,966,287)**	**-16%**
OCCUPANCY COSTS									
Internal Charges	(417,892)	(399,090)	(545,480)	(402,981)	(607,454)	(449,912)	(157,542)	(204,473)	51%
Electrical	107,108	59,000	235,418	113,639	19,300	151,178	(131,878)	(94,339)	-83%
Plumbing	57,400	44,525	52,579	16,700	34,900	1,164	33,736	18,200	109%
Building Consultants	153,998	69,758	486,143	521,750	536,550	11,721	524,829	14,800	3%
Mechanical	96,205	163,177	143,040	89,304	127,650	118,282	9,368	38,346	43%
Depreciation	1,236,585	1,216,936	1,224,169	1,215,474	1,466,822	1,494,914	(28,092)	251,348	21%
Housekeeping	201,523	211,807	231,790	229,430	244,250	242,208	2,042	14,820	6%
Other Building Costs	64,792	212,670	94,594	33,900	217,000	324,601	(107,601)	183,100	540%
Offsite Leasing	627,325	680,117	727,355	728,760	725,000	712,357	12,643	(3,760)	-1%
Insurance	500,276	514,556	545,263	550,000	615,000	585,278	29,722	65,000	12%
Realty Taxes	87,457	94,302	102,593	105,000	105,000	148,049	(43,049)	-	0%
Hydro	216,016	172,330	180,394	165,000	165,000	114,528	50,472	-	0%
Natural Gas	14,021	15,387	15,093	17,000	17,000	14,354	2,646	-	0%
Water and Other Utilities	18,288	20,939	18,358	17,000	17,000	11,821	5,179	-	0%
TOTAL OCCUPANCY COSTS	**2,963,102**	**3,076,416**	**3,511,306**	**3,399,976**	**3,683,018**	**3,814,025**	**(131,007)**	**283,042**	**8%**
TOTAL EXPENDITURES (BEFORE CRCC`S)	**64,795,961**	**66,331,719**	**70,414,190**	**75,632,456**	**72,523,161**	**73,647,764**	**(1,124,603)**	**(3,109,295)**	**-4%**

EXPENDITURES BY DEPARTMENT (BEFORE CRCC'S)

College of Phys. & Surgs. Ont

Cost Centre

Reporting as of: Jun, 2020

	ACTUALS			BUDGET					
	ACTUALS 2017	ACTUALS 2018	ACTUALS 2019	BUDGET 2020	BUDGET 2021	FORECAST FOR 2020	DIFFERENCE TO FORECAST	CHANGE FROM PY BUDGET $	CHANGE FROM PY BUDGET %
REGISTRAR DIVISION									
Executive Department	2,436,289	1,829,442	2,908,039	1,469,869	1,999,114	1,706,294	292,821	529,246	36%
TOTAL REGISTRAR DIVISION	**2,436,289**	**1,829,442**	**2,908,039**	**1,469,869**	**1,999,114**	**1,706,294**	**292,821**	**529,246**	**36%**
CHIEF MEDICAL ADVISOR DIVISION									
Chief Medical Advisor			2,757,832	3,581,342	3,210,616	3,436,384	(225,768)	(370,726)	-10%
TOTAL CHIEF MEDICAL ADVISOR DIVISION	-	-	**2,757,832**	**3,581,342**	**3,210,616**	**3,436,384**	**(225,768)**	**(370,726)**	**-10%**
QUALITY MANAGEMENT DIVISION									
Education Committee	44,938	23,476	15,621	36,077	28,527	2,338	26,189	(7,549)	-21%
Changing Scope Working Group	35,228	40,239	3,081	41,581		-	-	(41,581)	-100%
Registration Pathways Evaluati	31,023	46,578	84,652	45,000		-	-	(45,000)	-100%
Quality Assurance Committee	910,348	887,216	598,769	587,322	586,706	147,581	439,125	(617)	0%
Peer Assessment Program	2,488,853	1,643,621	752,669	836,693	835,843	101,429	734,413	(851)	0%
Peer Redesign Assessment	132,697	1,805,974	1,179,592	1,210,009	1,209,660	239,000	970,660	(349)	0%
Assessor Bi-Annual Meeting	1,369	219,649	35	181,381	80,692	64,876	15,816	(100,689)	-56%
Assessor Training	43,796	89,936	47,933	78,362	63,743	40,927	22,816	(14,619)	-19%
Assessor Networks	91,655	25,738	30,093	128,528	42,584	460,985	(418,402)	(85,945)	-67%
Quality Management Department	1,390,598	1,452,883	857,556	631,800	(66,960)	416,515	(483,475)	(698,760)	-111%
Quality Assurance Program	2,819,711	2,735,005	3,012,173	3,329,957	3,061,205	3,306,859	(245,654)	(268,752)	-8%
TOTAL QUALITY MANAGEMENT DIVISION	**7,990,215**	**8,970,314**	**6,582,175**	**7,106,711**	**5,841,999**	**4,269,055**	**1,572,945**	**(1,264,712)**	**-18%**
REGISTRATION & MEMBERSHIP SERVICES DIVISION									
Registration Committee	216,728	160,481	154,981	181,277	173,602	101,831	71,771	(7,676)	-4%
Annual Membership Survey	53,485	22,159	11,330	8,000		260	(260)	(8,000)	-100%
Applications and Credentials	2,752,415	2,919,183	2,958,205	3,326,237	4,052,418	3,032,183	1,020,235	726,181	22%
Membership Department	710,698	752,526	762,744	900,287		717,345	(717,345)	(900,287)	-100%
Corporations Department	980,321	971,990	928,961	784,765		729,457	(729,457)	(784,765)	-100%
TOTAL REGISTRATION & MEMBERSHIP SERVICES DIVISION DIVISION	**4,713,646**	**4,826,339**	**4,816,222**	**5,200,566**	**4,226,020**	**4,584,810**	**(358,790)**	**(974,546)**	**-19%**
COMMUNICATIONS AND MEDIA DIVISION									
Outreach Program	34,651	60,186	11,291	25,000	25,000	4,784	20,216	(0)	0%
Communications Department	2,396,558	2,969,513	1,909,833	1,765,233	1,502,354	1,724,654	(222,300)	(262,879)	-15%
TOTAL COMMUNICATIONS AND MEDIA DIVISION	**2,431,209**	**3,029,699**	**1,921,124**	**1,790,233**	**1,527,354**	**1,728,603**	**(201,249)**	**(262,879)**	**-15%**
TRANSFORMATION OFFICE DIVISION									
Finance Committee	65,166	76,680	77,593	67,137	66,167	30,574	35,594	(970)	-1%
Education Program Development	59,200	1,636	950	87,000	81,600	-	81,600	(5,400)	-6%
AD&D Support Projects	159,337	124,089	67,628	23,083		29,176	(29,176)	(23,083)	-100%
Human Resources Department	1,095,444	954,771	1,417,604	1,315,325	1,233,492	1,010,575	222,917	(81,833)	-6%
Control Accounts	(0)	(0)	0			(8,959)	8,959	-	0%
Facility Services	1,061,877	983,034	1,039,424	1,108,327	921,978	972,043	(50,065)	(186,349)	-17%
Records Management	944,970	904,102	883,158	1,243,360	1,430,457	1,268,521	161,935	187,097	15%
Business Services	264,412	224,909	199,696	219,826		271,487	(271,487)	(219,826)	-100%
Finance Department	1,972,241	2,067,462	2,583,762	1,794,371	1,741,465	2,167,893	(426,428)	(52,907)	-3%
Continuous Improvement	-		-	1,545,413	2,662,333	1,455,877	1,206,456	1,116,920	72%
IT Support	3,726,040	3,956,428	4,539,285	2,800,787	3,155,380	3,964,019	(808,639)	354,593	13%
Operations and Support						543	(543)	-	0%

Infrastructure	1,024,013	1,564,455	4,069,669	8,042,799	2,820,739	5,366,479	(2,545,740)	(5,222,060)	-65%
Enterprise Systems					3,985,861	6,106,212	(2,120,351)	3,985,861	0%
AD&D Support Department	1,190,055	1,271,377	1,853,906	1,749,781	1,277,663	1,053,975	223,688	(472,118)	-27%
Occupancy	2,576,179	2,117,057	2,603,259	2,457,679	2,677,345	2,591,804	85,541	219,666	9%
800 Bay Street	674,849	690,526	717,978	729,260	725,500	712,506	12,994	(3,760)	-1%
TOTAL TRANSFORMATION OFFICE DIVISION	**14,813,782**	**14,936,524**	**20,053,911**	**23,184,148**	**22,779,980**	**27,969,122**	**(5,189,142)**	**(404,169)**	**-2%**
LEGAL OFFICE DIVISION									
Legal Services	4,931,400	4,912,920	4,909,346	5,482,782	5,575,996	5,739,917	(163,921)	93,214	2%
TOTAL LEGAL OFFICE DIVISION	**4,931,400**	**4,912,920**	**4,909,346**	**5,482,782**	**5,575,996**	**5,739,917**	**(163,921)**	**93,214**	**2%**
COMPLAINTS DIVISION									
Caution Panels	113,897	115,575	95,473	93,274	83,092	47,434	35,658	(10,183)	-11%
Business, Leadership, Training	184,631	183,841	228,022	239,206	204,954	58,240	146,714	(34,251)	-14%
Gen,Hybrid,Teleconfs,Ad-Hocs	1,400,030	1,291,199	1,172,348	1,187,288	1,142,980	785,749	357,231	(44,308)	-4%
ICRC - Specialty Panels	1,060,003	1,008,040	911,923	984,133	923,429	753,589	169,840	(60,704)	-6%
ICRC - Health Inquiry Panels	90,935	58,855	21,839	49,737	45,199	42,785	2,414	(4,538)	-9%
Training - Non-Staff	6,937	12,214	29,241	56,000	48,000	2,304	45,696	(8,000)	-14%
Discipline Committee Hearings	1,925,953	1,685,868	1,727,728	1,639,553	1,689,651	1,845,253	(155,602)	50,098	3%
Discipline Committee Case Mana	266,798	263,505	200,047	260,629	244,363	187,950	56,413	(16,266)	-6%
Discipline Committee Policy/Tr	249,352	259,836	300,575	333,678	405,009	165,700	239,310	71,331	21%
Fitness to Practice Committee	46,261	19,912	856	53,645		-	-	(53,645)	-100%
Health Assessments	65,399	154,243	128,747	145,602	145,429	51,891	93,538	(173)	0%
Medical Assessors (MIs)	1,611,889	1,063,962	690,739	630,355	629,615	496,233	133,382	(740)	0%
Peer Opinions (IOs)	213,528	186,334	231,893	196,094	195,855	163,774	32,081	(239)	0%
Advisory Services Department	1,384,867	1,369,556	1,448,322	1,480,651	1,289,051	1,483,851	(194,800)	(191,600)	-13%
I&R Administration	2,188,267	2,188,580	592,266	1,003,824	1,137,394	564,660	572,734	133,570	13%
ICR Committee Support	1,901,149	2,231,379	2,287,726	2,436,755	2,701,012	1,900,732	800,279	264,256	11%
Compliance Monitoring	1,568,818	1,892,010	2,082,242	2,174,691	1,909,756	1,929,553	(19,797)	(264,936)	-12%
PC Resolutions	1,104,378	1,614,764	2,994,558	10,054,336	9,954,960	10,222,627	(267,667)	(99,375)	-1%
Sexual Impropriety Investigati	1,358,107	1,005,476	1,035,826	127,800		86,281	(86,281)	(127,800)	-100%
PC Investigations	4,237,045	3,844,164	3,641,255	162,205		76,629	(76,629)	(162,205)	-100%
Registrar's Investigations	2,813,274	2,824,079	1,924,565	194,250		79,806	(79,806)	(194,250)	-100%
Incapacity Investigations	479,404	545,299	426,689	17,000		2,753	(2,753)	(17,000)	-100%
Hearings Office	542,683	693,143	905,379	781,509	546,234	741,283	(195,049)	(235,275)	-30%
TOTAL COMPLAINTS DIVISION	**24,813,605**	**24,511,833**	**23,078,260**	**24,302,215**	**23,295,982**	**20,507,603**	**2,788,379**	**(1,006,233)**	**-4%**
GOVERNANCE & POLICY DIVISION									
Council	522,088	464,212	487,344	519,632	493,150	731,957	(238,808)	(26,483)	-5%
Strategic Planning Project		35,560	270,443	80,000		7,615	(7,615)	(80,000)	-100%
Governance Committee	33,901	46,306	42,472	53,410	154,675	96,140	58,535	101,265	190%
Council Elections	7,998	3,040	4,508	6,000	6,500	-	6,500	500	8%
Executive Committee	168,004	123,417	81,084	99,868	123,337	59,108	64,229	23,468	23%
President's Expenses	66,111	83,362	89,803	109,743	154,640	101,369	53,271	44,897	41%
FMRAC	490,620	433,900	445,616	460,000	460,000	453,752	6,248	-	0%
Policy Working Group	68,546	94,820	80,017	96,869	96,602	164,203	(67,601)	(268)	0%
Patient Relations Program	168,080	980,204	424,110	141,684	119,649	264,771	(145,123)	(22,035)	-16%
Policy	1,052,083	1,036,008	1,443,285	1,034,019	1,046,349	849,630	196,719	12,330	1%
Governance	-		-	913,365	1,411,199	876,580	534,619	497,834	55%
TOTAL GOVERNANCE & POLICY DIVISION	**2,577,431**	**3,300,830**	**3,368,682**	**3,514,590**	**4,066,100**	**3,428,992**	**637,108**	**551,509**	**16%**
TOTAL EXPENDITURES (BEFORE CRCC`S)	**64,707,577**	**66,317,901**	**70,395,591**	**75,632,456**	**72,523,161**	**73,370,778**	**(847,616)**	**(3,109,295)**	**-4%**

MRA	2013	2014	2015	2016	2017	2018	2019	2020	2021	CHANGE FROM 2013 TO 2020
Alberta	$1,960	$1,960	$1,960	$1,960	$1,960	$1,960	$1,960	$2,150	$2,150	1.2%
PEI	$1,665	$1,865	$1,865	$1,900	$1,900	$1,900	$1,950	$1,950	$1,950	2.1%
Nova Scotia	$1,555	$1,555	$1,555	$1,750	$1,750	$1,850	$1,950	$1,950	$1,950	3.2%
Saskatchewan	$1,600	$1,700	$1,800	$1,880	$1,880	$1,880	$1,880	$1,880	$1,880	2.2%
Manitoba	$1,650	$1,700	$1,700	$1,700	$1,780	$1,780	$1,816	$1,870	$1,870	1.7%
NFLD & Labrador	$1,650	$1,750	$1,750	$1,750	$1,750	$1,850	$1,850	$1,850	$1,850	1.5%
Ontario	**$1,550**	**$1,570**	**$1,570**	**$1,595**	**$1,625**	**$1,725**	**$1,725**	**$1,725**	**$1,725**	1.4%
British Columbia	$1,500	$1,542	$1,590	$1,625	$1,670	$1,685	$1,700	$1,715	$1,715	1.8%
Quebec	$1,320	$1,345	$1,380	$1,420	$1,420	$1,520	$1,595	$1,625	$1,700	3.6%
New Brunswick	$500	$540	$600	$600	$600	$600	$600	$600	$580	2.0%
Average										2.1%

MEMBER TOPICS

(No materials)

Council Motion

Motion Title: eLearning Program High-Level Overview

Date of Meeting: December __, 2020

It is moved by_____,

and seconded by_____, that:

The Council approves the High-Level Overview of the eLearning Program, which replaces the Governance Process Manual.

CPSO

Council Briefing Note

December 2020

TOPIC: Orientation eLearning Program

FOR DECISION

ISSUE:

- This past summer, CPSO began developing a new eLearning Program for prospective physician Council members and newly appointed public members. Based on feedback from the working group that was established to support this work, the scope has expanded to also include new non-Council committee members.

- The Governance and Executive Committees have reviewed the key topics and high-level outline of the eLearning Program and is putting forward a recommendation for Council approval (Appendix A).

BACKGROUND:

- Currently, CPSO does not have a pre-election orientation training program. On September 1, 2020, the Ministry of Health informed health regulatory colleges of a new reporting tool that would need to be completed and submitted to the Ministry of Health beginning in March 2021. One of the new expectations of the Ministry requires pre-election orientation for prospective Council members.

- The program currently in development can be used to fulfill this requirement. Additionally, this program can bolster the existing orientation provided to newly-appointed public members.

- The content in this eLearning Program will serve to replace the Governance Process Manual that is currently provided to Council and committee members. The eLearning Program will update the information previously included in the Governance Process Manual and make it more accessible and user-friendly for Council and committee members.

- Recently, the scope of the eLearning Program expanded after positive feedback regarding the comprehensiveness of the content. The decision was made to include non-Council committee members as an additional audience, to support consistent governance orientation across CPSO's committees.

- Once development is complete, the eLearning Program will be made available through the Learning Management System (LMS), which is the platform used by newly licensed physicians who must complete a new member orientation. While it might take some time to finalize the program on the LMS, the content (through a document or during a live session) can be delivered as soon as early 2021 for candidates who are interested in running for election.

- The sections of the proposed program include:

    - Section 1: CPSO Organizational Structure, Strategic Plan, and Mandate
    - Section 2: Legislation and By-Law Overview
    - Section 3: Fiduciary Duty and Protecting and Serving the Public Interest
    - Section 4: Confidentiality
    - Section 5: An Overview of Council Activities and the Policy Approval and Review Process
    - Section 6: An Overview of CPSO Committees
    - Section 7a: The Election Process and Remuneration (Physician Members)
    - Section 7b: Remuneration (Public Members)

- This eLearning program will provide an online pre-election orientation for prospective Council members, with the ability for candidates to test their knowledge. Key competencies expected for Council members are addressed in Section 7a, which also outlines the election process.

- Portions of the eLearning Program will be adapted for committee-specific orientation, which is also an expectation of health regulatory colleges according to the Ministry's new reporting requirements. Specifically, modules 5 and 6 will be adapted to have a committee-specific version, as well as a Council-specific version.

CURRENT STATUS:

- To date, a jurisdictional scan with 11 Ontario-based and national health regulators, key informants with eight CPSO elected physician Council members and four appointed public Council members, and an initial framework for the learning program have been completed.

- A working group has been established to design the content for the eLearning Program. The members of the working group are Dr. Sarah Reid, Dr. Patrick Safieh, Mr. Mehdi Kanji, and Mr. Peter Pielsticker.

- Staff from Governance & Policy and Analytics, Data & Decision Support have completed an initial content draft. The draft was informed by various areas of the organization including the Legal, Quality Management, Investigations & Resolutions and Governance & Policy departments.

- The high-level overview has undergone working group, Senior Management, Governance Committee, Executive Committee, and legal review. Feedback on the program was very positive and indicated that the content was comprehensive and covered all relevant topics required to develop a good understanding of the CPSO and a Council or committee member's role.

NEXT STEPS:

- Next steps include:

    - Completing key informant interviews for non-Council committee members

- Finalizing all content;
- Storyboarding the content; and,
- eLearning program development utilizing Pathways, the College's vendor who specializes in eLearning and LMS.

DECISION FOR COUNCIL:

1. Does Council have any feedback regarding the high-level overview of the Council/Committee eLearning Program?

2. Does Council approve the high-level overview?

Contact: Laura Rinke-Vanderwoude, Jr. Governance Analyst
Deanna Bowlby, Education Lead
Laurie Cabanas, Director of Governance and Policy

Date: November 13, 2020

Attachments:

Appendix A: CPSO Governance Orientation Module – High Level Overview

APPENDIX A - CPSO GOVERNANCE E-LEARNING PROGRAM – HIGH LEVEL OVERVIEW

Updated October 2020

Guiding Principles

- The following is the draft of high-level content for a proposed online eLearning program for prospective Council members and newly appointed public Council members.
    - Content outline development has been informed by a jurisdictional scan with 11 Ontario-based and national health regulators and key informant interviews with a number of physician and public Council members.
    - Finalization of content will take place in several stages and includes a working group with both elected physicians Council members and appointed public Council members.
    - The scope of the project recently expanded to include non-Council committee members as part of the target audience. Key informant interviews with non-Council committee members will be completed by end of 2020.
- The content focuses on:
    - the prospective physician Council member learning needs prior to election.
    - the appointed public Council member learning needs to ease transition on to Council and committees.
    - newly-appointed non-Council committee members' learning needs to ease their transition on to committees and support governance education.

Objectives (for eLearning Program)

1. To support prospective Council members' decision process prior to election, and to support newly appointed public Council and non-Council committee members by ensuring all participants:
    - Comprehend the mandate and duties under legislation governing CPSO.
    - Identify and apply key legislation and bylaws.
    - Comprehend the role of Council and committees, and the relationship between them.
    - Comprehend the roles, responsibilities and expectations of Council and committee members, including confidentiality, conflict of interest, fiduciary duty, and the duty to serve and protect the public interest.

Key Considerations

- Though the majority of content is relevant to all audiences, there will be content that has specific relevance to each individual audience. This can be managed through a backend login structure where access scope is determined based on the audience.
- This curriculum should be designed with a view to inclusivity, equity, and anti-discrimination best practices. This means that all content should be developed in a way that encourages and embeds these principles in the minds of new Council and committee members.
- Embedded in this curriculum map are some ideas for assets that could be included in the eLearning module to highlight important concepts and themes.
    1. Short testimonials from Council and committee members to provide insights on specific concepts throughout the module
    2. Videos
    3. Interactive activities
    4. Case studies
- The working group may determine additional content to incorporate.

Organization

- The content is organized into key areas and concepts. While the concepts flow in a logical manner, the purpose of this map is to capture parcels of content for review. As the eLearning program is developed it is likely some elements of this organizational structure will change.
- The overall design of the eLearning program will include:
    - enhanced text screens with visuals and animation, use of stock photography for a consistent look and feel, audio narration to accompany all screens
    - complex media including videos (e.g. whiteboard video), quizzes (true-false, multiple choice) and interactive activities (drag and drop, hot spot*) to be used or created where appropriate
    - navigation will include a clickable sidebar menu, bottom of the screen navigation (play bar with forward, rewind, pause/play)
- Tracking and reporting will include who accessed and completed the modules.

Note: This eLearning Program would support training of appointed Academic Council Representatives

**A hotspot is another way for a user to interact with content. A mouse slides over an area and content is revealed.*

Governance Orientation Module Program Overview

*Note this modelling does not include relevant tables of contents, a module introduction or content specifically relevant to non-Council committee members.

Module Chapter	Section Content	Media/ Activities	Objectives	Relevant Legislation/By-laws/policy	Content Location/ Resources
Chapter 1: Introduction to The College of Physicians and Surgeons	College location and land acknowledgement Role of the College Strategic plan Council role Types of Council members (physician, public member, academic appointment) Role of Council members Overview Committees of Council Process for Committee appointment College staff	Individual slide animation CPSO Strategic Plan (user interaction hotspotting with graphic) Organizational chart graphic Drag and drop quiz Testimonial: Council member	• Identify College structure and composition, including role of Council, committees, the Registrar, and President • Recognize the types of Council members • Comprehend the mandate, duties and role of CPSO • Recognize the difference between a physician advocacy association and CPSO	RHPA By-laws	Council virtual land acknowledgement Mandate wording from Declaration of Adherence Organizational Chart Committee page on website New Member Orientation in LMS

Module Chapter	Section Content	Media/ Activities	Objectives	Relevant Legislation/By-laws/policy	Content Location/ Resources
	Organization chart CPSO financial information				
Chapter 2: Legislation, Regulations and By-laws	RHPA overview • Minister of Health • Health Professions Regulatory Advisory Council • Health Professions Procedural Code Medicine Act overview College By-law review • General By-Law; • Fees and Remuneration By-Law; and,	Individual slide animation Quizzes Testimonial: Council member on the legal framework the College operates within and the significance of this. Interactive questions	• Comprehend the legislative framework of the College • Recognize which Acts, regulations, and by-laws are applicable to the College and what they do • Identify how relevant Acts, regulations, and by-laws affect Council work	RHPA Medicine Act College By-laws	E-laws College By-laws on website

Module Chapter	Section Content	Media/ Activities	Objectives	Relevant Legislation/By-laws/policy	Content Location/ Resources
	• Declared Emergency By-Law.				
Chapter 3: Fiduciary Duty and Protecting the Public	Fiduciary duty The public interest mandate, and how it relates to being on Council Conflicts of interest	Individual slide animation Quizzes (multiple choice) Testimonial: College lawyer speaking about what fiduciary duty is and how it interacts with Council work. Case study 1: Conflict of interest Case study 2: Conflict of interest	• Demonstrate the duty to serve and protect the public interest mandate, and what that means for the work of Council/committees • Recognize that Council members do not represent the interests of their electorates/appointing body • Comprehend what fiduciary duty is and how it applies to their role • Demonstrate an understanding of what conflict of interest is, and how to avoid it	RHPA Conflict of Interest Policy	Declaration of Adherence wording RHPA Orientation materials

Module Chapter	Section Content	Media/ Activities	Objectives	Relevant Legislation/By-laws/policy	Content Location/ Resources
			• Identify the nature of conflicting interests		
Chapter 4: Confidentiality and Communications	What confidentiality means, and how it applies to members Protecting the privacy and confidentiality of information: • Transporting confidential information • Emailing confidential information • Storing confidential information • Discussing confidential information Media requests Council spokesperson The role of the Communications and Media department	Individual slide animation Case study 1: Confidential information Case study 2: Confidential information Case study 3: Media relations Case study 4: Social media	• Understand the duty of members in terms of confidentiality and protection of information • Indicate who speaks to media and/or stakeholders • Demonstrate an understanding of use of social media in Council member context • Comprehend what representing the College means	Confidentiality Policy Communications with Media Policy RHPA and fines	Confidentiality Policy Communications Policy Declaration of Adherence

Module Chapter	Section Content	Media/ Activities	Objectives	Relevant Legislation/By-laws/policy	Content Location/ Resources
	Social media and personal communications				
Chapter 5: A Day at Council (Different versions for committee vs Council members)	Role of Council Overview of Council meetings Who attends or can listen to Council meetings The role of Council members and others at a meeting What happens before, during, and after a Council meeting Policy development and review process	Individual slide animation Quizzes Drag and drop activity Case Study 1: Policy process Case Study 2: Policy process Case Study 3: Policy process	• Explain the role of Council members and meetings • Identify Council behavioral norms, meeting process expectations, and member preparation expectations • Demonstrate an understanding of Council member role in policy development, review and approval • Recognize what acting in the public interest is, with a lens to anti-bias/discrimination	By-laws RHPA Declaration of Adherence	Past Agendas Recordings of previous Council meetings Orientation documents Declaration of Adherence
Chapter 6: A Day at Committee (Different versions for	Overview of statutory and standing committee processes	Individual slide animation	• Describe committee mandates and the time commitment expectations	Terms of Reference RHPA	Committee orientation materials

Module Chapter	Section Content	Media/ Activities	Objectives	Relevant Legislation/By-laws/policy	Content Location/ Resources
committee vs Council members)	Responsibilities of committee members Average time commitments for committee work Key competencies for committee work	Video: Snapshot of Registration Committee Process Video: Snapshot of Investigations, Complaints and Reports Committee Process Video: Snapshot of Discipline Committee Process A decision tool to help members determine an appropriate committee for their service based on key competencies, interests and time commitments	• Determine the key skills required for each committee	Medicine Act HPARB By-laws	Terms of Reference RHPA Medicine Act HPARB
Chapter 7a: Election Process (physicians only)	Eligibility to run for election Campaigning Nomination statements and communications	Individual slide animation Case study: Conflict of interest by competing fiduciary obligations with another organization	• Comprehend how the election process works, and timelines • Demonstrate what to do in nomination forms	By-laws	Orientation documents By-laws Governance manual

Module Chapter	Section Content	Media/ Activities	Objectives	Relevant Legislation/By-laws/policy	Content Location/ Resources
	Timelines and key dates Length of Council terms Compensation Documents to read before the election Key competencies	Drag and drop interactive activity: Identification of own key behavioural competencies	• Explain public interest in context of election process • Identify the key competencies of Council members • Explain that prospective members do not represent those whom elect them		
Chapter 7b: Renumeration (public members only)	Overview of the renumeration process for public Council and committee members Responsibilities of public members and College staff in renumeration process	Individual slide animation Case study: public member renumeration	• Comprehend the renumeration process for public member, including role of Ministry of Health • Identify College staff support roles and the Public member roles in the renumeration process • Identify key documents in the process		

Council Motion

Motion Title: Declaration of Adherence Refresh

Date of Meeting: December _, 2020

It is moved by_____,

and seconded by_____, that:

The Council approves the revised Declaration of Adherence, a copy of which forms Appendix “ “ to the minutes of this meeting, and the revised Council and Committee Code of Conduct, a copy of which forms Appendix “ “ to the minutes of this meeting.

Council Briefing Note

CPSO

December 2020

TOPIC: Declaration of Adherence Refresh

FOR DECISION

ISSUE:

- The Declaration of Adherence and its accompanying policies have not been updated since 2016 (Appendix A). They are undergoing a review to ensure they are clear, consistent and accurately reflect good governance principles and CPSO's expectations of Council and Non-Council committee members.

BACKGROUND:

- The Declaration of Adherence is an annual form that Council and committee members sign at appointment and annually thereafter, which confirms their primary responsibilities to the College as outlined in a series of governance policies.

- Non-Council committee candidates are also provided with the form and associated policies to ensure they are aware of their fiduciary duties, key CPSO policies and expectations prior to accepting a committee position.

- The signed forms are kept on file by Governance staff for one year, after which the signed forms are retained for up to thirty years. From time to time, Legal Counsel looks at documents from past years if there is a Council or committee member issue that arises concerning one of the governance policies, such as conflict of interest or concerns with confidentiality.

CURRENT STATUS:

- The Governance and Executive Committees, external legal counsel, and internal legal counsel have provided their feedback and provided recommendations regarding the Council and Committee Code of Conduct. These recommendations have been incorporated into the revised version attached to this document (Appendix B).

- At this time, changes have only been made to the Declaration of Adherence and the Council and Committee Code of Conduct. Associated standalone policies have been included for reference purposes, but are not the subject of the current review.

- A high-level overview of changes includes:

    - Incorporating the Statement of Public Interest into the Council and Committee Code of Conduct;

    - Clarifying and centering the duty to protect and serve the public interest;

    - Providing additional clarity regarding provisions of the *Regulated Health Professions Act* referred to in the Declaration of Adherence;

    - Providing greater clarity regarding fiduciary duty;

    - Adding sections on social media use, e-mail and CPSO technology;

    - Clarifying communication and representation sections;

    - Adding a section on diversity, equity, and inclusion;

    - Reorganized and combined sections for better flow and clarity, where appropriate; and,

    - Replaced ‘he/she’ language with ‘they’.

NEXT STEPS:

- Once Council approves the amendments, the new Declaration of Adherence and Council and Committee Code of Conduct will be used moving forward.

DECISION FOR COUNCIL:

1. Does Council have any feedback or concerns about the proposed changes to the Declaration of Adherence?

2. Does Council approve the revisions?

Contact: Laura Rinke-Vanderwoude, Jr. Governance Analyst
Laurie Cabanas, Director of Governance and Policy
Marcia Cooper, Legal Counsel

Date: November 27, 2020

Attachments:

Appendix A: Declaration of Adherence (revised)

Appendix B: Declaration of Adherence (original)

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Members of CPSO Council and Committees

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

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

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

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

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

- I have read Section 40 (2) of the RHPA, and understand that it is an offence to contravene subsection 36 (1) of the RHPA. I understand that this means in addition to any action the CPSO or others may take against me, I could be convicted of an offence if I communicate confidential information in contravention of Section 36 (1) of the RHPA, and if convicted, I may be required to pay a fine of up to $25,000.00 (for a first offence), and a fine of not more than $50,000 for a second or subsequent offence.

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

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

- I have read and am familiar with the CPSO's By-laws and the governance policies listed below:
  - Council and Committee Code of Conduct
  - Conflict of Interest Policy
  - Impartiality in Decision Making Policy
  - Confidentiality Policy
  - Role Description of a CPSO Council/Committee Member (as applicable)

- I am bound to adhere to and respect the CPSO's By-laws, the governance policies, and all other CPSO policies applicable to the Council.[1]

Declaration of Conflicts:

1.
2.
3.

☐ I confirm I have read, considered and understand the Declaration of Adherence including associated documents, and agree to abide by its provisions.
☐ I understand that any breach of this Declaration of Adherence may result in remedial action, censure or removal from office.

…… ……
Full Name (please print)

Signature ……

Date

[1] These other CPSO policies include but are not limited to the *Use of CPSO Technology* policy, the *Information Breach Protocol*, and the *E-mail Management* policy.

Council and Committee Code of Conduct

Purpose

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

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

Application

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

Fiduciary Duty and Serving and Protecting the Public Interest

Fiduciary Duty

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

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

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

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

Serving and Protecting the Public Interest

The CPSO is the self-regulating body for the province's medical profession. In carrying out its role as a regulator governed by the RHPA, the CPSO has a duty to "serve and protect the public interest". This duty takes priority over advancing any other interest. For greater clarity,

advancing other interests must **only** occur when those interests are not inconsistent with protecting and serving the public interest. As Council and committee members have a fiduciary duty to the CPSO, they must keep in mind that in performing their duties they are expected to work together to support the CPSO in fulfilling this mandate.

Advancing the Profession's Interests

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

Conduct and Behaviour

Respectful Conduct

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

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

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

Council and Committee Solidarity

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

Media Contact, Social Media, and Public Discussion

Council and CPSO Spokespersons

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

Media Contact and Public Discussion

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

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

Social Media Use

Members must take care in their social media posts and in sharing personal opinions that they do not appear to represent the CPSO. It is a member's responsibility to consider whether their post could possibly give rise to the appearance of representing the CPSO, even if such representation was not the intention of the post. This includes **all** manner of communications and social media use, whether private or public. For example, members should:

- Speak on behalf of the CPSO **only when authorized by the President or CEO/Registrar**;
- Make it clear that they are only speaking for themselves when commenting on matters that relate to the CPSO, and where their relationship to the CPSO is or could reasonably become known;
- Not respond to any negative or confrontational content that is or could be seen to be related to the CPSO, and notify CPSO staff should they discover or receive any negative/confrontational content on social media; and,
- Not engage in harassing, discriminatory or otherwise abusive behaviour.

Representation on Behalf of the CPSO

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

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

Diversity, Equity, and Inclusion

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

committee members approaching all work at the CPSO with a diversity, equity, and inclusion lens.

Email and CPSO Technology

CPSO Email Address

Council and committee members must use **only** their CPSO (cpso.on.ca) email address for any and all business related to the CPSO. CPSO emails (including virtual meeting invitations) should not be forwarded or sent to a personal email address under any circumstances. This is very important to maintain the confidentiality of CPSO-related communications. Members are expected to minimize the use of their CPSO email address with regards to personal or non-CPSO matters.

If a member is having difficulties accessing or using their CPSO email, the Information Technology department can provide assistance.

CPSO Technology

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

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

Council and committee members are expected to use laptop computers or other technology or devices provided by the CPSO for CPSO business purposes only. Additionally, the Information Technology department must approve any software downloads to CPSO technology or systems. The CPSO may approve the use of a personal device for CPSO work in some circumstances, in which case the member will be expected to sign an Undertaking with the CPSO regarding its use and security.

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

Other Council and Committee Member Commitments

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

- uphold strict standards of honesty, integrity and loyalty;
- adhere to all applicable CPSO by-laws and policies, in addition to those listed or referred to in this Code of Conduct;
- attend Council and committee meetings, as applicable to the member, be on time and engage constructively in discussions undertaken at these meetings;
- prepare prior to each Council and committee meeting, as applicable to the member, so that they are well-informed and able to participate effectively in the discussion of issues and policies;
- state their ideas, beliefs and contributions to fellow Councillors, committee members and CPSO staff in a clear and respectful manner;
- where the views of the Council or committee member differ from the views of the majority of Council or committee members, work together with Council or the committee, as applicable, toward an outcome in service of the highest good for the public, the profession and the CPSO;
- uphold the decisions and policies of the Council and committees;
- behave in an ethical, exemplary manner, including respecting others in the course of a member's duties and not engaging in verbal, physical or sexually harassing or abusive behaviour;
- participate fully in evaluation processes requested by CPSO that endeavor to address developmental needs in the performance of the Council, Committee and/or individual member;
- willingly participate in committee responsibilities;
- promote the objectives of the CPSO through authorized outreach activities consistent with CPSO's mandate and strategic plan and in accordance with this Code of Conduct;

- respect the boundaries of CPSO staff whose role is neither to report to nor work for individual Council or committee members; and,

- if a member becomes the subject of a hearing by the Discipline Committee or the Fitness to Practice Committee of the CPSO, withdraw from the activities of Council or any committee on which the member serves until those proceedings are formally concluded.

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

Amendment

This Code of Conduct may be amended by Council.

Updated and approved by Council: Month, Day, Year

Schedule 1: Relevant Sections of the *Regulated Health Professions Act* and the *Health Professions Procedural Code*

Regulated Health Professions Act

Confidentiality

36 (1) Every person employed, retained or appointed for the purposes of the administration of this Act, a health profession Act or the *Drug and Pharmacies Regulation Act* and every member of a Council or committee of a College shall keep confidential all information that comes to his or her knowledge in the course of his or her duties and shall not communicate any information to any other person except,

(a) to the extent that the information is available to the public under this Act, a health profession Act or the *Drug and Pharmacies Regulation Act*;

(b) in connection with the administration of this Act, a health profession Act or the *Drug and Pharmacies Regulation Act*, including, without limiting the generality of this, in connection with anything relating to the registration of members, complaints about members, allegations of members' incapacity, incompetence or acts of professional misconduct or the governing of the profession;

(c) to a body that governs a profession inside or outside of Ontario;

(d) as may be required for the administration of the *Drug Interchangeability and Dispensing Fee Act*, the *Healing Arts Radiation Protection Act*, the *Health Insurance Act*, the *Health Protection and Promotion Act*, the *Independent Health Facilities Act*, the *Laboratory and Specimen Collection Centre Licensing Act*, the *Long-Term Care Homes Act, 2007*, the *Retirement Homes Act, 2010*, the *Ontario Drug Benefit Act*, the *Coroners Act*, the *Controlled Drugs and Substances Act* (Canada) and the *Food and Drugs Act* (Canada);

Note: On a day to be named by proclamation of the Lieutenant Governor, clause 36 (1) (d) of the *Act* is amended by striking out "the *Healing Arts Radiation Protection Act*". (See: 2017, c. 25, Sched. 9, s. 115 (1))

Note: On a day to be named by proclamation of the Lieutenant Governor, clause 36 (1) (d) of the Act is amended by striking out "the *Independent Health Facilities Act*". (See: 2017, c. 25, Sched. 9, s. 115 (2))

Note: On a day to be named by proclamation of the Lieutenant Governor, clause 36 (1) (d) of the Act is amended by adding "the *Oversight of Health Facilities and Devices Act, 2017*" after "the *Long-Term Care Homes Act, 2007*". (See: 2017, c. 25, Sched. 9, s. 115 (3))

(d.1) for a prescribed purpose, to a public hospital that employs or provides privileges to a member of a College, where the College is investigating a complaint about that member or where the information was obtained by an investigator appointed pursuant to subsection 75 (1) or (2) of the Code, subject to the limitations, if any, provided for in regulations made under section 43;

(d.2) for a prescribed purpose, to a person other than a public hospital who belongs to a class provided for in regulations made under section 43, where a College is investigating a complaint about a member of the College or where the information was obtained by an investigator appointed pursuant to subsection 75 (1) or (2) of the Code, subject to the limitations, if any, provided for in the regulations;

(e) to a police officer to aid an investigation undertaken with a view to a law enforcement proceeding or from which a law enforcement proceeding is likely to result;

(f) to the counsel of the person who is required to keep the information confidential under this section;

(g) to confirm whether the College is investigating a member, if there is a compelling public interest in the disclosure of that information;

(h) where disclosure of the information is required by an Act of the Legislature or an Act of Parliament;

(i) if there are reasonable grounds to believe that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons;

(j) with the written consent of the person to whom the information relates; or

(k) to the Minister in order to allow the Minister to determine,

(i) whether the College is fulfilling its duties and carrying out its objects under this Act, a health profession Act, the *Drug and Pharmacies Regulation Act* or the *Drug Interchangeability and Dispensing Fee Act*, or

(ii) whether the Minister should exercise any power of the Minister under this Act, or any Act mentioned in subclause (i). 2007, c. 10, Sched. M, s. 7 (1); 2014, c. 14, Sched. 2, s. 10; 2017, c. 11, Sched. 5, s. 2 (1, 2).

Offences

40 (1) Every person who contravenes subsection 27 (1), 29.1 (1) or 30 (1) is guilty of an offence and on conviction is liable,

(a) for a first offence, to a fine of not more than $25,000, or to imprisonment for a term of not more than one year, or both; and

(b) for a second or subsequent offence, to a fine of not more than $50,000, or to imprisonment for a term of not more than one year, or both. 2007, c. 10, Sched. M, s. 12; 2015, c. 18, s. 3.

Same

(2) Every individual who contravenes section 31, 32 or 33 or subsection 34 (2), 34.1 (2) or 36 (1) is guilty of an offence and on conviction is liable to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence. 2007, c. 10, Sched. M, s. 12.

Same

(3) Every corporation that contravenes section 31, 32 or 33 or subsection 34 (1), 34.1 (1) or 36 (1) is guilty of an offence and on conviction is liable to a fine of not more than $50,000 for a first offence and not more than $200,000 for a second or subsequent offence. 2007, c. 10, Sched. M, s. 12.

Health Professions Procedural Code

Duty of College

2.1 It is the duty of the College to work in consultation with the Minister to ensure, as a matter of public interest, that the people of Ontario have access to adequate numbers of qualified, skilled and competent regulated health professionals. 2008, c. 18, s. 1.

Objects of the College

3 (2) In carrying out its objects, the College has a duty to serve and protect the public interest. 1991, c. 18, Sched. 2, s. 3 (2).

Conflict of Interest Policy

Purpose

This policy defines conflict of interest and explains the duties of Council and committee members with respect to conflicts of interest.

Application

This policy applies to Council members and non-Council members of College committees (together referred to as "Members").

Policy

All Members have a duty to act solely in the best interest of the College, consistent with the mandate of the College to act in the public interest, and to maintain the trust and confidence of the public in the integrity of the decision making processes of Council and College committees.

To this end, Members must avoid or resolve conflicts of interest while performing their duties for the College. Even if there is no actual conflict of interest, Members must make best efforts to avoid situations that College members or a member of the public might consider or perceive as a conflict of interest.

Definition and Description of Conflict of Interest

Section 55 of the College's General Bylaw (the "bylaw") defines conflict of interest as follows:

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

The situations in which a potential conflict of interest may arise cannot be exhaustively set out. Conflicts generally arise in the following situations:

- Interest of a Member: when a Member enters into any business arrangement either directly or indirectly with the College, or has a significant interest in a transaction or contract with the College;

- Interest of a relative or association: when a Member's immediate family or practice/business partner(s) enters into any business arrangement with the College;

- Gifts: when a Member or a member of the Member's household or any other person, company or organization chosen by the Member, accepts gifts, credits, payments, services or anything else of more than a token or nominal value from a party with whom the College may enter into a business arrangement (including a supplier of goods or services) for the purposes of (or that may be perceived to be for the purposes of) influencing an act or decision of the Council or a committee of the Council;

- Other motivating or competing interests:

    - Self-interest: when a Member exercises his or her powers motivated by self-interest or any purpose other than the public interest;

    - Competing Fiduciary Obligations and Roles in Other Organizations: when a Member has competing "fiduciary obligations" (see below) to both the College and another organization, and the interests or mandate of that other organization may, or may be perceived to, conflict with or be inconsistent with the interests or mandate of the College. For example, the Member holds a position on the governing body of an organization that advocates for physicians generally or for particular specialists. This could conflict with, or be seen to conflict with, the Member's duty to act in the public interest in his or her role with the College. Members are asked to identify, on the Declaration of Adherence form, any relationships with other organizations that may create a conflict of interest by virtue of having competing fiduciary obligations.

        - A Member should avoid placing him/herself under an obligation to or entering into a relationship with another organization that gives rise to competing professional interests in the performance of his/her duties with the College, even if the Member's role in the other organization falls short of being a "fiduciary".

        - What do we mean by "fiduciary"? A person who is in a special relationship of trust and confidence with an organization (or an individual) is said to be a fiduciary of that organization, and as such, is obligated to act in the interests of that organization over the interests of others, including the person's own interests. By virtue of a Member's position on Council, the Member is a fiduciary of the College. A physician who has an executive position on the OMA, for example, would be a fiduciary to the OMA.

- Failure to disclose information: when Members fail to disclose information that is relevant to a vital aspect of the affairs of the College.

Process for Resolution of Conflicts of Interest

Acting in a conflict of interest is a breach of College policy and may be the basis for removal from Council or a Council committee. Section 56 to 59 of the General By-law (attached) contain a process for disclosing and resolving a potential conflict of interest. If Council is not satisfied that a conflict is resolvable through the process in the General By-Law, Council may ask the Member to resign or disqualify the Member.

Amendment

Council may amend this policy.

Updated and approved by Council: December 4, 2014

Appendix 1: Conflict of Interest Provisions in College By-Law

Definition of Conflict of Interest

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

Process for Resolution of Conflicts in Council Matters

56. A council member who has or may have a conflict of interest in connection with council business shall consult with the registrar and disclose the conflict to council at the earliest opportunity, and in any case before council considers the matter to which the conflict relates. If there is any doubt as to whether a conflict exists, the member must declare it to council and accept council's decision as to whether a conflict exists.

57. A council member who has a conflict of interest shall:
    (a) disclose the conflict;
    (b) leave the room when council is discussing the matter; and
    (c) not vote on the matter, or try to influence the vote.

Process for Resolution of Conflict in Committee Matters

58. A committee member who has or may have a conflict of interest in connection with a matter before a committee shall consult with the appropriate committee support representative. For adjudicative committees, the committee member should consult with the Hearings Office. The committee member should disclose the conflict at the earliest opportunity,

and in any case before the committee considers the matter. The committee member shall accept the Chair's direction as to whether there is a conflict of interest and any steps the Chair takes or requires to resolve the conflict. Where the Chair has or may have a conflict of interest, the Chair shall accept the executive committee's direction as to whether there is a conflict of interest and any steps the executive committee takes or requires to resolve the conflict.

Record of Declarations

59. Declarations with respect to conflicts of interest shall be recorded in the minutes of the meeting.

Impartiality in Decision Making Policy

Purpose

The purpose of this policy is to set out the appropriate processes for identifying and dealing with situations where a lack of impartiality might arise that could disqualify a member of a College committee from making a decision in a particular matter.

Application

Part I of this policy applies to all members of the Discipline and Fitness to Practice Committees in the context of a hearing involving a decision directly affecting the rights, interests or privileges of a named physician.

Part II of the policy applies to all members of College committees in the context of a meeting involving a decision directly affecting the rights, interests and privileges of a named physician or person.

This policy applies in addition to the Conflict of Interest Policy. This policy should be read in combination with Council's policy on the Provision of Opinions by Committee Members, attached as Appendix 1 to this policy.

PART I: Avoiding Perceptions of Bias in Adjudicative Decisions of the Discipline and Fitness to Practice Committees

Background

The Regulated Health Professions Act, 1991 calls upon the Discipline and Fitness to Practice Committees in certain circumstances to make final decisions in the context of a hearing which could affect a physician's rights, interests or privileges. Such final decisions are referred to in this policy elsewhere as "adjudicative decisions."

A Council or non-Council committee member sitting in an adjudicative role, for example, in a disciplinary hearing, must be free of a reasonable apprehension of bias. Whether actual bias exists or can be demonstrated is largely irrelevant. A physician whose rights and privileges may be curtailed as a result of an adjudicative decision is entitled to decision-makers who are neither biased, nor appear to a reasonable person to be biased.

A reasonable apprehension of bias exists where a reasonable and informed person, viewing the matter realistically and practically, and having thought the matter through, would conclude that the decision-maker, whether consciously or unconsciously, may not decide the matter fairly and impartially.

Policy

A committee member should not adjudicate in a hearing where circumstances may give rise to a reasonable apprehension of bias on the part of the member.

Identifying the Potential for Bias

It is impossible to outline all circumstances in which a reasonable apprehension of bias could arise, or to give definitive answers in the abstract. There are many different kinds of relationships, events and conduct that may give rise to a reasonable apprehension of bias. Committee members should be aware of the potential for bias and seek advice whenever a potential, even remote, likelihood of bias exists. By way of example, the following circumstances will often create a reasonable apprehension of bias on the part of the decision-maker in respect of a particular proceeding:

- The member has an association, relationship, non-financial interest or activity that would be seen to be incompatible with his or her responsibilities as an impartial decision-maker. Examples of these include:
    - The panel member provided an opinion in a case for or against the subject physician;
    - The panel member is the current or former practice partner of the subject physician; or
    - The panel member is a close friend or relative of the subject physician or the complainant.
- The member has prior knowledge of a matter, for example if a party is appearing before the member for a second time (but see note below), or the member obtained information about the matter through previous employment or other form of work or activity. Note that prior knowledge of a matter obtained through work at the College may not always create a reasonable apprehension of bias, depending on the context and the committees involved; the member should consult the Hearings Office or his/her committee support representative.
- The member has made past statements or expressed views about issues relevant to the matter before him or her that suggests prejudgment of the issue, or the member's past conduct or actions indicate prejudgment. The provision by a member of a letter of support (i.e. a character reference) to the College or a College committee in respect of a physician or facility for whom or which there is an investigation or review at any stage

by the College may create a reasonable apprehension of bias; members should not provide these letters of support.

- An appearance of bias may arise from the member's conduct during the hearing; examples include communicating with one party without the knowledge or inclusion of the other, overly aggressive questioning of one party, refusing to hear evidence, constant interruptions of one party, and laughing and making exasperated noises during testimony.

The following circumstances generally would not, of themselves, be considered to create a reasonable apprehension of bias on the part of a decision-maker in respect of a particular proceeding before a committee on which the member sits:

- The decision-maker went to medical school with the subject physician; or

- The decision-maker has attended educational conferences that the subject physician also attended.

Nothing set out above should be taken to interfere with the entitlement of a potential panel member to refuse to sit on a particular matter on the basis that he or she is of the view that an apprehension of bias may exist.

<u>Process for Dealing with Potential Bias in an Adjudicative Proceeding</u>

Prior to a particular matter coming before a panel of a committee, the Hearings Office, directly or indirectly through the independent legal counsel, should:

- provide each panel member with some basic information about the identity of the parties and their respective counsel or other representatives; and

- ask each panel member to advise whether he or she has had any interactions or relationship with the subject physician that could lead to a reasonable apprehension of bias in respect of that matter.

A committee member may at any time consult with the Hearings Office as to whether he or she should serve as a member of a panel hearing a particular matter, having regard to circumstances that might create a reasonable apprehension of bias on the part of the decision-maker.

Where at any time a committee member becomes aware of a circumstance or circumstances that might give rise to a reasonable apprehension of bias in respect of an adjudicative proceeding, he or she should immediately advise the Hearings Office. If the circumstance arises

during the conducting of a hearing, the committee member should immediately notify independent legal counsel.

PART II: Maintaining Impartiality in Non-adjudicative Decisions of College Committees
Background

Most decisions made by College committees are non-adjudicative; that is, they are not final decisions which affect a physician's rights, interests or privileges, which a committee arrives at through a hearing. However, similar principles of fairness may apply to these decisions as to adjudicative decisions. Accordingly, committee members must be aware of circumstances which could give rise to a perception that they are not able to decide a matter fairly and impartially because of some connection to or relationship with the physician or person about whom they are making a decision.

Policy

A committee member should not take part in a decision if a reasonable and informed person would conclude that the member is not able to decide fairly and impartially, for example, because of some connection to or relationship with the physician or person about whom they are making a decision.

Maintaining Impartiality

The standard of impartiality for non-adjudicative decisions may be lower than that for adjudicative decisions. In other words, circumstances that could create a reasonable apprehension of bias for an adjudicative decision may not raise concerns about the ability of a committee member to decide a matter fairly and impartially in a non-adjudicative context. Generally, committee members should appear amenable to persuasion and keep an open mind in making a decision about a physician or person outside the adjudicative or hearing context.

The factors that are relevant for determining whether there may be a reasonable apprehension of bias in adjudicative decisions are also relevant in the context of non- adjudicative decisions. The circumstances listed above under the heading "Identifying the Potential for Bias" in Part I should be used as a tool for determining whether circumstances create the potential for the appearance that a decision lacks fairness and impartiality. It may not be the case that a committee member has to refrain from making a decision due to these circumstances. However, committee members should be aware of the potential that a personal relationship or strongly held opinion may give rise to the perception that the member has a "closed mind". Committee members should seek advice with respect to any concerns about maintaining impartiality.

Process for Maintaining Impartiality in Non-Adjudicative Decisions

When a committee member receives an agenda for a meeting, before reviewing the supporting materials, the member should review the names of the physicians and persons under consideration. The member should identify any physician or person about whom the member may not be able to reach an impartial and fair decision, or who may give rise to a perception that the member would not make an impartial and fair decision.

If the committee member identifies any such physician or person, the member should advise the committee support representative, who will consult with College counsel to determine if the member should or should not participate in the decision. The committee support representative will advise the member accordingly. The committee member should not review any materials relevant to such a physician or person until the matter is resolved.

If it is determined that there is a potential that the committee member would not make an impartial and fair decision, or a potential for a perception that the member would not make an impartial and fair decision, the member will leave the room or not participate in the conference call while the committee considers the particular physician or person's case. The committee will not ask the committee member to review or discuss any materials regarding the matter.

Amendment

Council may amend this policy. Updated and approved by Council: December 4, 2014

Appendix 1: Provision of Opinions by Committee Members

A. No member of Council or of any College Committee shall provide an opinion in respect of matters that are currently being investigated or reviewed in any College department or by any College Committee.

B. (1) Prior to agreeing to provide any professional opinion for any type of proceeding or potential proceeding outside of the College, Council or non-Council Committee members shall:

I. satisfy themselves that the matter is not at any stage of investigation or review in any College department or by any College Committee by:

a. asking the party who wishes to retain them if the matter is at the College; and

b. contacting their committee support person to confirm that the matter is not at the College; and

II. satisfy themselves that the party who is retaining them does not intend to bring the matter to the College, and has received no indication that the opposing party has any intention to bring the matter to the College.

(2) After being retained to provide an opinion or act as an expert, the Council or Committee member must advise support staff for Council or the relevant Committee of his or her involvement in a proceeding or potential proceeding involving a member of the College ("subject member"), in order to ensure that the appropriate internal College screen be established, to be used if the need arises. This is to ensure that the expert Council or Committee member is not involved in any future College matter involving the subject member.

C. If the College begins an investigation or review of the subject matter after a Council or relevant Committee member has been retained to provide an opinion or act as an expert, but prior to the Council or Committee member providing a draft or final opinion or testifying (whichever comes first), the Council or Committee member shall (i) immediately end his or her retainer to provide an opinion or act as an expert, (ii) ensure that no confidential information about the matter is provided to any other Council or Committee member, and that no College information is provided to any participant in the matter outstanding with the College, and (iii) recuse him/herself from the matter outstanding with the College.

D. If the College begins an investigation or review of the subject matter after a Council or Committee member provides any draft or final opinion or testifies in a proceeding, the Council or Committee member shall (i) immediately notify the College support person of the Council or Committee member's involvement in the case, (ii) ensure that no confidential information about the matter is provided to any other Council or Committee member, and that no College information is provided to any participant in the matter outstanding with the College, and (iii) recuse him/herself from the matter outstanding with the College.

Confidentiality Policy

Purpose

To ensure that confidential matters are not disclosed until disclosure is authorized by the Council.

Policy

Council and Committee members owe to the College a duty of confidence; not to disclose or discuss with another person or entity or to use for their own purpose, confidential information concerning the business and affairs of the College received in their capacity as Council and/or Committee members unless otherwise authorized by the Council.

Every Council or Committee member shall ensure that no statement not authorized by the Council is made by him or her to the press or public.

Application

This policy applies to all Council and non-Council Committee members.

Confidential Matters

All matters which are the subject of closed sessions of the Council are confidential until disclosed in an open session of the Council.

All matters which are before a committee or task force of the Council are confidential until disclosed in an open session of the council.

All matters which are the subject of open sessions of the Council are not confidential.

Notwithstanding that information disclosed or matters dealt with in an open session are not confidential, no Council member shall make any statement to the press or the public in his capacity as a Council member unless such statement has been authorized by the Council. Council members are referred to Council's Media Relations Policy.

1. Every Council member and Committee member is subject to section 36 (1) of the Regulated Health Professions Act, 1991 which provides as follows:

   36. (1) Every person employed, retained or appointed for the purposes of the administration of this Act, a health profession Act or the Drug and Pharmacies Regulation Act and every member of a Council or committee of a College shall keep

confidential all information that comes to his or her knowledge in the course of his or her duties and shall not communicate any information to any other person except,

a) to the extent that the information is available to the public under this Act, a health profession Act or the Drug and Pharmacies Regulation Act;
b) in connection with the administration of this Act, a health profession Act or the Drug and Pharmacies Regulation Act, including, without limiting the generality of this, in connection with anything relating to the registration of members, complaints about members, allegations of members' incapacity, incompetence or acts of professional misconduct or the governing of the profession;
c) to a body that governs a profession inside or outside of Ontario;
d) as may be required for the administration of the Drug Interchangeability and Dispensing Fee Act, the Healing Arts Radiation Protection Act, the Health Insurance Act, the Health Protection and Promotion Act, the Independent Health Facilities Act, the Laboratory and Specimen Collection Centre Licensing Act, the Long-Term Care Homes Act, 2007, the Retirement Homes Act, 2010, the Ontario Drug Benefit Act, the Coroners Act, the Controlled Drugs and Substances Act (Canada) and the Food and Drugs Act (Canada);

(d.1) for a prescribed purpose, to a public hospital that employs or provides privileges to a member of a College, where the College is investigating a complaint about that member or where the information was obtained by an investigator appointed pursuant to subsection 75 (1) or (2) of the Code, subject to the limitations, if any, provided for in regulations made under section 43;

(d.2) for a prescribed purpose, to a person other than a public hospital who belongs to a class provided for in regulations made under section 43, where a College is investigating a complaint about a member of the College or where the information was obtained by an investigator appointed pursuant to subsection 75 (1) or (2) of the Code, subject to the limitations, if any, provided for in the regulations;

e) to a police officer to aid an investigation undertaken with a view to a law enforcement proceeding or from which a law enforcement proceeding is likely to result;
f) to the counsel of the person who is required to keep the information confidential under this section;
g) to confirm whether the College is investigating a member, if there is a compelling public interest in the disclosure of that information;
h) where disclosure of the information is required by an Act of the Legislature or an Act of Parliament;
i) if there are reasonable grounds to believe that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons;
j) with the written consent of the person to whom the information relates; or
k) to the Minister in order to allow the Minister to determine,

i. whether the College is fulfilling its duties and carrying out its objects under this Act, a health profession Act, the Drug and Pharmacies Regulation Act, or the Drug Interchangeability and Dispensing Fee Act, or
ii. whether the Minister should exercise any power of the Minister under this Act, or any Act mentioned in subclause (i). 2007, c. 10, Sched. M, s. 7 (1); 2014, c. 14, Sched. 2, s. 10; 2017, c.11, Sched. 5,s. 2(1.2).

2. Every individual who contravenes subsection 36 (1) of the Regulated Health Professions Act, 1991 is guilty of an offence and on conviction is liable to a fine of not more than $25,000.00 for a first offence and a fine of $50,000 for subsequent offences.

Procedure for Maintaining Minutes

Minutes of closed sessions of the Council shall be recorded by the Secretary or designate or if the Secretary or designate is not present, by a Council member designated by the President of the College.

All minutes of closed sessions of the Council shall be marked confidential and shall be handled in a secure manner.

All minutes of meetings of committees and task forces of the Council shall be marked confidential and shall be handled in a secure manner.

Amendment

This policy may be amended by Council.

Approved by Council: November 24, 2006

Updated: February 2010

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Members of CPSO Council and Committees

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

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

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

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

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

- I have read Section 40 (2) of the RHPA, and understand that it is an offence to contravene subsection 36 (1) of the RHPA. I understand that this means in addition to any action the CPSO or others may take against me, I could be convicted of an offence if I communicate confidential information in contravention of Section 36 (1) of the RHPA, and if convicted, I may be required to pay a fine of up to $25,000.00 (for a first offence), and a fine of not more than $50,000 for a second or subsequent offence.

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

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

- I have read and am familiar with the CPSO's By-laws and governance policies. I am bound to adhere to and respect the CPSO's By-laws and the policies applicable to the Council, including without limitation, the following:
    - Council and Committee Code of Conduct
    - Conflict of Interest Policy
    - Impartiality in Decision Making Policy
    - Confidentiality Policy
    - Use of CPSO Technology Policy
    - Information Breach Protocol
    - E-mail Management Policy
    - Role Description of a CPSO Council/Committee Member (as applicable)

Declaration of Conflicts:

1.
2.
3.

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

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

…… ……

Full Name (please print)

Signature ……

Date

Council and Committee Code of Conduct

Purpose

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

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

Application

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

Fiduciary Duty and Serving and Protecting the Public Interest

Fiduciary Duty

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

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

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

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

Serving and Protecting the Public Interest

The CPSO is the self-regulating body for the province's medical profession. In carrying out its role as a regulator governed by the RHPA, the CPSO has a duty to "serve and protect the public interest". This duty takes priority over advancing any other interest. For greater clarity,

advancing other interests must **only** occur when those interests are not inconsistent with protecting and serving the public interest. As Council and committee members have a fiduciary duty to the CPSO, they must keep in mind that in performing their duties they are expected to work together to support the CPSO in fulfilling this mandate.

Advancing the Profession's Interests

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

Conduct and Behaviour

Respectful Conduct

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

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

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

Council and Committee Solidarity

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

Media Contact, Social Media, and Public Discussion

Council and CPSO Spokespersons

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

Media Contact and Public Discussion

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

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

Social Media Use

Members must take care in their social media posts and in sharing personal opinions that they do not appear to represent the CPSO. It is a member's responsibility to consider whether their post could possibly give rise to the appearance of representing the CPSO, even if such representation was not the intention of the post. This includes **all** manner of communications and social media use, whether private or public. For example, members should:

- Speak on behalf of the CPSO **only when authorized by the President or CEO/Registrar**;
- Make it clear that they are only speaking for themselves when commenting on matters that relate to the CPSO, and where their relationship to the CPSO is or could reasonably become known;
- Not respond to any negative or confrontational content that is or could be seen to be related to the CPSO, and notify CPSO staff should they discover or receive any negative/confrontational content on social media; and,
- Not engage in harassing, discriminatory or otherwise abusive behaviour.

Representation on Behalf of the CPSO

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

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

Diversity, Equity, and Inclusion

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

committee members approaching all work at the CPSO with a diversity, equity, and inclusion lens.

Email and CPSO Technology

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

- Use of CPSO Technology Policy
- Information Breach Protocol
- E-mail Management Policy

CPSO Email Address

Council and committee members must use **only** their CPSO (cpso.on.ca) email address for any and all business related to the CPSO. CPSO emails (including virtual meeting invitations) should not be forwarded or sent to a personal email address under any circumstances. This is very important to maintain the confidentiality of CPSO-related communications. Members are expected to minimize the use of their CPSO email address with regards to personal or non-CPSO matters.

If a member is having difficulties accessing or using their CPSO email, the Information Technology department can provide assistance.

CPSO Technology

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

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

Council and committee members are expected to use laptop computers or other technology or devices provided by the CPSO for CPSO business purposes only. Additionally, the Information Technology department must approve any software downloads to CPSO technology or systems. The CPSO may approve the use of a personal device for CPSO work in some circumstances, in which case the member will be expected to sign an Undertaking with the CPSO regarding its use and security.

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

Other Council and Committee Member Commitments

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

- uphold strict standards of honesty, integrity and loyalty;
- adhere to all applicable CPSO by-laws and policies, in addition to those listed or referred to in this Code of Conduct;
- attend Council and committee meetings, as applicable to the member, be on time and engage constructively in discussions undertaken at these meetings;
- prepare prior to each Council and committee meeting, as applicable to the member, so that they are well-informed and able to participate effectively in the discussion of issues and policies;
- state their ideas, beliefs and contributions to fellow Councillors, committee members and CPSO staff in a clear and respectful manner;
- where the views of the Council or committee member differ from the views of the majority of Council or committee members, work together with Council or the committee, as applicable, toward an outcome in service of the highest good for the public, the profession and the CPSO;
- uphold the decisions and policies of the Council and committees;
- behave in an ethical, exemplary manner, including respecting others in the course of a member's duties and not engaging in verbal, physical or sexually harassing or abusive behaviour;
- participate fully in evaluation processes requested by CPSO that endeavor to address developmental needs in the performance of the Council, Committee and/or individual member;
- willingly participate in committee responsibilities;
- promote the objectives of the CPSO through authorized outreach activities consistent with CPSO's mandate and strategic plan and in accordance with this Code of Conduct;

- respect the boundaries of CPSO staff whose role is neither to report to nor work for individual Council or committee members; and,

- if a member becomes the subject of a hearing by the Discipline Committee or the Fitness to Practice Committee of the CPSO, withdraw from the activities of Council or any committee on which the member serves until those proceedings are formally concluded.

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

Amendment

This Code of Conduct may be amended by Council.

Updated and approved by Council: Month, Day, Year

Schedule 1: Relevant Sections of the *Regulated Health Professions Act* and the *Health Professions Procedural Code*

Regulated Health Professions Act

Confidentiality

36 (1) Every person employed, retained or appointed for the purposes of the administration of this Act, a health profession Act or the *Drug and Pharmacies Regulation Act* and every member of a Council or committee of a College shall keep confidential all information that comes to his or her knowledge in the course of his or her duties and shall not communicate any information to any other person except,

(a) to the extent that the information is available to the public under this Act, a health profession Act or the *Drug and Pharmacies Regulation Act*;

(b) in connection with the administration of this Act, a health profession Act or the *Drug and Pharmacies Regulation Act*, including, without limiting the generality of this, in connection with anything relating to the registration of members, complaints about members, allegations of members' incapacity, incompetence or acts of professional misconduct or the governing of the profession;

(c) to a body that governs a profession inside or outside of Ontario;

(d) as may be required for the administration of the *Drug Interchangeability and Dispensing Fee Act*, the *Healing Arts Radiation Protection Act*, the *Health Insurance Act*, the *Health Protection and Promotion Act*, the *Independent Health Facilities Act*, the *Laboratory and Specimen Collection Centre Licensing Act*, the *Long-Term Care Homes Act, 2007*, the *Retirement Homes Act, 2010*, the *Ontario Drug Benefit Act*, the *Coroners Act*, the *Controlled Drugs and Substances Act* (Canada) and the *Food and Drugs Act* (Canada);

Note: On a day to be named by proclamation of the Lieutenant Governor, clause 36 (1) (d) of the *Act* is amended by striking out "the *Healing Arts Radiation Protection Act*". (See: 2017, c. 25, Sched. 9, s. 115 (1))

Note: On a day to be named by proclamation of the Lieutenant Governor, clause 36 (1) (d) of the Act is amended by striking out "the *Independent Health Facilities Act*". (See: 2017, c. 25, Sched. 9, s. 115 (2))

Note: On a day to be named by proclamation of the Lieutenant Governor, clause 36 (1) (d) of the Act is amended by adding "the *Oversight of Health Facilities and Devices Act, 2017*" after "the *Long-Term Care Homes Act, 2007*". (See: 2017, c. 25, Sched. 9, s. 115 (3))

(d.1) for a prescribed purpose, to a public hospital that employs or provides privileges to a member of a College, where the College is investigating a complaint about that member or where the information was obtained by an investigator appointed pursuant to subsection 75 (1) or (2) of the Code, subject to the limitations, if any, provided for in regulations made under section 43;

(d.2) for a prescribed purpose, to a person other than a public hospital who belongs to a class provided for in regulations made under section 43, where a College is investigating a complaint about a member of the College or where the information was obtained by an investigator appointed pursuant to subsection 75 (1) or (2) of the Code, subject to the limitations, if any, provided for in the regulations;

(e) to a police officer to aid an investigation undertaken with a view to a law enforcement proceeding or from which a law enforcement proceeding is likely to result;

(f) to the counsel of the person who is required to keep the information confidential under this section;

(g) to confirm whether the College is investigating a member, if there is a compelling public interest in the disclosure of that information;

(h) where disclosure of the information is required by an Act of the Legislature or an Act of Parliament;

(i) if there are reasonable grounds to believe that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons;

(j) with the written consent of the person to whom the information relates; or

(k) to the Minister in order to allow the Minister to determine,

(i) whether the College is fulfilling its duties and carrying out its objects under this Act, a health profession Act, the *Drug and Pharmacies Regulation Act* or the *Drug Interchangeability and Dispensing Fee Act*, or

(ii) whether the Minister should exercise any power of the Minister under this Act, or any Act mentioned in subclause (i). 2007, c. 10, Sched. M, s. 7 (1); 2014, c. 14, Sched. 2, s. 10; 2017, c. 11, Sched. 5, s. 2 (1, 2).

Offences

40 (1) Every person who contravenes subsection 27 (1), 29.1 (1) or 30 (1) is guilty of an offence and on conviction is liable,

(a) for a first offence, to a fine of not more than $25,000, or to imprisonment for a term of not more than one year, or both; and

(b) for a second or subsequent offence, to a fine of not more than $50,000, or to imprisonment for a term of not more than one year, or both. 2007, c. 10, Sched. M, s. 12; 2015, c. 18, s. 3.

Same

(2) Every individual who contravenes section 31, 32 or 33 or subsection 34 (2), 34.1 (2) or 36 (1) is guilty of an offence and on conviction is liable to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence. 2007, c. 10, Sched. M, s. 12.

Same

(3) Every corporation that contravenes section 31, 32 or 33 or subsection 34 (1), 34.1 (1) or 36 (1) is guilty of an offence and on conviction is liable to a fine of not more than $50,000 for a first offence and not more than $200,000 for a second or subsequent offence. 2007, c. 10, Sched. M, s. 12.

Health Professions Procedural Code

Duty of College

2.1 It is the duty of the College to work in consultation with the Minister to ensure, as a matter of public interest, that the people of Ontario have access to adequate numbers of qualified, skilled and competent regulated health professionals. 2008, c. 18, s. 1.

Objects of the College

3 (2) In carrying out its objects, the College has a duty to serve and protect the public interest. 1991, c. 18, Sched. 2, s. 3 (2).

Conflict of Interest Policy

Purpose

This policy defines conflict of interest and explains the duties of Council and committee members with respect to conflicts of interest.

Application

This policy applies to Council members and non-Council members of College committees (together referred to as "Members").

Policy

All Members have a duty to act solely in the best interest of the College, consistent with the mandate of the College to act in the public interest, and to maintain the trust and confidence of the public in the integrity of the decision making processes of Council and College committees.

To this end, Members must avoid or resolve conflicts of interest while performing their duties for the College. Even if there is no actual conflict of interest, Members must make best efforts to avoid situations that College members or a member of the public might consider or perceive as a conflict of interest.

Definition and Description of Conflict of Interest

Section 55 of the College's General Bylaw (the "bylaw") defines conflict of interest as follows:

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

The situations in which a potential conflict of interest may arise cannot be exhaustively set out. Conflicts generally arise in the following situations:

- Interest of a Member: when a Member enters into any business arrangement either directly or indirectly with the College, or has a significant interest in a transaction or contract with the College;

- Interest of a relative or association: when a Member's immediate family or practice/business partner(s) enters into any business arrangement with the College;

- Gifts: when a Member or a member of the Member's household or any other person, company or organization chosen by the Member, accepts gifts, credits, payments, services or anything else of more than a token or nominal value from a party with whom the College may enter into a business arrangement (including a supplier of goods or services) for the purposes of (or that may be perceived to be for the purposes of) influencing an act or decision of the Council or a committee of the Council;

- Other motivating or competing interests:

    - Self-interest: when a Member exercises his or her powers motivated by self-interest or any purpose other than the public interest;

    - Competing Fiduciary Obligations and Roles in Other Organizations: when a Member has competing "fiduciary obligations" (see below) to both the College and another organization, and the interests or mandate of that other organization may, or may be perceived to, conflict with or be inconsistent with the interests or mandate of the College. For example, the Member holds a position on the governing body of an organization that advocates for physicians generally or for particular specialists. This could conflict with, or be seen to conflict with, the Member's duty to act in the public interest in his or her role with the College. Members are asked to identify, on the Declaration of Adherence form, any relationships with other organizations that may create a conflict of interest by virtue of having competing fiduciary obligations.

        - A Member should avoid placing him/herself under an obligation to or entering into a relationship with another organization that gives rise to competing professional interests in the performance of his/her duties with the College, even if the Member's role in the other organization falls short of being a "fiduciary".

        - What do we mean by "fiduciary"? A person who is in a special relationship of trust and confidence with an organization (or an individual) is said to be a fiduciary of that organization, and as such, is obligated to act in the interests of that organization over the interests of others, including the person's own interests. By virtue of a Member's position on Council, the Member is a fiduciary of the College. A physician who has an executive position on the OMA, for example, would be a fiduciary to the OMA.

- Failure to disclose information: when Members fail to disclose information that is relevant to a vital aspect of the affairs of the College.

Process for Resolution of Conflicts of Interest

Acting in a conflict of interest is a breach of College policy and may be the basis for removal from Council or a Council committee. Section 56 to 59 of the General By-law (attached) contain a process for disclosing and resolving a potential conflict of interest. If Council is not satisfied that a conflict is resolvable through the process in the General By-Law, Council may ask the Member to resign or disqualify the Member.

Amendment

Council may amend this policy.

Updated and approved by Council: December 4, 2014

Appendix 1: Conflict of Interest Provisions in College By-Law

Definition of Conflict of Interest

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

Process for Resolution of Conflicts in Council Matters

56. A council member who has or may have a conflict of interest in connection with council business shall consult with the registrar and disclose the conflict to council at the earliest opportunity, and in any case before council considers the matter to which the conflict relates. If there is any doubt as to whether a conflict exists, the member must declare it to council and accept council's decision as to whether a conflict exists.

57. A council member who has a conflict of interest shall:
    (a) disclose the conflict;
    (b) leave the room when council is discussing the matter; and
    (c) not vote on the matter, or try to influence the vote.

Process for Resolution of Conflict in Committee Matters

58. A committee member who has or may have a conflict of interest in connection with a matter before a committee shall consult with the appropriate committee support representative. For adjudicative committees, the committee member should consult with the Hearings Office. The committee member should disclose the conflict at the earliest opportunity,

and in any case before the committee considers the matter. The committee member shall accept the Chair's direction as to whether there is a conflict of interest and any steps the Chair takes or requires to resolve the conflict. Where the Chair has or may have a conflict of interest, the Chair shall accept the executive committee's direction as to whether there is a conflict of interest and any steps the executive committee takes or requires to resolve the conflict.

Record of Declarations

59. Declarations with respect to conflicts of interest shall be recorded in the minutes of the meeting.

Impartiality in Decision Making Policy

Purpose

The purpose of this policy is to set out the appropriate processes for identifying and dealing with situations where a lack of impartiality might arise that could disqualify a member of a College committee from making a decision in a particular matter.

Application

Part I of this policy applies to all members of the Discipline and Fitness to Practice Committees in the context of a hearing involving a decision directly affecting the rights, interests or privileges of a named physician.

Part II of the policy applies to all members of College committees in the context of a meeting involving a decision directly affecting the rights, interests and privileges of a named physician or person.

This policy applies in addition to the Conflict of Interest Policy. This policy should be read in combination with Council's policy on the Provision of Opinions by Committee Members, attached as Appendix 1 to this policy.

PART I: Avoiding Perceptions of Bias in Adjudicative Decisions of the Discipline and Fitness to Practice Committees

Background

The Regulated Health Professions Act, 1991 calls upon the Discipline and Fitness to Practice Committees in certain circumstances to make final decisions in the context of a hearing which could affect a physician's rights, interests or privileges. Such final decisions are referred to in this policy elsewhere as "adjudicative decisions."

A Council or non-Council committee member sitting in an adjudicative role, for example, in a disciplinary hearing, must be free of a reasonable apprehension of bias. Whether actual bias exists or can be demonstrated is largely irrelevant. A physician whose rights and privileges may be curtailed as a result of an adjudicative decision is entitled to decision-makers who are neither biased, nor appear to a reasonable person to be biased.

A reasonable apprehension of bias exists where a reasonable and informed person, viewing the matter realistically and practically, and having thought the matter through, would conclude that the decision-maker, whether consciously or unconsciously, may not decide the matter fairly and impartially.

Policy

A committee member should not adjudicate in a hearing where circumstances may give rise to a reasonable apprehension of bias on the part of the member.

Identifying the Potential for Bias

It is impossible to outline all circumstances in which a reasonable apprehension of bias could arise, or to give definitive answers in the abstract. There are many different kinds of relationships, events and conduct that may give rise to a reasonable apprehension of bias. Committee members should be aware of the potential for bias and seek advice whenever a potential, even remote, likelihood of bias exists. By way of example, the following circumstances will often create a reasonable apprehension of bias on the part of the decision-maker in respect of a particular proceeding:

- The member has an association, relationship, non-financial interest or activity that would be seen to be incompatible with his or her responsibilities as an impartial decision-maker. Examples of these include:
    - The panel member provided an opinion in a case for or against the subject physician;
    - The panel member is the current or former practice partner of the subject physician; or
    - The panel member is a close friend or relative of the subject physician or the complainant.
- The member has prior knowledge of a matter, for example if a party is appearing before the member for a second time (but see note below), or the member obtained information about the matter through previous employment or other form of work or activity. Note that prior knowledge of a matter obtained through work at the College may not always create a reasonable apprehension of bias, depending on the context and the committees involved; the member should consult the Hearings Office or his/her committee support representative.
- The member has made past statements or expressed views about issues relevant to the matter before him or her that suggests prejudgment of the issue, or the member's past conduct or actions indicate prejudgment. The provision by a member of a letter of support (i.e. a character reference) to the College or a College committee in respect of a physician or facility for whom or which there is an investigation or review at any stage

by the College may create a reasonable apprehension of bias; members should not provide these letters of support.

- An appearance of bias may arise from the member's conduct during the hearing; examples include communicating with one party without the knowledge or inclusion of the other, overly aggressive questioning of one party, refusing to hear evidence, constant interruptions of one party, and laughing and making exasperated noises during testimony.

The following circumstances generally would not, of themselves, be considered to create a reasonable apprehension of bias on the part of a decision-maker in respect of a particular proceeding before a committee on which the member sits:

- The decision-maker went to medical school with the subject physician; or

- The decision-maker has attended educational conferences that the subject physician also attended.

Nothing set out above should be taken to interfere with the entitlement of a potential panel member to refuse to sit on a particular matter on the basis that he or she is of the view that an apprehension of bias may exist.

<u>Process for Dealing with Potential Bias in an Adjudicative Proceeding</u>

Prior to a particular matter coming before a panel of a committee, the Hearings Office, directly or indirectly through the independent legal counsel, should:

- provide each panel member with some basic information about the identity of the parties and their respective counsel or other representatives; and

- ask each panel member to advise whether he or she has had any interactions or relationship with the subject physician that could lead to a reasonable apprehension of bias in respect of that matter.

A committee member may at any time consult with the Hearings Office as to whether he or she should serve as a member of a panel hearing a particular matter, having regard to circumstances that might create a reasonable apprehension of bias on the part of the decision-maker.

Where at any time a committee member becomes aware of a circumstance or circumstances that might give rise to a reasonable apprehension of bias in respect of an adjudicative proceeding, he or she should immediately advise the Hearings Office. If the circumstance arises

during the conducting of a hearing, the committee member should immediately notify independent legal counsel.

PART II: Maintaining Impartiality in Non-adjudicative Decisions of College Committees
Background

Most decisions made by College committees are non-adjudicative; that is, they are not final decisions which affect a physician's rights, interests or privileges, which a committee arrives at through a hearing. However, similar principles of fairness may apply to these decisions as to adjudicative decisions. Accordingly, committee members must be aware of circumstances which could give rise to a perception that they are not able to decide a matter fairly and impartially because of some connection to or relationship with the physician or person about whom they are making a decision.

Policy

A committee member should not take part in a decision if a reasonable and informed person would conclude that the member is not able to decide fairly and impartially, for example, because of some connection to or relationship with the physician or person about whom they are making a decision.

Maintaining Impartiality

The standard of impartiality for non-adjudicative decisions may be lower than that for adjudicative decisions. In other words, circumstances that could create a reasonable apprehension of bias for an adjudicative decision may not raise concerns about the ability of a committee member to decide a matter fairly and impartially in a non-adjudicative context. Generally, committee members should appear amenable to persuasion and keep an open mind in making a decision about a physician or person outside the adjudicative or hearing context.

The factors that are relevant for determining whether there may be a reasonable apprehension of bias in adjudicative decisions are also relevant in the context of non- adjudicative decisions. The circumstances listed above under the heading "Identifying the Potential for Bias" in Part I should be used as a tool for determining whether circumstances create the potential for the appearance that a decision lacks fairness and impartiality. It may not be the case that a committee member has to refrain from making a decision due to these circumstances. However, committee members should be aware of the potential that a personal relationship or strongly held opinion may give rise to the perception that the member has a "closed mind". Committee members should seek advice with respect to any concerns about maintaining impartiality.

Process for Maintaining Impartiality in Non-Adjudicative Decisions

When a committee member receives an agenda for a meeting, before reviewing the supporting materials, the member should review the names of the physicians and persons under consideration. The member should identify any physician or person about whom the member may not be able to reach an impartial and fair decision, or who may give rise to a perception that the member would not make an impartial and fair decision.

If the committee member identifies any such physician or person, the member should advise the committee support representative, who will consult with College counsel to determine if the member should or should not participate in the decision. The committee support representative will advise the member accordingly. The committee member should not review any materials relevant to such a physician or person until the matter is resolved.

If it is determined that there is a potential that the committee member would not make an impartial and fair decision, or a potential for a perception that the member would not make an impartial and fair decision, the member will leave the room or not participate in the conference call while the committee considers the particular physician or person's case. The committee will not ask the committee member to review or discuss any materials regarding the matter.

Amendment

Council may amend this policy. Updated and approved by Council: December 4, 2014

Appendix 1: Provision of Opinions by Committee Members

A. No member of Council or of any College Committee shall provide an opinion in respect of matters that are currently being investigated or reviewed in any College department or by any College Committee.

B. (1) Prior to agreeing to provide any professional opinion for any type of proceeding or potential proceeding outside of the College, Council or non-Council Committee members shall:

I. satisfy themselves that the matter is not at any stage of investigation or review in any College department or by any College Committee by:

a. asking the party who wishes to retain them if the matter is at the College; and

b. contacting their committee support person to confirm that the matter is not at the College; and

II. satisfy themselves that the party who is retaining them does not intend to bring the matter to the College, and has received no indication that the opposing party has any intention to bring the matter to the College.

(2) After being retained to provide an opinion or act as an expert, the Council or Committee member must advise support staff for Council or the relevant Committee of his or her involvement in a proceeding or potential proceeding involving a member of the College ("subject member"), in order to ensure that the appropriate internal College screen be established, to be used if the need arises. This is to ensure that the expert Council or Committee member is not involved in any future College matter involving the subject member.

C. If the College begins an investigation or review of the subject matter after a Council or relevant Committee member has been retained to provide an opinion or act as an expert, but prior to the Council or Committee member providing a draft or final opinion or testifying (whichever comes first), the Council or Committee member shall (i) immediately end his or her retainer to provide an opinion or act as an expert, (ii) ensure that no confidential information about the matter is provided to any other Council or Committee member, and that no College information is provided to any participant in the matter outstanding with the College, and (iii) recuse him/herself from the matter outstanding with the College.

D. If the College begins an investigation or review of the subject matter after a Council or Committee member provides any draft or final opinion or testifies in a proceeding, the Council or Committee member shall (i) immediately notify the College support person of the Council or Committee member's involvement in the case, (ii) ensure that no confidential information about the matter is provided to any other Council or Committee member, and that no College information is provided to any participant in the matter outstanding with the College, and (iii) recuse him/herself from the matter outstanding with the College.

Confidentiality Policy

Purpose

To ensure that confidential matters are not disclosed until disclosure is authorized by the Council.

Policy

Council and Committee members owe to the College a duty of confidence; not to disclose or discuss with another person or entity or to use for their own purpose, confidential information concerning the business and affairs of the College received in their capacity as Council and/or Committee members unless otherwise authorized by the Council.

Every Council or Committee member shall ensure that no statement not authorized by the Council is made by him or her to the press or public.

Application

This policy applies to all Council and non-Council Committee members.

Confidential Matters

All matters which are the subject of closed sessions of the Council are confidential until disclosed in an open session of the Council.

All matters which are before a committee or task force of the Council are confidential until disclosed in an open session of the council.

All matters which are the subject of open sessions of the Council are not confidential.

Notwithstanding that information disclosed or matters dealt with in an open session are not confidential, no Council member shall make any statement to the press or the public in his capacity as a Council member unless such statement has been authorized by the Council. Council members are referred to Council's Media Relations Policy.

1. Every Council member and Committee member is subject to section 36 (1) of the Regulated Health Professions Act, 1991 which provides as follows:

   36. (1) Every person employed, retained or appointed for the purposes of the administration of this Act, a health profession Act or the Drug and Pharmacies Regulation Act and every member of a Council or committee of a College shall keep

confidential all information that comes to his or her knowledge in the course of his or her duties and shall not communicate any information to any other person except,

a) to the extent that the information is available to the public under this Act, a health profession Act or the Drug and Pharmacies Regulation Act;
b) in connection with the administration of this Act, a health profession Act or the Drug and Pharmacies Regulation Act, including, without limiting the generality of this, in connection with anything relating to the registration of members, complaints about members, allegations of members' incapacity, incompetence or acts of professional misconduct or the governing of the profession;
c) to a body that governs a profession inside or outside of Ontario;
d) as may be required for the administration of the Drug Interchangeability and Dispensing Fee Act, the Healing Arts Radiation Protection Act, the Health Insurance Act, the Health Protection and Promotion Act, the Independent Health Facilities Act, the Laboratory and Specimen Collection Centre Licensing Act, the Long-Term Care Homes Act, 2007, the Retirement Homes Act, 2010, the Ontario Drug Benefit Act, the Coroners Act, the Controlled Drugs and Substances Act (Canada) and the Food and Drugs Act (Canada);

(d.1) for a prescribed purpose, to a public hospital that employs or provides privileges to a member of a College, where the College is investigating a complaint about that member or where the information was obtained by an investigator appointed pursuant to subsection 75 (1) or (2) of the Code, subject to the limitations, if any, provided for in regulations made under section 43;

(d.2) for a prescribed purpose, to a person other than a public hospital who belongs to a class provided for in regulations made under section 43, where a College is investigating a complaint about a member of the College or where the information was obtained by an investigator appointed pursuant to subsection 75 (1) or (2) of the Code, subject to the limitations, if any, provided for in the regulations;

e) to a police officer to aid an investigation undertaken with a view to a law enforcement proceeding or from which a law enforcement proceeding is likely to result;
f) to the counsel of the person who is required to keep the information confidential under this section;
g) to confirm whether the College is investigating a member, if there is a compelling public interest in the disclosure of that information;
h) where disclosure of the information is required by an Act of the Legislature or an Act of Parliament;
i) if there are reasonable grounds to believe that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons;
j) with the written consent of the person to whom the information relates; or
k) to the Minister in order to allow the Minister to determine,

i. whether the College is fulfilling its duties and carrying out its objects under this Act, a health profession Act, the Drug and Pharmacies Regulation Act, or the Drug Interchangeability and Dispensing Fee Act, or
ii. whether the Minister should exercise any power of the Minister under this Act, or any Act mentioned in subclause (i). 2007, c. 10, Sched. M, s. 7 (1); 2014, c. 14, Sched. 2, s. 10; 2017, c.11, Sched. 5,s. 2(1.2).

2. Every individual who contravenes subsection 36 (1) of the Regulated Health Professions Act, 1991 is guilty of an offence and on conviction is liable to a fine of not more than $25,000.00 for a first offence and a fine of $50,000 for subsequent offences.

Procedure for Maintaining Minutes

Minutes of closed sessions of the Council shall be recorded by the Secretary or designate or if the Secretary or designate is not present, by a Council member designated by the President of the College.

All minutes of closed sessions of the Council shall be marked confidential and shall be handled in a secure manner.

All minutes of meetings of committees and task forces of the Council shall be marked confidential and shall be handled in a secure manner.

Amendment

This policy may be amended by Council.

Approved by Council: November 24, 2006

Updated: February 2010

CPSO

Council Motion

Motion Title: Alternative Pathways to Registration – Draft for Consultation

Date of Meeting: December 4, 2020

It is moved by_____,

and seconded by_____, that:

The College engage in the consultation process in respect of the draft *Alternative Pathways to Registration* policy (a copy of which forms Appendix "A and B" to the minutes of this meeting).

CPSO

Council Briefing Note

December 2020

TOPIC: Alternative Pathways to Registration

FOR DECISION

ISSUE:

- The Registration Committee recommends revising the existing Council Policies on *Alternatives Pathways to Registration* ("Pathways policy") to reflect process changes and to provide increased clarity to applicants and stakeholders. Council is being asked to approve the recommendations and refer the matter to Council for its consideration.

BACKGROUND:

- In June 2008 the Government of Ontario announced that it would be initiating a more aggressive approach to the licensure of IMGs based on the recommendations in a report prepared by Parliamentary Assistant and MPP Laura Broten.

- Additionally, on June 16, 2008, Bill 97, Increasing Access to Qualified Health Professionals for Ontarians Act, was introduced. It amended the RHPA to place a duty on the health regulatory colleges to work in consultation with the Minister of Health and Long Term Care to ensure as a matter of public interest, that Ontarians have access to adequate number of qualified, skilled and competent regulated health professionals.

- In July 2008, the College reconstituted the CPSO Physician Resource Task Force. The Task Force developed a framework to expand the qualifications for certificates of registration in Ontario. The proposed new requirements were set out as the "*Policies on Alternative Pathways to Registration*".

- The policy on Alternative Pathways to Registration set out a variety of pathways for specific groups of applicants. The registration requirements varied depending on the source of the applicant's medical degree, where the applicant is currently practicing and where they received their postgraduate training.

- The Pathway policies were approved by Council in September 2008 (Appendix A). The Pathways are applicable to the following groups of physicians:

    i. Physicians with a Canadian medical degree and postgraduate training without Royal College of Physicians and Surgeons of Canada (RCPSC) or College of Family Physicians of Canada (CFPC) certification (Pathway 1)
    ii. International medical graduates (IMGs) with Canadian postgraduate training without RCPSC or CFPC certification (Pathway 2)
    iii. Physicians with a U.S. or Canadian medical degree or Doctor of Osteopathy degree with U.S. postgraduate training and certification (Pathway 3)
    iv. IMGs with US postgraduate training and certification (Pathway 4)

- The Pathways made it easier for candidates to become registered in Ontario by removing barriers and providing alternative options for acceptable qualifications (namely US training and Board certification).

- The Pathways add another route to licensure for applicants who are not certified by the RCPSC or CFPC and do not currently hold a certificate of registration in a Canadian jurisdiction.

- Under this policy, eligible candidates are issued an initial certificate of registration to practice medicine under supervision during which time the College receives regular reports from the supervisor.

- After one year of practice in Ontario, the College conducts a comprehensive assessment of the candidates' practice. Upon successful completion of the assessment (as determined by the Registration Committee), the candidates will be issued a certificate of registration to practice medicine independently in their scope of practice.

- Unsuccessful completion of an assessment will result in the expiry of the certificate of registration, unless it is renewed by the Committee with additional terms, conditions and limitations (increased supervision, additional assessment, etc.).

- An assessment report is then compiled and presented to the Registration Committee. If the report is acceptable to the Registration.

CURRENT STATUS:

- A redesigned policy has been drafted (Appendix B), incorporating the changes outlined below.

A. Removing Mentor Requirement

- Currently, a physician applying under a Pathway must submit a supervision arrangement identifying a primary supervisor, a back-up supervisor and a mentor, all of whom must satisfy the College's Guidelines for Approval of Clinical Supervision. Applicants have commented on the difficulty of finding three separate physicians to fill these roles while still residing outside of Ontario.
- The Registration Committee does not require a physician to obtain a mentor under any other Registration policy, although a mentor may be recommended to physicians entering into first-time practise in Canada.
- In 2017, the College's Advisory Group for Regulatory Excellence found that no other College Committees require mentoring as policy.

B. No longer distinguishing route based on source of medical degree

- Currently, the only difference in the requirements between Pathways 1 and 2 is the source of medical degree (Canada vs IMG).
- Aside from this requirement, all other eligibility requirements are the same. Candidates approved under either Pathway 1 or Pathway 2 are granted certificates of registration with the same terms, conditions and limitations.

- Similarly, the primary difference in the requirements between Pathways 3 and 4 is the source of medical degree. Candidates approved under Pathway 3 or 4 are granted certificates of registration with the same terms, conditions and limitations.
- As we treat candidates the same under Pathways 1/2 and3/4 regardless of the source of medical degree, it would appear the policy distinction is not necessary.
- The Pathways policy language has been updated to state that an applicant must hold an acceptable medical degree as defined in Ontario Regulation 865/93 under the Medicine Act, 1991.

C. Combining Pathways 1 & 2

- If the policies are no longer differentiated based on source of medical degree, it would be redundant to continue to have Pathway 1 and 2.
- Pathways 1 and 2 have been combined to a single policy.
- Due to the very few applications received under Pathways 1 and 2 since the implementation of the Pathways in 2008, the combined policy is designated "Pathway B".

D. Combining Pathways 3 & 4

- Currently, the only difference in the requirements between Pathways 3 and 4 are the source of medical degree (US/Canada vs. IMG), and license status in the US.
- If the policies are no longer differentiated based on source of medical degree, the only remaining requirement is evidence of licensure in the US.
- The current policy stipulates that a Pathway 3 applicant must hold an independent license in the US, while a Pathway 4 applicant needs only to demonstrate eligibility for an independent license in the US.
- An increasing number of Pathway 3 physicians apply to the College immediately upon completion of residency training in the US, and do not hold independent licensure, which is a requirement only under Pathway 3. This additional requirement can pose a barrier to physicians who otherwise meet the eligibility requirements under the policy.

- Pathways 3 and 4 have been combined to a single policy (Pathway A), which require that the applicant hold an acceptable degree in medicine and demonstrate that he or she is eligible for independent/full licensure in the United States.

E. Supervision Reporting Requirements

- Physicians approved under the Pathway policies are required to practice under supervision for a period of at least a year. The approved supervisor undertakes to directly observe patient care where appropriate; however, the undertaking does not specify the frequency or duration of the direct supervision.
- College assessors have reported that at the time of the practice assessment, some candidates have indicated that no direct observation occurred throughout the year of supervision. The assessors note that minor practice issues that could have been addressed at the onset of supervision have gone undetected and uncorrected.
- The language in the undertakings have been updated specify a period of limited direct observation for an initial period to be determined, and regular direct observation where appropriate.

F. Language Redesign

- In 2018, Council approved a proposal to redesign College policies in order to enhance clarity, without meaningfully altering the core content of the policy themselves.
- The language of the policy has been revised for conciseness and clarity.

ANALYSIS:

- In the past 5 years the Registration Committee has approved the following cases under Pathways 1-4

	2015	2016	2017	2018	2019
Pathway 1	**0**	**0**	**0**	**2**	**0**
Pathway 2	**0**	**0**	**0**	**0**	**0**
Pathway 3	**24**	**15**	**20**	**21**	**27**
Pathway 4	**83**	**55**	**63**	**64**	**66**

NEXT STEPS:

- Subject to Council's approval, external consultation is required under legislation due to the proposed substantive changes to the policy (i.e. collapsing Pathways 1 – 4 into Pathways A and B).

DECISION FOR COUNCIL:

1. Does Council recommend the approval of the revised *Alternative Pathways to Registration* policy to engage in the consultation process?

Contact: Samantha Tulipano, ext 709

Date: November 13, 2020

Attachments:

Appendix A: *Alternative Pathways to Registration* – Existing Policy

Appendix B: *Alternative Pathways to Registration* – Revised Draft Policy

APPENDIX A

ACCEPTABLE QUALIFYING EXAMINATIONS

Alternatives to the Medical Council of Canada Examinations Parts 1 and 2

Applicants who are not licentiates of the Medical Council of Canada but who have successfully completed one of the following examinations:

1. USMLE Steps 1, 2 and 3. Step 2 Clinical Skills (CS) is required if Step 2 was taken **after June 12, 2004**.
2. ECFMG certification plus USMLE Step 3. Applies to international medical school graduates who passed USMLE Step 2 Clinical Skills Assessment (CSA) between July 1, 1998 to June 14, 2004.
3. FLEX component 1 and component 2 successfully completed (score of 75 on each component) between January 1, 1992 and December 31, 1994.
4. NBME Part 1, 2 and 3, successfully completed between January 1, 1992 and December 31, 1994.
5. The Comprehensive Osteopathic Licensing Examination (COMLEX-USA) Levels 1, 2 and 3. COMLEX-USA Level 2 Performance Evaluation (PE) component is required if Level 2 was completed **after September 2004**. (Applies to graduates of osteopathic schools accredited by the American Osteopathic Association.)
6. Examen Clinique Objectif Structuré (ECOS) of the Collège des Médecins du Québec passed between January 1, 1992 and December 31, 2000.

may be eligible for a certificate of registration with the following conditions, provided the applicant meets all other criteria for registration:

1. The physician must practice with a mentor and/or supervisor until he or she has successfully completed an assessment.
2. The physician must undergo an assessment after completing a minimum of one year of practice in Ontario. The certificate of registration automatically expires 18 months from the date of issuance, but may be renewed by the Registration Committee, with or without additional or other terms, conditions and limitations.

All applications submitted under this policy require review and approval by the College's Registration Committee.

ALTERNATIVE TO THE MCCQE 2 EXAMINATION

Approved by Council: February 2008
Reviewed and Updated: September 2015

This policy sets out the criteria under which an applicant for a certificate of registration may apply to the College to undergo a practice assessment as an alternative to the requirement of completing Part 2 of the Medical Council of Canada Qualifying Examination (MCCQE).

An applicant may apply to the College for a practice assessment, if the applicant has:

1. Five or more years of independent practice experience;
2. Certification by examination from the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada; or recognized as a specialist by the College of Physicians and Surgeons of Ontario
3. MCCQE Part 1, or an acceptable alternative;
4. One year of successful practice in Ontario under supervision, demonstrated by the supervisor's reports to the College.

The Registration Committee considers each case individually. The Committee will consider the nature and scope of practice as well as the applicant's attempts at writing MCCQE Part 2 when considering each application. The Committee expects that applicants will have attempted the MCCQE Part 2 before applying for a practice assessment under this policy.

Candidates who fulfil the aforementioned criteria may be permitted to undergo a practice assessment by the College. The Registration Committee will consider the practice assessment report and if the Committee finds the assessment report satisfactory, it will direct the Registrar to:

- Issue the candidate a restricted certificate of registration authorizing independent practice, limited to their specialty or scope of practice.

The applicant must pay all cost associated with the assessment.

RECOGNITION OF CERTIFICATION WITHOUT EXAMINATION ISSUED BY CFPC

Approved by Council: November 2009, February 2010, September 2013

The College of Physicians and Surgeons of Ontario (CPSO) and the College of Family Physicians of Canada (CFPC) have been working together to improve access and reduce barriers for qualified physicians.

A joint statement prepared by the CPSO and the CFPC provides some general information about the application process. For further information, please contact the relevant College.

Preamble

The College's registration regulation sets out the requirements which must be met in order for an applicant to be issued a certificate of registration.

If an applicant does not meet the requirements set out in the regulation it may still be possible for an applicant to qualify pursuant to one of the exemption policies.

Please note if you currently hold a certificate of registration in any Canadian jurisdiction except Nunavut you may be eligible for registration in Ontario under new provisions of the *Health Professions Procedural Code* (the "Code"). Please refer to sections 22.15 to 22.23 of the Code.

Please see Legislation and By-Laws for more details.

All applicants must be able to demonstrate that their past and present conduct indicates that they are mentally competent to practise medicine; will practise with decency, integrity and honesty and in accordance with the law; have sufficient knowledge, skill and judgment to engage in the kind of practice authorized by the certificate and can communicate effectively; and will display an appropriately professional attitude.

In addition to the registration regulation and policies, all applicants will also be subject to other CPSO policies and regulations which apply to current registrants. In particular, the Changing Scope of Practice and Re-entering Practice policies, and the regulation pertaining to the use of specialist titles may have relevance for new applicants. All applicants will also be subject to the College's expectations with respect to continuing professional development.

All applicants may choose to proceed through any other applicable registration policy. In such instances, the provisions in this policy will not apply.

Policy

1. Certification without examination and completed an Acceptable Qualifying Examination:

The Registration Committee may direct the Registrar to issue a **restricted certificate** of registration to an applicant who has a medical degree from an acceptable medical school, if the applicant has:

1. Successfully obtained certification without examination by the CFPC;
2. Successfully completed an **acceptable qualifying examination** as defined in the College's Policy on Acceptable Qualifying Examinations;

The following conditions will be placed on the certificate of registration:

1. The physician must practice with a mentor and/or supervisor until he or she has successfully completed an assessment.
2. The physician must undergo an assessment after completing a minimum of one year of practice in Ontario. The certificate of registration automatically expires 18 months from the date of issuance, but may be renewed by the Registration Committee, with or without additional or other terms, conditions and limitations.

2. Certification without examination and completed Parts 1 & 2 of the Medical Council of Canada Qualifying Examination:

The Registration Committee may direct the Registrar to issue a certificate of registration authorizing **independent practice** to an applicant who has a medical degree from an acceptable medical school, if the applicant has:

1. Successfully obtained certification without examination by the CFPC;
2. Successfully completed Parts 1 & 2 of the Medical Council of Canada Qualifying Examination.

RESTRICTED CERTIFICATE OF REGISTRATION FOR EXAM ELIGIBLE CANDIDATES

Approved by Council: November 2003
Reviewed and Updated: November 2011; December 2016

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

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

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

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

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

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

APPENDIX B

1. Acceptable Qualifying Examinations

Learn about alternatives to the Medical Council of Canada Exams Parts 1 and 2.

Even if you are not a licentiate of the Medical Council of Canada, you may be eligible for a restricted certificate of registration. This may be the case if you have successfully completed one of the following exams:

1. **USMLE Steps 1, 2 and 3**. We require Step 2 Clinical Skills (CS) if you took Step 2 **after June 12, 2004.**
2. **ECFMG certification plus USMLE Step 3**. This applies to international medical graduates (IMGs) who passed USMLE Step 2 Clinical Skills Assessment (CSA) between July 1, 1998 and June 14, 2004.
3. **FLEX component 1 and component 2,** successfully completed (score of 75 on each component) between January 1, 1992 and December 31, 1994.
4. **NBME Part 1, 2 and 3**, successfully completed between January 1, 1992 and December 31, 1994.
5. **The Comprehensive Osteopathic Licensing Examination (COMLEX-USA) Levels 1, 2 and 3**. We require the COMLEX-USA Level 2 Performance Evaluation (PE) component if you completed Level 2 **after September 2004**. (This applies to graduates of osteopathic schools accredited by the American Osteopathic Association.)
6. **Examen Clinique Objectif Structuré (ECOS) of the Collège des Médecins du Québec** passed between January 1, 1992 and December 31, 2000.

Your certificate would come with the following terms, conditions and limitations, provided you meet all other criteria for registration:

1. You must practice with a mentor and/or supervisor until you have successfully completed an assessment.
2. You must undergo an assessment after completing a minimum of one year of practice in Ontario. The certificate of registration automatically expires 18 months from the date of issuance, but the Registration Committee may renew it with or without terms, conditions and limitations.

The CPSO's Registration Committee must review all applications submitted under this policy before approval.

2. Alternative to the MCCQE 2 Examination

Learn how you can undergo a practice assessment as an alternative to completing part 2 of the Medical Council of Canada Qualifying Exam

If you are applying to practice medicine in Ontario, there is an option to undergo a practice assessment as an alternative to completing Part 2 of the Medical Council of Canada Qualifying Examination (MCCQE).

You can apply for this practice assessment if you have:

i. Five or more years of independent practice experience;
ii. Certification by examination from the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada or are recognized as a specialist by the College of Physicians and Surgeons of Ontario;
iii. Successfully completed MCCQE Part 1, or an acceptable alternative;
iv. One year of successful practice in Ontario under supervision, demonstrated by the supervisor's reports to the CPSO.

Our Registration Committee considers each case individually. We will look at the nature and scope of your practice as well as your attempts at writing MCCQE Part 2. The Committee expects applicants to attempt the exam before applying for this practice assessment. Applicants must pay all costs associated with the assessment.

If you meet the criteria above, you may be permitted to undergo a practice assessment by the College. If we find your assessment report satisfactory, we will direct the Registrar to issue you a restricted certificate of registration. This will authorize independent practice, limited to your specialty or scope of practice.

3. Recognition of Certification without Examination Issued by CFPC

We have been working with **the College of Family Physicians of Canada to improve access and reduce barriers for qualified physicians.**

There are two scenarios in which the CPSO will recognize your certification in lieu of a CFPC examination. They are:

1. Certification without examination and completed an acceptable qualifying exam:

You may be issued a **restricted certificate** of registration if you have a medical degree from an acceptable medical school and have:

1. Successfully obtained certification without examination by the CFPC; and

2. Successfully completed an **acceptable qualifying examination** as defined in the College's Policy on Acceptable Qualifying Examinations.

The following conditions will be placed on the certificate:

1. You must practice with a mentor and/or supervisor until you have successfully completed an assessment.

2. You must undergo an assessment after completing a minimum of one year of practice in Ontario. The certificate of registration automatically expires 18 months from the date of
issuance, but we may renew it, with or without additional or other terms, conditions and limitations.

2. Certification without examination and completed Parts 1 & 2 of the Medical Council of Canada Qualifying Examination:

We may issue you a certificate of registration authorizing **independent practice** if you have a medical degree from an acceptable medical school and have:

1. Successfully obtained certification without examination by the CFPC; and

2. Successfully completed Parts 1 & 2 of the Medical Council of Canada Qualifying Examination.

4. Restricted Certificate of Registration for Exam Eligible Candidates

Learn how you may qualify for this type of licensure in Ontario.

The CPSO can issue a time-limited, restricted certificate of registration to physicians. This certificate is for those who are missing Medical Council of Canada Qualifying Examination (MCCQE) Parts 1 and 2, and/or Royal College of Physicians and Surgeons of Canada (RCPSC) or College of Family Physicians of Canada (CFPC) certification, but are officially eligible to take these exams. You may be issued a restricted certificate if you have provided proof that you:

1. have completed the certification exam of the RCPSC or the CFPC, but you have not yet completed parts 1 and 2 of the MCCQE, or
2. are currently eligible *without pre-condition* to take the RCPSC or CFPC certification exam. You may or may not have yet completed Parts 1 & 2 of the MCCQE.

This restricted certificate is subject to the following conditions:

1. You must practice with a supervisor until you have completed all outstanding exams.
2. Your restricted certificate will expire within a reasonable number of years, not to exceed three years from the date it is issued, if:
    a. you do not successfully complete all outstanding MCC examinations; and
    b. you do not receive certification by exam by either the RCPSC or by the CFPC.

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

Council Briefing Note

December 2020

TOPIC: Council Award Recipient

FOR INFORMATION

ISSUE:

- At the December meeting of Council, **Dr. Najma Ayesha Ahmed** from Toronto will receive the CPSO Council Award.

BACKGROUND:

- The CPSO Council Award recognizes physicians who demonstrate the ideal qualities that are required to effectively meet the health care needs of the people they serve. These abilities are articulated in the Royal College of Physicians and Surgeons of Canada's CANMEDS Framework which consist of seven roles:
    - The physician as medical expert (the integrating role)
    - The physician as communicator
    - The physician as collaborator
    - The physician as leader
    - The physician as health advocate
    - The physician as scholar
    - The physician as professional

- A competent physician seamlessly integrates the competencies of all seven CPSO Council Award qualities.

CURRENT STATUS:

- Council member Dr. Philip Berger will present the award.

Contact: Laurie Cabanas, ext. 503

Date: November 17, 2020

CPSO

Council Motion

Motion Title: **In-Camera Motion**

Date of Meeting: December 3, 2020

It is moved by_____,

and seconded by_____, that:

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

FRIDAY, DECEMBER 4, 2020

CPSO

GUEST PRESENTATION

“Diversity, Equity and Inclusion”

Guest Speaker: Dr. Javeed Sukhera

CPSO

CPSO

Council Briefing Note

December 2020

TOPIC: Skills and Diversity Matrix

FOR DISCUSSION

ISSUE:

- In June, the Governance Committee directed staff to consider opportunities for increasing diversity on CPSO Council and Committees.

- As part of this work, staff developed, and the Governance Committee approved, a Skills and Diversity Matrix (Appendix A); Council members are being asked for feedback and interest in participating in an exercise to map the diversity and skills of Council.

BACKGROUND:

- A Diversity and Skills matrix is a multi-faceted tool and a good governance practice used by boards across many different sectors,[1] and it can provide a comprehensive snapshot of current Council/Committee members' and Committee applicants' skills and perspectives.

- The Maytree Foundation notes that surveying the demographics of board/committee members and applicants by using a Diversity and Skills matrix can help to "build an applicant pool that better reflects the diversity of the

[1] See for example: Vancouver Airport Authority Board of Directors; New York City Comptroller's Board Accountability Project 2.0 which included many large public corporations adopting the use of a Diversity and Skills Matrix; Harbourfront Centre; and Family Services Toronto (see Maytree Foundation, *Diversity in Governance: A Toolkit for Nonprofit Boards*, 2011 [Maytree Report]).

population you serve and who will bring the range of perspectives and experience needed to govern well."[2]

- The matrix captures information about Council/Committee members' skill-level/experience on a high-to-low scale in areas such as legal skills, French proficiency, technological adeptness, risk management, among others.

- In addition to collecting professional information—i.e. year of medical school graduation, specialty, practice setting and locale, etc.—the "Identity/Background" component of the matrix aims to gather information on a Council/Committee member or applicant's ethno-cultural background and lived experiences through the optional self-identification categories.

- A matrix can help identify any gaps among the current Council and Committee composition and allow CPSO Council to consider making appointments, or targeting outreach efforts, to raise awareness and potential fill those areas. In this way, a matrix is an initial step towards increasing diversity at CPSO.

- The matrix also aligns with CPSO's focus on governance modernization and will help move the organization towards a competency-based board selection process.[3]

- Recognizing that Council has an elections-based process for professional members, further consideration will be given as to how the matrix could be used to support that the elections process.

CURRENT STATUS:

- The Governance Committee and the Executive Committee have both provided feedback and direction on the Skills and Diversity Matrix.

- It is also being proposed that Council members confidentially participate in a survey that would assess the current mix of skills and diversity around Council. This would be a confidential "mapping" exercise where the identity of each Council member would remain anonymous.

[2] Maytree Report at 12.
[3] See CPSO submission to government to reduce red tape.

- This is an initial step towards better understanding the range of experiences, skills, identities, and perspectives around the Council table and can inform future outreach efforts to raise awareness about Council elections.

NEXT STEPS:

- Staff will be using this matrix to support the Governance Committee and Council in the next Committee recruitment process to determine potential gaps and support discussions about the candidates.

- Council is asked whether it is willing to participate in an exercise to map the skills and diversity of Council members to determine a baseline and provide some information for discussion.

- Should Council be interested in participating, an online survey will be emailed to Council members following meeting and results of the survey will be shared with the Governance Committee initially prior to sharing with Council.

DISCUSSION FOR COUNCIL:

1. Does Council have any feedback on the Skills and Diversity Matrix that was presented?

2. Is Council amenable to completing the Skills and Diversity Matrix survey?

Contact: Laurie Cabanas, Director of Governance and Policy
Miriam Barna, Senior Government Relations Advisor

Date: November 13, 2020

Attachments: Appendix A: CPSO Skills and Diversity Matrix

APPENDIX A

Instructions:

1. Please feel free to fill in the Identity/Background* options in the manner that you are most comfortable with or best describes your identity/experience (e.g. by simply placing a checkmark in the appropriate option, or by providing specifics on your cultural/ethnic background or gender, etc.). You may also leave the options blank if they are not applicable to you or if you prefer not to self-identify.

2. For Practice Setting and Locale**, please fill in the number(s) and letter(s) that best captures your practice setting (e.g. 1A & 2D):

   1) Urban Centre 2) Mid-size City 3) Rural 4) Northern

   A. Hospital B. Solo Practice C. Group Practice D. Community Setting E. Specialty F. Academic

3. For Skills/Knowledge/Experience***, please check the number that best represents your skill/expertise in the specified area. This section is mandatory. The numbers are ranked as follows:

   1) None 2) Low 3) Medium 4) High

Name	**Professional Information (Physician Members Only)**				**Identity/Background***						**Skills/Knowledge/Experience***																		
	CPSO District	Specialty	Year of MD Graduation	Practice Setting & Locale**	Gender Identity	Ethnic/Cultural Identity	Indigenous	Person with Disability	LGBTQ2S+	Other[1]	Adult Learning & Education	Anti-Racism/Oppression Training	Board & Governance	Business Skills	Experience and Knowledge working w/Equity-seeking Groups	Finance & Accounting	French Proficiency	Govt & Govt Relations	Health System Knowledge	HR/People Management	Leadership	Legal Skills	Policy Development	Professionalism & Ethics	Professional Regulation	Risk Management	Strategic Planning	Technological Proficiency	Other
											1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
											2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	
											3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	
											4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	

[1] Examples: immigration status; language(s) spoken; low-income; etc.

CPSO

Council Motion

Motion Title: Key Performance Indicators for 2021

Date of Meeting: December __, 2020

It is moved by_____,

and seconded by_____, that:

The Council adopts the following 2021 Key Performance Indicators (KPIs) to measure and report progress on the Strategic Plan:

1. Target of 735 active physicians assessed (aged 70 and older and those who have not had assessments in past five years)
2. Target of 325 completed facility assessments
3. Respond to 90% of calls to Public Advisory Services within one business day
4. Target of 3000 Practice Improvement Plans submitted through Quality Improvement Program
5. Target of 20 hospitals collaborating in Quality Improvement Partnership
6. Compliance with Ontario Government's new College Performance Measurement Framework
7. Staff to achieve target of 395 Continuous Improvements
8. Meeting Solis and Vault project timelines
9. Monitor and continue to achieve 2-day benchmark for contacting complainants
10. Target to complete all complaint files within 150 days
11. Target of one year or 365 days to complete a file from referral to discipline to the start of hearing date.

CPSO

Council Briefing Note

December 2020

TOPIC: 2021 Proposed Key Performance Indicators

FOR DECISION

Quality Care

Physicians over 70: This target of 735 represents all active physicians who are turning 70 in addition to those who are older than 70 who have not had assessments in the past five years (including deferrals from 2020)

Completed Facility Assessments: The annual target of 325 represents the number of OHPs and IHFs we aim to assess in 2021. This represents 20% of facilities.

Meaningful Engagement

Public Advisory Services: We have set an ambitious goal of responding to 90% of calls to our PAS line within one business day. This slide also tracks the number of service calls and outgoing courtesy calls PAS handles on a monthly basis to display the volume of calls.

Physician Engagement: Individuals engaging in Quality Improvement Program (PIPs and Coaching): This slide includes a target of 3000 Practice Improvement Plans submitted in 2021 and also showcases the number of physicians who are referred to coaching.

System Collaboration

Quality Improvement Partnership – Hospitals collaborating in Quality Improvement Partnership: This slide represents the number of QI hospital partnerships we aim to

have solidified for the year. We have a goal of 20 hospital proposals submitted and approved in 2021

College Performance Measurement Framework: This is newly released by the Ontario government. We will be expected to submit our first set of data by March. Once that is submitted, we will share what our data points are. This will identify areas we need to improve.

Continuous Improvement

Staff-Level Continuous Improvement Achievements: This slide shows the number of improvements identified and completed for the year. In 2021 we have set a target of 395 (one per staff member)

Solis and Vault on-time and on-budget: We are continuing to roll-out our major enterprise system and document management system at the CPSO. This slide demonstrates meeting project timelines.

Right-Touch Regulation

Time to Contact Complainant and Early Resolution: This slide allows us to continuously monitor the 2-day benchmark for contacting complainants ensuring we sustain these timelines. This slide also shows the number of open complaint cases ending in early resolution and the relationship between these two targets.

Time to Complete All Complaint Files: We set a lofty target of 150 days to complete all types of Complaint Files. In just under two years, the number has gone from 344 days to 164 days. We are aiming to hit 150 in 2021.

Time from Referral to Discipline and Hearing Start Date: We have set a target of one year or 365 days to complete a file from referral to discipline to the start of the hearing date.

DECISION FOR COUNCIL:

1. Does Council approve the proposed Key Performance Indicators for 2021?

Contact: Fiona Hill-Hinrichs, ext. 552
Date: November 26th, 2020

CPSO

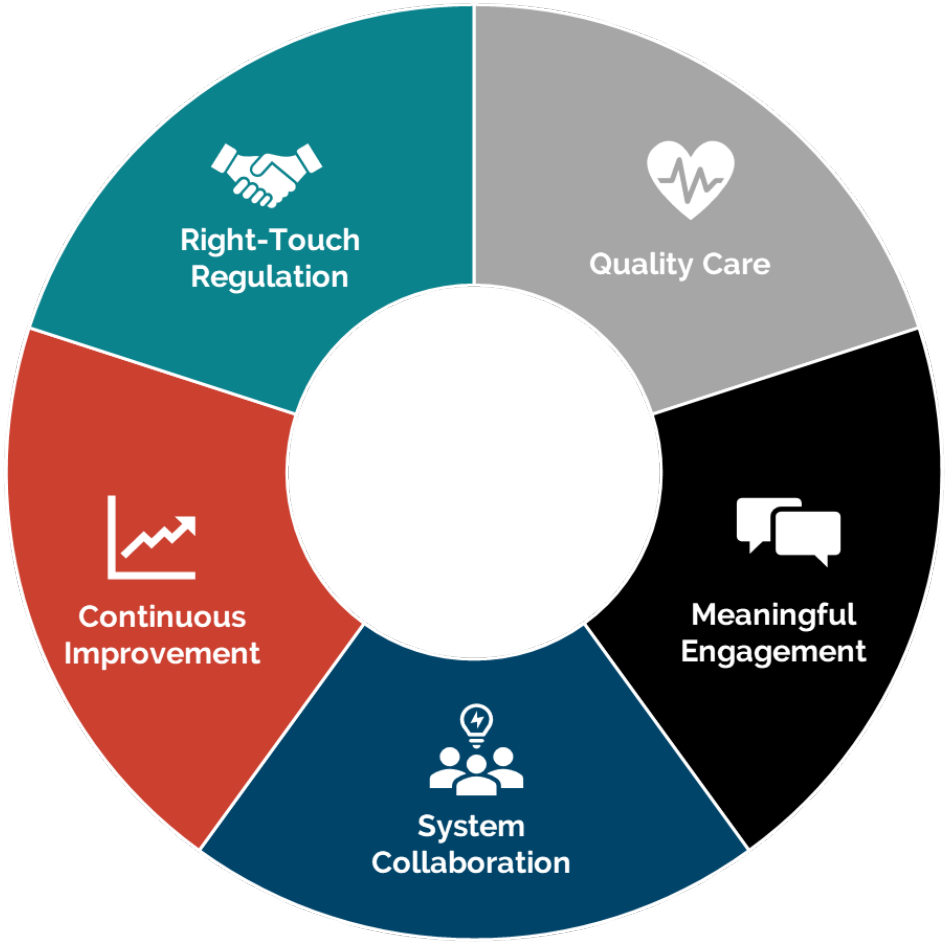
TRUSTED DOCTORS PROVIDING GREAT CARE

Key Performance Indicators for 2021

December 4, 2020

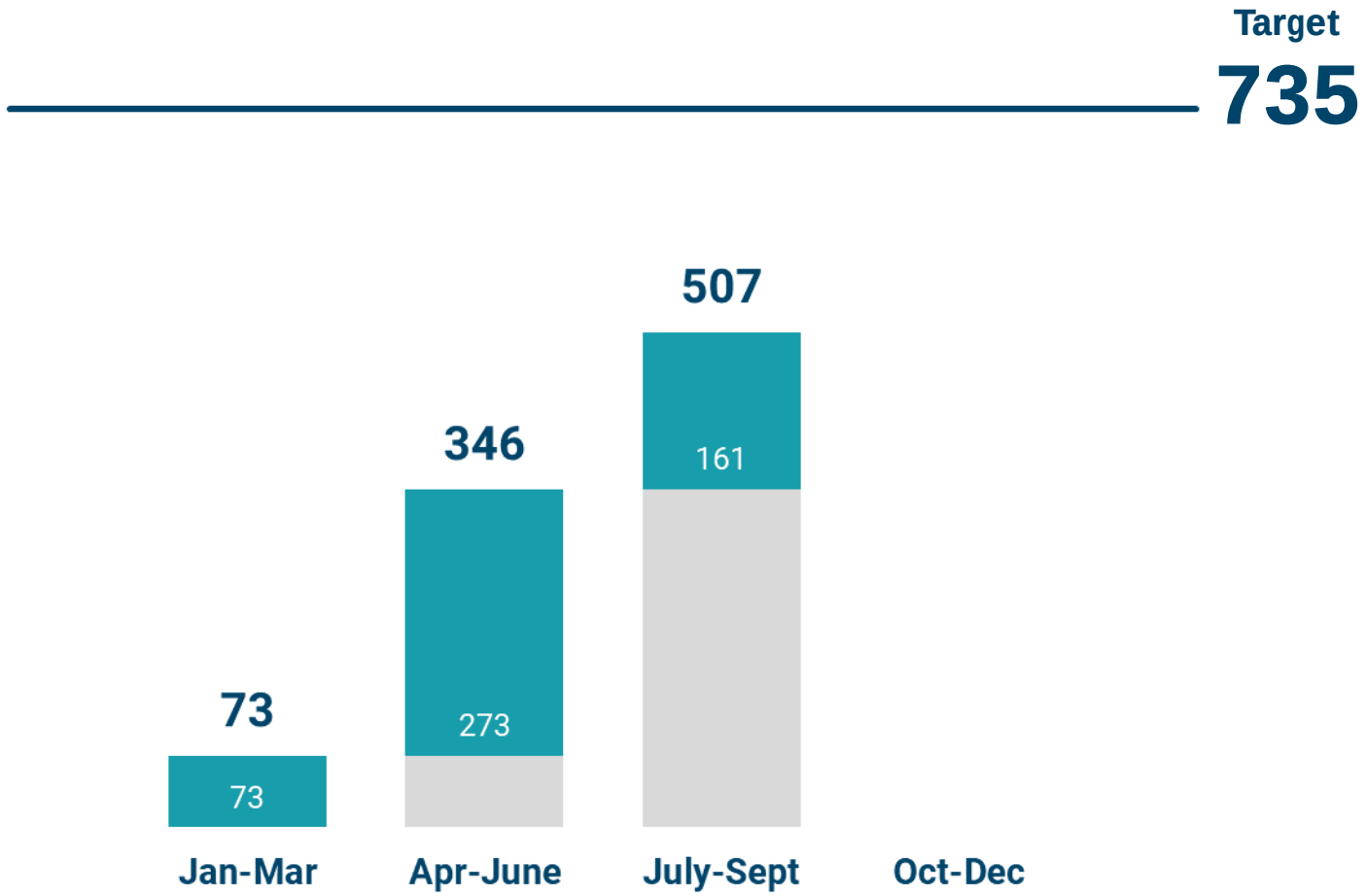
Dr. Nancy Whitmore

Strategic Plan

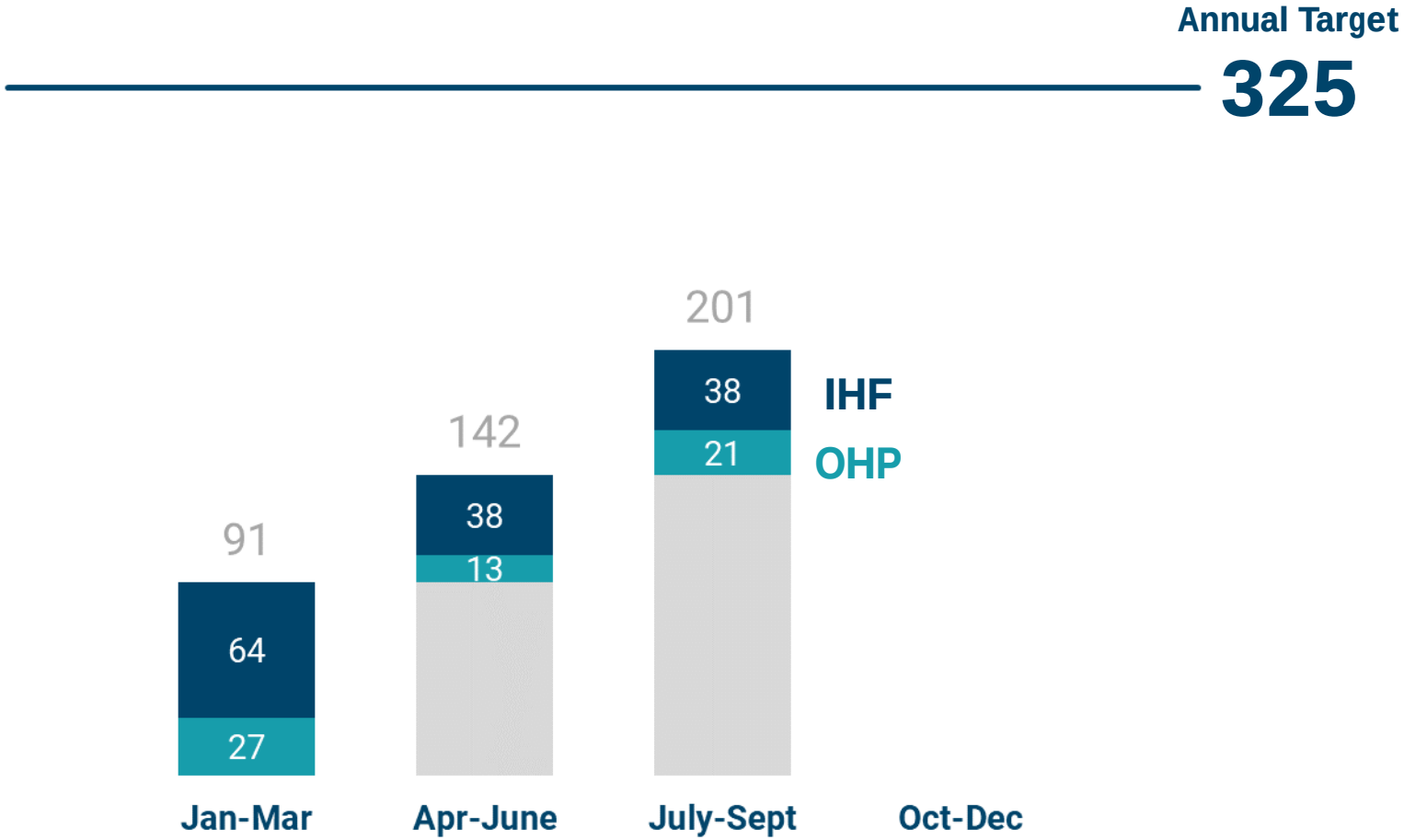


Strategic Plan

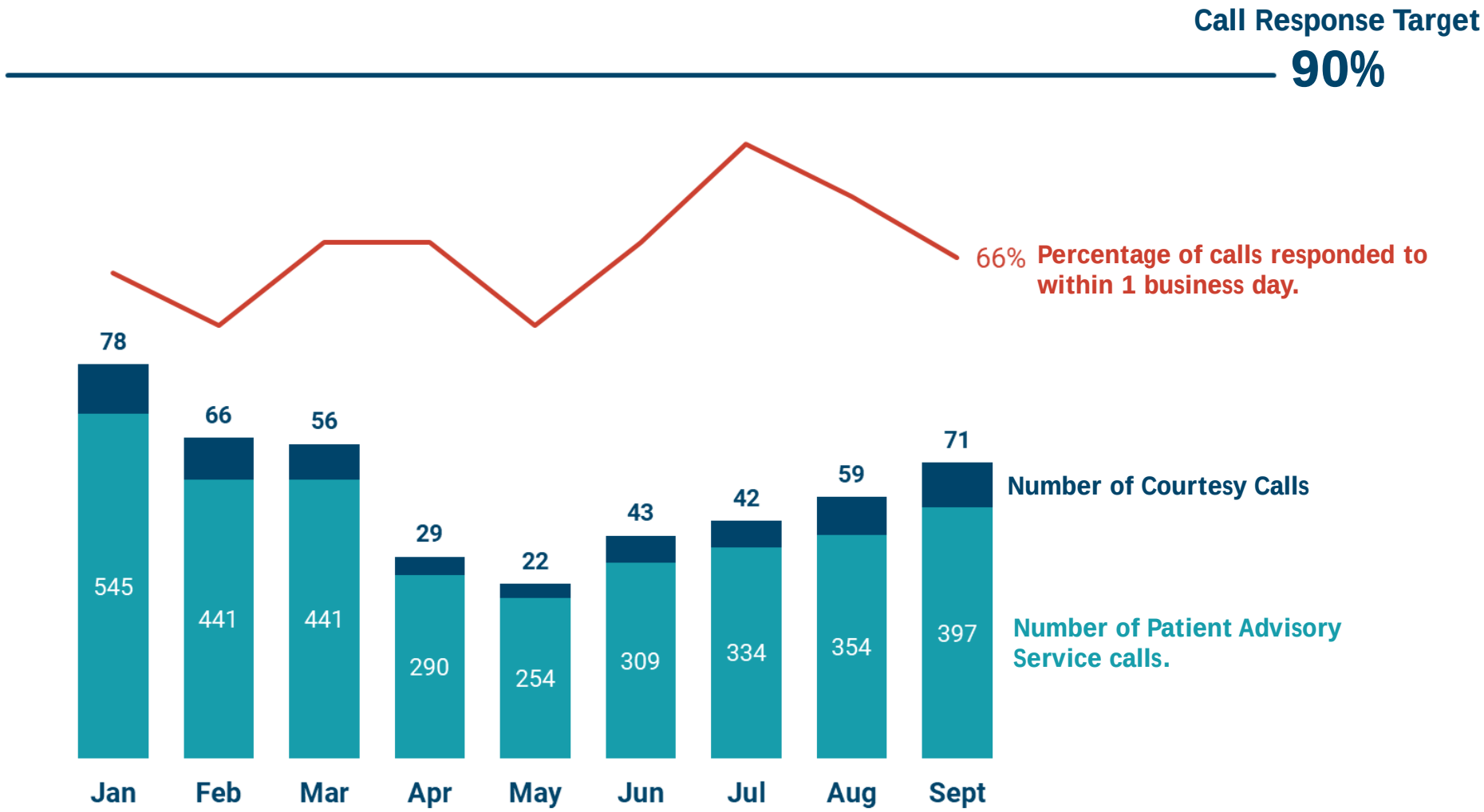
Physicians over 70 that have their assessment completed:



Completed Facility assessments:

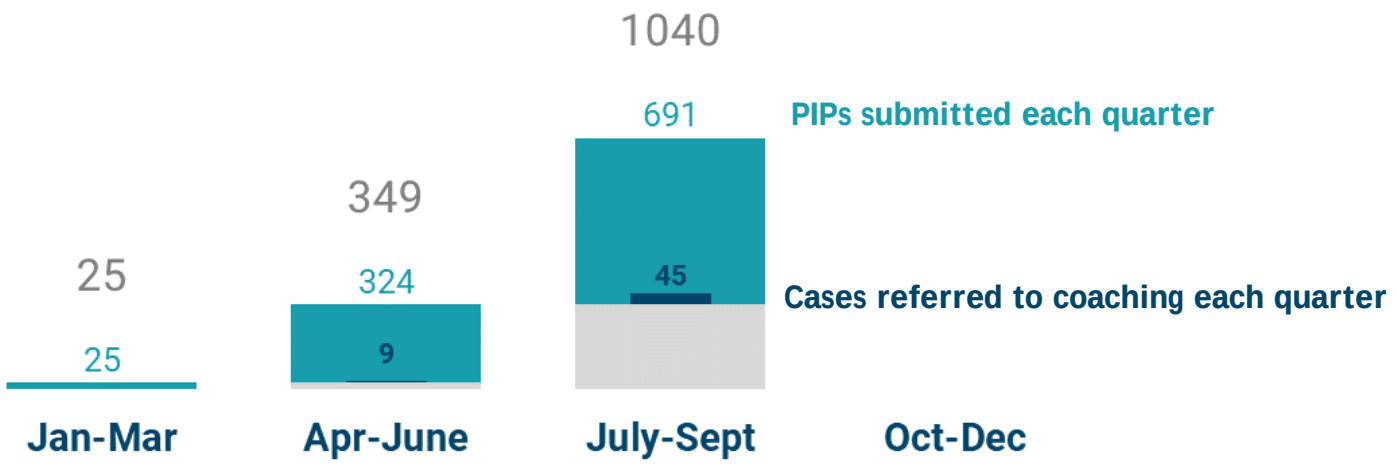


Public Advisory Service:



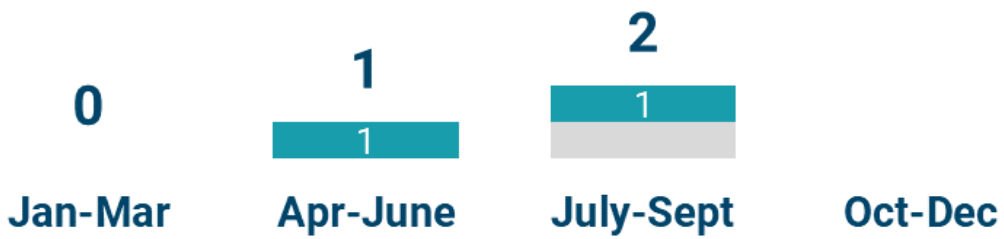
Physician Engagement: Individuals engaging in QI Program:

Target
3000
Practice Improvement Plans submitted



Hospitals Collaborating in QI Partnership

Target
20
Proposals submitted and approved.



College Performance Measurement Framework.

40 responses required over 7 domains:

Organizational Focus

Governance
15 responses required

Resources
3 responses required

System Partner
3 standards

Information Management
1 response required

Applicant / Registrant Focus

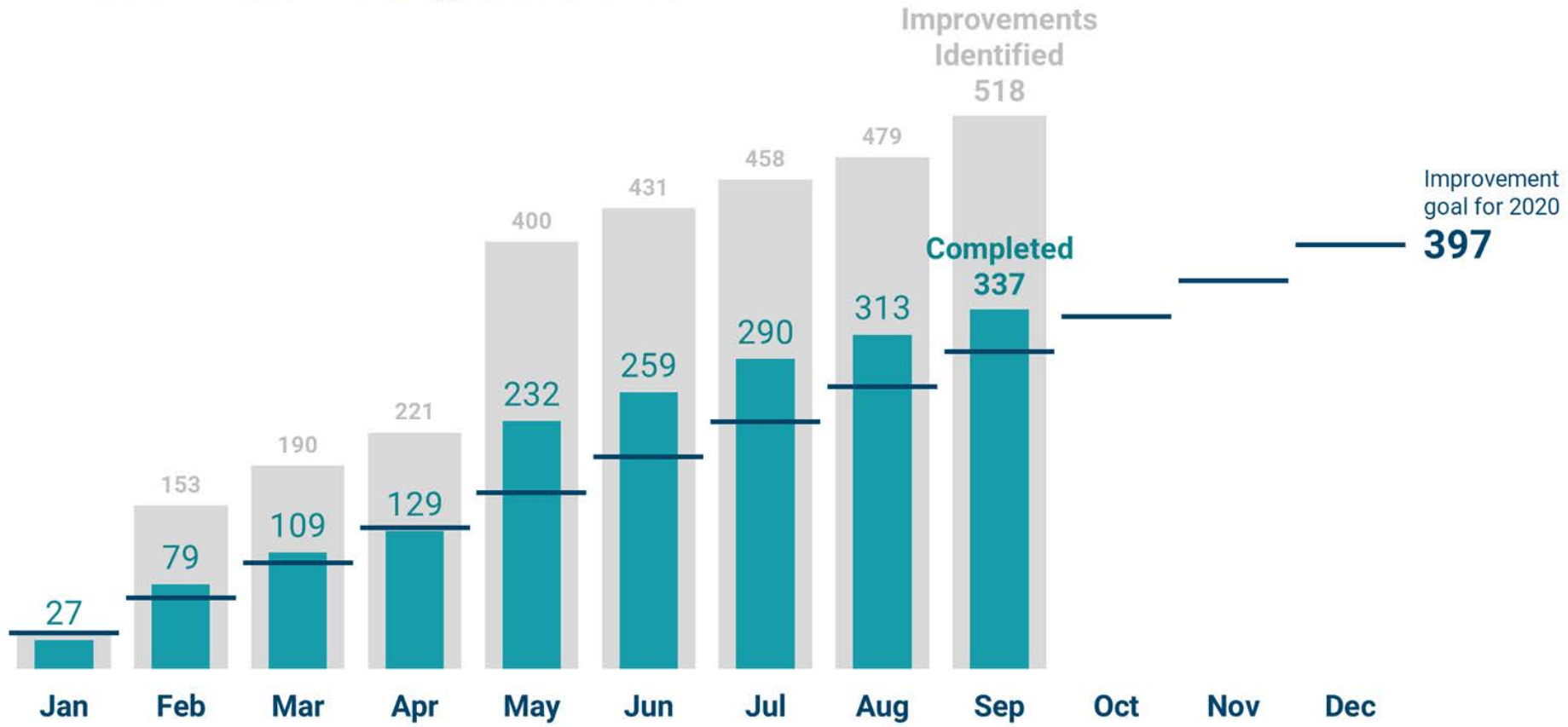
Regulatory Policies
2 responses required

Suitability to Practice
12 responses required

Results & Improvement

Measurement, Reporting, and Improvement
4 responses required

Staff have already **completed 337 improvements,** or **85%** of our **2020 goal of 397**.



Solis and Vault Timelines

COMPLETED: Release 1

Sept 2019 — Development → Testing → Training — Go-Live Sept 2020

IN PROGRESS: Release 2

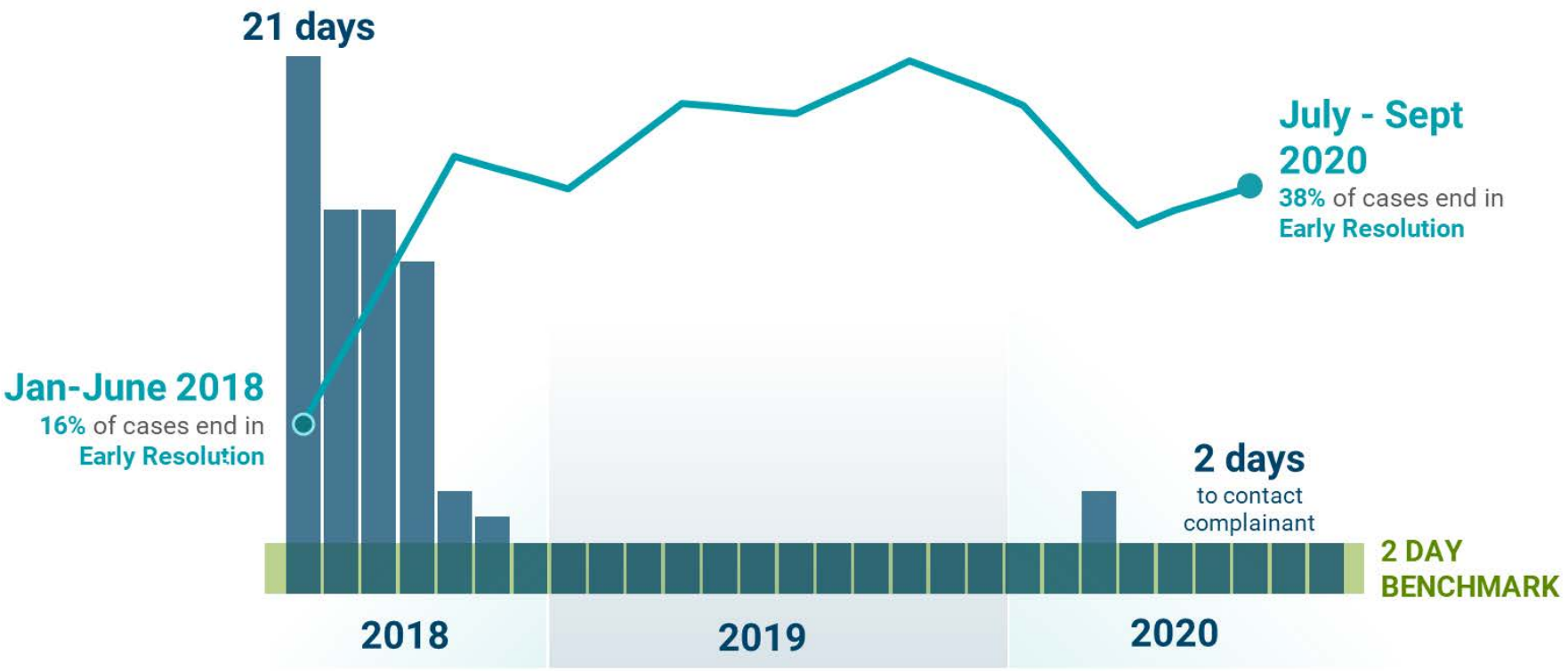
Sept 2020 — Development → Testing → Training — Go-Live July 2021

We are here Dec. 2020

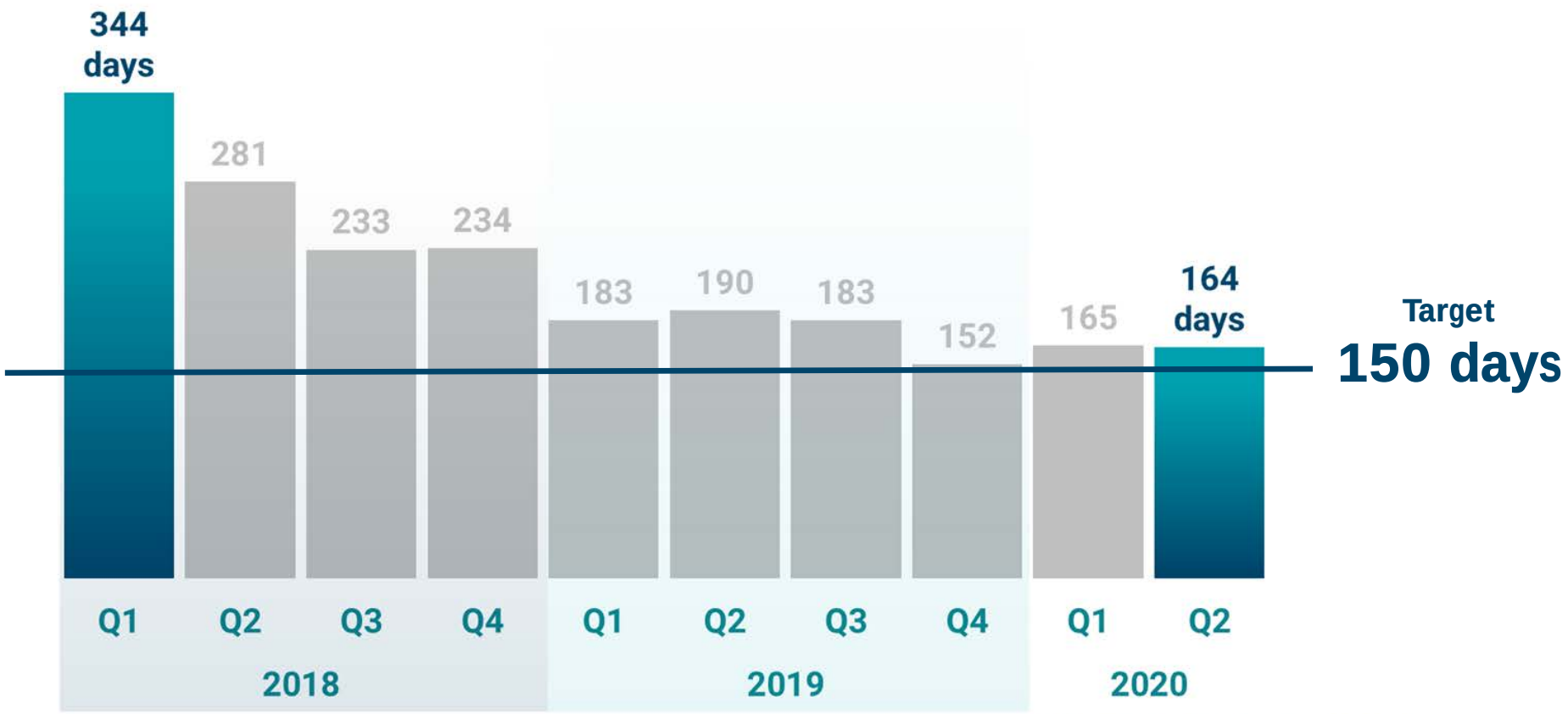
UP NEXT: Release 3

Aug 2021 — Development → Testing → Training — Go-Live Apr 2022

As the **Time to Contact a Complainant** has **decreased**,
the **% of Opened Cases** ending in **Early Resolution has increased**.

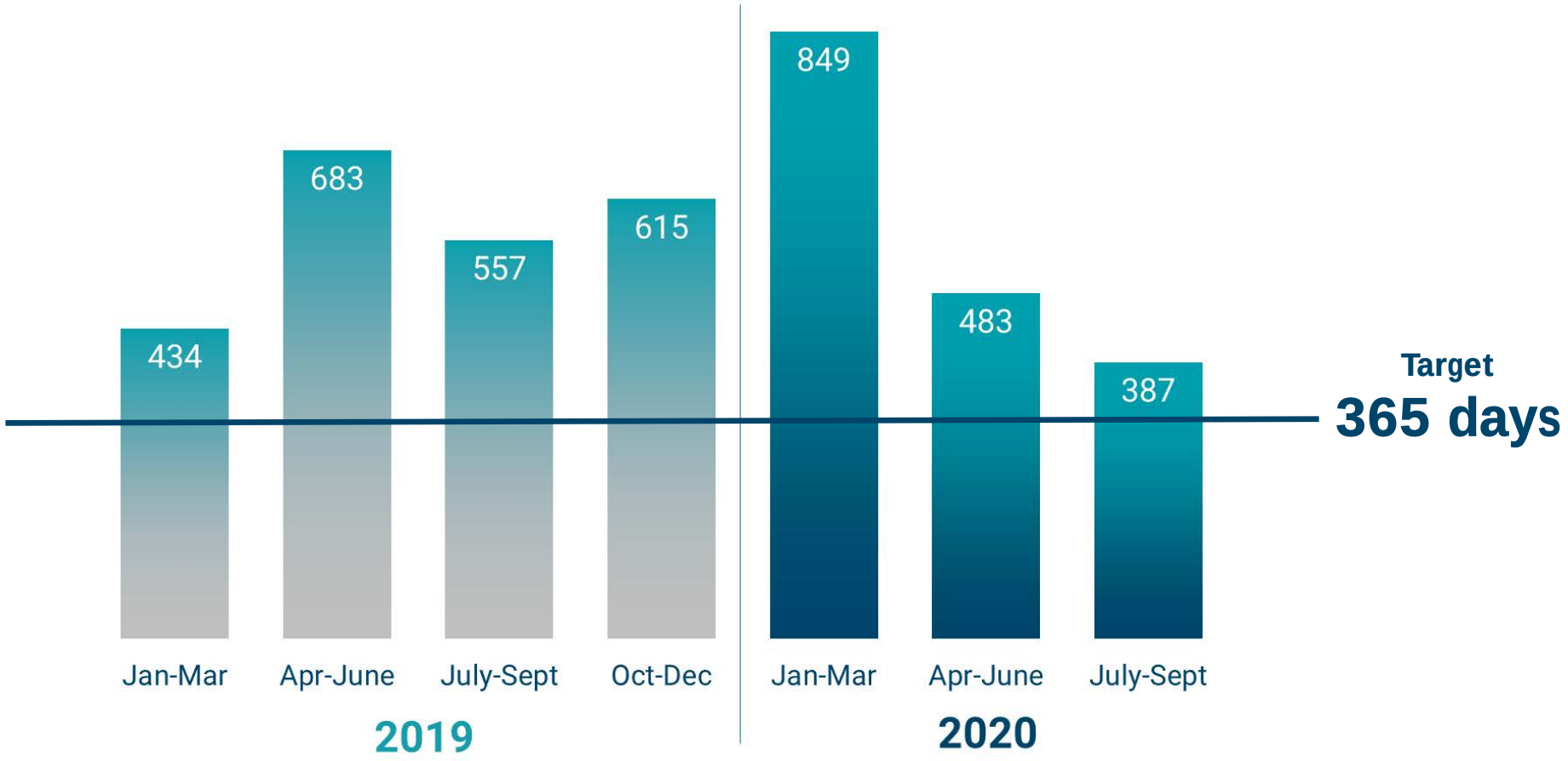


The **Time to Complete Complaint Files** (including Early Resolution) since the start of 2018.



(80th percentile, grouped by quarter in which a case was opened)

Time from referral to discipline and hearing start date:



Council Motion

Motion Title: Complementary and Alternative Medicine – Draft for Consultation

Date of Meeting: December 4, 2020

It is moved by_____,

and seconded by_____, that:

The College engage in the consultation process in respect of the draft policy "Complementary and Alternative Medicine" (a copy of which forms Appendix " " to the minutes of this meeting).

CPSO

Council Briefing Note

December 2020

TOPIC: *Complementary and Alternative Medicine* – Draft for Consultation

FOR DECISION

ISSUE:

- The College's *Complementary/Alternative Medicine* policy is currently under review. A new draft policy, titled *Complementary and Alternative Medicine,* has been developed along with a companion *Advice to the Profession* document.

- Council is asked if the draft policy can be released for external consultation and engagement.

BACKGROUND:

- The current policy was last reviewed and approved by Council in 2011. The draft policy was developed with direction from the Policy Review Working Group, consisting of Brenda Copps (Chair), Ellen Mary Mills (former Working Group member), and Janet Van Vlymen, as well as Medical Advisors Angela Carol and Keith Hay. Additional support was provided by Amy Block (Legal Counsel) and Joan Fisk who provided public member perspective on the draft policy following Ellen Mary Mills' departure from the Working Group.

- Preliminary research was undertaken in accordance with the usual policy review process.[1] In addition, feedback on the current policy was solicited through a public consultation in the Spring of 2019 and various other engagement activities.

[1] This included a literature review of scholarly articles and research papers; a jurisdictional review of Canadian and international medical regulatory authorities and Ontario health profession regulators; relevant statistical information regarding matters before the Inquiries, Complaints, and Reports

- The consultation garnered a total of 929 responses: 95 through written feedback and 834 via the online consultation survey. An overview of the feedback was provided in the Policy Report to Council in May 2019.

- In addition to hearing from patients and physicians, consultation feedback was received from organizations including: Canadian Integrative Medicine Association, Ontario Association of Naturopathic Doctors, the College of Naturopaths of Ontario, and the College of Homeopaths of Ontario.

- An in-person discussion was held with the Citizen Advisory Group, and public polling of 800 Ontario residents was also undertaken to understand the perspective of Ontarians on physicians offering complementary medicine.

CURRENT STATUS:

- A draft *Complementary and Alternative Medicine* policy (**Appendix A**) and *Advice to the Profession* document (**Appendix B**) have been developed in response to the research and the feedback received through various engagement activities undertaken to date. An overview of the key features of the drafts is set out below.

A. Draft *Complementary and Alternative Medicine* Policy

- As all complementary and alternative medicine departs from prevailing medical practice, it is a more challenging area to regulate, and the important role that policy plays in setting parameters of appropriate practice is heightened.

- In developing the draft policy, a concerted effort was made to strike the right balance between protecting patients from harm, while respecting patient autonomy to choose non-traditional medical treatments, and not unnecessarily impeding innovation and professional judgement.

Definitions

- To address a gap and align the scope of the policy with how it is being applied in practice, the definition of "complementary and alternative medicine" has been updated to explicitly capture a broader range of non-conventional treatments than

Committee; and feedback on the current policy from the College's Public and Physician Advisory Service.

are typically associated with the concept of “complementary and alternative medicine”.

  - The definition now specifically states that complementary and alternative medicine includes: conventional treatments, practices and products being used in non-conventional ways, and new treatments, practices and products that are based on or in conventional medical understanding. These treatments may lack strong evidence of effectiveness and pose similar risks of harm as with interventions that are traditionally considered complementary and alternative medicine, and so have historically been treated as falling within the current policy when questions regarding appropriate use are directed at the College.

Scope of Practice

- To clarify and refine an expectation that is implicit in the current policy, the draft has been updated to explicitly require that physicians only offer treatments for symptoms, complaints or conditions they are able to treat within their conventional scope of practice. This is to help ensure physicians are not using complementary medicine to practice across specialties where they lack formal training or education.

Conventional Assessment and Diagnosis

- The draft policy aims to strengthen physicians’ connection to conventional medicine even when providing complementary or alternative medicine. The draft policy requires that a conventional clinical assessment be undertaken and that the findings of this assessment and any conventional treatments options be communicated to the patient, prior to offering complementary or alternative medicine.

  - The current policy requires physicians to undertake a clinical assessment, but the draft policy makes it clear that this must be conventional in nature.

  - The Working Group felt strongly that physicians should always start from a position of conventional medicine, and so directed revisions to preclude the possibility of physicians proceeding with complementary or alternative treatments, without consideration of the conventional options available.

Evidence Requirements and Risk Benefit Analysis

- While many physicians provide low risk complementary or alternative treatments to patients supported by some evidence regarding their efficacy, through our regulatory experience the College has identified instances of physicians providing high risk treatments with little evidence to support their use. Updates to the policy were required to more strongly restrict this space and give the College the right tools to address these situations where necessary. Updates include:

    - A strengthening of the expectation for when a complementary or alternative treatment can be provided to a patient by requiring any such treatments to not only be *informed* but *supported* by evidence and scientific reasoning.

    - New factors that must be weighed as part of the risk benefit analysis have also been added, including: the health status and needs of the particular patient, the strength of evidence and scientific reasoning regarding the efficacy of the treatment, and the potential for harm to the patient.

- The Working Group felt strongly that when physicians depart from conventional medicine it must be done in a manner that is supported by sound clinical reasoning and where the risks posed to a patient do not outweigh the benefit.

Preventing Exploitation

- To support genuinely autonomous decision-making, the draft includes new provisions expressly prohibiting exploitation and outlining the factors that can make a patient more vulnerable to exploitation (e.g., potential financial hardship, or the patient suffering from a serious, life-threatening or terminal illness).

Obtaining Informed Consent

- While consent provisions in the current policy are fairly robust, updates were made to strengthen these provisions by requiring, for example, that patients be provided with an accurate representation of the quantity and quality of evidence and scientific reasoning that supports the decision to offer the treatment.

Documentation

- Given the importance of undertaking a risk benefit analysis and of communicating the additional elements for informed consent outlined in the consent provisions, the Working Group felt it was important to require that these be documented. The

new documentation expectations will help ensure the rationale for offering these treatments can be explained, and that patients are adequately informed when treatments outside the conventional standard of care are being provided.

Referrals

- In keeping with the policy redesign process where only mandatory expectations are set out in policies, a more permissive expectation in the current policy regarding referring patients to complementary or alternative medicine practitioners has been removed.

    - This recognizes that many physicians will have little experience with complementary or alternative medicine and may not agree with its use, and that physicians are not expected to have knowledge about complementary or alternative medical treatments or appropriate providers of such treatments.

B. Draft *Advice to the Profession* Document

- The draft *Advice to the Profession* document (**Appendix B**) sets out guidance on specific issues related to complementary and alternative medicine, and is meant to facilitate a better understanding of the expectations for providing or discussing complementary or alternative medicine with patients, including information on:

    - how to evaluate the evidence for complementary or alternative treatments;
    - how to consider and address potential patient vulnerability;
    - the limits to the treatments that can be provided; and
    - what to do when requests for referrals and tests are made.

NEXT STEPS:

- Subject to the Council's approval, the draft policy will be released for external consultation and engagement.

    - Specific efforts to solicit feedback from stakeholders that represent or advocate for the interests of diverse and/or vulnerable groups will be made, to help ensure the draft policy is reviewed with a diversity, equity and inclusion lens.

- We anticipate that this policy consultation will be controversial and generate significant feedback as there are strongly held opinions on both sides – that these approaches to medicine should be more strongly restricted, and that they should be more openly available.

- The Executive Committee and Council will be provided with an overview of the feedback received through these activities, and this feedback will be used to further refine the draft.

DECISION FOR COUNCIL:

1. Does Council approve the draft policy for external consultation and engagement?

Contact: Courtney Brown, Ext. 216

Date: November 13, 2020

Attachments:

Appendix A: Draft *Complementary and Alternative Medicine* policy
Appendix B: Draft *Advice to the Profession: Complementary and Alternative Medicine*

Complementary and Alternative Medicine

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[1]

Complementary and Alternative Medicine: refers to a diverse range of therapeutic concepts, diagnoses, treatments, practices, and products that are not generally considered a part of conventional medicine. For the purposes of this policy, it also includes:

- conventional treatments, practices, and products being used in non-conventional ways, and
- new treatments, practices, and products that are based on conventional medical understanding and scientific reasoning[2].

While some complementary or alternative medicine interventions may be supported by preliminary evidence or scientific reasoning and pose little risk of harm, others may present a serious risk of harm and/or exploitation, in light of the nature of the treatment and lack of evidence and/or scientific reasoning to support its use.

"Integrative medicine" is also a commonly used term within the complementary and alternative medicine environment, referring to an approach to patient care that integrates conventional and complementary medicine.

[1] The following definitions provide only a partial description of each term. Please see the College's *Advice to the Profession: Complementary and Alternative Medicine* document for additional information and clarification.

[2] This policy applies to new medical treatments, including devices, that are not otherwise subject to regulation by other bodies such as Health Canada. Health Canada requires that some treatments or therapies be registered with them as part of a clinical trial. For example, currently stem cell therapies must be authorized by Health Canada to ensure that they are safe and effective before they can be offered to patients. For more information please see Health Canada's website.

Professional affiliation: For the purposes of this policy a professional affiliation is where a physician associates themselves with a clinic, treatment, product, or device. For example, where a physician invests in or owns a clinic, sells a product in their practice, or speaks publicly in support of a treatment or device.

Treatment: For the purposes of this policy, treatment means anything that is done for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose. This includes the use of products and devices for medical purposes.

Policy

1. As in all other areas of clinical practice, physicians who provide complementary or alternative medicine **must** practise:

    a) in their patient's best interests;
    b) in a manner that is in keeping with their professional, ethical, and legal obligations;
    c) in a manner that is supported by evidence and scientific reasoning[3]; and
    d) within their conventional scope of practice and the limits of their knowledge, skill, and judgment[4].

2. Physicians **must** comply with the expectations of this policy whenever providing complementary or alternative medicine, regardless of whether they are doing so:

    a) in addition to a conventional treatment,
    b) as an alternative to a conventional treatment, or
    c) in the absence of an available conventional treatment.

3. Physicians **must** practice in a manner that is respectful of patient's treatment decisions and their ability to set health care goals in accordance with their own wishes, values and beliefs. This includes the decision to pursue or refuse treatment, whether that treatment is conventional, complementary or alternative.

Before Providing Complementary or Alternative Medicine

Conducting an Assessment

[3] For more information on use of evidence, please see the *Advice to the Profession* document.
[4] In compliance with Sections 2(1)(c), 2(5), O.Reg. 865/93, Registration, enacted under the Medicine Act, 1991, S.O. 1991, c.30, the College's *Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice* policy, and the Practice Guide.

4. Physicians **must** conduct a conventional clinical assessment in accordance with the standard of practice, including:

    a) conducting a comprehensive patient history;
    b) obtaining information regarding any relevant treatments the patient may already be receiving;
    c) considering, performing, or ordering any necessary medical or laboratory examinations or investigations to understand the patient's symptoms, complaints, or condition, or to reach a diagnosis;
    d) evaluating and considering the results of any conventional examinations or tests already undertaken by other health professionals; and
    e) taking any other reasonable steps that may be necessary to obtain relevant and comprehensive information about the patient's symptoms, complaints, or condition.

Reaching and Communicating a Diagnosis

5. Prior to offering complementary or alternative medicine, physicians **must** make a conventional diagnosis or differential diagnosis[5] on the basis of the conventional assessment, communicate it to the patient, and inform the patient of any conventional treatment options that are available to treat their symptoms, complaints or condition.

6. Physicians **must** only offer an additional diagnosis that is not generally accepted as part of conventional medicine, what is sometimes referred to as a 'complementary or alternative diagnosis', where:

    a) the diagnosis is informed by the conventional assessment and conventional diagnosis or differential diagnosis;
    b) any additional assessments conducted to reach the complementary or alternative diagnosis are supported by evidence and scientific reasoning; and
    c) the complementary or alternative diagnosis itself is supported by evidence and scientific reasoning.

Providing Complementary or Alternative Medicine

[5] This could include determining that there is no conventional diagnosis that can be made or that the patient is "not yet diagnosed".

7. Physicians **must not** provide complementary or alternative treatments that have been proven ineffective.

8. Physicians **must** only provide complementary or alternative treatments:

    a) to diagnose or treat symptoms, complaints or conditions that are within their scope of practice to treat using conventional medicine, including only using modalities of treatment that are within their conventional scope of practice;
    b) that they have the knowledge, skill, and judgment to provide;
    c) that are supported by sound clinical judgment; and
    d) that are supported by evidence and scientific reasoning regarding the efficacy of the treatment, where the degree of support required from evidence and scientific reasoning will depend on the particular circumstances, including the potential risks to the patient.

9. In addition to the requirements in provision 8, physicians **must** only provide a complementary or alternative treatment to a patient where there is a reasonable expectation that it will remedy or alleviate the patients symptoms, complaints, or condition and where the benefits outweigh the risks taking into account:

    a) The health status and needs of the patient;
    b) The strength of evidence and scientific reasoning regarding the efficacy of the complementary or alternative treatment for the patient's symptoms, complaints, or condition[6]; and
    c) The potential for harm to the patient due to factors including:
        i. the nature of the proposed complementary or alternative treatment itself,
        ii. the potential interaction between the proposed option and any other treatments the patient is undergoing,
        iii. the conventional options available to treat that patient and their respective efficacy, and
        iv. whether the treatment will be provided alongside conventional treatment or as an alternative to it.

Preventing Exploitation of Patients

10. As with all other areas of clinical practice, physicians **must not** exploit patients when providing complementary or alternative medicine.

[6] For more information on appropriate evidence please see the *Advice to the Profession* document.

11. Physicians **must** be aware of, consider, and take reasonable steps to address the patient's potential vulnerability[7]. A patient's potential vulnerability will depend on a number of factors including:
    - any potential financial hardship the patient may be experiencing;
    - the probability of the treatment producing a meaningful benefit; and
    - the patient's individual circumstances (for example, the patient suffers from a serious, life-threatening, or terminal illness).

Obtaining Informed Consent

12. Physicians **must** obtain informed consent as required by applicable legislation[8], the College's *Consent to Treatment* policy, and as set out in this policy.

13. As part of obtaining informed consent physicians **must** communicate the following information to the patient or their substitute decision-maker before providing complementary or alternative medicine:

    a) the extent to which the complementary or alternative diagnosis reached (if applicable) is supported by the conventional medical community;
    b) the rationale for recommending the treatment;
    c) any benefit, financial or otherwise, that the physician will receive for providing the treatment[9];
    d) an accurate representation of the strength of evidence (e.g., quality and quantity) and scientific reasoning that supports the decision to offer the treatment;
    e) reasonable expectations for the efficacy of the treatment; and
    f) a clear and impartial description of how the treatment compares to:
        i. any conventional treatment that could be offered to treat the patient (including a comparison of risks, side effects, expectations for therapeutic efficacy, cost to the patient, and any other relevant considerations); and
        ii. the option of receiving no treatment.

[7] For more information see the *Advice to the Profession* document.
[8] Applicable legislation includes the *Health Care Consent Act, 1996* (HCCA).
[9] Physicians are expected to comply with the O. Reg. 114/94: GENERAL under Medicine Act, 1991, S.O. 1991, c. 30 (the Conflicts of Interest Regulation) which states that it is a conflict of interest for a member where they or a member of their family, or a corporation wholly, substantially, or actually owned or controlled by them or their family… sells or otherwise supplies any drug, medical appliance, medical product or biological preparation to a patient at a profit, except, a drug sold or supplied by a member to his or her patient that is necessary, (A) for an immediate treatment of the patient, (B) in an emergency, or (C) where the services of a pharmacist are not reasonably readily available…

Documentation

14. Physicians providing complementary or alternative treatment **must** comply with the College's *Medical Records Documentation* policy which, among other expectations, includes the expectation that the medical record contain documentation that supports the treatment or procedure provided (i.e., the rationale for the treatment or procedure is evident in the record).

    a) In fulfilling this requirement, physicians **must** specifically document the risk benefit analysis undertaken to determine the appropriateness of providing the complementary or alternative treatment to the patient.

15. Physicians providing complementary or alternative treatment **must** document that consent to the treatment was obtained and that information was communicated to the patient in accordance with Provision 13 of this policy.

Conflicts of interest and professional affiliations

16. As in all areas of clinical practice, physicians **must:**

    a) avoid or recognise and appropriately manage conflicts of interest,[10] and
    b) **not** charge an excessive fee for the services provided.[11]

17. Physicians who wish to form professional affiliations with complementary or alternative clinics, therapies, products, or devices **must:**

    a) critically assess the efficacy and safety of the treatments offered by the clinic and/or the therapeutic benefit to be obtained from the therapy or device and only form a professional affiliation if they are satisfied that they comply with the expectations in this policy;
    b) comply with the Advertising provisions in the General Regulation under the *Medicine Act, 1991* including that they**:**

[10] See O.Reg. 114/94 General, Part IV, Conflicts of Interest, and O.Reg. 856/93 Professional Misconduct, enacted under the Medicine Act, 1991, S.O. 1991, c.30. For example, the Conflict of Interest Regulation requires a physician who or whose family has a proprietary interest in a facility where diagnostic or therapeutic services are performed to inform the College of the details of the interest. The College's Conflict of Interest Declaration Form can be found here.

[11] Section 1(1), paragraph 21, O.Reg. 856/93 Professional Misconduct, enacted under the Medicine Act, 1991 S.O. 1991, c.30. See also the Uninsured Services: Billing and Block Fees policy.

i. **not** associate themselves with any advertising for a commercial product or service other than their own medical services, or for any facility where medical services are not provided by the physician[12]; and
ii. ensure any published materials[13] relating to that professional affiliation are accurate, factual, and based on evidence and scientific reasoning.[14]

[12] As prohibited by the College's *Advertising* policy and O. Reg. 114/94: GENERAL under *Medicine Act, 1991*, S.O. 1991, c. 30.
[13] For example, presentation materials for conferences, published research or patient materials.
[14] O. Reg. 114/94: GENERAL under *Medicine Act, 1991*, S.O. 1991, c. 30.

APPENDIX B

Advice to the Profession: Complementary and Alternative Medicine

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.

This document is intended to provide guidance for how the obligations set out in the *Complementary and Alternative Medicine* policy can be effectively discharged. This document also seeks to provide physicians with practical advice for addressing common issues that arise in practice.

Much of this document is intended to assist physicians who provide complementary or alternative treatments to patients. However, even physicians who do not provide complementary or alternative medicine may be asked questions or have discussions with patients regarding these kinds of treatments. For more information on what physicians who do not provide complementary or alternative medicine need to know, please see the final two questions in this document.

What is complementary and alternative medicine?

Complementary and alternative medicine can be roughly described as any treatment that is not part of the conventional medicine that a physician would traditionally learn in medical school, and encompasses a range of therapeutic concepts, practices, and products. Generally, practices like naturopathy, chiropractic treatment, acupuncture, meditation, yoga, reiki, non-contact therapeutic touch, and homeopathy are associated with complementary and alternative medicine.[1]

However, as the policy states, also included in the definition of complementary and alternative medicine are both:

- non-conventional uses of an existing conventional treatment, and
- new treatments, practices, and products that are based on conventional medical understanding and scientific reasoning.

[1] While many different concepts, practices and products fall within the term "complementary and alternative medicine" this does not mean that all these concepts, practices or products would be permissible under the *Complementary and Alternative Medicine* policy. Only those which comply with the provisions of the policy may be acceptable for physicians to provide.

For example, the use of Botox to help with migraines, or the use of the birth control pill to help treat acne, were once both considered non-conventional ways of using an existing medical procedure or drug. Platelet rich plasma (PRP) injections, which involve collecting a patient's blood, concentrating the platelets, and reinjecting them for therapeutic purposes (for instance, for the treatment of osteoarthritis or rejuvenating/tightening skin cells), are an example of a new treatment, for which the evidence regarding efficacy is not yet settled.

What is or is not considered complementary and alternative medicine can change over time, as concepts, practices, and products that are proven to be effective are incorporated into conventional medicine.

Some new medical treatments may be subject to other regulatory limits. For example, Health Canada requires that some treatments or therapies be registered with them as part of a clinical trial. Physicians providing this kind of medicine will need to be aware of any other regulatory limits that may apply and comply with them.

Why does the CPSO set out expectations for physicians who provide complementary or alternative medicine?

As the medical regulator in the province of Ontario, the CPSO sets out expectations for physicians who provide care to patients, whether that care is conventional, complementary, or alternative.

In order to ensure the provision of quality care, the CPSO aims to strike a balance between protecting patients from harm, including exploitation, while respecting patient choice and autonomy, and not unnecessarily impeding innovation and professional judgment.

At their core, CPSO expectations aim to ensure that:

- physicians act with their patients' best interests in mind (for instance, by not exposing the patient to unnecessary risk, by being transparent with patients about the risks and benefits of treatments, etc.);
- physicians respect patient choice or autonomy regarding their health care goals and treatment decisions (for instance, by conveying information to and discussing treatments with patients in a non-judgemental way, providing impartial information, etc.); and

- physicians do not exploit their patients (for instance, by intentionally or unintentionally exploiting a patient's distress).

What are the health risks associated with complementary and alternative medicine?

On the basis of the available evidence, some complementary or alternative treatments appear to pose little risk in themselves, however, some can present significant, even life-threatening health risks. This may be, for example, because the treatment itself is inherently risky or harmful, or because it is interfering with or replacing the administration of a more effective conventional medical treatment, especially for a serious illness. Cases have been widely reported in the media where the administration of a treatment as an alternative to a more effective medical treatment has contributed to a patient's death. These risks are serious and need to be considered carefully in line with the values and principles of medical professionalism and the expectations set out in the policy.

What is the evidence for complementary and alternative medicine?

For both conventional and complementary or alternative medicine, clinical research can help to identify a treatment's risks and benefits and confirm the extent to which a treatment is effective.

Many complementary or alternative treatments have either not been the subject of randomized controlled clinical trials, or the results of the available research do not convincingly demonstrate any positive effect. There may be very little evidence to support the use of some proposed complementary or alternative treatments. As a result, the full risks and benefits of many such treatments are not well understood.

The policy requires physicians to only provide complementary or alternative treatments that are supported by evidence and scientific reasoning regarding the efficacy of the treatment. Physicians will need to exercise careful judgment of the evidence to ensure they meet this standard.

What should I consider in evaluating the strength of evidence?

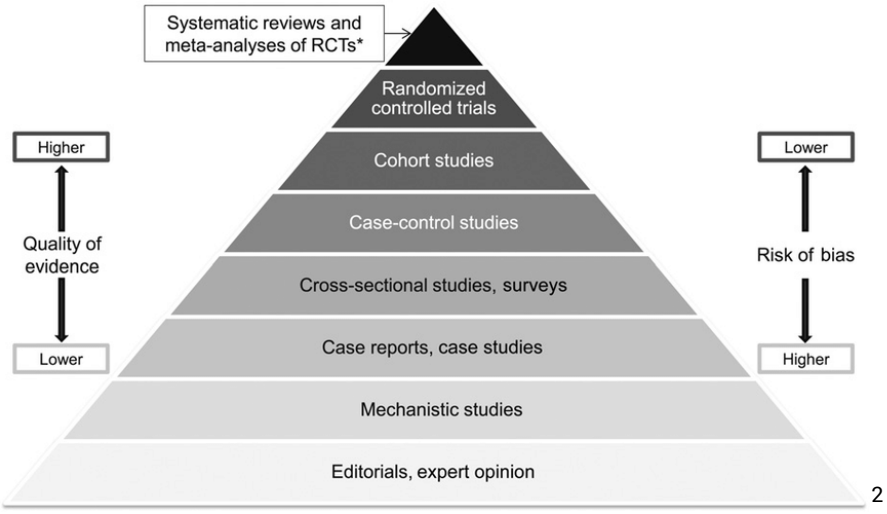
The policy requires that complementary or alternative treatments be supported by evidence and scientific reasoning in order to mitigate the risks associated with providing these treatments.

Recommending a treatment to patients without strong scientific evidence raises several risks, including that:

- it will not be effective,
- it will be less effective than another available treatment (for example, a conventional medical treatment),
- it will have unexpected negative consequences (e.g., side-effects), and/or
- the patient will be exploited.

Before providing such treatments, physicians must think carefully about the strength of evidence there is for a treatments efficacy and how providing a particular treatment could impact a patient and their health care decisions. For example, where the evidence for a treatment is modest, but the risk of harm to the patient is low and it would be undertaken alongside conventional treatment, it may be appropriate for a physician to provide such treatment. However, where the evidence for the treatment is modest, the risks to the patient are potentially high and it would be provided instead of a conventional treatment, the treatment may be inappropriate. Generally speaking, the higher the potential risk to the patient, the higher the level of evidence required.

The strength of evidence can be broadly assessed using the hierarchy of evidence below:



[2]

It will also be important to consider other factors that enhance the strength of evidence, such as:

- objectivity, and based on accepted principles of good research;

[2] Yetley, Elizabeth et al., (2016). Options for basing Dietary Reference Intakes (DRIs) on chronic disease endpoints: report from a joint US-/Canadian-sponsored working group. American Journal of Clinical Nutrition. 105. 10.3945/ajcn.116.139097.

- coming from reputable sources (for example, peer-reviewed journals);
- clear demonstration of the therapeutic claims made;
- findings that have been replicated and are consistent across multiple studies; and
- consistency with higher quality studies.

Evidence that would be considered less strong and may not be appropriate to rely on could include:

- studies involving no human subjects;
- before and after studies with little or no control or reference group (e.g. case studies);
- self-assessment studies;
- anecdotal evidence based on observations in practice; and
- patient self reporting.

Less strong evidence may not support offering a treatment at all or may not support offering it to a particular patient after engaging in the risk benefit analysis as set out in the policy.

While these types of evidence may have value in helping to inform a physician's decision-making, they are less reliable than the evidence produced by the kinds of research outlined in the pyramid above.

The evidence base for many areas of complementary and alternative medicine is constantly evolving so it is important that physicians keep current in terms of the evidence they rely on.

What will the College look at in determining whether it was appropriate for a physician to provide complementary or alternative medicine to a patient?

When the College receives a complaint or has concerns about a physician providing complementary or alternative medicine, there are a number of factors that will determine the appropriateness of the treatment being provided.

The policy requires physicians to only provide a complementary or alternative treatment to a patient where the benefits of providing the particular treatment outweigh the risks. Physicians need to determine this by weighing a number of factors, including:

- the health status and needs of the patient;

- the strength (e.g. quantity and quality) of evidence and scientific reasoning regarding the effectiveness of the treatment provided for the patient's symptoms, complaints or condition;
- the potential for harm to the patient;
- any potential interactions between the proposed treatment and any other treatments the patient is currently undertaking; and
- whether the treatment was provided alongside conventional treatment or as an alternative to it.

These factors exist on a spectrum and need to be considered in relation to each other. As outlined above the strength of evidence required to justify providing a particular treatment to a patient will vary depending on the other factors, such as the potential risks to the patient.

Physicians need to be aware that gaining patient consent is not enough to negate the risk benefit analysis. While patients have autonomy to make personal healthcare decisions, there are limits to the kind of treatments it would be appropriate for physicians to provide, regardless of whether the patient consents. Patient consent does not absolve physicians of their responsibility to use professional judgement and only offer treatments that are in the patient's best interest.

Even where a physician determines that the potential benefits of a treatment outweighs the risks, the policy requires physicians to consider a patient's vulnerability and potential for exploitation and to take steps to address this when providing a complementary or alternative treatment to a patient.

What steps do I need to take to address patient vulnerability when providing complementary or alternative medicine?

Patient vulnerability can vary depending on a variety of factors including the patient's individual circumstances (such as suffering from a life threatening or terminal illness), or where the cost of treatment may cause financial hardship for the patient.

If your patient is particularly vulnerable or at heightened risk of vulnerability additional steps may be needed to avoid (inadvertently) exploiting them. This could include taking extra care to ensure the patient understands the risks of treatment, providing them with additional resources and information, or giving them additional time to consider their options.

What are the limits for complementary or alternative treatments I as a physician can provide?

Physicians can only provide complementary or alternative treatments to address symptoms, complaints, or conditions that are within their conventional scope of practice to treat, and that they have the knowledge, skills, and judgement to provide. Physicians cannot offer treatments for conditions they would not be able to manage within their conventional scope of practice.

For example, a physician practising orthopedics may use complementary or alternative treatments that could assist with musculoskeletal injuries but would not be able to provide complementary or alternative treatments relating to, for example, pancreatic cancer. Such cancer treatment would not be within that physician's conventional scope of practice.

Complementary or alternative medicine is not a scope of practice for physicians. The College's focus is on the practice of medicine, and the role complementary or alternative medicine can play within a physician's conventional scope of practice. Physicians wishing to practice complementary or alternative medicine more broadly and across traditionally defined scopes of practice, will need to train and credential as a complementary or alternative medicine practitioner.

I am a physician who doesn't provide complementary or alternative medicine but have patients who use it – what do I need to know?

Complementary and alternative medicine is continually developing. Many physicians may have patients exploring its use and patients are entitled to make treatment decisions and set health care goals in accordance with their own wishes, values, and beliefs. This includes the decision to pursue complementary or alternative medicine.

Some awareness of complementary and alternative medicine would be beneficial and help physicians answer questions patients may have. However, physicians are not required to know about treatment options that are not part of conventional medicine. Physicians will need to determine what information they feel they are able to provide to a patient based on their knowledge of, and experience with, complementary or alternative medicine.

It is important that physicians inquire about their patients use of complementary or alternative medicine when assessing a patient in order to understand how these

treatments may interact with any course of action the physician is recommending. It will also be important for physicians to consider whether they need more information about any treatments a patient says they are undertaking before recommending conventional treatment that may interact with those complementary or alternative treatments.

As stated in the policy, physicians must respect a patient's choice to pursue complementary or alternative medicine. Patients have the right to make their own healthcare decisions and to pursue treatments outside of those provided by their physician.

What should I do if a patient asks me to refer them to another health care provider based on advice they have received from a complementary or alternative medicine practitioner? Or if I'm asked to order a test for a patient that a complementary or alternative medicine practitioner has told them they need?

Physicians are sometimes approached by patients seeking a referral either on the basis of advice the patient has received from a complementary or alternative medicine practitioner, or to investigate questions or concerns related to complementary or alternative medicine.

Physicians may also be approached by patients seeking diagnostic tests or other clinical investigations related to complementary or alternative medicine. Sometimes a complementary or alternative medicine practitioner may recommend some tests which only a physician can order, or where they would be covered by insurance if ordered by a physician.

It is important that physicians always consider whether such a referral or the ordering of a test or investigation would be in the patient's best interest, and whether there is a clinical basis for it. However, it is not appropriate for physicians to provide referrals, or order tests or investigations that are not clinically indicated. Physicians who make a referral or order a specific test or investigation are responsible for them and any follow-up that is required (see the *Managing Tests* policy for more information).

Council Motion

Motion Title: District Election Dates for 2021

Date of Meeting: December _, 2020

It is moved by_____,

and seconded by_____, that:

the Council approves the 2021 district election date set out below:

Districts 6, 7, 8 and 9: June 22, 2021

CPSO

Council Briefing Note

December 2020

TOPIC: District Election Dates for 2021

FOR DECISION

ISSUE:

- The date of the District Council election must be set for 2021.

BACKGROUND:

- The General By-law was amended in 2019 to move district Council elections from the fall to the spring, beginning in 2020 which enables time for orientation to occur as well as provides greater lead time for incoming Council members to arrange their schedules.

- While the 2020 date for district Council elections was set, the 2021 date has yet to be approved. The proposed dates for 2021 are as follows:

Year	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***
2021	6, 7, 8, 9	April 23	May 4	June 1	**June 22**

DECISION FOR COUNCIL:

Does Council approve the District Council Election dates for 2021?

Contact: Laurie Cabanas, Director of Governance and Policy

Date: November 19, 2020

Council Motion

Motion Title: By-law Amendments – Council Eligibility Criteria

Date of Meeting: December __, 2020

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. 140:

By-law No. 140

(1) Subsections 13(1)(f), (g), (h) and (i) of the General By-law are revoked and substituted with the following:

Eligibility for Election

13. (1) A member is eligible for election to the council in an electoral district if, on the date of the election, …

(f) the member is not, and has not been within one year before the date

of the election, a director or officer of the Ontario Medical Association, the Canadian Medical Protective Association, the Canadian Medical Association, the Coalition of Family Physicians and Specialists of Ontario or the Ontario Specialists Association;

(g) the member does not hold, and has not held within one year before the date of the election, a position which would cause the member, if elected as a councillor, to have a conflict of interest by virtue of having competing fiduciary obligations to both the College and another organization;

(h) the member is not, and has not been within five years before the date of the election, an employee of the College (whether on contract or permanent, and whether on a full-time or part-time basis);

(i) council has not disqualified the member from council or from one or more committees during the five years before the election date;

(j) the member has not resigned from council or from one or more committees during the five years before the election date where there are reasonable grounds to believe that the resignation is related to a proposed disqualification of the member from council or one or more committees;

(k) the member has completed and filed with the registrar a Conflict of Interest form by the deadline set by the registrar; and

(l) prior to the member submitting a nomination form and nomination statement for the election, the member has completed the orientation program specified by the College relating to the business and governance of the College and the duties, obligations and expectations of council and committee members.

(2) Subsection 22(1)(i) of the General By-law is revoked and substituted with the following:

Disqualification of Elected Members

22. (1) An elected member is disqualified from sitting on the council if the member, …

(i) is or becomes a director or officer of the Ontario Medical Association, the Canadian Medical Protective Association, the Canadian Medical Association, the Coalition of Family Physicians and Specialists of Ontario, or the Ontario Specialists Association;

(3) Subsections 24(3)(f), (g) and (h) of the General By-law are revoked and substituted with the following:

Academic Advisory Committee

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

(f) the member is not, and has not been within one year before the date of the election, a director or officer of the Ontario Medical Association, the Canadian Medical Protective Association, the Canadian Medical Association, the Coalition of Family Physicians and Specialists of Ontario, or the Ontario Specialists Association;

(g) the member does not hold, and has not held within one year before the date of the election, 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;

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

(i) the member is not, and has not been within five years before the date of the election, an employee of the College (whether on contract or permanent, and whether on a full-time or part-time basis);

(j) council has not disqualified the member from council or from one

or more committees during the five years before the election date;

(k) the member has not resigned from council or from one or more committees during the five years before the election date where there are reasonable grounds to believe that the resignation is related to a proposed disqualification of the member from council or one or more committees; and

(l) the member has completed the orientation program specified by the College relating to the business and governance of the College and the duties, obligations and expectations of council and committee members.

(4) Subsection 27(1)(i) of the General By-law is revoked and substituted with the following:

Disqualification of Selected Councillors

27. (1) A person selected as a councillor is disqualified from sitting on the council if the member, …

(i) is or becomes a director or officer of the Ontario Medical Association, the Canadian Medical Association, the Coalition of Family Physicians and Specialists of Ontario, or the Ontario Specialists Association; or

CPSO

Council Briefing Note

December 2020

TOPIC: Eligibility Criteria

FOR DECISION

ISSUES:

- Consider amending the Council elections criteria in the CPSO By-laws:
    - To provide for a cooling off period before physicians who have held certain positions with other organizations may be eligible to run for CPSO Council;
    - To require prospective Council election nominees to complete an orientation or educational session regarding the roles, responsibilities and obligations of CPSO Council members prior to the election; and
    - To clarify the eligibility criterion relating to disqualification and amend the time limit for its application.

BACKGROUND:

The changes proposed in this briefing note are part of CPSO's efforts to modernize the governance structure of the CPSO and align with anticipated government expectations for health regulatory colleges.

Cooling-Off Period

- The Ministry of Health has identified the use of cooling-off periods as a governance best practice and will be asking health regulatory colleges to report on this beginning in March 2021.

- A number of the other health profession regulators provide for a cooling-off period before a person who has held such positions may be eligible to run for Council; most commonly, the cooling-off period is 1-2 years.

- The General By-laws currently provide that a member is not eligible to run for CPSO Council if they are a director or officer of the Ontario Medical Association or other similar associations that represent physicians, or if they hold a fiduciary position with another organization that would put them in a conflict of interest if elected as a CPSO Council member.

- One benefit of introducing a cooling-off period may be to help reframe the perspective of potential Council members who have been involved with physician associations from one of representing physicians to one of focusing on the public interest, consistent with the CPSO mandate.

- Where a cooling-off period applies to former employees, it may also provide a period of time to re-establish the appearance of independence from the role as employee to the role as Councilor. A longer cooling-off period, for example five years, may be appropriate for previous employees.

- The Governance Committee and Executive Committee have expressed support for the introduction of cooling-off periods and the proposed amendments to the CPSO General By-laws (Appendix A.)

Mandatory Orientation

- The Governance Committee and Executive Committee also expressed interest in requiring members, prior to standing for Council elections, to complete an orientation and education session regarding the work of the College and duties, obligations and expectations of Council and committee members.

- This type of orientation and education session is also an expectation of health regulatory colleges under the Ministry of Health's new reporting requirements, which indicate that the orientation would have to be completed before the member is listed as a nominee for the election.

- The intent behind the orientation is to inform candidates about what being a Council member entails and what will be expected of them. The orientation can also be used to specifically educate candidates that if elected, they will not be

representing physicians in their district but rather will be required to act in the public interest. This may serve to improve the quality of nomination statements submitted by candidates on this issue.

- The By-laws will have to be amended to add mandatory orientation as an election eligibility criterion (Appendix A).

Disqualification

- Section 13(1)(h) of the By-laws currently provide that a member is not eligible for election to Council if Council has disqualified the member during the three years before the election date.

- We recommend that this provision be amended to clarify that it applies to both disqualification from Council and from a CPSO committee. The proposed amendments also address members who may have resigned from Council or from a committee in face of a disqualification.

- In addition, the Governance Committee and Executive Committee discussed the time limit on this eligibility criterion. Both Committees supported the extension of the three-year time period to five-years (Appendix A).

CONSIDERATIONS:

- The Governance and Executive Committees acknowledged that there is an opportunity to bring clarity and consistency with respect to academic representatives and is reflected in the proposed By-law amendments (Appendix A).

NEXT STEPS:

- By-laws relating to qualifications for election of Council members do not need to be circulated to the profession prior to Council approving them.

- However, the profession needs to be aware of changes to the eligibility criteria in case they are interested in running for election to Council.

- Accordingly, it is important that sufficient advance communication be made to the profession of any new or amended eligibility criteria. Any changes to the criteria will be communicated to the profession following the Council meeting.

DECISION FOR COUNCIL:

1. Does the Council approve the proposed By-law amendments for Council elections eligibility criteria?

Contact: Laurie Cabanas, Director of Governance and Policy

Marcia Cooper, Corporate Counsel and Privacy Officer Laura Rinke- Vanderwoude, Jr Governance Analyst

Date: November 26, 2020

Attachments: Appendix A: Proposed By-law Amendments

Appendix A

By-law Amendments

NOTE: Items in red indicate the proposed changes to the existing by-laws.

Eligibility For Election

13. (1) A member is eligible for election to the council in an electoral district if, on the date of the election, …

(f) the member is not, and has not been within one year before the date of the election, a director or officer of the Ontario Medical Association, the Canadian Medical Protective Association, the Canadian Medical Association, ~~or~~ the Coalition of Family Physicians and Specialists of Ontario or the Ontario Specialists Association;

(g) the member does not hold, and has not held within one year before the date of the election, a position which would cause the member, if elected as a councillor, to have a conflict of interest by virtue of having competing fiduciary obligations to both the College and another organization;

(h) the member is not, and has not been within five years before the date of the election, an employee of the College (whether on contract or permanent, and whether on a full-time or part-time basis);

(i) council has not disqualified the member from council or from one or more committees during the ~~three~~ five years before the election date;~~,~~ ~~and~~

~~(h)~~(j) the member has not resigned from council or from one or more committees during the five years before the election date where there are reasonable grounds to believe that the resignation is related to a proposed disqualification of the member from council or one or more committees;

(k) the member has completed and filed with the registrar a Conflict of Interest form by the deadline set by the registrar;~~,~~ and

~~(i)~~(l) prior to the member submitting a nomination form and nomination statement for the election, the member has completed the orientation program specified by the College relating to the business and governance of the College and the duties, obligations and expectations of council and committee members.

Disqualification of Elected Members

22. (1) An elected member is disqualified from sitting on the council if the member, …

(i) is or becomes a director or officer of the Ontario Medical Association, the Canadian

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Medical Protective Association, the Canadian Medical Association, ~~or~~ the Coalition of Family Physicians and Specialists of Ontario, or the Ontario Specialists Association;

Academic Advisory Committee

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

(f) the member is not, and has not been within one year before the date of the election, a director or officer of the Ontario Medical Association, the Canadian Medical Protective Association, the Canadian Medical Association, ~~or~~ the Coalition of Family Physicians and Specialists of Ontario, or the Ontario Specialists Association;

(g) the member does not hold, and has not held within one year before the date of the election, 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)~~.~~;

(i) the member is not, and has not been within five years before the date of the election, an employee of the College (whether on contract or permanent, and whether on a full-time or part-time basis);

(j) council has not disqualified the member from council or from one or more committees during the five years before the election date;

(k) the member has not resigned from council or from one or more committees during the five years before the election date where there are reasonable grounds to believe that the resignation is related to a proposed disqualification of the member from council or one or more committees; and

~~(i)~~(l) the member has completed the orientation program specified by the College relating to the business and governance of the College and the duties, obligations and expectations of council and committee members.

Disqualification of Selected Councillors [Academic Representatives]

27. (1) A person selected as a councillor is disqualified from sitting on the council if the member, …

(i) is or becomes a director or officer of the Ontario Medical Association, the Canadian Medical Association, ~~or~~ the Coalition of Family Physicians and Specialists of Ontario, or the Ontario Specialists Association; or

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Council Motion

Motion Title: Advertising – Revised Policy for Final Approval

Date of Meeting: December 4, 2020

It is moved by_____,

and seconded by_____, that:

The Council approves the revised policy “Advertising”, (a copy of which forms Appendix “ ” to the minutes of this meeting).

CPSO

Council Briefing Note

December 2020

TOPIC: Advertising – Revised Policy for Final Approval

FOR DECISION

ISSUE:

- A draft *Advertising* policy has been developed to help provide clarity or address areas of ambiguity with respect to the expectations for physician advertising set out in the General Regulation under the *Medicine Act, 1991* (the Regulation)[1]. In June 2020 Council released the draft *Advertising* policy for external consultation. The draft policy has been revised in light of the feedback received through this engagement activity.

- Council is provided with an overview of the changes and is asked whether the revised draft policy can be approved as a policy of the College.

BACKGROUND:

- The new draft policy was developed with direction from the Policy Review Working Group, consisting of Brenda Copps (Chair), Ellen Mary Mills (former Working Group member), and Janet Van Vlymen, as well as Medical Advisors Angela Carol and Keith Hay. Additional support was provided by Kirk Maijala (Legal Counsel), Michael Szul (Medical Advisor), and Lydia Miljan who provided public member perspective on the draft policy following Ellen Mary Mills' departure from the Working Group.

- The draft policy and accompanying *Advice to the Profession* document were developed following extensive research[2], and engagement activities including

[1] O. Reg. 114/94: GENERAL under *Medicine Act, 1991*, S.O. 1991, c. 30.
[2] This included a literature review of scholarly articles and research papers; a jurisdictional review of Canadian and international medical regulatory authorities; relevant statistical information regarding

undertaking a survey and an in-person meeting with the Citizen Advisory Group, public opinion polling of Ontario residents, and discussion with stakeholders.

- The draft policy was approved for external consultation by Council in March 2020.
    - 150 responses were received as part of this external consultation[3]. Overall respondents found the draft policy to be clear and comprehensive, and the expectations to be reasonable.
    - In addition to hearing from members of the public and physicians, feedback was received from organizational stakeholders including: Canadian Medical Protective Association, Ontario Medical Association, Professional Association of Residents of Ontario, Ontario Trial Lawyers Association, Ad Standards, and Canadian Academy of Facial Plastic and Reconstructive Surgery.
- All feedback received has been posted on a dedicated page of the College's website. A preliminary overview of the feedback was provided to Council in the September 2020 Policy Report.

CURRENT STATUS:

- In response to stakeholder feedback from the general consultation, the draft *Advertising* policy (**Appendix A**) and *Advice to the Profession* document (**Appendix B**) have been revised and updated.

A. Key Additions and Revisions

- Much of the critical feedback received related to obligations set out in the Regulation. This included feedback on a number of areas where the broad language of the Regulation appears to prohibit behaviours that many felt were sometimes appropriate, such as:
    - Referencing specific drugs, appliances or equipment in advertising;
    - Associating with products or services other than a physicians' own medical services; and

matters before the Inquiries, Complaints, and Reports Committee (ICRC); and feedback on the Regulation from the College's Public and Physician Advisory Service.

[3] 25 responses were received through the online discussion page, and 125 through the online survey. 89% of the survey respondents were physicians, and 6% were members of the public.

- Directing or targeting prospective patients.

- The existence of the Regulation is a limiting factor for the College regarding this policy, and as such we were not able to address much of the feedback received. As a result, the revised draft is largely consistent with the previous draft, but revisions have been made where possible to be as responsive to feedback, and as helpful to physicians, as possible.

- An overview of the key revisions is provided below.

Definitions

- To clarify the scope of what is considered advertising, a specific reference to social media was added to the definition. While the draft *Advice* document did provide additional information and reference social media, feedback suggested additional clarity could be achieved by updating the definition in the draft policy.

- The definition of "before and after photos and videos" was also updated to note that this term includes images or videos taken *during* procedures, as well as before and after. A number of respondents to the consultation had requested this be clarified.

Inappropriate Advertising Content

- Two significant revisions have been made to Provision 3 which outlines what constitutes inappropriate advertising content.

    - The Regulation prohibits physicians from referencing specific brand names of drugs, appliances and equipment in their advertising. The draft policy had contained an exception which allowed for such references where a brand name had come to be used to refer to a drug, appliance or equipment in a generic sense. This exception has been removed as this could lead physicians to inadvertently breach trademark law.

    - The draft policy prohibition on the use of incentives (e.g., time limited prices for a service, discount coupons, offering treatments or procedures as prizes in a contest, etc.) in advertising has been removed. Feedback suggested this prohibition was too paternalistic and infringed patient autonomy. The

College can continue to consider any inappropriate incentives under the general requirement that advertising be in "good taste" and the *Advice* outlines some instances where incentives might not meet this requirement.

Before and After Photos and Videos – Criteria for Use

- The feedback received was largely supportive of the College's proposal to allow for the use of before and after photos and videos in limited circumstances. Notwithstanding this support, respondents identified ways the provisions relating to before and after photos and videos could be improved.

- Several revisions were made to Provision 4 to clarify the intent of the criteria and ensure patients are receiving accurate information where before and after photos or videos are used.

    - A criterion was added to require that physicians only use before and after photos or videos where displayed alongside a statement that the outcome or results depicted are not guaranteed and may vary between patients.

    - Criteria relating to manipulation and consistency of images (Provisions 4.d. and 4.e.) were amended to help clarify that the intent of these criteria is to ensure that the results of medical procedures are not misrepresented, and that standardization of before and after images is maintained. These revisions were made in response to feedback that suggested the intent of these provisions was not always clear to respondents.

    - The wording of the criterion relating to the de-identification of patients in images was amended to respond to feedback that suggested it could be read as allowing physicians to use a photo or video without consent as long as they had been de-identified.

Before and After Photos and Videos – Unsolicited Display

- Feedback suggested the prohibition on paying to have before and after photos or videos reach patients who were otherwise not looking for them was unclear. The substance of the provision has been retained, but revisions have been made to clarify the intent.

    - More specifically, the revised provision clarifies that before and after photos and videos must not be displayed in advertising where they can be seen by

members of the public unsolicited. This is to ensure these images can be available for patients who wish to see them and may seek them out but are not in widespread use in advertising mediums such as magazine or television advertising.

Before and After Photos and Videos - Consent

- Based on consultation feedback, an addition has been made to Provision 6 which requires physicians to show the patient the final photos or videos to be used in advertising. This is to ensure the patient is fully aware of which images of them will be displayed and have the opportunity to decline to have them used in advertising if they so wish.

B. Draft *Advice to the Profession* Document

- In response to feedback and requests for additional information, the *Advice* document has been updated to further clarify what will be considered not in "good taste" in physician advertising, and how physicians should engage with third party review sites.

- Due to the overly broad nature of key prohibitions in the Regulation, new content was also added to help address physician questions and guide reasonable conduct.

    - New sections in the *Advice* document regarding physicians referencing specific drugs, appliances or equipment in their advertising, associating themselves with products and services other than their own medical services, and directing and targeting prospective patients, outline the intentions of these provisions and the types of behaviors they are trying to prevent, to assist physician understanding of their obligations.

NEXT STEPS:

- Should Council approve the revised draft policy, it will be announced in *Dialogue* and added to the College's website.

DECISION FOR COUNCIL:

1. Does Council approve the revised draft *Advertising* policy as a policy of the College?

Contact: Courtney Brown, Ext. 216

Date: November 13, 2020

Attachments:

Appendix A: Revised Draft *Advertising* policy

Appendix B: Revised Draft *Advice to the Profession: Advertising* Document

APPENDIX A

Advertising

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

Advertising: any communication, whether paid or unpaid, made in print, through electronic media, social media or via the internet by or on behalf of a physician (i.e., by a third party) that has as its primary purpose the promotion of the physician, a service they provide, or a clinic, facility or group with which they are associated, or the the communication of the availability of professional services.[1]

Testimonial: a statement endorsing the quality of a service, product or professional. A before and after photo or video that complies with the requirements of this policy will not be considered a testimonial.

Before and After Photo or Video: images or videos of a patient taken before, during and/or after a medical service, and used to document the process or demonstrate the result.

Policy

This policy sets out expectations for physician advertising and includes both expectations that are set out in the General Regulation under the *Medicine Act, 1991*[2], and expectations that have been set by the College of Physicians and Surgeons of Ontario.

1. Physicians **must** ensure that any advertisement prepared by them, or on their behalf by a third party, complies with the expectations contained in this policy and the General Regulation under the *Medicine Act, 1991*.

[1] For more information on what is and is not considered advertising please see the *Advice to the Profession* document.

[2] O. Reg. 114/94: GENERAL under *Medicine Act, 1991*, S.O. 1991, c. 30.

Advertising Content

2. Physicians **must** only advertise in a manner which:
    a. is readily comprehensible;
    b. is dignified;
    c. is in good taste;[3]
    d. is accurate and factual;
    e. is verifiable and supported by available evidence and science, if making statistical, scientific or clinical claims;
    f. is respectful and balanced in tone; and
    g. upholds the reputation of the profession.

3. Physicians **must not** advertise in a manner which:
    a. is false, misleading or deceptive (for example, by the inclusion or omission of any information);
    b. is sensationalised, exaggerated, or provocative;
    c. contains any statement that is discrediting, disparaging, or attacking in nature;
    d. contains any statement comparing themselves to other physicians or health professionals;
    e. contains any statement that promises or suggests a better or more effective service than any other physician or health professional;
    f. contains a testimonial; or
    g. contains any reference to a specific drug, appliance or equipment.

Before and After Photos or Videos

4. In addition to complying with the expectations set out in provisions 2 and 3, physicians **must** only use before and after photos or videos in advertising where the photos or videos:
    a. are for the purpose of providing accurate and educational information;
    b. portray an outcome that can reasonably and typically be expected;
    c. depict an actual patient who received the advertised medical service from the physician associated with the advertisement;
    d. are not manipulated to misrepresent the results of the medical service;[4]
    e. have consistent lighting, pose, photographic techniques, and setting to maintain a standardization of images;
    f. only depict a patient who has been de-identified, unless the patient has specifically consented to being identified; and

[3] Advertising that is excessively commercial in tone, as opposed to being educational or informational, will be less likely to be in good taste. For more information on what constitutes "good taste", please see the *Advice to the Profession* document.

[4] Cropping or resizing of images for display would not be considered manipulation provided that consistent techniques are applied to any before and after images.

g. are included alongside a statement that the outcome or results depicted are not guaranteed, and may vary between patients.

5. Physicians **must not** display before and after photos or videos in advertisements where members of the public are likely to see them unsolicited.[5]

6. In addition to the requirements set out in the *Personal Health Information Protection Act, 2004* regarding the collection, use and disclosure of personal health information[6], physicians **must** obtain express consent to the specific use of before and after photos or videos before using them in their advertising. As part of this physicians **must**:
    a. wait until after the medical service is provided to discuss and obtain consent to the use of the before and after photos or videos in their advertising;
    b. show the final images to be used in the advertisement to the patient before using them in any advertisements;
    c. inform the patient that they can withdraw their consent to the use of before and after photos and videos at any point;
    d. inform the patient about the risks of consenting to the use of before and after photos and videos (for example, that once posted on social media they may be unable to be completely withdrawn);
    e. engage in a dialogue with the patient about the use of the photos or videos, regardless of whether supporting documents (such as consent forms, patient education materials or pamphlets) are used;
    f. consider how the power imbalance inherent in the physician-patient relationship could cause patients to feel pressured to consent to the use of photos or videos and take reasonable steps to mitigate this potential effect; and
    g. **not** offer incentives[7] to consent to the use of before and after photos or videos.

Association with Products or Services Other than their own Medical Services

7. Physicians **must not** permit their name or likeness[8] to be used in or associated with advertising:
    a. for any commercial product or service other than their own medical services, or
    b. for facilities where medical services are not provided by the physician.

[5] As opposed to displaying before and after photos or videos in places where a prospective patient may seek them out. For example, before and after photos and videos can be displayed on a physician's website (even if the physician is paying to host that website), but cannot be used in print advertisements in magazines or newspapers, as this would constitute content being displayed in a setting where they would be seen unsolicited. For more information on the use of before and after photos or videos, please see the *Advice to the Profession* document.
[6] *Personal Health Information Protection Act*, 2004, S.O. 2004, c. 3, Sched. A.
[7] Incentives are offerings whose purpose would be to encourage a patient to consent to the use of their photos or videos in advertising. Incentives are often financial, in the form of discounts or special prices.
[8] For example, a representation, picture or image of the physician.

8. Notwithstanding provision 7, physicians who are part of a multi disciplinary practice are permitted to be associated with that practice's advertising, however they **must** ensure that advertising for the practice meets the following conditions:
    a. the advertisement does not provide or appear to provide any physician's endorsement of services at the practice not provided by the physician; and
    b. the advertisement does not state or imply that a physician provides all of the services offered at the practice, or that a physician provides any services that they do not in fact provide.

Directing and Targeting Prospective Patients

9. Physicians **must not** participate in an organized or co-ordinated effort in which another person directs someone to a particular physician for medical services.[9]

10. Physicians **must not** proactively target and contact, or attempt to contact, any person known to need medical services to solicit them to use their medical services.[10]

Use of Title

11. In any communication that advertises, promotes or relates to the provision of medical services, physicians **must** only reference titles, designations or medical specialties in accordance with the General Regulation under the *Medicine Act, 1991.*[11]

[9] This does not preclude physicians from undertaking a referral or transfer of a patient or patient's specimen, in good faith and in compliance with the conflict of interest provisions in Part IV of O. Reg. 114/94: GENERAL under *Medicine Act, 1991*, S.O. 1991, c. 30. For further information please see the *Advice to the Profession* document.

[10] This does not preclude physicians from contacting patients who have been referred to them, reminding a person who has made an appointment of the appointment or from communicating with regular patients to inform them of health maintenance procedures due to be carried out, health issues, preventative medicine and recent developments in medicine, or of a possible benefit from a change in therapy.

[11] O. Reg. 114/94: GENERAL under *Medicine Act, 1991*, S.O. 1991, c. 30. For more information on how a physician can refer to themselves in advertising please see the *Advice to the Profession* document.

APPENDIX B

Advice to the Profession: Advertising

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.

Advertising is used by physicians to attract patients to their practice, or to help inform patients about the services, products or treatments they offer. Currently the General Regulation under the *Medicine Act, 1991*[1] (the Regulation) sets out physicians' legal obligations when advertising.

The *Advertising* policy aims to help provide clarity around these rules and set out appropriate professional expectations where the rules of the Regulation are ambiguous or open to interpretation. This will assist physicians in advertising their services effectively, while assuring such advertising is appropriate and in the best interests of the public. Importantly, the policy captures *both* physicians' legal obligations as set out the Regulation as well as additional expectations of the College. This is to assist physicians in understanding their obligations, by having all expectations contained in one document.

This companion Advice document provides further guidance around how the expectations in the Regulation and policy can be met.

What is considered advertising?

As the policy outlines, advertising means any communication that has as its primary purpose the promotion of a physician, or a clinic, facility or group with which the physician is associated. This can be both paid or unpaid and includes:

- print ads in newspapers, magazines, and brochures;
- newsletters and mail outs;
- business cards and stationery;
- logos and signage;
- TV or radio ads;
- websites;
- blogs and social media posts (e.g., Facebook, Twitter, Instagram);
- posters and billboards; and
- other information related to the physician's practice, regardless of the form or the manner of distribution.

Under the Regulation, posters or pamphlets displayed in a physician's office or clinic waiting area are also considered to be advertising.

[1] O. Reg. 114/94: GENERAL under *Medicine Act, 1991*, S.O. 1991, c. 30.

What is not considered advertising?

While the term "advertising" covers a wide range of materials or activities, there are tools that physicians may use to inform patients that would not be considered "advertising" under the Regulation. Such tools would include materials that physicians use to inform patients about procedures in a clinical setting, for example, showing a patient images or pamphlets when discussing treatment with them during an appointment.

Fundraising efforts on behalf of a foundation or an organization are not generally considered advertising, as the primary purpose is to raise funds and not to attract patients to a particular physician or clinic. That said, there may be instances where the nature of the content is such that it is subject to the Regulation and so the requirements set out there and captured in the policy would apply. It will be important that physicians who choose to be associated with such campaigns use caution and ensure it is appropriate, based on the specific circumstances and content of the campaign.

What kind of advertising content would not be in "good taste"?

Advertising that is educational or informational in nature, is more likely to be found to be in "good taste" whereas advertising that is excessively commercial in tone is less likely to be in good taste.

Examples that may be considered to not be in good taste include advertising that uses incentives to entice the public to seek a medical service, such as offering medical treatments as prizes in contests or offering prospective patients products or gift certificates not related to the medical service to encourage them to undertake a procedure.

The setting and size of the advertisement may also inform whether something is in good taste or not. For example, content that may be considered acceptable on a clinic's website, could be in bad taste if displayed on a billboard. Advertising content that is displayed for "shock value" may also be in bad taste. Careful consideration will need to be undertaken when using images that depict devices or images of patients.

What kind of advertising content would be misleading or deceptive?

Content that is false or not based in fact will be in breach of the expectations contained in the policy. However, what would be considered "misleading or deceptive" is broader than this. Thinking carefully about whether the wording of advertisements includes content that may lead the reader to an incorrect conclusion, create a false impression, or that leaves out key information or context, will help physicians meet the expectations contained in the policy.

What are the rules around testimonials on third party sites?

The Regulation prohibits physicians from using testimonials in their advertising.

Internet sites currently exist on which patients and the public can post ratings, reviews and feedback on a particular physician, practice or clinic. These can take the form of testimonials, but there is no prohibition against such sites where the public are freely posting their opinions on a service.

Physicians will need to be very careful in considering how they interact with such sites to avoid engaging in activities prohibited by the Regulation. Some behaviour by physicians relating to testimonials on third party sites could potentially be considered a breach of the prohibition against testimonials. For example, if a physician:

- linked to their reviews on these sites in their advertising,
- directed patients to post about them or their practice on such sites,
- posted on such sites themselves under other names, or
- paid to remove negative reviews from such sites.

In particular, asking patients to post on such sites could cause patients to feel that they may not receive the same quality of services if they refuse and could impact the relationship of trust between a physician and a patient.

What should I do with comments on social media posts?

Many physicians choose to maintain a social media presence for themselves or their practice. Social media is a rapidly evolving space and is being used by physicians in a range of ways.

It may be that members of the public post comments on the social media accounts of physicians or their practices. When considering such comments and how they should be handled, physicians will need to use their professional judgment and act in compliance with the College's *Social Media – Appropriate Use by Physicians* statement.

While social media comments by third parties may not on their own be considered advertising, a physician taking an active role in managing social media comments could change the way such comments are perceived. For example, if a physician was to delete negative comments and not positive comments, this could be viewed as a breach of the Regulation and the *Advertising* policy as it relates to testimonials. This does not include the deletion of discriminatory or unprofessional comments, which would likely be permitted.

Why can't I reference specific drugs, appliances or equipment in my advertising?

The Regulation prohibits physicians from referencing specific drugs, appliances or equipment in advertising. The purpose of this prohibition is to prevent physicians from endorsing a specific brand of drug, appliance, or equipment, or by marketing their medical practice to patients through an association with a specific brand of drug, appliance, or equipment. Physicians will need to ensure the focus of their advertising is on the medical services and treatments they offer (e.g. I offer this medical procedure), rather than the brands or trademarked equipment or drugs they use (e.g. I use this *Trademarked Device*).

This provision may allow for physicians to reference in their advertising a drug, appliance or equipment used for treatment, where the drug, appliance or equipment is not identified by a specific commercial or brand name (e.g. "I offer fillers," rather than "I offer *this Trademarked Filler*").

When can I use before and after photos or videos in my advertising?

As stated in the policy, physicians cannot display before and after photos or videos in advertising where any member of the public may then see them unsolicited, without seeking them out. For example, advertising that is published in magazines or newspapers, tv advertisements, or paid for sponsored or promoted posts on social media that appear in the feeds of users who do not follow that physician or practice on social media.

Physicians are permitted to use before and after photos and videos in formats where prospective patients may seek them out, for example on their websites or on their social media pages generally (with no targeting or promotion of the posts), provided of course those photos or videos comply with the requirements of the policy.

Careful consideration will need to be given before posting photos or videos to social media, as the terms of use for social media sites can change and evolve, with potentially unforeseen consequences.

What constitutes "permitting" myself to be associated with an advertisement?

All advertising produced by a clinic or practice where a physician provides services, could be associated with that physician. It is important that physicians maintain awareness of any advertising or promotional material published or put out by an organization with which they have a direct connection, and whether that advertising is in compliance with advertising obligations.

Why can't I associate myself with products and services other than my own medical services?

The Regulation specifically prohibits physicians from associating themselves with products or services other then their own medical services. This prohibition is intended to ensure that physicians are not misusing their credentials to advertise and promote products or services to the public that may not be relevant or appropriate. The following examples are likely to be viewed as problematic and violating the prohibition in the Regulation:

- A physician marketing and selling commercial health products and/or supplements they created;
- A physician attaching their name to facilities where they do not practice or provide medical services;
- A physician appearing in advertising to use their credentials to endorse a product or service marketed to the public;
- A physician including in their advertising references to brand-name medications or devices to promote the benefits of these products.

What is the purpose of the prohibitions on directing and targeting prospective patients?

The Regulation prohibits physicians from:

- Participating, directly or indirectly, in a system in which someone else (e.g., a person or a company), steers or recommends patients to them for professional services, and
- contacting or communicating with, or attempting to contact or communicate with, any person known to need medical services to solicit or invite professional patronage.

The intention of the Regulation is to prevent physicians from attempting to generate business and income for themselves in a way that might not be in the best interests of prospective patients, or encouraging patients to seek a medical service for commercial reasons, rather than for medical reasons. Examples of where these prohibitions might be enforced include physicians offering services through group discount companies, or physicians giving "kickbacks" to a person or company in exchange for patient referrals.

This would not prevent physicians from doing such things as making referrals as part of their normal course of practice where there is no conflict of interest, recommending another particular physician, practice or clinic if asked by a patient to do so, or contacting existing regular patients about their services.

The College does not interpret these obligations in the Regulation as prohibiting physicians from participating in services such as Health Care Connect or outreach programs seeking to improve access to healthcare for vulnerable or marginalized populations, as long as they are complying with their other professional obligations while doing so.

How should I refer to myself in advertising?

The Regulation contains specific rules for the way physicians can refer to themselves and their areas of practice in advertising. There are a number of terms that are protected and can only be used where physicians have, for example, appropriate certification.

According to the Regulation, when a physician is referred to in any advertising, the physician's name must[2] be followed by either:

a. the term, title, or designation that the physician may use with respect to the specialty or subspecialty of the profession in which the member has been certified by the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College of Family Physicians of Canada (CFPC) or formally recognized in writing by the CPSO, or
b. the title "General Practitioner."

[2] According to O. Reg. 114/94: GENERAL under *Medicine Act, 1991*, S.O. 1991, c. 30.

Physicians can also have their designatory letters (indicating academic degrees, professional certification from the RCPSC, CFPC or formal recognition from the CPSO) follow their name.

Examples of Proper usage

- Dr. Joan Clark, Family Medicine
- Joan Clark, MD, CCFP, Family Medicine
- Dr. B. Ali, MBA, General Practitioner
- L. Rousseau, MD, CPSO Recognized Specialist (Anesthesia)

Focused Practice

Physicians who have a focused practice, for example, a family physician with a focus on pediatrics, may have completed additional training in specific practice areas but are not certified specialists in those disciplines. In keeping with their professional obligations, physicians must ensure they have the suitable knowledge, skills and judgment to practise in the areas that they describe. If physicians wish to describe other areas of their practice, they may do so, provided physicians comply with certain requirements:

- The physician must still state their specialty or subspecialty or designation as a general practitioner as explained above; and
- The phrase “practising in” must precede any descriptive terms that are used.

This is intended to ensure consistency in advertising and promotional materials, and that descriptive terms are not mistaken for formal specialization or sub-specialization.

Examples of Proper usage

- Charles Gauthier, MD, CCFP, Family Medicine, practising in pediatrics
- J.B. Rodriques, MD, General Practitioner, practising in psychotherapy

Other Credentials

Physicians can also include their other credentials in their advertising, if they wish, but that information cannot come before the required speciality designation and practice descriptor, if any.

Example of Proper usage

- F. Stevens, MD, General Practitioner, practising in sleep medicine, Diplomate of the American Board of Sleep Medicine

Restricted Practice Description Terms

Some practice description terms are restricted. Physicians cannot use the terms ‘surgeon,’ ‘surgery,’ ‘plastic,’ ‘facial plastic,’ ‘oculoplastic’ and ‘ophthalmic plastic’ unless they satisfy the conditions in the regulation. Specifically:

- No physician can use the title “surgery” or the term “surgeon,” or a variation or abbreviation to describe their practice unless he/she is certified by the RCPSC in a surgical specialty or subspecialty or formally recognized in writing by the CPSO as a surgical specialist or subspecialist.
- No physician can use “plastic” to describe his or her practice unless the physician is certified by the RCPSC in plastic surgery or formally recognized in writing as a plastic surgeon by the CPSO.
- No physician can use “facial plastic” to describe his or her practice unless the physician is certified by the RCPSC as an otolaryngologist – head and neck surgeon or is formally recognized in writing by the CPSO as an otolaryngologist – head and neck surgeon. In keeping with the other requirements of the regulation, otolaryngologists – head and neck surgeons can only use “facial plastic” as a practice descriptor; it can’t replace the full name of their specialty.
- No physician can use “oculoplastic” or “ophthalmic plastic” to describe his or her practice unless he/she has been certified by the RCPSC as an ophthalmologist or is formally recognized in writing by the CPSO as an ophthalmologist. Ophthalmologists must only use these terms as a practice descriptor; they cannot use them instead of the full name of their specialty.

Examples of Proper usage

- M. Liu, MD, FRCSC, Otolaryngology-Head and Neck Surgery, practising in facial plastic surgery
- Bonnie Smith-Fox, MD, CCFP, Family Medicine, practising in cosmetic procedures

Council Motion

Motion Title: Committee Mentoring Guide

Date of Meeting: December __, 2020

It is moved by_____,

and seconded by_____, that:

The Council approves the Committee Mentoring Guide, a copy of which forms Appendix “” to the minutes of this meeting.

CPSO

Council Briefing Note

December 2020

TOPIC: **Committee Mentoring Guide**

FOR DECISION

ISSUE:

- The Governance and Executive Committees have reviewed the Committee Mentoring Guide at its meetings on November 4, 2020 and November 10, 2020 and is putting forward a recommendation for Council approval (Appendix A).

BACKGROUND:

- A major priority for CPSO is modernizing and strengthening its governance structures and processes. In September 2019, Council approved by-law amendments to introduce term limits on CPSO Committees beginning in December 2020. To ensure that the Committees continue to function effectively as many Committee members transition off, the Governance Committee focused its attention on mentoring and succession planning.

- In February 2020, Committee Chairs participated in a facilitated workshop that was designed to provide them with some foundational tools and strategies to enhance the performance of the Committee. Committee Chairs expressed their need for resources and guidance to support them in maintaining effective Committee functioning including a consistent mentoring framework across all CPSO Committees.

- Based on a needs assessment conducted across all Committees, there are three types of informal mentoring occurring across College Committees:
    - Role mentoring (Mentors provide general advice and guidance to their mentees about their role to facilitate onboarding);
    - Skills mentoring (Mentors provided targeted knowledge and guidance related to a specific task); and
    - Other (Leadership mentoring (Committee Chair)).

CURRENT STATUS:

- The Committee Mentoring Program working group (chaired by Dr. Janet Van Vlymen) shared the Guide with Education Advisory Group members at its meeting in early November. Advisory Group members provided overall support and endorsement of the Guide.

- The Guide will complement the orientation and education offerings that are provided to Committee members.

- Deanna Bowlby (Education Lead) and Suzanne Mascarenhas (Governance Analyst) are meeting with senior committee support across the College to:

    - Discuss core components of the Program;
    - Explore nuances for each Committee as it relates to the practical application of the Program resources and tools; and
    - Design examples of mentor and mentee agreements based on the applicable type of mentoring that occurs within Committees

- The Advisory Group will be interested in feedback from mentors and mentees with the implementation of the Committee Mentoring Program. A program evaluation will be designed to assess the program's effectiveness, and the results will inform continuous improvement efforts.

NEXT STEPS:

- Several members of the working group will continue to provide oversight on project implementation of program components and continue to work closely with Chairs and senior Committee support to ensure a smooth transition of informal mentoring processes to formal processes.

- The Guide will be introduced to Committee Chairs at the Chairs' Orientation session in November.

- Once the pool of mentors is defined across Committees, the working group will explore options to develop an internal, skills building workshop for the orientation of mentors.

    - Given the unique nature of the Committees, having the internal contextual reference in the training is important.
    - The working group recommended a half-day virtual, facilitated session with a panel of experienced Committee mentors. The facilitator can help to frame the discussion in the context of best practices.
    - This session will be scheduled in late January/February 2021.

DECISION FOR COUNCIL:

- Council is asked to approve the Committee Mentoring Guide as recommended by the Governance and Executive Committees.

Contact: Dr. Peeter Poldre, Chair, Governance Committee
Laurie Cabanas (Director, Governance & Policy)
Suzanne Mascarenhas (Governance Analyst)
Deanna Bowlby (Education Lead)

Date: November 13, 2020

Attachment: Appendix A: Committee Mentoring Guide

APPENDIX A

Committee Mentoring Guide

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Executive Summary

I am pleased to launch the College of Physicians and Surgeons (CPSO) Committee Mentoring Guide.

The CPSO Governance Committee is committed to building a mentorship culture that will strengthen capacity in Committees across the organization. With the recent introduction of Committee term limits and subsequent succession plan development, there is a need for enhanced training, mentoring and knowledge transfer for CPSO Committee members.

A formal mentoring program will facilitate knowledge transfer between seasoned and newer Committee members in order to meet specific Committee needs across CPSO. Mentoring relationships also contribute to effective Committee succession planning and improving the overall experience of Committee members.

This resource provides guidance to Committees about how to implement a formal approach to mentoring that can be incorporated into a Committee's mentoring program. Recognizing that the mentoring needs of every Committee may vary, the Guide provides several options that can complement Committee orientation and education.

Informed by input from Committee Chairs and support staff, this resource will contribute to creating a mentorship culture that includes:

- Role mentoring: Mentors facilitate onboarding by providing general advice and guidance to their mentees about their role, typically for one year;
- Succession mentoring: Committee Chairs mentor the Vice-Chair or a Committee member who demonstrates strong leadership potential typically one year or longer; and
- Skills mentoring: Mentors provided targeted knowledge and guidance related to a specific task, as scheduling onto panels allows.

I would like to thank all who contributed to the development of this important resource including Committee Chairs, support staff and members of the Education Advisory Group. I trust it will be a valuable tool to enhance Committee experience and performance in the years to come.

Dr. Peeter Poldre
Chair, CPSO Governance Committee

Introduction

The College of Physicians and Surgeons of Ontario (CPSO) has seven statutory Committees and three standing Committees. Statutory Committees are required under the *Regulated Health Professions Act (Schedule 2 – Health Professions Procedural Code (Section 10)* and are aligned with CPSO's mandate, which is to serve and protect the public trust in Ontario's health-care system. Standing Committees recommend actions and propose policies for CPSO in the functional areas under their respective authorities.

We need to ensure that Committee members are able to work productively early in their Committee experience, particularly on Committees where the stakes are high.

While training and orientation provides the technical information that Committee members will need to be effective in their role, a Committee's culture, norms and processes take time to learn and aren't necessarily aspects of Committee work that is covered in orientation. A Committee Mentoring Program strives to fill that gap. Having clear and individualized mentoring plans at the outset of a member's Committee experience will help them in their work and enhance the overall effectiveness of the Committee.

The Committee Mentoring Program Guide identifies good mentoring principles and outlines how to maintain effective mentoring relationships. Good mentoring requires time and attention. It recognizes that there will be successes and challenges along the way.

Goals and Objectives of Formal Mentoring

Formal mentoring provides a consistent framework where seasoned Committee members will have the expectation to impart their wisdom and experience to less experienced Committee members. Building on the successes of the informal mentoring approach, anticipated outcomes from CPSO's Committee Mentoring Program include:

- Eased transition periods for new members on Committees;
- Accelerated knowledge transfer for Committees across the organization;
- Enhanced succession planning by providing pathways for mentees to become leaders and mentors; and
- Strengthened relationships between Committee members.

The Committee Mentoring Program can help Committee members accelerate the development of the skills and knowledge they need to succeed in their Committee work. This resource offers tools and techniques to ensure that mentors are focused on the unique kd` qmhmf mddcr nemdv Bnl l hssddl dl adq-

Types of Mentoring

To inform the development of the Committee Mentoring Program, a needs assessment was conducted across all Committees. It was clear from the results that there are three types of mentoring that occurs within Committees:

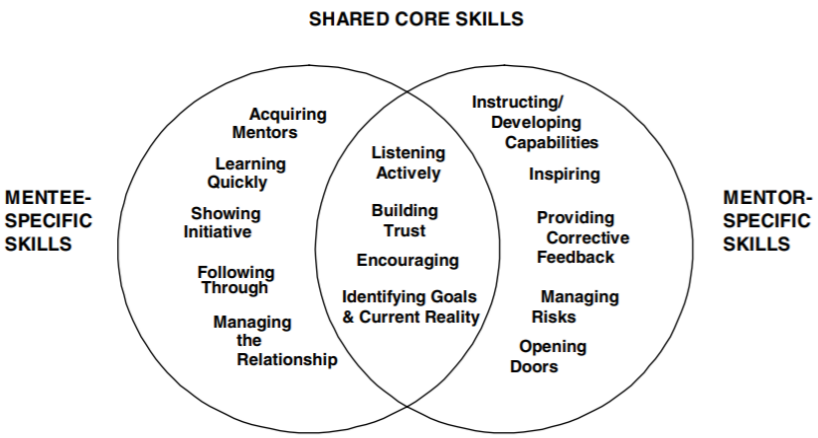
Role Mentoring	• Mentors facilitate onboarding by providing general advice and guidance to their mentees about their role
Succession Mentoring	• Committee Chairs mentor the Vice-Chair or a Committee member who demonstrates strong leadership potential
Skills Mentoring	• Mentors provided targeted knowledge and guidance related to a specific task

Formal mentoring can lead to focused mentoring relationships based on niche tasks within Committees that require significant mentoring and training. Examples include targeted coaching on how to chair panels, decision writing skills, leadership skills, critical thought process and other adjudicative skills.

Matching Process

Finding the right match between mentor and mentee for style, experience, personality, background, training, confidence and needs ensures that mentoring is mutually beneficial for the parties. Having a Mentoring Skills Model as illustrated in Figure 1, is beneficial in that it reflects mentor-specific skills, mentee-specific skills and shared core skills that are key in mentoring relationships.

Figure 1: Shared Core Skills illustrates the key skills that mentors and mentees should demonstrate (Reproduced from Skills for Successful Mentoring: Competencies of Outstanding Mentors and Mentees, by Linda Phillips-Jones, Ph.D.)



Within the context of Committee work, mentees may benefit from multiple mentors to gain exposure to a variety of styles, opinions, and experiences.

If the mentor-mentee match is not ideal, either the mentor or mentee can suggest a change by discussing with Chair of the Committee. Common concerns may include:

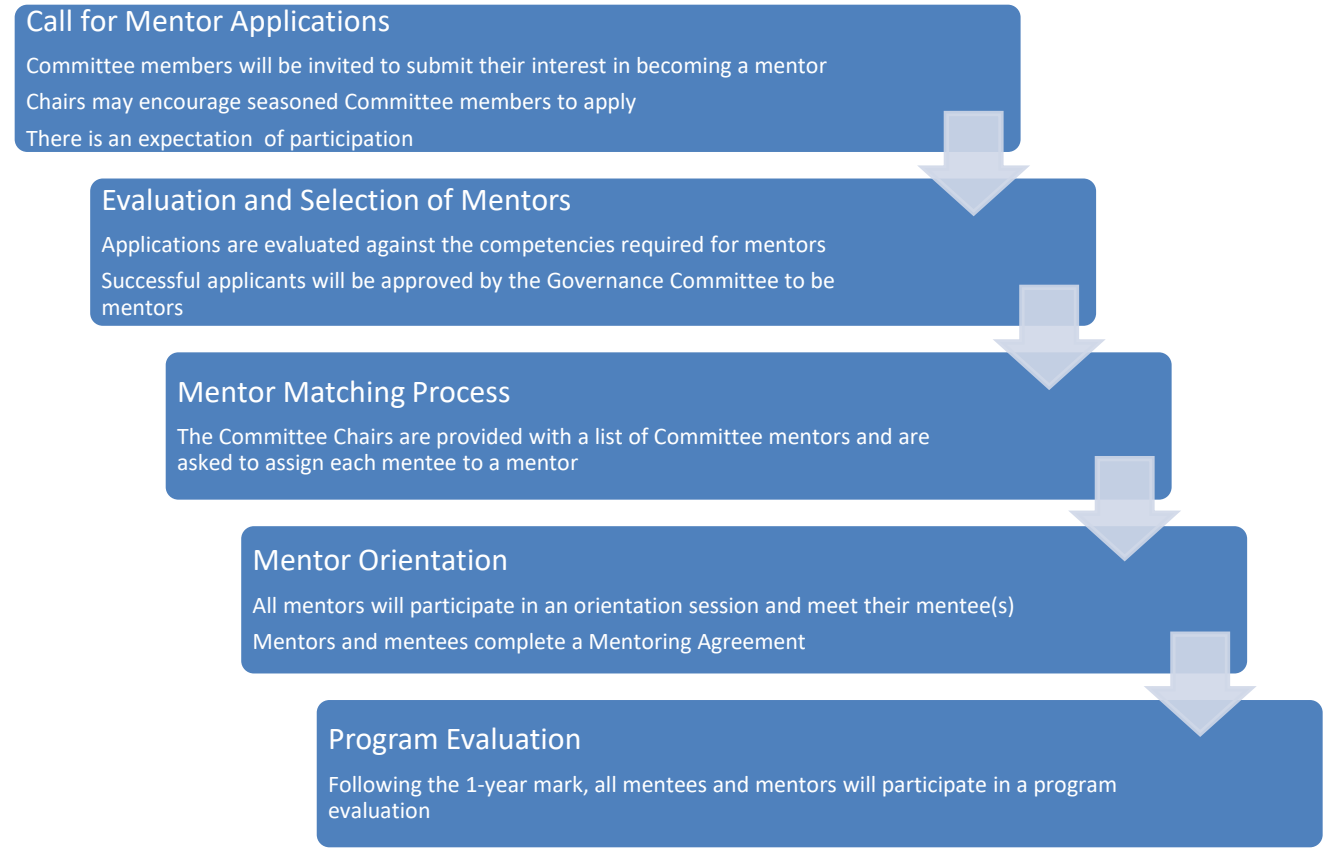
- the mentee does not follow through
- the mentee does not use the mentor's time effectively
- here is a poor fit with work style and/or personality.

The Committee Chair can offer advice to address any concerns raised by the mentor and/or mentee. The mentor and mentee should try to work together where possible. For example, mentors may need to provide constructive feedback to the mentee. Similarly, if the mentee is aware of potential difficulties early and knows his or her values and needs, managing up may help to address and/or avoid problems. *(Appendix D is referred to as part of "Key Program Components").*

	Mentor	**Mentee**
Key Responsibilities	• Assist with skills, training and knowledge transfer for Committee members • Encourage and support mentees • Help mentees become aware of unwritten rules and norms • Serve as an intentional model of professionalism	• Taking ownership of the mentoring relationship • Letting the mentor know learning needs
Ideal Candidates	• Mentors are seasoned Committee members that ideally represent diverse backgrounds and perspectives	• New Committee members • Vice-Chairs • Newly appointed Committee Chairs
Orientation and Training	• The Governance Committee and team will arrange a mentor orientation to provide guidance and clarity of expectations	• New Chairs, Vice-Chairs and Committee members will receive information about the mentoring program during their orientation
Success Factors	• Mentors can help ensure mentorship is mutually beneficial by taking an interest in the mentee, providing	• Managing up is one way of cultivating the mentoring relationship • It means the mentee takes

	Mentor	Mentee
	professional support, prompting a mentee to take risks, and helping open doors for mentees to different opportunities at CPSO • Mentoring dynamics are key to success by: - facilitating reflective practice; - establishing collaborative relationships; - developing observational skills; - understanding role nuances of committee work for mentees; and - understanding and evaluating mentoring relationships	ownership of the relationship by letting the mentor know what they need • The ideal mentee aspires to self-assessment, receptivity, initiative, responsibility, honesty, and appreciation for his or her mentor.

The key elements of the Committee Mentoring Program are outlined in Figure 2 below.



Key Program Components

Call for Mentor Applications

Establishing criteria is critical to selecting mentors who contribute by ensuring they possess the attitudes, communication skills, interpersonal skills and professional competence and experiences that are necessary for good mentors (Appendix A).

Potential mentors may complete a Mentoring Skills Self-Assessment to self-assess potential of becoming a mentor through rating mentoring skills (Appendix B).

Evaluation and Selection of Mentors

Choosing mentor is a joint process between the Chair and a potential mentor where an application process (including a skills matrix) will be developed unique to the Committee

(Appendix C).

Mentor Matching Process

A Mentees' Checklist requires the mentee to take responsibility for his or her part in the collaborative alliance and to be the leader of the relationship (Appendix D).

Mentor Orientation

Facilitating Mentoring Agreements with mentors and mentees. Both the mentor and mentee agreements should be discussed with the Chair to ensure goals and values are met. The Chair signs off on the agreements (Appendix E).

Program Evaluation

Program Evaluation provides continuous improvement and a means of identifying ways to increase effectiveness both at the individual and Committee level.

Feedback from participants helps establish best practices for Committee mentoring as it:

- Provides an opportunity for both the mentor and mentee to reflect upon what was learned, discussed next steps for the mentee, and provide feedback on the program and process;
- Promotes growth and development as a Committee member may be considered when a Committee member is eligible for reappointment to the Committee; and
- Identifies any learning gaps and opportunities for improvement through self-evaluation processes.

Recognition and Compensation

Recognition for mentoring is an explicit acknowledgement of the value of mentoring for both the mentor and the mentee.

Committee members are compensated for committee work and are reimbursed for expenses incurred in the conduct of committee business, in accordance with section 20 of CPSO By-Law No. 2 (Fees and Remuneration By-Law).

Committee members who are public members are compensated by the Minister of Health for

expenses and remuneration as determined by the Lieutenant Governor in Council. [HPPC, s. 8].

Various Forms of Mentoring

Mentoring groups can occur in several different ways. For example, one mentor may take on a small group of mentees, providing direct mentorship to multiple people rather than one-to-one. Working teams or peer-groups with complementary knowledge and skills may also form mentoring groups that focus on mutual learning and support. In this format, new members are offered specialized advice and ultimately a well-rounded view on all aspects of their careers at the College.

e-Mentoring is a mutually beneficial relationship between a mentor and a mentee which provides learning, advising, encouraging, promoting and modeling virtually.

A cross functional mentorship program allows participants to combine synergies through Chair and Committee workshops.

APPENDIX A - ESTABLISHING CRITERIA FOR MENTORS

Quality	Strategies to Foster, Develop & Support Quality
Commitment A good mentor is committed to the role of mentoring and believes in the value of mentoring.	• Provide mentor orientation. • Establish clear descriptions of the roles and responsibilities of mentors and mentees • Encourage mentors to document goals and plans for the mentor-mentee interaction • Support the time and efforts of mentors by maintaining balanced expectations of workload and mentoring.
Acceptance A good mentor is empathetic, and free of judgment.	• Mentors reflect on the qualities, skills and knowledge contributing to committee effectiveness. • Mentors understand the challenges, problems and concerns of people new to the committee.
Teaching A good mentor is a reflective supporter of the learning process who provides observational feedback and shares experiences.	• Time allocated for learning interactions between mentor and mentee.
Communication A good mentor is effective in different interpersonal contexts, adjusting their mentoring communication to meet the needs of mentees.	• Provide opportunities for mentors to learn about and discuss the challenges of interpersonal communication. • Provide opportunities for dialogue and discussion about the challenges that may arise in a mentoring relationship and how to address them.
Learning A good mentor values and models continuous learning, actively engaging mentees in their own learning and reflective processes.	• Establish clear criteria for mentor selection • Provide mentors with resources to enhance their work as a mentor. • Provide educational activities about mentorship.

Optimism A good mentor publicly and privately affirms the human potential of mentees.	• Incorporate a requirement for mentors to have positive outlook about mentorship into mentor selection criteria. • Acknowledge the value of mentoring through explicit statements.

APPENDIX B - MENTORING SKILLS SELF- ASSESSMENT

(Retrieved from Skills for Successful Mentoring: Competencies of Outstanding Mentors and Mentees,, by Linda Phillips Jones PhD

MY MENTORING SKILLS

Directions: *Assess your potential to be a successful mentor and mentee by rating yourself on the following mentoring skills. For each skill, circle the appropriate number. Total the numbers for each part (I, II, and III), and read the interpretations.*

Mentoring Skill	Quality of Skill: Excellent	Very Good	Adequate	Poor
Part I. Shared Core Skills				
1. Listening Actively	5	3	1	0
2. Building Trust	5	3	1	0
3. Encouraging	5	3	1	0
4. Identifying Goals and Current Reality	5	3	1	0
Subtotal Core Skills				____

16-20	Excellent core skills; you could coach others; concentrate improvement efforts on fine-tuning your style
11-15	Very good skills; continue to polish those skills that will make you even more effective and desirable as a mentor or mentee
6-10	Adequate core skills; work on your less-developed skills in order to have better relationships
5 or under	You'll benefit from coaching and practice on core skills; acquire training or coaching, and observe others who have strong skills

Part II. Mentor-Specific Skills				
1. Instructing/Developing Capabilities	5	3	1	0
2. Inspiring	5	3	1	0
3. Providing Corrective Feedback	5	3	1	0
4. Managing Risks	5	3	1	0
5. Opening Doors	5	3	1	0
Subtotal Mentor Skills				____

20-25	Excellent mentor skills; you could coach others; concentrate improvement efforts on fine-tuning your style with particular mentees
15-19	Very good skills; continue to polish those skills that will make you even more effective and desirable as a mentor
10-14	Adequate mentor skills; work on your less-developed skills in order to acquire strong mentees and have better relationships with them
9 or under	You'll benefit from coaching and practice on mentor skills; acquire training or coaching, and observe others who have strong skills

Part III. Mentee-Specific Skills				
1. Acquiring Mentors	5	3	1	0
2. Learning Quickly	5	3	1	0
3. Showing Initiative	5	3	1	0
4. Following Through	5	3	1	0
5. Managing the Relationship	5	3	1	0
Subtotal Mentee Skills				____

20-25	Excellent mentee skills; you could coach other mentees; concentrate any improvement efforts on fine-tuning your style with particular mentors
15-19	Very good skills; continue to polish those skills that will make you even more effective and desirable as a mentee
10-14	Adequate mentee skills; work on your less-developed skills in order to acquire strong mentors and have better relationships with them
9 or under	You'll benefit from coaching and practice on mentee skills; get training or coaching, and observe others who have strong skills

APPENDIX C - CHOOSING A MENTOR

Mentoring Skills Matrix categories developed for the Committee ***(example below)*** to align with Committee needs (input from chair and staff person)
Committee Member Survey to highlight knowledge, skills, experience and interest (minimum one-year committee participation)
Pool of mentors developed from Survey results tabulated to Mentoring Skills Matrix for each Committee (role, skills, knowledge, other mentoring) ***(update annually)***
Chair approval of each mentor based on Mentoring Skills Matrix
Chair after discussion with mentee determines required mentor skill sets and time commitment

Mentoring Skills Matrix Sample

To be developed based on relevant Committee identified needs

Committee Members			Knowledge, Skills, and Experience Please indicate the potential mentor's knowledge, skills, and experience for each category Advanced = 3 Intermediate = 2 Beginner = 1 None = 0																								
Name	Years on Comm	Experience as a professional mentor	**Role Mentor**	Extensive knowledge of Committee work and practical output	Ability to share examples of committee initiatives and deliverables (past and present)		**Skills Mentor**	Chairing Panels	Decision Writing	How to apply critical thinking and adjudicative skills using practical examples			**Leadership Mentor**	Skills to Chair a Committee		**Other**	Group Mentoring	Cross-functional mentoring across Committees		**Mentor Skills** (see Appendix C - Mentoring Skills Model)	Instructing/developing capacities, providing constructive		**Establishing Criteria for a Mentor** (see Appendix B)	
Total Rating																											

APPENDIX D - CHECKLIST FOR MENTEES TO "MANAGE UP" TO CREATE SUCCESSFUL MENTORING RELATIONSHIP

Adapted from Making the Most of Mentors: A Guide for Mentees by Judy T. Zerzan, MD, MPH]

Getting ready

☐What are my values?
☐What are my habits and work style?
☐ What knowledge do I have, and what are my skill gaps?
(Committee role development, Committee skills development, Committee knowledge development, Other- Leadership development)
☐ List specific opportunities sought – e.g. chair panels, decision writing, leadership goals
☐ Write down goals: 3 months, 6 months, 1 year, 3 years, 5 years

The first meeting

☐ Share your background, values, and needs
☐ Share specific opportunities sought – e.g. chair panels, decision writing, leadership goals

Cultivating the mentor-mentee relationship

☐ Agree on structure and objectives of relationship
☐ Plan and set the meeting agendas
☐ Ask questions
☐ Actively listen
☐ Be responsive
☐ Ask for feedback
☐ Manage up
(Set goals and expectations, be responsive and flexible, direct the flow of information, follow a regular meeting schedule with agenda)

Separation

☐ Talk about when the relationship should end
☐ Talk with your mentor about next steps
☐ Talk about future mentors

APPENDIX E- MENTOR AGREEMENT

Committee Name:	
Name of Mentor:	
Type of Mentorship (what is the primary purpose of this mentorship): Role Mentoring: Role functions and expectations Succession Mentoring: Leadership mentoring Skills Mentoring: Chair panels, Decision Writing Other: Cross-functional group mentoring across Committees	
Who are Mentees and what are their goals? (e.g. leadership development, role function, succession functions)	
Proposed Checkpoints based on Mentoring Timeframe: **(Check-In with Chair of Committee)**	
Telephone (Business):	**Telephone (Personal):**
Email address (Business):	**Email address (Personal):**
Mentor Signature:	
Committee Chair Signature (Date):	

APPENDIX E - MENTEE AGREEMENT

Committee Name:	
Name of Mentee:	
Mentee Goals (e.g. leadership development, role function, succession functions)	
Goal 1	Objectives
Goal 2	Objectives
Goal 3	Objectives
Proposed Checkpoints based on Mentoring Timeframe: **(Check-in with Mentor)** **(Check-In with Chair of Committee)**	
Telephone (Business):	**Telephone (Personal):**
Email address (Business):	**Email address (Personal):**
Mentee Signature:	
Committee Chair Signature (Date):	

EXAMPLE OF A ROLE MENTORING MENTORSHIP (Mentor)

Committee Name:
ICRC

Name of Mentor:
Dr. A

Type of Mentorship (what is the primary purpose of this mentorship):

Role Mentoring: Role functions and expectations
Succession Mentoring: Leadership mentoring
Skills Mentoring: Chair panels, Decision Writing
Other: Cross-functional group mentoring across Committees

Who are Mentees and what are their goals? (e.g. leadership development, role function, succession functions)

- **Newly appointed ICRC members would be the mentees.**

Competencies/Goals:

- **To ensure an appropriate level of knowledge of governing law and policy, and the jurisdiction and authority of the ICR Committee**
- **To ensure equality of treatment, possesses awareness of and demonstrates sensitivity toward cultural and other differences among all whose information is considered by the ICR Committee; other panel members; and the staff who support the committee.**
- **To ensure effective communication (oral/written) between all ICR Committee Members and Staff. Drafts clear, respectful and appropriate notes in a timely manner and actively listens at meetings to others' points of view.**
- **To ensure appropriate conduct at meetings, respecting meeting norms. Recognizes and discloses any potential conflicts that may raise a reasonable apprehension of bias and refrains from discussion the matter with other ICR Committee members or attempt to influence others in any way.**
- **To ensure reasonable and consistent dispositions and reasons and ensure dispositions are made in accordance with guiding principles.**

Proposed Checkpoints based on Mentoring Timeframe:
(Check-In with Chair of Committee)

- **Initial new member orientation, computer training and legal training occurs and then a**

role mentor is assigned who can answer general questions and provide general advice and guidance to their mentee about committee behaviors and competencies (Estimate this occurs within 1 month of being appointed depending on availability).

- New member is then assigned to observe 3 meetings and the role mentor or other seasoned members can be available to assist with advice and questions they have from meeting observation (Estimate 2-3 months)

- 1st Assigned Panel with mentor (or another seasoned member who will be the paired mentor for that specific meeting) – first check point for mentor to check in with mentee following first assigned panel to see how things are going and address issues and further questions (estimate 4 months).

- After mentee completes another 2 -3 panel assignments– second check point for mentor to check in with mentee and perhaps at this point the report to the Chair (estimate 6-7 months)

- After 9 months and another 2-3 assignments – third and final check in with mentee and Chair to identify further training needs.

Telephone (Business):	**Telephone (Personal):**
Email address (Business):	**Email address (Personal):**
Mentor Signature:	
Committee Chair Signature (Date):	

EXAMPLE OF A ROLE MENTORING MENTORSHIP (Mentee) ***(Mentee could fill this out after 3 months following orientation, observation and first assigned panel)***

Committee Name: **ICRC**	
Name of Mentee: **Dr. B.**	
Mentee Goals (e.g. leadership development, role function/skills training, succession functions)	
Goal 1 Technical Skills	Objectives Understand how to access and use the technology and tools (Laptops, SharePoint, Outlook email, how to download meeting materials to your laptop and using MS Teams or Skype for Business Platforms).
Goal 2 Knowledge and appropriate usage of ICRC Outcome Dispositions and applying the Risk Assessment Framework Tool	Objectives Learn all the available disposition outcomes for various types of investigations and how to assess and apply the Risk Framework to decision making
Goal 3 Learn and understand the relevant legislation, regulations, bylaws, and policies and how to apply these to the decision-making process and work.	Objectives Ensure compliance with relevant legislation, regulations, bylaws and policies are being followed in decision making process to allow reasonable decisions.

Goal 4 Review the submission and use the Members' Notes Template to write reasons ensuring all areas of concerns are addressed	Objectives Learn how to use the decision template to draft notes to address all areas of concerns and provide medical rational to support the proposed ICRC outcome decision.
Proposed Checkpoints based on Mentoring Timeframe: **(Check-in with Mentor) – every 3 months up to 9 months** **(Check-In with Chair of Committee) – at 6 months point to identify further training if needed**	
Telephone (Business):	**Telephone (Personal):**
Email address (Business):	**Email address (Personal):**
Mentee Signature:	
Committee Chair Signature (Date):	

EXAMPLE OF A SUCCESSION PLANNING MENTORSHIP

<table>
<tr><td colspan="2">Committee Name
Patient Relations Committee</td></tr>
<tr><td>Name of Mentor(s):
Chair</td><td>Name of Mentee:
Incoming Chair</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">Type of Mentorship (what is the primary purpose of this mentorship):

Role Mentoring: Role functions and expectations
Succession Mentoring: Leadership mentoring
Skills Mentoring: Chair panels, Decision Writing
Other: Cross-functional group mentoring across Committees</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">Mentee's Goals (e.g. leadership development, role functions, skill functions)</td></tr>
<tr><td>Goal 1 Meeting Facilitation Skills</td><td>Objectives

Learn/understand how to facilitate meetings. OR Chair at least 5 meetings in advance of assuming Chair role.

Ensuring appropriate conduct at meetings, for example respecting meeting norms.</td></tr>
<tr><td>Goal 2 To ensure reasonable and consistent decisions and ensure decisions are made in accordance with legislation.</td><td>Objectives

Lead discussion of applications at Committee meetings.
Correct members if they are not applying eligibility criteria correctly.</td></tr>
<tr><td>Goal 3 To ensure that the annual report to Council reflects the work of the Patient Relations Committee and provides Council with sufficient information.</td><td>Objectives

Participate in development of Annual Report prior to assuming role of Chair.</td></tr>
<tr><td>Goal 4 To ensure that relevant issues pertaining to the work of the Patient Relations Committee are brought to</td><td>Objectives

Work with staff to identify relevant issues in the</td></tr>
</table>

other College departments or Council as necessary and to recommend new initiatives to Council regarding CPSO's patient relations program as it pertains to sexual abuse, as appropriate.	year prior to assuming the role of Chair.
Proposed Checkpoints based on Mentoring Timeframe: **(Check-In with Mentor)** **(Check-In with Chair of Committee)** Time frame for mentee assuming the role of Chair (succession) will be approximately one-year. Before each Patient Relations Committee meeting, the mentor (current Committee staff) and mentee and Staff will meet to discuss issues pertaining to upcoming meeting as well as any concerns or needs that the mentee may have. At the end of each meeting which will be Chaired by the mentee, the mentee will ask for feedback from the Committee about their performance.	
Telephone:	**Telephone:**
Email address:	**Email address:**
Mentor Signature:	**Mentee Signature:**
Committee Chair Signature (Date):	

Council Motion

Motion Title: **Vote for 2020-2021 Governance Committee**

Date of Meeting: December ___ 2020

It is moved by_____,

and seconded by_____, that:

the Council appoints the following people to the 2020-2021 Governance Committee for the term indicated below:

Dr. Brenda Copps, Chair	**1 year**
Dr. Judith Plante, Vice Chair	1 year
Dr. Janet van Vlymen	1 year
XXX-Physician Member of Council	1 year
XXX-Public Member of Council	1 year
XXX-Public Member of Council	1 year

CPSO

Council Briefing Note

December 2020

TOPIC: **Governance Committee Report**

FOR DECISION:

- **2020-2021 Governance Committee Election**

ISSUE:

- As per the General By-Law,
- 44.-(1) The governance committee shall be composed of,
  - (a) the president, the vice-president and a past president;
  - (b) one councilor who is a member of the College and who is not a member of the executive committee; and
  - (c) two persons appointed to the Council by the Lieutenant Governor in Council who are not members of the Executive Committee.

  (2) A past president shall chair the governance committee.
- There will be an election for one physician member and two public members for the 2020-2021 Governance Committee (if more than one physician member is nominated and more than two public members are nominated). The vote will take place at the December 3-4 meeting of Council to fill these positions.
- Governance Committee members are expected to demonstrate the Key Behavioural Competencies for Council and Committee members. (Appendix A)

- One nomination has been received for one physician member position:
  - Dr. Ian Preyra
- Three nominations have been received for two public member positions:
  - Mr. Pierre Giroux
  - Mr. Mehdi Kanji

- Ms. Catherine Kerr

- Nomination Statements are included in Appendix B.

- Nominees will be given the opportunity to address Council, prior to the election.

- Where there is only one candidate for a position, the candidate will be acclaimed; where there is more than one candidate for a position, an election will be held using an electronic voting software that facilitates secret ballot voting (ElectionBuddy). All voting Council members must have access to their CPSO e-mail during the voting period to access the voting link.

- As per the General By-Law, the term for Governance Committee members is one year.

- Dr. Brenda Copps, as Past President, will serve as Chair for the 2021 Governance Committee.

DECISION FOR COUNCIL:

1. Vote, if applicable, for elected positions for 2020-2021 Governance Committee; one physician member and two public members on the Council. If applicable, appoint acclaimed nominees to the Governance Committee.

Contact: Dr. Peeter Poldre, Chair, Governance Committee
Laurie Cabanas, Director Governance & Policy
Debbie McLaren, Governance Coordinator
Laura Rinke-Vanderwoude, Junior Governance Analyst

Date: November 13, 2020

Attachments:

Appendix A: Key Behavioral Competencies of Council Members
Appendix B: Nomination Statements for:

- Dr. Ian Preyra

- Mr. Pierre Giroux
- Mr. Mehdi Kanji
- Ms. Catherine Kerr

Continuous Learning
Involves taking actions to improve personal capability and includes the ability to quickly understand and apply information, concepts, and strategies. Demonstrates an interest in continuous personal learning.

Creativity
Is generating new solutions, developing creative approaches, and implementing new approaches that lead to improved performance. It requires the ability to anticipate and lead change that contributes to organizational success.

Effective Communication
Is willing and able to see things from another person's perspective. Demonstrates the ability for accurate insight into other people's/group's behaviour and motivation, and responds appropriately. It is the ability to accurately listen, understand, and respond effectively with individuals and groups.

Planning & Initiative
Recognizes and acts upon present opportunities or addresses problems. Displays effective use of time management skills. Is able to plan and organize workflow and meetings in an efficient manner to address the opportunity or problem.

Relationship Building
Is working to build or maintain ethical relationships or networks of contacts with people who are important in achieving Council-related goals and the College mission.

Results Oriented
Makes specific changes in own work methods or systems to improve performance beyond agreed standards (i.e., does something faster, at lower cost, more efficiently; improves quality; stakeholder satisfaction; revenues, etc.).

Stakeholder Focused
Desires to help or serve others, meets the organization's goals and objectives. It means focusing one's efforts on building relationships and discovering and meeting the stakeholders' needs. Partnerships between internal colleagues within the College are essential to meet external stakeholders' needs.

Strategic Thinking
Understands the implications of decisions and strives to improve organizational performance. It requires an awareness of organizational issues, processes, and outcomes as they impact key stakeholders and the organization's strategic direction.

Teamwork
Demonstrates cooperation within and beyond the Council or the College. Is actively involved and "rolls up sleeves". Supports group decisions, even when different from one's own stated point of view. Is a "good team player", does his/her share of work. Compromises and applies rules flexibly and adapts tactics to situations or to others' response. Can accept setbacks and change own immediate behaviour or approach to suit the situation. Is candid about opinions and raises justified concerns.

APPENDIX B

MR. PIERRE GIROUX

Public Member of Council
Toronto, Ontario

Occupation: Sales and Marketing

Appointed Council Terms:
2012-2016
2016-2019
2019- December 4, 2022

CPSO Committees and Other CPSO Work:

Discipline Committee:	2013 - 2020
Executive Committee:	2015 - 2017
Finance and Audit Committee:	Chair: 2014 - 2017, Member: 2013 - 2020
Quality Assurance Committee:	2013 - 2019
Registration Committee:	2018 - 2020
Policy Working Group: *Prescribing Drugs*	March 2018 – December 2019

NOMINATION STATEMENT:

Governance is defined as how society or groups within it organize to make decisions. At this College, this means the Council members have a voice in decision making and that good governance mediates differing interests to reach a broad consensus in the best interests of the group.

We must also have a strategic plan and a long- term perspective on which the strategic vision is grounded.

Finally, we need to ensure that there is accountability, transparency, and fairness in all our actions so that we are perceived as acting in the interest of the physician members of the College and our stakeholders the general public to whom we are ultimately accountable.

As the longest serving public member of Council and having been an active participant in many Committees, I believe I bring a broad knowledge of the working of this College and can make a meaningful contribution to its Governance.

MR. MEHDI KANJI

Public Member of Council
Richmond Hill, Ontario

Occupation:
Director, MK Consulting (current)
Project Director, Courthouse Development Projects (retired)

Appointed Council Terms:
2018 – 2021
Reappointment Status: Pending

CPSO Committees and Other CPSO Work:

Discipline Committee:	2018-2020
Governance Committee:	2019-2020
New Council Member Orientation and Education Working Group:	2020

NOMINATION STATEMENT:

I have spent my professional career in the public sector with the Government of Ontario in several ministries in various leadership positions in human resources management, policy development, stakeholder management, labour relations, and in public/private partnerships for courthouse construction projects.

I was elected to the Governance Committee last year. In the past year, the Governance Committee has embarked on several innovative projects in support of good governance of the College and also planning for governance reform. There remains much work to be done and continuity in membership is crucial. I believe I can make a significant contribution with my diversity of experiences and competencies as the College moves forward with its journey on governance review. I have really enjoyed my participation on the Committee and would like to continue my involvement for another year.

Since joining CPSO, I have been serving on the Discipline Committee and more recently on the Council Member Orientation and Education Working Group.

I would very much appreciate your support for election on the Governance Committee for 2021.

DR. IAN PREYRA

District 4 Representative
Burlington, Ontario

Principal Area of Practice or Specialty:
Emergency Medicine

Elected Council Terms:
2019-2022

CPSO Committees and Other CPSO Work:

Discipline Committee	2019 – 2020

NOMINATION STATEMENT:

The privilege of self-governance afforded to physicians in Ontario carries with it a commitment to the public to effectively regulate the province`s doctors in a transparent, accountable manner. It also requires that the CPSO communicates with our members and with the public as we fulfill our regulatory responsibilities, and perform our mission with compassion and sensitivity.

The CPSO's commitment to renewing our governance structures in the face of evolving government policy offers an unprecedented opportunity to redefine the framework within which we deliver on our promise of Trusted Doctors Providing Great Care.

I bring to the Governance Committee deep experience in corporate governance, having served on both public and private boards. I am a member of the Institute of Corporate Directors, have formal governance training, and will be certified as a Chartered Director. I received my MBA from the Schulich School of Business, with a focus on finance and organizational behaviour.

In my current roles, I am Chief of Staff at Joseph Brant Hospital, a Coroner and team emergency physician for the Toronto Maple Leafs.

If elected, I will serve with integrity, thoughtfulness and industry, and to advance our Mission by working to create a governance structure that effectively serves the public and the membership.

MS. CATHERINE KERR

Public Member of Council
Toronto, Ontario

Occupation: Management, Operations, Corporate Services, Ontario Government, Ministry of Health and Long-Term Care

Appointed Council Terms:
2018-2021
Reappointment Status: Pending

CPSO Committees and Other CPSO Work:

Inquiries, Complaints and Reports Committee:	2018-2020

NOMINATION STATEMENT:

First, I would like to say that I am not seeking your support for the vacancy on Governance Committee because I think I am better equipped than any other public appointee. I simply feel that it is beneficial for appointees and agencies to have opportunities to participate and make contributions during their tenure.

I have a comprehensive appreciation for the challenging role of regulatory colleges. I have been a public appointee to the CPSO for the past 2 ½ years and have sat on many ICRC Panels. Prior to this, I was a public member on the Council of the Royal College of Dental Surgeons of Ontario. During that time, I was a member of the Executive, Quality Assurance and Patient Relations Committees (Chair) and numerous working groups. I also had the opportunity to benefit from the insights of Harry Cayton and Linda Rothstein (who spoke at one of our recent Council meetings) and many other scholars who shared their expertise on various subjects related to self-regulation and governance.

All regulated health agencies are in the fortunate position of being self-regulating. That is quite a responsibility – but it provides opportunities for Colleges to play a major role in establishing and implementing steps to continue to protect the public by ensuring quality health care in a safe environment by trusted health professionals.

Self-regulation also reflects a high level of confidence in an agency's ability to govern itself and fulfil its mandate in a way that instills trust and confidence by the public, members of the profession and other outside stakeholders.

I hope that you consider my application to make a meaningful contribution as the College continues to move forward in planning and implementing governance reform.

Council Motion

Motion Title: Quality Assurance Committee Request for Exceptional Circumstances

Date of Meeting: December __, 2020

It is moved by_____,

and seconded by_____, that:

Council approves the application of the exceptional circumstances clause in Section 37 (8) of the General By-Law in respect to Dr. Patrick Safieh, when his appointment to the Quality Assurance Committee expires at the Annual General Meeting of Council in December 2020.

CPSO

Council Briefing Note

December 2020

TOPIC: **Governance Committee Report**

FOR DECISION:

Quality Assurance Committee Request for Exceptional Circumstances

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ISSUE:

Request for Exceptional Circumstances

- The Governance and Executive Committees have reviewed a Quality Assurance Committee (QAC) Request for Exceptional Circumstances at its meetings on November 4, 2020 and November 10, 2020 and is putting forward a recommendation for Council approval (Appendix A).

BACKGROUND:

Request for Exceptional Circumstances

- Council approved 14 requests for exceptional circumstances, which extends the terms of certain Committee members for another year, ending December 2021.
- The Governance Committee continues to encourage Committees to revisit succession plans at least twice a year in order to have the right mix of members on a Committee, whose skills together, could effectively discharge the responsibilities of the Committee.

Exceptional Circumstances

- Although Dr. Safieh was approved by the Governance Committee to transition off QAC in December 2020, the Chair of QAC has requested that the Governance Committee consider a request (Appendix A) for exceptional circumstances for Dr. Safieh.

- The Committee has had an unprecedented year and is in the process of getting back on track.

Committee Member	Years on Committee	Reason for Extension
Dr. Patrick Safieh *(Family Medicine)*	12 years 10 months	-Very experienced member of QAC. There will be several departures of experienced Committee members this year and many remaining members have limited experience with panels and interviews. -As a Council member, he has a great understanding of the direction the College has directed regarding the quality improvement/quality assurance initiative -Provides continued experience and mentorship to committee members including Dr. Reid

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DECISION FOR COUNCIL:

- Council approves the application of the exceptional circumstances clause in Section 37 (8) of the General By-Law in respect to Dr. Patrick Safieh, when his appointment to the Quality Assurance Committee expires at the Annual General Meeting of Council in December 2020.

Contact: Dr. Peeter Poldre, Chair, Governance Committee

Laurie Cabanas (Director, Governance & Policy)
Suzanne Mascarenhas (Governance Analyst)
Debbie McLaren (Governance Coordinator)

Date: November 13, 2020

Attachment: **Appendix A:** QAC Request for Exceptional Circumstances

APPENDIX A

Exceptional Circumstances Request Form

Name of Committee	Quality Assurance Committee		
Committee Member	Dr. Patrick Safieh		
# of Yrs. on Committee	End of 2020: 12 years and 10 months	**Total Years of Service: 12 years and 10 months**	
Number of submissions for Committee Member/Year Requested	First submission for this member Date: November 3, 2020	**The Governance Committee will approve requests for one year at a time**	
Committee Member's Specific Knowledge, Skills or Experience	**Family Medicine** • Dr. Safieh is a very experienced member of QAC. There will be several departures of experienced committee members this year and many remaining members have limited experience with panels and interviews. • As a Council member, Dr. Safieh has a great understanding of the direction the College has directed regarding the quality improvement / quality assurance initiative. • Dr. Safieh was Co-chair of QAC from 2014 – 2017. With the recent resignation of both Co-chairs, there is a need for an experienced chair for mentoring and support of the new chair. • We commonly see family physicians on QAC panel meetings, and we need to ensure there is sufficient expertise in family medicine on the committee. We will be losing another experienced family medicine physician from QAC when Dr. Tsao finishes his term this year. • He is very fair in his committee work and he is someone who keeps calm under pressure. We have had some confrontational interviews with subject physicians. His demeanor helps to de-escalating the situations. He is well respected by his fellow QAC members. • For a period, he was a QA representative for the IHF Review Panels, and again, he was quick to get well versed in the IHFA program and different panel members. He was great in asking questions to further educate himself on these processes and was able to bring that knowledge to the QAC meetings when certain IHF Assessments were referred to the QAC. • Dr. Safieh works very well with the QA Committee Support team and has a very welcoming personality. • Dr. Safieh was the only physician on QAC who took the opportunity to do participate in QI program. He provided positive feedback and conveyed the positive aspects of this new program and he even admitted that there were process improvements in his own practice he identified through this QI program that he had never considered. • Given all the concerns raised this year with the QAC, Dr. Safieh has been very professional and when asked to speak about his thoughts about the QI program.		

Mentoring Strategy	• Dr. Safieh will be a key support and resource for mentoring of the new chair of QAC. • Given the number of years on the QAC, Dr. Safieh has mentored many of the family physicians who have come on board. When he is notified of new members joining, he takes the time to reach out to the new member and will avail himself to clarify any questions the new member has. • When he Chairs an MSI meeting and there are new members joining in an observation capacity, Dr. Safieh takes the time to go over how the meeting will proceed and encourages the new members to ask any questions regarding any material reviewed and/or decisions made. He does not rush and takes the time for the new members to be comfortable with how the committee functions. He also advises that the Committee support staff are great and always available to support the new member. • Given this year with Dr. Reid joining QAC with no formal training, Dr. Safieh agreed to provide assistance to Dr. Reid resulting in her smooth transition to the committee.
Requested Length of Extension	I year
Description of Recruitment Strategy and/or Succession Plan	Regarding recruitment strategy, I believe that Dr. Safieh will be able to support and provide feedback to Dr. van Vlymen in determining the future needs for QAC committee members.

23. Governance Committee Report

3. 2021-2022 Chair Appointments

4. Committee Appointment(s)

(Materials to follow)

CPSO