Meeting of Council

September 21 & 22, 2023

NOTICE
OF
MEETING OF COUNCIL

A meeting of the Council of the College of Physicians and Surgeons of Ontario (CPSO) will take place in person on September 21st and 22nd, 2023, in the Council Chamber of the College at 80 College Street, Toronto, Ontario.

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

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

The meeting will convene at 9:00 a.m. on September 21st, 2023.

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

September 5, 2023

Council Meeting Agenda

September 21-22, 2023

THURSDAY, SEPTEMBER 21, 2023

Item	Time	Topic and Objective(s)	Purpose	Page No.
1	**9:00 am** (10 mins)	**Call to Order and Welcoming Remarks** (R. Gratton) • Participate in roll call and declare any conflicts of interest	Discussion	N/A
2	**9:10 am** (5 mins)	**Consent Agenda** (R. Gratton) 2.1 Approve Council meeting agenda 2.2 Approve draft minutes from Council meeting held on June 8, 2023	Approval (with motion)	7-104
3	**9:15 am**	**Items for information:** 3.1 Executive Committee Report 3.2 Ontario Physicians and Surgeons Discipline Tribunal Cases 3.3 Government Relations Report 3.4 Policy Report 3.5 Medical Learners Report 3.6 Update on Council Action Items 3.7 2024 Council Meeting Dates	Information	 105-106 107-111 112-115 116-119 120-124 125-129 130
4	**9:15 am** (60 mins)	**CEO/Registrar's Report** (N. Whitmore)	Discussion	N/A
5	**10:15 am** (15 mins)	**President's Report** (R. Gratton)	Discussion	N/A
*	**10:30 am** (30 mins)	**NUTRITION BREAK**		
6	**11:00 am** (20 mins)	**Governance Committee Report** (J. van Vlymen) 6.1 Governance Committee Appointments 6.2 Chair and Vice-Chair Appointments and Reappointments 6.3 2023-2024 Committee Appointments and Reappointments	 Decision Decision Decision	 131-139 140-143 144-148
7	**11:20 am** (40 mins)	**General By-law** (C. Silver, M. Cooper) • Council is asked to provide feedback on proposed governance changes and other proposed amendments to the General By-law	Discussion	149-168

Item	Time	Topic and Objective(s)	Purpose	Page No.
*	**12:00 pm** (60 mins)	**LUNCH (Lunch available in the Dining Room)**		
	1:00 pm (1.5 hrs)	**General By-law** (C. Silver, M. Cooper) • Council is asked to provide feedback on proposed governance changes and other proposed amendments to the General By-law	Discussion	149-168
*	**2:30 pm** (30 mins)	**NUTRITION BREAK**		
	3:00 pm (1.5 hrs)	**General By-law** (C. Silver, M. Cooper) • Council is asked to provide feedback on proposed governance changes and other proposed amendments to the General By-law	Discussion	149-168
8	**4:30 pm**	**Adjournment Day 1** (R. Gratton)	N/A	N/A

FRIDAY, SEPTEMBER 22, 2023

Item	Time	Topic and Objective(s)	Purpose	Page No.
*	**8:30 am**	**INFORMAL NETWORKING (Breakfast available in the Dining Room)**		
9	**9:00 am** (10 mins)	**Call to Order** (R. Gratton) • Participate in roll call and declare any conflicts of interest	Discussion	N/A
10	**9:10 am** (40 mins)	**Spotlight on the Quality Program** (A. Jacobs, S. Reid) • Council receives a highlight on the Quality Improvement Program	Information	N/A
11	**9:50 am** (10 mins)	**Proposed Approval of Quality Improvement (QI) Enhanced as a program option for members aged 70-74** (A. Jacobs, N. Novak) • Council receives an overview of the QI Enhanced program and is asked to approve the transition of the QI enhanced as a program option for members aged 70-74	Decision (with motion)	169-171
*	**10:00 am** (30 mins)	**NUTRITION BREAK**		
12	**10:30 am**	**Motion to move in-camera**	Decision (with motion)	172
13	**10:30 am** (45 mins)	**In-Camera Items**		
14	**11:15 am** (30 mins)	**Declaration of Adherence and Code of Conduct Amendments (**C. Huang, M. Cooper, C. Allan) • Council is asked to consider approving the proposed amendments to the Declaration of Adherence and Code of Conduct	Decision (with motions)	173-193
15	**11:45 am** (15 mins)	**COUNCIL AWARD PRESENTATION** (Dr. Madhu Azad) Celebrate the achievements of Dr. Katherine Rouleau, Toronto		
*	**12:00 pm** (60 mins)	**LUNCH (Lunch available in the Dining Room)**		
16	**1:00 pm** (20 mins)	**Out-of-Hospital Premises (OHP) by-law updates** (J. Kitchen) • Council is asked to consider approving the circulation of the by-law amendments to the profession to reflect the new OHP Standards' requirements related to adverse events reporting	Decision (with motion)	194-197
17	**1:20 pm** (20 mins)	**PA Regulation: Registration and Membership fees – By-law amendments for consultation** (S. Tulipano) • Council is asked to approve the proposed by-law amendments for circulation to the profession	Decision (with motion)	198-203

Item	Time	Topic and Objective(s)	Purpose	Page No.
18	**1:40 pm** (20 mins)	**Final Policy for Approval - Human Rights in the Provision of Health Services** (T. Terzis) • Council is asked to consider approving the Human Rights in the Provision of Health Services policy as a policy of the College	Decision (with motion)	204-224
*	**2:00 pm** (30 mins)	**NUTRITION BREAK**		
19	**2:30 pm** (20 mins)	**Register and Member Information By-laws** (C. Silver, M. Cooper) • Council is asked to consider approving the by-law amendments to be put into effect at a future date	Decision (with motion)	225-238
20	**2:50 pm** (20 mins)	**Waiving the fees for out-of-province electives** (S. Tulipano) • Council is asked to consider approving the waiver of fees for out-of-province electives	Decision (with motion)	239-242
21	**3:10 pm**	**Adjournment Day 2** (R. Gratton) • Reminder that the next meeting is scheduled on December 7-8, 2023	N/A	N/A
*	**3:10 pm**	**Meeting Reflection** (R. Gratton)		

DRAFT PROCEEDINGS OF THE MEETING OF COUNCIL
June 8, 2023

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

June 8, 2023

Attendees

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

Non-Voting Academic Representatives on Council Present:

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

Regrets:

Ms. Lucy Becker

1. Call to Order and Welcoming Remarks

R. Gratton, President and Chair of Council called the meeting to order at 9:00 am. R. Patel delivered the land acknowledgment as a demonstration of recognition and respect for Indigenous peoples of Canada. R. Gratton welcomed all Council Members, including new Council Member, F. Bilal and the OMSA and PARO Representatives attending in person. He also welcomed staff and members of the public tuning in via YouTube. He reminded the meeting participants of the College's mission, vision, and values.

The following conflicts of interest were declared:

R. Kirkpatrick declared a conflict of interest with respect to the following items, Item 8: Draft Policies for Consultation: Academic Registration and Specialist Recognition Criteria in Ontario and Item 10: Draft Policies for Consultation: Recognition of RCPSC Subspecialist Affiliate Status and Specialist Recognition Criteria in Ontario.

G. Bandiera declared a conflict of interest with respect to the following items, Item 8: Draft Policies for Consultation: Academic Registration and Specialist Recognition Criteria in Ontario, Item 9: Draft Policy for Consultation: Practice Ready Assessment and potential fees, and Item 10: Draft Policies for Consultation: Recognition of RCPSC Subspecialist Affiliate Status and Specialist Recognition Criteria in Ontario.

J. van Vlymen declared a conflict of interest with respect to Item 6.4: 2024 Voting Academic Representative Selection.

There were no other conflicts of interest declared.

R. Gratton conducted a roll call and noted regrets.

2. Consent Agenda

R. Gratton provided an overview of the items listed on the Consent Agenda for approval.

01-C-06-2023

The following motion was moved by L. Miljan, seconded by S. Reid and carried, that:

The Council of the College of Physicians and Surgeons of Ontario approves the items outlined in the consent agenda, which include in their entirety:

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

CARRIED

3. For Information

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

3.1 Executive Committee Report

3.2 Ontario Physicians and Surgeons Discipline Tribunal Cases

3.3 Government Relations Report

3.4 Finance & Audit Committee Report

3.5 Policy Report

3.6 Medical Learners Reports – Ontario Medical Students Association (OMSA) and Professional Association of Residents of Ontario (PARO)

3.7 Update on Council Action Items

4. Chief Executive Officer / Registrar's Report

N. Whitmore, Chief Executive Officer and Registrar, presented her report to Council. She highlighted the College's mission, vision, values, and strategic pillars.

An overview was provided on the following department programs:

- Registration and Membership Services;
- Quality Improvement program including an update on the number of hospitals collaborating in the Quality Improvement partnership;
- Out of Hospital Premises Inspection Program;
- Patient & Public Help Centre;
- Ontario Physicians and Surgeons Discipline Tribunal.

A status update was provided on the Annual Renewal process noting that several enhancements were implemented.

On behalf of Council, the Executive Committee approved two new pathways, (i) Alternative Pathways to Registration for Physicians Trained in the United States and (ii) Recognition of Certification without Examination Issued by the College of Family Physicians of Canada (CFPC) policies. Both pathways have been utilized since coming into effect last month.

N. Whitmore advised Council that the Emergency Circumstances Practice Class of Registration Regulation approved by Council at the ad-hoc April 2023 meeting has been amended in accordance with government feedback. The Government requested that all Colleges have the same trigger for opening this class (that Council *or* the Minister of Health can open this class). Council will still determine qualifications and terms, conditions, and limitations.

An overview of the metrics and targets for the Key Performance Indicators was provided.

An update was provided on the Employee Pulse Survey with a 98 percent response rate; the top factors were reviewed (i) Diversity & Inclusion; (ii) Goals & Alignment; and (iii) Work Environment.

May 1, 2023 was Doctor's Day, and a message was sent out to the profession with a 64 percent open rate.

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

- Launch of the 2024 Council Award nominations
- Release of the Annual Report
- Dialogue Updates – Message to the profession highlighting Health Disinformation
- June 2023 Dialogue Issue features Primary Care Reform
- Pride Month is celebrated, In Dialogue Podcast episode and lunch and (Un)Learn session with Dr. Jordan Goodridge, a family physician, specialist in LGBTQ+ health and HIV primary care
- By-law Refresh
- Transformation: Implementation of Data Lake
- June 1st Launch of staff rewards & recognition platform (high5)
- Lean Update

Council thanked N. Whitmore and staff for all the hard work to date and the efforts underway.

5. President's Report and Emerging Issues

R. Gratton, President, presented his report to Council highlighting recent outreach activities, including a recent convocation address at Western University.

He highlighted a recent article in Dialogue entitled "Putting Patients First," noting that while there are multiple simultaneous crises, the CPSO continues to serve in the public interest and fulfill its mandate and strategic plan. The next article coming out in Dialogue will focus on addressing burnout, wellness, and moral injury.

As noted in N. Whitmore's report, the Executive Committee met on May 16 to approve the registration policies as highlighted in the Executive Committee Report to Council.

R. Gratton attended at several committee business meetings and conveyed a message of appreciation and thanks on behalf of Council.

Updates were provided on R. Gratton's participation in a recent In-dialogue podcast with Mr. Imran Ahmed on health disinformation and the launch of the enhanced Council Awards process for 2024 nominations. Council will have an opportunity to focus on governance modernization during the Council Education Session being held in the afternoon and a full day on June 9th.

He shared a few words of thanks from S., Chaudhry, former public Council Member.

There was discussion on the topics coming forward at the FMRAC Conference, including International Medical Graduates, how other jurisdictions are managing licenses and national licensure opportunities, as well as insights coming in from the United States and New Zealand. Council will be provided with an update following the conference.

6. Governance Committee Report

J. van Vlymen, Chair of the Governance Committee, provided the Governance Committee Report.

6.1 Council Elections Update

An update was provided on the Council election results, noting that all five incumbents from Districts 5 and 10 have been elected to serve an additional three-year term. In addition, Dr. Mitchell Whyne was the successful candidate elected in District 5. An overview of enhancements to the Council elections was provided, noting that the notice period was extended by one week, and photos were removed from Nomination Statements. Low voter turnout was noted.

6.2 Executive Committee Elections

J. van Vlymen provided an overview of the process for the Executive Committee Elections, noting that the appointments will be effective as of the end of the December 2023 Council meeting. Nomination statements have been received from the following individuals:

Dr. Ian Preyra, for President
Ms. Joan Fisk, for Vice-President or, alternatively, Executive Member Representative
Dr. Sarah Reid, for Vice-President or, alternatively, Executive Member Representative
Dr. Lydia Miljan (PhD), for Executive Member Representative
Dr. Patrick Safieh, for Executive Member Representative

In accordance with governance best practices, a call for nominations from the floor will no longer be part of the committee elections process. Each of the nominees for the vacant positions addressed Council prior to the election. An election for the Vice-President position was held using the electronic voting software (ElectionBuddy). The President position was acclaimed. Dr. Sarah Reid was elected for the Vice-President position. Joan Fisk, Lydia Miljan, and Patrick Safieh were acclaimed as Executive Member Representatives.

<u>02-C-06-2023</u>

The following motion was moved by P. Pielsticker, seconded by L. Marks de Chabris and carried, that:

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

Dr. Ian Preyra (as President),

Dr. Sarah Reid (as Vice President),

Dr. Patrick Safieh (as Executive Member Representative),

Ms. Joan Fisk (as Executive Member Representative),

Dr. Lydia Miljan (as Executive Member Representative),

and Dr. Robert Gratton (as Past President),

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

CARRIED

6.3 Committee Appointments

J. van Vlymen provided an overview of the Committee Appointments as set out in the briefing materials. Council was asked to consider four Registration Committee appointments and the appointment of Dr. Faiq Bilal (Ph.D.) to the Inquiries, Complaints and Reports Committee.

03-C-06-2023

The following motion was moved by S. Weber, seconded by C. Lemieux and carried, that:

The Council of the College of Physicians and Surgeons of Ontario appoints the following individuals to the following Committees for the terms indicated below, effective immediately:

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

CARRIED

J. van Vlymen departed the meeting for item 6.4 due to a conflict of interest.

6.4 2024 Voting Academic Representative Selection

On behalf of J. van Vlymen, R. Gratton provided an overview of the 2024 Voting Academic Representative selection recommended by the Governance Committee. He provided the rationale for the recommended slate of voting academic representatives on Council, noting that

members who serve on the Ontario Physicians and Surgeons Discipline Tribunal must be voting members of Council.

04-C-06-2023

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

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

Dr. Janet van Vlymen,

Dr. Roy Kirkpatrick, and

Dr. Marie-Pierre Carpentier.

CARRIED

J. van Vlymen rejoined the meeting.

7. Final Approval: Revised Draft Out-of-Hospital Premises Standards

L. Reid, Director, Investigations and Accreditation, and T. Terzis, Interim Manager, Policy, provided an overview of the revised draft Out-of-Hospital Premises (OHP) Standards, noting that the draft standards previously brought to Council have been revised and are coming back to Council for final approval. The draft OHP standards have been modernized and updated, with a focus on areas of greatest risk and expectations that are principle-based. Generally, positive feedback was received on the standards, and highlights on key updates were provided. It was noted that key changes included updates to the scope of program, patient selection guidance, and expectations for OHPs that provide overnight or extended stays. Additionally, OHPs have historically been classified by levels, based on the procedures done in the premises and the type of anesthesia used, and those levels have been re-instated.

Next steps were provided; the approved standards will be added to the website and Dialogue, and notification will be provided to the OHPs. There was discussion on the level of the Medical Director responsibility and timing as to the implementation of the standards. Standards are expected to come into force immediately. Following discussion, Council expressed support for approving the revised draft OHP standards.

05-C-06-2023

The following motion was moved by D. Robertson, seconded by P. Malette and carried, that:

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

CARRIED

G. Bandiera departed the meeting for items 8, 9, and 10 due to a conflict of interest.

R. Kirkpatrick departed the meeting for items 8, and 10 due to a conflict of interest.

8. Draft Policies for Consultation: Academic Registration and Specialist Recognition Criteria in Ontario

S. Tulipano, Director, Registration and Membership Services, provided an overview of the draft Academic Registration and the draft Specialist Recognition Criteria in Ontario policies. An overview was provided on the current Academic Registration policy and the proposed changes to remove the practice assessment requirement. Such changes will also affect the Specialist Recognition Criteria in Ontario policy.

Following questions and discussion, Council expressed support to engage in the notice and consultation process in respect of the policies. Council also expressed support for the Executive Committee to approve the final policies on behalf of Council in the interests of time, subject to feedback received.

06-C-06-2023

The following motion was moved by S. Weber, seconded by R. Payne and carried, that:

The Council of the College of Physicians and Surgeons of Ontario engage in the notice and consultation process in accordance with Section 22.21 of the Health Professions Procedural Code in respect of the draft revised policy, "*Academic Registration*" (a copy of which forms Appendix "B" to the minutes of this meeting) and the draft revised policy, "*Specialist Recognition Criteria in Ontario*" (a copy of which forms Appendix "C" to the minutes of this meeting).

CARRIED

R. Kirkpatrick rejoined the meeting.

9. Draft Policy for Consultation: Practice Ready Assessment Program

S. Tulipano, Director, Registration and Membership Services, provided an overview of the Practice Ready Assessment Program policy, noting that the Practice Ready Ontario (PRO) is a Ministry initiative that provides an assessment process to facilitate qualified international medical graduates (IMGs) to enter practice. The CPSO is the licensing component and is supporting the development and implementation of PRO by creating two registration policies that provide for the issuance of restricted certificates of registration. This is a new policy that will be published and come into force at a later date when PRO is ready for launch, which is anticipated in early 2024. An overview of the PRO process was provided, noting that a maximum of fifty candidates are anticipated in the first iteration. It was noted that all candidates applications will have to go to the Registration Committee prior to the issuance of certificates of registration.

Although the approval of the policy is not urgent, the Government has indicated its desire to have this part of the work complete. Following questions and discussion, Council expressed support to engage in the notice and consultation process in respect of the policy. Council also expressed support for the Executive Committee to approve the final policies on behalf of Council in the interests of time, subject to feedback received.

07-C-06-2023

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

The Council of the College of Physicians and Surgeons of Ontario engage in the notice and consultation process in accordance with Section 22.21 of the Health Professions Procedural Code in respect of the draft policy, "*Practice Ready Assessment Program*" (a copy of which forms Appendix "D" to the minutes of this meeting).

CARRIED

R. Kirkpatrick departed the meeting.

10. Draft Policies for Consultation: Recognition of RCPSC Subspecialist Affiliate Status and Specialist Recognition Criteria in Ontario

S. Tulipano, Director, Registration and Membership Services, provided an overview of the draft Recognition of RCPSC Subspecialist Affiliate Status and the draft Specialist Recognition Criteria in Ontario policies. It was noted that the Recognition of RCPSC Subspecialist Affiliate Status is a new policy. An overview was provided on the route to examination.

The Specialist Recognition Criteria in Ontario will also require amendments to reflect the addition of the Recognition of RCPSC Subspecialist Affiliate Status policy. Following questions and discussion, Council expressed support to engage in the notice and consultation process in respect of the policies. Council also expressed support for the Executive Committee to approve the final policies on behalf of Council in the interests of time, subject to feedback received.

08-C-06-2023

The following motion was moved by S. Weber, seconded by J. Goyal and carried, that:

The Council of the College of Physicians and Surgeons of Ontario engage in the notice and consultation process in accordance with Section 22.21 of the Health Professions Procedural Code in respect of the draft policy, "*Recognition of RCPSC Subspecialist Affiliate Status*" (a copy of which forms Appendix "E" to the minutes of this meeting) and the draft revised policy, "*Specialist Recognition Criteria in Ontario*" (a copy of which forms Appendix "F" to the minutes of this meeting).

CARRIED

G. Bandiera and R. Kirkpatrick rejoined the meeting.

11. Approval Item: Waiver of Certain Fees Under the Residents Working Additional Hours for Pay (“Moonlighting”) Policy

S. Tulipano, Director, Registration and Membership Services, provided an overview of the proposal to consider waiving the application fees for residents applying under the Residents Working Additional Hours for Pay (“Moonlighting”) Policy for the period from July 1, 2023, to June 30, 2024. It was noted that there are approximately 218 individuals holding a license under the policy.

There was discussion on the fee amount and whether this waiver should be permanent. This decision will be revisited next year. Council was asked whether it approves waiving the Moonlighting-related fees for the 2023-2024 academic year. Following discussion, Council expressed its support to waive the fees for the 2023-2024 academic year.

09-C-06-2023

The following motion was moved by C. Massarella, seconded by D. Robertson and carried, that:

The Council of the College of Physicians and Surgeons of Ontario approves waiving the application fees for residents holding a postgraduate education certificate of registration who apply for a restricted certificate of registration under the *Residents Working Additional Hours for Pay (“Moonlighting”)* Policy for the July 2023 to June 2024 academic year.

CARRIED

12. Finance and Audit Committee Update

T. Bertoia, Chair of the Finance and Audit Committee, provided an overview of the Finance and Audit Committee update. He turned the meeting over to M. Rooke, Auditor from Tinkham LLP, Chartered Accountants, to provide highlights from the audited financial statements, including an overview of the audit process.

12.1 Audited Financial Statements for the 2022 Year

M. Rooke noted that the audit was clean, the College has excellent internal controls, and that the auditors have no recommendations to improve internal control processes. Council members asked questions, and there were discussions on the intangible asset fund, membership fees, and strategic infrastructure planning.

12.2 For Approval: Audited Financial Statements for the 2022 Year

10-C-06-2023

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

The Council of the College of Physicians and Surgeons of Ontario approves the audited financial statements for the fiscal year ended December 31, 2022, as presented (a copy of which forms Appendix “G” to the minutes of this meeting).

CARRIED

12.3 For Approval: Appointment of the Auditor (for fiscal year 2023)

11-C-06-2023

The following motion was moved by C. Massarella, seconded by L. Marks de Chabris and carried, that:

The Council of the College of Physicians and Surgeons of Ontario appoints Tinkham LLP, Chartered Accountants, as auditors to hold office until the next annual financial meeting of Council.

CARRIED

13 Draft Regulations for Consultation: Physician Assistant Regulations

T. Terzis, Interim Manager, Policy, presented an overview of the draft Physician Assistant Regulations to Council. The proposed regulatory amendments are required in order to bring physician assistants (PAs) under CPSO's oversight. For example, the legislative framework requires that regulations be developed to articulate how PAs will perform controlled acts. An overview of each of the regulation amendments was provided, including the enabling regulation setting out the delegation framework, the registration regulation setting out the requirements to become PA members, the quality assurance regulation, and the professional misconduct regulation. The next steps were detailed, and it was noted that the regulation amendments will be released for a 60-day period. Following the consultation, the feedback will be reviewed, and the regulations will be brought back to Council, with revisions to incorporate feedback, if necessary.

There were discussions regarding delegation details, governance and infrastructure, and insurance. Following discussion, Council expressed support for releasing the draft regulations for external consultation and to engage in the notice and consultation process in accordance with the code.

12-C-06-2023

The following motion was moved by P. Malette, seconded by M. Azad and carried, that:

The Council of the College of Physicians and Surgeons of Ontario release for external consultation and engage in the notice and consultation process in accordance with Section 22.21 of the Health Professions Procedural Code, in respect of the draft physician assistant regulatory amendments to the *Medicine Act, 1991* regulations (a copy of which amendments form Appendices "H", "I", "J", and "K" to the minutes of this meeting).

CARRIED

14 Motion to move in-camera

13-C-06-2022

The following motion was moved by R. Payne, seconded by L. Marks de Chabris and carried, that:

The Council of the College of Physicians and Surgeons of Ontario exclude the public from the part of the meeting immediately after this motion is passed, under clauses 7(2)(b) and (d) of the Health Professions Procedural Code (set out below).

Exclusion of public

7(2) Despite subsection (1), the Council may exclude the public from any meeting or part of a meeting if it is satisfied that,

(b) financial or personal or other matters may be disclosed of such a nature that the harm created by the disclosure would outweigh the desirability of adhering to the principle that meetings be open to the public; and

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

CARRIED

15 In-camera Session

The Council of the College of Physicians and Surgeons of Ontario entered into an in-camera session at 2:30 pm and returned to the open session at 2:45 pm.

16 Close Meeting

R. Gratton closed the Meeting of Council at 2:45 pm on June 8, 2023. The next Council meeting is scheduled on September 21 and 22, 2023.

Chair | Recording Secretary

Out-of-Hospital Premises Standards

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Advice to the Profession: Medical Director

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Advice to the Profession: Patient Selection

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Advice to the Profession: Infection Prevention and Control

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Advice to the Profession: Quality Assurance

Out-of-Hospital Premises Inspection Program Overview

The Out-of-Hospital Premises Inspection Program (OHPIP) supports continuous quality improvement through developing and maintaining standards for the provision of procedures in Ontario out-of-hospital premises (OHPs) and by inspecting premises for safety and quality of care. The OHP Standards are intended to articulate the core requirements for the performance of procedures in certain settings/premises outside a hospital as defined in [Ontario Regulation 114/94] under the *Medicine Act, 1991* (hereinafter "the Regulation").

The OHP Standards are used for the inspection of premises and are applicable to all physicians who work in such premises. The OHP Standards include information applicable to the range of procedures performed in OHPs.

The OHPIP is overseen by CPSO's Premises Inspection Committee. Decisions made by the Premises Inspection Committee will be based on the information within these Standards as well as any additional relevant guidelines, protocols, standards and legislation (e.g., the Canadian Anesthesiologists' Society *Guidelines to the Practice of Anesthesia*, the *Food and Drugs Act*, etc.), including requirements set out by other regulatory bodies and provincial guidelines.

What is the purpose of the Regulation?

The Regulation creates the framework for the regulation of OHPs in Ontario and sets out which procedures are captured by the OHPIP, along with CPSO's powers and responsibilities in relation to inspection of OHPs.

The Regulation sets out specific criteria regarding the procedures that are captured by the OHPIP. How do I determine which procedures are captured by the OHPIP, and therefore can only be performed in an OHP that meets the requirements set out in the OHP Standards?

Any procedure performed under general or regional anesthesia or parenteral sedation is captured by the program and is therefore subject to the requirements set out in the OHP Standards, including approval of and inspection by CPSO.

Some procedures that are performed using local anesthesia are also captured by the Program. This includes any procedure performed with local anesthetic that is:

- A tumescent procedure involving the administration of dilute, local anesthetic
- A nerve block for chronic pain
- A cosmetic procedure involving the surgical alteration or removal of lesions or tissue; or
- A cosmetic procedure involving the injection or insertion of any permanent filler, autologous tissue (i.e., tissue from the patient's own body), synthetic device, materials or substances.

There are some procedures performed with local anesthetic that **are not** captured by the Program, including:

- A minor dermatological procedure such as the removal of skin tags, benign moles and cysts
- A procedure involving the alteration or removal of tissue where done for clinical and *not* cosmetic reasons

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- Procedures using only an external topical anesthetic (e.g., Lasik eye surgery).

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

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

What are the OHP Levels and how are they determined?

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

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

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

Local Anesthesia refers to the application, either topically, intradermally or subcutaneously, of agents that directly interfere with nerve conduction at the site of the procedure.

Sedation is an altered or depressed state of awareness or perception of pain brought about by pharmacologic agents and which is accompanied by varying degrees of depression of respiration and protective reflexes.

Minimal Sedation ("Anxiolysis") is a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.[2]

Moderate Sedation ("Conscious Sedation") is a drug-induced depression of consciousness during which patients respond purposefully[3] to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

Deep Sedation is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. Note: Due to the potential for rapid and profound changes in sedative/anesthetic depth and the lack of antagonist medications, patients that receive potent intravenous induction agents (including, but not limited to Propofol, Ketamine, Etomidate, and Methohexital) must receive care that is consistent with deep sedation even if moderate sedation is intended. These medications must be administered by a physician qualified to provide deep sedation.

Regional anesthesia: Major nerve blocks include, but are not limited to, spinal, epidural, caudal, retrobulbar, stellate, paravertebral, brachial plexus, transcapular, intravenous regional analgesia, celiac, pudendal, hypogastric, sciatic, femoral, obturator, posterior tibial nerve and cranial nerve block.

General anesthesia is regarded as a continuum of depressed central nervous system function from pharmacologic agents resulting in loss of consciousness, recall, and suppression of somatic and autonomic reflexes.

What are CPSO's responsibilities in relation to regulating OHPs?

CPSO's responsibilities include but are not limited to:

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

[1] The definitions of anesthesia have been adapted from the "Continuum of Depth of Sedation" and "Statement on Safe Use of Propofol" by the American Society of Anesthesiologists.
[2] For the purpose of the OHP Standards, sole or minimal use of oral anxiolysis for the purpose of pre-medication is not considered sedation.
[3] Reflex withdrawal from painful stimulus is NOT considered a purposeful response.

3. Approving OHP Medical Directors
4. Approving new OHP procedures
5. Conducting inspection of the premises and in some cases observing procedures to ensure that services for patients are provided according to the standard of the profession
6. Determining the outcome of inspections
7. Maintaining a current public record of inspection outcomes on CPSO's website
8. Issuing notices for payment of OHP fees.

What does the inspection process involve?

New premises or relocating premises will be inspected within 180 days of notification. All OHPs are inspected every 5 years, or more often if CPSO deems it necessary or advisable.

The inspection may involve but is not limited to:

1. completion of the on-line notification form
2. completion of a pre-visit questionnaire
3. a site visit by a nurse inspector appointed by CPSO that includes:
    - a review of records and other documentation
    - review of the OHP's compliance with accepted standards
    - review of any other material deemed relevant to the inspection
4. enquiries or observation of procedures, where relevant.

CPSO provides a copy of the inspection report to the Medical Director.

As outlined in the Regulation, the Premises Inspection Committee determines the inspection outcome and an OHP will be given either a "Pass", "Pass with Conditions", or "Fail" outcome.

What does a "Pass" outcome mean?

A "Pass" outcome means the OHP Standards are met for the specific procedures identified by the OHP at the time of the inspection and that no deficiencies were identified.

What does a "Pass with Conditions" outcome mean?

A "Pass with Conditions" outcome means that deficiencies have been identified in the OHP. If an OHP receives this outcome they may:

1. be restricted to specific procedures
2. be required to make submissions in writing to CPSO within 14 days of receiving the report
3. be subject to a follow-up inspection at CPSO's discretion within 60 days of receiving the OHP's written submission
4. receive a "Pass" outcome when deficiencies have been corrected to CPSO's satisfaction.

What does a "Fail" outcome mean?

A "Fail" outcome means that significant deficiencies have been identified in the OHP. Where a "Fail" outcome is given:

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1. All OHP procedures must cease in the OHP;
2. The OHP may make submissions in writing to CPSO within 14 days of receiving the report; and
3. A follow-up inspection may be conducted at CPSO's discretion within 60 days of receiving the OHP's written submission.

The Medical Director is responsible for ensuring compliance with the OHP Standards and providing any information necessary in relation to the premises. Failure to provide the information may result in an outcome of Fail by the Premises Inspection Committee, in accordance with the *Co-operation with the Out-of-Hospital Premises Inspection Program* Standard and may result in the removal of the Medical Director and direction to appoint a new Medical Director.

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Co-operation with the Out-of-Hospital Premises Inspection Program Standard

Those working in OHPs, including Medical Directors, have a duty to co-operate with the CPSO, to communicate promptly and accurately with CPSO, to foster a respectful relationship and demonstrate co-operation with the Out-of-Hospital Premises Inspection Program (OHPIP). Failure to co-operate, communicate with, or provide information to CPSO in the required manner may result in an outcome of Fail by the Premises Inspection Committee, which requires the OHP to cease operation of all OHP procedures, or may trigger a reinspection or a referral to CPSO's Inquires, Complaints, and Reports Committee.

Standards

1. All physicians practising in OHPs **must**:

    a. provide accurate information to CPSO, in the form and timeframe specified by CPSO;
    b. co-operate with inspections undertaken by CPSO in order to ensure compliance with the OHP Standards.

2. Medical Directors **must** annually confirm, in the form and manner required by CPSO, their understanding of their responsibilities as set out in the OHP Standards and that they are compliant with these responsibilities. This will include agreement to:

    a. perform their duties with due diligence and in good faith;
    b. ensure that the OHP complies with the OHP Standards and meets its responsibilities;
    c. ensure the OHP provides safe and effective care.

3. Medical Directors **must** respond to CPSO requests for documentation and information in the form and timeframe required, as follows:

    a. within 5 business days for information regarding adverse events;
    b. within 14 days for regular CPSO requests, or
    c. any otherwise specified timeframe as identified by CPSO for other CPSO requests.

4. Medical Directors **must** ensure the OHP does not:

    a. operate in contravention of the OHP Standards; and/or
    b. operate in contravention of any conditions or restrictions imposed by the OHPIP and/or the Premises Inspection Committee.

5. Medical Directors **must** ensure OHPs cease performance of all OHP procedures if they receive a fail outcome from an inspection.

6. All physicians planning to practise in an OHP **must** complete the online Staff Affiliation form prior to performing procedures in an OHP.

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Notification to CPSO

7. Medical Directors who plan to operate a new OHP **must** notify CPSO of their plans to do so.

8. Medical Directors **must** ensure that no procedures are performed in the OHP until they receive approval from the OHPIP to do so and that only approved OHP procedures are performed.

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

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

    a. ownership of the OHP
    b. name of the OHP
    c. numbers of procedures performed: any significant increase/decrease (>50% of the last reported inspection)
    d. a new arrangement to rent space to other physicians intending to perform OHP procedures
    e. decision to cease operation of the OHP[2]
    f. intention to provide extended or overnight stays[3].

11. Medical Directors **must** notify CPSO in writing at least two weeks or as soon as reasonably possible prior to any of the following intended changes to the OHP and receive approval (and where necessary undergo a re/inspection):

    a. OHP Medical Director (in accordance with the *Medical Director* Standard);
    b. OHP location/address;
    c. structural changes to patient care areas (including equipment);
    d. addition of new OHP procedures.

Inspection Process

12. Medical Directors and physicians practising in the OHP **must** participate fully in the inspection process and comply with CPSO requests in relation to this process, including:

    a. submitting to an inspection of the OHP;
    b. promptly answering any questions or complying with any requirement of the inspector that is relevant to the inspection;
    c. co-operating fully with CPSO and the inspector who is conducting the inspection;

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[1] Please see the *Adverse Events* Standard for more information.
[2] For more information on the appropriate steps to follow when ceasing operation, please see CPSO's *Closing a Medical Practice* policy.
[3] An extended or overnight stay is where a patient has not met discharge criteria and is required to stay in the OHP beyond normal operating hours.

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

13. Medical Directors **must** ensure that complete records are onsite and available to the CPSO and inspector on the date of planned inspections, including all books, accounts, reports, records, or similar documents that are relevant to the performance of a procedure done in the OHP.

14. Medical Directors **must** be on site during inspections, where requested.

15. Medical Directors **must** participate in any requested post inspection processes (e.g., an exit interview with the inspector, completion of a post inspection questionnaire, and providing any required follow-up documentation).

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Advice to the Profession: Co-Operation with the Out-of-Hospital Premises Inspection Program Standard

As the Medical Director, how do I need to annually confirm my understanding of my responsibilities?

Medical Directors will need to confirm their understanding of their responsibilities through an Annual Attestation. This attestation is made as part of the annual premises renewal process and is done through the CPSO Member Portal.

If I am planning to operate a new OHP, what do I need to do?

Before you can perform any procedures at a new OHP you will need to complete and submit a New Premise Application, pay the required fee and pass a premise inspection, which will be conducted within 180 days of receiving your notice. To complete the application:

1. log into the CPSO Member Portal,
2. click on the OHP tile,
3. click on the New Premises Application button.

Where I am required to notify CPSO of specific changes to the OHP, how do I do this?

You will need to complete a New Request or Notification form and include as many details as possible regarding the change to the OHP. CPSO will then decide if your OHP needs to be re-inspected. To complete a New Request or Notification form:

1. log into the CPSO Member Portal,
2. click on the OHP tile,
3. click on the OHP number of the OHP for which you wish to make changes,
4. click on OHP Requests/Notifications on the left-hand navigation,
5. select the appropriate request or notification button.

What information needs to be available for inspections?

The Standard requires that the Medical Director ensures that complete records are onsite on the date of the inspection. In carrying out an inspection of an OHP, the inspector may require any examination and copies of books, accounts, reports, records or similar documents that are, in the opinion of CPSO, relevant to the performance of the OHP.

More information related to inspections can be found in the *Out-of-Hospital Premises Inspection Program Overview* document.

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Medical Director Standard

Definitions

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

Acting Medical Director: An Acting Medical Director refers to a CPSO approved physician who is overseeing the OHP in the absence of the Medical Director.

Standards

1. All OHPs **must** have a Medical Director or an Acting Medical Director who has been approved by CPSO, and who is responsible for oversight of the OHP, including ensuring compliance with all applicable legislation, regulations, by-laws, CPSO policies, and the OHP Standards.

2. Medical Directors **must** annually affirm their compliance with their responsibilities in relation to the OHP, in the manner and form required by CPSO (e.g., complete the Annual Attestation[1]).

Qualifications

3. Physicians acting as a Medical Director in an OHP **must** have the skills and experience necessary to effectively oversee the OHP[2] and **must** at minimum meet the following criteria:

    a. reside in Ontario;
    b. hold a valid and active CPSO certificate of registration;
    c. not be the subject of any disciplinary or incapacity proceeding in any jurisdiction;
    d. not have lost their hospital privileges or been terminated from employment for reasons of professional misconduct, incompetence, or incapacity; and
    e. not have any terms, conditions or limitations on their certificate of registration that would impact their ability to fulfill the role of a Medical Director.[3]

4. Medical Directors **must** inform the CPSO if they become the subject of a disciplinary or incapacity proceeding and may be required to appoint an Acting Medical Director at the discretion of CPSO.

    a. The Medical Director **must** only resume the role upon CPSO approval.

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[1] Please see the *Co-operation with the Out-of-Hospital Premises Inspection Program* Standard for more information

[2] For more information about the types of skills and experience necessary to effectively oversee an OHP, please see the *Advice to the Profession* document.

[3] For additional considerations please see the *Advice to the Profession* document.

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Appointment of Acting Medical Director

5. Medical Directors **must** ensure that whenever they are unable or unavailable to perform their duties, they have designated another physician practising in the OHP to do so.

6. Medical Directors who plan to take an extended leave of absence or who will be unable to fulfill the duties of their role for one month or more, **must** inform CPSO, who will then determine whether an Acting Medical Director needs to be appointed.

7. Where an Acting Medical Director needs to be appointed, Medical Directors **must** ensure the Acting Medical Director:

    a. meets the criteria set out in provision 3 above; and
    b. is approved by CPSO.

8. Where an Acting Medical Director is appointed, the Acting Medical Director **must** affirm their compliance with their responsibilities in relation to the OHP, in the manner and form required by CPSO (e.g., complete an Annual Attestation).

9. The Medical Director or Acting Medical Director **must** ensure that all staff working in the OHP are notified when an Acting Medical Director is appointed.

Credentialing and Ensuring Competence

Ensuring competence is a key component of the role of the Medical Director and Medical Directors are ultimately accountable and responsible for all the care provided in the OHP (i.e., for the care provided by the staff practising in the OHP).

10. Medical Directors **must** ensure there are policies and procedures addressing the issues set out in Appendix B, and that they are regularly reviewed, updated, and implemented.

11. Medical Directors **must** ensure that all staff practising in the OHP have the requisite knowledge, skill, and judgment to do so competently and safely and that they are practising within their scope of practice and any limitations of their certificate of registration.

12. Medical Directors **must** ensure all staff practising in the OHP have the appropriate qualifications[4] and competence prior to working in the OHP, by at minimum, ensuring the following:

    a. the training and credentials of all staff who wish to practise in the OHP have been reviewed and verified;
    b. all staff are in good standing with their regulatory body, where applicable (i.e., a Certificate of Professional Conduct has been reviewed) including that they:

        i. have a valid and active certificate of registration with their regulatory body;
        ii. are not the subject of any disciplinary or incapacity proceeding in any jurisdiction;
        iii. have not lost their hospital privileges or been terminated from

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

employment for reasons of professional misconduct, incompetence, or incapacity;

iv. do not have any terms, conditions or limitations on their certificate of registration that would impact their ability to practise in an OHP.

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

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

15. Medical Directors **must** ensure that all staff:

    a. read the Policies and Procedures (P&P) manual upon being hired and annually, or where there is a change, and confirm this action (e.g., with a signature and date);
    b. read their individual job descriptions of duties and responsibilities, indicating they have been read and understood (e.g., with a signature and date); and
    c. have professional liability protection as required by their regulatory body, where applicable.

Appropriate Supervision

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

17. Medical Directors **must:**

    a. be on site as needed, to oversee the premises and ensure the OHP is operating safely and effectively, at least one day per month; and
    b. be readily available to provide appropriate oversight and assistance, when necessary.

18. Medical Directors **must** be satisfied that all staff practising within the OHP:

    a. understand the extent of their responsibilities; and
    b. know when and who to ask for assistance, if necessary.

19. Medical Directors **must:**

    a. take reasonable steps to ensure that all staff are practising in accordance with the standard of care; and
    b. take appropriate action where there are concerns about the conduct or care of any staff practising in the OHP (e.g., concerns about the number of adverse events), including:

        i. Addressing and documenting the issue with the individual;
        ii. Ensuring appropriate remediation;
        iii. Suspending or terminating the individual, where appropriate;
        iv. Reporting to the professional's regulatory body, where necessary.

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Appendix A: Staff Qualifications

Appropriate qualifications generally include the following:

Qualifications for Physicians Performing Procedures

Physicians who perform procedures using local anesthesia in OHPs will hold one of the following:

a. Royal College of Physicians and Surgeons of Canada (RCPSC) or College of Family Physicians of Canada certification that confirms training and specialty designation pertinent to the procedures performed;
b. CPSO recognition as a specialist that would include, by training and experience, the procedures performed (as confirmed by the CPSO's *Specialist Recognition Criteria in Ontario* policy);
c. Satisfactory completion of all CPSO requirements for a physician requesting a change in their scope of practice (based on the CPSO policy, *Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice*). This may include physicians who are currently engaged in a CPSO approved change in scope of practice process.

Qualifications for Physicians Administering Anesthesia

Physicians Administering General or Regional Anesthesia or Deep Sedation

Physicians administering general or regional anesthesia or deep sedation will hold one of the following:

a. RCPSC designation[5] as a specialist in anesthesia;
b. Completion of a program accredited by the College of Family Physicians of Canada under the category of "Family Practice Anesthesia";
c. CPSO recognition as a specialist in anesthesia, or other specialty pertinent to the regional anesthesia performed, as confirmed by CPSO's *Specialist Recognition Criteria in Ontario* policy;
d. Satisfactory completion of all CPSO requirements for a physician requesting a change in their scope of practice (based on the CPSO policy, *Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice*). This may include physicians who are currently engaged in a CPSO approved change in scope of practice process.

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

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[5] Physicians who are trained in general or regional anesthesia or deep sedation but who have not been practising in this area for two years or more would be subject to CPSO's *Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice* policy, if they wished to return to this area of practice.

Physicians Administering Minimal to Moderate Sedation

Where a physician is not qualified to administer general anesthesia or deep sedation, but is administering minimal-to-moderate sedation, the physician will hold:

- Education and experience to manage the potential medical complications of sedation/anesthesia, including ability to:
    i. identify and manage the airway and cardiovascular changes which occur in a patient who enters a state of general anesthesia,
    ii. assist in the management of complications, and
    iii. understand the pharmacology of the drugs used, and
- Current ACLS certification.

Nurse Qualifications

Nurses working in OHPs will have training, certification, and appropriate experience as required for the procedures performed, including holding qualifications in accordance with those set out in the National Association PeriAnesthesia Nurses of Canada's *Standards for Practice*, where applicable, as well as current ACLS if administering sedation to, monitoring or recovering patients.

Qualifications for Physicians and Nurses Providing Pediatric Care

If pediatric care is provided to children 12 and under, all physician and nursing staff will:

a. be trained to handle pediatric emergencies; and
b. maintain a current PALS certification.

If administering or recovering pediatric patients from general or regional anesthesia or sedation, staff will need to have recent clinical experience doing so (i.e., within 2 years).

Reprocessing of Medical Equipment

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

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Appendix B: OHP Policies and Procedures

The OHP policies and procedures, which must be regularly reviewed, updated, and implemented include the following:

Administrative issues and responsibilities, including:

a. responsibility for developing and maintaining the policy and procedure manual,
b. scope and limitations of OHP services provided,
c. extended and overnight stays, if applicable (including a plan for managing any unplanned extended or overnight stays),
d. staff qualifications, hospital privileges, and records.

Response to emergencies, including those related to:

a. need to summon additional staff assistance urgently within the OHP,
b. fire,
c. power failure,
d. other emergency evacuation,
e. need to summon help by 911, and coordination of OHP staff with those responders.

Urgent transfer of patients, including:

a. appropriate transportation (e.g., ambulance) and accompaniment (e.g., Most Responsible Physician, OHP staff, etc.), and
b. timely transfer of relevant documentation/medical records.

Job Descriptions, including:

a. OHP staff job descriptions that define scope and limitations of functions and responsibilities for patient care; and
b. Responsibility for supervising staff.

Procedures related to:

a. Adverse events (i.e., monitoring, reporting, reviewing and response)
b. Combustible and Volatile Materials
c. Delegating controlled acts and medical directives
d. Routine maintenance and calibration of equipment
e. Infection control, including staff responsibilities in relation to the *Occupational Health and Safety Act*
f. Medications handling and inventory
g. Patient booking system
h. Detailed and clear patient selection/admission/exclusion criteria for services provided
i. Patient consent in accordance with CPSO's *Consent to Treatment* policy
j. Patient preparation for OHP procedures
k. Response to allergic reactions (e.g., latex)
l. Blood borne viruses in relation to exposure prone procedures (to support post exposure testing and ongoing monitoring)
m. Safety precautions regarding electrical, mechanical, fire, and internal disaster
n. Waste and garbage disposal

Forms used

Inventories/Lists of equipment to be maintained

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Advice to the Profession: Medical Director Standard

The role of the Medical Director is essential to ensuring safe and quality care within an OHP. The quality of the leadership and oversight of the OHP correlates with the quality of the care provided within the OHP.

Accordingly, many of the expectations set out within the OHP Standards are the responsibility of the Medical Director. This companion *Advice to the Profession* document *(Advice)* is intended to help Medical Directors interpret their obligations as set out in the *Medical Director* Standard and provide guidance around how the expectations may be effectively discharged.

The Medical Director Standard sets out minimum criteria that must be met in order to be a Medical Director. If I meet the minimum criteria, will I automatically be approved to be a Medical Director?

No. Satisfaction of minimum criteria does not guarantee approval to be a Medical Director. CPSO will exercise reasonable discretion in approving Medical Directors. Additional considerations may include, but will not be limited to, whether:

- a physician has active investigation(s) and the nature of the investigation(s) (e.g. whether the complaint has a specific impact on the ability to perform in the role);
- a physician is subject to any other regulatory activity or condition that may be relevant to the role;
- a physician is the subject of a discipline finding;
- a physician has had their certificate of registration revoked or suspended;
- the number of OHPs a physician is currently holding the role of a Medical Director for.

The Medical Director Standard requires that Medical Directors have the skills and experience necessary to effectively oversee the OHP. What are the skills and experience necessary to oversee an OHP?

Relevant skills needed to be effective in the role include strong leadership skills, relevant clinical expertise, and knowledge of relevant clinical practice guidelines, quality improvement, and infection prevention and control standards. There are a variety of ways in which the necessary skills and experience can be acquired. While some Medical Directors may have such knowledge, skills and experience before taking on this role, others may acquire the skills over time. For those seeking additional training to help develop the necessary skills, professional development is available. For example, leadership training is offered through programs such as the Canadian Medical Association's The Physician Leadership Institute.

I'm considering hiring a regulated health professional whose certificate of professional conduct (CPC) indicates they have an active investigation. Am I permitted to hire them?

It depends. The *Medical Director* Standard sets out minimum criteria that must be met for staff practising in an OHP. Given that Medical Directors are responsible for their staff and all of the care provided in the OHP, even if these criteria are met, Medical Directors will need to use their professional judgement and carefully consider the nature and seriousness of the complaint or investigation and how quickly it will be resolved.

Medical Directors are responsible for ensuring their staff are appropriately qualified and have the competence necessary to practise safely in an OHP. Depending on the nature and seriousness of the complaint or investigation (e.g., whether there are concerns about clinical competence) Medical Directors may wish to hold off on hiring the individual until the outcome of the investigation is known, or to take additional steps to satisfy their obligation to ensure the individual's competence. Medical Directors are ultimately responsible for the care provided in the OHP and for exercising due diligence when hiring.

What happens if CPSO determines that a Medical Director cannot fulfill their duties?

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

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

Whenever a Medical Director is unable to fulfill their duties as set out in the OHP Standards, they are required to ensure that another physician practising in the OHP will fulfill these duties. If the Medical Director will be unavailable or unable to fulfill their duties for one month or more they are required to notify the CPSO and where deemed necessary, appoint an Acting Medical Director who meets the criteria set out in the Standard and who is approved by CPSO. Temporary or short-term absences (less than a month) do not require the appointment of an Acting Medical Director that is approved by CPSO but do require the Medical Director to designate a physician within the OHP to perform their role while they are unavailable.

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Medical Directors are required to be on site as needed, but at least one day per month, to oversee the premises and ensure the OHP is operating safely and effectively. What kind of things would a Medical Director be doing when they are on site?

There are a number of responsibilities that Medical Directors have with respect to the OHP, including those related to supervision, quality assurance, and infection prevention and control. In order to effectively fulfill these duties, it is important that Medical Directors are on site as needed to oversee the premises, ensure that policies and procedures are being adhered to and to ensure that safe, quality care is being provided. The more present and involved a Medical Director is within the OHP, the better the patient care tends to be.

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Physicians Practising in Out-of-Hospital Premises Standard

Standards

1. All physicians practising in an Out-of-Hospital Premises (OHP) **must**:
   a. have completed the online Staff Affiliation form for each OHP they wish to practise in, prior to practising in that OHP;
   b. report any revocation, suspension, or restriction of hospital privileges to the Medical Director within 2 weeks;
   c. meet the standard of practice of the profession, which applies regardless of the setting in which care is being provided;
   d. practise within their scope of practice and within the limits of their knowledge, skill and judgement;
   e. comply with all applicable requirements in the OHP Standards, including:
      i. cooperating with and providing information to CPSO in accordance with the *Co-operation with the Out-of-Hospital Premises Inspection Program* Standard;
      ii. being appropriately qualified to perform all procedures they perform in that OHP, in accordance with Appendix A of the *Medical Director* Standard;
      iii. complying with pre-procedure, intra-procedure and post-procedure care requirements when performing procedures in accordance with the *Procedures Standard*;
      iv. complying with all infection prevention and control standards and requirements in accordance with the *Infection Prevention and Control* Standard;
      v. managing and reporting all adverse events in accordance with the *Adverse Events* Standard;
      vi. participating in quality assurance processes within the OHP, in accordance with the *Quality Assurance* Standard;
   f. comply with all applicable CPSO policies[1];
   g. comply with the requirements for the OHP set out by the Medical Director and all applicable policies and procedures of the OHP, including those set out in Appendix B of the *Medical Director* Standard; and
   h. comply with existing standards or guidelines from applicable speciality societies. [2]

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

Physical Space Standard

Standards

General[1]

1. Medical Directors **must** ensure that the requirements in Public Health Ontario's *Infection Prevention and Control for Clinical Office Practice* document regarding physical spaces, including the surgical space and reprocessing space, are met.

2. Medical Directors **must** ensure:

    a. The OHP complies with all applicable building codes including fire and safety requirements;
    b. All electrical devices are certified by the Canadian Standards Association (CSA) or are licensed for use in Canada;
    c. Any anesthetic or ancillary equipment and any medical compressed gases and pipelines comply with the CSA or be licensed for use in Canada;
    d. There is an emergency power supply that allows for safely completing a procedure that is underway and for recovering the patient (e.g., generator, uninterrupted power supply, etc.);
    e. Access for persons with disabilities complies with provincial legislation[2] and municipal bylaws;
    f. Necessary spaces can be accessed by and accommodate stretchers and wheelchairs;
    g. The size of the OHP is adequate for all the procedures that will be performed within it;
    h. The OHP layout facilitates safe patient care and patient flow; and
    i. At minimum, the following areas of the OHP are functionally separate:
        i. administration and patient-waiting area
        ii. procedure room and/or operating room
        iii. recovery area (where applicable)
        iv. clean utility area
        v. dirty utility room
        vi. reprocessing room (where applicable)
        vii. endoscope cabinet (where applicable)
        viii. staff change room and staff room.

3. Medical Directors **must** ensure the physical space allows for appropriate movement of patients in an emergency, including:

    a. safely evacuating patients and staff if necessary (e.g., stretchers, wheelchairs, or other adequate methods of transport are available), and

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

[2] *Accessibility for Ontarians with Disabilities Act, 2005*, S.O. 2005, c. 11.

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

Procedure Room/Operating Room Physical Standards

Physical Requirements

4. Medical Directors **must** ensure the OHP has:

    a. lighting as required for the specific procedure being performed;
    b. floors, walls, and ceilings that can be cleaned to meet infection control requirements;
    c. immediate access to hand-washing facilities and proper towel disposal;
    d. openings to the outside effectively protected against the entrance of insects or animals; and
    e. space sufficient to accommodate equipment and staff required for the procedure, and to move around while sterile, without contamination.

Ventilation

5. Medical Directors **must** ensure:

    a. there is ventilation sufficient to ensure patient and staff comfort, and fulfill occupational health and safety requirements;
    b. there is ventilation and air circulation augmented to meet manufacturer's standards and address procedure-related air-quality issues (e.g., cautery smoke, endoscopy, disinfecting agents, anesthesia gases), where applicable;
    c. air exchanges meet infection control standards[3] for the type of procedure being performed; and
    d. if using gas sterilization for reprocessing, a positive pressure outbound system is used and vented directly to the outside.

Equipment Maintenance and Inspection

6. Medical Directors **must** ensure:

    a. Medical equipment is maintained and inspected at least yearly and as necessary by a qualified biomedical technician and has an active service contract;
    b. Equipment necessary for emergency situations (i.e., defibrillators, oxygen supply, suction) is inspected on a weekly basis and documented;
    c. Related documentation for all equipment is available, including:
        a. record of certification of medical equipment by a qualified biomedical technician,
        b. equipment operating manuals,
        c. equipment maintenance contracts with an independent and certified biomedical technician, and
        d. log for maintenance of all medical devices.

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

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Recovery Area Physical Standards

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

8. For Level 2 and 3 facilities, Medical Directors **must** ensure:

   a. The size of the recovery area can accommodate the number of patients for two hours of operating room time (i.e., 1 hour procedure = 2 patients, 0.5 hour procedure = 4 patients); and
   b. The recovery area allows for transfer of patients to/from a stretcher and performance of emergency procedures.

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Drugs and Equipment Standard

Standards

Drugs - General

1. Medical Directors **must** ensure the following practices are undertaken in the OHP:

    a. a general drug inventory record is maintained;
    b. periodic inspection of all drugs is undertaken to ensure drugs are not expired;
    c. single dose vials of drugs are used wherever possible;
    d. if multidose vials of drugs must be used, they are dated on opening, disposed of according to manufacturer's guidelines, and are used in accordance with Public Health Ontario's *Updated Guidance on the Use of Multidose Vials*;
    e. drugs are labelled in accordance with the *Food and Drug Act*[1] and the *Controlled Drugs and Substances Act*[2] and any regulations made under those statutes;
    f. drugs are stored securely and in accordance with the manufacturer's recommendations (e.g., refrigeration if required); and
    g. emergency drugs are stored in a common location[3].

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

Controlled Substances

3. Medical Directors **must** ensure that controlled substances are:

    a. handled, stored, and administered in accordance with *Food and Drug Act* and the *Controlled Drugs and Substances Act* and any regulations made under those statutes;
    b. accessed by a qualified designated staff member[4];
    c. stored in a designated fixed and locked cabinet to prevent theft and loss; and
    d. accounted for in a "Log of Controlled Substances".[5]

4. Medical Directors **must** ensure that at the beginning and end of each day that controlled substances are used, a balance of the inventory is calculated by physical count and verified.

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

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[1] *Food and Drug Act* R.S.C., 1985, c. F-27, s. 1
[2] *Controlled Drugs and Substances Act* (CDSA)S.C. 1996, c.19
[3] A crash cart may be appropriate in OHPs where procedures are done in multiple procedure rooms.
[4] For example, an RN, RPN with medication skills, or a physician.
[5] For additional information on appropriate practices please see the Canadian Society of Hospital Pharmacist's *Controlled Drugs and Substances in Hospitals and Healthcare Facilities: Guidelines on Secure Management and Diversion Prevention.*

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Equipment – General

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

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

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

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

Drugs and Equipment for Urgent or Emergency Situations

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

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

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drugs, when necessary.

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

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

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

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

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

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[9] The drugs required will depend on the type of procedures and anesthesia used at the OHP. Please see the *Advice* document for more information on the drugs typically used to respond to the listed conditions.
[10] For more information see Malignant Hyperthermia Association of the United States' *What should be on an MH cart?*

Advice to the Profession: Drugs and Equipment Standard

Where can I find more information on how to appropriately store and handle controlled substances?

Additional information on appropriate practices relating to controlled substances can be found in the Canadian Society of Hospital Pharmacists' document *Controlled Drugs and Substances in Hospitals and Healthcare Facilities: Guidelines on Secure Management and Diversion Prevention.*

The Drugs and Equipment Standard requires drugs to be immediately available to respond to a number of urgent and emergency situations – which specific drugs are recommended?

Medical Directors are responsible for ensuring that the OHP has the appropriate drugs needed to address the situations outlined in the Standard. This may be achieved in a number of ways but generally speaking the following drugs will support physicians in managing urgent and emergency situations:

Hypertension

- Antihypertensive IV such as Labetalol, Hydralazine or Nitroglycerine (at least 1 for circumstances where sedation or regional anesthesia is being administered, and at least 2 where general anesthesia is being administered)
- BETA Blocker IV such as Metoprolol, Propranolol, Esmolol
- Intravenous diuretic such as Furosemide

Hypotension

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

Anaphylaxis

- Diphenhydramine IV
- Hydrocortisone IV
- Epinephrine

Cardiac Events

- Epinephrine
- Amiodarone IV
- ASA
- IV agent for supraventricular tachycardia such as Adenosine, Esmolol, Verapamil, or Metoprolol (at least 2 for circumstances where sedation or regional anesthesia is being administered, and at least 3 where general anesthesia is being administered)
- Nitroglycerine spray
- Atropine IV

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- Calcium IV
- Lidocaine 2% pre-filled syringe

Bleeding

- Tranexamic acid

Respiratory Events

- Bronchodilators

Malignant hyperthermia

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

Benzodiazepine Excess or Overdose

- Flumazenil IV

Opioid Excess or Overdose

- Naloxone IV - if narcotics are stocked

Electrolyte Disturbances

- Magnesium Sulfate IV
- Calcium IV

Hypoglycemia

- Dextrose 50% IV

Other

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

What kind of equipment is appropriate to have immediately available for urgent or emergency situations?

Medical Directors are responsible for ensuring that the OHP has the appropriate equipment needed to address the relevant urgent or emergency situations outlined in the Standard. This may be achieved in a number of ways but generally speaking, depending on the types of procedures being performed and the level of the facility, the following equipment will support physicians in managing urgent and emergency situations:

- AED (Level 1 facilities) or cardiopulmonary resuscitation equipment with current ACLS/PALS - compatible defibrillator (Level 2 and 3 facilities)
- IV setup
- Difficult Airway Kit
- Adequate equipment to manage local anesthetic toxicity

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- Appropriately sized equipment for infants and children, if required
- Assortment of disposable syringes, needles, and alcohol wipes
- Laryngeal mask airways
- Means of giving manual positive pressure ventilation (e.g., manual - self-inflating resuscitation device)
- Qualitative and quantitative means to verify end-tidal CO2
- ECG monitor
- Intubation tray with a variety of appropriately sized blades, endotracheal tubes, and oral airways
- Oxygen source
- Pulse oximeter
- Suction with rigid suction catheter
- Devices to provide active warming
- Torso backboard
- Cognitive Aids (for example, for difficult airways, ACLS algorithms, Malignant Hyperthermia, etc)

The *Physical Space* Standard contains requirements around maintaining and inspecting equipment. Please see that Standard for more information.

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Patient Selection Standard

Patient selection is a crucial component of ensuring procedures performed in an OHP are safe. The appropriateness of performing a procedure in the OHP setting depends on ensuring that the proposed procedure can be performed safely for that particular patient and their particular circumstances.

Standards

1. Physicians **must** use their professional judgement to determine whether a procedure can be provided to a particular patient safely and effectively in an OHP, on a case by case basis.

2. Physicians **must** only perform a procedure on a patient where they are satisfied that the procedure can be safely and effectively performed in the OHP, and it is in the patient's best interest to do so, taking into account:

    a. the patient's existing health status (e.g., any co-morbidities, frailty, stability of any existing conditions), their specific health-care needs and the specific circumstances;
    b. the potential complications that could arise from that specific procedure, including potential complications in surgical management if more than one procedure is to be performed at a time;
    c. anesthetic or sedation factors that may place the patient at a higher risk;
    d. the resources that may be required to perform a procedure on that particular patient;
    e. the duration of the procedure and the potential for a prolonged recovery period; and
    f. the location of the OHP and its proximity to emergency services or hospitals[1], should complications arise from the procedure.

3. Where a prospective patient would be required to undergo general or regional anesthesia or sedation, the physician administering the anesthesia or sedation **must** assign an ASA classification[2] for that prospective patient.

    a. Physicians **must** only perform Level 2 or 3 procedures on patients classified as ASA III if:
        i. the comorbid condition is unlikely to add significant risk to the anesthetic, sedation or procedure; and
        ii. the comorbid condition could not reasonably be expected to be adversely affected by the anesthetic, sedation, or procedure;
    b. The physician administering the anesthesia or sedation and the physician performing the procedure[3] **must**, where possible, discuss all potential ASA III cases well in advance of the scheduled procedure where more than mild sedation will be administered, with regard to the:

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[1] The *Adverse Events* Standard requires OHPs to have an established protocol to facilitate the urgent transfer of patients to the hospital for the management of an urgent adverse patient event.
[2] For more information on ASA classifications see the *Advice to the Profession* document.
[3] In a situation where the same physician is administering the anesthesia or sedation and performing the procedure (e.g., for surgical abortion), the physician will need to consider all ASA III cases in advance, including the considerations in provision 3.b., and consult with a colleague where appropriate.

iii. appropriateness of OHP setting for the safe performance of the procedure (including the factors listed in Provision 2 above),
iv. pre-procedure assessment and care required, and
v. intra-procedure and post-procedure requirements.

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Advice to the Profession: Patient Selection Standard

Why is patient selection so important in an OHP?

Appropriate patient selection is critical to help ensure that patients can receive safe care in OHPs. The Out-of-Hospital Premises Inspection Program has historically seen a number of adverse events that result from inappropriate patient selection. The *Patient Selection* Standard requires physicians to classify patients, prior to a procedure where general or regional anesthesia or sedation will be used, using the American Society of Anesthesiologists' Physical Status Classification System and only perform procedures on patients who are classified as ASA I, ASA II or, in some circumstances, ASA III. Generally, ASA IV patients are unsuitable to be treated in an OHP.

The process of determining suitability of a patient to undergo a procedure in an OHP involves the complex interplay of several factors, and there can be a significant difference in the way physicians classify patients and determine which ASA III patients they consider appropriate to treat in an OHP. The *Patient Selection* Standard and this Advice are intended to help physicians appropriately exercise professional judgment in relation to these patients.

How do I determine which ASA classification a patient should have?

In determining the appropriate ASA classification for a patient there are a number of factors that need to be considered. The table below[1] outlines some examples of conditions or diseases that would influence the determination of a patient's ASA classification.

ASA Classification	Definition	Adult Examples
I	A normal healthy patient	Healthy, non-smoking, no or minimal alcohol use
II	A patient with mild systemic disease	Mild diseases only without substantive functional limitations. Examples include (but not limited to): • current smoker, • well-controlled diabetes mellitus or hypertension, • mild lung disease
III	A patient with severe systemic disease	Substantive functional limitations; 1 or more moderate to severe diseases. Examples include (but not limited to): • poorly controlled diabetes mellitus or hypertension, • chronic obstructive pulmonary disease, • transient ischemic attack, • coronary artery disease/stents

[1] Modified from Rajan, N, Rosero E, and Joshi, G 2021, 'Patient Selection for Adult Ambulatory Surgery: A Narrative Review', *International Anesthesia Research Society*, vol. 133, no. 6, pp 1415-1430. Please see this article for more information.

What are key considerations when determining whether it's appropriate to perform a procedure on a patient in an OHP?

Several comorbid conditions have been demonstrated to have an effect on patient outcomes after procedures in an OHP type setting and therefore need to be carefully considered in patient selection. Independent factors identified by a majority of studies include:

- advanced age
- morbid obesity
- obstructive sleep apnea
- cardiac disease
- chronic obstructive pulmonary disease
- diabetes mellitus
- end-stage renal disease
- transient ischemic attack/stroke,
- chronic opioid use or opioid use disorder, and
- malignant hyperthermia.[2]

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

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

- have unstable or poorly managed chronic illnesses;
- have unmanaged alcohol or substance use disorders; or
- are undergoing active immunosuppressant cancer treatment.

Physicians are required to exercise their professional judgement when determining the appropriateness of performing procedures on patients in an OHP, and where they are unsure or where the patient is classified as ASA III and will be receiving more than mild sedation, are required to consult with the physician administering the anesthesia or sedation well in advance of the procedure.

Why do physicians need to discuss ASA III cases well in advance?

The *Patient Selection* Standard does allow room for professional judgement when it comes to determining which ASA III patients may be appropriate to have a procedure in an OHP. However, it is important that professional judgment in these circumstances be exercised in a considered way. Requiring that discussions take place between the physician who will be performing the procedure and the physician administering the anesthesia or sedation will help to ensure that both physicians have thought through the potential complicating factors of performing a procedure on the patient in the OHP setting, and both agree that it is appropriate to do so in the circumstances. It is important for discussions to take place in advance in order to manage patient expectations and avoid any pressure to perform a procedure that has been scheduled where it might not be appropriate.

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[2] Rajan, N, Rosero E, and Joshi, G 2021, 'Patient Selection for Adult Ambulatory Surgery: A Narrative Review', *International Anesthesia Research Society*, vol. 133, no. 6, pp 1415-1430.

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Procedures Standard

Standards[1]

1. Physicians **must** meet the standard of practice of the profession, which applies regardless of the setting in which care is being provided.

2. Physicians administering anesthesia or sedation **must** do so in accordance with the Canadian Anesthesiologists' Society *Guidelines to the Practice of Anesthesia,* including requirements for patient assessment, pre-procedural testing, fasting guidelines, patient monitoring, documentation of care in the patient record[2], and anesthesia support personnel.

   a. Where a physician is administering anesthesia or sedation to a pediatric patient they **must** do so in accordance with the Canadian Pediatric Society's *Recommendations for procedural sedation in infants, children, and adolescents*[3].

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

4. Medical Directors **must** ensure that care provided in the OHP complies with the National Association of PeriAnesthesia Nurses of Canada *Standards for Practice*, including requirements for appropriate staffing, discharge of patients from recovery phases, documentation of care in the patient record and appropriate discharge instructions.

5. Prior to procedure acceptance, physicians **must** have assessed the suitability of the patient to undergo the procedure in the OHP setting in accordance with the *Patient Selection* Standard.

   a. For patients with significant co-morbidities, physicians **must** undertake appropriate consultation (for example, discussion with an anesthesiologist or other specialists) as required, prior to making a decision to proceed with the procedure in the OHP setting.

Pre-Procedure Requirements

6. Physicians **must** provide appropriate pre-procedure instructions to patients including any fasting instructions, and whether they will require adult accompaniment upon discharge from the OHP.

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

8. Where anesthesia or sedation will be administered, the physician administering the anesthesia or sedation **must**, on the day of the procedure, undertake a pre-anesthetic assessment.

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[1] Where this standard uses the term "physician" the expectation can be fulfilled by either the physician performing the procedure, or the physician administering the anesthesia or sedation. Expectations that must be fulfilled by a specific physician state this explicitly.
[2] For more information on appropriate documentation, please see the *Advice to the Profession* document.
[3] While this resource may refer to hospitals, the expectations will equally apply in an OHP setting.

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9. Physicians **must** ensure informed consent has been obtained for the procedure, including the use of anesthesia or sedation where applicable, in accordance with CPSO's *Consent to Treatment* policy.

Intra-Procedure Care for Mild and Moderate Sedation and Regional Anesthesia

10. If the physician administering the regional anesthesia or sedation is also performing the procedure[4], the physician **must** ensure the patient is attended by a second individual[5] who is solely responsible for actively monitoring the patient and is appropriately qualified, in accordance with Appendix A of the *Medical Director* Standard, to monitor patients undergoing regional anesthesia or sedation.

Post-Procedure Patient Care

11. A physician **must** remain on site until the patient has met discharge criteria for the most acute phase of recovery, in accordance with the National Association of PeriAnesthesia Nurses of Canada *Standards for Practice*.

Extended and Overnight Stays[6]

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

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

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

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

Patient Discharge After Anesthesia or Sedation

14. When a patient is being discharged, a physician **must:**

    a. write the discharge order for a patient, and
    b. direct that a summary of the care provided be distributed to the patient's primary care provider (e.g., an operative or procedural note), if there is one and, the patient has provided consent.

15. Recovery area staff **must** ensure that patients are:

    a. provided with appropriate written discharge instructions[7];
    b. accompanied by an adult when leaving the OHP, and are advised to have an adult stay with the patient during the postoperative period (most commonly 24 hours);
    c. informed that they need to notify the OHP of any unexpected admission to a hospital within 10 days of the procedure.

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[7] For example, no driving for 24 hours, who to contact for routine and emergency follow-up, and instructions for pain management, wound care, and activity.

Advice to the Profession: Procedures Standard

What kind of pre-procedure assessments are appropriate to undertake before performing a procedure on a patient in an OHP?

The *Procedures* Standard requires that an appropriate pre-procedure assessment is undertaken by the physician performing the procedure including a baseline history and physical examination.

Where anesthesia or sedation will be administered, the Standard also requires the physician administering the anesthesia or sedation to complete a pre-anesthetic assessment. Such an assessment would typically include the following:

- American Society of Anesthesiologists' (ASA) physical status classification of the patient
- a review of the patient's clinical record (including pre-procedure assessment)
- an interview with the patient
- a physical examination relevant to anesthetic aspects of care
- a review and ordering of tests as indicated
- a review or request for medical consultations as necessary for patient assessment and planning of care
- a review of pre-procedure preparation such as fasting, medication, or other instructions that were given to the patient.

When determining which tests are indicated or appropriate for a particular patient, physicians may wish to consult Choosing Wisely Canada's recommendations in relation to anesthesia.

What elements of patient care need to be documented when administering anesthesia or sedation in an OHP?

When anesthesia or sedation is administered, an Anesthesia/Sedation Record is required to be completed. A typical Anesthesia/Sedation record includes the following information:

a. pre-procedure anesthetic/sedation assessment
b. all drugs administered including dose, time, and route of administration
c. type and volume of fluids administered, and time of administration
d. fluids lost (e.g., blood, urine) where it can be measured or estimated
e. measurements made by the required monitors:
    - Oxygen saturation must be continuously monitored and documented at frequent intervals (at least every 5 minutes). In addition, if the trachea is intubated, a supraglottic airway is used, or moderate to deep sedation is being administered, end-tidal carbon dioxide concentration must be continuously monitored and documented at frequent intervals
    - Pulse and blood pressure documented at least every 5 minutes until patient is recovered from sedation
    - Temperature and neuromuscular blockade monitors
f. complications and incidents (if applicable)
g. name of the physician responsible (and the name of the person monitoring the patient, if applicable)

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h. start and stop time for anesthesia/sedation care.[1]

What elements of care need to be documented during the recovery period?

In relation to care provided during the recovery period appropriate documentation would typically include:

a. patient identification
b. date and time of transfer to recovery area
c. initial and routine monitoring of: blood pressure, pulse, respirations, oxygen saturation, temperature, level of consciousness, pain score, procedure site and general status
d. continuous monitoring of vital signs until the patient has met requirements of discharge criteria using an objective scoring system from time of transfer to recovery area until discharge
e. medication administered: time, dose, route, reason, and effect
f. treatments given and effects of such treatment
g. status of drains, dressings, and catheters including amount and description of drainage
h. summary of fluid balance
i. discharge score using a validated discharge scoring system.

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

CPSO's *Medical Records Documentation* policy states that the goal of the medical record is to "tell the story" of the patient's health care journey. In order to ensure that a full picture of the patient's health care journey is reflected in their record, the following documents or notes would typically be included:

- Documentation of the consent process in accordance with CPSO's *Consent to Treatment* policy, including a record of any forms that were used
- Pre-procedure assessment
- A copy of the completed Surgical Safety Checklist
- The Anesthetic/Sedation Record
- Discharge summary, where applicable
- Any adverse event reports, as required by CPSO.

[1] For more information see the Canadian Anesthesiologists' Society *Guidelines to the Practice of Anesthesia*.

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Infection Prevention and Control (IPAC) Standard

All OHP staff are responsible for complying with appropriate IPAC practices and for taking action where inappropriate practices are occurring (i.e., those that are out of line with infection prevention and control standards). Everyone has a responsibility to monitor their own practice as well as the practice of the other health care providers working in the OHP to ensure patient safety.

Standards

1. Medical Directors **must** ensure appropriate infection prevention and control practices are occurring within the OHP, including compliance with all applicable legislation and regulations[1] and any directives or guidelines issued by Public Health Ontario or the Ministry of Health, as well as with Public Health Ontario's *Infection Prevention and Control for Clinical Office Practice*[2].[3]

2. In particular, Medical Directors **must** ensure that the following is occurring within the OHP:

    a. Adherence to Routine Practices[4] and Additional Precautions[5];
    b. Compliance with safe medication practices;[6]
    c. Maintenance of a clean and safe health care environment with environmental cleaning and disinfection appropriate to the clinical setting performed on a routine and consistent basis;
        i. Areas where surgery and invasive procedures are performed are cleaned and disinfected according to standards set by the Operating Room Nurses Association of Canada (ORNAC);[7]
    d. Reprocessing of medical equipment is done in accordance with the manufacturer's instructions and/or accepted standards and reflects the intended use of the

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[1] This includes, for example, the *Occupational Health and Safety Act* (hereinafter OHSA), as well as the *Needle Safety Regulation (O. Reg 474/07)* under the *OHSA,* and the Workplace Hazardous Materials Information System (WHMIS).
[2] Ontario Agency for Health Protection and Promotion (Public Health Ontario), Provincial Infectious Diseases Advisory Committee. *Infection Prevention and Control for Clinical Office Practice.* 1st Revision. Toronto, ON: Queen's Printer for Ontario; April 2015.
[3] A summary of mandatory practices and best practice recommendations for clinical office practice is set out on page 72 of *Infection Prevention and Control for Clinical Office Practice*.
[4] Routine Practices are based on the premise that all patients are potentially infectious, even when asymptomatic, and that the same standards of practice must be used routinely with all patients to prevent exposure to blood, body fluids, secretions, excretions, mucous membranes, non-intact skin or soiled items and to prevent the spread of microorganisms.
[5] "Additional Precautions" refer to IPAC interventions (e.g., barrier equipment, accommodation, additional environmental controls) to be used in addition to Routine Practices to protect staff and patients and interrupt transmission of certain infectious agents that are suspected or identified in a patient.
[6] For additional information see *Appendix H: Checklist for Safe Medication Practices* set out in *Infection Prevention and Control for Clinical Office Practice*.
[7] For more information about environmental cleaning in surgical areas refer to the Operating Room Nurses Association of Canada (ORNAC) standards, which are now under the auspices of the Canadian Standards Association.

equipment or device and the potential risk of infection involved in the use of the equipment or device[8];

e. Accepted standards of handling regulated waste are adhered to[9].

3. Medical Directors **must** ensure the following is in place to support appropriate IPAC practices:

   a. well documented policies and procedures which are periodically reviewed by staff;
   b. all staff are properly trained and are provided with regular education and support to assist with consistent implementation of appropriate IPAC practices;
   c. responsibility for specific obligations are clearly defined in writing and understood by all staff; and
   d. mechanisms are in place for ensuring a healthy workplace, appropriate staff immunizations and written protocols for exposure to infectious diseases, including a blood-borne pathogen exposure protocol.[10]

4. Where substandard IPAC practices are occurring, all staff **must** take appropriate action, including advising the Medical Director, addressing the issue with the individual responsible for the infraction, and/or reporting to the relevant Medical Officer of Health, where required[11].

[8] For additional information see *Appendix I: Recommended Minimum Cleaning and Disinfection Level and Frequency for Medical Equipment* set out in *Infection Prevention and Control for Clinical Office Practice*.
[9] "Regulated Waste" means: a) liquid or semi-liquid or other potential infectious material; b) contaminated items that would release blood or other potential infectious materials in a liquid or semi-liquid state are compressed; c) items that contain dried blood or other potential infectious materials and are capable of releasing these materials during handling; d) contaminated sharps; e) pathological and microbiological wastes containing blood or other potentially infectious materials.
[10] For additional information see *Appendix J: Checklist for Office Infection Prevention and Control* set out in *Infection Prevention and Control for Clinical Office Practice*.
[11] Please see CPSO's *Mandatory and Permissive Reporting* policy for more information on the specific instances that require reporting to the Medical Officer of Health.

Advice to the Profession: Infection Prevention and Control (IPAC) Standard

Why is it important to ensure OHPs are complying with IPAC standards?

IPAC is an important element of care in any health care institution. Given the nature of the procedures done in OHPs, for example the level of invasiveness, it is important to ensure that appropriate IPAC practices are in place. Failure to do so can have serious consequences for both patients and staff.

What are common IPAC infractions observed during inspections?

Many OHPs that fail their inspections do so from a failure to comply with appropriate IPAC practices. Common IPAC deficiencies observed during inspections include the following:

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

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

What are some actions that minimize risk of infection in the operating room?

Actions that minimize risk of infection in the operating room include adherence to proper use of disinfectants, proper maintenance of medical equipment that uses water (e.g., automated endoscope reprocessors), proper ventilation standards for specialized care environments (i.e., airborne infection isolation, protective environment, and operating rooms), and prompt management of water intrusion into OHP structural elements.

[1] Ontario Agency for Health Protection and Promotion (Public Health Ontario), Provincial Infectious Diseases Advisory Committee. *Infection Prevention and Control for Clinical Office Practice.* 1st Revision. Toronto, ON: Queen's Printer for Ontario; April 2015.

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Where can I find more information about appropriate IPAC practices?

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

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

Please see their website for more information and additional resources.

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Adverse Events Standard

Definitions

Adverse Event: An incident that has resulted in harm to the patient as a result of the care provided in the OHP (also known as a "harmful incident"). For specific examples, please see the *Advice to the Profession* document.

Standards

Preparing for Adverse Events

1. Medical Directors **must:**

    a. ensure there are written protocols in place to support the recognition and reporting of adverse events and to appropriately manage any adverse events that occur;
    b. ensure there is an established written protocol to facilitate the urgent transfer of patients to the hospital for the management of an urgent adverse patient event;
    c. be available to provide assistance in managing any adverse events, if necessary;
    d. be satisfied that staff practising within the OHP are aware of the written protocols and are capable of managing any adverse events themselves; and
    e. have a communication plan in place to keep informed of any adverse events that take place and any actions taken to manage them.

Managing Adverse Events

2. When an adverse event occurs, physicians involved in the adverse event **must** take appropriate and timely action, including:

    a. managing any urgent adverse events appropriately by:
        i. providing any necessary care to address the patient's immediate needs;
        ii. ensuring timely initiation of emergency care or services, where necessary (e.g., where the patient is experiencing severe suffering or is at risk of sustaining serious bodily harm if treatment is not administered promptly);
        iii. initiating a timely transfer to hospital by appropriate means in light of the patient's condition, where necessary;
        iv. accompanying the patient to hospital, where necessary;
        v. communicating with the receiving physician or premises to notify them of the transfer, where the patient is unaccompanied;
        vi. ensuring essential medical information and the referring physician's contact information is sent with the patient to support continuity of care;
    b. caring for, supporting, and following-up with patients, family, and caregivers as necessary.

Documenting and Reporting Adverse Events

3. When an adverse event occurs, physicians involved in the adverse event **must**:

    a. document the details of the adverse event in the patient's medical record;
    b. provide a written report to the Medical Director within 24 hours of learning of the

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event which includes all relevant information (e.g., date and type of procedure, description of the incident and treatment rendered, analysis of reasons for the incident, outcome);
c. report the incident, including all relevant details, to CPSO in the form and manner required by CPSO, within 5 business days of learning of the event;
d. provide CPSO with any relevant medical records and additional information as requested;
e. ensure appropriate disclosure to the patient, in accordance with CPSO's *Disclosure of Harm* policy; and
f. where a death occurs, make a report to the Coroner.

4. Where an adverse event occurs, Medical Directors **must** ensure the reporting obligations set out above are complied with (e.g., that the adverse event has been reported to the CPSO within 5 business days).[1]

Incident Analysis

5. Once the adverse event has been appropriately managed, Medical Directors **must** initiate a process with the physician(s) and staff involved in the adverse event to analyze and learn from the event, including:

   a. undertaking an investigation to understand how and/or why the incident occurred;
   b. developing recommendations to help prevent similar incidents from occurring, where appropriate;
   c. sharing the learnings and recommendations with other staff in the OHP, as appropriate.[2]

6. Medical Directors **must** ensure that recommendations are implemented within the OHP and are monitored over time to assess their effectiveness.

Analyzing and Learning from Adverse Events

7. Medical Directors **must**:

   a. critically review all adverse events that have occurred over a 12 month period and evaluate the effectiveness of the OHP's practices and procedures to improve patient safety;
   b. document the review and any relevant corrective actions and quality improvement initiatives taken; and
   c. provide feedback to all staff regarding identified patterns of adverse events.

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[1] Failure to report an adverse event may result in an outcome of Fail by the Premises Inspection Committee.

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

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Advice to the Profession: Adverse Events Standard

An adverse event is defined as an incident that has resulted in harm to the patient as a result of care provided in the OHP. What are some specific examples of adverse events that must be reported to CPSO?

A key component of the definition is that the adverse event must be related to the procedure performed in the OHP. Indicators of adverse events generally include complications related to the use of sedation/anesthesia or to the procedure itself. This includes both serious complications, such as:

- Death within the premises;
- Death within 10 days of a procedure performed at the premises;
- Any procedure performed on the wrong patient, site, or side; or
- Transfer of a patient from the premises directly to a hospital for care.

It also includes other quality assurance incidents which are deemed less critical for immediate action, such as:

- Unplanned extended or overnight stays[1];
- Unscheduled treatment of a patient in a hospital within 10 days of a procedure performed at a premises in relation to the procedure;
- Complications such as infection, bleeding, or injury to other body structures;
- Cardiac or respiratory problems during the patient's stay at the OHP;
- Allergic reactions; or
- Medication-related adverse events.

Patient harm that occurs as a result of an unrelated activity is not considered an adverse event as defined by the Standard and does not need to be reported to CPSO. For example, if a patient has an injury that results in a hospital stay within 10 days of the procedure performed in the OHP but is unrelated to the OHP procedure, this would not be considered an adverse event.

What is the purpose of reporting adverse events to CPSO? What will CPSO do with this information?

CPSO is responsible for the effective oversight of OHPs. Reviewing the severity and frequency of adverse events within each OHP helps CPSO to fulfill this duty by helping to identify any concerning trends. In order to fulfill CPSO's obligation to monitor for higher risk events, and to fulfill their own obligations, Medical Directors are accountable to CPSO for ensuring that this information is reported and for taking any appropriate corrective action.

CPSO recognizes that adverse events can result from a variety of factors, including risks inherent in the procedure, system failures, or even performance issues with individual physicians, however they offer opportunity for learning and improvement and can offer insight into areas which might benefit from practice improvement or additional safety measures. Depending on the nature and frequency of adverse events, they are not necessarily an

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

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indication of poor practice. However, lack of reporting of adverse events may serve as indication that OHPs are failing to comply with their obligations as set out in the *Adverse Events* Standard.

CPSO is committed to assisting OHPs with improving their practices and collecting information regarding adverse events helps us to do so.

How can I report adverse events and what information needs to be submitted to CPSO?

Adverse events can be reported through the Member Portal on CPSO's website. Physicians involved in the adverse event are required to report all relevant information and submit relevant medical records, including any referral letters, pre- and post-operative notes and tests, surgical notes, the anesthesia record, and an update of the patient's outcome.

Why has CPSO moved away from distinguishing between Tier 1 and Tier 2 adverse events?

With the implementation of CPSO's new Member Portal, you are now required to report all adverse events as they occur, so the distinction between Tier 1 and Tier 2 adverse events no longer serves a purpose. CPSO will continue to review all adverse events that occur within OHPs and respond accordingly. Medical Directors must also review all adverse events and respond accordingly. Investigations and any corresponding actions need to be proportionate to the circumstances and to the adverse event that occurred. More serious adverse events may require a more in-depth investigation and/or more significant corrective actions.

Where can I learn more about adverse events?

The CMPA's Good Practices Guide and *Learning from adverse events: Fostering a just culture of safety in Canadian hospitals and health care institutions* have additional guidance related to adverse events, including the best approach for reviewing these events.

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Quality Assurance Standard

Standards

Creating a Culture of Safety and Quality

1. Medical Directors **must** foster a culture of safety and quality within the OHP.

2. Medical Directors **must** ensure that the OHP maintains a Quality Assurance program and that it undertakes initiatives to improve the quality of care within the premises.

3. Medical Directors **must** ensure the OHP has a Quality Assurance (QA) committee for the purpose of creating processes to establish standards, monitor activity, and improve performance to ensure appropriate volume and scope of services provided.

4. Medical Directors **must:**

    a. hold, at a minimum, two QA committee meetings at each OHP site per year, that address quality issues (e.g., infection control) and review policies and procedures, challenging cases, near misses[1], adverse events and protocols as appropriate to minimize adverse events;
    b. ensure meetings are attended by all staff providing patient care where possible, and that all staff who are unable to attend are updated on the meeting discussions and outcomes;
    c. ensure all meetings, including the staff who were in attendance, are documented and that the documentation is available to CPSO upon request.

5. Medical Directors **must** ensure that members of staff undertake continuing education relevant to their practice in the OHP, in accordance with applicable regulatory requirements, to maintain clinical competency and knowledge of best practices.

Monitoring Quality of Care

6. Medical Directors **must** ensure there is a documented process in place to regularly monitor the quality of care provided to patients through activities, including the following:

    a. review of all staff performance (i.e., both medical and non-medical staff);
    b. review of individual physician care to assess:
        - patient and procedure selection are appropriate
        - patient outcomes are appropriate
        - adverse events;
    c. review a selection of individual patient records to assess completeness and accuracy of entries by all staff[2];

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[1] Near miss incident is defined in CPSO's *Disclosure of Harm* policy as an incident with the potential for harm that did not reach the patient due to timely intervention or good fortune (also known as a "close call"). For specific examples, please see the *Advice to the Profession: Disclosure of Harm*.
[2] In an OHP where the Medical Director is the only practising physician, the process for reviewing records will need to include a review of that physician's patient records by a peer.

d. review of activity related to cleaning, sterilization, maintenance, and storage of equipment;
e. documentation of the numbers of procedures performed (i.e., any significant annual increase/decrease (>50% of the last reported assessment)).

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Advice to the Profession: Quality Assurance Standard

What is "Quality Assurance" and what does it mean to foster a culture of safety and quality within the OHP?

The term "Quality Assurance" generally refers to the identification, assessment, correction, and monitoring of important aspects of patient care. The *Quality Assurance* Standard sets out a number of quality assurance activities that must be undertaken in an OHP which, when undertaken effectively, can help to foster a culture of safety and quality within the OHP.

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

The CMPA's *Learning from adverse events: Fostering a just culture of safety in Canadian hospitals and health care institutions*[1] also has guidance around fostering a just culture of safety within an institution.

Medical Directors are required to regularly monitor the quality of care provided to patients through activities such as reviewing a selection of patient records. What are best practices with respect to this quality assurance activity?

An annual review of a random selection of medical records (e.g., 5-10 records) can help to monitor the quality of care within an OHP, including review of the following:

- record completion[2] and documentation of informed consent
- percentage and type of procedures
- appropriate patient selection[3]
- appropriate patient procedure
- where required, reporting results in a timely fashion
- evaluation of complications
- assessment of transfer to hospital, where required
- follow-up of abnormal pathology and laboratory results.

[1] *Learning from adverse events: Fostering a just culture of safety in Canadian hospitals and health care institutions*. Ottawa, ON: Canadian Medical Protective Association; 2009.
[2] For more information see the *Advice to the Profession: Procedures Standard* document.
[3] For more information see the *Patient Selection* Standard.

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ACADEMIC REGISTRATION

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

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Requirements

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

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

There are additional requirements for assistant professors:

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

Terms, conditions and limitations

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

In addition, for assistant professors:

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

Application for a restricted certificate of registration

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

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

End Notes

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

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Appendix B

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

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

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Appendix C

SPECIALIST RECOGNITION CRITERIA IN ONTARIO

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

Purpose

In order to practise medicine in Ontario, an individual must hold a valid certificate of registration issued by the College. Specialty recognition is distinct from registration.

The Ontario Regulation 114/94 provides that no member shall use a term, title or designation relating to a specialty or subspecialty of the profession in respect of their practice of the profession unless the member has been,

1. certified by the Royal College of Physicians and Surgeons of Canada (RCPSC) in a specialty or subspecialty of the profession to which the term, title or designation relates;
2. certified by the College of Family Physicians of Canada (CFPC) in a specialty or subspecialty of the profession to which the term, title or designation relates; or
3. formally recognized in writing by the College as specialist in the specialty or subspecialty of the profession to which the term, title or designation relates.

This policy sets out the criteria that a physician must meet in order to be recognized as a specialist by the College of Physicians and Surgeons of Ontario.

Scope

This policy applies to individuals who have met the criteria for registration and have been issued a certificate of registration to practise medicine in Ontario.

Under this policy, the College will recognize specialty titles only in areas for which specialties and sub-specialties are granted by the RCPSC and the CFPC.

This policy does not apply to physicians who hold certification by RCPSC or the CFPC who are requesting sub-specialist recognition at a time when the sub-specialty examination is available.

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Specialist recognition granted under paragraph 3 above is tied to the physician's practice in Ontario and will automatically expire upon expiry of the physician's certificate of registration.

The determination as to which specialists should be paid as specialists under the Ontario Health Insurance Plan will be made by the Ministry of Health and Long-Term Care of Ontario.

Policy

A physician who meets any of the requirements below will be recognized by the College as a **specialist**:

1. holds certification by the RCPSC; or
2. holds certification in family medicine by the CFPC; or
3. holds specialist certification, obtained by examination, by the Collège des médecins du Québec; or
4. holds certification by a specialty member board of the American Board of Medical Specialties (ABMS), and:
    a. ABMS certification was obtained by examination, and
    b. ABMS certification was obtained following successful completion of postgraduate specialty training in a program accredited by the Accreditation Council for Graduate Medical Education (ACGME); or
5. holds a restricted certificate of registration authorizing academic practice in Ontario, and:
    a. has successfully completed specialty training and obtained certification as a specialist by the certifying body in the country where the individual completed their training, by an organization outside of North America that recognizes medical specialties, and
    b. the organization which recognized the applicant as a medical specialist did so using standards that are substantially similar to the standards of the RCPSC or the CFPC, and
    c. holds a full-time academic appointment at a medical school in Ontario at the rank of assistant professor, associate professor or full professor; or
6. holds a restricted certificate of registration that has been issued under the College's *Academic Registration* policy, and:
    a. has completed a minimum of five years of clinical practice in an academic setting in Ontario, and
    b. has provided evidence of satisfactory clinical performance, knowledge, skill, judgement, and professional conduct from the medical school where the academic appointment was held; or
7. has completed a minimum of one year of independent or supervised practice in Ontario, and:

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    a. has successfully completed specialty training and obtained certification as a specialist by the certifying body in the country where the individual completed their training by an organization outside of North America that recognizes medical specialties, and
    b. the organization which recognized the applicant as a medical specialist did so using standards that are substantially similar to the standards of the RCPSC or the CFPC, and
    c. has successfully completed a practice assessment that has been directed by the Registration Committee[1]; or
8. holds a restricted certificate of registration in Ontario that has been issued under the College's *Alternative Pathways to Registration for Physicians Trained in the United States* policy, and:
    a. has received written confirmation from a US Specialty Board of eligibility to take the certification examination on the basis of satisfactory completion of a residency program accredited by the ACGME within the last five years; or
9. holds a restricted certificate of registration in Ontario that has been issued under the College's *Restricted Certificates of Registration for Exam Eligible Candidates* policy, and:
    a. has received written confirmation from the RCPSC of current eligibility, with no pre-conditions, to take the certification examination on the basis of satisfactory completion of a RCPSC-accredited residency program in Canada or a RCPSC recognized program outside of Canada; or
10. holds a restricted certificate of registration in Ontario that has been issued under the College's *Restricted Certificates of Registration for Exam Eligible Candidates* policy, and:
    a. has received written confirmation from the CFPC of current eligibility, with no pre-conditions, to take the certification on the basis of satisfactory completion of a CFPC-accredited residency program in Canada or a CFPC recognized program outside of Canada.
11. holds a restricted certificate of registration in Ontario that has been issued under the College's *Recognition of RCPSC Subspecialist Affiliate Status* policy.[2]

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Endnotes

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

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

Practice Ready Assessment Program

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

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

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

Eligibility and Applicant Screening

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

Clinical Field Assessment (CFA)

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

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

Your restricted certificate will expire the earlier of either:

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

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Supervised Practice

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

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

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

Independent Practice

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

Upon the completion of your ROS commitment and successfully obtaining CFPC certification, if you are otherwise qualified for an independent practice certificate of registration and satisfy the non-exemptible requirements set out in *Section 2(1) of Ontario Regulation 865/93*, you may apply for an independent practice certificate of registration.

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RECOGNITION OF RCPSC SUBSPECIALIST AFFILIATE STATUS

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

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

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

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

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Appendix F

SPECIALIST RECOGNITION CRITERIA IN ONTARIO

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

Purpose

In order to practise medicine in Ontario, an individual must hold a valid certificate of registration issued by the College. Specialty recognition is distinct from registration.

The Ontario Regulation 114/94 provides that no member shall use a term, title or designation relating to a specialty or subspecialty of the profession in respect of their practice of the profession unless the member has been,

1. certified by the Royal College of Physicians and Surgeons of Canada (RCPSC) in a specialty or subspecialty of the profession to which the term, title or designation relates;
2. certified by the College of Family Physicians of Canada (CFPC) in a specialty or subspecialty of the profession to which the term, title or designation relates; or
3. formally recognized in writing by the College as specialist in the specialty or subspecialty of the profession to which the term, title or designation relates.

This policy sets out the criteria that a physician must meet in order to be recognized as a specialist by the College of Physicians and Surgeons of Ontario.

Scope

This policy applies to individuals who have met the criteria for registration and have been issued a certificate of registration to practise medicine in Ontario.

Under this policy, the College will recognize specialty titles only in areas for which specialties and sub-specialties are granted by the RCPSC and the CFPC.

This policy does not apply to physicians who hold certification by RCPSC or the CFPC who are requesting sub-specialist recognition at a time when the sub-specialty examination is available.

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Specialist recognition granted under paragraph 3 above is tied to the physician's practice in Ontario and will automatically expire upon expiry of the physician's certificate of registration.

The determination as to which specialists should be paid as specialists under the Ontario Health Insurance Plan will be made by the Ministry of Health and Long-Term Care of Ontario.

Policy

A physician who meets any of the requirements below will be recognized by the College as a **specialist**:

1. holds certification by the RCPSC; or
2. holds certification in family medicine by the CFPC; or
3. holds specialist certification, obtained by examination, by the Collège des médecins du Québec; or
4. holds certification by a specialty member board of the American Board of Medical Specialties (ABMS), and:
    a. ABMS certification was obtained by examination, and
    b. ABMS certification was obtained following successful completion of postgraduate specialty training in a program accredited by the Accreditation Council for Graduate Medical Education (ACGME); or
5. holds a restricted certificate of registration authorizing academic practice in Ontario, and:
    a. has successfully completed specialty training and obtained certification as a specialist by the certifying body in the country where the individual completed their training, by an organization outside of North America that recognizes medical specialties, and
    b. the organization which recognized the applicant as a medical specialist did so using standards that are substantially similar to the standards of the RCPSC or the CFPC, and
    c. holds a full-time academic appointment at a medical school in Ontario at the rank of assistant professor, associate professor or full professor; or
6. holds a restricted certificate of registration that has been issued under the College's *Academic Registration* policy, and:
    a. has completed a minimum of five years of clinical practice in an academic setting in Ontario, and
    b. has provided evidence of satisfactory clinical performance, knowledge, skill, judgement, and professional conduct from the medical school where the academic appointment was held; or
7. has completed a minimum of one year of independent or supervised practice in Ontario, and:

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    a. has successfully completed specialty training and obtained certification as a specialist by the certifying body in the country where the individual completed their training by an organization outside of North America that recognizes medical specialties, and
    b. the organization which recognized the applicant as a medical specialist did so using standards that are substantially similar to the standards of the RCPSC or the CFPC, and
    c. has successfully completed a practice assessment that has been directed by the Registration Committee[1]; or
8. holds a restricted certificate of registration in Ontario that has been issued under the College's *Alternative Pathways to Registration for Physicians Trained in the United States* policy, and:
    a. has received written confirmation from a US Specialty Board of eligibility to take the certification examination on the basis of satisfactory completion of a residency program accredited by the ACGME within the last five years; or
9. holds a restricted certificate of registration in Ontario that has been issued under the College's *Restricted Certificates of Registration for Exam Eligible Candidates* policy, and:
    a. has received written confirmation from the RCPSC of current eligibility, with no pre-conditions, to take the certification examination on the basis of satisfactory completion of a RCPSC-accredited residency program in Canada or a RCPSC recognized program outside of Canada; or
10. holds a restricted certificate of registration in Ontario that has been issued under the College's *Restricted Certificates of Registration for Exam Eligible Candidates* policy, and:
    a. has received written confirmation from the CFPC of current eligibility, with no pre-conditions, to take the certification on the basis of satisfactory completion of a CFPC-accredited residency program in Canada or a CFPC recognized program outside of Canada.
11. holds a restricted certificate of registration in Ontario that has been issued under the College's *Recognition of RCPSC Subspecialist Affiliate Status* policy.[2]

Endnotes

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

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

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Financial statements of the

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 31, 2022

COUNCIL DRAFT

TINKHAM LLP | CHARTERED PROFESSIONAL ACCOUNTANTS

D C Tinkham FCPA FCA CMC LPA
P J Brocklesby CPA CA LPA
M Y Tkachenko CPA CA
M W G Rooke CPA CA LPA
A C Callas CPA CA LPA
G P Kroeplin CPA
C R Braun CPA CA
H S Grewal CPA

300 - 2842 Bloor Street West
Toronto Ontario M8X 1B1
Canada

TEL 1 416 233 2139
TOLL FREE 1 877 283 3305
FAX 1 416 233 1788

TINKHAMCPA.COM

INDEPENDENT AUDITOR'S REPORT

To the Members of the
College of Physicians and Surgeons of Ontario

We have audited the accompanying financial statements of the College of Physicians and Surgeons of Ontario ("College"), which comprise the statement of financial position as at December 31, 2022 and the statements of operations and changes in unrestricted net assets and cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the College as at December 31, 2022, and the results of its operations and its cash flows for the year then ended in accordance with Canadian accounting standards for not-for-profit organizations.

COUNCIL DRAFT

Basis for Opinion

We conducted our audit in accordance with Canadian generally accepted auditing standards. Our responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of our report. We are independent of the College in accordance with the ethical requirements that are relevant to our audit of the financial statements in Canada, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide basis for our opinion.

Responsibilities of Management and Those Charged with Governance for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with Canadian accounting standards for not-for-profit organizations and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is responsible for assessing the College's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless management either intends to liquidate the College or to cease operations, or has no realistic alternative but to do so.

Those charged with governance are responsible for overseeing the College’s financial reporting process.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Canadian generally accepted auditing standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with Canadian generally accepted auditing standards, we exercise professional judgment and maintain professional skepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the College's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast doubt on the College's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the College to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

COUNCIL DRAFT

TORONTO, Ontario
June 8, 2023

Licensed Public Accountants

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
Statement of Financial Position

As at December 31	**2022**	2021
Assets		
Current		
Cash	**$ 62,375,231**	$ 58,578,305
Accounts receivable	**972,073**	1,903,588
Prepaid expenses	**3,097,552**	1,573,129
	66,444,856	62,055,022
Investments (note 3)	**50,694,192**	50,331,712
Capital assets (note 4)	**14,613,491**	16,828,346
	$131,752,539	$129,215,080
Liabilities		
Current		
Accounts payable and accrued liabilities	**$ 8,101,808**	$ 9,208,460
Current portion of obligations under capital leases (note 7)	**500,341**	689,167
	8,602,149	9,897,627
Deferred revenue (note 5)	**32,989,051**	33,240,949
	41,591,200	43,138,576
Accrued pension cost (note 6)	**4,542,816**	5,256,150
Obligations under capital leases (note 7)	**475,105**	316,093
	46,609,121	48,710,819
Net assets		
Internally restricted (note 8)		
Invested in capital assets	**13,638,045**	15,823,086
Building Fund	**60,700,276**	60,700,276
Intangible Asset Fund	**10,805,097**	3,980,899
Pension remeasurements	**(725,130)**	(1,284,280)
Unrestricted	**725,130**	1,284,280
	85,143,418	80,504,261
	$131,752,539	$129,215,080

Commitments and contingencies (notes 9 and 10, respectively)

Approved on behalf of the Council

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See accompanying notes to the financial statements.

COUNCIL DRAFT

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Statement of Operations and Changes in Unrestricted Net Assets

Year ended December 31	**2022**	2021
Revenue		
Membership fees		
General and educational (note 5)	**$ 68,881,162**	$ 67,443,326
Penalty fee	**991,749**	563,126
	69,872,911	68,006,452
Application fees	**9,038,049**	8,837,479
OHPIP annual and assessment fees (note 5)	**1,339,476**	1,440,239
IHF annual and assessment fees (note 5)	**2,269,119**	1,431,792
OHPIP, IHF application fees and penalties	**102,099**	62,525
Cost recoveries and other income	**1,779,428**	2,290,504
Interest income	**1,835,684**	553,628
	86,236,766	82,622,619
Expenses		
Staffing costs (schedule I)	**52,360,938**	51,707,598
Per diems (schedule II)	**9,002,543**	7,869,158
Other costs (schedule III)	**9,825,788**	7,805,729
Professional fees (schedule IV)	**4,353,531**	4,886,444
Amortization of capital assets	**4,541,294**	3,503,959
Occupancy (schedule V)	**2,435,145**	2,629,811
	82,519,239	78,402,699
Excess of revenue over expenses before undernoted items	**3,717,527**	4,219,920
Investment income	**362,480**	342,192
Excess of revenue over expenses for the year	**4,080,007**	4,562,112
Unrestricted net assets, beginning of year	**1,284,280**	1,173,107
Less: Invested in capital assets (net)	**2,185,041**	(2,470,040)
Less: Transfer to Intangible Asset Fund	**(6,824,198)**	(1,980,899)
Unrestricted net assets, end of year	**$ 725,130**	$ 1,284,280

COUNCIL DRAFT

See accompanying notes to the financial statements.

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Statement of Cash Flows

Year ended December 31	**2022**	2021
Cash flows from operating activities:		
Excess of revenue over expenses for the year	**$ 4,080,007**	$ 4,562,112
Amortization of capital assets	**4,541,294**	3,503,959
	8,621,301	8,066,071
Net change in non-cash working capital items:		
Accounts receivable	**931,515**	(277,581)
Prepaid expenses	**(1,524,423)**	(429,216)
Accrued interest receivable	**(362,480)**	(331,712)
Accounts payable and accrued liabilities	**(1,106,652)**	(14,338)
Deferred revenue	**(251,898)**	(9,491)
Pension cost	**(154,184)**	(174,821)
Cash provided by operating activities	**6,153,179**	6,828,912
Cash flows used by investing activities:		
Purchase of capital assets	**(1,563,448)**	(5,137,442)
Cash flows used by financing activities:		
Payment of capital lease obligations	**(792,805)**	(836,557)
Net increase in cash	**3,796,926**	854,913
Cash, beginning of year	**58,578,305**	57,723,392
Cash, end of year	**$ 62,375,231**	$ 58,578,305

COUNCIL DRAFT

See accompanying notes to the financial statements.

1 Organization

College of Physicians and Surgeons of Ontario ("College") was incorporated without share capital as a not-for-profit organization under the laws of Ontario for the purpose of regulating the practice of medicine to protect and serve the public interest. Its authority under provincial law is set out in the Regulated Health Professions Act (RHPA), the Health Professions Procedural Code under RHPA and the Medicine Act.

The College is exempt from income taxes.

2 Significant accounting policies

These financial statements have been prepared by management in accordance with Canadian accounting standards for not-for-profit organizations.

(a) Cash

Cash includes cash deposits held in an interest bearing account at a major financial institution.

(b) Investments

Guaranteed investment certificates are carried at amortized cost.

(c) Capital assets

The cost of a capital asset includes its purchase price and any directly attributable cost of preparing the asset for its intended use.

When conditions indicate a capital asset no longer contributes to the College's ability to provide services or that the value of future economic benefits or service potential associated with the capital asset is less than its net carrying amount, its net carrying amount is written down to its fair value or replacement costs. As at December 31, 2022, no such impairment exists.

(i) Tangible assets

Tangible assets are measured at cost less accumulated amortization and accumulated.

Amortization is provided for, upon the commencement of the utilization of the assets, on a straight-line basis over their estimated lives as follows:

Building	10 - 25 years	Computer and other equipment	3 - 5 years
Furniture and fixtures	10 years	Computer equipment under capital lease	2 - 4 years

(ii) Intangible assets

Intangible assets, consisting of separately acquired computer application software, are measured at cost less accumulated amortization.

Amortization is provided for, upon the commencement of the utilization of the assets, on a straight-line basis over their estimated useful lives of four years.

COUNCIL DRAFT

2 Significant accounting policies (continued)

(d) Pension plans

(i) Healthcare of Ontario Pension Plan

Healthcare of Ontario Pension Plan (“HOOPP”) is a multi employer best five consecutive year average pay defined benefit pension plan.

Defined contribution accounting is applied to HOOPP and contributions are expensed when due.

(ii) CPSO Retirement Savings Plan 2019

CPSO Retirement Savings Plan 2019 is a defined contribution plan. Contributions are expensed when due.

(iii) Designated Employees' Retirement Plan for the College of Physicians and Surgeons on Ontario

The College maintains a closed (1998) defined benefit pension plan and supplementary arrangements for certain designated former employees. The retirement benefits of these designated employees are provided firstly through a funded plan and secondly through an unfunded supplementary plan.

The College recognizes its defined benefit obligations as the employees render services giving them right to earn the pension benefit. The defined benefit obligation at the statement of financial position date is determined using the most recent actuarial valuation report prepared for accounting purposes. The measurement date of the plan assets and the defined benefit obligation is the College's statement of financial position date.

In its year-end statement of financial position, the College recognizes the defined benefit obligation, less the fair value of plan assets, adjusted for any valuation allowance in the case of a net defined benefit asset. The plan cost for the year is recognized in the excess of revenues over expenses for the year. Past service costs resulting from changes in the plan are recognized immediately in the excess of revenue over expenses for the year at the date of the changes.

Remeasurements and other items comprise the aggregate of the following: the difference between the actual return on plan assets and the return calculated using the discount rate; actuarial gains and losses; the effect of any valuation allowance in the case of a net defined pension asset; past service costs; and gains and losses arising from settlements or curtailments. Remeasurements are recognized as a direct charge (credit) to net assets.

(e) Revenue recognition

(i) Members' fees and application fees

These fees are set annually by Council and are recognized as revenue proportionately over the fiscal year to which they relate. Fees received in advance are recorded as deferred revenue.

(ii) Independent Health Facility (IHF) and Out of Hospital Premises Inspection Program (OHPIP) fees

IHF and OHPIP annual and assessment fees are recognized at the same rate as the related costs are expensed.

(iii) Cost recoveries

Cost recoveries are recognized at the same rate as the related costs are expensed.

(iv) Other income

Other income is recognized as the services are provided, the amount is known and collection is reasonably assured.

COUNCIL DRAFT

2 Significant accounting policies (continued)

(e) Revenue recognition (continued)

(v) Interest and investment income

Interest income is comprised of interest on cash deposits held in an interest bearing account at a major financial institution. Investment income is comprised of income on guaranteed investment certificates.

Interest and investment income are recognized when earned. Income on guaranteed growth investment certificates is determined at maturity based on the percentage change in price of an equally weighted portfolio of five Canadian bank's shares. Interest is accrued at the minimum guaranteed rates.

(f) Financial instruments

(i) Measurement

The College initially measures its financial assets and financial liabilities at fair value, adjusted by, in the case of a financial instrument that will not be measured subsequently at fair value, the amount of transaction costs directly attributable to the instrument.

The College subsequently measures its financial assets and liabilities at amortized cost. Transaction costs are recognized in income in the period incurred.

(ii) Impairment

At the end of each reporting period, the College assesses whether there are any indications that a financial asset measured at amortized cost may be impaired. When there is an indication of impairment, the College determines whether a significant adverse change has occurred during the period in the expected timing or amount of future cash flows from the financial asset.

(g) Management estimates

In preparing the College's financial statements, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and reported amounts of revenue and expenses during the period. Actual results may differ from these estimates, the impact of which would be recorded in future periods. Estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognized in the year in which the estimates are revised and in any future years affected.

(h) Internally restricted reserves

Council has established the following internally restricted reserves:

(i) Invested in capital assets which comprises the net book value of capital assets less the related obligations under capital leases;

(ii) Building Fund which comprises assets restricted for future building requirements; and

(iii) Intangible Asset Fund which comprises assets restricted for future information technology infrastructure development and improvements.

COUNCIL DRAFT

3 Investments

As at December 31	**2022**	2021
Guaranteed Investment Certificates (GIC)		
Bank of Montreal (BMO) Extendible GIC	**$ 25,000,000**	$ 25,000,000
National Bank of Canada (NBC) Canadian Banks Portfolio Flex GIC	**25,000,000**	25,000,000
Accrued interest	**694,192**	331,712
	$ 50,694,192	$ 50,331,712

The BMO Extendible GIC earns interest at 1.45% and had an initial maturity date of February 1, 2022. The issuer exercised its option to extend the maturity date on the initial maturity date. The maturity date can continue to be extended by the issuer in six month increments on each extended maturity date thereafter extending to August 1, 2027. The GIC is not redeemable at the option of the College. At maturity the principal amount of $25,000,000, plus accrued interest, is guaranteed. The fair market value, including accrued interest, of the GIC as at December 31, 2022 is $21,632,459 (2021 - $24,139,209).

The NBC Canadian Bank Portfolio Flex GIC matures on January 29, 2026 and earns a return determined at maturity based on the percentage change in price of an equally weighted portfolio of five Canadian bank's shares. At maturity the principal amount of $25,000,000 is guaranteed. The fair market value of the GIC as at December 31, 2022 is $21,832,500 (2021 - $24,212,500).

4 Capital assets

As at December 31		**2022**		2021
	Cost	**Accumulated Amortization**	Cost	Accumulated Amortization
Tangible assets				
Land	**$ 2,142,903**	**$ -**	$ 2,142,903	$ -
Building and building improvements	**21,282,321**	**17,158,430**	21,101,419	16,639,886
Furniture and fixtures	**4,625,827**	**4,289,074**	4,571,754	4,155,683
Computer and other equipment	**2,960,347**	**2,868,451**	1,984,487	1,951,546
Computer equipment under capital lease	**3,850,304**	**2,874,858**	4,038,383	3,033,123
Intangible assets				
Computer application software	**12,368,526**	**5,425,924**	11,122,247	2,352,609
	47,230,228	**32,616,737**	44,961,193	28,132,847
Net book value		**$ 14,613,491**		$ 16,828,346

COUNCIL DRAFT

5 Deferred revenue

Deferred revenue consists of membership fees received in advance for the next year as well as unearned fees related to the Independent Health Facility program (IHF) and Out of Hospital Premises Inspection Program (OHPIP). The change in the deferred revenue accounts for the year is as follows:

	Membership Fees	**IHF**	**OHPIP**	**2022 Total**	2021 Total
Balance, beginning of year	**$ 28,645,293**	**$ 3,392,841**	**$ 1,202,815**	**$ 33,240,949**	$ 33,250,440
Amounts billed during the year	**69,490,715**	**1,398,430**	**1,348,714**	**72,237,859**	70,305,866
Less: Recognized as revenue	**(68,881,162)**	**(2,269,119)**	**(1,339,476)**	**(72,489,757)**	(70,315,357)
Balance, end of year	**$ 29,254,846**	**$ 2,522,152**	**$ 1,212,053**	**$ 32,989,051**	$ 33,240,949

The IHF and OHPIP Programs are budgeted and billed on a cost recovery basis.

6 Employee future benefits

(a) Designated Employees' Retirement Plan and Supplementary Arrangements

(i) Reconciliation of funded status of the defined benefit pension plan to the amount recorded in the statement of financial position

Defined Benefit Plan	**Funded Plan**	**Unfunded Plan**	**2022 Total**	2021 Total
Plan assets at fair value	**$ 2,053,650**	**$ -**	**$ 2,053,650**	$ 2,698,132
Accrued pension obligations	**(3,084,053)**	**(3,512,413)**	**(6,596,466)**	(7,954,282)
Funded status - deficit	**$ (1,030,403)**	**$ (3,512,413)**	**$ (4,542,816)**	$ (5,256,150)

(ii) Pension plan assets

Defined Benefit Plan	**Funded Plan**	**Unfunded Plan**	**2022 Total**	2021 Total
Fair value, beginning of year	**$ 2,698,132**	**$ -**	**$ 2,698,132**	$ 2,845,069
Interest income	**72,850**	**-**	**72,850**	62,592
Return (loss) on plan assets (excluding interest)	**(382,787)**	**-**	**(382,787)**	112,592
Employer contributions	**-**	**296,102**	**296,102**	291,856
Benefits paid	**(334,545)**	**(296,102)**	**(630,647)**	(613,977)
Fair value, end of year	**$ 2,053,650**	**$ -**	**$ 2,053,650**	$ 2,698,132

COUNCIL DRAFT

6 Employee future benefits (continued)

(a) Designated Employees' Retirement Plan and Supplementary Arrangements (continued)

(iii) Accrued pension obligations

Defined Benefit Plan	Funded Plan	Unfunded Plan	2022 Total	2021 Total
Balance, beginning of year	$ 3,689,691	$ 4,264,591	$ 7,954,282	$ 8,164,867
Interest cost on accrued pension obligations	99,622	115,144	214,766	179,627
Benefits paid	(334,545)	(296,102)	(630,647)	(613,977)
Actuarial (gains) losses	(370,715)	(571,220)	(941,935)	223,765
	$ 3,084,053	$ 3,512,413	$ 6,596,466	$ 7,954,282

The most recent actuarial valuation of the pension plan for funding purposes was made effective December 31, 2021. The next required actuarial valuation for funding purposes must be as of a date no later than December 31, 2024.

(iv) The net expense for the College's pension plans is as follows:

	2022	2021
Funded defined benefit plan	$ 26,772	$ 20,797
Unfunded supplementary defined benefit plan	115,144	96,238
Defined contribution plan	659,766	708,993
Healthcare of Ontario Pension Plan	3,323,141	3,019,898
	$ 4,124,823	$ 3,845,926

(v) The elements of the defined benefit pension expense recognized in the year are as follows:

Defined Benefit Plan	Funded Plan	Unfunded Plan	2022 Total	2021 Total
Interest cost on accrued pension obligations	$ 99,622	$ 115,144	$ 214,766	$ 179,627
Interest income on pension assets	(72,850)	-	(72,850)	(62,592)
Pension expense recognized	$ 26,772	$ 115,144	$ 141,916	$ 117,035

(vi) Remeasurements and other items recognized as a direct charge (credit) to net assets are as follows:

Defined Benefit Plan	Funded Plan	Unfunded Plan	2022 Total	2021 Total
Actuarial (gains) losses	$ (370,717)	$ (571,220)	$ (941,937)	$ 223,765
Return (loss) on plan assets (excluding interest)	382,787	-	382,787	(112,592)
Charge to net assets	$ 12,070	$ (571,220)	$ (559,150)	$ 111,173

COUNCIL DRAFT

6 Employee future benefits (continued)

(a) Designated Employees' Retirement Plan and Supplementary Arrangements (continued)

(vii) Actuarial assumptions

The significant actuarial assumptions adopted in measuring the accrued pension obligations as at December 31 are as follows:

	2022	2021
Discount rate	**5.00 %**	2.70 %

(b) Healthcare of Ontario Pension Plan

Employer contributions made to the plan during the year total $3,323,141 (2021 - $3,019,898). These amounts are included in staffing costs in the statement of operations.

Each year an independent actuary determines the funding status of HOOPP by comparing the actuarial value of invested assets to the estimated present value of all pension benefits that members have earned to date. The most recent actuarial valuation of the Plan as at December 31, 2022 indicates the Plan is 112% funded. HOOPP's statement of financial position as at December 31, 2022 disclosed total pension obligations of $92.7 billion with net assets at that date of $103.7 billion indicating a surplus of $11 billion.

(c) Restructuring benefits

The College continues to restructure its affairs during the year for the purpose of achieving long-term savings, which resulted in severance benefits to employees in the amount of $2,721,876 (2021 - $2,006,829), which has been included in staffing costs.

7 Obligations under capital leases

The College has entered into capital leases for computer equipment. The following is a schedule of the future minimum lease payments over the term of the leases:

2023	$ 500,341
2024	287,022
2025	188,083
	975,446
Less: current portion	500,341
	$ 475,105

COUNCIL DRAFT

8 Internally restricted net assets

2022	**Invested in Capital Assets**	**Intangible Asset Fund**	**Building Fund**	**Pension Re-measurement**
Balance, January 1	**$ 15,823,086**	**$ 3,980,899**	**$ 60,700,276**	**$ (1,284,280)**
Deficiency of revenue over expenses for the year	**(4,541,294)**	**-**	**-**	**-**
Transfer to Intangible Asset Fund	**-**	**6,824,198**	**-**	**-**
Actuarial remeasurement for pensions	**-**	**-**	**-**	**559,150**
Transfer to Invested in Capital Assets	**2,356,253**	**-**	**-**	**-**
Balance, December 31	**$ 13,638,045**	**$ 10,805,097**	**$ 60,700,276**	**$ (725,130)**

2021	Invested in Capital Assets	Intangible Asset Fund	Building Fund	Pension Re-measurement
Balance, January 1	$ 13,353,046	$ 2,000,000	$ 60,700,276	$ (1,173,107)
Deficiency of revenue over expenses for the year	(3,503,959)	-	-	-
Transfer to Intangible Asset Fund	-	1,980,899	-	-
Actuarial remeasurement for pension	-	-	-	(111,173)
Transfer to Invested in Capital Assets	5,973,999	-	-	-
Balance, December 31	$ 15,823,086	$ 3,980,899	$ 60,700,276	$ (1,284,280)

Net assets invested in capital assets is calculated as follows:

As at December 31	**2022**	2021
Net book value of capital assets	**$ 14,613,491**	$ 16,828,346
Less: obligations under capital leases	**(975,446)**	(1,005,260)
	$ 13,638,045	$ 15,823,086

9 Commitments

The College has a lease for additional office space which extends to February 28, 2024. Minimum payments for base rent and estimated maintenance, taxes and insurance in aggregate and for each year of the current term are estimated as follows:

2023	$ 782,404
2024	123,117
Total	$ 905,521

10 Contingencies

The College has been named as a defendant in lawsuits with respect to certain of its members or former members. The College denies any liability with respect to these actions and no amounts have been accrued in the financial statements. Should the College be unsuccessful in defending these claims, it is not anticipated that they will exceed the limits of the College's liability insurance coverage.

COUNCIL DRAFT

11 Financial instruments

General objectives, policies and processes

Council has overall responsibility for the determination of the College's risk management objectives and policies.

Credit risk

Credit risk is the risk that one party to a financial instrument will cause a financial loss for the other party by failing to discharge an obligation. The College is exposed to credit risk through its cash, accounts receivable and investments.

Credit risk associated with cash and investments is mitigated by ensuring that these assets are invested in financial obligations of major financial institutions.

Accounts receivable are generally unsecured. This risk is mitigated by the College's requirement for members to pay their fees in order to renew their annual license to practice medicine. The College also has collection policies in place.

Liquidity risk

Liquidity risk is the risk that the College will not be able to meet a demand for cash or fund its obligations as they come due. The College meets its liquidity requirements and mitigates this risk by monitoring cash activities and expected outflows by holding cash.

Market risk

Market risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices. Market risk is comprised of currency risk, interest rate risk and equity risk.

(i) Currency risk

Currency risk reflects the risk that the College's earnings will vary due to the fluctuations in foreign currency exchange rates. The College is not significantly exposed to foreign exchange risk.

(ii) Interest rate risk

Interest rate risk refers to the risk that the fair value of financial instruments or future cash flows associated with the instruments will fluctuate due to changes in market interest rates. The exposure of the College to interest rate risk arises from its interest bearing investments and cash. The primary objective of the College with respect to its fixed income investments ensures the security of principal amounts invested, provides for a high degree of liquidity, and achieves a satisfactory investment return giving consideration to risk. The College has mitigated exposure to interest rate risk.

(iii) Equity risk

Equity risk is the uncertainty associated with the valuation of assets arising from changes in equity markets. The College is not exposed to this risk.

Changes in risk

There have been no significant changes in risk exposures from the prior year.

COUNCIL DRAFT

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
Schedules to the Financial Statements
December 31, 2022

Schedule I - Staffing costs

Year ended December 31	**2022**	2021
Salaries	**$ 41,596,600**	$ 41,679,796
Employee benefits	**5,628,852**	4,741,440
Pension (note 6)	**4,124,823**	3,845,926
Training, conferences and employee engagement	**884,860**	1,297,111
Professional association fees	**125,803**	143,325
	$ 52,360,938	$ 51,707,598

Schedule II - Per diem

Year ended December 31	**2022**	2021
Attendance	**$ 3,838,874**	$ 2,929,045
Preparation time	**2,879,945**	2,895,023
Decision writing	**1,093,725**	1,208,111
Travel time	**677,543**	411,359
HST on per diems	**512,456**	425,620
	$ 9,002,543	$ 7,869,158

Schedule III - Other costs

Year ended December 31	**2022**	2021
Software	**$ 3,362,074**	$ 2,382,274
Credit card service charges	**1,688,446**	1,628,051
Meals and accommodations	**618,370**	195,328
Survivors fund	**567,560**	241,476
Travel	**458,983**	169,542
FMRAC membership fee	**454,528**	454,578
Reporting and transcripts	**405,166**	461,481
Telephone	**379,172**	408,998
Members dialogue	**360,649**	360,445
Equipment leasing	**288,845**	104,998
Miscellaneous	**243,248**	560,903
Offsite storage	**213,668**	192,813
Publications and subscriptions	**172,938**	164,444
Photocopying	**171,679**	137,841
Office supplies	**156,185**	115,203
Equipment maintenance	**120,010**	33,104
Grants	**74,000**	74,000
Postage	**64,102**	94,050
Courier	**26,165**	26,200
	$ 9,825,788	$ 7,805,729

COUNCIL DRAFT

Schedule IV - Professional fees

Year ended December 31	**2022**	2021
Consultant	**$ 3,231,121**	$ 3,723,378
Legal	**855,482**	916,475
Recruiting	**200,088**	169,530
Audit	**66,840**	77,061
	$ 4,353,531	$ 4,886,444

Schedule V - Occupancy

Year ended December 31	**2022**	2021
Insurance	**$ 776,044**	$ 723,127
Building maintenance and repairs	**690,516**	878,364
Rent	**666,412**	748,012
Utilities	**185,518**	167,515
Realty taxes	**116,655**	112,793
	$ 2,435,145	$ 2,629,811

COUNCIL DRAFT

Enabling Mechanism (Delegation) – General Regulation Amendments

NOTE: The following new sections will need to be added in order to set out the enabling mechanism for PAs.

O. Reg. 114/94: General. Made under the *Medicine Act, 1991*.

PART XII

Physician Assistants

52. (1) A member who is a physician assistant shall only perform an act under the authority of section 4 if the performance of the act has been delegated to the member who is a physician assistant by a member who is a physician.

(2) Despite subsection (1), a member who is a physician shall not delegate to a member who is a physician assistant the authorized act of treating, by means of psychotherapy technique delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgment, insight, behaviour, communication or social functioning.

(3) A member who is a physician assistant shall not delegate the performance of an act that has been delegated to them.

(4) A member who is a physician shall ensure, before delegating an authorized act to a member who is a physician assistant, that,

(a) The member who is a physician has the knowledge, skill and judgment to perform the authorized act safely and competently themselves; and

(b) The member who is a physician is satisfied, after taking reasonable steps, that the member who is a physician assistant has the knowledge, skill and judgment to perform the act safely and competently.

(5) A member who is a physician assistant is entitled to presume that a member who is a physician is permitted to delegate an authorized act to them, unless the member who is a physician assistant has reasonable grounds to believe otherwise.

(6) A member who is a physician assistant shall only perform an authorized act delegated to them by a member who is a physician if, before performing the authorized act, the member who is a physician assistant ensures that they have the knowledge, skill and judgement to perform the authorized act safely and competently.

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Appendix I

Registration Regulation Amendments

NOTE: The existing general requirements under this regulation will apply to both physician and PA members of CPSO. Two new sections (see below) will need to be added in order to set out entry-to-practice requirements for PAs and create an emergency class of registration for PAs.

O. Reg 865/93: Registration. Made under the *Medicine Act, 1991*.

Physician Assistant - General

9.1 The standards and qualifications for a certificate of registration authorizing practice as a physician assistant are as follows:

(1) The applicant must have a minimum of a baccalaureate degree evidencing the successful completion of a program designed to educate and train persons to be practising physician assistants which was:

a. accredited by the Canadian Medical Association or Accreditation Canada at the time the applicant graduated;

b. accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) at the time the applicant graduated;

c. another accrediting body as approved by Council; or

d. another program as approved by Council; and

(2) The applicant must hold certification as a physician assistant as follows:

a. Canadian Certified Physician Assistant (CCPA) certification by the Physician Assistant Certification Council of Canada (PACCC);

b. Physician Assistant-Certified (PA-C) by the National Commission on Certification of Physician Assistants NCCPA (US); or

c. another certification as approved by Council.

9.2 (1) Where section 22.18 of the *Health Professions Procedural Code* applies to an applicant for a certificate of registration authorizing practice as a physician assistant, the applicant is deemed to have met the requirements of subsection 9.1.

(2) Where an applicant to whom subsection (1) applies is unable to satisfy the Registrar or a panel of the Registration Committee that the applicant practised the profession of medicine to the extent that would be permitted by a certificate of registration authorizing practice as a physician assistant at any time in the three years immediately preceding the date of that applicant's application, the applicant must meet any further requirement to undertake, obtain or undergo material additional training, experience, examinations or assessments that may be specified by a panel of the Registration Committee.

DRAFT

(3) Despite subsection (1), an applicant is not deemed to have met a requirement if that requirement is described in subsection 22.18 (3) of the *Health Professions Procedural Code*.

Transition

9.3 The following apply for the first 24 months after the day this Regulation comes into force,

Paragraph (1) of subsection 9.1. does not apply in respect of an application for a certificate of registration authorizing practice as a physician assistant where:

(a) the applicant successfully completed the Canadian Armed Forces Health Training Centre Physician Assistant Program or the Ontario Physician Assistant Integration Program by the Centre for the Evaluation of Health Professionals Educated Abroad; and

(b) the applicant is able to satisfy the Registrar or a panel of the Registration Committee that the applicant engaged in practice in Canada within the scope of a physician assistant during the two-year period that immediately preceded the date that the applicant submitted their application.

Physician Assistants - Emergency Circumstances Practice

9.4 (1) The standards and qualifications for a certificate of registration authorizing practice in emergency circumstances for physician assistants are as follows:

1. The Minister has requested the College to initiate registrations under this class based on the Minister's opinion that emergency circumstances call for it, or Council has determined that there are emergency circumstances, and that it is in the public interest that the College issue emergency certificates of registration for physician assistants to address the emergency circumstances.
2. The applicant must have a minimum of a baccalaureate degree evidencing the successful completion of a program designed to educate and train persons to be practising physician assistants which was:

   (a) accredited by the Canadian Medical Association or Accreditation Canada at the time the applicant graduated;

   (b) accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) at the time the applicant graduated;

   (c) accredited by another accrediting body as approved by Council; or

   (d) a program as approved by Council.

3. The applicant must have any other standard or qualification that Council has identified as necessary in order for emergency certificates of registration for physician assistants to assist in addressing the determined emergency circumstances.

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

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

1. The certificate expires the earlier of the following:
    - (a) one year from the date the certificate was issued or renewed; or
    - (b) the 90th day after Council declares that the emergency circumstances have ended; and
2. The holder must adhere to any other terms, conditions and limitations that Council has identified as necessary in order for holders of emergency certificates of registration for physician assistants to assist in addressing the determined emergency circumstances.

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

9.5 (1) An applicant who in the year immediately preceding their application for a certificate of registration authorizing practice as a physician assistant, has held a certificate of registration issued by the College authorizing practice in emergency circumstances for physician assistants, is exempt from the standards and qualifications required under clause 2(2)(c), only in respect of payment of the relevant application fee but not in respect of payment of the annual membership fee.

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Appendix J

Quality Assurance (CPD) – General Regulation Amendments

NOTE: Amendments are required to s. 29 to distinguish the CPD program for physicians. A new s. 29.1 sets out the CPD requirements for PAs.

O. Reg. 114/94: General. Made under the *Medicine Act, 1991*.

Part VII, ss. 26-29 – Quality Assurance and CPD

CONTINUING PROFESSIONAL DEVELOPMENT AND SELF-ASSESSMENT

29. (1) Members who are physicians shall participate in a program of continuing professional development that includes a self-assessment component and that meets the requirements for continuing professional development set by the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada. O. Reg. 346/11, s. 1.

(2) As evidence of a member who is a physician's participation in a program of continuing professional development, members who are physicians shall, each year, provide to the College,

(a) in the case of a program of continuing professional development offered by the Royal College of Physicians and Surgeons of Canada or by the College of Family Physicians of Canada, proof of the member's participation that is satisfactory to the Committee; or

(b) in the case of a program of continuing professional development offered by an organization other than the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada that has been approved by the Council for that purpose, written confirmation, satisfactory to the Committee, that the member has completed a program of continuing professional development that meets the requirements for continuing professional development set by the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada. O. Reg. 346/11, s. 1.

(3) A member who is a physician shall maintain a record of his or her participation in a program of continuing professional development in the form and manner approved by the Committee and shall retain the record for a minimum of 10 years from the date of his or her participation in the program. O. Reg. 346/11, s. 1.

(4) At the request of the Committee, an assessor or an employee of the College, a member who is a physician shall submit his or her record of participation in a program of continuing professional development to the College within the time period specified in the request or, if no time period is specified, within 30 days of the request. O. Reg. 346/11, s. 1.

29.1 (1) Members who are physician assistants shall participate in a program of continuing professional development that meets the requirements for continuing professional development set by the certifying body of the member.

(2) As evidence of a member who is a physician assistant's participation in a program of continuing professional development, members who are physician assistants shall, each year, provide to the College proof of the member's participation that is satisfactory to the Committee.

(3) A member who is a physician assistant shall maintain a record of his or her participation in a program of continuing professional development in the form and manner approved by the Committee and shall retain the record for a minimum of 10 years from the date of his or her participation in the program.

(4) At the request of the Committee, an assessor or an employee of the College, a member who is a physician assistant shall submit his or her record of participation in a program of continuing professional development to the College within the time period specified in the request or, if no time period is specified, within 30 days of the request.

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<u>Professional Misconduct Regulation Amendments</u>

NOTE: The following amendment is required in order to capture PAs within this heading of professional misconduct.

O. Reg 856/93: Professional Misconduct. Made under the *Medicine Act, 1991*.

1. (1) The following are acts of professional misconduct for the purposes of clause 51 (1) (c) of the Health Professions Procedural Code:

…

34. Conduct unbecoming a physician <u>or physician assistant</u>.

DRAFT

CPSO

Council Motion

Motion Title	Council Meeting Consent Agenda
Date of Meeting	September 21, 2023

It is moved by__________________, and seconded by___________________, that:

The Council of the College of Physicians and Surgeons of Ontario approves the items outlined in the consent agenda, which include in their entirety:

- The Council meeting agenda for September 21 and 22, 2023; and
- The minutes from the meeting of Council held June 8, 2023.

CPSO

Council Briefing Note

September 2023

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

Executive Committee Meeting – July 14, 2023

01-EX-July-2023 **Academic Registration, Recognition of RCPSC Subspecialist Affiliate Status, Specialist Recognition Criteria in Ontario and Practice Ready Assessment Program – Draft Policies for Final Approval**

On a motion moved by I. Preyra, seconded by S. Reid and carried, that the Executive Committee of the College of Physicians and Surgeons of Ontario approves the following as policies of the College:

1. the revised policy, "Academic Registration" (a copy of which forms Appendix "A" to the minutes of this meeting);
2. the policy, "Recognition of RCPSC Subspecialist Affiliate Status" (a copy of which forms Appendix "B" to the minutes of this meeting);
3. the revised policy, "Specialist Recognition Criteria in Ontario" (a copy of which forms Appendix "C" to the minutes of this meeting); and
4. the policy "Practice Ready Assessment Program" (a copy of which forms Appendix "D" to the minutes of this meeting.

Executive Committee Meeting – August 22, 2023

04-EX-August-2023 **Inquiries, Complaints and Reports Committee Chair and Vice-Chair Appointments**

On a motion moved by J. Fisk, seconded by I. Preyra and carried, that the Executive Committee approves on behalf of Council the following Chair and Vice-Chair appointments effective immediately:

Committee	Role	Member Name	Term Length	End Date
Inquiries, Complaints and Reports Committee	Chair	Dr. Thomas Bertoia	1 year, 4 months	December 2024
	Vice-Chair	Dr. Jane Lougheed	1 year, 4 months	December 2024

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

Date: September 6, 2023

CPSO

Council Briefing Note

September 2023

Topic:	Ontario Physicians and Surgeons Discipline Tribunal Report of Completed Cases | May 20, 2023 – September 1, 2023
Purpose:	For Information
Relevance to Strategic Plan:	Right-Touch Regulation
Public Interest Rationale:	**Accountability:** Holding physicians accountable to their patients/clients, the public, and their regulatory body. **Protection:** Fulfilling the College's mandate to ensure public protection.
Main Contacts:	Dionne Woodward, Tribunal Counsel
Attachments:	None

Issue

- This report summarizes reasons for decision released between May 20, 2023 and September 1, 2023 by the Ontario Physicians and Surgeons Discipline Tribunal.
- It includes reasons on discipline hearings (liability and/or penalty), costs hearings, motions and case management issues brought before the Tribunal.
- This report is for information.

Current Status and Analysis

In the period reported, the Tribunal released 8 reasons for decision:

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

Findings

Liability findings included:

- 6 findings of disgraceful, dishonorable or unprofessional conduct

- 1 finding of failure to maintain the standard of practice of the profession
- 3 findings of contravening a term, condition or limitation on certificate of registration
- 2 findings of failing to respond appropriately or within a reasonable period of time to a written inquiry from the College
- 2 findings of conduct unbecoming a physician
- 1 finding of incompetence

Penalty

Penalty orders included:

- 6 reprimands
- 4 suspensions
- 2 revocations
- 3 impositions of terms, conditions or limitations on the physician's Certificate of Registration
- 1 fine to the Minister of Finance

Costs

The Tribunal imposed a costs order on the physician in all penalty reasons. The maximum costs ordered were $250,510 and the minimum costs ordered were $6000.

Motions and case management decisions

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

TABLE 1: TRIBUNAL DECISIONS – FINDINGS (May 20, 2023 to September 1, 2023)

Citation and hyperlink to published reasons	Physician	Date of Reasons	Incompetence	Disgraceful, Dishonourable or Unprofessional Conduct	Failed to maintain standard of practice	Other
2023 ONPSDT 13	Steinberg	June 1, 2023		X		
2023 ONPSDT 14	Luchkiw	July 6, 2023		X		- Failed to respond appropriately or within a reasonable period of time to a written inquiry from the College - Contravened a term, condition or limitation on certificate of registration
2023 ONPSDT 16	Phillips	July 14, 2023	X	X	X	- Failed to respond appropriately or within a reasonable period of time to a written inquiry from the College - Contravened a term, condition or limitation on certificate of registration
2023 ONPSDT 17	El-Tatari	August 15, 2023		X		- Contravened a term, condition or limitation on certificate of registration
2023 ONPSDT 18	Karim	August 24, 2023		X		- Conduct unbecoming a physician
2023 ONPSDT 20	Iannantuono	September 1, 2023		X		- Conduct unbecoming a physician

TABLE 2: TRIBUNAL DECISIONS - PENALTIES (May 20, 2023 to September 1, 2023)

Citation and hyperlink to published reasons	Physician	Date of reasons	Penalty (TCL = Terms, Conditions or Limitations)	Length of suspension in months	Costs
2023 ONPSDT 13	Steinberg	June 1, 2023	Suspension, reprimand, TCL	3	$6000
2023 ONPSDT 15	Kadri	July 13, 2023	Revocation, reprimand		$250,510
2023 ONPSDT 16	Phillips	July 14, 2023	Revocation, reprimand		$6000
2023 ONPSDT 17	El-Tatari	August 15, 2023	Suspension, reprimand	3	$6000
2023 ONPSDT 18	Karim	August 24, 2023	Suspension, reprimand, TCL, fine to the Minister of Finance ($16, 636)	5	$6000
2023 ONPSDT 20	Iannantuono	September 1, 2023	Suspension, reprimand, TCL	18	$6000

TABLE 3: TRIBUNAL DECISIONS - MOTIONS AND CASE MANAGEMENT (May 20, 2023 to September 1, 2023)

Citation and hyperlink to published reasons	Physician(s)	Date of reasons	Motion/Case management outcome	Nature of motion/case management issue
2023 ONPSDT 19	Gill	July 13, 2023	The physician's motion asking the Tribunal to allow her to publicly disclose certain documents in the College's disclosure and identify them as part of the College's case was dismissed.	The Tribunal determined that the implied undertaking rule, which restricts sharing or distributing College disclosure for purposes other than the discipline proceeding, applied to materials obtained by the member through disclosure and/or the investigation. An exception allowing the member to publicly disclose or disseminate this information was not justified.

CPSO

Council Briefing Note

September 2023

Topic:	Government Relations Report
Purpose:	For Information
Relevance to Strategic Plan:	Right-Touch Regulation System Collaboration
Public Interest Rationale:	Government relations supports CPSO to regulate in a more effective, efficient, and coordinated manner.
Main Contacts:	Tanya Terzis, Interim Manager, Policy Heather Webb, Senior Government Relations Program Lead, Policy
Attachments:	N/A

Update on the Ontario Legislature

- Legislators are currently on summer recess and are anticipated to return to Queen's Park on September 25.

- The next Liberal party leader will be announced on December 2. The declared candidates so far are Bonnie Crombie (former mayor of Mississauga), Nathaniel Erskine-Smith (MP for Beaches-East York), Ted Hsu (MPP for Kingston and the Islands), Yasir Naqvi (former MPP and current MP for Ottawa Centre), and physician Adil Shamji (MPP for Don Valley East).

- Two provincial by-elections were held in July, with both contests won by Liberal candidates. Andrea Hazell retained the riding of Scarborough-Guildwood, while Karen McCrimmon picked up the Ottawa-area riding of Kanata-Carleton.

Issues of Interest

a) Bill 60, Your Health Act Update

- The government's Bill 60, the *Your Health Act* received Royal Assent on May 18.

- Schedule 1 of Bill 60 enacts the *Integrated Community Health Services Centres (ICHSCs) Act*, which enables government's plans to expand diagnostic and surgical procedures in community-based clinics. Schedule 1 is scheduled to take effect on September 25.

- An initial package of regulations to support Schedule 1 will also take effect on September 25. It primarily focuses on carrying over existing *Independent Health Facilities Act* requirements with some changes, such as removing licensing fees and prescribing a complaints process that must be in place in every centre.

- A second regulations package, likely to be released for consultation sometime in the fall, is anticipated to include additional requirements regarding transparency, licensing, and quality and safety.

- Schedule 2 of Bill 60 advances government's "As of Right" rules for select out-of-province regulated health professionals. In June, government released for consultation proposed regulations that would support the implementation of Schedule 2.

  - In particular, the regulatory amendments would permit eligible out-of-province physicians to practise in Ontario public hospitals, long-term care homes, and the University of Ottawa Heart Institute for up to 6 months without being registered with CPSO, provided they have applied for a certificate of registration to the College.

    - CPSO made a submission to government expressing support for the intention of the regulatory amendments, while offering suggestions for their safe and effective implementation.
    - The submission emphasized that while out-of-province physicians are practising in Ontario without a license, it will be the employer's responsibility to determine initial and ongoing eligibility, as well as to provide oversight and to address complaints should they arise prior to licensing. Additionally, while we support the provision limiting unlicensed practice to 6 months, the submission noted that CPSO will have no way of knowing whether practise has ceased.

  - The regulatory amendments took effect on July 24 without significant amendments.

b) Physician Assistant Regulation

- The consultation on proposed regulations to regulate physician assistants (PAs) closed on August 14. An overview of the consultation feedback has been provided in the Policy Report.

- In response to consultation feedback, staff has been meeting with other health regulatory colleges to better understand how PAs work with regulated health professionals, particularly in the context of medical directives, to ensure that the regulations reflect the status quo and avoid creating unnecessary barriers to effective patient care.

- Staff also continue to meet with major stakeholders, such as the Ministry and the Canadian Association of Physician Assistants, as the regulations and accompanying guidance materials are refined in the final steps of the consultation process.

- It is anticipated that the final draft regulations will be presented to Council at the December meeting for consideration and approval, following which they will be forwarded to the Ministry for finalization.

c) Emergency Circumstances Practice Class of Registration

- The Committee will recall that Council approved a final draft emergency circumstances practice class of registration at an ad-hoc meeting in April. The proposed regulatory changes were submitted to the Ministry on May 1.

- Shortly following submission, the Ministry returned with proposed changes to enable the Minister of Health, in addition to Council, to trigger the opening of the class, on the basis of promoting consistency across the health Colleges and with the RHPA. Council was notified of the change at its June meeting.

- In July, the Ministry returned with further changes to the clause for the opening of the emergency class, again to ensure consistency across the health Colleges.

    - The changes included a requirement that when Council exercises its discretion to determine that there are emergency circumstances, it must "take into account all of the relevant circumstances that impact the ability of applicants to meet the ordinary registration requirements".

- The Ministry's changes were accepted on the basis that the final version maintains the spirit of the version approved by Council. The regulation has since been finalized and these amendments took effect on August 31.

d) Regulation of Applied Behaviour Analysts

- In July 2023, government approved regulations to bring the profession of applied behaviour analysts (ABA) under the College of Psychologists of Ontario (CPO). The changes will take effect on July 1, 2024, when the CPO will change its name to the College of Psychologists and Behaviour Analysts of Ontario.

Interactions with Government

- Staff continue to engage with government on Bill 60 and the regulations to enact it, registration matters, public members, and other emergent issues.

- Staff also anticipate regular interaction with government regarding the regulation of PAs for the rest of the year, as the regulations are finalized.

Council Briefing Note

CPSO

September 2023

Topic:	Policy Report
Purpose:	For Information
Relevance to Strategic Plan:	Right-Touch Regulation Meaningful Engagement
Public Interest Rationale:	Keeping Council apprised of ongoing policy-related issues and activities for monitoring and transparency
Main Contact:	Tanya Terzis, Interim Manager, Policy
Attachment:	**Appendix A:** Policy Status Report

Issue

- An update on recent policy-related activities is provided to Council for information.

Current Status

1. Consultation Update

Proposed Regulatory Amendments to Regulate Physician Assistants

- CPSO is working towards regulating Physician Assistants (PAs) in accordance with the *Advancing Oversight and Planning in Ontario's Health System Act, 2021*, and consequential amendments to the *Medicine Act, 1991*.

- To support the regulation of PAs by CPSO, draft amendments to the General, Registration, and Professional Misconduct regulations under the *Medicine Act, 1991* have been developed.

- In June 2023 Council approved the draft regulatory amendments for external consultation, and a 60-day consultation was launched. This consultation received 200 responses. The vast majority of respondents were Ontario physicians and other health-care professionals, including PAs. We also received feedback from seven organizations.[1]

[1] Organizational respondents included: Canadian Association of Physician Assistants (CAPA), Canadian Medical Protective Association (CMPA), a family health team (FHT), Ontario Trial Lawyers Association (OTLA), College of Nurses of Ontario (CNO), Ontario Medical Association (OMA), and Professional Association of Residents of Ontario (PARO).

- Key issues that emerged from the feedback included the following:
    - **Delegation framework and the prohibition on sub-delegation:** While some stakeholders (CNO and OMA) support the prohibition of sub-delegation, we also heard concerns suggesting that it could hinder a PA's ability to work with other healthcare providers. Although this prohibition is a universal and well-established principle of delegation, respondents requested guidance on how PAs and other healthcare professionals can work together to implement physicians' orders in light of this provision.
        - CAPA and others requested clarity around how the prohibition on sub-delegation impacts PAs' ability to supervise and sign orders for PA trainees.
        - CAPA and others felt that medical directives were overly restrictive, and suggested they should be more flexible and less prescriptive.
    - **Prohibition on delegation of psychotherapy:** Many respondents felt that this restriction was unreasonable. They noted that PA education and training are similar to other health professionals who can perform psychotherapy, and PAs should be allowed to perform psychotherapy with appropriate training and supervision.
        - Some physicians strongly agreed with the prohibition on psychotherapy, while others noted that clarification on what constitutes "psychotherapy" is required.
        - In response to CPSO feedback that PAs wishing to perform the controlled act of psychotherapy can register with another college whose members are authorized to perform psychotherapy (e.g., the College of Registered Psychotherapists), CAPA requested clarification around dual licensure.
    - **Internationally educated physicians (IEPs):** Several respondents discussed the applicability of the regulations to IEPs and whether they would be able to obtain a PA license. Some expressed that IEPs and PAs have different training and that IEPs would need to be trained as a PA in order to use the PA title.
    - The feedback also included questions around how physicians can bill for PA services; whether PAs will be represented within CPSO's Council; and what "reasonable steps" physicians need to take to ensure a PA has the requisite knowledge, skill, and judgment. There was also discussion of whether "Physician Associate" was a more appropriate title for the profession.

2. Policy Status Table

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

Appendix A: Policy Status Report – September 2023 Council

Table 1: Current Reviews

Policy	Launch	Stage of Policy Review Cycle						Target Comp.	Notes
		Prelim. Consult	Analysis/ Drafting	Approval to Consult	Consult on Draft Policy	Revising Draft Policy	Final Approval		
Physician Behaviour in the Professional Environment	Mar-23		✓					**2024**	
Practice Guide	Dec-22		✓					**2024**	
Mandatory and Permissive Reporting	Jun-22		✓					**2024**	
Physicians' Relationships with Industry: Practice, Education and Research	Dec-21					✓		**2023**	The draft policy has been retitled *Conflicts of Interest and Industry Relationships*.
Professional Obligations and Human Rights	Dec-20						✓	**2023**	The draft policy has been retitled *Human Rights in the Provision of Health Services*.
Medical Assistance in Dying	Dec-20					✓		**2023**	

Table 2: Policy Review Schedule

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

Ontario Medical Students' Association CPSO Council Update September 22-23, 2023

Presented by:
Jeeventh Kaur, President
Maxim Matyashin, President-Elect

Thank you once again to the CPSO for inviting representatives from the Ontario Medical Students Association (OMSA) to observe and participate in your Council meeting. OMSA represents the interests and concerns of Ontario's 4,000+ medical students, and is entrusted with advocating for changes in education, health policy, and care delivery that will benefit the future physicians of Canada and the communities that we serve.

While the summer months have historically been quiet for our organization, this year OMSA took a more proactive approach in planning for the upcoming year. For the first time ever, we completed recruitment of the leadership of most of OMSA's 23 committees before the start of classes. Our Committee Chairs have already started working towards the planning and organization of many of OMSA's initiatives.

As the fall term begins, **OMSA is thrilled to welcome all first year students (Class of 2027, and 2026 for McMaster's 3-year program) to our ranks!** We are ramping up our "welcome" activities through various means:

1. **Ontario Medical Students' Weekend (OMSW):** for the first time since 2019, we are bringing back OMSW, an event that will welcome over 450 first- and second-year medical students from across Ontario over the weekend of October 27-29
2. **Introduction to OMSA presentations:** to introduce medical students to OMSA, the OMA, and ways to get involved
3. **Clerkship Kits:** small tokens of appreciation for incoming clerks, with useful items such as mugs, pens, notepads, a bookmark, and more
4. **2023-2024 Incoming Student Handbook:** beginning of school "to-do" list, mental health and wellness advice, preliminary outline of medical specialties

This year, **high-level goals from the President's portfolio for 2023-2024 include:**

- **Increasing effectiveness of internal operation**s, through restructuring of our Public Relations portfolio, Education Policy Committee, and forming a new Sponsorship Committee
- **Better using student funds**, by expanding existing initiatives (e.g., conference grants) and forming new ones based on input and feedback from students
- **Creating excitement for OMSA**, by taking advantage of key opportunities like OMSW to connect with students and get them involved with OMSA early
- **Planning for the future**, by looking ahead to the integration of TMU within OMSA and finalize the 2025-2029 strategic plan to guide OMSA in the years to come

We look forward to attending, contributing to, and learning from CPSO meetings to help achieve these goals. Thank you as always for welcoming medical students to the table.

Sincerely,

Jeeventh Kaur
President, OMSA
president@omsa.ca

Maxim Matyashin
President-Elect, OMSA
president_elect@omsa.ca

CPSO Council September 2023

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

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

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

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

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

PARO-OTH Collective Agreement
There are two issues related to our Collective Agreement with the Ontario Teaching Hospitals, which expired on June 30, 2023.

Bill 124 Contract Re-opener
Our current contract was negotiated while Bill 124 was in effect. This Bill essentially restricted salary increases to one percent per year for three consecutive years for many parts of the public sector, including us. On November 29, 2022, the Ontario Superior Court ruled that Bill 124 is unconstitutional. We are very fortunate that our legal team played a lead role in this determination.

Of paramount importance is the fact that in our last round of negotiations, we obtained a Bill 124 reopener, which states that the Arbitration Panel from the last round of bargaining remained "seized to reopen compensation issues should the outstanding constitutional challenges prove successful, or should Bill 124 be otherwise modified or repealed".

PARO and the OTH met with Mediation Mr. Kaplan in at the end of June 2023 to see if we could reach agreement. Our Employer, however, had not received a mandate from Government to enter into discussions. We were not surprised by this, given that every other group, that had the right to re-open their contract, had encountered the same situation. In anticipation of this outcome, we had already secured dates to have the matter Arbitrated.

Our Arbitration Hearing will take place September 6th, 2023. We have been hard at work preparing our Arbitration Brief. We will be presenting compelling arguments and data to explain why our members deserve more than the 1% we were limited to under Bill 124. We

have been carefully analyzing the recent Arbitration decisions of other groups that had the right to re-open their contract and we feel well prepared to make a strong case.

2023 Negotiations Preparation

Our current Collective Agreement expired on June 30, 2023. We have agreed with the Employer that we will start contract negotiations once we have finalized the re-opener. From our perspective, it is important to resolve the re-opener issue so that we are able to build on any gains that we might achieve. Until the new contract is ratified, the 2020-2023 PARO-OTH Collective Agreement remains in effect.

As part of our process, we also rely heavily on our PARO Senior Staff and Legal Counsel to provide us with an analysis of the bargaining climate together with knowledge of what other bargaining units are achieving through collective bargaining, mediation or arbitrated settlements.

Restricted Registration

We are very grateful to the CPSO Council for approving the suspension of additional licensing fees for residents wishing to participate in the *Restricted Registration Program* in Ontario.

The decision of the CPSO Council was met with great excitement by residents already participating in the program and more importantly, we have seen a marked increase in applications.

The Motion by CPSO Council communicates the recognition that residents, beyond the work they do every day, are important contributors through the RR Program in helping to mitigate the health human resource issues that Ontario continues to experience.

PARO General Council and Site Chairs

Over the month of July, PARO held its annual elections for General Council and we are pleased that all 100 positions have been filled. As with previous years, our GC is approx. 40% returning reps and 60% first-time reps. Following our General Council elections, each site team selected a Site Chair who will be responsible for leading the work of the team locally. We have had the opportunity to begin our training and onboarding process for our Site Chairs, and they are eager to begin work with their local site teams. We are very pleased that both the GC and Site Chairs elections were very competitive, and we are excited to get started with this new team.

PARO Board

In June we elected our PARO Board and we are engaged with the robust training and team-building PARO provides to help us and the PARO Staff develop into a high-performing team. Through a series of sessions, we learn about ourselves, how to work with each other and how to employ critical thinking discussion and decision-making. The access to this training at PARO has become a significant reason for the competitive Board elections we have been fortunate to have.

This year's Board elections were particularly successful in achieving our leadership progression goal of having Site Chairs stand for Board elections, and this year five were elected to the Board team.

PARO CEO

We have important news to share that Dr. Robert Conn, PARO's CEO, has notified us of his plan to retire and so we are undertaking a search for PARO's next CEO.

PARO's HR Committee, which is tasked with the role of hiring the CEO, has embarked on the process to replace him, a tall order we certainly all appreciate. We have retained a search firm and they have begun the process to find suitable candidates.

We are certainly sad to lose Robert's leadership and mentorship especially knowing the many significant achievements PARO has achieved during his tenure as our CEO. He will leave huge shoes to fill. We are extremely happy and excited for Robert in this decision and to support him transitioning to the next phase of his busy life.

Kind Regards,

Pooya Dibajnia, MD
PARO Board of Directors

Council Briefing Note

CPSO

September 2023

Topic:	Update on Council Action Items
Purpose:	For Information
Relevance to Strategic Plan:	Right Touch Regulation, Quality Care, Meaningful Engagement, System Collaboration, Continuous Improvement
Public Interest Rationale:	Accountability: Holding Council and the College accountable for the decisions made during the Council meetings
Main Contacts:	Carolyn Silver, Chief Legal Officer Cameo Allan, Manager of Governance Adrianna Bogris, Board Administrator

Issue

- To promote accountability and ensure that Council is informed about the status of the decisions it makes, an update on the implementation of Council decisions is provided below.

Current Status

- Council held a meeting on June 8, 2023. The motions carried and the implementation status of those decisions are outlined in Table 1.

Table 1: Council Decisions from the June Meeting

Reference	Motions Carried	Status
01-C-06-2023	**Consent Agenda** The Council of the College of Physicians and Surgeons of Ontario approves the items outlined in the consent agenda, which include in their entirety: • The Council meeting agenda for June 8, 2023; and • The minutes from the meeting of Council held March 2 and 3, 2023, and the minutes from the Special Council meeting held April 14, 2023.	Completed.

Reference	Motions Carried	Status
02-C-06-2023	**Governance Committee Report – Executive Committee Elections** The Council of the College of Physicians and Surgeons of Ontario appoints: Dr. Ian Preyra (as President), Dr. Sarah Reid (as Vice President), Dr. Patrick Safieh (as Executive Member Representative), Ms. Joan Fisk (as Executive Member Representative), Dr. Lydia Miljan (as Executive Member Representative), and Dr. Robert Gratton (as Past President), to the Executive Committee for the year that commences with the adjournment of the Annual General Meeting of Council in December 2023.	Completed.
03-C-06-2023	**Committee Appointments** The Council of the College of Physicians and Surgeons of Ontario appoints the following individuals to the following Committees for the terms indicated below, effective immediately:	Completed.

Committee	Member Name	Role	Term Length	End Date
Registration Committee	Dr. Diane Hawthorne	Physician Committee Member	2.5 years	AGM 2025
Registration Committee	Dr. Sachdeep Rehsia	Physician Committee Member	2.5 years	AGM 2025
Registration Committee	Dr. Anjali Kundi	Physician Committee Member	2.5 years	AGM 2025
Registration Committee	Dr. Faiq Bilal	Public Committee	2.5 years	AGM 2025

<table>
<tr><th>Reference</th><th>Motions Carried</th><th>Status</th></tr>
<tr><td></td><td><table><tr><td></td><td>(Ph.D.)</td><td>Member</td><td></td><td></td></tr><tr><td>Inquiries, Complaints and Reports Committee</td><td>Dr. Faiq Bilal (Ph.D.)</td><td>Public Committee Member</td><td>2.5 years</td><td>AGM 2025</td></tr></table></td><td></td></tr>
<tr><td><u>04-C-06-2023</u></td><td><u>2024 Voting Academic Representative Selection</u>

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

Dr. Janet van Vlymen,

Dr. Roy Kirkpatrick, and

Dr. Marie-Pierre Carpentier.</td><td>Completed.</td></tr>
<tr><td><u>05-C-06-2023</u></td><td><u>Final Approval: Revised Draft Out-of-Hospital Premises Standards</u>

The Council of the College of Physicians and Surgeons of Ontario approves the revised “Out-of-Hospital Premises Standards”, formerly titled “Out-of-Hospital Premises Inspection Program (OHPIP) Program Standards”, (a copy of which forms Appendix “A“ to the minutes of this meeting).</td><td>Completed.</td></tr>
<tr><td><u>06-C-06-2023</u></td><td><u>Draft Policies for Consultation: Academic Registration and Specialist Recognition Criteria in Ontario</u>

The Council of the College of Physicians and Surgeons of Ontario engage in the notice and consultation process in accordance with Section 22.21 of the Health Professions Procedural Code in respect of the draft revised policy, “Academic Registration” (a copy of which forms Appendix “B” to the minutes of this meeting) and the draft revised policy, “Specialist Recognition Criteria in Ontario” (a copy of which forms Appendix “C“ to the minutes of this meeting).</td><td>Final Policies approved by the Executive Committee on behalf of Council.</td></tr>
</table>

Reference	Motions Carried	Status
07-C-06-2023	**Draft Policy for Consultation: Practice Ready Assessment Program** The Council of the College of Physicians and Surgeons of Ontario engage in the notice and consultation process in accordance with Section 22.21 of the Health Professions Procedural Code in respect of the draft policy, "*Practice Ready Assessment Program*" (a copy of which forms Appendix "D" to the minutes of this meeting).	Final Policy approved by the Executive Committee on behalf of Council.
08-C-06-2023	**Draft Policies for Consultation: Recognition of RCPSC Subspecialist Affiliate Status and Specialist Recognition Criteria in Ontario** The Council of the College of Physicians and Surgeons of Ontario engage in the notice and consultation process in accordance with Section 22.21 of the Health Professions Procedural Code in respect of the draft policy, "*Recognition of RCPSC Subspecialist Affiliate Status*" (a copy of which forms Appendix "E" to the minutes of this meeting) and the draft revised policy, "*Specialist Recognition Criteria in Ontario*" (a copy of which forms Appendix "F" to the minutes of this meeting).	Final Policies approved by the Executive Committee on behalf of Council.
09-C-06-2023	**Approval Item: Waiver of Certain Fees Under the Residents Working Additional Hours for Pay ("Moonlighting") Policy** The Council of the College of Physicians and Surgeons of Ontario approves waiving the application fees for residents holding a postgraduate education certificate of registration who apply for a restricted certificate of registration under the *Residents Working Additional Hours for Pay ("Moonlighting")* Policy for the July 2023 to June 2024 academic year.	Completed.
10-C-06-2023	**For Approval: Audited Financial Statements for the 2022 Year** The Council of the College of Physicians and Surgeons of Ontario approves the audited financial statements for the fiscal year ended December 31, 2022, as presented (a copy of which forms Appendix "G" to the minutes of this meeting).	Completed.

<table>
<tr><th>Reference</th><th>Motions Carried</th><th>Status</th></tr>
<tr><td><u>11-C-06-2023</u></td><td><u>For Approval: Appointment of the Auditor (for fiscal year 2023)</u>

The Council of the College of Physicians and Surgeons of Ontario appoints Tinkham LLP, Chartered Accountants, as auditors to hold office until the next annual financial meeting of Council.</td><td>Completed.</td></tr>
<tr><td><u>12-C-06-2023</u></td><td><u>Draft Regulations for Consultation: Physician Assistant Regulations</u>

The Council of the College of Physicians and Surgeons of Ontario release for external consultation and engage in the notice and consultation process in accordance with Section 22.21 of the Health Professions Procedural Code, in respect of the draft physician assistant regulatory amendments to the Medicine Act, 1991 regulations (a copy of which amendments form Appendices “H“, “I“, “J“, and “K“ to the minutes of this meeting).</td><td>Completed.</td></tr>
<tr><td><u>13-C-06-2023</u></td><td><u>Motion to Go In Camera</u>

The Council of the College of Physicians and Surgeons of Ontario exclude the public from the part of the meeting immediately after this motion is passed, under clause 7(2)(b) and (d) of the Health Professions Procedural Code (set out below).

Exclusion of public

7(2) Despite subsection (1), the Council may exclude the public from any meeting or part of a meeting if it is satisfied that,

(b) financial or personal or other matters may be disclosed of such a nature that the harm created by the disclosure would outweigh the desirability of adhering to the principle that meetings be open to the public; and
(d) personnel matters or property acquisitions will be discussed.</td><td>Completed.</td></tr>
</table>

2024 CPSO MEETING DATES

Jan-2024

M	T	W	T	F
1 New Year's Day	2	3	4	5
8	9 EC-V	10	11	12
15	16	17	18	19
22	23 GC-V	24	25 FC	26
29	30	31		

Feb-2024

M	T	W	T	F
			1	2
5	6 EC	7	8	9
12	13	14	15	16
19 Family Day	20	21	22	23
26	27	28	29 C	

Mar-2024

M	T	W	T	F
				1 C
4	5	6	7	8
11	12	13 March Break	14	15
18	19 GC-V	20	21	22
25	26	27	28	29 Good Friday

Apr-2024

M	T	W	T	F
1 Easter Monday	2	3	4	5
8	9 EC	10 Eid al-Fitr	11	12
15	16 FC-V	17	18 FSMB (Apr 18-20) Nashville	19
22	23 GC-V	24	25	26
29	30			

May-2024

M	T	W	T	F
		1	2	3
6	7 EC	8	9	10
13	14	15	16	17
20 Victoria Day	21	22	23 CCPL (Mtl) May 23-24	24
27	28	29 CMA (V)	30 C	31 C

Jun-2024

M	T	W	T	F
3	4	5	6	7
10	11 FMRAC (Muskoka) Jun 11-14	12	13	14
17	18 Eid al-Adha	19	20	21
24	25	26	27	28

Jul-2024

M	T	W	T	F
1 Canada Day	2	3	4	5
8	9	10	11	12
15	16	17	18	19
22	23	24	25	26
29	30 GC-V	31		

Aug-2024

M	T	W	T	F
			1	2
5 Civic Holiday	6	7	8	9
12	13 EC	14 CMPA (Halifx)	15	16
19	20	21	22	23
26	27	28	29	30

Sep-2024

M	T	W	T	F
2 Labour Day	3	4	5 TIFF	6 C-V
9 TIFF	10 TIFF	11 TIFF	12 TIFF	13 TIFF
16 CLEAR (Baltimore) Sep 16-19; ISQua (Turkey) Sep 15-18	17	18	19	20
23 MCC (Ottawa) Sep 23-24	24	25	26 FC-V	27
30 TR Day				

Oct-2024

M	T	W	T	F
	1 EC-V	2 Rosh Hashanah	3	4
7 CNAR (Ottawa) Oct 7-9	8	9	10	11 Yom Yippur
14 Thanksgiving	15 GC-V	16	17 FC-V	18
21	22	23	24	25
28	29	30	31 Diwali Oct 31-Nov 4	

Nov-2024

M	T	W	T	F
				1 Diwali
4 Diwali	5 EC	6	7	8
11 Rem Day	12	13	14	15
18	19	20	21	22
25	26	27	US Thx 28 C	29 C

Dec-2024

M	T	W	T	F
2	3	4	5	6
9	10	11	12	13
16	17	18	19	20
23	24 CPSO Closure	25 Christmas	26 Boxing Day	27 CPSO Closure
30 CPSO Closure	31	Hanukkah Dec 26-Jan 2		

Legend

Code	Meaning
C	Council
C-V	Council-Virtual
EC	Executive
EC-V	Executive-Virtual
GC-V	Governance-Virtual
GSM-V	General Staff Meeting-Virtual
FC	Finance & Audit
FC-V	Finance & Audit-Virtual
(grey)	Stat/religious holidays/Mar break
(purple)	Conference/AGM

Last updated: 2023-09-074:21 PM

Council Briefing Note

CPSO

September 2023

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

Issue

- There are three upcoming vacancies for the Governance Committee for 2024. The General By-Law sets out Governance Committee composition requirements and the convention has been to hold an election to fill these vacancies.

Background

- Section 44 of the College's General By-law states that the Governance Committee shall be comprised of the President, Vice-President, and a Past-President of Council, as well as one physician Council member and two public Council members who are not members of the Executive Committee. The term for all Governance Committee appointments is one year.

- An election is required for the purpose of selecting the two public and one physician Council members. If the number of nominations matches the number of open positions in the Governance Committee, they may be acclaimed rather than elected.

- All Governance Committee members are expected to demonstrate the relevant key behavioural competencies set out in the Council Member Skills and Attributes and the Committee Profile.

Current Status and Analysis

- Dr. Rob Gratton (2023-2024 Past President) is slated for appointment by Council to the Governance Committee in his upcoming capacity as Past President. As such, Dr. Gratton will serve as the Governance Committee Chair for 2023-2024.
- Dr. Ian Preyra (2023-2024 President) and Dr. Sarah Reid (2023-2024 Vice-President) will also be appointed to the Governance Committee by Council.
- Out of the remaining three vacancies, one must be filled by a physician member of Council and two must be filled by public members of Council.
- Nominations for the physician vacancy have been received from Dr. Madhu Azad and Dr. Andrea Steen.
- In addition, nominations for the public member vacancies have been received from Mr. Rob Payne and Shannon Weber.

Next Steps

- All nominees will be given the opportunity to address Council prior to the election.
- Elections for the physician member position will be held using an electronic voting software that facilitates secret ballot voting (ElectionBuddy). All Council members must have access to their CPSO Email during the voting period to access the voting link.
- Results will then be tabulated, and Council will have the opportunity to appoint members for the 2023-2024 Governance Committee.

Question for Council

1. Who does Council appoint to fill the three vacancies on the Governance Committee for 2023-2024?

Governance Committee Elections

Appendix A: Nomination Statements

Mr. Rob Payne, Public Member of Council

Financial Advisor

Nominated For:

Member, Governance Committee

Appointed Council Terms:

2020-2024

CPSO Involvement:

Finance and Audit	2020-Present
Fitness to Practice Committee	2020-Present
Governance	2022-Present
Ontario Physicians and Surgeons Discipline Tribunal	2020-Present

Nomination Statement:

Upon reviewing the Governance Committee Terms of Reference and the necessary skills and competencies required to be successful, Rob has demonstrated the relevant experience as a current member of the Governance Committee while also following best practices in governance principles and practices.

More specifically, Rob is well-suited for the committee, including the following key behavioural competencies and previous governance experience.

1. Effective Communicator – Rob is an active listener and communicates a clear and compelling vision and perspective.

2. Strategic Thinking - Rob has a solid track-record for inspiring strategic thinking (including previous senior roles with Nestle & Bell Canada and as a previous elected Municipal Councillor/Chair of Finance & Audit), and implementing, managing organizational changes (developed vision, customer engagement strategy as part of Government of Canada re-procurement - National Student Loans Service Centre, Student Lending Program).

3. Teamwork – Rob has developed effective & positive relationships and takes an active approach. He consistently demonstrates a cooperative and calm methodology while maintaining an open-mind and respecting others. He maintains a positive attitude.

4. Results Oriented – Rob is performance focused with a keen interest for driving key performance indicators (KPI's) including driving revenue, EBITDA and other key performance and organizational indicators.

Governance Committee Elections

Appendix A: Nomination Statements

Dr. Madhu Azad, District 9 Representative (Thunder Bay)

Principal area of practice: Family Medicine

Nominated For:

Member, Governance Committee

Appointed Council Terms:

2022-2024

CPSO Involvement:

Ontario Physicians and Surgeons Discipline Tribunal	2022-Present
Fitness to Practice Committee	2022-Present

Governance Committee Elections

Appendix A: Nomination Statements

CPSO

Nomination Statement:

Dear colleagues,

During my tenure on CPSO Council, I have witnessed firsthand the organization's commitment to effective, impactful regulation. Our collaborative culture fostered my strong commitment to advance the College's Mission. I am proud to stand for election to the Governance Committee.

I have diverse experiences as a physician and leader. My work in three healthcare systems (India, UK, Canada) offers a unique perspective on the healthcare system's challenges. As Chair of Credentialing at TBRHSC, I created systems that ensure inclusive decision-making, clear accountability, and diverse stakeholder consensus. As lead physician at Superior FHO, I have led structural governance changes to enhance our organization's quality and performance.

I recently completed a master's in healthcare leadership from McGill University; my master's thesis, *Adaptive Leadership and Microsystems Thinking*, was based on practical implementation of learned concepts. I am also completing the Rotman-ICD Governance Essentials course to enhance my capacity to advance the CPSO's governance modernization commitment.

The work ahead in governance is daunting yet exciting! The transformation will enhance the CPSO's effectiveness and transparency, gaining further trust from members and the public. I am excited at the opportunity to contribute to the Governance Committee and thank you for your consideration.

Governance Committee Elections

Appendix A: Nomination Statements

Dr. Andrea Steen, District 1 Representative (Windsor)

Principal area of practice: Family Medicine

Nominated For:
Member, Governance Committee

Appointed Council Terms:
2022-2025

CPSO Involvement:

Not applicable	

Nomination Statement:

I am applying for the position of physician member of the Governance committee. I have been the VPMA at Hotel Dieu Grace Healthcare for the past 10 years. In that time, I have been an ex-officio member of the Board as well as an employee of the Board. In 2019 the hospital did a refresh of the By-laws both general and Professional staff, giving me the experience of going through a thorough review with our legal advisors.

Working with physicians the past 10 years I have realized the importance of strong bylaws to help in situations of conflict, disputes and quality concerns. I have also had the opportunity to participate in two strategic planning sessions for the hospital, most recently in June 2023. This exercise was extremely engaging and gave me great insight into the importance of aligning strategic planning with the hospitals mandate as well as the mission, vision and values.

I would be excited to be able to participate in the Governance Committee for the CPSO as a new member.

Governance Committee Elections

Appendix A: Nomination Statements

Ms. Shannon Weber, Public Member of Council

External Relations & Governance Consultant with specialties in higher education, public and not-for-profit sectors

Nominated For:

Member, Governance Committee

Appointed Council Terms:

2020-2021
2021-2024

CPSO Involvement:

Governance	2022-Present
Ontario Physicians and Surgeons Discipline Tribunal	2020-Present

Nomination Statement:

I have served on the Governance Committee over the past two years and offer my service and opportunity for continuity.

I bring years of governance and leadership experience working with public and non-profit Boards and leadership teams. I have served as a governance coach including as an Executive-in-Residence with Capacity Canada. One of the many effective governance tools that I have used is a generative form of stakeholder engagement. I would like to explore this approach with CPSO to further engagement and impact of Council.

I have additional experience in both external relations and organizational leadership. I am currently consulting with the University of Guelph in external relations and community engagement, within the Office of the President. Previously, I was a faculty member in a graduate business program at Conestoga College. In my volunteer capacity, I have served as a Coach for the Fora Network Girls on Boards program & Startup Laurier; as Strategic Planning Advisor for KW4 Ontario Health Team and Wellbeing Waterloo Region; and as Co-Chair of the Economic Development Advisory Committee in Kitchener. I have also served as Board Chair of our Ontario Early Years Centre.

I appreciate your consideration of my interest in serving the CPSO.

CPSO

Council Motion

Motion Title	For Approval: Governance Committee Appointments
Date of Meeting	September 21, 2023

It is moved by___________________, and seconded by____________________, that:

The Council of the College of Physicians and Surgeons of Ontario appoints the following individuals to the 2023-2024 Governance Committee each for a one-year term commencing upon the adjournment of the Annual General Meeting of Council in December 2023:

Dr. Robert Gratton, Chair
Dr. Ian Preyra, Vice-Chair
Dr. Sarah Reid – Vice President
X – Physician Member of Council
X – Public Member of Council
X – Public Member of Council

CPSO

Council Briefing Note

September 2023

Topic:	Committee Chair and Vice-Chair Appointments
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation System Collaboration
Public Interest Rationale:	Ensuring that CPSO Committees have qualified and diverse members will enable the College to carry out its strategic objectives and fulfill its mandate to serve in the public interest.
Main Contacts:	Caitlin Ferguson, Governance Coordinator Cameo Allan, Manager of Governance

Issue

- Council is asked to appoint Committee Chairs and Vice-Chairs for 2023-2024.

Background

- The Governance Office has canvassed the Committees regarding succession planning for Chair and Vice-Chair vacancies.

Current Status

- The Committees listed in the table below have Chairs and/or Vice-Chairs whose leadership term expires at the conclusion of the Annual General Meeting of Council in 2023.
- Committee leadership and Committee Support staff have been canvassed regarding succession planning for these leadership positions.
- Candidates for leadership positions have been approached by either the current Chair, current Vice-Chair, or a Committee Support staff member to confirm that they are willing and able to take on a leadership position.

- The Governance Office has verified that the members are eligible to serve the terms suggested without reaching their term limit for the individual Committee or their overall term limit for service on Council and Committees.
- Vice-Chair appointees typically serve a subsequent two-year term as Chair. Therefore, the Governance Office has also verified that all candidates nominated for a Vice-Chair appointment have at least four years remaining before reaching their term limit for the Committee.
- Several Committees have requested to have their Chairs re-appointed for a one-year term, instead of having the current Vice-Chair move into the Chair position. This was requested to either provide adequate training and mentorship for a new Vice-Chair who is proposed to commence their term in December 2023, or to give Chairs and Vice-Chairs adequate time to mentor and select new Committee leadership.
- The following members are recommended for Chair or Vice-Chair appointments that would begin at the conclusion of the 2023 Annual General Meeting of Council, for terms as specified in the table:

Committee	Role	Member Name	Term Length	End Date
OPSDT & FTP	Chair	Mr. David Wright	5 years	December 2028
	Vice-Chair	Dr. Joanne Nicholson	2 years	December 2025
Patient Relations	Chair	Ms. Nadia Bello	2 years	December 2025
Quality Assurance	Chair	Dr. Sarah Reid	1 year	December 2024
	Vice-Chair	Dr. Ashraf Sefin	1 year	December 2024

- Chair and Vice-Chair appointments for the Registration Committee, Finance and Audit Committee, and ICRC Specialty Panels are pending and will be brought to the December Council meeting.

ICRC Chair and Vice-Chair Appointments

- In light of Dr. Brian Burke's recent passing, the ICRC urgently required new leadership.
- At its August 22, 2023 meeting, the Executive Committee voted to appoint Dr. Thomas Bertoia as Chair and Dr. Jane Lougheed as Vice-Chair of the ICRC, for a term effective immediately and ending at the 2024 Annual General Meeting of Council.

Next Steps.

- The remaining appointments will be presented at the December Council meeting.

Question for Council

1. Does Council appoint the nominees as laid out in this briefing note?

CPSO

Council Motion

Motion Title	For Approval: 2023-2024 Chair and Vice-Chair Appointments
Date of Meeting	September 21, 2023

It is moved by__________________, and seconded by___________________, that:

The Council of the College of Physicians and Surgeons of Ontario appoints the following Committee Members as Chairs and Vice-Chairs, as noted below, to the following Committees, for the terms indicated below, as of the close of the Annual General Meeting of Council in December 2023:

Committee	Role	Member Name	Term Length
OPSDT & FTP	Chair	Mr. David Wright	5 years
	Vice-Chair	Dr. Joanne Nicholson	2 years
Patient Relations	Chair	Ms. Nadia Bello	2 years
Quality Assurance	Chair	Dr. Sarah Reid	1 year
	Vice-Chair	Dr. Ashraf Sefin	1 year

Council Briefing Note

CPSO

September 2023

Topic:	Committee Re-appointments
Purpose:	For Decision
Relevance to Strategic Plan:	Right Touch Regulation System Collaboration
Public Interest Rationale:	Ensuring that CPSO Committees have qualified and diverse members will enable the College to carry out its strategic objectives and fulfill its mandate to serve in the public interest.
Main Contacts:	Caitlin Ferguson, Governance Coordinator Cameo Allan, Manager of Governance

Issue

- Council is asked to approve the re-appointment of existing Committee members.

Background

- The Governance Office has canvassed Committee Support staff and Committee Chairs to confirm which Committee members with appointments expiring in December 2023 should be re-appointed for a subsequent term.

Current Status

Re-appointments of Existing Committee Members

- The Committee members listed below have current appointments that will end at the Annual General Meeting of Council in December 2023.
- Committee Chairs have been canvassed to ensure they would like the Committee members to be re-appointed for a further term.
- The members have also been approached by a member of Committee Support staff to confirm that they would like to serve a subsequent term.

- Governance staff have verified that these Committee members are eligible to serve the terms suggested below without reaching their term limit for the individual Committee or their overall term limit for service on Council and Committees.

- The Committee members recommended for re-appointment are as follows:

Committee	Member Name	Term Length	End Date	Committee Start Date
PIC	Peter Pielsticker	3 months	March 30, 2024[1]	December 2015
	George Beiko	1 year	December 2024	September 2022
	Patrick Davison	3 years	December 2026	May 2019
	Kashif Pirzada	1 year	December 2024	December 2020
	Ted Xenodemetropoulos	3 years	December 2026	June 2019
OPSDT & FTP	Raj Anand	3 years	December 2026	June 2021
	Glen Bandiera	3 years	December 2026	December 2020
	Lucy Becker	1 year	December 2024	September 2021
	Marie-Pierre Carpentier	1 year	December 2024	December 2022
	Catherine Grenier	3 years	December 2026	June 2021
	Stephen Hucker	3 years	December 2026	December 2018
	Shayne Kert	3 years	December 2026	June 2021
	Roy Kirkpatrick	1 year	December 2024	December 2020
	Sherry Liang	3 years	December 2026	June 2021
	Sophie Martel	3 years	December 2026	June 2021
	Veronica Mohr	2 years	December 2025	December 2016
	Joanne Nicholson	3 years	December 2026	December 2017
	Deborah Robertson	3 years	December 2026	December 2020
	Jennifer Scott	3 years	December 2026	June 2021
	Janet van Vlymen	1 year	December 2024	December 2022
	James Watters	1 year	December 2024	December 2015
	David Wright	3 years	December 2026	December 2020
	Susanna Yanivker	3 years	December 2026	December 2018
ICRC	George Beiko	1 year	December 2024	December 2018
	Mary Bell	1 year, 3 months	February 26, 2025	February 2016
	Thomas Faulds	3 years	December 2026	December 2017
	Joan Fisk	3 years	December 2026	December 2017
	Daniel Greben	1 year	December 2024	December 2017
	Elaine Herer	1 year	December 2024	December 2015
	Christopher Hillis	1 year	December 2024	December 2020

[1] Mr. Pielsticker's appointment as a public member will end on March 30, 2024 as he reaches his 9 years of service on Council.

	Asif Kazmi	1 year	December 2024	December 2020
	Jane Lougheed	3 years	December 2026	April 2019
	Robert Myers	1 year	December 2024	December 2018
	Wayne Nates	1 year	December 2024	December 2020
	Dori Seccareccia	3 years	December 2026	April 2018
	David Tam	3 years	December 2026	December 2020
	Anne Walsh	3 years	December 2026	April 2018
PRC	Nadia Bello	3 years	December 2026	December 2020
	Rajiv Bhatla	3 years	December 2026	December 2018
	Heather Sylvester	3 years	December 2026	December 2018
	Angela Wang	3 years	December 2026	June 2018
QAC	No re-appointments required			

- Re-appointments from the Finance and Audit and Registration Committees will be presented to Council at its December meeting.

Next Steps

- If approved, these re-appointments will take effect at the 2023 Annual General Meeting of Council
- The remaining re-appointments will be presented to Council at its December meeting.

Question for Council

1. Does Council appoint the individuals as laid out in this briefing note?

Council Motion

CPSO

Motion Title	For Approval: Committee Re-appointments
Date of Meeting	September 21, 2023

It is moved by__________________, and seconded by___________________, that:

The Council of the College of Physicians and Surgeons of Ontario re-appoints the following individuals to the following Committees for the terms indicated below as of the close of the Annual General Meeting of Council in December 2023:

Committee	Member Name	Term Length	End Date
PIC	Peter Pielsticker	3 months	March 30, 2024
	George Beiko	1 year	December 2024
	Patrick Davison	3 years	December 2026
	Kashif Pirzada	1 year	December 2024
	Ted Xenodemetropoulos	3 years	December 2026
OPSDT & FTP	Raj Anand	3 years	December 2026
	Glen Bandiera	3 years	December 2026
	Lucy Becker	1 year	December 2024
	Marie-Pierre Carpentier	1 year	December 2024
	Catherine Grenier	3 years	December 2026
	Stephen Hucker	3 years	December 2026
	Shayne Kert	3 years	December 2026
	Roy Kirkpatrick	1 year	December 2024
	Sherry Liang	3 years	December 2026
	Sophie Martel	3 years	December 2026
	Veronica Mohr	2 years	December 2025
	Joanne Nicholson	3 years	December 2026
	Deborah Robertson	3 years	December 2026
	Jennifer Scott	3 years	December 2026
	Janet van Vlymen	1 year	December 2024
	James Watters	1 year	December 2024
	David Wright	3 years	December 2026
	Susanna Yanivker	3 years	December 2026
ICRC	George Beiko	1 year	December 2024
	Mary Bell	1 year, 3 months	February 26, 2025
	Thomas Faulds	3 years	December 2026

	Joan Fisk	3 years	December 2026
	Daniel Greben	1 year	December 2024
	Elaine Herer	1 year	December 2024
	Christopher Hillis	1 year	December 2024
	Asif Kazmi	1 year	December 2024
	Jane Lougheed	3 years	December 2026
	Robert Myers	1 year	December 2024
	Wayne Nates	1 year	December 2024
	Dori Seccareccia	3 years	December 2026
	David Tam	3 years	December 2026
	Anne Walsh	3 years	December 2026
PRC	Nadia Bello	3 years	December 2026
	Rajiv Bhatla	3 years	December 2026
	Heather Sylvester	3 years	December 2026
	Angela Wang	3 years	December 2026

CPSO

Council Briefing Note

September 2023

Topic:	By-law Refresh Project – General By-laws – Governance Modernization
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation; Meaningful Engagement; System Collaboration Continuous Improvement
Public Interest Rationale:	**Accountability:** Holding regulated health professionals accountable to their patients/clients, the College and the public **Protection:** Ensuring the protection of the public from harm in the delivery of health care services
Main Contacts:	Carolyn Silver, Chief Legal Officer Marcia Cooper, Senior Corporate Counsel & Privacy Officer
Attachment:	**Appendix A:** Outline of Proposed Changes to the General By-law

Issue

- Proposed governance modernization changes to be effected through the General By-laws are being brought to Council for further discussion.

Current Status and Analysis

- We have reviewed the feedback received from Council at the June governance education session about the proposed governance modernization initiatives to be effected through by-laws. In discussion with the Executive Committee, we have been refining the proposed initiatives based on this feedback.

- Many of the proposed initiatives represent significant changes and would benefit from further discussion and direction before bringing draft revised by-laws to Council for review and potential approval.

- To guide this discussion, we have prepared an outline (attached in Appendix A) of the proposed initiatives, as refined.

Next Steps

- We will revise the General By-laws based on the feedback and direction of Council and present them to Council for review.
- The Fees and Remuneration By-law will be refreshed and revised to align with terminology and formatting changes in the revised General By-laws. These will also be brought to Council for review.

Question for Council

Please see Appendix A for the questions being raised for Council's consideration.

APPENDIX A

GOVERNANCE MODERNIZATION: PROPOSED BY-LAW CHANGES

<table>
<tr><th>PROPOSED CHANGES</th><th>QUESTIONS FOR DISCUSSION AND DECISION</th></tr>
<tr><td colspan="2">1. Governance Terminology</td></tr>
<tr><td>Goal: Promote clarity by aligning CPSO's governance terminology with conventional terms more commonly used and understood by the general public and other corporations and organizations.

Proposal: Replace governance terminology as follows:

<table>
<tr><th>CURRENT CPSO TERMS</th><th>PROPOSED TERMS</th></tr>
<tr><td>Council</td><td>Board of Directors (the Board)</td></tr>
<tr><td>President</td><td>Board Chair</td></tr>
<tr><td>Vice-President</td><td>Board Vice-Chair</td></tr>
<tr><td>Council members / Councillors</td><td>Directors</td></tr>
<tr><td>Annual General Meeting

Note: Annual General Meetings are more typically used to describe the annual meeting of a not-for-profit corporation or society where the members participate in the meeting. This is not applicable to CPSO.</td><td>Annual Organizational Meeting

Note: Annual Organizational Meeting is suggested as an alternative to reflect that this is a significant meeting of the CPSO Board: when the Executive changes, expiry of certain Director terms, start and expiry of committee appointments, etc.</td></tr>
</table>
</td><td>1. Do you support changing the governance terminology as proposed?</td></tr>
</table>

<table>
<tr><th>PROPOSED CHANGES</th><th>QUESTIONS FOR DISCUSSION AND DECISION</th></tr>
<tr><td colspan="2">2A. New Election Model: Competency-Based Elections</td></tr>
<tr><td>Goal: Achieve a balanced Board composed of skilled, qualified directors who also reflect the diversity of Ontario’s population and the practice of medicine.

Proposal: Implement a process for determining candidates for election to the Board based on their competencies, skills, attributes and diversity.

Steps:
• Expand the mandate of the Governance Committee and rename it the Governance and Nominating Committee (GNC).
• GNC will create and periodically update a “Board Profile/Matrix” for the Board’s approval which reflects desired competencies, skills, attributes and diversity (including practice settings and geography) for Board Directors.
• GNC will review all interested election candidates (who have first met threshold eligibility requirements, discussed below in the Eligibility Chart) based on the Board Profile/Matrix and select qualified candidates that will be on the election ballot. GNC may also identify and solicit candidates, who will also be subject to the review process.
• The slate of qualified candidates is determined by GNC and will not be brought to the Executive Committee or Council for approval.
• Dispute resolution process: A member not approved by GNC as eligible or qualified to stand for election may submit a written dispute. The Executive Committee (excluding any members of GNC) will review and make the final decision as to whether the member may stand for election.</td><td>1. Do you support moving to a competency-based selection process as proposed?</td></tr>
</table>

PROPOSED CHANGES	QUESTIONS FOR DISCUSSION AND DECISION
2B. New Election Model: Election Districts	
Goal: Achieve a balanced Board by facilitating competency-based selection of Directors consistent with the Board/Profile Matrix, without geography being the overriding factor. **Proposal:** Move to province-wide elections where all members vote for all candidates. Eliminate elections by geographic district. • The whole membership would vote annually for approx. 1/3 of the elected Board seats (i.e. based on expiry of 3 year terms). • The Board/Profile Matrix would include geographic attributes to be considered by GNC in proposing the candidate slate. (For example, it may include urban, rural and remote practice locations.)	1. Do you support moving to province-wide elections not based on geographic districts?

PROPOSED CHANGES	QUESTIONS FOR DISCUSSION AND DECISION
3. Academic Representation	
Goals: 1. Reduce the size of the Board within legislative constraints. 2. Achieve a balanced Board by selecting academic Directors through a competency-based selection process. 3. Apply the corporate governance best practice that only Directors should participate as members in Board discussions. (Note the legislation only contemplates that three Ontario medical schools would be represented at any time.) **Proposal:** Have a total of 3 academic representatives on the Board, all of whom will be Directors, and selected based on their competencies, skills, attributes and diversity. **Steps:** • The deans of each faculty of medicine will be invited annually to nominate faculty members to be considered for Director position(s) on the Board. • GNC will review the academic nominees (who have first met threshold eligibility requirements, discussed below in the Eligibility Chart) based on the Board Profile/Matrix and select nominees for Academic Directors. • GNC will select a nominee (usually only one per year) from those eligible and qualified, and recommend that nominee to the Board for appointment as a Director. • The Board Profile/Matrix and GNC may take the nominee's medical faculty into account when assessing diversity attributes.	1. Do you support a total of three academic representatives on the Board, selected using a competency-based approach, as proposed?

PROPOSED CHANGES	QUESTIONS FOR DISCUSSION AND DECISION
4A. Board Committees: Composition of Governance and Nominating Committee (GNC)	

Goal: Achieve optimal GNC composition to enable GNC to perform its important new roles in determining the overall composition of Council and the Executive Committee. Reduce overlap between GNC and Executive Committee.
 	
Proposed Composition:
• Minimum of 5 persons consisting of:
    • Board Vice-Chair (Vice-President) – **serves as chair of GNC**
    • Minimum of 2 Elected Directors and/or Academic Directors (i.e. physicians) who are not on the Executive Committee (to be elected – see below)
    • Minimum of 2 Elected Public Directors who are not on the Executive Committee (to be elected – see below)
 	
The Board Chair (President) will not be on GNC. This reduces overlap with the Executive Committee, making GNC more independent of the Executive Committee.
 	
The Past President will not automatically be on GNC but may be nominated for election to GNC if they are still a Director on the Board. The Past-President cannot be on both GNC and the Executive Committee.
 	
GNC may engage experts in governance and/or professional regulation as advisors, particularly for competency-based selection of Directors (Elected and Academic).
 	
Election of GNC Members (other than Board Vice-Chair):
• The Executive Committee will review the competencies, skills, attributes and diversity of Directors interested in standing for election to GNC based on the Board Profile/Matrix and mandate of GNC. GNC may also identify and solicit candidates, who will also be subject to the review process.
• Based on its review, the Executive Committee will forward nominees for GNC positions to the Board for election.
• Nominations from the floor will not be permitted for these positions.
• The Board will hold **an election** for the GNC positions (other than the Board Vice-Chair).
	1. Do you support the composition of GNC, and how GNC positions are selected, as proposed?

PROPOSED CHANGES	QUESTIONS FOR DISCUSSION AND DECISION
4B. Board Committees: Composition of Executive Committee	
Goal: Achieve optimal Executive Committee (EC) composition in an efficient manner (minimizing unnecessary elections) to enable EC to perform its important role. **Proposed Composition:** • Board Chair (President) – **serves as chair of EC** • Board Vice-Chair (Vice-President) • 4 Directors who are not on GNC (Executive Member Representatives) EC must have a minimum of 3 Elected Directors and/or Academic Directors (i.e. physicians). EC must have a minimum of 2 Public Directors. The Past President will not automatically be on EC but may be appointed to EC (as one of the 4 Executive Member Representatives) if they are still a Director on the Board. The Past-President cannot be on both GNC and EC. **Appointment of EC Members (other than Board Chair and Vice-Chair):** • GNC will review Directors interested in serving on EC based on the Board Profile/Matrix and mandate of EC. GNC may also identify and solicit candidates, who will also be subject to the review process. • Based on its review, GNC will recommend nominees to the Board for appointment to EC. **Election of Board Chair and Board Vice-Chair:** • GNC will review the competencies, skills, attributes and diversity of Directors interested in standing for election as Board Chair and Board Vice-Chair. GNC may also identify and solicit candidates, who will also be subject to the review process. • The established convention that the Board Vice-Chair progresses to the Board Chair position will continue. • Based on its review, the Executive Committee will forward nominees for Board Chair and Board Vice-Chair to the Board for election. • Nominations from the floor will not be permitted for these positions. • The Board will hold an annual election for the Board Chair and Board Vice-Chair positions, as required by the Medicine Act.	1. Do you support the composition of EC, and how EC positions are selected, as proposed? 2. Do you support the selection process for nominees for the Board Chair and Board Vice-Chair positions as proposed?

PROPOSED CHANGES	QUESTIONS FOR DISCUSSION AND DECISION
4C. Special Meetings of the Board	
Goals: Provide an additional option for calling a special Board meeting, while maintaining a significant threshold for calling a special meeting. **Proposal:** Special meetings of the Board may be called by any 4 members of the Executive Committee. This is in addition to the options in the current By-laws, which provide that special meetings of the Board may be called by the Board Chair or any 12 Council members.	1. Do you support the proposal to permit 4 members of the Executive Committee to call a special Board meeting?

PROPOSED CHANGES	QUESTIONS FOR DISCUSSION AND DECISION
4D. Board Committees: Finance and Audit Committee	
Goal: Streamline the composition of the Finance and Audit Committee (FAC). **Proposed Composition:** • Board Chair (President) • 4 Directors FAC must have a minimum of 2 Elected Directors and/or Academic Directors (i.e. physicians). FAC must have a minimum of 2 Public Directors. The Board Vice-Chair (Vice-President) will not sit on FAC. FAC members are appointed by the Board. FAC may invite the auditors (or other experts as needed) to attend FAC meetings.	1. Do you support the proposed composition of the Finance and Audit Committee?

<table>
<tr><th>PROPOSED CHANGES</th><th>QUESTIONS FOR DISCUSSION AND DECISION</th></tr>
<tr><td colspan="2">5A. Eligibility Criteria for Board Directors and Committee Members</td></tr>
<tr><td>Goals:
1. Achieve a Board consisting of Directors that satisfy more stringent eligibility criteria.
2. Achieve committees composed of CPSO members who satisfy more stringent eligibility criteria.

Note:
• Eligibility criteria are threshold requirements that a College member must satisfy to be eligible to stand for election as an Elected Director or be appointed as an Academic Director. They are mandatory. GNC, together with CPSO staff, will review eligibility.
• Eligibility criteria are separate and distinct from the competencies, skills, attributes and diversity that will be listed in the Board Profile/Matrix. College members are expected to have some, but not all, of the competencies skills, attributes and diversity to be qualified to be a Director, to be determined by GNC using its judgment and discretion.

Proposal: The following chart sets out the eligibility criteria that CPSO members will have to meet to be eligible to stand for election as a Director or be appointed as a Director or a member of a CPSO committee.
• The eligibility criteria apply to both Directors and committee members unless indicated otherwise (in Application column in following chart).
• Note the eligibility criteria do not apply to public members (whether as Directors or committee members).
• Some of the eligibility criteria already apply under the current By-laws. The criteria are marked as Existing, Revised or New.
• The eligibility criteria listed below are summarized and are not the exact language in the By-laws.</td><td>1. Do you support the eligibility criteria for Board Directors and committee members, as proposed?</td></tr>
</table>

Eligibility Criteria	**Status**	**Application** (applies to Directors and Committee members unless indicated otherwise)
For Elected Directors, while elections are held by district: The member practises medicine in the electoral district where they are nominated or if not in practice, resides in that electoral district.	Existing	Elected Directors
For Elected Directors, once elections are held province-wide: The member principally practises medicine in Ontario or if not in practice, resides in Ontario.	Revised	Elected Directors
For Committee members: The member principally practises medicine in Ontario, or if not in practice, resides in Ontario. Current By-laws: The member practises medicine in Ontario or resides in Ontario.	Revised	Committee members
For Academic Directors: The member is on the academic staff of an Ontario university medical faculty.	Existing	Academic Directors
Member is not in default of payment of any fee payable to CPSO.	Existing	
Physician Assistants are not eligible to be a Board Director (once PA legislation comes into effect).	New	Directors
Member is not (and has not been for one year) a director or officer of OMA, CMPA or certain other organizations.	Existing	Directors
Member does not hold (and has not held for one year) a position with an organization that would create a conflict of interest by having competing fiduciary obligations to the organization and CPSO.	Existing	Directors
Member does not hold (and has not held for one year) an employment position or any position of responsibility with any organization whose mandate conflicts with the mandate of the College.	New	Directors
In the case of a Director, the member is not (and has not been for five years) an employee of CPSO.	Existing	Directors
In the case of a non-Director committee member, the member is not an employee of CPSO.	New	Committee members
Member has filed a completed conflict of interest declaration form.	Existing	Directors
Member has completed the CPSO orientation program.	Existing	Directors
Member is not, and has not ever been, in litigation against CPSO and/or CPSO Directors, officers, employees (not including judicial review or appeals of disciplinary or other regulatory decisions).	New	

Eligibility Criteria	**Status**	**Application** (applies to Directors and Committee members unless indicated otherwise)
Anti-nepotism clause: member is not a spouse or other specified relative of a CPSO employee or in the case of a Director, another Director.	New	
Member has never been disqualified from the Board or a committee or has not resigned from the Board or a committee where there are reasonable grounds to believe the resignation is related to a proposed disqualification. Current By-laws: Only applies to disqualification or resignation in the last 5 years.	Revised	Directors
Except for administrative suspensions, member's certificate of registration has never been revoked or suspended. Member's certificate of registration has not been suspended for an administrative suspension (i.e. for failure to complete annual renewal) in the last six years. Current By-laws: Member's certificate of registration has not been revoked or suspended in the last six years.	Revised	
Member's certificate of registration is not subject to a term, condition or limitation (other than a "standard" one prescribed by regulation or imposed by Registration Committee pursuant to a CPSO registration policy). Revised to add reference to the Registration Committee and registration policy for completeness and clarity.	Revised	
Member is not the subject of a disciplinary or incapacity proceeding.	Existing	
Member does not exceed applicable term limits. For Directors, the member can serve the full 3 year term on the Board.	Existing	
Member has not had a finding of professional misconduct or incompetence by OPSDT or finding of incapacity by Fitness to Practise Committee, unless the finding has been removed from the Register under the Code s. 23(11).	New	

Eligibility Criteria	**Status**	**Application** (applies to Directors and Committee members unless indicated otherwise)
Member is not subject to an interim order by ICRC under the Code.	New	
Member has not had a SCERP ordered in the past five years.	New	
Member has not been cautioned in the past five years.	New	
Member has no findings of guilt or outstanding charges under the Health Insurance Act (Ontario), the Criminal Code of Canada or the Controlled Drugs or Substances Act (Canada).	New	
Member is in compliance with continuing professional development requirements.	New	
Member is not an undischarged bankrupt (i.e. member is subject to a bankruptcy process that has not been completed).	New	
Member has not been found to be incapable of managing property under Substitute Decisions Act (Ontario) or Mental Health Act (Ontario).	New	
Member has not been declared incapable by any court in Canada or elsewhere.	New	

<table>
<tr><th>PROPOSED CHANGES</th><th>QUESTIONS FOR DISCUSSION AND DECISION</th></tr>
<tr><td colspan="2">5B. Grounds for Disqualification of Board Directors and Committee Members</td></tr>
<tr><td>Goals:
1. Maintain a Board consisting of Directors that continue to meet more stringent criteria.
2. Maintain committees composed of CPSO members who continue to meet more stringent criteria.

Proposal: The following chart sets out the grounds for disqualifying Board Directors and committee members. They are divided into two categories:
a) Grounds that would <u>automatically</u> result in disqualification.
b) Grounds where the Board may exercise its discretion to disqualify the member.
• The disqualification grounds apply to both Directors and committee members unless indicated otherwise (in Application column in chart below).
• The disqualification grounds and process do not apply to public members (whether as Directors or committee members).
• Some of the disqualification grounds already apply under the current By-laws. The grounds are marked as Existing, Revised or New. The categories of automatic and discretionary grounds are new.
• The disqualification grounds listed below are summarized and are not the exact language in the By-laws.</td><td>1. Do you support the grounds for disqualification of Board Directors and committee members, as proposed?</td></tr>
</table>

Category	Disqualification Grounds	Status	Application (applies to Directors and Committee members unless indicated otherwise)
Automatic	**For Elected Directors, while elections are held by district:** The Elected Director ceases to practice medicine or reside in their electoral district.	Existing	Elected Directors
Automatic	**For Elected Directors, once elections are held province-wide:** The Elected Director ceases to principally practice medicine in Ontario or reside in Ontario.	Revised	Elected Directors
Automatic	**For Committee members:** The member ceases to principally practice medicine in Ontario or reside in Ontario.	Revised	Committee members
Automatic	**For Academic Directors:** The Academic Director ceases to be on the academic staff of an Ontario university medical faculty.	Existing	Academic Directors
Automatic	Director becomes a director or officer of OMA, CMPA or certain other organizations.	Existing	Directors
Automatic	Anti-nepotism clause: Member becomes a spouse or other specified relative of a CPSO employee or in the case of a Director, another Director.	New	
Automatic	Member becomes an adverse party to litigation against CPSO and/or CPSO Directors, officers, employees (not including judicial review or appeals of disciplinary or other regulatory decisions).	New	
Automatic	Member's certificate of registration is revoked or suspended (including an administrative suspension, i.e. for failure to complete annual renewal).	New	
Automatic	Member's certificate of registration becomes subject to a term, condition or limitation (other than a "standard" one prescribed by regulation or imposed by Registration Committee pursuant to a CPSO registration policy). Revised to add reference to the Registration Committee and registration policy for completeness and clarity.	Revised	
Automatic	Member becomes the subject of any disciplinary or incapacity proceeding. Current By-laws: The member is suspended from serving on the Board or committees until the proceeding is finally completed, but is not actually disqualified. Since it typically takes a	New	

Category	Disqualification Grounds	Status	**Application** (applies to Directors and Committee members unless indicated otherwise)
	long time for the proceeding to be completed, it is proposed that the member be disqualified instead. If there is no finding of professional misconduct etc., the member will no longer be prevented from standing for election or appointment to the Board or committee(s) due to the prior disqualification.		
Automatic	Member is found by OPSDT to have committed professional misconduct or be incompetent.	Existing	
Automatic	Member is found by Fitness to Practise Committee to be incapacitated.	Existing	
Automatic	Member becomes subject to an interim order by ICRC under the Code.	New	
Automatic	Member is required by ICRC to complete a SCERP.	New	
Automatic	Member is ordered to be cautioned.	New	
Automatic	Member is charged with an offence under the Health Insurance Act (Ontario), the Criminal Code of Canada or the Controlled Drugs or Substances Act (Canada). If the member is not found guilty of any of the charges when the criminal proceedings are completed, the member will no longer be prevented from standing for election or appointment to the Board or committee due to the prior disqualification.	New	
Automatic	Member is found guilty under the Health Insurance Act (Ontario), the Criminal Code of Canada or the Controlled Drugs or Substances Act (Canada).	New	
Automatic	Member is not in compliance with continuing professional development requirements.	New	
Automatic	Member becomes an undischarged bankrupt (i.e. member becomes subject to a bankruptcy process that has not been completed).	New	
Automatic	Member is found to be incapable of managing property under the Substitute Decisions Act (Ontario) or Mental Health Act (Ontario).	New	
Automatic	Member is declared incapable by any court in Canada or elsewhere.	New	
Board's Discretion	• Director fails to attend three consecutive meetings of the Board.	Revised	

Category	Disqualification Grounds	Status	Application (applies to Directors and Committee members unless indicated otherwise)
	• Director or Committee member fails to attend three consecutive meetings of which they are a member. (A Director would be subject to disqualification from the Board and the committee(s).) • Director or Committee member fails to attend a hearing or review panel for which they were selected. (A Director would be subject to disqualification from the Board and the committee(s).) Current By-laws: • The disqualification ground is for failure to attend "without cause". Under the new proposal, any failure to attend 3 consecutive meetings would be subject to consideration by the Board for disqualification. • The third ground (failure to attend hearing or review panel) currently applies only to committee members.		
Board's Discretion	Member is in default of payment of any fee payable to CPSO for more than 30 days.	Existing	
Board's Discretion	Member fails, in the Board's opinion, to discharge their duties to the College (e.g. acted in conflict of interest, or in breach of CPSO By-law or governance policies).	Existing	
Board's Discretion	Director holds a position which could cause the Director to be in a conflict of interest by virtue of having competing fiduciary obligations to both CPSO and another organization (except with an organization specified above that would result in automatic disqualification (e.g. OMA)).	Existing	Directors
Board's Discretion	Member holds an employment position or any position of responsibility with any organization whose mandate conflicts with the mandate of the College.	New	Directors
Board's Discretion	Director becomes an employee or holds a position of responsibility with an organization whose mandate conflicts with the mandate of CPSO.	New	Directors

Category	Disqualification Grounds	Status	**Application** (applies to Directors and Committee members unless indicated otherwise)
Board's Discretion	Director becomes an employee of CPSO.	New	Directors
Board's Discretion	Member did not satisfy one or more eligibility criteria at the date of election to the Board or appointment to the Board or a committee, and did not disclose this to CPSO or was untruthful or misled CPSO about it.	New	

PROPOSED CHANGES	QUESTIONS FOR DISCUSSION AND DECISION
5C. Disqualification Process	
Goals: 1. Maintain a Board consisting of Directors that continue to meet more stringent criteria. 2. Maintain committees composed of CPSO members who continue to meet more stringent criteria. **Process for Disqualification:** Automatic Disqualification: If a ground for automatic disqualification occurs, the Director or committee member will be automatically disqualified as of the time the College learns of it. The Director or committee member will be advised. Automatic disqualification will not go to Council for approval or decision. **Discretionary Disqualification of Directors:** If a ground for discretionary disqualification occurs regarding a Director, the disqualification process in the current By-law will apply (with necessary amendments), namely:	**No decision point. Explanatory**

• If the Executive Committee learns that a Director may meet one of the disqualification criteria, the Executive Committee determines if it warrants the Board's consideration. • The Director is advised and given an opportunity to respond before the Executive Committee makes a decision to refer it to the Board. • If the Executive Committee refers the matter to the Board, the member in question may make written or oral submissions to the Board at the meeting. • Disqualification requires approval of a 2/3 majority of Directors present at the Board meeting. Note that when a Director is disqualified from the Board (whether automatically or by decision of the Board), the member ceases to be both a Director and a member of any committees. **Discretionary Disqualification of Committee Members:** If a ground for discretionary disqualification occurs regarding a committee member, the disqualification process will be similar to that for Directors, except that the disqualification only requires approval of 50% of the Directors present at the Board meeting.	

Council Briefing Note

CPSO

September 2023

Topic:	Proposed Approval of QI Enhanced as a program option for members aged 70-74
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation Quality Care
Public Interest Rationale:	Quality Care: Ensuring that the care provided by individual regulated health professions is of high quality and that the standard of care provided by each regulated health professional is maintained and/or improved. Accountability: Holding regulated health professionals accountable to their patients/clients, the College, and the public.
Main Contacts:	April Jacobs, Manager, Quality Programs Nathalie Novak, Chief Operations Officer

Issue

- This matter is related to the Quality Improvement (QI) Enhanced pilot (presently available for physicians who are aged 70-72 and currently subject to a Peer Assessment in 2023 or 2024).

- Following the implementation of the QI Enhanced pilot, the Quality Assurance Committee (QAC) approval in June 2023, and subsequent Executive Committee's endorsement in August 2023, we are proposing Council's approval of QI Enhanced as a program option for all physicians 70-74 who are subject QA Age-Targeted Peer Assessment.

Background

- The QI program presently includes the following options for physicians: QI for individuals (inclusive of Groups subset), QI Partnership for Hospitals, and the current QI Enhanced-Partnership pilot and QI Enhanced- Individuals pilot options.
- The current QI Enhanced pilot has been limited to physicians aged 70-72 who were selected for Peer Assessment in 2023/2024 and has not been available to physicians aged 73 and 74 years old to date.

- The QA program currently conducts peer assessments for physicians who are age 70+ and every 5 years thereafter.

Current Status and Analysis

63 physicians have completed the QI Enhanced pilot. Of those 63 physicians:

- 79% (50 physicians) received an exemption from Peer Assessment for this 5-year cycle from QAC (i.e., NFA)
- 21% (13 physicians) were directed to continue with their required Peer Assessment

This outcome data mirrors the outcome percentages seen in both Age-Targeted Peer Assessments (physicians 70+) and those physicians <70 years of age (referred from QI).

As a result, we are proposing a motion to approve the QI Enhanced pilot as a formal program option for physicians who are aged 70-74 and who have been selected for QA Age-Targeted assessment as follows:

1. If enrolled in QI Partnership for Hospitals: Members will have the option to complete **QI Enhanced- Partnership** (requiring an Attestation from their Chief, completion of the Physician Questionnaire [PQ], Practice Profile, Self-Guided Chart Review [SGCR], and mandatory session with a QI Coach).
2. If a member is **not enrolled** in QI Partnership for Hospitals: Members will have the option to complete **QI Enhanced- Individuals** (requiring completion of PQ, Practice Profile, SGCR, Data-Driven QI, submission of a Practice Improvement Plan [PIP], and participation in a mandatory session with a QI Coach, with option to resubmit a revised PIP).
3. Following QI Coaching, a report will be submitted to the QAC for consideration; and
4. QAC will continue to have the power to deliberate and determine the need for the member to undergo a QA Peer Assessment.

Next Steps

Should members of Council agree to this proposal, the Quality Management Division operations team will implement the option for physicians aged 70-74 to choose to participate in the QI Enhanced Program to fulfill their CPSO Quality requirements in 2024.

Question for Council

1. Does Council support the proposed approval of the QI Enhanced program option for physicians 70-74 years of age and its alignment to Council's strategic initiative of Right touch Regulation?

CPSO

Council Motion

Motion Title	Approval of QI Enhanced as a Quality Program Option
Date of Meeting	September 22, 2023

It is moved by___________________, and seconded by____________________, that:

The Council of the College of Physicians and Surgeons of Ontario approves QI Enhanced-Individuals and QI Enhanced-Partnership as Quality Improvement program options for physicians who are 70 to 74 years of age.

CPSO

Council Motion

Motion Title	Motion to Go In-Camera
Date of Meeting	September 22, 2023

It is moved by__________________, and seconded by___________________, that:

The Council of the College of Physicians and Surgeons of Ontario exclude the public from the part of the meeting immediately after this motion is passed, under clauses 7(2)(b) and (d) of the Health Professions Procedural Code (set out below).

Exclusion of public

7(2) Despite subsection (1), the Council may exclude the public from any meeting or part of a meeting if it is satisfied that,

(b) financial or personal or other matters may be disclosed of such a nature that the harm created by the disclosure would outweigh the desirability of adhering to the principle that meetings be open to the public; and

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

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CPSO

Council Briefing Note

September 2023

Topic:	Declaration of Adherence and Code of Conduct Amendments
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation Continuous Improvement
Public Interest Rationale:	Ensuring appropriate governance of the CPSO through regular updates to the Declaration of Adherence package.
Main Contacts:	Christina Huang, Governance Analyst Cameo Allan, Manager of Governance Marcia Cooper, Senior Legal Counsel and Privacy Officer
Attachment:	**Appendix A**: 2024 Declaration of Adherence with tracked changes

Issue

- Council is asked to consider changes to the Declaration of Adherence and Code of Conduct.

Background

- The Declaration of Adherence package was updated and last approved by Council:
    - in 2020, updates included a section regarding the use of social media in the Council and Committee Code of Conduct; and
    - in 2022, updates were added to the section about social media to reflect the changes to the Social Media Policy.
- The Governance Committee and the Executive Committee have reviewed the proposed amendments to the Declaration of Adherence and Code of Conduct.

Current Status and Analysis

- In summary, the following proposed changes are recommended (See Appendix A for specifics):
    - Language was added to reflect procedure around hard copies of meeting materials and handwritten notes for Council and Committee members. It is good governance practice to have the minutes of each meeting be the official records of that meeting and any other record be destroyed. This practice is in place to mitigate the risk of inconsistency and to ensure proper record-keeping.
    - Clarification and addition of language regarding conflicts of interest and social media interactions.
    - To facilitate the electronic signature process, formatting edits have been included to better transfer the pdf into a fillable form.
- Small grammatical corrections and formatting changes to ensure consistency within the Declaration of Adherence were accepted and not tracked in Appendix A to streamline the main changes for ease of review.

Next Steps

- All Council and Committee members are required to sign the approved Declaration of Adherence by the end of this year for the 2024 Council year.

Question for Council

1. Does Council approve the proposed changes to the Declaration of Adherence and Code of Conduct?

CPSO

Declaration of Adherence Package 2024

2023-2024

Declaration of Adherence

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~~I must avoid conflicts between ~~their self-interest and their~~my duty to the CPSO and my personal/self-interest or other professional interests. This includes, but is not limited to, 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).~~ or holding another position with an organization whose mandate conflicts with the mandate of the CPSO. More information about conflicts of interest is contained in the Conflict of Interest Policy. A conflict of interest is defined in the CPSO General By-law as:
    - *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.*

- As part of my Council or Committee work, I am expected to declare any actual or potential conflicts of interest.

- As part of this Declaration of Adherence, I have completed the attached Disclosure Form to the best of my ability, by identifying any relationship(s) I

currently have or had in the last three years or anticipate having with any organization in order to assist the CPSO with determining if the relationship(s) may create a conflict of interest, even if I do not believe the relationship(s) creates a conflict of interest.

- I will promptly notify CPSO if I become involved with an organization (for example, take on a new job or become a director of the Board of the organization) or of any other changes or additions to the disclosed information.

- 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 (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 I may be disqualified from sitting on Council or 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 and Committee members, 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
- ☐ Protocol for Access to CPSO Information
- ☐ Safe Disclosure Policy
- ☐ Role Description of a CPSO Council/Committee Member (as applicable)

- I must conduct CPSO work using a CPSO-issued computer or laptop, and that I am not permitted to use a personal computer or laptop for CPSO work.

- I must use **only** my CPSO-provided email address (eg., cpso.on.ca) for any and all communications relating to CPSO work.
- ~~I have completed the attached Conflict of Interest Disclosure Form to the best of my ability, and will notify the CPSO of any changes or additions to the disclosed information at the earliest opportunity, in accordance with the Conflict of Interest Policy.~~

☐ 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.

Printed Name:	
Signature:	
Date:	

Disclosure Form

~~As part of your Council or committee work, you are expected to declare any actual or potential conflicts of interest. A conflict of interest is defined the CPSO General By-law as:~~

> ~~*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.*~~

~~Please indicate any financial or personal interests that are or may be perceived to be a conflict of interest with your duties at CPSO, including any positions you hold as an officer or director of any other entity whose interests or mandate could reasonably appear to be in conflict or inconsistent with the CPSO. Please review the *Conflict of Interest* policy for more details and examples of what may constitute a conflict of interest.~~

~~Potential conflicts~~ Please complete this Disclosure Form in full. This information will be ~~investigated~~reviewed by the CPSO to ~~confirm~~determine whether a conflict ~~exists~~of interest exists or may be perceived to exist, and the extent of the impact of any conflicts or potential conflicts on your involvement in ~~work. If you are unsure~~ CPSO work. Please note that listing an interest in or relationship with an organization does not necessarily mean there is a conflict of interest. Please indicate if ~~something is a conflict, please disclose~~any of the following apply, even if you do not think it ~~below.~~ creates a conflict of interest:

	Yes	No
I have a financial or personal interest (or a person who is related to me has a financial or personal interest) that may relate to the CPSO in any way and therefore may be perceived to be a conflict of interest.	☐	☐
I am, or have been within the last three years, an employee, Board director or officer of, or in another position of responsibility with, any of the following organizations or types of organizations:	☐	☐

- The Ontario Medical Association
- The Canadian Medical Protective Association
- The Canadian Medical Association
- The Coalition of Family Physicians and Specialists of Ontario
- The Ontario Specialists Association
- A medical specialty association or society (for example, Canadian Anesthesiologists Society)
- An organization involved in physician advocacy
- Hospital (including a Hospital Board or other leadership positions)
- Ontario government agency (ex. Ontario Health) or Ministry etc.
- Royal College of Physicians and Surgeons of Canada
- The College of Family Physicians of Canada
- Ontario College of Family Physicians
- Medical Council of Canada
- Other regulatory authority

~~I have no conflicts of interest to report~~

~~I have the following potential or actual conflicts of interest~~

I am, or have been within the last three years, an employee, Board director or officer of, or in another position of responsibility with, any other organization (not listed or covered above).	☐	☐

If you selected "Yes" to any of the above, please provide the name of the organization, your position, when and for how long the role was held and any other explanation or information about it. If you think there may be any potential conflict not captured in the above questions please disclose it below, providing all relevant information.

1.
2.
3.

☐ I confirm I have no conflicts to declare and selected "No" to all of the above.

Printed Name:

Signature:

Date:

CPSO Council and Committee
Code of Conduct

CPSO

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~~Professional members of academic faculties who are appointed to Council ~~by their academic institutions~~ do not represent the interests of their academic 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 Committee members must always consider the potential impact of all their communications, media contact, social media use and online conduct, whether public or private, on the reputation of, or public trust in, the CPSO, the profession, medical self-regulation or a CPSO stakeholder (including the Ontario Medical Association, the government, medical schools and others). This applies whether the member has or has not explicitly stated that their views do not reflect the views of the CPSO.

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, Communications 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, communicate 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 of Council or a CPSO Committee are held to a very high standard that moves beyond the Social Media policy that applies to physicians generally. In addition, Council and Committee members must recognize that effective advocacy is generally difficult to balance with their role at the CPSO.

~~Council and Committee members must always consider the potential impact of all their communications, social media use and online conduct on the reputation of, or public trust in, the CPSO, the profession, medical self-regulation or a CPSO stakeholder (including the~~

~~Ontario Medical Association, the government, medical schools and others). This applies to all manner of communications and social media use, whether private or public, and whether the member has or has not explicitly stated that their views do not reflect the views of the CPSO. For example, members must:~~

~~Speak~~Council and Committee members are permitted (and encouraged) to share and positively comment on or interact with social media postings that have been approved by the CPSO, for example, sharing CPSO job postings, eDialogue, or other posts from CPSO official channels. Doing so is consistent with speaking with one voice when representing the CPSO.

If or When Engaging on Social Media:

- Do not speak on behalf of the CPSO ~~only when~~unless authorized by the President ~~or CEO/~~(or, in the President's absence, the Vice-President) and the Registrar~~;~~/CEO;
~~Not~~
- Do not engage on social media in any way that could be interpreted to represent or establish the position of the CPSO, ~~reflect bias in the CPSO's decision-making,~~ or compromise the reputation of the CPSO, its Council, or its Committees, even if the views expressed are noted to be a member's individual views and not representative of the CPSO~~;~~.
~~Not~~
- Do not engage (including posting, responding or commenting) on matters that relate or could relate to the CPSO or issues that the CPSO is involved in. It is up to the CPSO to determine if it will respond to these postings. A response or comment by a Council or Committee member to such matters on social media may be perceived by others as being a response or comment by or on behalf of CPSO, even if they say they are not speaking on behalf of CPSO;

- Do not engage on matters that relate to or touch upon specific cases or general themes with regards to cases that may have come before a CPSO Committee. This may create a possible apprehension of bias on the part of the Committee member for future cases. For example, strong statements about a specific physician or group of physicians, or an area of medical practice, could give rise to the appearance of bias when deciding cases related to them.

- Do 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,

- Be professional and respectful on social media, including but not limited to not engaging in harassing, discriminatory or otherwise abusive behaviour.

~~In particular, while using social media, members must not engage with matters (including posting, commenting, or reacting to them) when:~~

- ~~The member's comments may be inconsistent with a stated CPSO position;~~
- ~~The matters discussed relate to or touch upon specific cases or general themes with regards to cases that may have come before a CPSO Committee. This may create a possible apprehension of bias on the part of the committee member for future cases. For example, strong statements about a specific physician or group of physicians, or an area of medical practice, that could give rise to the appearance of bias when deciding cases related to them.~~

~~Council and Committee members are permitted (and encouraged) to share, comment on, and positively comment on or interact with social media postings that have been approved by the CPSO, for example, sharing CPSO job postings, eDialogue, or other posts from CPSO official channels. Doing so is consistent with speaking with one voice when representing the CPSO.~~

All Council and Committee members are expected to respond to and cooperate with the CPSO if the CPSO raises concerns about the member's social media engagement. ~~This may include but is not limited to complying with requests to remove or edit previous posts, comments, or reactions, or to cease further posts that cause similar or related concerns.~~ If asked by the CPSO, the Council or committee member will immediately stop engaging in social media identified by the CPSO, and will follow the direction of the CPSO, including to remove or edit the post, stop posting to or engaging on social media, whether or not the Council or committee member thinks their posts are appropriate.

Council and Committee members are encouraged to obtain guidance from the CPSO prior to engaging with social media to assist with compliance with this Code of Conduct. Contact the Governance Office should you have any questions (govsupport@cpso.on.ca).

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.

Equity, Diversity, and Inclusion

Equity, diversity, 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
- ☐ Protocol for Access to CPSO Information

CPSO Email Address

Council and Committee members must use **only** their CPSO-provided email address (eg., cpso.on.ca) for all communications relating to their CPSO work. CPSO emails (including virtual meeting invitations) must 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. The use of the CPSO email system by Council and Committee members for personal matters should be incidental and kept to a minimum.

Members are expected to check their CPSO email account regularly. Council and Committee members should not expect to receive notifications that CPSO email has

been sent to them via a personal email, text or phone number, and should not ask CPSO staff to send these notifications. Council and Committee members may contact IT for assistance with accessing or using their CPSO email, including having IT download the CPSO Outlook app on their personal mobile phones.

CPSO Technology

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.

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 must conduct CPSO work using CPSO-issued computers or laptops, not personal computers or laptops. Use of CPSO-issued computers or laptops by CPSO Council and Committee members for personal or non-CPSO matters should be kept to a minimum.

Additionally, the Information Technology department must approve any software downloads to CPSO Technology or systems.

CPSO information must be saved in CPSO systems, and Council and Committee members should not download, save or store CPSO information on CPSO Technology (e.g. on C drive or desktop) or on personal devices.

Any printed hard copies of materials and handwritten notes relating to any Council and Committee meetings should be securely destroyed (such as cross-shredding) immediately after the meeting. For OPSDT and FTP matters, notes and materials must be shredded or deleted once any appeals have concluded.

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 Council and 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 Ontario Physicians and Surgeons Discipline Tribunal[1] or the Fitness to Practise 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 Council Committee member who is unable to or fails to comply with this Code of Conduct or the Declaration of Adherence~~,~~ (which failure shall be determined by CPSO), 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: September 22, 2023 ~~September 22, 2022~~

[1] The Ontario Physicians and Surgeons Discipline Tribunal is the Discipline Committee established under the Health Professions Procedural Code. For convenience, it is referred to as the OPSDT in other instances in this package.

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 *Fixing Long-Term Care Act, 2021*, 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. 1, s. 10; 2017, c. 11, Sched. 5, s. 2(1.2); 2021, c. 39, Sched. 2, s.23 (1).

Offences

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

(3) Every corporation that contravenes section 31, 21, 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.

CPSO

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)

CPSO

Council Motion

Motion Title	For Approval: Revised Declaration of Adherence and Code of Conduct
Date of Meeting	September 22, 2023

It is moved by__________________, and seconded by___________________, that:

The Council of the College of Physicians and Surgeons of Ontario approves the revised Declaration of Adherence and Code of Conduct, (a copy of which forms Appendix " " to the minutes of this meeting).

Council Briefing Note

CPSO

September 2023

Topic:	Out-of-Hospital Premises (OHP) by-law updates
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation Quality Care
Public Interest Rationale:	The OHP Program Standards have been revised as of June 2023, therefore the by-laws related to these need to be updated to reflect the changes.
Main Contacts:	Jennifer Kitchen, Accreditation Manager Laurie Reid, Investigations and Accreditation Director Elisabeth Widner, Senior Legal Counsel Marcia Cooper, Senior Corporate Counsel and Privacy Officer
Attachment:	**Appendix A:** Proposed by-law amendment

Issue

- Consider the proposed by-law amendments to align with the new OHP Program Standards that were approved by Council in June 2023.

Background

- To ensure OHPs are operating safely and effectively, the OHP Inspection Program inspects all facilities performing procedures requiring the use of anesthesia or sedation.
- The Program also enforces a set of standards ("Program Standards"), outlining the core requirements that must be met when performing these procedures in OHPs.
  - o The Program Standards include details regarding the inspection regime and sets out specific standards in relation to, for example, infection-prevention and control, quality assurance, and adverse event reporting.
- The new OHP Program Standards were approved by Council in June 2023.

Current Status and Analysis

- The new Adverse Event Standard captures expectations for adverse events reporting and monitoring, along with new expectations around planning for and managing adverse events to create a more robust framework.
- In particular, the reporting timeline has been changed to five business days rather than 24 hours.
- The by-law needs to be updated accordingly so that the timing for reporting adverse events aligns with the Adverse Event Standard. (See Appendix A for the proposed by-law amendment).

Next Steps

- If Council approves of the proposed by-law amendments, they will be circulated to the profession. The proposed by-law amendments will then be brought back to December Council for final approval.

Question for Council

1. Does Council approve of the proposed by-law changes and recommend circulating them to the profession?

Appendix A

Proposed Amendment of General By-law

Notification Required by Members
51. …

(3.1)…

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

(i) d~~D~~eath within the premises;
(ii) d~~D~~eath within 10 ~~ten~~ days of a procedure performed at the premises;
(iii) a~~A~~ny procedure performed on wrong patient, site, or side; or
(iv) t~~T~~ransfer of a patient from the premises directly to a hospital for care.

CPSO

Council Motion

Motion Title	For Circulation: By-law Amendments to General By-law re OHPIP Adverse Event Reporting
Date of Meeting	September 22, 2023

It is moved by__________________, and seconded by___________________, that:

The Council of the College of Physicians and Surgeons of Ontario proposes to make the following By-law No. 164, after circulation to stakeholders:

By-law No. 164

Subsection 51(3.1)(b) of the General By-law is revoked and substituted with the following:

Notification Required by Members

51. (3.1)…

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

(i) death within the premises;
(ii) death within 10 days of a procedure performed at the premises;
(iii) any procedure performed on wrong patient, site, or side; or
(iv) transfer of a patient from the premises directly to a hospital for care.

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

Council Briefing Note

CPSO

September 2023

Topic:	By-law Amendments Related to Physician Assistant Regulation
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation
Public Interest Rationale:	Bringing physician assistants under the authority of CPSO will ensure the protection of patients and work to fulfill our public interest mandate.
Main Contacts:	Samantha Tulipano, Director, Registration & Membership Services Marcia Cooper, Senior Corporate Counsel and Privacy Officer
Attachment:	**Appendix A:** Blacklined By-law Amendments

Issue

- Amendments to the Fees and Remuneration By-law are proposed to provide for application and annual membership fees related to Physician Assistant Regulation.

Background

- On June 3, 2021, Bill 283, the legislation that would enable CPSO to regulate Physician Assistants (PAs), received Royal Assent and Council received an update regarding the bill at its June 2021 meeting.

- Following the Bill's passage, CPSO moved quickly to initiate work on implementing PA regulation. In the fall of 2021, work was significantly delayed due to uncertainty regarding the core regulatory framework being designed but resumed in earnest in summer of 2022.

- The legislation and CPSO's oversight of PAs will not be enacted until a later date, which the provincial government has signaled will be in 2024, in order to give time for the necessary regulatory amendments to be developed and approved.

- At the June 8, 2023 meeting of Council, the regulations were approved to be released for consultation for a 60-day period per the requirements set out in s. 95(1.4) of the

Health Professions Procedural Code and circulated for notice in accordance with s. 22.21 of the Health Professions Procedural Code.

- In anticipation of the PA Regulation becoming effective in January 2024, the College has begun preparations to operationalize this work.

- The Regulation of PAs will require both registration and membership renewal fees. The Fees and Remuneration By-law requires amendments to reflect the associated fees.

Analysis

- We are proposing an application fee of $300 and a renewal fee of $425.

- A jurisdictional scan of FMRAC jurisdictions that regulate PA's is as follows:

Jurisdiction	PA Registration	PA Renewal
Alberta	$400	$537.50
Manitoba	$300	$432
Saskatchewan	$450	$475
***Proposed Ontario**	**$300**	**$425**
New Brunswick	$300	$100

Next Steps

- If Council supports these proposed amendments, they will be circulated to the profession.
- After circulation, the by-law amendments would be brought back to Council in December for final approval.

Question for Council

1. Does Council approve the proposed by-law amendments for external consultation?

Appendix A
Proposed Amendments to By-law No. 2 (Fees and Remuneration By-law) Re Physician Assistant Fees

APPLICATION FEES

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

(a) For a certificate of registration authorizing postgraduate education, 25% of the annual fee specified in section 4(a);
(b) For a certificate of registration authorizing supervised practice of a short duration, 20% of the annual fee specified in Section 4(a);
(b.1) For a certificate of registration authorizing temporary independent practice, 25% of the annual fee specified in section 4(a);
(b.2) For a certificate of registration authorizing practice as a physician assistant, $300;
(c) For an application for reinstatement of a certificate of registration, 60% of the annual fee specified in s. 4(a);
(d) For any other certificate of registration, 60% of the annual fee specified in Section 4(a);
(e) *[repealed:* May 31, 2019]
(f) For a certificate of authorization, $400.00;
(g) For an application to the Registration Committee for an order directing the Registrar to modify or remove terms, conditions or limitations imposed on the member's certificate of registration by the Registration Committee, 25% of the annual fee specified in section 4(a);
(h) If the person:
  (i) meets the registration requirements applicable to the class of certificate of registration applied for, as prescribed in the Registration Regulation, Ontario Regulation 865/93 under the Medicine Act, 1991; and
  (ii) requests the College to conduct the initial assessment of the application within three weeks after receipt by the College of the application,
  an additional fee equal to 50% of the application fee applicable to such person under subsection 1(a), (b), (b.1), (b.2) or (d).

4. Annual fees as of June 1, 2018, are as follows:

(a) $1725 for holders of a certificate of registration other than a certificate of registration authorizing postgraduate education, a certificate of registration authorizing supervised practice of a short duration, ~~or~~ a certificate of registration authorizing temporary independent practice, or a certificate of registration

authorizing practice as a physician assistant;

(b) For a holder of a certificate of registration authorizing postgraduate education applying to renew his/her certificate of registration, 20% of the annual fee set out in subsection 4(a); ~~and~~

~~(b)~~(c) For a holder of a certificate of registration authorizing practice as a physician assistant, $425; and

(d) Notwithstanding subsections 4(a), ~~and~~ (b) and (c), where the holder of a certificate of registration will be taking parental leave for a period of four months or longer during the membership year for which the annual fee applies because the holder is pregnant, has recently given birth or will be caring for their newborn or newly adopted child, the annual fee for such membership year is 50% of the annual fee applicable to the holder of the certificate of registration as set out in subsection 4(a), (b) or (c), ~~as follows:~~

~~i. 50% of the annual fee set out in subsection 4(a) for holders of a certificate of registration (except as set out in subsection 4(c)(ii)); or~~

~~ii. 50% of the annual fee set out in subsection 4(b) for holders of a certificate of registration authorizing postgraduate education,~~

so long as the holder applies to the College for this parental leave reduced annual fee prior to the close of the annual renewal period for such membership year. Where applications for the parental leave reduced annual fee are received after the close of such annual renewal period, the parental leave reduced annual fee will be applied to the following membership year. The parental leave reduced annual fee is not available for holders of a certificate of registration authorizing supervised practice of a short duration. This subsection 4(d~~c~~) only applies to annual fees for membership years commencing on or after June 1, 2020.

CPSO

Council Motion

Motion Title	For Circulation – Amendments to Fee and Remuneration By-law re Physician Assistant Fees
Date of Meeting	September 22, 2023

It is moved by___________________, and seconded by____________________, that:

The Council of the College of Physicians and Surgeons of Ontario proposes to make the following By-law No. 165, after circulation to stakeholders:

By-law No. 165

1. Section 1 of By-law No. 2 (the Fees and Remuneration By-law) is amended by adding subsection (b.2) set out below:

APPLICATION FEES

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

(b.2) For a certificate of registration authorizing practice as a physician assistant, $300;

2. Subsection 1(h) of By-law No. 2 (the Fees and Remuneration By-law) is revoked and substituted with the following:

(h) If the person:
(i) meets the registration requirements applicable to the class of certificate of registration applied for, as prescribed in the Registration Regulation, Ontario Regulation 865/93 under the Medicine Act, 1991; and
(ii) requests the College to conduct the initial assessment of the application within three weeks after receipt by the College of the application,
an additional fee equal to 50% of the application fee applicable to such person under subsection 1(a), (b), (b.1), (b.2) or (d).

3. Section 4 of By-law No. 2 (the Fees and Remuneration By-law) is revoked and substituted with the following:

4. Annual fees as of June 1, 2018, are as follows:

(a) $1725 for holders of a certificate of registration other than a certificate of registration authorizing postgraduate education, a certificate of registration authorizing supervised practice of a short duration, a certificate of registration authorizing temporary independent practice, or a certificate of registration authorizing practice as a physician assistant;

(b) For a holder of a certificate of registration authorizing postgraduate education applying to renew his/her certificate of registration, 20% of the annual fee set out in subsection 4(a);

(c) For a holder of a certificate of registration authorizing practice as a physician assistant, $425; and

(d) Notwithstanding subsections 4(a), (b) and (c), where the holder of a certificate of registration will be taking parental leave for a period of four months or longer during the membership year for which the annual fee applies because the holder is pregnant, has recently given birth or will be caring for their newborn or newly adopted child, the annual fee for such membership year is 50% of the annual fee applicable to the holder of the certificate of registration as set out in subsection 4(a), (b) or (c), so long as the holder applies to the College for this parental leave reduced annual fee prior to the close of the annual renewal period for such membership year. Where applications for the parental leave reduced annual fee are received after the close of such annual renewal period, the parental leave reduced annual fee will be applied to the following membership year. The parental leave reduced annual fee is not available for holders of a certificate of registration authorizing supervised practice of a short duration. This subsection 4(d) only applies to annual fees for membership years commencing on or after June 1, 2020.

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

CPSO

Council Briefing Note

September 2023

Topic:	Revised Policy for Final Approval — *Human Rights in the Provision of Health Services*
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation Quality Care
Public Interest Rationale:	Setting clear expectations for physicians to support the provision of safe, inclusive, and accessible health services and ensuring patient access to services which conflict with physicians' conscience or religious beliefs.
Main Contact:	Tanya Terzis, Interim Manager, Policy
Attachments:	**Appendix A:** Revised draft *Human Rights in the Provision of Health Services* policy **Appendix B:** Revised draft *Advice to the Profession: Human Rights in the Provision of Health Services*

Issue

- CPSO's *Professional Obligations and Human Rights* policy is currently under review. A newly titled draft *Human Rights in the Provision of Health Services* policy and companion *Advice to the Profession* (*Advice*) document were developed and released for external consultation from September to November 2022.

- Council is provided an overview of the key issues and proposed revisions to the draft policy and is asked whether the revised draft policy can be approved as a policy of the College.

Background

- The *Professional Obligations and Human Rights* policy was approved by Council in September 2008 and last updated in March 2015.

- Council approved the draft policy for external consultation in September 2022. Additional consultation activities included public opinion polling, a Stakeholder Roundtable Discussion, and a Citizen Advisory Group discussion.

    - CPSO received a total of 247 responses as part of the consultation: 122 through written feedback and 125 via the online survey. All written feedback is posted on a

dedicated page of the College's website. Council received an overview of the feedback in the December 2022 Policy Report.

Current Status and Analysis

- The revised draft *Human Rights in the Provision of Health Services* policy (**Appendix A**) retains most of the core expectations found in the *Professional Obligations and Human Rights* policy.

- The revised draft policy and *Advice* (**Appendix B**) include strengthened expectations and guidance to support physicians in providing safe, inclusive, and accessible health services, and continue to balance the rights of physicians with conscientious or religious objections to the provision of certain health services and patients' access to those services.

Key Revisions in Response to Feedback

- Overall, the revised draft policy is more focused and contains fewer expectations than the current policy. The section on limiting health services for legitimate reasons (e.g., clinical competence) has been removed, as this is addressed in the *Accepting New Patients* policy.

Definitions

- Minor amendments have been made to the definition of "discrimination," to align more closely with the Ontario Human Rights Commission's definition.

- In response to feedback, the revised draft policy includes a new definition of "protected grounds under the *Human Rights Code*." Previously, these grounds were referenced in a footnote in the policy; the term has been included under "Definitions" for easier reference.

Providing safe, inclusive, and accessible health services

- In support of CPSO's commitment to bring equity, diversity, and inclusion (EDI) to our policies, the revised draft policy requires physicians to take reasonable steps to create and foster a safe, inclusive, and accessible environment, including by incorporating cultural humility, cultural safety, anti-racism, and anti-oppression into their practices (provision 1).

    - These terms are defined in an EDI glossary on the CPSO website. The *Advice* contains guidance and resources to help physicians understand how they can incorporate these concepts into their practice.

- The revised draft policy includes expectations which address discrimination by physicians as well as against physicians by patients or others.

- Provision 2.a., which prohibits physicians from expressing personal moral judgments about patients, was updated to clarify that this does not preclude expressing appropriate opinions when having discussions with patients, but prohibits judgments made in a demeaning manner. The *Advice* clarifies that this provision also applies when communicating a conscientious objection.

- Provision 2.b., which prohibits relying on stereotypes to determine a patient's needs, was added based on a recommendation by the Ontario Human Rights Commission.

- Provision 7, related to patient requests for physicians of a particular identity, was revised to require physicians to determine whether the request is reasonable (rather than discriminatory), and to give physicians greater discretion to exercise professional judgment where a request is not reasonable.

- Provision 8, related to addressing violence, harassment, and discrimination, was broadened to indicate that physicians can take other reasonable actions (other than simply "stopping" these acts). The *Advice* provides new guidance under the question, "What steps can I take to address acts of violence, harassment, and/or discrimination against patients, health-care professionals, and/or staff?"

Health services that conflict with physicians' conscience or religious beliefs

- In previous years, some Christian organizations[1] and individual physicians challenged the constitutional validity of the "effective referral"[2] requirements in the policy. CPSO defended the policy on behalf of Council, maintaining that the requirement strikes a reasonable balance between physicians' right to practise in accordance with their beliefs and patients' right to access health services. The Courts agreed with CPSO in 2018 and 2019 and the policy was maintained as is.

- The draft policy that went out for consultation included new proposed requirements for physicians to take reasonable steps to confirm that a patient was connected to a non-objecting, available, and accessible physician, other health-care professional, or agency and to take further action to provide an effective referral if the patient was not connected.

  - These requirements were proposed as additional safeguards given that the draft *Advice* now explicitly states that a physician may use a 'self-referral option'—for example, providing contact information to a physician or agency to a patient in appropriate circumstances—which may not always ensure a patient is connected.

[1] The Christian Medical and Dental Society of Canada, Canadian Federation of Catholic Physicians' Societies, and Canadian Physicians for Life.

[2] Making an effective referral requires that physicians take positive action to ensure the patient is connected to a non-objecting, available, and accessible physician, other health-care professional, or agency.

- In the revised draft policy, these requirements were removed based on feedback and consideration of the history of litigation on the effective referral provisions. Therefore, the existing requirements around effective referral in the revised draft policy are not substantively changed from the current policy.
    - Instead, additional guidance is included in the *Advice* for physicians to consider the patient's vulnerability and urgency of their needs when considering what steps to take when providing an effective referral under the question, "What are some examples of an effective referral?"
- A preamble was reintroduced in this section to recognize the importance of balancing the rights of physicians' freedom of conscience and religion and patients' access to care.

Next Steps

- Should Council approve the revised draft policy, it will be announced in *eDialogue* and added to the College's website.

Question for Council

1. Does Council approve the revised draft *Human Rights in the Provision of Health Services* policy as a policy of the College?

HUMAN RIGHTS IN THE PROVISION OF HEALTH SERVICES

Policies of the College of Physicians and Surgeons of Ontario ("CPSO") 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 CPSO and its Committees when considering physician practice or conduct.

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

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

Definitions

Discrimination: An act, communication, or decision that results in the unfair treatment of an individual or group, for example, by excluding them, imposing a burden on them, or denying them a right, privilege, benefit, or opportunity enjoyed by others. Discrimination may be direct and intentional; it may also be indirect and unintentional, where rules, practices, or procedures appear neutral but have the impact of disadvantaging certain groups of people.

Effective referral: Taking positive action to ensure the patient is connected to a non-objecting, available, and accessible[1] physician, other health-care professional, or agency.

Protected grounds under the *Human Rights Code*: The Ontario *Human Rights Code* prohibits actions that discriminate against people based on protected grounds in protected social areas (including goods, services, and facilities, such as hospitals and health services). The protected grounds include age; ancestry, colour, race; citizenship; ethnic origin; place of origin; creed; disability; family status; marital status; gender identity, gender expression; receipt of public assistance; record of offences; sex; and sexual orientation.[2]

For more definitions of key terms and concepts related to this policy, including **anti-oppression**, **anti-racism**, **cultural humility**, and **cultural safety**, see CPSO's Equity, Diversity, and Inclusion Glossary.

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[1] "Available and accessible" means that the health-care professional must be operating and/or accepting patients at the time the effective referral is made, and in a physical location the patient can reasonably access, or where appropriate, accessible via virtual care. Additional information on effective referrals can be found in the *Advice to the Profession*.

[2] For more information on the protected grounds and protected social areas under the *Human Rights Code*, see the Ontario Human Rights Commission's website.

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Policy

Providing Safe, Inclusive, and Accessible Health Services

1. Physicians **must** take reasonable steps to create and foster a safe, inclusive, and accessible environment in which the rights, autonomy, dignity, and diversity of all people are respected, including by incorporating cultural humility, cultural safety, anti-racism, and anti-oppression[3] into their practices.
2. Physicians **must not:**
    a. express personal moral judgments in a manner that is demeaning towards patients' beliefs, lifestyle, identity, or characteristics or the health services that patients are considering;
    b. rely on stereotypes associated with one or more aspects of the patient's identity to determine their needs; [4]
    c. refuse or delay the provision of health services because the physician believes the patient's own actions have contributed to their condition;[5] or
    d. promote or impose their own spiritual, secular, or religious beliefs when interacting with patients.

The Duty to Provide Services Free from Discrimination

3. Physicians **must** comply with the relevant legal requirements under the *Human Rights Code*[6] and the *Accessibility for Ontarians with Disabilities Act, 2005*.
4. Physicians **must not** discriminate, either directly or indirectly, based on a protected ground under the *Human Rights Code* when making decisions relating to the provision of health services, including when:
    a. accepting or refusing individuals as patients;

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[3] For definitions of cultural humility, cultural safety, anti-racism, and anti-oppression, see the Equity, Diversity, and Inclusion Glossary. Additional guidance and resources on how to incorporate these concepts into practice can be found in the *Advice to the Profession*.
[4] Stereotypes are generalizations about people based on assumptions about qualities and characteristics of the group they belong to. Stereotyping typically involves attributing the same characteristics to all members of a group, regardless of their individual differences. It is often based on misconceptions, incomplete information, and/or false generalizations.
[5] See the *Ending the Physician-Patient Relationship* policy for circumstances where physicians must not end the physician-patient relationship.
[6] The *Human Rights Code* has primacy over all other provincial legislation, including the *Substitute Decisions Act, 1992*; *Health Care Consent Act, 1996*; *Mental Health Act*; and the *Accessibility for Ontarians with Disabilities Act, 2005*. If there is a conflict between the *Human Rights Code* and another provincial law, the *Human Rights Code* prevails unless the other law includes a specific exception.

b. providing information to patients;

c. providing or limiting health services;[7]

d. providing formal clinical referrals and effective referrals; and

e. ending the physician-patient relationship.

The Duty to Accommodate

5. Physicians **must** comply with their duty to accommodate the needs of patients arising from protected grounds under the *Human Rights Code* in a manner that respects the dignity, autonomy, privacy, and confidentiality of the person.[8]

6. In discharging provision 5, physicians **must** explore and implement accommodation measures up to the point that they would:

    a. subject the physician to undue hardship (e.g., excessive cost, health or safety concerns); or

    b. significantly interfere with the legal rights of others.

7. Where a patient requests to receive care from a physician with a particular identity (e.g., race, ethnicity, culture, religion, gender identity), physicians **must:**

    a. with appropriate consent,[9] provide any emergent or urgent medical care the patient requires; and

    b. when the situation is non-emergent or non-urgent:

        i. take appropriate steps to accommodate the patient's request, where resources are available, if the request is reasonable (e.g., the patient requests care from a physician who is of the same gender for religious reasons or based on a history of trauma); or

        ii. determine the safe and appropriate steps to take with respect to the patient's care if the request is not reasonable (e.g., the patient requests

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[7] This policy addresses limiting health services for reasons based on conscience or religion in the section "Health Services that Conflict with Physicians' Conscience or Religious Beliefs." The *Accepting New Patients* policy sets out expectations for physicians limiting health services on the basis of clinical competence, scope of practice, and/or a focused practice area.

[8] A physician's duty to protect the confidentiality of personal health information and the privacy of individuals with respect to that information is governed by the *Personal Health Information Protection Act, 2004*.

[9] See the *Consent to Treatment* policy for expectations on obtaining consent during emergencies.

care from a physician of a certain race based on racist beliefs), which may include refusing to accommodate the request.[10]

Addressing Violence, Harassment, and Discrimination

8. If physicians see acts of violence, harassment (including intimidation), or discrimination occurring against patients, health-care professionals, and/or staff, they **must** take necessary[11] and reasonable steps to stop and/or otherwise address these acts (e.g., providing support) in a manner that does not compromise the safety of themselves or others.[12]

Health Services that Conflict with Physicians' Conscience or Religious Beliefs

CPSO recognizes that physicians have the right to limit the health services they provide for reasons of conscience or religion. Physicians' freedom of conscience and religion must also be balanced against the right of existing and potential patients to access care. The Court of Appeal for Ontario has confirmed that where an irreconcilable conflict arises between a physician's interest and a patient's interest, as a result of physicians' professional obligations and fiduciary duty owed to their patients, the interest of the patient prevails.[13]

CPSO has expectations for physicians who have a conscientious or religious objection to the provision of certain health services. These expectations accommodate the rights of objecting physicians to the greatest extent possible while ensuring that patients' access to healthcare is not impeded.

9. Where certain health services conflict with physicians' conscience or religious beliefs in a manner that would impact patient access to those health services, physicians **must** fulfill their professional obligations and fiduciary duty to their patients by putting patients' interests first.

10. Physicians **must** provide patients with accurate, complete, and unbiased information about all available and appropriate options to meet their clinical needs or concerns

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[10] See the *Ending the Physician-Patient Relationship* policy for expectations when deciding to end the physician-patient relationship. Additional guidance around determining whether a request is reasonable can be found in the *Advice to the Profession*.

[11] Necessary steps include complying with applicable legislation (e.g., the *Occupational Health and Safety Act*) and any other relevant policies (e.g., the *Professional Responsibilities in Medical Education* policy), institutional codes of conduct, or by-laws.

[12] Physicians will need to take into consideration the mental and/or physical state of the patient or individual when determining reasonable steps, where at times their behaviour may be due to a health condition (e.g., severe mental illness, neurocognitive or neurodevelopmental disorder) and/or their current health status (e.g., intoxication, delirium).

[13] See para. 187 *Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario*, 2019 ONCA 393.

106 so that patients are able to make an informed decision[14] about exploring a particular
107 option.[15]

108 11. Physicians **must not**:

109 a. withhold information about the existence of any relevant service, treatment,
110 or procedure because it conflicts with their conscience or religious beliefs; or

111 b. impede access to information and/or care.

112 12. When a particular service, treatment, or procedure is an option for a patient and
113 conflicts with a physician's conscience or religious beliefs in a manner that would
114 impact patient access, physicians **must**:

115 a. make any decisions to limit the provision of health services in accordance
116 with the *Human Rights Code*;[16]

117 b. inform the patient that they do not provide that service, treatment, or
118 procedure;

119 c. have a plan in place around how they will connect patients to the services that
120 would typically be requested in their type of practice, but that conflict with
121 their conscience or religious beliefs; and

122 d. provide the patient with an effective referral in a timely manner to allow
123 patients to access care and not expose them to adverse clinical outcomes
124 due to a delay.

125 13. In discharging provisions 10 and 12, physicians **must**:

126 a. communicate the necessary information in a clear, straightforward, non-
127 judgmental, and understandable manner;[17]

128 b. document in accordance with the expectations set out in the *Medical Records*
129 *Documentation* policy and, where relevant, the *Medical Assistance in Dying*

[14] In accordance with the *Consent to Treatment* policy and the *Health Care Consent Act, 1996*, physicians need to obtain valid consent in order to proceed with a particular treatment option. In order for consent to be valid, it must be related to the treatment, informed, given voluntarily, and not obtained through misrepresentation or fraud.
[15] For specific guidance related to medical assistance in dying (MAID), see the *Advice to the Profession: Medical Assistance in Dying*.
[16] Limiting health services on the basis of conscience or religion does not permit physicians to discriminate on the basis of a protected ground under the *Human Rights Code* and limit to whom they provide services they otherwise offer.
[17] Communicating in an understandable manner may involve addressing language and/or other communication barriers (e.g., due to neurodiversity or disability) and using the best available resources for interpretation.

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130 policy, and transfer any copies of records in accordance with the *Medical*
131 *Records Management* policy; and

132 c. where formal clinical referrals are provided, comply with the relevant
133 expectations set out in the *Transitions in Care* policy.

134 14. Physicians **must** provide any necessary care in an emergency, even where that care
135 conflicts with their conscience or religious beliefs.[18]

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[18] For clarity, MAID would never be a treatment option in an emergency.

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ADVICE TO THE PROFESSION: HUMAN RIGHTS IN THE PROVISION OF HEALTH SERVICES
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4 *Advice to the Profession* companion documents are intended to provide physicians with
5 additional information and general advice in order to support their understanding and
6 implementation of the expectations set out in policies. They may also identify some
7 additional best practices regarding specific practice issues.
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9 The *Human Rights in the Provision of Health Services* policy articulates physicians' legal
10 and professional obligations regarding the provision of health services, including with
11 respect to accessibility and human rights legislation and when limiting health services
12 that conflict with their conscience or religious beliefs. This *Advice to the Profession*
13 ("*Advice*") document is intended to help physicians understand their obligations and
14 provide guidance on how they may be effectively discharged.

15
Providing Safe, Inclusive, and Accessible Health Services

16 ***Why has CPSO referenced cultural humility, cultural safety, anti-racism, and anti-***
17 ***oppression in the policy?***

18 CPSO recognizes that a patient's racial/ethnic/cultural background, sexual orientation,
19 gender identity, socio-economic status, and where they live are often the primary
20 determinants of their health. Those belonging to racialized or marginalized groups are
21 more likely to have difficulties accessing care and experience poorer health outcomes.[1]

22 CPSO has committed to examining how we can better fulfill our mandate by bringing
23 equity, diversity, and inclusion (EDI) to our processes and policies. Many other medical
24 organizations also recognize EDI, cultural safety, and cultural humility as priorities.[2]

25 As part of this commitment, the policy supports physicians taking steps to
26 acknowledge themselves as learners when it comes to understanding a patient's
27 experience (cultural humility), to consider how social and historical contexts shape
28 health and health-care experiences (cultural safety), to attempt to mitigate the effects
29 of oppression in society (anti-oppression), and to engage in the process of actively
30 identifying and eliminating racism (anti-racism). Incorporating these concepts will help
31 create and foster a safe, inclusive, and accessible environment and improve patient
32 experience, health outcomes, and the quality of the physician-patient relationship.

[1] University of Toronto, Family & Community Medicine. (2020). Family Medicine Report: Caring for Our Diverse Populations.

[2] For example, the Federation of Medical Regulatory Authorities of Canada; Royal College of Physicians and Surgeons of Canada; College of Family Physicians of Canada; and the Canadian Medical Protective Association (resources include good practices around cultural safety).

As these concepts may be new to some physicians, examples and resources are provided below as well as on CPSO's Equity, Diversity, and Inclusion webpage.

How do I create and foster a safe, inclusive, and accessible environment in my practice?

Some specific examples include, but are not limited to:

- undertaking ongoing education, becoming aware of your assumptions, beliefs, and privileges, and taking steps to minimize biases when providing care;
- learning about and respecting your patient's lived experience, racial/ethnic/cultural background, values/beliefs/worldview, sexual orientation, gender identity, and socioeconomic status, and understanding how they relate to patient health outcomes;
- communicating and collaborating with patients and/or others they wish to involve in their care to ensure treatment plans address patients' specific needs;
- incorporating a trauma/violence-informed approach to care (e.g., using EQUIP Health Care's Trauma- and Violence-Informed Care Tool); and
- identifying and addressing barriers (e.g., language, physical) that may prevent or limit access to health services, and creating safe and inclusive spaces.

You may also help create safe, inclusive, and accessible environments through your role as a health advocate. This may mean advocating for an individual patient's health care needs, advancing policies that promote the health and well-being of the public and a safe health care system, or actively challenging structures (e.g., policies and programs) that perpetuate inequities in the health care system.

The policy says that physicians must not promote their own spiritual, secular, or religious beliefs when interacting with patients or impose these beliefs on patients. Can I ever discuss my beliefs with patients?

Yes. CPSO recognizes that patients' spiritual, secular, and religious beliefs can play an important role in decisions about health care and can offer comfort to patients facing difficult news about their health. It can be appropriate to inquire about and/or discuss patients' beliefs when they are relevant to a patient's decision-making or where it will enable you to suggest support and resources that may assist the patient.

It is important not to imply that your beliefs are superior to the patient's, attempt to influence the patient's beliefs, or attempt to convert patients to your own beliefs. This includes when you are communicating a conscientious or religious objection to certain treatments, services, or procedures. Allowing patients to guide discussions about their beliefs will help avoid the perception that you are attempting to influence them.

Does the Accessibility for Ontarians with Disabilities Act, 2005 (AODA) apply to me? How does the AODA relate to the Ontario Human Rights Code?

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Yes. The *AODA* applies to organizations with at least one employee, including those that provide health-care services (e.g., physicians' offices, clinics, and hospitals). The *AODA* sets general accessibility standards that organizations must meet in different areas, such as information and communication standards and customer service standards.

Under the *Human Rights Code*, all individuals and organizations that provide services or employ people have a duty to accommodate persons with disabilities, making individualized adaptations or adjustments to provide equitable opportunities for participation. Physicians must comply with the *Human Rights Code* and *AODA* standards that are applicable to their office[3] and any policies developed in accordance with *AODA* in their workplace.

While the *Human Rights Code* and *AODA* work together, compliance with the *AODA* does not necessarily mean compliance with the *Human Rights Code*. Even where a physician meets all their obligations under the *AODA*, they will still be responsible for making sure that discrimination and harassment based on disability do not take place in their operations and that they respond to individual requests for accommodation.[4]

What is the duty to accommodate set out in the Human Rights Code? How do I fulfil it?

The legal, professional, and ethical obligation to provide services free from discrimination includes a duty to accommodate. The duty to accommodate under the *Human Rights Code* relates to accommodations required to meet the needs of protected groups. Common grounds for accommodation requests are disability, creed, family status, gender identity, gender expression, and sex. Patients have a right to take part in the process of determining an appropriate accommodation and the process should maximize the patient's right to privacy and confidentiality.

Individuals and organizations can adopt the principles of inclusive design and proactively anticipate and offer accommodations that may be required to ensure equal opportunity to individuals seeking to become a patient.

Examples of accommodation may include, but are not limited to: permitting a service dog to accompany a patient into an exam room; using interpreters[5] or other aids to overcome communication barriers; ensuring signage reflects diverse family configurations (e.g., families with two mothers or two fathers); designing areas (e.g.

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[3] Physicians can use the Ontario government's Accessibility Standards Checklist to help identify which requirements apply to their office. For example, requirements under the Information and Communication Standards may include ensuring that the physician's office can communicate with patients in accessible ways (e.g., having documents in accessible formats, providing communication supports upon request,).

[4] For more information, see the Ontario Human Rights Commission (OHRC) eLearning series, Working Together: The *Code* and the *AODA*.

[5] The use of an interpreter would likely involve the disclosure of patient personal health information (PHI) by the physician to the interpreter. Physicians must have legal authority (e.g., patient consent) before disclosing any PHI to an interpreter.

waiting rooms, hallways) to be navigable by wheelchair-dependent patients; ensuring that Indigenous patients[6] who need to smudge can do so in a dignified and timely way; and using forms that reflect the diversity of patients' gender identities and expression.

What happens if I cannot accommodate a patient?

The threshold to establish undue hardship is very high and, often, it will not be difficult to accommodate a patient's *Human Rights Code*-related needs. Where a particular accommodation measure would cause undue hardship (based on excessive cost or health and safety issues) or significantly interfere with the rights of others,[7] you still have a duty to explore and implement any other measures that would meet the patient's *Human Rights Code*-based needs, fall short of undue hardship, and do not interfere significantly with others' legal rights. If you are aware of another health-care professional who is available and able to accommodate the patient, you can also connect the patient to them.

What are "service animals" and "support animals"? Am I required to allow them?

The *AODA* Customer Service Standards defines an animal as a "service animal" for a person with a disability if:

- the animal can be readily identified as one that the person is using for reasons relating to their disability, as a result of visual indicators such as the vest or harness worn by the animal; or
- the person provides documentation[8] from a regulated health professional confirming that they require the animal for reasons relating to the disability.[9]

A "support animal" (also commonly referred to as an "emotional support animal") is not defined in the *AODA* or the *Human Rights Code*.

Physicians are required to allow service animals and may be required to allow support animals under the *Human Rights Code* if support animals are required as a form of accommodation for patients with disabilities, subject to undue hardship.

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[6] For more information on accommodations for Indigenous spiritual practices, see Section 11 of the OHRC's Policy on preventing discrimination based on creed.
[7] For more information on undue hardship and other limits on the duty to accommodate, see the OHRC's Policy on ableism and discrimination based on disability, including Section 9, "Undue Hardship" and "Balancing the duty to accommodate with the rights of other people" under Section 10 "Other limits on the duty to accommodate."
[8] It is important that physicians who receive this documentation do not use their own assumptions and observations to second-guess this confirmation. CPSO's *Third Party Medical Reports* policy sets expectations that would apply to providing third party medical reports, including documentation for a service and/or support animal.
[9] See the Ontario government's website for more information about service animals.

Guidance on patient requests for documentation for a service or support animal can be found in the *Advice to the Profession: Third Party Medical Reports*.

How do I determine if a patient's request to receive care from a physician with a particular identity is reasonable?

If a patient requests to receive care from a physician with a particular identity, you may sensitively explore the reason(s) for the request. Physician-patient concordance is associated with greater trust, comprehension, satisfaction, and other critical patient-centred outcomes. For example, patients from racial or ethnic minority groups may request a physician of the same race or ethnicity based on a history of discrimination or other negative experiences with the health-care system that resulted in mistrust. Such requests can be considered reasonable.

In some instances, it may be difficult to evaluate a request, such as when the patient does not feel comfortable disclosing their reason (e.g., a patient may not disclose that a request for a physician of a particular gender is due to a history of sexual assault). You will need to use your professional judgment to determine whether fulfilling the request is reasonable in the circumstances.

At other times, it may be obvious that the request is not reasonable because the patient uses discriminatory and derogatory language. In these cases, once a patient's emergent or urgent medical needs are met, you will need to use your professional judgment (including considering the safety of everyone involved) when determining what steps to take next. This may include continuing to provide treatment to the patient's other needs or transferring the patient's care to another provider.

It is also prudent to consider the patient's mental and/or physical state. For example, patients may not be cognitively aware of what they are saying or doing due to a severe mental illness, neurocognitive or neurodevelopmental disorder, intoxication, or delirium. Physicians may be more willing to care for patients in these cases. Professionalism requires physicians to accept a broad range of human behaviour in response to illness or incapacity. You will need to use your professional judgment to determine when behaviour becomes unsafe. It would not be in anyone's best interest to provide care where you feel unsafe and/or may be harmed.

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Physician Safety, Health, and Wellness

What steps can I take to address acts of violence, harassment, and/or discrimination against patients, health-care professionals, and/or staff?

Physicians have a right to be free from violence, harassment, and discrimination in their workplace. Physicians suffer harm (e.g., emotional exhaustion, fear, self-doubt, and increased cynicism) after encounters with discriminatory patients, which can lead to physician burnout and negatively impact patient care.

162 The policy enables physicians to take steps to stop and address acts of violence,
163 harassment, or discrimination, where it does not compromise their own or others'
164 safety. Steps that can be taken to address these acts can include, but are not limited to:

165 - Naming the behaviour as violent, harassing, and/or discriminatory;
166 - Explicitly stating that the behaviour is not appropriate and will not be tolerated;
167 - Developing a safety plan for the workplace and being aware of any other relevant
168 policies and procedures in place;
169 - Making a report to the appropriate authority or supporting the individual who
170 experienced the violence, harassment, and/or discrimination in doing so; and
171 - Providing the individual who experienced the violence, harassment, and/or
172 discrimination with the opportunity to debrief with someone with the necessary
173 skills to do the debriefing.

174 If a physician determines that it would be unsafe to care for a patient and decides to
175 end the physician-patient relationship, they must comply with the *Ending the Physician-*
176 *Patient Relationship* policy.

177 Additional guidance on addressing violence, harassment, and discrimination in the
178 workplace can be found in the CMPA articles, Challenging patient encounters: How to
179 safely manage and de-escalate and When physicians feel bullied or threatened.

180 ***I am a physician with a disability. What resources are available to support me?***

181 Physicians with disabilities play an important role in providing health care. In addition to
182 their medical skills and knowledge, their lived experiences can enrich the learning and
183 clinical environment, increase empathy for patients, and improve care for patients with
184 disabilities. Full inclusion of physicians with disabilities, however, requires structural
185 and cultural changes.[10]

186 The Canadian Medical Association recommends bolstering processes which provide
187 reasonable accommodations to physicians and learners with existing disabilities while
188 allowing for safe patient care. The Royal College Physician Wellness Task Force has
189 recommended that policies and practices support flexibility in training and practice to
190 meet varied needs and circumstances (e.g., accommodations, modified training, work
191 and call schedules).

192 Resources for physicians with disabilities can be found through the Canadian
193 Association of Physicians with Disabilities. Physician wellness resources are also
194 available on CPSO's website.

[10] Canadian Journal of Physician Leadership. (2021). Fostering inclusion of physicians with disabilities at The Ottawa Hospital.

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195 ## Health Services that Conflict with Physicians' Conscience or Religious
196 ## Beliefs

197 ***Can I practise in accordance with my conscience or religious beliefs?***

198 Yes. The *Canadian Charter of Rights and Freedoms* protects the freedom of conscience
199 and religion.[11] This freedom must also be balanced against patients' right to access
200 health services. Reasonable limits may be justifiable to achieve other objectives, such
201 as protecting public safety, health, or the fundamental rights and freedoms of others.[12]
202 The balancing of rights must be done in context.[13] Courts will consider the degree to
203 which an act in question interferes with a sincerely held religious belief and determine
204 whether it interferes in a manner that is more than trivial or insubstantial.[14]

205 ***What does an effective referral involve?***

206 An effective referral involves taking the following steps:

207 1. **The physician must take positive action to ensure the patient is connected with**
208 **another physician, health-care professional, or agency.** The physician can take
209 these steps themselves or assign the task to someone else (i.e., their designate),
210 so long as this other person complies with CPSO's expectations.

211 2. **The effective referral must be made to a non-objecting physician, health-care**
212 **professional, or agency that is available and accessible to the patient.** The
213 physician, health-care professional, or agency to which the effective referral is
214 made cannot have conscientious or religious beliefs that would impact patient
215 access to the service, treatment, or procedure, must be operating and/or
216 accepting patients, and must be in a location that is reasonably physically
217 accessible to the patient or accessible via virtual care, where appropriate.

218 3. **The effective referral must be made in a timely manner so that the patient will**
219 **not experience an adverse clinical outcome due to a delay in making the**
220 **effective referral.** A patient would experience an adverse outcome due to a delay
221 if, for example, the patient is no longer able to access the service, treatment, or
222 procedure (e.g., for time-sensitive matters such as emergency contraception or
223 abortion); their clinical condition deteriorates; or their untreated pain or suffering
224 is prolonged.

225 An effective referral *does not:*

[11] *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act*, *1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11, s 2(a).
[12] *R. v. Big M Drug Mart Ltd.*, [1985] 1 S.C.R. 295 at para 95.
[13] Ontario Human Rights Commission, Policy on Competing Human Rights.
[14] *Syndicat Northcrest v. Amselem*, [2004] 2 S.C.R. 551 at paras 59-61.

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- necessarily require that the physician make a formal clinical referral (i.e., a written request for the provision of expert services by another physician to a patient)[15];
- require that the physician assess the patient or determine whether they are a suitable candidate, or eligible, for the service, treatment, or procedure; or
- guarantee that the patient will receive the service, treatment, or procedure as they may ultimately not choose that particular clinical option or be a suitable or eligible candidate for it; or
- require that the physician endorse or support the service, treatment, or procedure.

What are some examples of an effective referral?

When making an effective referral, you will need to use your professional judgment to determine what specific action to take, as some patients may need more assistance than others. A patient may have greater needs and vulnerability (e.g., due to a lack of resources, location, marginalization, and/or the nature of their health condition). You will also need to consider whether the service, treatment, or procedure can be accessed by the patient directly or whether a clinical referral is required (e.g., to access a specialist) from you or your designate. Even where patients can access services directly, many patients may require their physicians' assistance in doing so.

It is important that a patient does not feel abandoned when seeking to be connected to a service, treatment, or procedure to which their physician objects. It would be prudent for you or your designate to discuss with the patient whether they would like you or your designate to follow up with them.

When a patient is particularly vulnerable and/or has urgent needs, you may need to take additional steps to ensure they are connected to an available and accessible provider, unless the patient has indicated that they prefer otherwise. This may mean verifying that the provider to whom you referred the patient continues to be available and accessible, confirming whether the patient was connected, and/or taking another action if the patient was not connected. For example, if the first action you took was to provide the patient with a contact number for a non-objecting, available, and accessible physician, the next action may be to directly contact another physician, health-care professional, or agency on the patient's behalf and arrange for them to be seen.

The following is a non-exhaustive list of actions physicians or their designate can take:

- Contacting a non-objecting, available, and accessible physician or other health-care professional and arranging for the patient to be seen.

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[15] This definition has been adopted from the definition of "referral" set out in the Ontario Health Insurance Program's Physician Services – Schedule of Benefits.

- Making a clinical referral to a non-objecting, available, and accessible physician or other health-care professional to access the service, treatment, or procedure (e.g., a fertility specialist).
- Partially transferring[16] the patient's care to a non-objecting, available, and accessible physician or other health-care professional with whom the patient can explore all options in which they have expressed an interest. This other physician or health-care professional could make a clinical referral if it is required.
- Connecting the patient with an agency charged with facilitating referrals for the service, treatment, or procedure, and arranging for the patient to be seen at that agency. For instance, in the medical assistance in dying (MAID) context, contacting Ontario's care coordination service, which would connect the patient with a willing provider of MAID-related services. In the context of reproductive care, the physician or their designate could contact the National Abortion Federation's National Abortion Hotline and/or Action Canada for Sexual Health and Rights' Access Line.
- In appropriate circumstances (e.g., where the patient does not need assistance), providing the patient with contact information for a non-objecting, available, and accessible physician, other health-care professional, or agency.
- Connecting the patient with the point person in a practice group in a hospital, clinic, or family practice model who will facilitate an effective referral or provide the patient with the services, treatment, or procedure.
- Working in a practice group in a hospital, clinic, or family practice model which identifies patient queries or needs through a triage system. The patient is directly matched with a non-objecting physician in the practice group with whom the patient can explore all options in which they have expressed an interest.

Does the expectation to provide patients with an effective referral apply to faith-based hospitals and hospices?

Yes. Physicians are required to provide patients with access to information, including an effective referral, for the services, treatments, and procedures not provided in the faith-based hospital or hospice.

Can I end the physician-patient relationship because my patient wishes to explore a care option that conflicts with my conscience or religious beliefs?

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[16] In this situation, the physician would only transfer the care that they choose not to provide for reasons of conscience or religion. This partial transfer of care is not equivalent to ending the physician-patient relationship. The *Ending the Physician-Patient Relationship* policy states that physicians must not end the physician-patient relationship solely because the patient wishes to explore a care option that the physician chooses not to provide for conscience or religious reasons.

No. CPSO's *Ending the Physician-Patient Relationship* policy states that physicians must not end the physician-patient relationship solely because the patient wishes to explore a care option that conflicts with the physician's conscience or religious beliefs.

Physicians are obligated to continue to manage other elements of a patient's care where applicable. For example, if you are a primary care provider, you are obligated to continue to offer comprehensive and continuous care to patients seeking MAID who may still need help managing the symptoms that led to their desire to explore MAID. If the patient's natural death is not reasonably foreseeable, the physician or nurse practitioner exploring MAID with the patient may also need your assistance to treat the patient's medical condition by other means.

Resources

Accessibility and accommodation

- Accessibility in Ontario
- OHRC, Duty to Accommodate eLearning module
- OHRC, A policy primer: Guide to developing human rights policies and procedures
- OHRC Policies and Guidelines focusing on specific *Human Rights Code* grounds

Racism and discrimination

- *eDialogue* articles on Implicit Bias in Health Care and Treating Patient Bias
- Share Your Story: Indigenous-Specific Racism & Discrimination in Health Care Across the Champlain Region
- Call it Out: Racism, Racial Discrimination, and Human Rights
- San'yas Anti-Racism Indigenous Cultural Safety and Training Program

Safe and inclusive spaces

- *eDialogue* article on Creating An Inclusive Space
- Cultural Religious Competence in Clinical Practice
- Religious Diversity: Practical Points for Health Care Providers
- eDialogue, Obesity Guideline Addresses Root Drivers
- Rainbow Health Ontario Education & Training
- Action Canada for Sexual Health and Rights, A Handbook for health care providers working with clients from diverse communities

Trauma-informed care and gender-based violence

- EQUIP Health Care, Trauma- and Violence-Informed Care (TVIC)
- OAITH Training Portal for those supporting survivors of gender-based violence
- OAITH, Beneath the Iceberg Video Guide

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CPSO

Council Motion

Motion Title	Revised Policy for Final Approval – *Human Rights in the Provision of Health Services*
Date of Meeting	September 22, 2023

It is moved by__________________, and seconded by___________________, that:

The Council of the College of Physicians and Surgeons of Ontario approves the revised policy "Human Rights in the Provision of Health Services", formerly titled "Professional Obligations and Human Rights", as a policy of the College (a copy of which forms Appendix " " to the minutes of this meeting).

CPSO

Council Briefing Note

September 2023

Topic:	Register and Member Information By-laws
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation Meaningful Engagement System Collaboration Continuous Improvement
Public Interest Rationale:	**Accountability:** Holding regulated health professionals accountable to their patients/clients, the College and the public **Protection:** Ensuring the protection of the public from harm in the delivery of health care services
Main Contacts:	Carolyn Silver, Chief Legal Officer Marcia Cooper, Senior Corporate Counsel & Privacy Officer
Attachment:	**Appendix A:** Council Motion with Proposed Register and Member Information By-laws

Issue

- Proposed changes to the by-laws relating to the public register and member information are being brought back to Council after circulation for approval with a future effective date.

Background

- One of the 2023 KPIs is to refresh the CPSO by-laws. The first stage of the by-law review was focused on those by-laws that relate to the public register content and information required to be provided by members to CPSO for the public register and for other purposes.

- We reviewed the register by-laws with a lens to reduce redundancies as between the by-laws and the Code or Regulations where appropriate.[1] We also considered whether the information required by the by-laws (not the legislation, as we are not seeking legislative change at this time) is beneficial or helpful for the public.

[1] There are three sources of authority for what is required to be posted on the public register:

1. Health Professions Procedural Code (Schedule 2 of the RHPA);
2. Regulations under the RHPA; and
3. CPSO By-laws (in the General By-law).

- Proposed changes to the register and member information by-laws were presented to Council for consideration in March 2023, and subsequently circulated as required by the Code.

Current Status and Analysis

- No comments were received from external stakeholders on the proposed by-law amendments circulated after March Council.

- At March Council, the following two issues were raised for further consideration:

  a) Where a member has changed their name, consider if the member's former name is required to be posted on the public register in all cases.
  b) Consider if a member's gender should be posted on the register.

Former Name:

- Indicating a member's former name (that was used in practice or since medical training) on the register is important for identification and continuity purposes.

- It is also recognized that, in some circumstances, there may be other considerations that outweigh the benefits of displaying a member's former name. For example, it may not be appropriate or necessary in all cases to display the former name (deadname) of a transgender or non-binary member.

- Some of the other RHPA Colleges provide for former names of members to be listed on the register.

- We recommend that CPSO continue to post former names on the register.

- However, individual members may request that the Registrar exercise statutory discretion to remove or not post the member's former name, on one of the following grounds:

  a) it is obsolete and no longer relevant to the member's suitability to practice (under section 23(7) of the Code); or
  b) it may jeopardize the safety of an individual, if that is applicable (under section 23(6) of the Code).

- The website will include information as to how members may request that a former name be removed or not posted on the public register.

Gender:

- At least four other RHPA Colleges (including the Pharmacists, Psychologists, Massage Therapists and Optometrists) indicate gender of their members on the register, although we note that more RHPA Colleges do not include gender on the register.

- Several, though not all, of the other medical regulators in other provinces indicate gender on their register (namely, B.C., Alberta, Saskatchewan, Quebec and Nova Scotia).

- Members of the public may use the register to select a physician of their preferred gender or to check the gender of a physician they have been referred to for this purpose. There are studies indicating that patients sometimes prefer physicians of the same gender for some health problems or types of care, but not for all.[2]

- Gender is often used (such as by hospitals) as a means of identification of a physician, along with their name and other information.

- For these reasons, we think it is in the public interest to continue posting gender on the public register.

- Members may report the gender with which they identify. Currently, members may choose from these options: Male, Female or Non-Binary. After discussion with the Executive Committee, it is proposed that the options be changed to: Man, Woman, Non-Binary and "Prefer not to answer", the latter to help address individual concerns over disclosing gender. These options will not be indicated in the By-laws but will be reflected on the annual renewal survey and on the renewed website (see below).

Timing and Approach

- Technological changes will need to be made to the website to implement many of the proposed changes to the register by-laws. IT is working on a project to revamp the website, and in particular the register (Doctor Search). This project is not expected to be completed until later in 2024.

- The Executive Committee reviewed the revised register and member information by-laws, and the proposed approach to former names and gender on the register. The Executive Committee recommended these by-laws be brought to Council for approval at this time but not to come into effect until a future date to be set by Council based on the status and progress of the website project.

[2] **Objective Data Reveals Gender Preferences for Patients' Primary Care Physician (2020)**
Does physicians' gender has any influence on patients' choice of their treating physicians? (2018)
Patient preference for genders of health professionals (1997)

- The by-law provisions relating to the public register and member information are currently part of the General By-law. Until the revised by-laws are effective, the provisions currently in the General By-law will continue to be in effect and apply.
- We also recommend approving the revised register and member information by-laws (subject to the future effective date) as a separate, stand-alone By-law in the interim, while work proceeds on the rest of the General By-law.

Next Steps

- Council will be asked to determine the effective date of these by-laws closer to the anticipated completion of the website project.

Question for Council

1. Does Council approve the revised register and member information by-laws to be made effective at a future date to be determined by Council?

Council Motion

APPENDIX A

Motion Title	For Approval: Register and Member Information By-laws
Date of Meeting	September 22, 2023

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. 158 effective as of a date to be determined by the Council:

By-law No. 158

1. Sections 48, 49, 50.1, 50.2, 51 and 51b of the General By-law are revoked.

2. The following are enacted as the Register and Member Information By-laws (Bylaw No. 158).

Register and Member Information By-laws (By-law No. 158)

Member Names and Addresses

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

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

(3) The registrar may give a direction under subsection 1(2) before or after the initial entry of the member's name in the register.

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

Additional Register Content

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

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

2. The member's registration number.

3. The member's gender.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

    i. a summary of the allegation and/or notice of hearing if it was referred to the Ontario Physicians and Surgeons Discipline Tribunal prior to **[DATE BY-LAW COMES INTO EFFECT];**
    ii. the notice of hearing if it was referred to the Ontario Physicians and Surgeons Discipline Tribunal on or after **[DATE BY-LAW COMES INTO EFFECT]**;
    iii. the anticipated date of the hearing, if the date has been set;
    iv. if the hearing has been adjourned and no future date has been set, the fact of the adjournment; and

    if the decision is under reserve, that fact.

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

    i. the date on which the Ontario Physicians and Surgeons Discipline Tribunal made the finding;
    ii. the date on which the Ontario Physicians and Surgeons Discipline Tribunal ordered any penalty; and
    iii. if the finding is appealed, the status of the appeal and the disposition of the appeal.

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

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

    i. the date on which the fitness to practise committee made the finding;
    ii. the effective date of any order of the fitness to practise committee;
    iii. if the finding is under appeal, a notation to that effect; and
    iv. when an appeal of a finding of incapacity is finally disposed of, the notation added under subparagraph iii of this paragraph 22 shall be removed.

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

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

    i. that fact;

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

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

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

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

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

    i. the fact and content of the charge; and

    ii. the date and place of the charge.

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

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

    i. a brief summary of the finding;

    ii. a brief summary of the sentence;

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

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

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

i. the date of the finding; and

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

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

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

Public Information

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

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

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

(2) Notwithstanding subsection 3(1), the content of terms, conditions or limitations are no longer public information if:

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

ii. the terms, conditions or limitations have been removed from the register.

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

Liability Protection

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

(a) membership in the Canadian Medical Protective Association;

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

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

Notification Required by Members

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

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

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

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

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

(2) If there is a change in the information provided under subsection 5(1), the member shall notify the College in writing or electronically, as specified by the College, of the change within thirty days of the effective date of the change.

(3) The College may at any time and from time to time request information from its members. In response to each such request, each member shall accurately and fully provide the College with the information requested using the Member Portal (as defined in section 9), or such other form or method specified by the College, by the due date set by the College. A College request for member information may include (but is not limited to) the following:

(a) the member's home address;

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

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

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

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

(f) the member's date of birth;

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

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

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

   i. information that relates to the member's health;
   ii. information about actions taken by other regulatory authorities and hospitals in respect of the member;
   iii. information related to civil lawsuits involving the member;
   iv. information relating to criminal arrest(s) and charge(s); and
   v. information relating to offences; and

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

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

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

(a) Death within the premises;

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

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

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

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

7. (1) When applying for a certificate of registration or a renewal of a certificate of registration, an applicant must sign a declaration that the member complies with section 4.

(2) A member must have available at the member's business address, in written or electronic form, for inspection by the College, evidence that the member complies with section 4, or may have the provider of the protection under section 4 provide regular updates to the College confirming compliance with section 4.

(3) Section 4 and subsection 7(1) do not apply to:

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

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

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

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

9. If the College specifies, or these by-laws require or permit, that a member or a health profession corporation provide or submit to the College a notice, information, declaration or other documentation electronically, the term "electronically" includes (but is not limited to,

unless the College specifies otherwise) the College's electronic member portal system (the **"Member Portal"**).

Explanatory Note: This by-law is not currently in effect. It will come into effect at a date to be determined by the Council.

Council Briefing Note

CPSO

September 2023

Topic:	To Consider Waiving Application Fees for Out-of-Province Electives
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation
Public Interest Rationale:	**Accessibility:** Ensuring individuals have access to services provided by the health profession of their choice and individuals have access to the regulatory system as a whole
Main Contact:	Samantha Tulipano, Director, Registration & Membership Services

Issue

- To consider waiving the application fees for residents seeking to complete an elective in Ontario who are registered in another Canadian jurisdiction (Out-of-Province Electives).

Background

- Typically, a residency program consists of various rotations that can also be referred to as blocks. A trainee is able to arrange for one of these rotations to be done outside of their home program. An elective block is typically a short duration of time and elective appointments must not exceed 15 weeks.

- Section 14 of the Registration Regulation O. Reg. 865/93 permits postgraduate medical residents to register for an elective rotation at one of the six Ontario medical schools to satisfy educational requirements in their home residency training program.

Current Status and Analysis

Existing Application Process

- After obtaining confirmation of elective appointment, an out-of-province resident (a resident whose home program is in another Canadian province) submits an application package to CPSO for a postgraduate certificate.

- The CPSO application fee for this activity is presently $431.25.

- As elective appointments cannot exceed a maximum period of 15 weeks, CPSO does not charge the postgraduate membership fee for elective certificates.

Ongoing Work to Reduce Barriers and Support Inter-Provincial Mobility

- Residency electives provide a unique learning experience for residents and is supported as an enrichment opportunity by the Canadian Medical School system.
- Electives, by nature, require an individual to hold an appointment as a Resident at Canadian medical school, and by extension requires an individual to hold a postgraduate license in their jurisdiction and pay membership fees to their home Medical Regulatory Authority (MRA).
- For electives that occur within Ontario (meaning an exchange rotation between 2 Ontario Universities); there is no application or additional fee associated for this practice. There is a formal approval process within the Universities that manage and monitor these requests.
- For electives that occur in Ontario but originate from an Out-of-Province Resident (i.e. a Resident from Alberta completing an elective rotation in Ontario), they are required to apply to CPSO and be issued a postgraduate certificate for this activity.
- The application itself has few requirements as this individual is presently registered in another Canadian jurisdiction and undergone a review of qualifications, however, we presently charge an application fee of $431.25 for these time limited certificates – which can be issued for a period of anywhere from a few days to no more than 15 weeks.
- As the application fees may be a barrier to registration for this activity, we are seeking your approval to waive the application fees for out-of-province electives.
- This is one way CPSO can support enhanced learning opportunities and promote increased inter-provincial mobility.

Analysis

- For the 2023 calendar year we have 331 planned electives for individuals registered in another Canadian province/medical school.
  - Based on this data, the estimated annual revenue loss would be 331x431.25 for a total of $142,743.75.

- We are seeking Council's approval to waive the out-of-province elective fees in an effort to alleviate some of the strain on the health care system.

Question for Council

1. Does Council support waiving the application fees for out-of-province electives?

CPSO

Council Motion

Motion Title	For Approval: To Consider Waiving Application Fees for Out-of-Province Electives
Date of Meeting	September 22, 2023

It is moved by__________________, and seconded by___________________, that:

The Council of the College of Physicians and Surgeons of Ontario approves waiving the application fees for postgraduate education certificate of registration for out-of-province electives.