April 26, 2017

Mr. Monte McNaughton, MPP  
Chair, Standing Committee on the Legislative Assembly  
Room 1405, Whitney Block  
Queen’s Park, Toronto, ON  
M7A 1A2

Dear Mr. McNaughton,

Re: Bill 87, Protecting Patients Act, 2017

We write to provide you with the College of Physicians and Surgeons of Ontario’s response to Bill 87, Protecting Patients Act, 2017. The College’s response is focused on Schedule IV of the Bill; the amendments to the Regulated Health Professions Act, 1991 (RHPA).

Bill 87 is an important piece of legislation for Ontario’s patients and for all Health Regulatory Colleges who regulate Ontario’s health professions in the public interest, in accordance with the RHPA.

We note and express support for the objectives that underlie Bill 87: strengthening the sexual abuse and transparency provisions in the RHPA, and improving the complaints, investigation and discipline processes.

The College shares the government’s commitments to these objectives. As you are aware, the College has strongly advocated for legislative change that will enhance our ability to protect patients from sexual abuse by physicians and strengthen the penalties for sexual abuse. The College Council launched its Sexual Abuse Initiative more than two years ago to ensure that the College is doing everything possible to support and protect patients from sexual abuse by physicians. The Initiative included a review of the legislative framework and College processes and culminated in the College putting forward a series of recommendations for legislative change in 2015.

Additionally, as part of the College’s work to ensure transparency, this College along with a number of other health colleges in Ontario have made a number of by-law changes over the past several years to increase the amount and categories of information available to the public about Ontario physicians as part of our transparency initiative. We have made these changes via existing by-law authority.

The College, however, has a number of significant concerns with Bill 87 as it is currently drafted. In our submission, attached as Appendix A, we identify those concerns, and where possible propose alternative legislative language that will more effectively meet the government’s objectives and will avoid negative unintended consequences. We also propose a number of technical drafting amendments that will enhance the clarity and efficacy of the Bill.
Our submission is consistent with our preliminary response of March 17 2017 (attached as Appendix B), and is generally consistent with the submission of the Federation of Health Regulatory Colleges of Ontario (FHRCO) of which the College is a member.

We appreciate the opportunity to make these submissions. Louise Verity, Director of Policy and Communications, is available to provide assistance on these and other issues.

Sincerely,

David Rouselle MD, FRCSC
President

Rocco Gerace MD
Registrar

Attachments
Appendix A:  CPSO Submission on Bill 87
Appendix B:  CPSO Preliminary Response to Bill 87, March 2017
Introduction

The College supports the objectives that underlie Bill 87: strengthening the sexual abuse and transparency provisions in the RHPA, and improving the complaints, investigation and discipline processes.

We do, however, have concerns with a number of provisions included in the Bill and feel that it contains key gaps that must be addressed.

Through this submission, the College identifies these concerns and key gaps, and where possible proposes draft legislative language that will ensure the government’s objectives are met, and negative unintended consequences are avoided. We also propose technical drafting amendments to a number of provisions to help enhance the clarity and efficacy of the legislation.

The content is listed in order of priority. Our remarks are grounded in the following themes:

- Broad Ministerial Regulation-Making Powers
- Strengthening sexual abuse provisions and supporting patients
- Improving the complaints, investigations and discipline processes
- Enhancing transparency

Constructive Feedback and Proposed Revisions

1. Broad Ministerial Regulation-Making Powers

The Bill provides the Minister with a number of new regulation-making powers (Subsection 6(2)). These powers are significant; in some cases permitting the Minister to establish by regulation fundamental governance matters that are currently addressed in the statute.

Our response to this very broad new Ministerial regulatory authority is focused in two areas:

- College Statutory Committees and Governance
- Processes, Functions and Duties: in relation to misconduct of a sexual nature.

a) College Statutory Committees and Governance

The Bill grants the Minister the authority to make regulations with respect to the composition, panel quorum, eligibility requirements and disqualification grounds for each of the College’s seven statutory committees. These are sweeping new governance-related regulatory powers that are broad and undefined.

We understand that the government’s objective is to address concerns raised by the Sexual Abuse Task Force and the media that the Discipline Committee is not sufficiently independent from the College. We agree that this is an important objective, and we support greater independence of the Discipline Committee.
In order to achieve this objective, the College recommends that these provisions be struck from the Bill, and a different approach be adopted.

We recommend bold statutory change: amendments to ensure there is complete separation between the Discipline Committee and Council, with no overlap in membership between the two entities. We believe this approach will directly achieve the government’s objective and will address concerns regarding the perceived lack of independence of the Discipline Committee.

We recommend that provisions to achieve the separation of the Discipline Committee should be made in statute, not in regulation. Including these proposed provisions in statute will ensure that there is transparency and public debate of the provisions as they proceed through the legislative process. Including these provisions in statute is also consistent with the current approach to similar governance provisions. At present, the composition of Council, the roles of statutory committees and some of the more significant quorum requirements are set out in statute as opposed to regulation. The existing quorum requirement that there be two public members of Council and one professional member of Council on panels of the Discipline Committee is also set out in statute.

We recommend that provisions related to the separation of the Discipline Committee should ensure that both public and professional members are included in the composition of Discipline Committee panels. The College feels strongly that public and physician perspectives are essential to effective Discipline Committee panels.

We recommend that the structure and composition of other statutory committees of the College should not be prescribed by regulation. Our reasoning is three-fold. First, by-law is a preferred approach to regulation, as it affords Colleges the ability to nimbly address emerging issues and concerns. We are regularly improving and changing our by-laws on these issues to address matters including qualifications and disqualifications, and in response to new and unforeseen situations that arise. We want to retain our ability to be responsive to problems as they arise.

Second, the concerns regarding a perceived lack of independence have been limited to the Discipline Committee. As such, the College submits that it is not necessary to deviate from the current approach used to set the composition of statutory committees. We note that there is value in retaining strong professional representation on the statutory committees. This is highlighted in particular when one considers the Registration and the Quality Assurance Committees. These Committees both require strong professional representation in order to accurately and appropriately assess the issues before them: to assess risk, appropriate standards of practice, and suitability of qualifications and training.

Third, in relation to the Investigations, Complaints and Reports Committee (ICRC), the College currently has a significant proportion of non-Council physician members included on panels. They are appointed on the basis of merit and possess a broad range of medical expertise. Complaints are screened by ICRC panels which include specialty panels and others. The structure of the ICRC and its panels has been developed to strengthen and ensure the integrity of the screening function.
We note that in relation to item six, set out later in this submission, the College has proposed that legislative change be made to enable non-Council public members to participate in ICRC. Both current practices regarding non-Council physician members and the proposal to include non-Council public members together with the public oversight provided by Health Professions Appeal and Review Board (HPARB) ensure that ICRC is independent and has integrity.

**Proposed Revisions**

Proposed revisions 1 and 2 will achieve the College’s recommended approach, as set out above. Should government not wish to proceed with this approach, the College proposes that the Bill be amended to specify that the regulation-making authority with respect to committee composition, quorum, eligibility, disqualification is restricted to College Discipline Committees only.

1. Delete subsections 43(1) (p)(q)(r)(s) of the Bill.

2. Amend section 38 of the *Health Professions Procedural Code* to specify the composition of Discipline Committee panels to ensure there is complete separation between Council and the Discipline Committee, with no overlap in membership between Council and the Discipline Committee.

**DISCIPLINE COMMITTEE:**

Panel for discipline hearing

38 (1) The chair of the Discipline Committee shall select a panel from among the members of the Committee to hold a hearing of allegations of a member’s professional misconduct or incompetence referred to the Committee by the Inquiries, Complaints and Reports Committee.

*There are two options advanced. They differ only in terms of which entity appoints the non-Council public members: the College or government.*

**Option A: College Appointment**

Composition

(2) A panel shall be composed of at least three and no more than five persons, at least two of whom shall be persons who are residents of Ontario who are not members of the College and who have neither been members of the College nor have been registered to practice medicine in any other jurisdiction, appointed to the Council by the Lieutenant Governor in Council.

Idem

(3) At least one of the members of a panel shall be both a member of the College and a member of the Council.

Exclusion from panel

(4) No person shall be selected for a panel who has taken part in the investigation of what is to be the subject-matter of the panel’s hearing.

(4.1) No person shall be selected for a panel who is a member of the Council.

**Quorum**
Three members of a panel, at least one of whom must be a person who is a resident of Ontario who is not a member of the College, and has neither been a member of the College nor has been registered to practice medicine in any other jurisdiction who was appointed to the Council by the Lieutenant Governor in Council, constitute a quorum.

**Option B – LGIC appointment**

(2) A panel shall be composed of at least three and no more than five persons, at least two of whom shall be persons appointed to the Committee Council by the Lieutenant Governor in Council.

**Idem**

(3) At least one of the members of a panel shall be both a member of the College, and a member of the Council.

**Exclusion from panel**

(4) No person shall be selected for a panel who has taken part in the investigation of what is to be the subject-matter of the panel’s hearing.

(4.1) No person shall be selected for a panel who is a member of the Council.

**Quorum**

(5) Three members of a panel, at least one of whom was appointed to the Committee Council by the Lieutenant Governor in Council, constitute a quorum.

*Note: with option B need to also amend s. 10(2) of Code:*

The Council shall appoint the members of the committees, with the exception of those who shall be appointed by the Lieutenant Governor in Council.

**b) Processes, Functions and Duties: misconduct of a sexual nature**

The Bill grants the Minister the power to develop regulations to “clarify” how the ICRC and Discipline Committee are to perform their functions with respect to matters involving allegations of misconduct of a sexual nature. This includes investigative processes.

The College is supportive of ensuring consistency and integrity in all of our processes. As specified in our March 2017 letter, the College’s concerns with this provision are three-fold. First, the College believes that regulation is not the appropriate tool to specify processes as dynamic and variable as investigations. Second, the College notes that investigations often involve both sexual and non-sexual allegations, and that sexual allegations are not always clearly distinguishable from other misconduct issues at the investigation stage. Third, we note that it is not clear how the word ‘clarify’ is to be understood in this context, and what new functions and duties of the ICRC and Discipline Committee are being contemplated and would be captured in regulation.
2. Definition of Patient

The Bill proposes to include a definition of patient for the purpose of sexual abuse allegations (S. 7), and to add an additional regulation-making power to allow the Minister to develop regulations specifying further criteria defining patient for the purpose of sexual abuse (s. 43(1)(o) RHPA and S. 6(1) of the Bill).

The College has significant concerns with this provision. In our view, the intention of this section of the Bill is clear and unassailable – to prohibit sexual relationships between physicians and former patients, while the power imbalance forged during the physician-patient relationship may remain in place. The College is fully in support of this goal. However, the means chosen to achieve it are, in our view, unclear and unworkable.

i) The language of the provision is unclear and problematic.

The Bill defines patient for the purpose of sexual abuse as an ‘individual who was a member’s patient within the last year’. It is unclear, however, how the phrase, ‘within the last year’ is to be understood. The provision seems to be alluding to an undefined and unnamed incident, from which a one-year time period would start to run. We presume the incident is the termination of the physician-patient relationship, yet the provision does not make it clear what specifically might trigger the one-year period to start running. It is possible that this might be a final appointment, a letter of termination, or some other event.

Even if this undefined incident were clarified, the provision remains problematic. It attempts to extend a physician-patient relationship beyond its termination. Doing so does not reflect reality. There is a point at which a physician-patient relationship ends, either because the relationship is formally terminated, in accordance with the College’s Ending the Physician-Patient Relationship policy, or because the treating relationship has reached its conclusion, such as when a patient is seeing a physician for a specific purpose, like surgery. To deny this reality through legislation; to attempt to state that the physician-patient relationship is ongoing for one more year after the relationship has been terminated is illogical, confusing and ripe for legal challenge.

ii) Defining someone to be a patient for sexual abuse, but not for other potential misconduct is unworkable.

Matters before the Discipline Committee can include allegations of sexual abuse along with other misconduct, such as fraud or unprofessional behaviour. In such matters, the existence of the physician-patient relationship is relevant to both allegations yet, by virtue of the Bill, ‘patient’ would be defined differently for the purposes of the different allegations. This would result in unnecessary and unproductive complexity and could lead to a high likelihood of error and confusion.

iii) It is problematic to extend all physician-patient relationships for one year after termination, for the purpose of sexual abuse allegations.

The language of the provision would extend all physician-patient relationships for one year following termination, for the purposes of sexual abuse. This is problematic in two respects.

First, given the tremendously wide-ranging nature of physician-patient encounters, it would be unfair to have a single period of one year during which the physician-patient relationship is legally extended such that sexual contact with the former patient would constitute sexual abuse of a patient. As noted
in the College’s March 2017 submission, there is a wide disparity in the types of physician-patient relationships that may be formed. For example, a physician-patient relationship may be created when a radiologist reads a patient’s x-ray, when a patient sees a physician once in a walk-in clinic for a flu shot, and when a patient sees a physician for ongoing psychiatric treatment. Each of these relationships is strikingly different, and extending the definition of sexual abuse and the serious sanctions that follow to capture conduct that occurs within a year of some of these brief relationships seems inappropriate.

Second, the provision does not propose to address in statute those situations where the physician-patient relationship is of such an intense nature that a sexual relationship may never be appropriate, or certainly would not be appropriate after only one year has elapsed. It is unclear whether the companion regulation-making authority may be used to address this issue. The College has taken the position in its Maintaining Appropriate Boundaries and Preventing Sexual Abuse policy that in situations where the physician-patient relationship involves a significant component of psychoanalysis or psychotherapy, sexual involvement with the patient is likely never appropriate.

As alternative to the Bill’s proposed definition of patient, and accompanying regulation-making authority, the College makes two proposals.

1. Create a statutory definition that articulates factors to be weighed in determining whether a physician-patient relationship is ongoing.

This proposal provides a more nuanced and comprehensive approach to the issue, by articulating when a physician-patient relationship exists (and therefore when it does not exist). In doing so, it avoids the Bill’s current problematic approach, which is to anchor the definition to an unspecified event which may or may not actually represent the termination of a physician-patient relationship.

Setting out a list of factors offers clarity. It supports a case-by-case assessment as to whether a physician-patient relationship exists. Such a nuanced approach is important, given the variation amongst the type and duration of physician-patient relationships.

It is essential that these factors be set out in statute, not regulation. This allows for the greatest degree of transparency, as the provision and the list will be subject to public debate as the Bill proceeds through the legislative process. It also ensures that the list of factors will be made clear at the same time as the remainder of the Bill is passed. If the Bill is passed without these factors being set out, we are very concerned that we will enter an era of confusion, which gives rise to litigation.

The factors that we propose be included are consistent with those considered by the College’s Discipline Committee in prior cases (see College of Physicians and Surgeons v. Redhead, 2013 ONCPSD 18 (CanLII)). They are also consistent with the process contemplated by and endorsed by Ontario courts in cases such as Mussani v. College of Physicians and Surgeons of Ontario [2003] O.J. No. 1956, aff’d [2004]O.J. No. 5176 (C.A.), and Leering v. College of Chiropractors of Ontario 2010 ONCA 87 and with the approach taken in the College’s Maintaining Appropriate Boundaries and Preventing Sexual Abuse policy.
2) Create a new head of professional misconduct for engaging in a sexual relationship with a former patient while there is still a power imbalance.

Through this element of the proposal, the College recommends that sexual relationships with former patients be explicitly characterized as professional misconduct. This achieves the government’s and the College’s shared objective to prohibit sexual relationships between physicians and former patients, while the power imbalance forged during the physician-patient relationship may remain in place. It avoids the challenges noted earlier with characterizing a terminated relationship as ongoing, and avoids referring to such conduct as sexual abuse, which does not align with existing provisions defining sexual abuse. While the College has some concerns, expressed above, about using an arbitrary period (in this case one year) as the period during which sexual contact is prohibited in all circumstances, should the government be of the view that it is important to do so the College has proposed language below that would capture that intention within this new head of professional misconduct.

The College further recommends that a specific head of misconduct be added that would permanently ban physicians from engaging in sexual relationships with former patients, when the relationship included psychiatric care, recurrent psychotherapy and/or counselling, or any similar treatment. Doing so reflects the College’s position, currently set out in the Maintaining Appropriate Boundaries and Preventing Sexual Abuse policy.

The College further notes that should the government wish, it could add a finding under this new head of professional misconduct to the list of acts of professional misconduct that trigger mandatory revocation, if it is of the view that such a consequence would be the appropriate penalty in all circumstances.

Proposed Revisions

Delete 6 (1) of the Bill

6. (1) Subsection 43 (1) of the Act is amended by adding the following clause:

(o) establishing criteria for the definition of “patient” in relation to professional misconduct involving the sexual abuse of a patient for the purposes of subsection 1 (3) of the Code.

Amend paragraph 7 of the Bill

7. Subsection 1(6) of Schedule 2 to the Act is repealed and the following substituted:

Definitions

(6) For the purposes of subsections 1 (3) and (5),

‘patient’, without restricting the ordinary meaning of the term, includes,

(a) an individual who was a member’s patient within the last year or within such longer period of time as may be prescribed, and

(b) an individual who is determined to be a patient in accordance with the criteria in any regulations made under clause 43(1)(o) of the Regulated Health Professions Act, 1991; (‘patient’)

APPENDIX A

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any one or more of the following factors will be considered in determining whether an individual is a patient:

(a) the presence or absence of a patient file or medical record maintained by the member for the individual;
(b) the presence or absence of billings for services provided to the individual;
(c) the type and frequency of treatment provided by the member, including whether the treatment provided was isolated treatment for a minor condition or provided on an emergency basis;
(d) the location at which the treatment was provided by the member;
(e) whether the member referred to the individual as his or her patient;
(f) whether the individual referred to the member as his or her physician;
(g) whether the member requested testing, consultations, prescribed medications, made referrals to other professionals or coordinated the individual’s treatment;
(h) whether the member received test results or reports back from other members or health care professionals about the individual;
(i) whether the individual had other physicians providing the same or similar treatment; and
(j) whether the patient has shared personal or private information with the physician.

Amend O. Reg. 856/93 made under the Medicine Act, 1991 to add the following:

35. Engaging in any of the conduct set out in section 1 (3) of the Health Professions Procedural Code with a former patient within one year of the end of the physician-patient relationship.

36. Engaging in any of the conduct described in section 1 (3) of the Health Professions Procedural Code at any time with a former patient, where the treatment included psychiatric care, recurrent psychotherapy and/or counselling, or any similar treatment.

3. **Interim Orders**

The College is pleased to see that Bill 87 includes a power for the ICRC to restrict or suspend prior to a referral to the Discipline Committee or to the Fitness to Practise Committee. This is an important addition to the RHPA and one that the College had indeed requested previously.

The College is however, recommending amendments to enhance clarity of the language and to ensure Colleges have the necessary tools to fulfil their mandate. First, the title of the provision needs to be changed to ‘Interim Orders’ to reflect all interim powers, not just those related to suspension. Second, the provision needs to be amended to ensure that it is clear the authority to make Interim Orders arises at the commencement of an investigation. The current language of ‘receipt of report’ is typically interpreted in practice as being a report to the ICRC, which would be furnished at the end of an investigation. Third, the authority needs to be expanded to capture situations where physician conduct jeopardizes the health care system. This would address situations where, for instance, physicians were engaged in fraudulent conduct. Fourth, amendments are required to clarify that Interim Orders can be varied by the ICRC and will remain in force until the matter is finally determined.
Proposed Revisions

Interim Orders

25.4 (1) The Inquiries, Complaints and Reports Committee or a panel of the Committee may, subject to subsections (2) and (6), at any time following the receipt of a complaint or appointment of investigators under s. 75, report make an interim order directing the Registrar to suspend, or to impose terms, conditions or limitations on, a member’s certificate of registration if it is of the opinion that:

a) the conduct of the member or the member’s physical or mental state exposes or is likely to expose the member’s patients to harm or injury; or
b) there is a risk of harm to the public interest in the administration of the health care system and making an order would reduce that risk.

(4) An order under subsection (1) may be varied by the ICRC and continues in force until the matter is finally determined withdrawn, resolved by way of an alternative dispute resolution process or otherwise disposed of by a panel of the Inquiries, Complaints and Reports Committee, the Discipline Committee or the Fitness to Practise Committee.

4. Third Party Records

The Bill does not address the proposals that have been advanced by the College in support of the protection of the privacy interests of patients or complainants. The College believes that this is a significant issue which must be addressed in order to respect patient rights and to avoid creating a ‘chill-effect’ amongst survivors with respect to their willingness to come forward to the College when they have been sexually abused by physicians.

It is essential for the Bill to articulate a high threshold for when third party records are ordered to be produced, similar to that which already exists in the Criminal Code but that which reflects the civil/regulatory nature of College proceedings. We do not believe it should be easier to access these very private personal records in the College process than it is in the criminal process.

It is important that patients/complainants be guaranteed the right to standing on motions to disclose their confidential records. This will help ensure an appropriate balance is struck between the privacy interests of patients and/or witnesses and the interests of the physician in having access to information to assist in defending serious allegations in a regulatory context. Guaranteed standing would also help ensure that patients/complainants have a clear opportunity to have their voice heard when a panel is considering whether their confidential records can be released.

Proposed Revisions:

Disclosure of Evidence

42.2 (1) Where a member seeks an order of the panel for the production and disclosure from a third party of a record that contains personal information for which there is a reasonable expectation of privacy, any one or more of the following assertions by the member are not sufficient on their own to establish that the record is likely relevant to an issue at the hearing or to the competence of a witness to testify:
(a) that the record exists;
(b) that the record relates to medical or psychiatric treatment, therapy or counselling that the complainant or witness has received or is receiving;
(c) that the record relates to the incident that is the subject-matter of the proceedings;
(d) that the record may disclose a prior inconsistent statement of the complainant or witness;
(e) that the record may relate to the credibility of the complainant or witness;
(f) that the record may relate to the reliability of the testimony of the complainant or witness merely because the complainant or witness has received or is receiving psychiatric treatment, therapy or counselling;
(g) that the record may reveal allegations of sexual abuse of the complainant or witness by a person other than the member;
(h) that the record relates to the sexual activity of the complainant or witness with any person, including the accused;
(i) that the record relates to the presence or absence of a recent complaint;
(j) that the record relates to the sexual reputation of the complainant or witness; or
(k) that the record was made close in time to a complaint or report or to the activity that forms the subject-matter of the allegation against the member.

(2) In considering a motion under (1), the panel shall consider the following:

a) the regulatory nature of the proceedings, including the absence of any possible penal consequences to the member if a finding is made;
b) the primary purpose of the proceedings, which is to protect the public and regulate the profession in the public interest;
c) the privacy interest of the complainant or witness in the record(s) sought in the motion; and
d) the nature and purpose of the record(s) sought in the motion.

(3) Where a person who has a privacy interest in the records that are the subject of a motion under subsection (1) seeks standing on the motion, the panel shall grant the request for standing on the motion.

5. Mental Health Act & Discipline Proceedings

The Bill is currently silent on this issue. The College seeks an amendment to clarify that section 35(9) of the Mental Health Act (MHA) is not applicable to College hearings.

This recommendation is based on three arguments.

First, the MHA was not intended to apply to College Discipline proceedings.

The MHA does not contemplate the effective regulation of physicians, nor was it intended to govern in this area. As a result, it does not consider the complex question of how to balance the privacy rights of patients with the competing public interest in an effective regulatory regime. It also does not consider
how to balance the patient’s privacy interests with the College’s interest in using medical records in disciplinary proceedings for the purpose of regulating the medical profession in the public interest.

Should section 35(9) be applied to College Discipline proceedings, physicians who are the subject of such proceedings will effectively be permitted to invoke their patients’ privacy rights to shield their alleged misconduct from review. Applying section 35(9) will also create an artificial distinction between psychiatrists who practice within designated ‘psychiatric facilities’ (which include most hospitals where psychiatric care is provided) and those who operate private practices in the community. The files of those physicians who work in facilities will be inadmissible to the College without consent or a Court order, whereas the files of those who work in the community will be admissible. Further, should a physician work in both settings, the effect could be that some of that physician’s patient files will be inadmissible and some will be admissible. The College submits that this cannot have been the intention.

Second, applying section 35(9) of the MHA will needlessly delay Discipline Committee proceedings.

Section 35(9) will require notice to be provided to every patient who received care in a facility whose health information is involved in a proceeding. This could involve dozens of patients. Often, patient charts may be several years old and patient contact information may be out of date. It could take significant resources to locate affected patients. Even if every patient could be located, the College would have to consider how to effect notification in light of each individual patient’s particular mental health or vulnerability. The application itself would require an evidentiary record. In short, applying section 35(9) would bifurcate the proceedings and would require the College to run a lengthy and cumbersome hearing in the Divisional Court before the Discipline hearing can proceed.

Third, applying section 35(9) of the MHA is not needed in order to ensure that patient privacy interests are respected in the context of Discipline Proceedings, and will pose unnecessary harm to patients.

Currently, under the RHPA, the College takes a number of steps to protect the privacy interests of patients. This includes invoking publication bans to ensure patient identities are not revealed.

The notification requirement in section 35(9) may exacerbate the symptoms of patients suffering from many different types of mental health conditions, including paranoia, anxiety, personality disorders and obsessive compulsive disorder. Notification may also needlessly undermine the therapeutic relationship between the physician and the patient. It will call into question the care provided by the physician, before any finding of misconduct has been made. Should no finding be made, or should a finding be made, but not in relation to a specific patient’s care, the patient will be unnecessarily alarmed, and may question or reject treatment that has been competently provided and that is in accordance with the standard of care.
**Proposed revision**

Amend Regulated Health Professions Act as follows:

**Section 35(9) of Mental Health Act does not apply**

36(4) Section 35(9) of the Mental Health Act does not apply to any proceeding under this Act or a health profession Act.

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**6. Supporting Public Council Members and creating a broader pool of public members**

The Bill does not address important issues related to the public members of Council. The College recommends amendments to address these issues.

First, the College recommends amendments to allow public members who are not members of Council to be included in the quorum for the ICRC and Discipline Committee. This will allow the College to create a broader pool of public members available to perform College work and will enhance the efficiency and timeliness of College processes. Some public members are contributing more than 150 days per year and the average contribution is now more than 80 days per year. We are facing increased challenges convening Discipline and ICRC panels and are concerned about public member burnout.

Second, we recommend amendments to remove the existing legislative barriers that prevent health colleges from compensating public Council members for their work. Public members are compensated inadequately at $150 a day for this work. The public member compensation scheme is a longstanding concern, particularly in an environment where their workload is overwhelming and not sustainable.

**Proposed Revisions**

1. Non-Council public members to be included in quorum requirements for ICRC and Discipline Committee panels.

**Discipline Committee:**

*Please see revisions proposed under ‘Broad Ministerial Regulation-Making Powers: College Statutory Committees and Governance’*

**ICRC:**

*Two options are advanced, which allow for either College appointment of Non-Council public members or government appointment of Non-Council public members.*

**Option A – College appointment**

25(2) A panel shall be composed of at least three persons, at least one of whom must be a resident of Ontario who is not a member of the College and has neither been a member of the College nor has been registered to practice medicine in any other jurisdiction. A person appointed to the Committee Council by the Lieutenant Governor in Council.

**Option B – LGIC appointment**
25(2) A panel shall be composed of at least three persons, at least one of whom shall be a person appointed to the Committee Council by the Lieutenant Governor in Council.

with option B need to also amend s. 10(2) of Code:

The Council shall appoint the members of the committees, with the exception of those who shall be appointed by the Lieutenant Governor in Council.

2. Amendments to remove barriers regarding public member compensation
The College seeks amendments to remove the existing legislative barriers that prevent health colleges from compensating public Council members for their work.

7. Discretion to provide information to police about non-members
The Bill does not currently address information sharing with police about non-members. The College believes that this is a gap in the legislation which must be addressed.

Under the current language of section 36(1) of the RHPA, Colleges are not permitted to share information with police about non-members. There are instances, however, where it is in the public interest to do so. This includes situations where individuals have hacked into members’ systems to obtain prescriptions without the member’s knowledge; where individuals have engaged in fraud in relation to accident benefits; and where individuals have engaged in trafficking of narcotics by receiving multiple prescriptions from multiple members.

In such circumstances, it is vital that the College be permitted to share information with police so that they can take appropriate steps to investigate in an effective and efficient manner. The proposed amendment would protect the privacy of victims but would allow the College to report misconduct to the police when that is in the public interest.

Proposed Revisions

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,

(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;

Limitation

(1.3) No person or member described in subsection (1) shall disclose, under clause (1)(e), any information with respect to a person other than a member, unless there are reasonable grounds to believe the non-member has engaged in conduct that could constitute an offence.

8. Enhancing Transparency
The College is supportive of increased transparency and has taken a leadership role in this area. Through our own Transparency Initiative launched in 2012, the College has taken a number of steps, proactively, to make information about physicians and College processes more accessible and to add categories of information about physicians to our public register.

Many of the categories of information Bill 87 requires to be added to registers has already been added by the College and other Colleges that form part of the Federation of Health Regulatory Colleges of Ontario (FHRCO), and indeed in many instances, the College has gone beyond what is set out in Bill 87.

In addition, the College posts Council meeting dates, and meeting materials including Agendas on our website and we have done so for many years.

a) Public Register – Duty to Correct Information
The Bill includes an amendment (Section 12 (6)) that imposes a duty on the Registrar to correct any information in the public register where a member demonstrates that the information is incomplete or inaccurate.

Currently, there is an implied obligation on all Colleges to have fair and accurate information on its register. The College has processes in place to ensure this obligation is met.

The College does not believe this provision is necessary, and is concerned that adding it may give rise to negative unintended consequences. For example, registers typically include (and in some cases are required to include) summaries of information which by their nature are not ‘complete’. This provision invites members to complain to the College that the summary is “incomplete”, and purportedly imposes a duty on the Registrar to correct it. This could invite significant waste of Colleges’ resources on matters that are unrelated to the protection of the public.

**Proposed Revisions**
The College advances three options. The College prefers Option 1. As an alternative, the College prefers Option 2.

<table>
<thead>
<tr>
<th>Option 1: Delete provision from the Bill (preferred College option)</th>
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<tr>
<td><strong>Option 2: Amend the provision as follows:</strong></td>
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<tr>
<td><strong>Correction of Information</strong></td>
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<td>(13.1) The Registrar shall correct any information contained in the register that emanates from a third party where a member demonstrates, to the satisfaction of the Registrar, that the information contained in the register is incomplete or inaccurate and where the member provides the Registrar with the information that is necessary to enable the Registrar to correct the incomplete or inaccurate information.</td>
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b) No Finding Made

The Bill (Section 7) requires health colleges to post on the register where there is a “failure to make a finding”. The College is supportive of this provision, but seeks a minor amendment to enhance clarity and accuracy. We ask that this language be changed to ‘no finding was made’ or ‘allegations dismissed’, or similar equivalent language. The fact that no finding was made against a member does not constitute a ‘failure’ but rather can be a legitimate disposition, based on the evidence before the Discipline Committee panel. This request is consistent with an amendment the College previously sought in relation to the Health Professions Procedural Code and the ability of Colleges to post public Discipline Committee ‘no findings’ on the register.

Proposed Revision

Amend section 7 of the Bill to delete the words ‘failure to make a finding’, and replace it with ‘no finding was made’ or ‘allegations dismissed’.

c) Other transparency related drafting issues

A number of other minor drafting amendments are required in order to enhance the clarity and precision of the Bill. These relate to former members, ‘acknowledgements or undertakings’ and incapacity proceedings.

With respect to former members, the Bill should be amended to clarify that all public information about former members is kept on the public register; not just the name and date of death of former members.

Regarding ‘acknowledgements or undertakings’, a number of amendments are required. The Bill does not clarify what ‘acknowledgement’ refers to. For clarity, this term should be deleted from the relevant provisions as members may make acknowledgements to the College in many ways, including in routine correspondence during the course of investigations, quality assurance, or registration proceedings. Further, we note that there is a requirement to post undertakings but there is no limit associated with this provision. This would mean that undertakings may not be automatically removed from the register even when the terms are fulfilled, as they are now. We are concerned that the provision will prove to be a disincentive for members to enter into an undertaking (which is purely voluntary on the member’s part) when it is appropriate. In this regard, we believe it would be helpful to specify that undertakings that are currently in effect should be on the register (consistent with the term, condition and limitation language) in the same register section of the legislation.

We have suggested removing the results of incapacity proceedings where no finding is made, in order to protect personal health information as much as possible.

Proposed Revisions

Amend section 23(2) as follows:
2. The name of each former member of the College, and where a former member is deceased, the date upon which the former member died, if known to the Registrar.

10. The result, including a synopsis of the decision, of every disciplinary and incapacity proceeding.

11. A notation and synopsis of any acknowledgements or undertakings in relation to professional misconduct and incompetence that a member has entered into with the College that are in effect.

9. Patient Relations Program – Funding for Therapy and Counselling

We focus on two specific elements related to the Patient Relations Program: eligibility criteria related to funding, and the five year time limit within which funding must be used.

a) Eligibility Criteria

Bill 87 alters the criteria that specify when an individual is eligible for funding under the Program. It repeals specific criteria for eligibility and instead indicates that funding will be available to an individual who makes a complaint or who is the subject of a mandatory report, alleging sexual abuse.

This aspect of the Bill is problematic in two respects. First, it compels individuals to either make complaints or to consent to be named in mandatory reports in order to obtain access to funding for therapy. This does not demonstrate respect for the autonomy of survivors to choose their own path to recovery. Second, by removing the evaluative process undertaken by the Patient Relations Committee, it would grant access to funding in instances where allegations may be proven to be false.

The College proposes that applications for funding continue to be subject to an evaluative process by the Patient Relations Committee, and that individuals not be compelled to make a complaint or be named in a mandatory report in order to access funding.

The College also proposes that eligibility for funding be expanded to include non-patients who have been sexually abused by physicians, when the physician was acting in a professional capacity. Doing so explicitly recognizes that a power imbalance can exist not only between physicians and patients, but also between physicians and non-patients in certain circumstances where physicians are acting in a professional capacity. This can include: former patients, persons closely associated with patients and persons in an employment relationship with the physician. Non-patient survivors may experience harm that is comparable to patient survivors and therefore may similarly benefit from funding for therapy/counselling.
Proposed Revisions

Maintain the current s.1.1 of the Health Professions Procedural Code:

1.1 The purpose of the provisions of this Code with respect to sexual abuse of patients by members is to encourage the reporting of such abuse, to provide funding for therapy and counselling for patients who have been sexually abused by members and, ultimately, to eradicate the sexual abuse of patients by members.

Amend s. 28(1) of Bill 87 as follows:

Funding provided by College

(1) There shall be a program, established by the College, to provide funding for the following purposes in connection with allegations of sexual abuse by members:

1. Therapy and counselling for persons alleging sexual abuse by a member who were sexually abused by members while they were patients and for persons who were sexually abused by members who acted in a professional capacity with respect to the person and occupied a position of trust or power over the person.

2. Any other purposes prescribed in regulations made under clause 43 (1) (y) of the Regulated Health Professions Act, 1991.

Amend s. 28(2) of Bill 87 as follows:

(4) A person is eligible for funding if it is alleged, in a complaint or report, there is sufficient information presented to the Patient Relations Committee to support a reasonable belief that the person was sexually abused by a member while the person was a patient of the member or while the member acted in a professional capacity with respect to the person and occupied a position of trust or power over the person.

b) Time Period for Funding

Section 1 of O.Reg. 59/94 read together with the changes to section 85.7 of the Health Professions Procedural Code (made by Bill 87) suggests that an individual will become eligible for funding on the day they complain to the College about sexual abuse by a physician or on the day that the College receives a mandatory report about such abuse. This means that the five-year time period within which individuals must use their funding would start to run from the date the complaint or report was made. This will have an unfair impact as individuals may not yet be ready to undertake therapy at that point in time.

The College believes that once deemed eligible to receive funding, individuals should not have any restrictions on the timelines associated with using that allotted funding. In keeping with the principle of autonomy which underpins the RHPA provisions relating to the Program for Funding and Counselling, the College believes that all survivors should be entitled to use their allotted funding on a timeline that aligns with their own path of recovery, their treatment goals and/or the therapeutic plan they have developed with their chosen therapist.
Proposed Revisions

Amend O. Reg. 59/94 as follows:

1. For the purposes of a program established under section 85.7 of the Code,
   (a) the maximum amount of funding that may be provided for a person in respect of a case of sexual abuse is the amount that the Ontario Health Insurance Plan would pay for 200 half-hour sessions of individual out-patient psychotherapy with a psychiatrist on the day the person becomes eligible under subsection 85.7 (4) of the Code; and
   (b) the period of time within which funding may be provided for a person in respect of a case of sexual abuse is five years from,
      (i) the day on which the person first received therapy or counselling for which funding is provided under subsection 85.7 (10) of the Code, or
      (ii) if funding is not provided under subsection 85.7 (10) of the Code, the day on which the person becomes eligible for funding under subsection 85.7 (4) of the Code. O.Reg. 59/94, s. 1.

10. Mandatory revocation – immediate suspension power
The College is supportive of the inclusion of this provision in the Bill. It is one that the College itself had requested. We are concerned however, about the scope of the provision. It is connected directly to findings of sexual abuse that trigger mandatory revocation but does not extend to other forms of misconduct that trigger mandatory revocation (for example, being convicted of an offence at a different health regulatory college that would trigger mandatory revocation in Ontario, or being convicted of a prescribed offence).

We can determine no principled reason to limit the provision in this manner. In order to protect patients, this provision needs to be amended so that the suspension power applies to all professional misconduct for which there is a penalty of mandatory revocation.

Proposed Revision

Interim suspension of certificate

(4.2) If a panel finds a member has committed an act of professional misconduct by sexually abusing a patient and the sexual abuse involves conduct listed under subparagraphs 3 i to vii of subsection (5), or if it finds a member has committed an act of professional misconduct that will result in the application of subparagraph 5.1(a) or (b), the panel shall immediately make an interim order suspending the member’s certificate of registration until such time as the panel makes an order under subsection (5).

11. Alternative Dispute Resolution (ADR)
Bill 87 includes a number of amendments to the ADR process/scheme (Section 14).

ADR can result in greater complainant satisfaction in low risk matters. The College is supportive of using ADR but has significant concerns with the current confidentiality requirements. Under the existing Health Professions Procedural Code (s.25.1 (2)), the College cannot access the details of communications made in order to achieve resolutions. This allows for the possibility that the College may endorse a
resolution reached between a physician and a patient through ADR that does not protect or serve the public interest. There is no acknowledgement/protection of the public interest in a private dispute resolution mechanism. Any requirements for secrecy must be deleted to ensure that the College can rely on ADR without compromising its ability to fulfill its mandate.

**Proposed Revision**

| The College recommends that the RHPA be amended to delete any and all language requiring that communication, notes, and records related to the ADR process be kept confidential. |

12. Withdrawal of complaints (discretion)

The Bill includes provisions (S. 15) that would permit the Registrar to withdraw a complaint at the request of the complainant prior to any action being taken by a panel of the ICRC.

The College has previously asked the government for greater discretion in managing complaints to provide the necessary latitude to focus attention to those matters that are more substantive, such as those about care and professionalism.

The Bill’s provision regarding withdrawal of complaints does not provide meaningful assistance. Justice Goudge in his recent review, *Streamlining the Physician Complaints Process in Ontario* recommended the College have the authority that exists in Alberta where the Registrar or Complaints Director be required to conduct an early review of public complaints and be given the power to dismiss a public complaint where satisfied that there is no reasonable prospect of an outcome from the ICRC other than “No Action.” Justice Goudge recommended that in such cases complainants be provided with brief written reasons and the ability to appeal decisions to ICRC.

13. Amendments to confidentiality provisions to clarify that the College can share non-nominal data for research/public health

Bill 87 is silent on the issue of information sharing for public health or research purposes. The College proposes that section 36(1) of the RHPA be amended to clarify that the College can disclose non-nominal information for research and/or public health purposes. This amendment is consistent with other Ontario statutes and would facilitate and further support important College research and research of our health systems partners.

**Proposed Revision**

| The College recommends that section 36(1) of the RHPA be amended to clarify the Colleges’ ability to disclose non-nominal information for research and/or public health purposes. |
March 17, 2017

The Honourable Dr. Eric Hoskins MPP
Minister of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, Ontario M7A 2C4

Dear Minister,

Re: Bill 87, the Protecting Patients Act, 2016

We write to provide you with the College of Physicians and Surgeons of Ontario’s (College, CPSO) preliminary response to Bill 87, the Protecting Patients Act, 2016.

The Bill is an important piece of legislation for Ontario’s patients and for health colleges who regulate Ontario’s health professions in the public interest. The College response is focused on Schedule IV of the Bill; the amendments to the Regulated Health Professions Act.

In summary, the College shares the government’s objectives of strengthening the sexual abuse and transparency provisions in the Regulated Health Professions Act (RHPA), and improving the complaints, investigation and discipline processes.

Our response to Bill 87 is provided within the context of providing advice to the Minister and government to help inform how legislators might wish to amend and improve the Bill as it progresses through the legislative process. We derive our regulatory authority from the RHPA and associated Acts (e.g., Medicine Act, 1991). Our analysis and response to Bill 87 is grounded in our desire to achieve the necessary improvements to the legislative framework so we have the tools needed to protect the public. Much of the College’s feedback is framed as drafting/housekeeping in nature. A few items are highlighted as more substantive.

The College is also a member of the Federation of Health Regulatory Colleges of Ontario (FHRCO). Much of what is contained in this submission is consistent with the Federation’s February 27 submission.

This preliminary response to the Bill is informed by College work to protect patients from sexual abuse and enhance transparency. The College put forward a series of recommendations for legislative change in 2015 as part of our own sexual abuse initiative. As part of the College’s work to ensure transparency, this College along with a number of other health colleges in Ontario have made a number of by-law changes over the past several years to increase the amount and categories of information available to the public about Ontario physicians as part of our transparency initiative. We have made these changes via existing by-law authority. We appreciate that the Ontario government is moving forward with many of the statutory changes the College has requested to improve its ability to protect patients from sexual abuse, and is also making recommendations to put into legislation or regulation many of the transparency improvements and practices already adopted by this College.

Finally, the College has also put forward a number of other recommendations to enhance and improve our regulatory processes. Many of these changes have been endorsed previously by the Federation of Health Regulatory Colleges of Ontario. Some of these recommendations are put forward as part of the...
College’s response to Bill 87. The Regulated Health Professions Act is not opened frequently and we see the Bill as an opportunity to promote these additional legislative changes that will further the government’s objectives of promoting and protecting patient safety.

Our review of the Bill is grouped in four themes:

1. Strengthening sexual abuse provisions and supporting patients
2. Enhancing transparency
3. Improving the complaints, investigations and discipline processes
4. New Ministerial regulation-making powers

1. Strengthening sexual abuse provisions and supporting patients

The College’s response to the provisions in the Bill to strengthen the legislative framework pertaining to sexual abuse is grounded by the College belief that a strong and effective legislative regime is required to protect patients from sexual abuse. The College maintains a very strong stance in opposition to sexual abuse and in support of victims.

The College has strongly advocated for legislative change that will enhance our ability to protect patients from sexual abuse by physicians and strengthen the penalties for sexual abuse. The College Council launched its sexual abuse initiative more than two years ago to ensure that the College is doing everything possible to support and protect patients from sexual abuse by physicians. The initiative included a review of the legislative framework and College processes. The College response to the sexual abuse provisions in the Bill reflect this activity and the legislative changes recommended in October 2015.

Bill 87 contains several of the legislative changes the College has requested (at least partially) including:

- the ability to immediately suspend a physician’s ability to practice when a finding that triggers mandatory revocation has been made;
- a new authority to suspend during an investigation, when appropriate;
- requiring mandatory revocation in a wider range of circumstances;
- enhancing support to patients through the funding for therapy and counselling program.

Our suggestions in this area are put forward to ensure that the amendments contained in the Bill achieve the desired results. In many cases, our recommendations are small but important drafting changes to avoid unintended negative consequences.

**Patient Relations Program – Funding for therapy and counselling**

The Bill contains changes to the funding for therapy and counselling program that is overseen by the College’s Patient Relations Committee (PRC) (S. 28 (2)). The Bill alters the criteria that specify when an individual is eligible for funding under the Program. It repeals specific criteria for eligibility and instead
The Honourable Dr. Eric Hoskins MPP, Minister of Health and Long-Term Care  
March 17, 2017

states that funding will be available to an individual who makes a complaint or is the subject of a mandatory report alleging sexual abuse.

The CPSO is concerned that these changes remove the Patient Relation Committee’s discretion to award funding for therapy in accordance with the criteria that are found in College regulation. Currently, O. Reg. 114/94 under the *Medicine Act, 1991* provides that the College’s Patient Relations Committee (PRC) can award funding to applicants in a number of circumstances, including if there is “sufficient evidence presented to the Patient Relations Committee to support a reasonable belief that the person, while a patient, was sexually abused by a member”. This criterion has allowed the College to award funding to some applicants who have not made a complaint or who have declined to have their name included in a mandatory report.

The language contained in Bill 87 removes any ability of the PRC to evaluate or consider an application for funding for therapy and counselling, as essentially, these amendments grant automatic access to funding upon the filing of a complaint or a mandatory report, with no evaluative process. We believe that with small changes, the legislation could achieve the best result: a minimal evaluative process, coupled with language to allow people in respect of whom there is no complaint or report (for example, someone found in a criminal proceeding to have been a victim, who did not complain to the College) to be eligible for funding.

The CPSO recommends that College Patient Relations Committees continue to have the ability to consider eligibility for funding and that funding be available in a broader set of circumstances than is prescribed in the Bill. We recommend that eligibility criteria for funding be expanded to explicitly include sexual abuse that occurs when physicians are both acting in a professional capacity and occupying other positions of trust or power.

The College supports the provision that would enable funding to cover related expenses, such as child care or medication. This provision is consistent with prior recommendations we have made for legislative change.

We do, however, suggest changes as the language of the provision suggests that individuals must use their funding for therapy within five years of the abuse taking place. We suggest that there is no need to restrict access in this manner, therefore this timeline should be removed and the legislation should clarify that eligible applicants be able to use the funding they have been awarded past the five-year timeframe. This would enable eligible applicants to use the therapy/counselling in a manner that best fits their needs.

In relation to the two new regulation-making powers included in the Bill that pertain to the patient relations program, the College recommends that functions of statutory committees (Patient Relations Committee) be set in the statute as opposed to the regulation (S. 25 and S. 2 (6) of the Bill).

**Definition of Patient**
The Bill proposes to include a definition of patient for the purpose of sexual abuse allegations (S. 7), and add an additional regulation-making power to allow the Minister to develop regulations specifying further criteria defining patient for the purpose of sexual abuse (s. 43(1)(o) RHPA and S. 6(1) of the Bill).

While we understand and are supportive of the government’s overall objective, we are concerned about the unintended outcome. The definition of ‘Patient’ as proposed in the Bill, and specifically the one-year time period included in the definition, poses a number of challenges.

The College used to have “Physician-Patient Dating Guidelines”, which stated that in situations where the physician-patient relationship did not involve psychoanalysis or psychotherapy, the general rule was that sexual contact between a physician and former patient was not to occur for a period of one year following the date of the last professional contact with the patient. The guidelines also stated that, in some instances, it may never be appropriate for a post-termination sexual relationship to develop and, in other situations, it may be unnecessary to wait one year before a sexual relationship can develop. The guidelines were rescinded in 2008 and replaced with the Maintaining Appropriate Boundaries and Preventing Sexual Abuse policy, for a number of compelling reasons. The earlier “one size fits all” approach did not adequately reflect the variance in the types of physician-patient encounters.

Further, the drafting of this provision is confusing. The definition implies that once one year from an undefined event has elapsed, individuals will no longer be considered patients. This would permit physicians to engage in a sexual relationship with such individuals when it is not appropriate. For instance, in some physician-patient relationships where the contact has been enduring (as in psychotherapy), it may never be appropriate for a physician to form a sexual relationship with a former patient. A ‘rule’ is too arbitrary given the tremendously wide-ranging nature of physician-patient encounters. Further, without specifying the undefined event that starts the clock running, the definition will not be able to be implemented.

The College policy Maintaining Appropriate Boundaries and Preventing Sexual Abuse provides guidance on this issue. The policy identifies factors to be used to determine the propriety of a sexual relationship between a physician and a former patient including (but not limited to) the length and intensity of the former professional relationship, and the nature of the patient’s clinical problem and type of care provided.

In addition, limiting the definition to sexual abuse matters poses significant challenges in instances where there are blended allegations (sexual and non-sexual), or where it is difficult to determine if the conduct was sexual, and it is not clear whether the conduct occurred before or after termination. This would increase the complexity of hearings and create risk of legal error by discipline panels. On the other hand, applying the definition across the board creates its own significant problems. This section requires further analysis and consideration.

At a minimum we recommend that patient be more clearly defined. We look forward to further discussion about this issue.
**Interim power to restrict/suspend**

The College supports the elimination of gender based restrictions with sufficient new authority to restrict or suspend prior to a referral. The Bill includes a power for the Inquiries, Complaints and Reports Committee (ICRC) to restrict or suspend prior to a referral to the Discipline Committee or to the Fitness to Practise Committee and we are pleased to see the inclusion of this provision in the Bill *(S 15 of the Bill; S. 25.4 Health Professions Procedural Code (Code).* We had requested that government provide colleges with this power.

We do note, however, that amendments are required in order to ensure that it achieves the goal of protecting patients. Drafting changes are required to provide the ICRC with the ability to impose terms, conditions and limitations during a fitness to practise inquiry or during a Registrar’s investigation.

Amendments are also required to clarify the duration of interim orders, the ability to amend orders and the ongoing existence of the power when there is a significant risk of harm to the public interest in the regulation of the medical profession and/or the administration of the health-care system. For example, additional information may come to the attention of the College indicating that a more restrictive interim order is required.

These are vital drafting changes.

**Mandatory revocation – immediate suspension power**

The Bill includes provisions (Section 19) that we have requested that would result in immediate suspension of members in specific instances: where they have been found guilty of sexual abuse or any other finding triggering mandatory revocation, and the penalty hearing has been deferred.

The issue with the provision as worded is that it is more limited in scope than what we had requested. It is connected directly to findings of sexual abuse that trigger mandatory revocation and does not extend to other forms of misconduct that trigger mandatory revocation (for example, being convicted of an offence at a different health regulatory college, or being convicted of a prescribed offence).

This change is designed to protect the public. We recommend an amendment that extends the suspension power to cover all professional misconduct for which there is a penalty of mandatory revocation.

**Third Party Records**

One of the most intrusive aspects of a discipline hearing for patients/complainants in sexual abuse hearings is the ability of the subject physician to access and then use against them publicly in a hearing, details of their private medical records, which can include psychiatric records, records of therapy sessions, and other records with extremely confidential information. The release of such records is an
event that has led patient/complainants to reconsider or abandon participation in the disciplinary process.

Therefore, we have strongly recommended that the threshold for when third party records are ordered to be produced be increased and codified in statute (or perhaps in regulation), just as it is in the Criminal Code. We note that the higher threshold in the Criminal Code has been found to be appropriate even when an accused has a right to make full answer and defence, which does not exist in the same way in an administrative hearing such as ours. We do not believe it should be easier to access these very private personal records in our process than in the criminal process.

We also believe that where patient/complainants seek standing on motions to disclose their confidential records, they should be guaranteed the right to standing. This will help ensure an appropriate balance between the privacy interests of victims and/or witnesses and the interest of the physician in having access to information to assist in defending serious allegations in a regulatory context. It would also help ensure that patients/complainants have a clear opportunity to have their voice heard when a panel is considering whether their confidential records can be released.

2. Enhancing Transparency

The College is generally supportive of the amendments contained in Bill 87 that pertain to transparency. Council initiated a transparency initiative in 2012 to make information about physicians and College processes more accessible. Since then, a number of additional categories of information about physicians have been added to our public register.

The Bill contains provisions (S. 12 (1)) to add information to all health college’s registers. It also contains amendments that will require more information about college meetings be included on the college websites. The new information categories identified in Bill 87 are generally consistent with action this College and many others have already taken.

The CPSO is a transparency leader and has already added the following categories of information to the public register: criminal charges and convictions, bail conditions, illegal practitioners, cautions, specified continuing education or remediation program orders, and licences held in and discipline findings from other jurisdictions.

The goal of the College transparency work is to ensure that patients have access to useful information about their physicians that will help inform their health-care decisions. This work is ongoing.

The provisions in the Bill relating to the public register include amendments that require additional elements be included in the register. The College supports the expansion of the information contained on the public register but notes that the CPSO goes well beyond what is prescribed in Bill 87. For example the College currently posts charges, bail conditions and criminal convictions on the public register.
Finally, the Bill also establishes new website posting requirements for health colleges (Section 9) including posting Council meeting dates and agendas. We note that the CPSO has posted Council agenda and meeting dates on our website for many years. We also post Council material on the College website to ensure the public has access to both information about Council meetings and the accompanying meeting material.

**Transparency and College by-law authority**

The College supports the ability to maintain the by-law authority that permits Council to add categories of information to the existing list of what is posted on the register. The CPSO currently has more categories of information about physicians on the register than is proposed in Bill 87. We support retention of this by-law flexibility. This flexibility is in the public interest and will complement the Minister’s proposed new regulatory power to prescribe additional information to be contained in a College’s register (Subsection 6(3) of Schedule 4).

Following are some drafting/housekeeping issues with the transparency provisions in the Bill.

**No Finding Made**

One proposed amendment in the Bill (Section 7) requires health colleges to post on the register where there is a “failure to make a finding”. This language should be changed to ‘no finding was made’. The College previously asked that the Health Professions Procedural Code be amended to allow colleges to post public Discipline Committee ‘no findings’ on the register. The wording in the Bill does not adequately reflect this request and we do not believe it is appropriate to suggest that a ‘no finding’ decision constitutes a ‘failure’.

We ask that government consider this drafting change.

**Other transparency related drafting issues**

Other wording changes are required to include the way in which former members are referred to – that is, we keep all public information about former members on our register; we do not want the new provision to be read as meaning that only their name and date of death are to be included; and concern with respect to the way acknowledgements or undertakings are referred to in Subsection 12 (1) of the Bill (paragraph 11). Appendix 1 of the February 27 FHRCO submission identifies these issues and proposes drafting suggestions to address them.

We are not certain what the term “acknowledgment” refers to. Further, the requirement to post undertakings with no time limit and without an established term, limitation or condition means they will not automatically be removed when the terms are fulfilled as they now are. We are concerned about the implications, such as loss of any incentive for physicians to enter into an undertaking (which is purely voluntary) when it is appropriate. In this regard, we believe it would be helpful to specify that
undertakings that are currently in effect should be on the register (consistent with the term, condition and limitation language).

Public Register – duty to correct information

The Bill also includes an amendment (Section 12 (6)) that imposes a duty on the Registrar to correct any information in the public register where a member demonstrates that the information is incomplete or inaccurate.

There is an implied obligation on the College currently to have fair and accurate information on its register and the College has processes in place to ensure this duty is met. All health colleges would share the view that they are responsible for ensuring their register is as accurate and fair as possible. This section may have unintended consequences. For example, registers typically include (and in some cases are required to include) summaries of information which by their nature are not ‘complete’. We are concerned that this provision will lead to new internal issues and court challenges.

We are concerned with this provision and strongly recommend that it be struck from the Bill or that it be narrowed to refer only to information gained from third parties (criminal charges, bail conditions, etc.) as opposed to encompassing the College’s own information.

3. Improving the Complaints, Investigation and Discipline Processes

The College is pleased to also provide feedback on amendments contained in Bill 87 designed to enhance the efficiency of the complaints, investigation and discipline processes. We support the objective of accountability and this includes effective use and support of public Council members in College processes.

We have also identified a handful of other recommendations for legislative change that fit into this category that are consistent with the government’s objectives. We believe it is crucial that other important issues that will promote our shared goals of patient safety and public accountability be considered.

Alternate Dispute Resolution (ADR)

Bill 87 includes a number of amendments to the ADR process/scheme (Section 14).

While the amendments are well intended, the College has significant concerns with the use of ADR as set out in the legislation as a means of resolving patient complaints and does not currently use ADR. We remain most concerned with the confidentiality of details in the ADR process.
That is, the College cannot access the details of communications made in order to achieve resolutions under the existing Health Professions Procedural Code (s.25.1 (2)).

Despite this or any other Act, all communications at an alternative dispute resolution process and the facilitator’s notes and records shall remain confidential and be deemed to have been made without prejudice to the parties in any proceeding.

We are uncomfortable with the ADR framework, as it allows for the possibility that the College may endorse a resolution reached between a physician and a patient through ADR that does not protect or serve the public interest. There is no acknowledgement/protection of the public interest in a private dispute resolution mechanism. We suggest that this existing secrecy provision be removed.

Withdrawal of complaints (discretion)

The Bill includes provisions (S. 15) that would permit the Registrar to withdraw a complaint at the request of the complainant prior to any action being taken by a panel of the ICRC.

The College has previously asked the government for greater discretion in managing complaints to provide the necessary latitude to focus attention to those matters that are more substantive, such as those about care and professionalism.

The Bill’s provision regarding withdrawal of complaints does not provide meaningful assistance. Justice Goudge in his recent review, Streamlining the Physician Complaints Process in Ontario recommended the College have the authority that exists in Alberta where the Registrar or Complaints Director be required to conduct an early review of public complaints and be given the power to dismiss a public complaint where satisfied that there is no reasonable prospect of an outcome from the ICRC other than “No Action.” Justice Goudge recommended that in such cases complainants be provided with brief written reasons and the ability to appeal decisions to ICRC.

This next section includes other priority amendment areas that we feel should be considered as the Bill moves through the legislative process. They are consistent with the objective of protecting the public and enhancing the integrity of College processes.

Discretion to provide information to police about non-members

Currently, the College only has the discretion to provide information to police about members in specific circumstances. Giving the College discretion to share relevant information would allow the College to provide information about non-members in appropriate circumstances, where it is in the public interest to do so.

This discretion would be particularly important in cases where there is a strong public interest in the police being able to investigate. During a CPSO investigation, we may uncover information that suggests a non-member has or may have engaged in conduct that could constitute an offence and, in these cases,
we are unable to pass this information on to the police. Our experience shows that there are cases where it is clearly in the public interest for the College to pass along information to the police. Examples include fraud and opioid diversion activity.

**Supporting and creating a broader pool of public members**

The College seeks amendments to allow public members who are not members of Council to be included in the quorum for the ICR and Discipline Committees. This will allow the College to create a broader pool of public members available to perform College work.

We also seek amendments to remove the existing legislative barriers that prevent health colleges from compensating public Council members for their work. The *RHPA* requires that most of the College’s statutory committees include at least one public member of Council to establish a quorum. The Discipline Committee requires two public members of Council to form quorum for each panel. Some public members are contributing more than 150 days per year and the average contribution is now more than 80 days per year. They are compensated inadequately at $150 a day for this work. The public member compensation scheme is a longstanding concern, particularly in an environment where their workload is overwhelming and not sustainable. We are facing increased challenges convening discipline and ICRC panels and are concerned about public member burnout.

The College seeks an amendment to the *RHPA* to allow for non-Council members (public representatives who do not hold a seat on our Council) to be appointed to sit on the College’s ICRC and Discipline Committees to meet the need for public representation.

**Amendments to confidentiality provisions to enable the College to share non-nominal data for research/public health**

Section 36 of the *RHPA* states that anyone working with/for a College must keep all information that comes to his or her knowledge in the course of his/her duties confidential and then lists a series of exceptions to that duty.

We propose an amendment to expand the exceptions to the duty of confidentiality to make it clear that the College can communicate non-nominal information. This amendment is consistent with other Ontario statutes and would facilitate and further support College research work.

**Exclude College proceedings from the requirement in the Mental Health Act which requires either patient consent or a court order to enter evidence relating to care of a patient in a psychiatric facility**

A recent decision of the Discipline Committee has determined that before evidence can be led in a hearing regarding any care provided in a psychiatric facility (which includes most hospitals where mental health care is provided), the College needs the consent of the patient to whom the information relates or a court order, which must be obtained on notice to the patient.
This means that the College would have to locate and notify each patient whose information may be the subject of evidence at a hearing—including expert evidence—before the hearing. In many cases that are not triggered by a complaint (i.e., most s. 75 investigations) patients would not be aware that their chart has been obtained and will be the subject of expert evidence. The contact information on the chart may no longer be accurate and the challenge of locating and notifying patients is significant.

Further, patients with some psychiatric conditions could find it extremely alarming to learn that the College is reviewing their medical records and viewing the details of their care. It seems the purpose of this section of the Mental Health Act is to protect the confidentiality interests of patients, which the College already does in its proceedings. We take a number of steps to ensure that each patient’s identity is protected. Further, the public interest in having the College be able to review the psychiatric care a physician has provided is significant. This requirement impedes our ability to do so. This is a vital change that we require to help ensure that psychiatrists in mental health facilities are practicing safely.

4. New Ministerial Regulation-Making Powers

The Bill provides the Minister with a number of new regulation-making powers (Subsection 6(2)). These powers are significant; in some cases permitting the Minister to establish by regulation fundamental governance matters that are currently addressed in the statute.

Our response to proposed new regulatory authority is focused in two areas:

- College Committees and Governance: New provisions that would allow the Minister to develop regulations relating to all aspects of the structure of the seven statutory committees.
- New provisions that would allow the Minister to develop regulations specifying processes and additional functions and duties for the College in relation to misconduct of a sexual nature.

*Regulation-Making Power: College Committees and Governance*

The Bill grants the Minister the authority to make regulations with respect to the composition, panel quorum, eligibility requirements and disqualification grounds for each of the College’s seven statutory committees. This includes the Executive, Discipline and ICR Committees. These are sweeping new governance-related regulatory powers that we believe should be made in the statute as opposed to regulation. These powers are broad and undefined. Currently, significant governance-related matters are addressed in statute where they are set by the legislature.

For example, currently, some of the more significant quorum requirements are set out in statute as opposed to regulation (e.g., quorum requirement that there be two public members of Council and one professional member of Council on Discipline Committee panels).
We note that the Executive Committee is a subset of Council and Council’s composition is set out in the *Medicine Act*. Further, the Executive Committee’s authority to exercise the powers of Council between meetings is set in the existing statute. The Executive Committee should not be captured by this regulation. Any move by government to dictate the composition of the Executive Committee would be a significant departure from what exists currently and could create a concerning disconnect between Council and the Executive Committee.

Currently, other matters relating to committee composition, eligibility and disqualification are set out in by-law. There is a significant loss of flexibility to colleges by enshrining these matters in regulations rather than in by-laws. We are regularly improving and changing our by-laws on these issues; to address matters including qualifications and disqualifications, in response to new and unforeseen situations that arise. We want to retain our ability to be responsive to problems as they arise. One-size fits all approaches may compromise the ability of some colleges to fulfill their mandates.

We seek further information about what specific problem government wishes to address so that there can be a full and frank discussion about any issues and the proposed remedy to address them. We support the government’s objective to ensure accountability and integrity of College processes.

The College Council supports greater independence of the Discipline Committee. While the Discipline Committee operates as an independent tribunal, separate from the College, we feel that changes could enhance the integrity of the Discipline Committee and its processes. We want to address the perception that exists in some quarters that the Discipline Committee lacks independence from the College.

In summary, we put forward an alternative approach; that statutory change be made to ensure accountability by making the Discipline Committee/hearings more independent from the College. We do not support the regulation in its current form. A second option is to narrow the regulation so that it applies solely to the Discipline Committee.

**Regulation-Making Power: Investigative and Discipline Processes**

The Bill also grants the Minister the power to develop regulations to “clarify” how the ICRC and Discipline Committees are to perform their functions with respect to matters involving allegations of misconduct of a sexual nature. This includes investigative processes.

While supportive of consistency and rigor of processes, we suggest that a detailed process like an investigation should be established in policy rather than regulation. We are supportive of consistency of investigative processes, where possible, yet we want to ensure that we retain the ability to employ best and current practises in our investigations. If changes need to be made to processes, and the processes are set out in regulation, achieving regulatory change is time-consuming and uncertain. We are always improving our approach to investigations and worry that we will lose the ability to make necessary and swift improvements.
Further, the provision only relates to sexual abuse investigations. In doing so, the provision assumes that sexual abuse matters are always clearly distinguishable from other misconduct issues at the investigation stage. That assumption does not accord with the College’s experience. In reality, some matters may initially appear to be clinical in nature, yet as the investigation proceeds, be revealed to be of a sexual nature (and vice versa).

With respect to the duties and functions of Committees, the provisions raise questions about what new functions and duties of the ICRC and Discipline Committees are being contemplated. We would appreciate further clarification on this point. Consistent with our earlier response, functions of statutory committees are currently set out in the statute and arguably belong in the statute.

We are pleased to provide this initial response to Bill 87 and look forward to working with you as the Bill moves through the legislative process. Louise Verity is available to provide any further information that might be helpful.

Yours truly,

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C: Mr. Jeff Yurek MPP, PC Health Critic
    Mme. France Gélinas MPP, NDP Health Critic
    Dr. Robert Bell, Deputy Minister of Health and Long-Term Care