CPSO

Board of Directors Meeting

March 6 and 7, 2025

NOTICE

OF

BOARD OF DIRECTORS MEETING

A meeting of the Board of Directors (Board) of the College of Physicians and Surgeons of Ontario (CPSO) will take place in person on March 6 and 7, 2025, in the CPSO Boardroom at 80 College Street, 3rd Floor, Toronto, Ontario.

The Board meeting will be open to members of the public who wish to attend in person. Members of the public who wish to observe the meeting in person will be required to register online by 4:30 p.m. on March 3. Details on this process are available on the CPSO's website.

The meeting will convene at 11:30 a.m. on Thursday, March 6, 2025, and at 11:30 a.m. on Friday, March 7, 2025.

Nancy Whitmore, MD, FRCSC, MBA, ICD.D
Registrar and Chief Executive Officer

February 13, 2025

Board Meeting Agenda
March 6 and 7, 2025

CPSO

Thursday, March 6, 2025

Item	Time	Topic and Objective(s)	Purpose	Page No.
1	**11:30 am** (5 mins)	**Call to Order and Welcoming Remarks** (S. Reid) • Note regrets and declare any conflicts of interest • Review Board Letter of Commitment	Discussion	N/A
2	**11:35 am** (5 mins)	**Consent Agenda** (S. Reid) 2.1 Approve Board meeting agenda 2.2 Approve minutes from the Board meeting held November 28 and 29, 2024 2.3 Committee Appointment Consent Agenda Motion	Approval (with motion)	 6-24 25 26
3	**11:40 am** (5 mins)	**Items for information:** 3.1 Executive Committee Report 3.2 Ontario Physicians and Surgeons Discipline Tribunal Cases 3.3 Government Relations Report 3.4 Policy Report 3.5 Medical Learners Reports 3.6 Update on Board Action Items 3.7 Q1 2026 Meeting Dates 3.8 2024 College Performance Measurement Framework	Information	 27-28 29-33 34 35-38 39-41 42-49 50 51
4	**11:45 am** (15 mins)	**Board Chair Report** (S. Reid)	Discussion	N/A
*	**12:00 pm** (60 mins)	**LUNCH** (Lunch available in the Dining Room)		
5	**1:00 pm** (90 mins)	**CEO/Registrar's Report** (N. Whitmore)	Discussion	N/A
*	**2:30 pm** (20 mins)	**NUTRITION BREAK** (Refreshments available in the Members Lounge)		
6	**2:50 pm** (30 mins)	**Governance and Nominating Committee Report** (P. Safieh) • Update from the Governance and Nominating Committee	Information	N/A

Item	Time	Topic and Objective(s)	Purpose	Page No.
7	**3:20 pm** (60 mins)	**Review Feedback and Board Discussion: Treatment of Self, Family Members, and Others Close to You Draft Policy** (T. Terzis) • The Board is asked to review and discuss feedback received from the external consultation	Discussion	52-61
*	**4:20 pm**	**Motion to move In-Camera** (S. Reid)	Decision (with motion)	62
8	**4:20 pm** (30 mins)	**In-Camera Items**		Materials provided under separate cover
9	**4:50 pm**	**Adjournment Day 1** (S. Reid)	N/A	N/A

Friday, March 7, 2025

Item	Time	Topic and Objective(s)	Purpose	Page No.
10	**11:30 am** (5 mins)	**Call to Order** (S. Reid) • Note regrets and declare any conflicts of interest	Discussion	N/A
11	**11:35 am** (5 mins)	**By-law Amendments: PA Register and Fees for Emergency Class Certificate of Registration** (C. Silver, M. Cooper) • The Board is asked to consider approving the proposed By-law amendments regarding PA Register and Fees for PA Emergency Class Certificate of Registration	Decision (with motion)	63-67
12	**11:40 am** (10 mins)	**Alternative Pathways to Registration for Physicians Trained in the United States Directive** (S. Tulipano) • The Board is asked to consider approving the proposed directive relating to Alternative Pathways to Registration for Physicians Trained in the United States policy	Decision (with motion)	68-70
*	**11:50 am** (60 mins)	**LUNCH**		
13	**12:50 pm** (60 mins)	**Review Feedback and Board Discussion: Accepting New Patients Draft Policy** (T. Terzis) • The Board is asked to review and discuss feedback received from the external consultation	Discussion	71-77
*	**1:50 pm** (20 mins)	**NUTRITION BREAK**		
14	**2:10 pm** (60 mins)	**Review Feedback and Board Discussion: Ending the Physician-Patient Relationship Draft Policy** (C. Brown) • The Board is asked to review and discuss feedback received from the external consultation	Discussion	78-85
15	**3:10 am** (25 mins)	**Final Approval: Consent to Treatment Policy** (T. Terzis) • The Board is asked to consider approving the revised draft policy for final approval	Decision (with motion)	86-103
16	**3:35 pm** (5 mins)	**Close Meeting - Day 2** (S. Reid) • Reminder that the next meeting is scheduled on May 29 and 30, 2025	N/A	N/A
*	**3:40 pm**	**Meeting Reflection Session** (S. Reid) • Share observations about the effectiveness of the meeting and engagement of Board Directors	Discussion	N/A

DRAFT PROCEEDINGS OF THE MEETING OF THE BOARD
November 28 and 29, 2024

Location: Boardroom, 80 College Street, Toronto, Ontario

November 28, 2024

Attendees:

Dr. Baraa Achtar
Dr. Madhu Azad
Dr. Glen Bandiera
Ms. Lucy Becker
Dr. Faiq Bilal (Ph.D.)
Mr. Stephen Bird
Dr. Marie-Pierre Carpentier
Mr. Markus de Domenico
Ms. Joan Fisk
Dr. Vincent Georgie (Ph.D.)
Mr. Murthy Ghandikota
Dr. Robert Gratton
Dr. Roy Kirkpatrick
Dr. Camille Lemieux
Mr. Paul Malette
Dr. Lionel Marks de Chabris
Dr. Carys Massarella
Dr. Lydia Miljan (Ph.D.)
Dr. Rupa Patel
Mr. Rob Payne
Dr. Judith Plante
Dr. Ian Preyra (Board Chair)
Dr. Sarah Reid (Board Vice-Chair)
Ms. Linda Robbins
Dr. Deborah Robertson
Dr. Patrick Safieh
Mr. Fred Sherman
Ms. Anu Srivastava *(partial attendance)*
Dr. Andrea Steen
Dr. Janet van Vlymen
Dr. Anne Walsh
Dr. Mitchell Whyne

Non-Voting Academic Representatives on the Board Present:
Dr. P. Andrea Lum
Dr. Karen Saperson
Dr. Katina Tzanetos

Regrets:
Dr. Marie-Pierre Carpentier
Mr. Jose Cordeiro
Dr. Janet van Vlymen

Guests:
Ms. Deanna Williams, Dundee Consulting Group Ltd.

1. Call to Order and Welcoming Remarks

I. Preyra, Board Chair, called the meeting to order at 10:30 am. The Board Chair welcomed Directors and staff to the Board meeting and acknowledged members of the public in attendance.

J. Plante, Board Director, provided the land acknowledgment as a demonstration of recognition and respect for the Indigenous peoples of Canada.

The Board Chair welcomed the new Public Director, V. Georgie, to his first Board meeting.

Meeting regrets were noted.

Conflicts of interest on day 1 were noted for L. Marks de Chabris for item 9 Proposed Recission of the Cannabis for Medical Purposes Policy. Conflicts of interest on day 2 were noted for G. Bandiera and R. Kirkpatrick for the following registration policies:

18.1 Alternative Pathways to Registration for Physicians Trained in the United States; and

18.2 Restricted Certificate of Registration for Royal College of Physicians and Surgeons of Canada (RCPSC) Practice Eligibility Route and Specialist Recognition Criteria in Ontario

2. Consent Agenda

I. Preyra provided an overview of the items listed on the Consent Agenda for approval. He noted that the in-camera session will be extended by 10 minutes.

01-B-11-2024 – For Approval – Consent Agenda

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

The Board of Directors[1] of the College of Physicians and Surgeons of Ontario approves items 2.1 to 2.4 outlined in the consent agenda, which include in their entirety:

2.1 The Board meeting agenda for November 28 and 29, 2024, as amended;

2.2 The draft minutes from the Board meeting held on September 6, 2024;

2.3 Committee Appointments for 2024/25[2]

The Board of Directors of the College of Physicians and Surgeons of Ontario appoints / re-appoints the following individuals to the following Committees effective as of the close of the Annual Organizational Meeting (AOM) of the Board in 2024, and expiring at the close of the AOM of the Board in 2025.

Committee	Member Name
Ontario Physicians and Surgeons Discipline Tribunal	Janet van Vlymen (re-appointment)
	Camille Lemieux
	Virginia Roth
	Katina Tzanetos
Fitness to Practise	Janet van Vlymen (re-appointment)
	Camille Lemieux
	Virginia Roth
	Katina Tzanetos
Quality Assurance	Gina Neto

[1] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulated Health Professions Act*) and the *Medicine Act*.

[2] A separate motion was carried for items 2.3 and 2.4, only one motion was required for the whole consent agenda, a second motion was done in error, with both motions carried. Only one motion for the consent agenda is recorded in the minutes.

2.4 2024 Chair/Vice-Chair Committee Re-appointments

The Board of Directors of the College of Physicians and Surgeons of Ontario appoints the following Committee Members as Chairs and Vice-Chairs, as noted below, to the following Committees, effective as of the close of the AOM of the Board in 2024 and expiring at the close of the AOM of the Board in 2025.

Committee	Position	Name
Premises Inspection	Chair	Dr. Patrick Davison
	Vice-Chair	Dr. Hae Mi Lee
Quality Assurance	Vice-Chair	Dr. Tina Tao

CARRIED

3. For Information

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

3.1 Executive Committee Report – No Report
3.2 Ontario Physicians and Surgeons Discipline Tribunal Cases
3.3 Government Relations Report
3.4 Committee Annual Reports
3.5 Policy Report
3.6 Medical Learners Reports – Ontario Medical Students Association (OMSA) and Professional Association of Residents of Ontario (PARO)
3.7 Update on Board Action Items
3.8 2025 Q3 and Q4 meeting dates

4. Chief Executive Officer/Registrar's Report

N. Whitmore, Chief Executive Officer and Registrar, presented her report to the Board.

She provided an update on the 2024 key performance indicators, targets, and metrics.

An overview of the following departments and programs was provided:

- Registration and Membership Services including updates on the Practice Ready Assessment program noting that there are 12 candidates undergoing the assessment and Physician Assistants, noting that they will become registered with the CPSO in April 2025 with applications starting early in the new year;
- Quality Improvement / Quality Assurance;
- Out of Hospital Premises Inspection Program;
- Integrated Community Health Services Centres (ICHSCs);
- Communications – an update was provided on e-Dialogue;
- Patient & Public Help Centre;
- Legal including the By-law implementation and Governance update;

- Ontario Physicians and Surgeons Discipline Tribunal (OPSDT);
- Policy/Government Relations and stakeholder collaboration.

5. Key Performance Indicators for 2025

N. Whitmore, Chief Executive Officer and Registrar, provided an update on the 2025 key performance indicators, targets, and metrics.

02-B-11-2024 – Key Performance Indicators for 2025

The following motion was moved by L. Becker, seconded by G. Bandiera and carried, that:

The Board of Directors[3] of the College of Physicians and Surgeons of Ontario adopts the following 2025 Key Performance Indicators (KPIs) to measure and report progress on the Strategic Plan:

1. Time From Licence Application Received to Assessment (Excluding Postgraduate Licences)
   Target: 15 Business Days; 80th Percentile

2. Time From Final Document Verification to Licence Issued (Excluding Postgraduate Licences)
   Target: 5 Business Days; 80th Percentile

3. Complete First Quality Improvement Cycle by Engaging Remaining Physicians
   Target: ~3,648 Physicians

4. Build & Pilot Quality Improvement 2.0 Program
   Target: 600 Physicians

5. Build & Pilot Quality Improvement Program Specific to OHP Medical Directors
   Target: 40 OHP Medical Directors

6. Time to Complete Complaints (Including Public Complaints & Registrars' Investigations)
   Target: 150 Days; 80th Percentile

7. Time from Referral to Completion of Discipline Process
   Target: 12 Months; 80th Percentile

8. Build & Launch New Finance & Operations System
   Target: Go live by fall 2025

9. Implement Full Plan-Do-Check-Act (PDCA) Cycle for Province-wide Election Process
   Target: Complete by fall 2025

[3] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulated Health Professions Act*) and the *Medicine Act*.

6. Board Chair Report

I. Preyra, Board Chair, presented his report to the Board providing an update on the Individual Board Performance Evaluation pilot. Positive feedback was provided on the process and areas of improvement were identified for future iterations. The Board Chair and Vice-Chair noted the high level of engagement of the Directors. It was noted that Directors have been reaching out to seek clarification and ask questions about the Board package in advance of the Board meeting, indicating good preparation. An update was provided about the International Society for Quality in Health Care (ISQua) conference attended by the Board Chair and CEO/Registrar, noting that the CPSO is a leader in best practices and advanced in its governance modernization initiatives.

7. Governance and Nominating Committee Report

R. Gratton, Chair of the Governance and Nominating Committee (GNC), provided the GNC Report, including an update on the items from the October 15, 2024, meeting. He also provided an overview of the governance modernization initiatives that have been implemented over the past year, including moving towards a skills-based Board and developing the Board Profile. He highlighted the skills self-assessment process and noted that this process will help to inform the gap analysis.

An overview was provided on the following:

- Timeline of governance modernization work;
- 2025 province-wide election; and
- Process regarding the 2025/26 Academic Director appointments.

The Board Chair recognized the Chair of the GNC for his leadership and for moving several governance modernization initiatives forward.

8. Review Feedback and Discussion: Consent to Treatment Policy

K. Saperson, Chair of the Policy Working Group, and T. Terzis, Manager, Policy & Governance provided an overview of the draft Consent to Treatment Policy that was released for consultation after the September Board meeting and the feedback received from the policy consultation. Key changes to the draft policy were highlighted. The Board was given the opportunity to discuss the draft policy and provide input. There was a discussion relating to documenting consent for sensitive examinations, amongst other topics. The Policy Working Group will consider the points raised.

L. Marks de Chabris departed the meeting due to a conflict of interest.

9. Proposed Rescission of the Cannabis for Medical Purposes Policy

C. Brown, Team Lead, Policy, provided an overview of the proposed rescission of the Cannabis for Medical Purposes policy. Background on the policy was provided, including its implementation and various changes over the years. The rationale for rescinding the policy was provided, including significant changes to the legal landscape. Following questions and discussion, the Board expressed support for rescinding the policy.

03-B-11-2024 – Proposed Rescission of the Cannabis for Medical Purposes Policy

The following motion was moved by L. Becker, seconded by A. Steen and carried, that:

The Board of Directors[4] of the College of Physicians and Surgeons of Ontario rescind the College's *Cannabis for Medical Purposes* policy (a copy of which forms Appendix "A" to the minutes of this meeting).

CARRIED

L. Marks de Chabris re-joins the meeting.

Motion to move in-camera

04-B-11-2024 – Motion to Go In-Camera

The following motion was moved by C. Massarella, seconded by R. Gratton and carried, that:

The Board of Directors[5] of the College of Physicians and Surgeons of Ontario exclude the public from the part of the meeting immediately after this motion is passed, under clauses 7(2)(b) and (d) of the Health Professions Procedural Code (set out below).

Exclusion of public

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

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

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

CARRIED

10. In-Camera Session

The Board of Directors of the College of Physicians and Surgeons of Ontario entered into an In-Camera session at 2:40 pm and returned to the open session at 3:50 pm.

[4] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulated Health Professions Act*) and the *Medicine Act*.
[5] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulated Health Professions Act*) and the *Medicine Act*.

11. Adjournment - Day 1

I. Preyra, Board Chair, adjourned day 1 of the Board Meeting at 3:50 pm.

Board Chair

Recording Secretary

DRAFT PROCEEDINGS OF THE MEETING OF THE CPSO BOARD OF DIRECTORS
November 29, 2024

Attendees:

Dr. Baraa Achtar
Dr. Madhu Azad
Dr. Glen Bandiera
Ms. Lucy Becker
Dr. Faiq Bilal (Ph.D.)
Mr. Stephen Bird
Dr. Marie-Pierre Carpentier
Mr. Markus de Domenico
Ms. Joan Fisk
Dr. Vincent Georgie (Ph.D.)
Mr. Murthy Ghandikota
Dr. Robert Gratton
Dr. Roy Kirkpatrick
Dr. Camille Lemieux
Mr. Paul Malette
Dr. Lionel Marks de Chabris
Dr. Carys Massarella
Dr. Lydia Miljan (Ph.D.)
Dr. Rupa Patel
Mr. Rob Payne
Dr. Judith Plante
Dr. Ian Preyra (Board Chair)
Dr. Sarah Reid (Board Vice-Chair)
Ms. Linda Robbins
Dr. Deborah Robertson
Dr. Patrick Safieh
Mr. Fred Sherman
Ms. Anu Srivastava *(partial attendance)*
Dr. Andrea Steen
Dr. Janet van Vlymen
Dr. Anne Walsh
Dr. Mitchell Whyne

Non-Voting Academic Representatives on the Board Present:
Dr. Katina Tzanetos
Dr. P. Andrea Lum
Dr. Karen Saperson

Regrets:
Dr. Marie-Pierre Carpentier
Mr. Jose Cordeiro
Dr. Janet van Vlymen

Guests:
Ms. Deanna Williams, Dundee Consulting Group Ltd.
Dr. John Rawlinson, Board Award Winner *(partial attendance)*
Ms. Linda Rawlinson, Board Award Winner Guest *(partial attendance)*
Ms. Julie Scott, Board Award Winner Guest *(partial attendance)*
Ms. Amy Rawlinson-Smith, Board Award Winner Guest *(partial attendance)*
Mr. Brandon Smith, Board Award Winner Guest *(partial attendance)*

12. Call to Order

I. Preyra, Board Chair, called the meeting to order at 9:00 am. He welcomed everyone back to the Board meeting and noted regrets.

Committee Appointment

I. Preyra, Board Chair, noted that a Committee Appointment was inadvertently omitted in the Consent Agenda approved by the Board. As such, the Board was asked to approve a motion to appoint Jay Sengupta to the Ontario Physicians and Surgeons Discipline Tribunal and the Fitness to Practise Committee.

05-B-11-2024 – For Approval – Committee Appointment

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

The Board of Directors[6] of the College of Physicians and Surgeons of Ontario appoints Jay Sengupta to the Ontario Physicians and Surgeons Discipline Tribunal and the Fitness to Practise Committee effective as of the close of the Annual Organizational Meeting (AOM) of the Board in 2024, and expiring at the close of the AOM of the Board in 2025.

CARRIED

13. 2025 Draft Budget

S. Califaretti, Corporate Controller, presented an overview of the 2025 Operating Budget and 2025 Capital Budget. Following questions and discussion, the Board expressed support for approving the 2025 Operating and Capital Budget.

06-B-11-2024 – For Approval: 2025 Operating Budget and 2025 Capital Budget

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

The Board of Directors[7] of the College of Physicians and Surgeons of Ontario approves the following budgets authorizing expenditures for the benefit of the College during the year 2025:

1. the 2025 Operating budget in the amounts of $87.068 million in revenues, $87.004 million in expenses, and a surplus of $64,000, and
2. the 2025 Capital budget in the amount of $5.617 million in capital asset expenses.

CARRIED

[6] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the Regulated Health Professions Act) and the Medicine Act.

[7] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulation Health Professions Act*) and the *Medicine Act*.

14. Draft Policies for Consultation

14.1 Accepting New Patients

C. Brown, Team Lead, Policy provided an overview of the Accepting New Patients draft policy for consultation. The Board was reminded of a new process being trialed whereby draft policies will be discussed in detail by the Board after they have been released for consultation and feedback has been received. Following a few questions and discussion, the Board expressed support for sending out the draft policy for consultation.

07-B-11-2024 – Draft Policy for Consultation: Accepting New Patients

The following motion was moved by L. Miljan, seconded by B. Achtar and carried, that:

The Board of Directors[8] of the College of Physicians and Surgeons of Ontario engage in the consultation process in respect of the draft revised policy, "*Accepting New Patients*," (a copy of which forms Appendix "B" to the minutes of this meeting).

CARRIED

14.2 Ending the Physician-Patient Relationship

C. Brown, Team Lead, Policy provided an overview of the Ending the Physician-Patient Relationship draft policy for consultation. Following a few questions and discussion, the Board expressed support for sending out the draft policy for consultation in accordance with the newly trialed process.

08-B-11-2024 – Draft Policy for Consultation: Ending the Physician-Patient Relationship

The following motion was moved by P. Malette, seconded by J. Fisk and carried, that:

The Board of Directors[9] of the College of Physicians and Surgeons of Ontario engage in the consultation process in respect of the draft revised policy, "Ending the Physician-Patient Relationship," (a copy of which forms Appendix "C" to the minutes of this meeting).

CARRIED

14.3 Treatment of Self, Family Members and Others Close to You

T. Terzis, Manager, Governance & Policy provided an overview of the Treatment of Self, Family Members and Others Close to You draft policy for consultation. Following a few questions and discussion, the Board expressed support for sending out the draft policy for consultation in accordance with the newly trialed process.

[8] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulated Health Professions Act*) and the *Medicine Act*.
[9] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulated Health Professions Act*) and the *Medicine Act*.

09-B-11-2024 – Draft Policy for Consultation: Treatment of Self, Family Members, and Others Close to You

The following motion was moved by A. Steen, seconded by F. Bilal and carried, that:

The Board of Directors[10] of the College of Physicians and Surgeons of Ontario engage in the consultation process in respect of the draft revised policy, "Treatment of Self, Family Members, and Others Close to You," [formerly titled "Physician Treatment of Self, Family Members, and Others Close to Them"] (a copy of which forms Appendix "D" to the minutes of this meeting).

CARRIED

15. Proposed Amendments: Boundary Violations policy

T. Terzis, Manager, Policy & Governance provided an overview of the proposed amendments to the Boundary Violations policy. The proposed amendments remove the stated expectation that physicians must not engage in sexual relations with a former patient for at least 5 years if more than minor or insubstantial psychotherapy was provided and clarify that it may be professional misconduct for a physician to have a sexual relationship with a former patient, even after the 1 year time period in the Health Professions Procedural Code has passed. These revisions are intended to clarify that sexual relations with former patients are likely always inappropriate if psychotherapy is provided. Following questions and discussion, the Board expressed support to approve the amendments made to the policy. No consultation is being sought on these discrete changes.

10-B-11-2024 – Revised Policy for Final Approval: Boundary Violations

The following motion was moved by L. Miljan, seconded by F. Sherman and carried, that:

The Board of Directors[11] of the College of Physicians and Surgeons of Ontario approves the revised policy "Boundary Violations" as a policy of the College (a copy of which forms Appendix "E" to the minutes of this meeting).

CARRIED

16. Revised Draft Policy for Final Approval: Reporting Requirements

K. Saperson, Chair of the Policy Working Group and T. Terzis, Manager, Policy & Governance presented the Reporting Requirements policy that is coming back to the Board for final approval. An overview of the consultation feedback and key revisions made to the draft policy and advice were provided. It was noted that the changes to the companion document, which is now titled Guide to Legal Requirements, provide guidance on issues that pose the highest risk but advise that it is not a replacement for legal advice. Following questions and discussion, the Board expressed support to approve the revised draft as a policy of the College.

[10] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the Regulated Health Professions Act) and the Medicine Act.
[11] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the Regulated Health Professions Act) and the Medicine Act.

11-B-11-2024 – Revised Policy for Final Approval: Reporting Requirements

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

The Board of Directors[12] of the College of Physicians and Surgeons of Ontario approves the revised policy "Reporting Requirements", formerly titled "Mandatory and Permissive Reporting", as a policy of the College (a copy of which forms Appendix "F" to the minutes of this meeting).

CARRIED

17. Minor Amendments: Professional Responsibilities in Medical Education and Social Media Policies

C. Brown, Team Lead, Policy provided an overview of the minor amendments proposed to the Professional Responsibilities in Medical Education and Social Media policies that are coming to the Board for final approval. The amendments are intended to align the language in these policies with the language in the Professional Behaviour policy related to disruptive behaviour, approved in September 2024. It was noted in line 12 of the Social Media policy that the reference to "Twitter" should be updated to reflect "X". Following questions and discussion, the Board expressed support to approve the proposed minor amendments to the policies.

12-B-11-2024 – Revised Policy for Final Approval: Professional Responsibilities in Medical Education

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

The Board of Directors[13] of the College of Physicians and Surgeons of Ontario approves the revised policy, "*Professional Responsibilities in Medical Education*" as a policy of the College (a copy of which forms Appendix "G" to the minutes of this meeting).

CARRIED

13-B-11-2024 – Revised Policy for Final Approval: Social Media

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

The Board of Directors[14] of the College of Physicians and Surgeons of Ontario approves the revised policy, "*Social Media*" as a policy of the College (a copy of which forms Appendix "H" to the minutes of this meeting).

CARRIED

G. Bandiera and R. Kirkpatrick depart the meeting due to a conflict of interest.

[12] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulated Health Professions Act*) and the *Medicine Act*.
[13] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulated Health Professions Act*) and the *Medicine Act*.
[14] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulated Health Professions Act*) and the *Medicine Act*.

18. Draft Policies for Circulation

18.1 Alternative Pathways to Registration for Physicians Trained in the United States

S. Tulipano, Director, Registration and Membership Services, provided an overview of the proposed changes to the existing Alternative Pathways to Registration for Physicians Trained in the United States policy. The draft policy allows physicians certified by an American specialty board who have practised continuously in Ontario for five years under a restricted certificate of registration to apply for an independent practice certificate.

The Board is being asked to approve the proposed amendments for notice and consultation as set out in the motion. The Board is asked that the final policy be brought to the Executive Committee for final approval (subject to feedback received) to expedite implementation of the policy. Following questions and discussion, the Board expressed support for approving the policy for notice and consultation.

14-B-11-2024 – Draft Revised Policy for Notice and Consultation: Alternative Pathways to Registration for Physicians Trained in the United States

The following motion was moved by B. Achtar, seconded by F. Sherman and carried, that:

The Board of Directors[15] of the College of Physicians and Surgeons of Ontario engage in the notice and consultation process in accordance with Section 22.21 of the *Health Professions Procedural Code* in respect of the draft revised policy, "*Alternative Pathways to Registration for Physicians Trained in the United States*," (a copy of which forms Appendix "I" to the minutes of this meeting).

CARRIED

18.2 Restricted Certificate of Registration for Royal College of Physicians and Surgeons of Canada (RCPSC) Practice Eligibility Route and Specialist Recognition Criteria in Ontario

S. Tulipano, Director, Registration and Membership Services, provided an overview of the draft newly developed Restricted Certificate of Registration for Royal College of Physicians and Surgeons of Canada (RCPSC) Practice Eligibility Route. The draft policy creates a new pathway to licensure for internationally-trained physicians registered in the RCPSC Practice Eligibility Route. Revisions are proposed to the existing Specialist Recognition Criteria in Ontario policy to allow physicians registered under the RCPSC Practice Eligibility Route policy to use the specialist designation.

The Board is being asked to approve the proposed draft policy and draft revised policy for notice and consultation as set out in the motion. The Board is asked to bring the policies to the Executive Committee for final approval (subject to feedback received) to expedite

[15] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulated Health Professions Act*) and the *Medicine Act*.

implementation of the policies. Following questions and discussion, the Board expressed support for approving the policy for notice and consultation.

15-B-11-2024 – Draft Policies for Notice and Consultation: Restricted Certificate of Registration for RCPSC Practice Eligibility Route and Specialist Recognition Criteria in Ontario

The following motion was moved by P. Malette, seconded by L. Robbins and carried, that:

The Board of Directors[16] of the College of Physicians and Surgeons of Ontario engage in the notice and consultation process in accordance with Section 22.21 of the *Health Professions Procedural Code* in respect of the draft policy, "*Restricted Certificate of Registration for RCPSC Practice Eligibility Route*," and the draft revised policy "*Specialist Recognition Criteria in Ontario*," (copies of which forms Appendices "J" and "K" to the minutes of this meeting).

CARRIED

G. Bandiera and R. Kirkpatrick rejoin the meeting.

Item 20 By-law Amendments: Committee Appointments moved up.

20. By-law Amendments: Committee Appointments

It was noted that the proposed By-law Amendments outlined in items 20 to 23 are being brought to the Board for consideration and approval. To simplify the process, these items will be approved together in one motion that combines all proposed amendments. The proposed Board motion will revoke By-law No. 168 and will substitute it with the revised By-law No. 168.

T. Terzis, Manager, Policy & Governance provided an overview of the proposed By-law Amendments relating to how Committee Appointments are brought to the Board. The Chairs and Vice-Chairs of non-Board committees will make committee appointment recommendations to the Board, instead of the Governance and Nominating Committee.

Item 21 By-law Amendments: Enable Physician Assistants (PAs) to be eligible to Stand for Election to the Board and incorporating PAs into CPSO's Governance Structure moved up.

21. By-law Amendments: Enabling Physician Assistants (PAs) to be eligible to Stand for Election to the Board and Incorporating PAs into CPSO's Governance Structure

T. Terzis, Manager, Policy & Governance, provided an overview of the proposed By-law Amendments to enable Physician Assistants (PAs) to be eligible to stand for election to the Board and incorporate PAs into CPSO's governance structure. The Board discussed the process on how PAs would stand for election. It was noted that as registrants under the legislation, PAs would stand for election the same way as physician registrants. There would not be designated seat for PAs. PAs would be eligible to stand for election to the Board in 2026. The election process will be reviewed over time to determine if improvements need to be made to the election process for PAs. As part of the recruitment process, opportunities for PAs to join Committees will also be considered.

[16] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulated Health Professions Act*) and the *Medicine Act*.

22. By-law Amendments: Remuneration and Reimbursement, and Introduction of Operational Reimbursement Rules

T. Terzis, Manager, Policy & Governance, provided an overview of the proposed By-law amendments to clarify that Board Physician Director and committee member remuneration and expense reimbursement are subject to limits, rules, and processes established by CPSO in accordance with usual approvals processes and financial management practices. There is also a proposal to rescind the existing Board and Committee Member Expense Reimbursement Board policy. There was discussion about PAs and Physician Directors being compensated at different rates than Public Directors. It was noted that there are ongoing discussions with the Government to close this gap and advocate for the rights of Public Directors so that they are treated equally to Registrants of the College.

23. By-law Amendments: Minor Housekeeping Changes

M. Cooper, Senior Corporate Counsel and Privacy Officer, provided an overview of the proposed minor housekeeping changes made to the By-laws to clean up and provide clarification. Following questions and discussion, the Board expressed support for all the proposed By-law amendments in agenda items 20, 21, 22 and 23, and for rescission of the Board and Committee Member Expense Reimbursement Board policy.

16-B-11-2024 – For Approval: CPSO By-law Amendments

The following motion was moved by M. Ghandikota, seconded by G. Bandiera and carried, that:

The Board of Directors[17] of the College of Physicians and Surgeons of Ontario:

1. revokes By-law No. 168 (the CPSO By-laws) and substitutes it with the revised By-law No. 168 (the CPSO By-laws) set out in Appendix "L" to this motion; and
2. revokes the CPSO Board Policy titled "Board and Committee Member Expense Reimbursement Policy" set out in Appendix "M" to this motion.

CARRIED

19. Board Award Presentation

I. Preyra, Board Chair and Director, presented the Board Award to Dr. John Rawlinson of Burlington. Dr. Rawlinson was recognized as a leader in diagnostic and interventional radiology at Joseph Brant Hospital in Burlington. Dr. Rawlinson was recognized for his dedication to his patients and his specialty, consistently providing accurate and timely diagnoses.

Item 24 General By-law Revocation will follow item 19 Board Award Presentation

[17] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulated Health Professions Act*) and the *Medicine Act*.

24. General By-law Revocation

M. Cooper, Senior Corporate Counsel and Privacy Officer, provided an overview of the proposed General By-law Revocation, a decision item. It was noted that the CPSO By-laws (By-law No. 168) now contains all of the College's By-law provisions. All of the provisions within the General By-law have been revoked, and the shell General By-law is no longer needed. The Board expressed support for revoking the General By-law.

17-B-11-2024 – For Approval: Revocation of General By-law

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

The Board of Directors[18] of the College of Physicians and Surgeons of Ontario revokes the General By-law.

CARRIED

25. By-law Amendments for Circulation: PA Register and Fees for Emergency Class Certificate of Registration

M. Cooper, Senior Corporate Counsel and Privacy Officer, provided an overview of the proposed By-law Amendments relating to PA information in the public register and fees for Emergency Class Certificates of Registration for PAs for circulation. The Board expressed support for circulating the proposed By-law amendments to the profession.

18-B-11-2024 – For Circulation: By-law Amendments re PA Register and Fees for Emergency Class Certificate of Registration

The following motion was moved by L. Robbins, seconded by D. Robertson and carried, that:

The Board of Directors[19] of the College of Physicians and Surgeons of Ontario proposes to amend By-law No. 168 (the **"CPSO By-laws"**) as set out below, after circulation to stakeholders:

1. Section 17.1.1(d) of the CPSO By-laws is revoked and substituted with the following:

17.1 Application Fees

17.1.1 A person who submits an application for a certificate of registration or authorization shall pay an application fee. The application fees are as follows:

…

[18] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions
Procedural Code (Schedule 2 to the *Regulated Health Professions Act*) and the *Medicine Act*.

[19] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions
Procedural Code (Schedule 2 to the *Regulated Health Professions Act*) and the *Medicine Act*.

(d) for a certificate of registration authorizing practice as a physician assistant or for a certificate of registration authorizing practice in emergency circumstances for physician assistants, $300;

2. Section 18.1.2(c) of the CPSO By-laws is revoked and substituted with the following:

18.1 Annual Fees

18.1.2 Annual fees as of June 1, 2018, are as follows:

…

(c) for a holder of a certificate of registration authorizing practice as a physician assistant or for a certificate of registration authorizing practice in emergency circumstances for physician assistants, $425; and

3. Section 21.1.1 of the CPSO By-laws is revoked and substituted with the following:

21.1 Registrant Names and Addresses

21.1.1 A Registrant's name in the Register shall be the Registrant's full name and consistent with the name of the Registrant as it appears on the Registrant's degree of medicine, in the case of a Physician Registrant, or the Registrant's physician assistant degree, in the case of a PA Registrant, in each case as supported by documentary evidence satisfactory to the College.

4. Sections 21.2.1(e) and (h) of the CPSO By-laws are revoked and substituted with the following:

21.2 Additional Register Content

21.2.1 For purposes of paragraph 20 of subsection 23(2) of the Code, the Register shall contain the following additional information with respect to each Registrant:

…

(e) in addition to the Registrant's business address, other locations at which the Registrant practises medicine, if a Physician Registrant, or practises as a physician assistant, if a PA Registrant, reported by the Registrant to the College;

…

(h) in the case of a Physician Registrant, the name of the medical school from which the Registrant received their degree in medicine, or in the case of a PA Registrant, the name of the physician assistant training program from which the Registrant received their physician assistant degree, and in each case, the year in which the Registrant obtained the degree;

5. Section 23.1.3(b) of the CPSO By-laws is revoked and substituted with the following:

23.1 Notification Required by Registrants

23.1.3 The College may at any time and from time to time request information from its Registrants. In response to each such request, each Registrant shall accurately and fully provide the College with the information requested using the Member Portal, or such other form or method specified by the College, by the due date set by the College. A College request for Registrant information may include the following:

…

(b) the address of all locations at which the Registrant practises medicine, if a Physician Registrant, or practises as a physician assistant, if a PA Registrant, in each case together with a description or confirmation of the services and clinical activities provided at all locations at which the Registrant practises;

Explanatory Note: This proposed by-law must be circulated to the profession.

CARRIED

26. Board Chair Items

The following Board Chair items were presented to the Board:

1. Acknowledge Outgoing Directors
2. Board Chair Address
3. Induction of New Board Chair
4. Welcome Incoming Directors

I. Preyra, Board Chair, recognized the contributions of the following outgoing Director, Academic Representatives, and Academic Director:

R. Kirkpatrick – Academic Director
A. Lum – Academic Representative
J. Plante - Director
K. Saperson – Academic Representative

Each of the outgoing members were given the opportunity to address the Board.

I. Preyra addressed the Board and reflected on the past year. I. Preyra welcomed S. Reid to her role as CPSO Board Chair for the 2025 year.

S. Reid was inducted as the new Board Chair. S. Reid addressed the Board, thanked I. Preyra for his leadership and welcomed incoming Director, V. Roth. The new Director was invited to receive her Board pin, address the Board, and take her seat at the Board table as a Director of the CPSO.

27. Close Meeting - Day 2

S. Reid, Board Chair, closed the meeting at 1:35 p.m. The next Board meeting is scheduled on March 6 and 7, 2025.

Board Chair

Recording Secretary

MARCH 2025

Title:	Committee Appointment (For Decision)
Main Contacts:	Caitlin Ferguson, Governance Coordinator Tanya Terzis, Manager, Policy & Governance
Question for Board:	Does the Board of Directors (Board) wish to appoint the individual as laid out in this briefing note?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- The Board is asked to make a new committee appointment.
- Ensuring that CPSO committees have qualified and diverse members allows CPSO to carry out its strategic objectives and fulfill its mandate to serve in the public interest.

Current Status & Analysis

- The Ontario Physicians and Surgeons Discipline Tribunal (OPSDT) and the Fitness to Practise Committee (FTP) recommend the appointment of Dr. Carys Massarella.
- Dr. Massarella is a Physician Director who was first elected in 2022.
- The Executive Committee recommends appointing Dr. Massarella to the OPSDT and the FTP for a term commencing March 7, 2025 and lasting until the close of the 2025 Annual Organizational Meeting.

Board Motion

Motion Title	For Approval: Consent Agenda
Date of Meeting	March 6, 2025

It is moved by_____, and seconded by_____, that:

The Board of Directors[1] of the College of Physicians and Surgeons of Ontario approves items 2.1 to 2.3 outlined in the consent agenda, which include in their entirety:

2.1 The Board meeting agenda for March 6 and 7, 2025;

2.2 The draft minutes from the Board meeting held on November 28 and 29, 2024;

2.3 Committee Appointment

The Board of Directors of the College of Physicians and Surgeons of Ontario appoints Dr. Carys Massarella to the Ontario Physicians and Surgeons Discipline Tribunal and the Fitness to Practise Committee effective March 7, 2025, and expiring at the close of the Annual Organizational Meeting of the Board in 2025.

[1] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulated Health Professions Act*) and the *Medicine Act*.

MARCH 2025

Title:	Executive Committee Report (For Information)
Main Contact:	Carolyn Silver, Chief Legal Officer

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- The Board of Directors is provided with an update on decisions made on behalf of the Board by the Executive Committee in between meetings.

Executive Committee – January 2025

02-EX-January 2025 **Committee Appointments**

On a motion moved by P. Safieh, seconded by L. Miljan and carried, that the Executive Committee approves on behalf of the Board the proposed appointments of Dr. Ian Preyra, and Dr. Vincent Georgie (Ph.D.) to the Ontario Physicians and Surgeons Discipline Tribunal and the Fitness to Practise Committee for a term effective January 7, 2025, and ending at the conclusion of the Annual Organizational Meeting of the Board in November 2025.

Executive Committee – February 2025

02-EX-February 2025 **Committee Appointment**

On a motion moved by P. Safieh, seconded by R. Gratton and carried, that the Executive Committee approves on behalf of the Board the proposed appointment of Dr. Faiq Bilal (Ph.D.) to the Registration Committee for a term effective February 11, 2025, and ending at the conclusion of the Annual Organizational Meeting of the Board in November 2025.

05-EX-February 2025 **Draft Policy for Final Approval: Alternative Pathways to Registration for Physicians Trained in the United States**

On a motion moved by L. Miljan, seconded by R. Gratton and carried, that the Executive Committee approves on behalf of the Board of Directors of the College of Physicians and Surgeons of Ontario, the revised draft policy "Alternative Pathways to Registration for Physicians Trained in the United States" as a policy of the College (a copy of which forms Appendix "C" to the minutes of this meeting).

07-EX-February 2025 **Draft Policies for Final Approval: Restricted Certificate of Registration for RCPSC Practice Eligibility Route and Specialist Recognition Criteria in Ontario**

On a motion moved by J. Fisk, seconded by A. Steen and carried, that the Executive Committee approves on behalf of the Board of Directors of the College of Physicians and Surgeons of Ontario, the draft policy "Restricted Certificate of Registration for Royal College of Physicians and Surgeons of Canada (RCPSC) Practice Eligibility Route" and revised draft policy, "Specialist Recognition Criteria in Ontario" as policies of the College (copies of which form Appendices "E" and "F" to the minutes of this meeting).

Contact: Sarah Reid, Board Chair
Carolyn Silver, Chief Legal Officer

Date: February 18, 2025

MARCH 2025

Title:	Ontario Physicians and Surgeons Discipline Tribunal Report of Completed Cases | November 9, 2024 – February 15, 2025 (For Information)
Main Contact:	Dionne Woodward, Tribunal Counsel

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- This report summarizes reasons for decision released between November 9, 2024 – February 15, 2025 by the Ontario Physicians and Surgeons Discipline Tribunal. It includes reasons on discipline hearings (liability and/or penalty), reinstatement applications, costs hearings, motions and case management issues brought before the Tribunal.

Current Status and Analysis

In the period reported, the Tribunal released 10 reasons for decision:

- 7 reasons on findings (liability) and penalty
- 1 set of reasons on a motion
- 2 sets of reasons on applications for reinstatement

Findings

Liability findings included:

- 3 findings of sexual abuse
- 4 findings of disgraceful, dishonourable or unprofessional conduct
- 1 finding of contravening a term, condition or limitation on the physician's certificate of registration

Penalty

Penalty orders included:

- 3 revocations
- 3 suspensions
- 7 reprimands
- 2 impositions of terms, conditions or limitations on the physician's certificate of registration

Costs

The Tribunal imposed a costs order on the physician in all penalty reasons, the highest of which was $6000.

TABLE 1: TRIBUNAL DECISIONS – FINDINGS (November 9, 2024 – February 15, 2025)

Citation and hyperlink to published reasons	Physician	Date of Reasons	Sexual Abuse	Contravened term, condition or limitation on certificate of registration	Disgraceful, Dishonourable or Unprofessional Conduct	Failed to maintain standard of practice	Other
2025 ONPSDT 3	Cook	Feb. 12, 2025			X		
2025 ONPSDT 2	Guiang	Jan. 31, 2025	X				
2025 ONPSDT 1	Zhang	Jan. 10, 2025			X		
2024 ONPSDT 31	Nahvi	Dec 13, 2024			X		
2024 ONPSDT 29	Israel	Dec. 4, 2024	X				
2024 OPSDT 28	Armstrong	Nov. 25, 2024		X	X		
2024 ONPSDT 26	Clottey	Nov. 19, 2024	X				

TABLE 2: TRIBUNAL DECISIONS – PENALTIES (November 9, 2024 – February 15, 2025)

Citation and hyperlink to published reasons	Physician	Date of reasons	Penalty (TCL = Terms, Conditions or Limitations)	Length of suspension in months	Costs
2025 ONPSDT 3	Cook	Feb. 12, 2025	Suspension, reprimand, TCL	6 months	$6000
2025 ONPSDT 2	Guiang	Jan. 31, 2025	Revocation, reprimand, reimbursement for complainant's therapy and counselling		$6000
2025 ONPSDT 1	Zhang	Jan. 10, 2025	Suspension, reprimand	4 months	$6000
2024 ONPSDT 31	Nahvi	Dec 13, 2024	Reprimand **Registrant resigned certificate of registration and undertook never to re-apply in any jurisdiction.*		$6000
2024 ONPSDT 29	Israel	Dec. 4, 2024	Revocation, reprimand, reimbursement for complainants' therapy and counselling		$6000
2024 OPSDT 28	Armstrong	Nov. 25, 2024	Suspension, reprimand, TCL	2 months	$6000
2024 ONPSDT 26	Clottey	Nov. 19, 2024	Revocation, reprimand, reimbursement for complainants' therapy and counselling		$6000

TABLE 3: TRIBUNAL DECISIONS - MOTIONS AND CASE MANAGEMENT (November 9, 2024 – February 15, 2025)

Citation and hyperlink to published reasons	Physician(s)	Date of reasons	Motion/Case management outcome	Nature of motion/case management issue
2025 ONPSDT 4	Khulbe	Feb. 12, 2025	The registrant's request for an indefinite adjournment pending the conclusion of criminal proceedings against one of the complainants was dismissed.	The Tribunal determined that further delaying the case would be prejudicial to the complainants waiting to testify; could affect the quality of evidence; and would be inconsistent with the objective of addressing serious allegations of misconduct, in this case sexual abuse, in a timely manner. The Tribunal dismissed the registrant's request and ordered that the hearing proceed in May and June 2025.

TABLE 3: TRIBUNAL DECISIONS – REINSTATEMENT APPLICATIONS (November 9, 2024 – February 15, 2025)

Citation and hyperlink to published reasons	Physician(s)	Date of reasons	Outcome	Details
2024 ONPSDT 30	Fagbemigun	Dec. 10, 2024	Dr. Fagbemigun's application for reinstatement was dismissed.	The Tribunal found that Dr. Fagbemigun failed to meet his onus of establishing that he posed a low risk of future misconduct. Dr. Fagbemigun's application for reinstatement was dismissed.
2024 ONPSDT 27	Kayilasanathan	Nov. 19, 2024	Dr. Kayilasanathan's certificate of registration was reinstated.	The Tribunal ordered the reinstatement of Dr. Kayilasanathan's certificate of registration, subject to terms, conditions and limitations.

MARCH 2025

Title:	Government Relations Report (For Information)
Main Contact:	Heather Webb, Manager of Communications

Legislative Update

- The Legislature has not been in session since mid-December 2024.

- Following months of speculation, an election in Ontario is being held on February 27, 2025. Major campaign issues for the election at time of writing are the threat of US tariffs and access to primary care.

    - For their part, both the NDP and Liberals have pushed to make health care generally (and access to family doctors specifically) a central election issue.
    - All three major parties (PCs, Liberals, and NDP) have made commitments to expand health care in northern Ontario and to support the provision of team-based care.
    - Specific details of the PC Party's plan to promote access to primary care for Ontarians are covered below.

- As of mid-February, the PC Party were maintaining a sizable lead in the polls, with the Liberals seeing a slight uptick and the NDPs sliding downward. Barring exceptional circumstances, we expect the PC Party to again form government come February 27.

Issues of Interest

- **Primary care access and funding**: Just prior to the election, government announced $1.4B in new funding to connect two million more people to family doctors or a primary care team within four years, on top of $400M in already-approved primary care funding. These investments are to be delivered through Dr. Jane Philpott's Primary Care Action Team.

    - To support this initiative, government has announced that it would introduce new legislation to establish best-in-class standards outlining what people in Ontario can expect when accessing primary care services.

    - Government has also committed to providing regular public updates on progress and performance tied to this initiative, including indicators of primary care teams such as the number of patients attached.

- **HART Hubs**: Government has also announced $529M in funding for 27 new Homelessness and Addiction Recovery Treatment (HART) Hubs across the province. The HART Hubs were announced in parallel with the decision to shut down many supervised injection sites as of March 2025.

- **Public member update:** Since the last Board meeting, the terms of four public members (Lucy Becker, Fred Sherman, Anu Srivastava, and Murthy Ghandikota) were renewed. CPSO is working with the Ministry and the Minister's Office to ensure that they are aware of CPSO's needs.

MARCH 2025

Title:	Policy Report (For Information)
Main Contact:	Tanya Terzis, Manager, Policy & Governance
Attachment:	**Appendix A:** Policy Status Report

Purpose, Public Interest Mandate & Relevance to Strategic Plan

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

Current Status & Analysis

- Three policy consultations launched following the November 2024 Board meeting:

Consultation Feedback Overview
General: ***Accepting New Patients***[1] **107** responses received[2] • Consultation feedback on the draft policy and *Advice* document was largely positive. The majority of survey respondents agreed that the draft policy was clearly written and easy to understand, addressed the relevant and important issues related to accepting new patients, and set reasonable expectations for physicians. • In general, respondents support moving away from the current policy's default "first-come, first-served" approach to accepting new patients. Feedback from physicians and key stakeholders (e.g., CMPA) highlights the benefits of both the increased flexibility permitted under the draft policy and the ability for physicians to establish their own appropriate criteria for accepting and prioritizing new patients. • Physician respondents were largely supportive of the draft expectations regarding introductory meetings (e.g., "meet and greets") though some indicated that additional clarity on how to bill for these meetings would be useful. Most patient and caregiver respondents agreed that introductory meetings are useful for helping ensure that physicians and patients can work well together, but they also supported the draft expectations that physicians be transparent about their use of introductory meetings. • While most respondents agreed that the draft policy should focus on expectations that apply to all physicians, some specialist respondents suggested that not all of the draft policy expectations are applicable to them.
General: ***Ending the Physician-Patient Relationship*** **262** responses received[3] • Consultation feedback on the draft policy and *Advice* document was mixed. While the majority of respondents felt that the policy was clear and easy to understand, respondents were more split on whether the policy addresses all relevant issues, and whether the policy sets reasonable expectations for physicians. • Many physician respondents expressed that a patient making a complaint to CPSO about a physician should be reasonable grounds for ending the physician-patient relationship. The *Advice* document states that physicians should not automatically end the relationship where there has been a complaint, but may do so where they feel the complaint has led to a breakdown in the physician-patient relationship. • Respondents largely agreed with the exceptions in the policy for situations where physicians felt their safety or the safety of others was threatened due to a patient's behaviour. Many respondents expressed concern about abuse physicians receive, and requested a clear statement that physicians are not expected to tolerate abuse from patients. • Respondents generally thought it was important for the policy to set out a specific timeframe for how long a physician needs to provide necessary medical services after the physician-patient relationship has ended, but did not agree with the period of three months that was set out in the draft policy.

[1] A preliminary consultation refers to consulting on an existing policy and a general consultation refers to consulting on a draft policy.
[2] Organizational respondents included the Canadian Medical Protective Association (CMPA), College of Nurses of Ontario (CNO), Ontario College of Family Physicians (OCFP), Ontario Medical Association (OMA), OMA Section on Plastic Surgery (OMA-SPS), Ontario Trial Lawyers Association (OTLA), Ottawa Public Health, Professional Association of Residents of Ontario (PARO), and Registered Nurses Association of Ontario (RNAO) Chapter 10 – Ottawa.
[3] Organizational respondents included CMPA, CNO, OCFP, OMA, OMA-SPS, OTLA, and PARO.

Consultation Feedback Overview
General: ***Treatment of Self, Family Members, and Others Close to You*** **135** responses received[4] • Consultation feedback on the draft policy and *Advice* document was mixed. While the majority of respondents said that the policy was clear and easy to understand, less than half the respondents found the policy reasonable. • In general, respondents expressed a desire to have clearer, concrete definitions of minor conditions, and what constitutes "others close to them" or another health-care professional being readily available. • Many respondents felt that it was unreasonable to have to consider whether another health-care professional was readily available before providing treatment for a minor condition. They felt they should be able to treat minor conditions with no further considerations, especially conditions that pharmacists are now able to prescribe for. • Some respondents expressed concern and disbelief that treating their spouse could result in a finding of sexual abuse and felt this was an unreasonable position for CPSO to take. However, this is actually set out in legislation, and the policy reflects this to help physicians avoid unintentionally engaging in conduct that could carry mandatory disciplinary penalties for sexual abuse under the legislation. • Other concerns with the policy centered around the access to care crisis, with a desire for more flexibility in what physicians could treat. Several respondents expressed that physicians should be able to use their professional judgment to determine when it would be appropriate to treat themselves or someone close to them. • Several physicians who identified themselves as urban practitioners disagreed with having an explicit carve-out for small communities as they felt that treatment options were also often limited in larger centers. Physicians and other respondents from small or Indigenous communities were very supportive of those provisions.

Citizen Advisory Group (CAG):

- In late November 2024, CPSO partnered with eight other Ontario health regulators[5] to engage with CAG Members to understand patient and caregiver experiences, perspectives, and expectations related to healthcare providers' use of AI. A virtual discussion with external facilitation was held to explore Members' understanding of AI and to learn what would make them feel confident with healthcare providers using AI.
    - The discussion focused on understanding AI's emerging role in healthcare, its potential benefits and concerns, ensuring its ethical use, and maintaining the "human element" in care delivery.[6] These insights can help inform any future guidance on AI use in medicine.
- A companion public resource, based on CPSO's recently updated *Human Rights in the Provision of Health Services* policy, has been published online following review and validation from CAG Members. The resource explains the policy expectations in plain language and outlines what responsibilities physicians have to provide safe, inclusive, and accessible health services (including effective referrals). The resource also details what patients can do to support their own healthcare experiences.
- Concurrent with the *Accepting New Patients* policy and *Ending the Physician-Patient Relationship* policy public consultations, an online survey was distributed to CAG Members asking about the updated drafts. Feedback on the draft policies suggested that the drafts largely align with the responsibilities CAG Members think physicians should have when accepting new patients and/or ending physician-patient relationships.
- The status of ongoing policy development and reviews, including last reviewed dates and targets for completion, is presented for the Board's information **(Appendix A: Policy Status Report)**.

[4] Organizational respondents included CMPA, CNO, OCFP, OMA, OMA-SPS, OTLA, and PARO.
[5] College of Dental Hygienists of Ontario, College of Kinesiologists of Ontario, College of Midwives of Ontario, College of Nurses of Ontario, College of Occupational Therapists of Ontario, College of Physiotherapists of Ontario, Ontario College of Social Workers and Social Service Workers, and the Royal College of Dental Surgeons of Ontario.
[6] The report summarizing the full discussion can be read on the CAG website (CAG Meeting Report: November 25, 2024).

Appendix A

Table 1: Current Reviews

Policy	Launch	Stage of Policy Review Cycle						Target Comp.	Notes
		Prelim. Consult	Analysis/ Drafting	Approval to Consult	Consult on Draft Policy	Revising Draft Policy	Final Approval		
Delegation of Controlled Acts	Mar-25	✓						**2026**	
Boundary Violations	Mar-25	✓						**2026**	
Closing a Medical Practice	Sep-24		✓					**2025**	
Accepting New Patients	Feb-24					✓		**2025**	
Ending the Physician-Patient Relationship	Feb-24					✓		**2025**	
Physician Treatment of Self, Family Members, or Others Close to Them	Dec-23					✓		**2025**	The draft has been retitled *Treatment of Self, Family Members, and Others Close to You*.
Consent to Treatment	Dec-23						✓	**2025**	

Table 2: Policy Review Schedule

Policy	Reviewed	Policy	Reviewed
Reporting Requirements	2024	*Advertising*	2020
Essentials of Medical Professionalism	2024	*Medical Records Management*	2020
Infection Prevention and Control for Clinical Office Practice	2024	*Medical Records Documentation*	2020
Professional Behaviour	2024	*Protecting Personal Health Information*	2020
Conflicts of Interest and Industry Relationships	2024	*Disclosure of Harm*	2019
Medical Assistance in Dying	2023	*Prescribing Drugs*	2019
Human Rights in the Provision of Health Services	2023	*Availability and Coverage*	2019
Decision-Making for End-of-Life Care	2023	*Managing Tests*	2019
Dispensing Drugs	2022	*Transitions in Care*	2019
Virtual Care	2022	*Walk-in Clinics*	2019
Social Media	2022	*Ensuring Competence: Changing Scope of Practice and Re-entering Practice*	2018
Complementary and Alternative Medicine	2021	*Public Health Emergencies*	2018
Professional Responsibilities in Medical Education	2021	*Uninsured Services: Billing and Block Fees*	2017
Third Party Medical Reports	2021	*Providing Physician Services During Job Actions*	2014

Ontario Medical Students' Association
CPSO Council Update
March 6 and 7, 2025

Maxim Matyashin, President
Zoe Tsai, President-Elect

OMSA Ontario Medical Students Association
AÉMO Association des étudiant·e·s de médecine de l'Ontario

Thank you once again to the CPSO for inviting representatives from the Ontario Medical Students Association (OMSA) to observe and participate in your Council meeting.

Now into the 2025 academic year, students across Ontario are still struggling to receive the education that Ontarians expect for our future physicians. We have provided some updates on ongoing initiatives and highlighted some of the top key concerns that Ontario medical students have across the province.

Updates on Previous Advocacy Efforts:

1. **Difficulties with Distributed Education -** Previously, we received strong interest from the Ministry of Colleges and Universities and the Ministry of Health in expanding funding for electives in northern and rural Ontario. We will be having our OMSA Day of Action (medical students' equivalent of Queens' Park Day) with this year's topic being the Family Medicine Crisis on March 22-24th to further these conversations. We would appreciate support from our colleagues at the CPSO on this matter as much as possible.
2. **A Provincial Medical Education Standards Document -** We are currently in the thick of policy analysis with specific focus on Professionalism, Mistreatment, and Appeals policies. Following, our task force will synthesize and come up with recommendations to be brought forth to each medical school faculty.

New Updates:

1. **CaRMS Match Day Support for Unmatched Grads -** We have collaborated with PARO and CFMS to provide support (including monetary support) for unmatched grads for the 2024-2025 CaRMS application cycle. We would greatly appreciate it if the CPSO could also help distribute and inform students' of these resources.
2. **Dr. Elaine Ma Vaccine Clinic -** We have been in conversations with the OMA District 7 Chair and the local Queens' University Medical Students' Society regarding, who have spoken to students that have taken part in the vaccine clinic in the past. At this point, OMSA has not been asked for any further support, however we will continue to monitor the situation and any potential impacts on medical education.

Thank you once again for inviting us to the CPSO meetings. If you have any questions, or wish to help with our advocacy priorities, please do not hesitate to reach out.

Sincerely,

Maxim Matyashin Zoe Tsai

President, OMSA
president@omsa.ca

President-Elect, OMSA
president_elect@omsa.ca

PARO
Inspired by our love of medicine

PARO Update to CPSO March 2025

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

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

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

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

We are pleased to submit this update on PARO.

Resident Appreciation 2025

Resident Appreciation 2025 ran from February 10-14, 2025. Many hospitals and PGME Offices took the time to recognize residents with a variety of initiatives and messages of appreciation. PARO General Council Representatives also held several events for residents to enjoy over the week.

Program Director & Program Administrator Sessions

PARO has launched the PARO PD & PA sessions, specifically designed for Program Administrators and Program Directors. These sessions provide an overview of the PARO-OTH Collective Agreement, create an opportunity for discussion about how best to support residents, and think about how we might resolve some of the challenges PDs and PAs may encounter in their roles. We look forward to continuing to hold these sessions over the next few months.

PARO Awards

The PARO awards season is underway. Each year, PARO provides an opportunity for residents to submit nominations for the following Awards:

- *Excellence in Clinical Teaching Award*
- *Lois H. Ross Resident Advocate Award for Non-Clinicians*
- *Dr. Robert Conn Resident Advocate Award for Clinicians*
- *Residency Program Excellence Award*

Nominations closed in late January, and we look forward to honouring the award recipients at our annual PARO Awards Banquet in the Spring.

MARCH 2025

Title:	Update on Board Action Items (For Information)
Main Contacts:	Carolyn Silver, Chief Legal Officer Tanya Terzis, Manager, Policy & Governance Adrianna Bogris, Board Administrator

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- An update on the status of the Board's decisions is provided below to promote accountability and ensure that the Board remains informed.

Current Status and Analysis

- The Board held a meeting on November 28 and 29, 2024. The motions carried, and the implementation status of the decisions are outlined in Table 1.

Table 1: Board Decisions from the November 28 and 29, 2024 meeting

<table>
<tr><th>Reference</th><th>Motions Carried</th><th>Status</th></tr>
<tr><td><u>01-B-11-2024</u></td><td><u>Consent Agenda</u>

The Board of Directors[1] of the College of Physicians and Surgeons of Ontario approves items 2.1 to 2.4 outlined in the consent agenda, which include in their entirety:
2.1 The Board meeting agenda for November 28 and 29, 2024, as amended;
2.2 The draft minutes from the Board meeting held on September 6, 2024;
2.3 Committee Appointments for 2024/25[2]

The Board of Directors of the College of Physicians and Surgeons of Ontario appoints / re-appoints the following individuals to the following Committees effective as of the close of the Annual Organizational Meeting (AOM) of the Board in 2024, and expiring at the close of the AOM of the Board in 2025.

<table>
<tr><th>Committee</th><th>Member Name</th></tr>
<tr><td rowspan="4">Ontario Physicians and Surgeons Discipline Tribunal</td><td>Janet van Vlymen (re-appointment)</td></tr>
<tr><td>Camille Lemieux</td></tr>
<tr><td>Virginia Roth</td></tr>
<tr><td>Katina Tzanetos</td></tr>
<tr><td rowspan="4">Fitness to Practise</td><td>Janet van Vlymen (re-appointment)</td></tr>
<tr><td>Camille Lemieux</td></tr>
<tr><td>Virginia Roth</td></tr>
<tr><td>Katina Tzanetos</td></tr>
</table></td><td>Completed.</td></tr>
</table>

[1] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulated Health Professions Act*) and the *Medicine Act*.

[2] A separate motion was carried for items 2.3 and 2.4, only one motion was required for the whole consent agenda, a second motion was done in error, with both motions carried. Only one motion for the consent agenda is recorded in the minutes.

<table>
<tr><th>Reference</th><th>Motions Carried</th><th>Status</th></tr>
<tr><td></td><td>
<table>
<tr><td>Quality Assurance</td><td>Gina Neto</td></tr>
</table>

2.4 2024 Chair/Vice-Chair Committee Re-appointments
The Board of Directors of the College of Physicians and Surgeons of Ontario appoints the following Committee Members as Chairs and Vice-Chairs, as noted below, to the following Committees, effective as of the close of the AOM of the Board in 2024 and expiring at the close of the AOM of the Board in 2025.

<table>
<tr><th>Committee</th><th>Position</th><th>Name</th></tr>
<tr><td rowspan="2">Premises Inspection</td><td>Chair</td><td>Dr. Patrick Davison</td></tr>
<tr><td>Vice-Chair</td><td>Dr. Hae Mi Lee</td></tr>
<tr><td>Quality Assurance</td><td>Vice-Chair</td><td>Dr. Tina Tao</td></tr>
</table>

<u>CARRIED</u>
</td><td></td></tr>
<tr><td><u>02-B-11-2024</u></td><td>
<u>Key Performance Indicators for 2025</u>

The Board of Directors[1] of the College of Physicians and Surgeons of Ontario adopts the following 2025 Key Performance Indicators (KPIs) to measure and report progress on the Strategic Plan:

1. Time From Licence Application Received to Assessment (Excluding Postgraduate Licences)
Target: 15 Business Days; 80th Percentile

2. Time From Final Document Verification to Licence Issued (Excluding Postgraduate Licences)
Target: 5 Business Days; 80th Percentile

3. Complete First Quality Improvement Cycle by Engaging Remaining Physicians
Target: ~3,648 Physicians

4. Build & Pilot Quality Improvement 2.0 Program
Target: 600 Physicians

5. Build & Pilot Quality Improvement Program Specific to OHP Medical Directors
Target: 40 OHP Medical Directors

6. Time to Complete Complaints (Including Public Complaints & Registrars' Investigations)
Target: 150 Days; 80th Percentile

7. Time from Referral to Completion of Discipline Process
Target: 12 Months; 80th Percentile
</td><td>Ongoing.</td></tr>
</table>

Reference	Motions Carried	Status
	8. Build & Launch New Finance & Operations System *Target: Go live by fall 2025* 9. Implement Full Plan-Do-Check-Act (PDCA) Cycle for Province-wide Election Process *Target: Complete by fall 2025* **CARRIED**	
03-B-11-2024	**Proposed Rescission of the Cannabis for Medical Purposes Policy** The Board of Directors[1] of the College of Physicians and Surgeons of Ontario rescind the College's *Cannabis for Medical Purposes* policy (a copy of which forms Appendix "A" to the minutes of this meeting). **CARRIED**	Completed.
04-B-11-2024	**Motion to move in-camera** The Board of Directors[1] of the College of Physicians and Surgeons of Ontario exclude the public from the part of the meeting immediately after this motion is passed, under clauses 7(2)(b) and (d) of the Health Professions Procedural Code (set out below). *Exclusion of public* 7(2) Despite subsection (1), the Council may exclude the public from any meeting or part of a meeting if it is satisfied that, (b) financial or personal or other matters may be disclosed of such a nature that the harm created by the disclosure would outweigh the desirability of adhering to the principle that meetings be open to the public; (d) personnel matters or property acquisitions will be discussed. **CARRIED**	Completed.
05-B-11-2024	**Committee Appointment** The Board of Directors[1] of the College of Physicians and Surgeons of Ontario appoints Jay Sengupta to the Ontario Physicians and Surgeons Discipline Tribunal and the Fitness to Practise Committee effective as of the close of the Annual Organizational Meeting (AOM) of the Board in 2024, and expiring at the close of the AOM of the Board in 2025. **CARRIED**	Completed.

Reference	Motions Carried	Status
06-B-11-2024	**For Approval: 2025 Operating Budget and 2025 Capital** The Board of Directors[1] of the College of Physicians and Surgeons of Ontario approves the following budgets authorizing expenditures for the benefit of the College during the year 2025: 1. the 2025 Operating budget in the amounts of $87.068 million in revenues, $87.004 million in expenses, and a surplus of $64,000, and 2. the 2025 Capital budget in the amount of $5.617 million in capital asset expenses. **CARRIED**	Completed.
07-B-11-2024	**Draft Policy for Consultation: Accepting New Patients** The Board of Directors[1] of the College of Physicians and Surgeons of Ontario engage in the consultation process in respect of the draft revised policy, "*Accepting New Patients*," (a copy of which forms Appendix "B" to the minutes of this meeting). **CARRIED**	Policy sent out for consultation.
08-B-11-2024	**Draft Policy for Consultation: Ending the Physician-Patient Relationship** The Board of Directors[1] of the College of Physicians and Surgeons of Ontario engage in the consultation process in respect of the draft revised policy, "Ending the Physician-Patient Relationship," (a copy of which forms Appendix "C" to the minutes of this meeting). **CARRIED**	Policy sent out for consultation.
09-B-11-2024	**Draft Policy for Consultation: Treatment of Self, Family Members, and Others Close to You** The Board of Directors[1] of the College of Physicians and Surgeons of Ontario engage in the consultation process in respect of the draft revised policy, "*Treatment of Self, Family Members, and Others Close to You*," [formerly titled *"Physician Treatment of Self, Family Members, and Others Close to Them"*] (a copy of which forms Appendix "D" to the minutes of this meeting). **CARRIED**	Policy sent out for consultation.
10-B-11-2024	**Revised Policy for Final Approval: Boundary Violations** The Board of Directors[1] of the College of Physicians and Surgeons of Ontario approves the revised policy "*Boundary Violations*" as a policy of the College (a copy of which forms Appendix "E" to the minutes of this meeting). **CARRIED**	Completed.

Reference	Motions Carried	Status
11-B-11-2024	**Revised Policy for Final Approval: Reporting Requirements** The Board of Directors[1] of the College of Physicians and Surgeons of Ontario approves the revised policy "Reporting Requirements", formerly titled "Mandatory and Permissive Reporting", as a policy of the College (a copy of which forms Appendix "F" to the minutes of this meeting). **CARRIED**	Completed.
12-B-11-2024	**Revised Policy for Final Approval: Professional Responsibilities in Medical Education** The Board of Directors[1] of the College of Physicians and Surgeons of Ontario approves the revised policy, "*Professional Responsibilities in Medical Education*" as a policy of the College (a copy of which forms Appendix "G" to the minutes of this meeting). **CARRIED**	Completed.
13-B-11-2024	**Revised Policy for Final Approval: Social Media** The Board of Directors[1] of the College of Physicians and Surgeons of Ontario approves the revised policy, "*Social Media*" as a policy of the College (a copy of which forms Appendix "H" to the minutes of this meeting). **CARRIED**	Completed.
14-B-11-2024	**Draft Revised Policy for Notice and Consultation: Alternative Pathways to Registration for Physicians Trained in the United States** The Board of Directors[1] of the College of Physicians and Surgeons of Ontario engage in the notice and consultation process in accordance with Section 22.21 of the *Health Professions Procedural Code* in respect of the draft revised policy, "*Alternative Pathways to Registration for Physicians Trained in the United States*," (a copy of which forms Appendix "I" to the minutes of this meeting). **CARRIED**	Final policy approved by Executive Committee on Feb. 11, 2025. Motion in the March EC Report to the Board.

Reference	Motions Carried	Status
15-B-11-2024	**Draft Policies for Notice and Consultation: Restricted Certificate of Registration for RCPSC Practice Eligibility Route and Specialist Recognition Criteria in Ontario** The Board of Directors[1] of the College of Physicians and Surgeons of Ontario engage in the notice and consultation process in accordance with Section 22.21 of the *Health Professions Procedural Code* in respect of the draft policy, "*Restricted Certificate of Registration for RCPSC Practice Eligibility Route*," and the draft revised policy "*Specialist Recognition Criteria in Ontario*," (copies of which forms Appendices "J" and "K" to the minutes of this meeting). **CARRIED**	Final policy approved by Executive Committee on Feb. 11, 2025. Motion in the March EC Report to the Board.
16-B-11-2024	**For Approval: CPSO By-law Amendments** The Board of Directors[1] of the College of Physicians and Surgeons of Ontario: 1. revokes By-law No. 168 (the CPSO By-laws) and substitutes it with the revised By-law No. 168 (the CPSO By-laws) set out in Appendix "L" to this motion; and 2. revokes the CPSO Board Policy titled "Board and Committee Member Expense Reimbursement Policy" set out in Appendix "M" to this motion. **CARRIED**	Completed.
17-B-11-2024	**For Approval: Revocation of General By-law** The Board of Directors[1] of the College of Physicians and Surgeons of Ontario revokes the General By-law. **CARRIED**	Completed.
18-B-11-2024	**For Circulation: By-law Amendments re PA Register and Fees for Emergency Class Certificate of Registration** The Board of Directors[1] of the College of Physicians and Surgeons of Ontario proposes to amend By-law No. 168 (the **"CPSO By-laws"**) as set out below, after circulation to stakeholders: 1. Section 17.1.1(d) of the CPSO By-laws is revoked and substituted with the following: **17.1 Application Fees** 17.1.1 A person who submits an application for a certificate of registration or authorization shall pay an application fee. The application fees are as follows:	By-law Amendments sent out for circulation to the profession.

Reference	Motions Carried	Status
	… (d) for a certificate of registration authorizing practice as a physician assistant or for a certificate of registration authorizing practice in emergency circumstances for physician assistants, $300; 2. Section 18.1.2(c) of the CPSO By-laws is revoked and substituted with the following: **18.1 Annual Fees** 18.1.2 Annual fees as of June 1, 2018, are as follows: … (c) for a holder of a certificate of registration authorizing practice as a physician assistant or for a certificate of registration authorizing practice in emergency circumstances for physician assistants, $425; and 3. Section 21.1.1 of the CPSO By-laws is revoked and substituted with the following: **21.1 Registrant Names and Addresses** 21.1.1 A Registrant's name in the Register shall be the Registrant's full name and consistent with the name of the Registrant as it appears on the Registrant's degree of medicine, in the case of a Physician Registrant, or the Registrant's physician assistant degree, in the case of a PA Registrant, in each case as supported by documentary evidence satisfactory to the College. 4. Sections 21.2.1(e) and (h) of the CPSO By-laws are revoked and substituted with the following: **21.2 Additional Register Content** 21.2.1 For purposes of paragraph 20 of subsection 23(2) of the Code, the Register shall contain the following additional information with respect to each Registrant: … (e) in addition to the Registrant's business address, other locations at which the Registrant practises medicine, if a Physician Registrant, or practises as a physician assistant, if a PA Registrant, reported by the Registrant to the College; … (h) in the case of a Physician Registrant, the name of the medical school from which the Registrant received their	

Reference	Motions Carried	Status
	degree in medicine, or in the case of a PA Registrant, the name of the physician assistant training program from which the Registrant received their physician assistant degree, and in each case, the year in which the Registrant obtained the degree; 5. Section 23.1.3(b) of the CPSO By-laws is revoked and substituted with the following: **23.1 Notification Required by Registrants** 23.1.3 The College may at any time and from time to time request information from its Registrants. In response to each such request, each Registrant shall accurately and fully provide the College with the information requested using the Member Portal, or such other form or method specified by the College, by the due date set by the College. A College request for Registrant information may include the following: … (b) the address of all locations at which the Registrant practises medicine, if a Physician Registrant, or practises as a physician assistant, if a PA Registrant, in each case together with a description or confirmation of the services and clinical activities provided at all locations at which the Registrant practises; Explanatory Note: This proposed by-law must be circulated to the profession. **CARRIED**	

MARCH 2025

Title:	Q1 2026 Meeting Dates (For Information)
Main Contact:	Cameo Allan, Director, Governance

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- The Board of Directors (Board) is provided with the CPSO meeting dates for Q1 of 2026.

Current Status & Analysis

- In the spirit of continuous improvement, a new model of scheduling meetings on a quarterly rolling basis was started in 2024. This gives Board Directors and staff further advance notice of upcoming Governance & Nominating Committee (GNC), Finance & Audit Committee, Executive Committee and Board of Directors meetings.

- The GNC meetings are tentatively scheduled as the Governance Office may adjust based on learnings from the first province-wide election cycle taking place this year.

- Below are the 2026 Q1 meeting dates, reviewed by the Executive Committee at its February 11, 2025, meeting:

January

M	T	W	T	F
			1 New Year's Day	2
5	6 EC-V	7	8	9
12	13	14	15	16
19	20	21	22	23
26	27 FAC-V	28	29	30

February

M	T	W	T	F
2	3 GNC-V	4	5	6
9	10 EC	11	12	13
16 Family Day	17	18	19	20
23	24	25	26	27

March

M	T	W	T	F
2	3	4	5 BOD	6 BOD
9	10 GNC-V	11	12	13
16	17	18	19	Eid al-Fitr 20
March Break (Mar 16-20)				
23	24	25	26	27
30	31			

BOD	Board of Directors
EC	Executive
EC-V	Executive-Virtual
GNC-V	Governance & Nominating-Virtual (tentative)
FAC-V	Finance & Audit-Virtual
	Stat/religious holidays/March break

MARCH 2025

Title:	2024 College Performance Measurement Framework (For Information)
Main Contact:	Heather Webb, Manager of Communications

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- The Board is being provided with CPSO's 2024 College Performance Measurement Framework (CPMF) prior to submission to the Ministry of Health. Please use this link to access the draft 2024 CPMF Report.

Current Status & Analysis

- Since 2020, the Ministry of Health has required all health regulatory Colleges to complete a CPMF report annually to provide standardized information about each College's activities and processes. CPSO's CPMF reports for the last four years are available on CPSO's website.

- The Ministry has indicated that the information provided will be used to strengthen their oversight role of the Colleges. In 2020 and 2021, the Ministry developed Summary Reports of key findings regarding the Colleges' collective performance, strengths and areas of improvement. A Summary Report is available online, but it is undated and may be from a previous year.

- There were no updates or changes to the 2024 CPMF report template from 2023. In some instances, the Ministry permitted Colleges to respond "met in 2023 and continues to meet in 2024" and we have taken this opportunity where available.

- For questions requiring a more fulsome answer, our responses summarized, built upon, and updated information already provided in previous years.

- The CPMF is divided into two parts. In Part 1: Measurement Domains (narrative-based questions), the 2024 report shows how CPSO was able to fulfill the Ministry's requirements in all seven Measurement Domains while meeting the priorities of the Strategic Plan.

- In Part 2: Statistical Data, the type of data required and the method in which it must be supplied is unique to the CPMF and does not always align with how the Key Performance Indicators are reported to the Board. Nevertheless, staff have taken the opportunity to align the data where possible and provide relevant context where there appears to be a divergence.

    - In one instance, certain data points required by the CPMF are not collected, coded or applicable in CPSO's context. In this case, the relevant field has been left blank with an explanation for context.

- Following the Board meeting, the final report will be posted online and submitted to the Ministry to meet the March 31, 2025 deadline.

MARCH 2025

Title:	Review Feedback and Board Discussion: *Treatment of Self, Family Members, and Others Close to You* Draft Policy (For Discussion)
Main Contacts:	Tanya Terzis, Manager, Policy & Governance Lynn Kirshin, Senior Policy Analyst Laura Rinke-Vanderwoude, Policy Analyst
Attachments:	**Appendix A:** Draft *Treatment of Self, Family Members, and Others Close to You* Policy **Appendix B:** Draft *Advice to the Profession: Treatment of Self, Family Members, and Others Close to You*
Question for Board:	Does the Board of Directors have any feedback on the draft policy?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- A new draft of CPSO's *Physician Treatment of Self, Family Members, or Others Close to Them* policy (**Appendix A**) and companion document, *Advice to the Profession: Treatment of Self, Family Members, and Others Close to You* ("*Advice*") (**Appendix B**), were released for external consultation following the November 2024 Board meeting.

- The Board will be provided with an overview of the feedback received and will have an opportunity to discuss the draft policy at the Board meeting.

Current Status and Analysis

- The current *Physician Treatment of Self, Family Members, or Others Close to Them* policy generally only allows physicians to treat family members or others close to them for minor conditions or in emergencies, and only when no other health care provider is readily available. The current policy and *Advice* were revised in response to preliminary consultation feedback and input from the Policy Working Group. These revisions resulted in an innovative approach among medical regulators to respond to the access to care crisis. Key revisions in the draft policy included:

    - Expanding the circumstances where physicians can treat themselves, family members, and others close to them by expanding the definition of emergency treatment;

    - Clarifying who is considered close to a physician by setting out factors that the physician can consider to determine whether their professional judgment would be reasonably affected by the relationship; and

    - Including provisions to enable physicians to treat family members or others close to them beyond emergency treatment and minor conditions in communities with limited treatment options, including Indigenous and remote communities.

- The *Advice* document was updated to provide further clarity and guidance about circumstances in which a physician can provide treatment to family members and those who are close to them. This includes a section highlighting the policy's application in Indigenous communities and examples of emergency and minor treatment.

- An overview of the feedback is provided in the Policy Report and will be shared during the Board meeting.

- Small group discussions will take place at the Board meeting so that Board Directors have an opportunity to provide feedback on the drafts that were released for consultation. The Board's feedback will be considered by the Policy Working Group and will inform future revisions to the drafts.

TREATMENT OF SELF, FAMILY MEMBERS, AND OTHERS CLOSE TO YOU

Policies of the College of Physicians and Surgeons of Ontario ("CPSO") set out expectations for the professional conduct of physicians practising in Ontario. Together with the *Essentials of Medical Professionalism* and relevant legislation and case law, they will be used by CPSO and its Committees when considering physician practice or conduct.

Within policies, the terms 'must' and 'advised' are used to articulate CPSO's expectations. When 'advised' is used, it indicates that physicians can use reasonable discretion when applying this expectation to practice.

Additional information, general advice, and/or best practices can be found in companion resources, such as *Advice to the Profession* documents.

Definitions

Treatment: Anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic, or other health-related purpose. This includes but is not limited to performing any controlled act[1]; ordering and performing tests (including blood tests and diagnostic imaging); providing a course of treatment, plan of treatment, or community treatment plan.[2]

Family member: An individual with whom the physician has a familial connection. This includes but is not limited to the physician's spouse or partner, parent, child, sibling, members of the physician's extended family, or those of the physician's spouse or partner (e.g., in-laws).

Others Close to Them: Individuals who have a close or personal relationship with the physician where the nature of the relationship could reasonably affect the physician's professional judgment as set out in Provision 1a.

Policy

1. When their professional judgment is considered reasonably affected, physicians **must only** provide treatment to themselves, family members, and others close to them in accordance with the exceptions set out in this policy.

    a. If any of the following factors apply, a physician's professional judgment is considered reasonably affected, even if the physician believes they would provide objective care:

    - There are barriers to or discomfort in sharing or hearing sensitive information;
    - There are factors that may affect the decision-making of the physician or the individual receiving treatment, for example, an individual receiving treatment feeling obligated to accept a physician's recommendations about treatment decisions;

[1] Controlled acts for physicians, as set out in s. 4 of the *Medicine Act,* S.O. 1991, c. 30.
[2] This definition is adapted from the *Health Care Consent Act.*

- The physician may be hesitant to make mandatory reports about the individual receiving care;
- The individual receiving treatment may be hesitant to voice concerns about the treatment provided or pursue legal options; or
- Any other factors that could cause a physician to lose objectivity or fail to meet the standard of care.[3]

Emergency Treatment

In this policy, "emergency treatment" is treatment that is necessary in a timely manner to prevent significant harm, suffering and/or deterioration.

2. Physicians **must only** provide emergency treatment to themselves, family members, and others close to them when no other qualified health-care professional is readily available.

a. Where additional or ongoing treatment is necessary, physicians **must** transfer treatment of the individual to another qualified health-care professional as soon as is practical.[4]

Treatment for Minor Conditions[5]

A "minor condition" is a health condition that can be managed with minimal, short-term treatment and usually does not require ongoing care or monitoring. In addition, the treatment of the condition is unlikely to mask a more significant underlying condition.

3. Physicians **must only** provide treatment for minor conditions to themselves, family members, and others close to them when no other qualified health-care professional is readily available.

a. Where additional or ongoing treatment is necessary, physicians **must** transfer treatment of the individual to another qualified health-care professional as soon as is practical.[6]

Treatment of Sexual or Romantic Partners

Ontario law defines who is a patient for the purpose of determining whether sexual abuse has occurred between a physician and a patient.[7] For the purposes of determining sexual abuse, a person is defined as a patient when:

1. the physician charges or receives a payment for health care services provided;
2. the physician contributes to a health record or file for the person;
3. the person has consented to a health care service recommended by the physician; or,
4. the physician prescribes a drug for which a prescription is needed to the person.

[3] For more information about other factors which determine whether individuals may be considered close to you, see the *Advice to the Profession: Treatment of Self, Family members, and Others Close to You* document.
[4] This also includes virtual care options, where appropriate.
[5] For the purposes of this policy, "minor condition" does not include providing sick notes or completing insurance claims for themselves, family members, or others close to them.
[6] This also includes virtual care options, where appropriate.
[7] S. 1(6) of the *Health Professions Procedural Code* (*Code*) under the *Regulated Health Professions Act, 1991* (*RHPA*) and O. Reg. 260/18 under the *RHPA* provide a definition of who is a patient for the purpose of determining whether sexual abuse has occurred between a physician and a patient. The *Code* also specifies that a person continues to be considered a patient for the purposes of findings of sexual abuse for one year after the conclusion of the physician-patient relationship.

4. Providing treatment to someone with whom a physician is sexually or romantically involved, including a spouse or partner, may result in a finding that the physician engaged in sexual abuse of a patient[8], if the treatment exceeds what is permissible in the legislation and as set out in this policy (emergency treatment or treatment of a minor condition). Physicians **must not** provide treatment to a spouse, partner, or anyone else with whom they are sexually or romantically involved beyond emergency treatment and treatment of minor conditions as set out in this policy.

Practising in Communities with Limited Treatment Options

5. CPSO recognizes that in some small communities, there may be family members or others close to the physician who do not have alternative options for treatment. If faced with these circumstances, the physician may provide treatment beyond emergency treatment or treatment for minor conditions to people other than a sexual or romantic partner and **must** document the circumstances in the patient's medical record, including why treatment was provided.

    a. Where additional or ongoing treatment is necessary, physicians **must** make every reasonable effort to transfer care to another qualified health-care professional as soon as is practical.

6. When determining if a person does not have alternative options for treatment, physicians **must** consider:

    a. Whether the treatment is within another available qualified health-care professional's scope of practice;
    b. The geographical distance and/or the person's ability to travel to other treatment options;
    c. Whether virtual care can be used to provide treatment; and,
    d. Any personal factors that would present a significant barrier to obtaining treatment[9] from another available qualified health-care professional, **and** which could not be managed through community supports or reasonable accommodations.

7. Despite Provision 5, physicians **must not:**

    a. Provide treatment outside of an emergency or minor condition to an individual with whom they have a sexual or romantic relationship.[10]
    b. Provide intimate examinations[11] outside of emergency treatment to family members; and/or,
    c. Provide psychotherapy to family members.

Prescribing or Administering Drugs

8. Physicians **must not** prescribe or administer the following for themselves, family members, or others close to them:

[8] See footnote 7.
[9] For examples of personal factors that would present a significant barrier to obtaining treatment, please see the *Advice to the Profession: Treatment of Self, Family Members, and Others Close to You* document.
[10] Please see footnote 7.
[11] Intimate examinations include breast, pelvic, genital, perineal, perianal and rectal examinations of patients.

- narcotics,[12,13]
- controlled drugs or substances,[14,15] or
- monitored drugs.[16]

Facilitating Continuity of Care

9. If a physician provides treatment under this policy, they **must** take reasonable steps to facilitate continuity of care where necessary.

[12] Narcotics are defined in s. 2 of the *Narcotic Control Regulations*, C.R.C. c. 1041, enacted under the *Controlled Drugs and Substances Act,* S.C. 1996, c. 19 (hereafter the *CDSA*) *CDSA*: the term 'narcotics' includes opioids.
[13] Regulations under the *CDSA* prohibit physicians from prescribing or administering narcotics, or controlled drugs or substances for anyone other than a patient whom the physician is treating in a professional capacity, for example, in an Emergency Department. There are no exceptions under the *CDSA* for prescribing or administering these drugs or substances to non-patients. See s. 53(2) of the *Narcotic Control Regulations* C.R.C. c. 1041, and s. 58 of the *Benzodiazepines and Other Targeted Substances Regulations*, SOR/2000-217, under the *CDSA.*
[14] Controlled drugs and substances are defined in s. 2(1) of the *CDSA* and mean a drug or substance included in Schedule I, II, III, IV or V of the Act.
[15] Please see footnote 13.
[16] The Ontario Ministry of Health (Ministry) monitors a number of prescription narcotics and other controlled substance medications as part of its Narcotics Strategy. A list of monitored drugs is available on the Ministry's website https://www.ontario.ca/page/narcotics-monitoring-system#section-1. See also s. 2 of the *Narcotics Safety and Awareness Act*, 2010, S.O. 2010, c. 22 for a definition of 'monitored drug'.

ADVICE TO THE PROFESSION: TREATMENT OF SELF, FAMILY MEMBERS, AND OTHERS CLOSE TO YOU

Advice to the Profession companion documents are intended to provide physicians with additional information and general advice in order to support their understanding and implementation of the expectations set out in policies. They may also identify some additional best practices regarding specific practice issues.

Physicians may find themselves in circumstances where they must decide whether it would be appropriate to provide treatment for themselves, family members, or others close to them, including friends, colleagues, and staff.

While physicians may have a genuine desire to deliver the best possible treatment, research suggests that a physician's ability to maintain emotional and clinical objectivity may be compromised when treating themselves or others close to them. This can impact the physician's ability to meet the standard of care and compromise the quality of treatment provided to the individual.

This document is intended to help physicians interpret the expectations set out in the *Treatment of Self, Family Members, and Others Close to You* policy and provide guidance about how these expectations can be met.

How can objectivity and professional judgment be compromised when providing treatment for myself, family members or others close to me?

Research demonstrates that your objectivity and the quality of care you provide can be compromised when treating yourself or people close to you[1].

[1] See for example:

- Francisca Beigel, et al. "A systematic review documenting reasons whether physicians should provide treatment to their family and friends" (2022) Family Practice, cmac142, Oxford Academic (3 January 2023), online: https://doi.org/10.1093/fampra/cmac142.
- Vijayalakshmi S, Ramkumar S, Rajsri T, et al. "A Doctor in the House, An Ethical Consideration on Treating Their Family Members: A Mixed-Method Study" (August 27, 2023). Cureus 15(8): e44230. DOI 10.7759/cureus.44230.
- Bernard Dickens, "Ethical issues in treating family members and close friends" (2016) International Journal of Gynecology and Obstetrics 133, 247-248 (2016), online: https://obgyn.onlinelibrary.wiley.com/doi/10.1016/j.ijgo.2016.02.002
- Joseph J. Fins, "Family Portrait" (2018) Narrative Inquiry in Bioethics, Vol. 8 N. 1, p. 4-6 (Spring 2018), online: https://muse.jhu.edu/article/690189

Quality of care can be impacted in a number of different ways by compromised objectivity, including but not limited to the physician:

- feeling uncomfortable discussing sensitive issues, including the individual's personal medical history. This can also apply to the individual being treated. This is particularly relevant when the issue involves sexual health and behaviour, drug use, mental health issues, or abuse or neglect.
- feeling obligated or pressured to treat problems that are beyond their expertise or training, or to prescribe drugs that are addicting/habituating, including narcotics or controlled substances.
- having difficulty recognizing the need to obtain informed consent and to respect the individual's decision-making autonomy.
- having difficulty recognizing that the duty of confidentiality applies the same way it would for a patient. For example, the physician may experience pressure to disclose confidential information if others close to the physician insist on knowing 'what is going on' in relation to an individual's health.
- being reluctant to make a mandatory report (e.g., an impairment affecting the individual's ability to drive, or a suspicion of child abuse).

How do I know if there are other factors that could cause someone to be considered someone close to me?

Physicians need to use their professional judgment when determining whether there are other factors not set out in the policy that may affect the quality of care an individual receives. If you think that, for any reason, your objectivity may be reasonably affected, you should consider the person close to you.

Some common examples of other factors include:

- A physician being hesitant to have a frank and open consent discussion or propose specific treatment options;
- External pressure, either from the person receiving care or mutual acquaintances, to practise outside of a physician's scope or expertise or provide care beyond what they would normally provide to a patient in the same situation;
- Pressure to disclose confidential information to third parties; or,

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- Solomiya Grushchak, Jane M. Grant-Kels, "Sweetheart, you should have that looked at: Ethical implications of treating family members" (February 2019). J Am Acad Dermatol Vol. 90, N. 2. (2019). DOI: 10.1016/j.jaad.2017.12.067
- Helene Hill, Matthew Hill, "When your mother wants a script: The ethics of treating family members" (2011). JAAPA 24(2) p. 59-60 (February 2011). DOI: 10.1097/01720610-201102000-00012
- Katherine J. Gold, et al. "No Appointment Necessary? Ethical Challenges in Treating Friends and Family" (2014) N Engl J Med 2014; 371:1254-1258.
- Kathy Oxtoby, "Doctors' Self Prescribing" BMJ Careers (10 January 2012), online: BMJ Careers.

- Property or financial ties to an individual.

Why am I limited in the type of treatment I can provide to someone with whom I am sexually or romantically involved, including my spouse or partner?

If a physician provides care or treatment to a sexual or romantic partner beyond what is set out in legislation and the *Treatment of Self, Family Members and Others Close to You* policy, a physician may be found to have committed an act of professional misconduct, specifically, a finding of sexual abuse.[2] The permitted care is limited to emergency treatment or treatment of a minor condition and when no other qualified health-care professional is readily available, requiring the transfer of treatment to another qualified health-care professional as soon as is practical.

The *RHPA* also contains mandatory penalties, including the revocation of a physician's certificate of registration, for several forms of sexual abuse. At an Ontario Physicians and Surgeons Discipline Tribunal hearing, the Tribunal is required to impose these mandatory penalties (up to and including revocation or a significant period of suspension, in some cases) even if there are mitigating circumstances.

What are some examples of minor conditions under this policy?

Depending on patient-specific factors, a few examples of minor conditions may include:

- Minor skin conditions (e.g., eczema, contact dermatitis, insect bites);
- Minor uncomplicated infections (e.g., conjunctivitis, otitis media, pharyngitis, cystitis); and,
- Minor injuries (e.g., small lacerations, bruises, sprains)

Patient-specific factors include but are not limited to:

- Age;
- Past medical history; and,
- The severity of the symptoms.

For example, a laceration on an elderly person with a blood clotting disorder may not be considered a minor condition. In contrast, a similar laceration on a healthy young adult may be considered a minor condition.

Physicians are advised to use their professional judgment to determine whether a person has a minor condition, and whether treating the minor condition would be appropriate given their scope of practice.

[2] The *Regulated Health Professions Act, 1991* (*RHPA*) and its regulations prohibit the sexual abuse of patients and provide a definition of who is a patient for the purposes of determining whether sexual abuse has occurred.

What is emergency treatment under this policy?

Emergency treatment is the treatment of a condition which should be initiated in a timely manner (e.g., within 24 hours) to prevent significant harm, suffering and/or deterioration. A few examples of conditions which may require emergency treatment include severe asthma, heart failure, and fractures or dislocations.

When would a person be considered to have alternative treatment options?

Examples of when a person would have other treatment options include having:

- The ability to travel to another community within a reasonable distance where they could obtain care (even if less convenient);
- Access to virtual care options that meet their treatment needs; or,
- The ability to be treated by another qualified health-care professional provider despite personal preferences (e.g., religious, language, ethnicity, or gender preferences).

In contrast, a person may not have other treatment options if:

- They are not reasonably able to travel to another qualified health-care professional and cannot access virtual treatment options (e.g., people experiencing homelessness);
- The only available physicians are those with whom the person has had a significant breakdown in the physician-patient relationship; or,
- There are severe systemic or other issues affecting the person's trust in the health-care system that may reasonably prevent the person from seeking care elsewhere (e.g., Indigenous people or individuals with a history of sexual abuse).

How does this policy apply to physicians practising in Indigenous communities?

CPSO recognizes that physicians practising in Indigenous communities may be interconnected with or related to the entire community. Additionally, systemic inequality has deeply affected the trust many Indigenous people have in the health-care system.

Physicians practising in Indigenous communities can provide emergency treatment or treatment for minor conditions in accordance with the policy. They may also consider whether a broader scope of treatment would be appropriate because a person may have no other treatment options. One aspect that can be considered when determining if there are alternative treatment options is whether there are personal factors that would present a significant barrier to obtaining treatment from any other available qualified health-care professional which cannot be managed through community supports or reasonable accommodations.

In the case of Indigenous people, deep and pervasive mistrust of other qualified health-care providers may mean that they do not have any other viable alternative treatment options. Therefore, physicians who are trusted by Indigenous community members can provide care under this exception in the policy when appropriate.

Am I allowed to provide informal medical advice?

Yes, physicians may provide informal medical advice that does not fall under the definition of "treatment" in this policy. For example, a physician may advise a family member to see a health-care professional for a worrisome symptom or help them understand medical information they have been given by another health-care professional.

Can I prescribe narcotics, controlled drugs or substances, or monitored drugs to family members or someone close to me?

You can only prescribe these drugs if your family members or those who are close to you, become your patient, for example, if you are providing treatment in an Emergency Department. Factors to consider before prescribing include consideration of treatment options in the community and whether it is within the standard of care to prescribe these drugs/substances.

Board Motion

Motion Title	Motion to Go In-Camera
Date of Meeting	March 6, 2025

It is moved by_____, and seconded by_____, that:

The Board of Directors[1] of the College of Physicians and Surgeons of Ontario exclude the public from the part of the meeting immediately after this motion is passed, under clauses 7(2)(b) and (d) of the Health Professions Procedural Code (set out below).

Exclusion of public

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

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

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

[1] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulated Health Professions Act*) and the *Medicine Act*.

MARCH 2025

Title:	By-law Amendments: PA Register and Fees for Emergency Class Certificate of Registration (For Decision)
Main Contacts:	Marcia Cooper, Senior Corporate Counsel and Privacy Officer Samantha Tulipano, Director, Registration and Membership Tanya Terzis, Manager, Policy & Governance Carolyn Silver, Chief Legal Officer
Attachment:	**Appendix A:** Proposed By-law Amendments
Question for Board:	Does the Board approve the proposed By-law amendments?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- Proposed By-law amendments relating to the Physician Assistant (PA) Register and fees for PA Emergency Class Certificate of Registration are being brought back after circulation for approval by the Board.

- The proposed By-law amendments facilitate and support the regulation of PAs and transparency, both of which are in the public interest.

Current Status & Analysis

- PAs will start to be regulated as members of the CPSO on April 1, 2025.

- At the November 2024 Board Meeting, the Board approved circulation to the profession of proposed By-law amendments relating to the PA Register and Fees for PA Emergency Class Certificate of Registration.
- The By-law amendments are proposed to capture PA information in the public register as well as information PAs are required to provide to CPSO. Most of these changes relate to references to PA education and degrees.

- By-law amendments are also proposed to add the application and annual renewal fees applicable to certificates of registration authorizing practice in emergency circumstances as PAs.

    - The fees for the emergency circumstances certificates will be $300 for the application and $425 for annual renewal, the same as the application and annual fees for the certificate of registration authorizing practice as PAs.[1]

- No feedback about the proposed By-law amendments was received from the circulation.

- Accordingly, the Board is asked to approve the proposed By-law amendments (see **Appendix A** for redline).

[1] This is consistent with the approach taken for the physician emergency circumstances class.

PROPOSED AMENDMENTS TO REGISTER AND REGISTRANT INFORMATION BY-LAWS FOR PHYSICIAN ASSISTANTS

17.1 Application Fees

17.1.1 A person who submits an application for a certificate of registration or authorization shall pay an application fee. The application fees are as follows:

…

(d) for a certificate of registration authorizing practice as a physician assistant or for a certificate of registration authorizing practice in emergency circumstances for physician assistants, $300;

...

18.1 Annual Fees

18.1.2 Annual fees as of June 1, 2018, are as follows:

…

(c) for a holder of a certificate of registration authorizing practice as a physician assistant or a certificate of registration authorizing practice in emergency circumstances for physician assistants, $425; and

…

ARTICLE 21 REGISTER

21.1 Registrant Names and Addresses

21.1.1 A Registrant's name in the Register shall be the Registrant's full name and consistent with the name of the Registrant as it appears on the Registrant's degree of medicine, in the case of a Physician Registrant, or the Registrant's physician assistant degree, in the case of a PA Registrant, in each case as supported by documentary evidence satisfactory to the College.

…

21.2 Additional Register Content

21.2.1 For purposes of paragraph 20 of subsection 23(2) of the Code, the Register shall contain the following additional information with respect to each Registrant:

…

(e) in addition to the Registrant's business address, other locations at which the Registrant practises medicine, if a Physician Registrant, or practises as a physician assistant, if a PA Registrant, reported by the Registrant to the College;

…

(h) in the case of a Physician Registrant, the name of the medical school from which the Registrant received their~~the Registrant's~~ degree in medicine, or in the case of a PA Registrant, the name of the physician assistant training program from which the Registrant received their physician assistant degree, and in each case, ~~and~~ the year in which the Registrant obtained the degree;

…

ARTICLE 23 REGISTRANT INFORMATION

23.1 Notification Required by Registrants

23.1.3 The College may at any time and from time to time request information from its Registrants. In response to each such request, each Registrant shall accurately and fully provide the College with the information requested using the Member Portal, or such other form or method specified by the College, by the due date set by the College. A College request for Registrant information may include the following:

…

(b) the address of all locations at which the Registrant practises medicine, if a Physician Registrant, or practises as a physician assistant, if a PA Registrant, in each case together with a description or confirmation of the services and clinical activities provided at all locations at which the Registrant practises ~~medicine~~;

Board Motion

Motion Title	For Approval: By-law Amendments re PA Register and Fees for Emergency Class Certificate of Registration
Date of Meeting	March 7, 2025

It is moved by_____, and seconded by_____, that:

The Board of Directors[1] of the College of Physicians and Surgeons of Ontario amends the CPSO By-laws (By-law No. 168) as set out below:

1. Paragraph (d) of Section 17.1.1 of the CPSO By-laws is revoked and substituted with the following paragraph (d):

17.1.1 A person who submits an application for a certificate of registration or authorization shall pay an application fee. The application fees are as follows:

…

(d) for a certificate of registration authorizing practice as a physician assistant or for a certificate of registration authorizing practice in emergency circumstances for physician assistants, $300;

2. Paragraph (c) of Section 18.1.2 of the CPSO By-laws is revoked and substituted with the following paragraph (c):

18.1.2 Annual fees as of June 1, 2018, are as follows:

…

(c) for a holder of a certificate of registration authorizing practice as a physician assistant or a certificate of registration authorizing practice in emergency circumstances for physician assistants, $425; and

(Continued on next page)

[1] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulated Health Professions Act*) and the *Medicine Act*.

3. Section 21.1.1 of the CPSO by-laws is revoked and substituted with the following:

21.1.1 A Registrant's name in the Register shall be the Registrant's full name and consistent with the name of the Registrant as it appears on the Registrant's degree of medicine, in the case of a Physician Registrant, or the Registrant's physician assistant degree, in the case of a PA Registrant, in each case as supported by documentary evidence satisfactory to the College.

4. Paragraphs (e) and (h) of Section 21.2.1of the CPSO By-laws are revoked and substituted with the following paragraphs (e) and (h):

21.2.1 For purposes of paragraph 20 of subsection 23(2) of the Code, the Register shall contain the following additional information with respect to each Registrant:

…

(e) in addition to the Registrant's business address, other locations at which the Registrant practises medicine, if a Physician Registrant, or practises as a physician assistant, if a PA Registrant, reported by the Registrant to the College;

…

(h) in the case of a Physician Registrant, the name of the medical school from which the Registrant received their degree in medicine, or in the case of a PA Registrant, the name of the physician assistant training program from which the Registrant received their physician assistant degree, and in each case, the year in which the Registrant obtained the degree;

5. Paragraph (b) of Section 23.1.3 of the CPSO By-laws is revoked and substituted with the following paragraph (b):

23.1.3 The College may at any time and from time to time request information from its Registrants. In response to each such request, each Registrant shall accurately and fully provide the College with the information requested using the Member Portal, or such other form or method specified by the College, by the due date set by the College. A College request for Registrant information may include the following:

…

(b) the address of all locations at which the Registrant practises medicine, if a Physician Registrant, or practises as a physician assistant, if a PA Registrant, in each case together with a description or confirmation of the services and clinical activities provided at all locations at which the Registrant practises;

MARCH 2025

Title:	Alternative Pathways to Registration for Physicians Trained in the United States Directive (For Decision)
Main Contact:	Samantha Tulipano, Director, Registration & Membership Services
Attachment:	**Appendix A:** Alternative Pathways to Registration for Physicians Trained in the United States Directive
Question for Board:	Does the Board approve the Directive?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- The Board is presented with a directive for the registration policy *Alternative Pathways to Registration for Physicians Trained in the United States.*

- The proposed directive aligns with the College's strategic plan for continuous improvement.

Current Status & Analysis

- In November 2024, the amendment to the "Alternative Pathways to Registration for Physicians Trained in the United States" policy was approved by the Board for circulation in accordance with Section 22.1 of the *Health Professions Procedural Code* (the *Code*).

- The Board also moved that the Executive Committee were permitted to approve the final policy (subject to feedback received) pursuant to its authority under Section 12 of the *Code* and Section 30 of the General By-Law. The Executive Committee approved the final policy at its meeting on February 11, 2025.

- Under the amended policy, physicians who hold a restricted certificate of registration under Pathway A, and have practiced in Ontario for five years, may apply for a certificate of registration authorizing independent practice, if all other requirements for registration are met.

- Since October 2018 the Registration Committee issued a series of Directives to the Registrar which provide that, if an applicant has satisfied the requirements of a particular policy, and all other requirements for registration are met, including the non-exemptible requirements set out in Section 2(1) of Ontario Regulation 865/93 (the "Registration Regulation"), the Committee considers the relevant section of the Registration Regulation to be satisfied, thus allowing for the processing of these applications at the staff level, without referral to the Registration Committee.

- Applicants applying under Pathway A, Pathway B, or Pathway C for a restricted certificate of registration in Ontario will continue to require approval by the Registration Committee. However, we are asking that the Registration Committee issue a Directive to the Registrar with respect to the recent amendment to the "Alternative Pathways to Registration for Physicians Trained in the United States" policy, to enable the registration of applicants who satisfy the Directive without referral to the Registration Committee.

Appendix A

Specific Direction to the Registrar from the Registration Committee
Alternative Pathways to Registration for Physicians Trained in the United States

Ontario Regulation 856/93 made under the *Medicine Act, 1991* (the "Registration Regulation") sets out the standards and qualifications for a certificate of registration authorizing independent practice as follows:

3. (1) The standards and qualifications for a certificate of registration authorizing independent practice are as follows:

1. The applicant must have a degree in medicine.
2. The applicant must have successfully completed Part 1 and Part 2 of the Medical Council of Canada Qualifying Examination.
3. The applicant must have completed one of the following:
    i. A clerkship at an accredited medical school in Canada which meets the criteria of a clerkship in clause (a) of the definition of "degree in medicine" in section 1.
    ii. A year of postgraduate medical education at an accredited medical school in Canada.
    iii. A year of active medical practice in Canada which includes significant clinical experience pertinent to the applicant's area of medical practice.
4. The applicant must have certification by examination by the Royal College of Physicians and Surgeons of Canada or by the College of Family Physicians of Canada.

In accordance with the policy Alternative Pathways to Registration for Physicians Trained in the United States ("Pathways Policy"), approved by the Board, the Registration Committee considers paragraphs 2, 3 and 4 of subsection 3(1) of the Registration Regulation to be satisfied if:

1. The applicant has held a certificate of registration issued under Pathway A of the Pathways Policy and practiced continuously in Ontario for 5 or more years and, during the 5-year period immediately preceding the application:
    a. The term, condition and limitation imposed by order of the Registration Committee authorizes the member to practice independently limited to a specified scope of practice as ordered by the Registration Committee; and
    b. No other terms, conditions or limitations are imposed on the certificate of registration, by any other Committee including the Registration Committee; and
2. The applicant satisfies all other registration requirements, including non-exemptible registration requirements, for an independent practice certificate of registration.

The Registration Committee approves the Registrar imposing the following terms, conditions and limitations on the applicant's certificate of registration:

1. Dr. {FULL NAME} may practice medicine only in the areas in which {FULL NAME} is educated and experienced.

Board Motion

Motion Title	Final approval: Registration Policy Directive – "*Alternative Pathways to Registration for Physicians Trained in the United States*"
Date of Meeting	March 7, 2025

It is moved by_____, and seconded by_____, that:

The Board of Directors[1] of the College of Physicians and Surgeons of Ontario approves the new registration policy directive, "*Alternative Pathways to Registration for Physicians Trained in the United States"*, as a directive of the College (a copy of which forms Appendix " " to the minutes of this meeting).

[1] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulated Health Professions Act*) and the *Medicine Act*.

MARCH 2025

Title:	Review Feedback and Board Discussion: Accepting New Patients Draft Policy (For Discussion)
Main Contacts:	Tanya Terzis, Manager, Policy & Governance Mike Fontaine, Policy Analyst Kaitlin McWhinney, Junior Policy Analyst
Attachments:	**Appendix A:** Draft Accepting New Patients Policy **Appendix B:** Draft Advice to the Profession: Accepting New Patients
Question for Board:	Does the Board of Directors have any feedback on the draft policy?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- A new draft of CPSO's Accepting New Patients policy (**Appendix A**) and companion document, Advice to the Profession: Accepting New Patients ("Advice") (**Appendix B**), were released for external consultation following the November 2024 Board meeting.
- The Board will be provided with an overview of the feedback received and will have an opportunity to discuss the draft policy at the Board meeting.

Current Status & Analysis

- The current Accepting New Patients policy and Advice were revised in response to preliminary consultation feedback and input from the Policy Working Group. Key revisions included:
    - More strongly emphasizing the principles (e.g., fairness and transparency) that must inform how physicians accept new patients;
    - Explicitly setting out when physicians cannot refuse to accept new patients into their practice (e.g., due solely to a patient having complex or chronic health needs) and when it is permissible for them to refuse to accept new patients (e.g., the physician serves a defined target population);
    - Allowing physicians to use scope-based criteria for accepting new patients, and no longer requiring physicians to use "first-come, first-served" as a standard approach to accepting new patients to give physicians added flexibility in determining who they are able to accept into their practice;
    - Expanding the patient populations for whom physicians can prioritize access to care (including older people, people experiencing homelessness or poverty, and those living in rural areas); and
    - Clarifying expectations related to using introductory meetings (e.g., "meet and greets"), including around transparency (e.g., disclosing the purpose of these meetings) and communication (e.g., informing patients as to whether they have been accepted following the meeting, and, if not, the reasons why).
- The Advice document was expanded to address physician and patient concerns related to catchment areas, patients seeking second opinions, and physician responsibilities when using self-managed waitlists.
- Consultation feedback on the draft policy and Advice was largely positive. An overview of the feedback is provided in the Policy Report and will be shared during the Board meeting.
- Small group discussions will take place at the Board meeting so that Board Directors have an opportunity to provide feedback on the drafts that were released for consultation. The Board's feedback will be considered by the Policy Working Group and will inform future revisions to the drafts.

ACCEPTING NEW PATIENTS

Policies of the College of Physicians and Surgeons of Ontario ("CPSO") set out expectations for the professional conduct of physicians practising in Ontario. Together with *Essentials of Medical Professionalism* and relevant legislation and case law, they will be used by CPSO and its Committees when considering physician practice or conduct.

Within policies, the terms 'must' and 'advised' are used to articulate CPSO's expectations. When 'advised' is used, it indicates that physicians can use reasonable discretion when applying this expectation to practice.

Additional information, general advice, and/or best practices can be found in companion resources, such as *Advice to the Profession* documents.

Definitions

Discrimination: An act, communication, or decision that results in the unfair treatment of an individual or group, for example, by excluding them, imposing a burden on them, or denying them a right, privilege, benefit, or opportunity enjoyed by others. Discrimination may be direct and intentional; it may also be indirect and unintentional, where rules, practices, or procedures appear neutral but have the impact of disadvantaging certain groups of people.

Good Faith: A legal term that means an intention to act in a manner that is honest and decent. The term may be characterized as a sincere intention to deal fairly with others.

High or Complex Care Needs: High or complex care needs include, but are not limited to, conditions or needs requiring urgent care; chronic conditions or comorbidities, particularly those that are unmanaged; activity-limiting disabilities; and/or mental illnesses. Social determinants of health may also contribute to patients' high or complex care needs.

Introductory Meetings: Meetings used by physicians to share information about the practice, disclose information about their scope of practice and/or focused practice area, inform the patient of any criteria they have for accepting new patients, and/or determine in collaboration with the patient whether there is a good foundation for an effective therapeutic relationship. Introductory meetings are not typically used to provide medical care.

Policy

1. Physicians are permitted to decide:

   a. Whether their practice is accepting new patients;[1] and
   b. Which patients to accept into their practice.

These decisions **must** be made in good faith and in accordance with this policy.

2. Physicians must not discriminate against patients based on any protected grounds under the *Ontario Human Rights Code* when determining whether to accept them into their practice.[2]

[1] The expectations set out in this policy apply broadly to all physicians, including family physicians and specialists, and to those acting on their behalf. For instance, physicians may rely upon clinical managers and/or office staff to accept new patients on their behalf. Organizations may also act as a physician's representative in this context.
[2] The *Ontario Human Rights Code ("Code")* prohibits actions that discriminate against people based on protected grounds in protected social areas (including goods, services, and facilities, such as hospitals and health services). The protected

3. Physicians **must not** refuse to accept a patient solely on the basis that the patient has:

a. Complex or chronic health-care needs, unless those needs are beyond the physician's clinical competence, scope of practice, and/or focused practice area;
b. A history of prescribed opioids and/or psychotropic medication; [3]
c. Needs that require additional time to manage;
d. A physical or mental health condition or disability[4] that may require the physician to prepare and provide additional documentation or reports; or
e. Beliefs or ideologies which do not align with the physician's own and which may impact the patient's therapeutic choices.

4. Physicians are permitted to establish criteria for accepting new patients. These criteria **must**:

a. Be directly relevant to the physician's clinical competence, scope of practice, and/or focused practice area;[5]
b. Comply with the terms and conditions of the physician's practice certificate and associated practice restrictions, if applicable;
c. Be fair and promote equitable access to health-care services;
d. Be clearly communicated to any prospective patient seeking care; and
e. Be shared with CPSO, on request.

5. Where a physician refuses to accept a patient, the physician **must**:

a. Do so in good faith;
b. Clearly communicate the reasons for the refusal to the patient (or referring provider, as needed); and
c. Document the reasons for the refusal.

6. Given the broad scope of practice of primary care physicians, there are few occasions where scope of practice would be an appropriate ground to refuse a prospective patient. Once accepted into a primary care practice, should elements of the patient's health-care needs be outside of the physician's clinical competence and/or scope of practice, the physician **must not** abandon the patient.

a. Physicians **must** make a referral to another appropriate health-care provider for those elements of care that they are unable to manage directly.

7. Physicians are permitted to prioritize access to care for patients with high or complex care needs and those belonging to priority populations. Physicians **must** use their professional judgment to determine whether prioritizing or triaging patients is appropriate, taking into account the patient's health-care needs and any known social factors that may influence the patient's health outcomes.

grounds include age; ancestry, colour, race; citizenship; ethnic origin; place of origin; creed; disability; family status; marital status; gender identity; gender expression; receipt of public assistance; record of offences; sex; and sexual orientation. For more information see CPSO's *Human Rights in the Provision of Health Services* policy.

[3] Physicians are advised to consult CPSO's *Prescribing Drugs* policy for further information on blanket 'no narcotics' prescribing policies.

[4] Physicians should be aware that under the *Code*, the term 'disability' is interpreted broadly and covers a range of conditions. 'Disability' encompasses physical, mental and learning disabilities, mental disorders, hearing or vision disabilities, epilepsy, drug and alcohol dependencies, environmental sensitivities, and other conditions. The *Code* protects individuals from discrimination because of past, present and perceived disabilities.

[5] Physicians with a 'focused practice area' may include those with a commitment to one or more specific clinical practice areas, such as geriatrics, psychotherapy or adolescent health, or who serve a defined target population.

8. Physicians are permitted to prioritize the family members of current patients but **must** use their professional judgment to determine whether accepting family members is appropriate (e.g., it would reasonably assist in the provision of quality care).[6]

9. Physicians are permitted to use introductory meetings to meet with prospective patients and to determine the patients' needs but **must not** use introductory meetings or questionnaires to unfairly screen prospective patients.[7]

10. Physicians who use introductory meetings **must** inform patients of the purpose of the meeting, for example, that:

a. An introductory meeting is not typically used to provide medical care;[8] and
b. Offering a patient an introductory meeting does not mean that the patient has been accepted as a patient.

11. Physicians who use introductory meetings **must** inform patients in a timely manner whether they have or have not been accepted into the practice.

[6] While the policy permits physicians to prioritize family members of current patients, physicians are not required to do so. It may be inappropriate for physicians practising in certain specialties (e.g., psychiatry) to accept family members of current patients into their practice.
[7] Medical questionnaires include those administered in person or virtually by physicians or those acting on their behalf.
[8] Once a physician provides any medical service or care to a patient, a physician-patient relationship will have been established. In these cases, patients may reasonably assume that they have been accepted into the physician's practice.

ADVICE TO THE PROFESSION: ACCEPTING NEW PATIENTS

Advice to the Profession companion documents are intended to provide physicians with additional information and general advice in order to support their understanding and implementation of the expectations set out in policies. They may also identify some additional best practices regarding specific practice issues.

The establishment of trust between a physician and a patient can begin as early as when patients start seeking care. A patient's perception about whether a physician is accepting new patients in a fair and transparent manner can support the establishment of a trusting physician-patient relationship and foster trust in the profession.

The *Accepting New Patients* policy sets out physicians' professional and legal obligations when accepting new patients and helps to ensure that decisions to accept new patients are equitable, transparent and non-discriminatory. This companion *Advice to the Profession* document is intended to help physicians interpret their obligations as set out in the *Accepting New Patients* policy and provide guidance around how these obligations can be met.

Acting in "good faith"

The term "good faith" is a legal term that means an intention to act in a manner that is honest and decent. In other words, the term may be characterized as a sincere intention to deal fairly with others.

In the context of accepting new patients, physicians can act in good faith by:

- Closing their practice when it has reached capacity, not as a way to refuse patients who may be perceived as less desirable;
- Assessing, in a fair and honest manner, whether their medical knowledge and clinical skills will meet a patient's health-care needs, and not using a lack of medical knowledge or clinical skills to unfairly refuse patients with complex or chronic health needs; and
- Prioritizing access to care because a patient truly has high and/or complex health-care needs, and not because a patient is perceived as "easy" and/or requires less time or resources.

Priority populations

"Priority populations" refers to any population group that experiences (or is at risk of experiencing) health inequities and/or that would benefit most from public health services. While priority populations may differ slightly depending on a physician's practice type and location, some common examples of priority populations include:

- Pregnant people and newborns;
- Older people;
- People living in rural, remote or other communities with poorer access to care;
- People experiencing homelessness;
- People experiencing severe and persistent mental illness;
- Marginalized people;[1]
- Refugees, asylum seekers, and migrants;
- People who use or misuse substances; and
- People experiencing poverty.

[1] Marginalization refers to a social process by which individuals or groups are (intentionally or unintentionally) distanced from access to power and resources, and constructed as insignificant, peripheral, or less valuable/privileged to a community or "mainstream" society.

Communicating physician criteria for accepting new patients

Some physicians may choose to establish criteria for accepting new patients. Physicians need to use their professional judgment to determine when and how to communicate any criteria they use when accepting patients into their practice. To promote patients' understanding and ensure that decisions to accept new patients are equitable, transparent, and non-discriminatory, physicians are encouraged to inform patients of any criteria they have at the earliest opportunity, for example, during an introductory meeting or when the patient first inquires whether the practice is accepting patients.

Physicians' criteria for accepting new patients must be directly relevant to their clinical competence, scope of practice, and/or focused practice area. Appropriate criteria for physicians who serve a defined target population could include, but are not limited to, the following examples:

- Family physicians focused on Indigenous health may decide to mostly accept First Nations, Inuit, and Métis patients.
- Family physicians with a focused practice on addiction medicine may decide to primarily accept patients with substance use disorders.
- (Sub)specialists who provide limited or highly specialized services may primarily accept patients with a specified condition, or those with a higher likelihood of having that specific condition.

Ensuring criteria for accepting new patients is "fair and equitable"

By ensuring that any criteria for accepting patients is fair and equitable, physicians fulfill their legal obligations under the *Ontario Human Rights Code (the 'Code')* which entitles every Ontario resident to equal treatment with respect to services, goods and facilities, without regard to race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status, or disability.

There are different ways in which physicians can ensure that their criteria are fair and equitable and that all prospective patients receive equal treatment with respect to accessing health services. For example, using "first-come, first-served" approaches, "lottery" systems, or other non-discriminatory, equal-opportunity approaches to accepting patients can help ensure that patients who fall under the physician's criteria for accepting new patients are accepted into the practice in a fair and transparent manner.

Physicians will need to use their professional judgment in determining what approach best fits with their practice and how they can meet this requirement.

Informing patients that they will not be accepted into a practice

Physicians are reminded of the importance of clear, respectful, and honest communication when informing patients of their decisions not to accept them into their practice. Some individuals may interpret refusal as discrimination even when the physician's reasons for refusing to accept the patient are legitimate, and effective communication can help dispel perceived discrimination. The Canadian Medical Protective Association's (CMPA) *Patient-centred communication* offers guidance to physicians on how to communicate effectively with patients to optimize their care.

Accepting patients with a history of opioid use

Physicians who feel that treating patients with a history of prescription opioid use is legitimately outside of their clinical competence and/or scope of practice are reminded that:

- Responsibly prescribing narcotics and controlled substances is part of good clinical care, and refusing to prescribe these drugs altogether (e.g., through "no narcotics" policies) may lead to inadequate management of some clinical problems and leave some patients without appropriate treatment.
- There are relevant resources and clinical practice guidelines that can assist in managing the care of patients with a history of prescription opioid use. For example, the Centre for Addiction and Mental

Health (CAMH) has developed the *Canadian Opioid Use Disorder Guideline*, a national clinical guideline that standardizes guidelines for Canadian prescribers of opioid agonist therapy.[2]

- Where elements of a patient's care needs are legitimately outside a physician's clinical competence and/or scope of practice, the patient will need to be referred to a provider for those elements of care that they are unable to manage directly.
- Given the broad scope of practice of primary care physicians, there are few occasions where scope of practice would be an appropriate ground to refuse a prospective patient, and determinations about whether a patient's health-care needs fall within their clinical competence and/or scope of practice must be made in good faith.

Patients who live a significant distance away from a practice

CPSO does not restrict physicians from accepting or refusing to accept new patients solely based on designated catchment areas or geographical boundaries. However, physicians will need to use their professional judgment to determine whether they can provide quality care to the patient despite the significant geographical distance between them.

For example, a physician may be able to accept a patient who lives far away from the practice if the patient is willing to travel to the clinic or if the physician feels appropriate care can be provided virtually.[3] On the other hand, it may not be appropriate for (or in the best interest of) patients whose care requires regular in-person visits to be accepted into a practice that is located a significant distance from where they live if they are unable to attend in-person appointments.

When determining whether to accept a patient who lives far away from their practice, physicians can discuss with the patient how the geographical distance between them could impact the patient's ability to receive the care they need.

Patients seeking a second opinion

Specialist physicians will need to use their professional judgment to determine whether it is appropriate to refuse a request for a second opinion. Specialist physicians will need to weigh any potential benefit to the patient of receiving a second opinion against the demand for health services from patients who have not yet received care. It would be inappropriate, however, for physicians to practise medicine in a manner that hinders patient autonomy or limits patient decisions about the care they receive.

Regardless of the reason for refusal, specialist physicians who refuse to accept a referral need to comply with the relevant expectations set out in CPSO policies, including *Accepting New Patients* and *Transitions in Care*.

Using waitlists

While physicians are not prohibited from using self-managed waitlists, those who use waitlists in their practice need to use them cautiously and carefully manage patient expectations by clearly communicating the expected waiting period.[4]

Resources such as CMPA's *Wait times when resources are limited* contain additional guidance for physicians who use waitlists. Physicians will need to use their professional judgment to balance the patient's best interest with the availability of resources and clearly communicate with the patient and their care team.

Where available, physicians who are accepting new patients are encouraged to use provincial wait lists (e.g., Health Care Connect for unattached patients seeking a primary care provider) and/or centralized referral systems (e.g., physician networks within Ontario Health Teams).

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[2] See CPSO's *Prescribing Drugs* policy and *Advice to the Profession: Prescribing Drugs* for more information, including the use of prescription treatment agreements ("narcotics prescribing contracts") and education and training resources.
[3] See CPSO's *Virtual Care* policy and *Advice to the Profession: Virtual Care* for more information, including on establishing physician-patient relationships in virtual settings and the limitations of virtual care.
[4] See CPSO's *Transitions in Care* policy for more information on consultant physicians' obligations to communicate wait times and appointment dates with referring physicians and patients.

MARCH 2025

Title:	Review Feedback and Board Discussion: *Ending the Physician-Patient Relationship* Draft Policy (For Discussion)
Main Contacts:	Tanya Terzis, Manager, Policy & Governance Courtney Brown, Team Lead, Policy
Attachments:	**Appendix A:** Draft *Ending the Physician-Patient Relationship* Policy **Appendix B:** Draft *Advice to the Profession: Ending the Physician-Patient Relationship*
Question for Board:	Does the Board of Directors have any feedback on the draft policy?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- A new draft of CPSO's *Ending the Physician-Patient Relationship* policy (**Appendix A**) and companion document, *Advice to the Profession: Ending the Physician-Patient Relationship* ("Advice") (**Appendix B**) were released for external consultation following the November 2024 Board meeting.

- The Board will be provided with an overview of the feedback received and will have an opportunity to discuss the draft policy at the Board meeting.

Current Status & Analysis

- The current *Ending the Physician-Patient Relationship* policy and *Advice* were revised in response to preliminary consultation feedback and input from the Policy Working Group. Key revisions included:
    - re-arranging and streamlining the draft policy to make it clearer and more succinct;
    - removing or amalgamating a number of prescriptive, detailed provisions to make the draft more high-level and principle-based;
    - setting out specific provisions that physicians are not required to meet if they do not feel safe doing so, because a patient poses a risk of harm to them, or others; and
    - specifying that physicians must provide necessary medical services[1] to patients for a period of at least three months once the physician-patient relationship has ended.
- Given that the draft policy has been streamlined, considerations for specific reasons for ending the physician-patient relationship have been moved to the draft *Advice*.
- The *Advice* has also been updated to better reflect the concerns of physicians and patients, including providing guidance related to patients seeking care outside of a rostered practice, navigating when the patient ends the physician-patient relationship, and managing difficult patient encounters.
- An overview of the feedback is provided in the Policy Report and will be shared during the Board meeting.
- Small group discussions will take place at the Board meeting so that Board Directors have an opportunity to provide feedback on the drafts that were released for consultation. The Board's feedback will be considered by the Policy Working Group and will inform future revisions to the drafts.

[1] For example, renewing prescriptions, where medically appropriate, and ensuring appropriate follow-up on all laboratory and test results ordered.

ENDING THE PHYSICIAN-PATIENT RELATIONSHIP

Policies of the College of Physicians and Surgeons of Ontario ("CPSO") set out expectations for the professional conduct of physicians practising in Ontario. Together with the *Essentials of Medical Professionalism* and relevant legislation and case law, they will be used by CPSO and its Committees when considering physician practice or conduct.

Within policies, the terms 'must' and 'advised' are used to articulate CPSO's expectations. When 'advised' is used, it indicates that physicians can use reasonable discretion when applying this expectation to practice.

Additional information, general advice, and/or best practices can be found in companion resources, such as *Advice to the Profession* documents.

Policy

1. Physicians **must** comply with the expectations set out in this policy when ending a physician-patient relationship, except when the end of the physician-patient relationship is due to the physician's retirement, relocation, leave of absence, or a result of disciplinary action by CPSO.[1]
2. Physicians, including specialists, **must** comply with the expectations set out in this policy when ending a physician-patient relationship *prior* to reaching the normal or expected conclusion of a patient's care. This policy does not apply when a physician's relationship with a patient reaches its normal or expected conclusion (for example, because treatment has concluded).

Circumstances where physicians may end the physician-patient relationship

3. Physicians are permitted to end a physician-patient relationship, but **must only** do so if there is a reasonable basis for ending the relationship, for example when:
    a. There has been a significant breakdown in the physician-patient relationship;
    b. They can no longer provide quality care to the patient; or
    c. They wish to decrease their practice size.[2]

Circumstances where physicians cannot end the physician-patient relationship

4. Physicians **must not** end a physician-patient relationship based on a prohibited ground of discrimination[3] or where otherwise prohibited by legislation.[4]
5. Physicians **must** respect patient autonomy with respect to lifestyle, healthcare goals, and treatment decisions, and **must not** end a physician-patient relationship solely because a patient:

[1] For more information on physician retirement, relocation, leave of absence, or disciplinary action, see CPSO's *Closing a Medical Practice* policy.
[2] Physicians need to ensure that when decreasing their practice size, they do not disproportionately discharge patients with high or complex needs. For more information on how to decrease a practice size appropriately, see the *Advice to the Profession: Ending the Physician-Patient Relationship*.
[3] The *Ontario Human Rights Code* ("*Code*") provides that every person has a right to equal treatment without discrimination, including discrimination on the grounds of age, gender, marital status, national or ethnic origin, physical or mental disability, race, religion, and sexual orientation.
[4] Physicians need to ensure that any decision to end the physician-patient relationship complies with relevant legislation. This legislation includes *The Commitment to the Future of Medicare Act, 2004*, which prohibits physicians from ending the physician-patient relationship because the patient chooses not to pay a block or annual fee, and the Professional Misconduct Regulations under the *Medicine Act, 1991*.

a. Does not follow medical advice; [5]
b. Suffers from an addiction or dependence, or is on a high dose of a prescribed controlled drug and/or substance;[6] or
c. Seeks treatment to which the physician objects for reasons of conscience or religion.[7]

Expectations when ending the physician-patient relationship

6. Prior to ending a physician-patient relationship, physicians **must:**

    a. Apply good clinical judgment and compassion to determine the most appropriate course of action;
    b. Consider the patient's specific circumstances and vulnerabilities, as well as the consequences for the patient of ending the relationship; and
    c. Make reasonable efforts to resolve the situation in the best interest of the patient, where they feel it is safe to do so.[8]

7. When ending a physician-patient relationship, physicians **must**:

    a. Inform the patient of the reasons why they are ending the physician-patient relationship, where they feel it is safe to do so;[9]
    b. Notify the patient in writing of their decision to end the physician-patient relationship and of the importance of seeking ongoing care; [10]
    c. Retain a copy of the written notification and any confirmation of receipt in the patient's medical record;
    d. Inform appropriate staff and the patient's other health-care providers, where necessary, that they are no longer providing care to the patient, unless the patient has expressly restricted the physician from sharing this information;[11]
    e. Provide necessary medical services[12] for a period of at least 3 months after ending the physician-patient relationship,[13] where they feel it is safe to do so;[14]
    f. Provide care in an emergency, where it is necessary to prevent imminent harm;
    g. Document the reasons for ending the physician-patient relationship and all the steps they have undertaken to attempt to resolve the issue(s) in the patient's medical record;

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[5] For example, with respect to smoking cessation, drug or alcohol use, or the patient's decision to refrain from being vaccinated or vaccinating their children.
[6] Controlled drugs and substances are defined in the *Controlled Drugs and Substances Act,* 1996.
[7] Expectations for physicians who limit care for reasons of conscience or religion can be found in CPSO's *Human Rights in the Provision of Health Services* policy.
[8] If there are reasonable grounds to believe there is a risk of harm to the physician, their staff and/or other patients, physicians are not required to meet with the patient prior ending the physician-patient relationship.
[9] If there are reasonable grounds to believe there is a risk of harm to the physician, their staff and/or other patients, physicians are not required to inform patients of the reason for ending the physician-patient relationship.
[10] Physicians need to consider privacy and confidentiality implications and the best method of communication to ensure the patient will receive the written notification. For more information, see the *Advice to the Profession: Ending the Physician-Patient Relationship*.
[11] Under the *Personal Health Information Protection Act*, *2004*, a physician may provide personal health information about a patient to another health care provider for the purposes of providing or assisting in the provision of health care, if the patient has not restricted the physician from doing so. If the patient has restricted the physician from providing personal health information, the physician must notify the health care provider who has requested information on the patient about this restriction and may advise them to direct any inquiry to the patient themselves for a response.
[12] This may include, for example, renewing prescriptions, where medically appropriate, and ensuring appropriate follow-up on all laboratory and test results ordered in accordance with CPSO's *Managing Tests* policy.
[13] Discontinuing professional services that are needed may constitute professional misconduct unless alternative services are arranged, or the patient is given a reasonable opportunity to arrange alternative services (O. Reg. 856/93 s.1(1)7).
[14] If there are reasonable grounds to believe there is a risk of harm to the physician, their staff and/or other patients, physicians are not required to provide interim care.

h. Inform the patient that they are entitled to a copy of their medical records;[15] and
i. Ensure the timely transfer of a copy or summary of the patient's medical records, if requested.[16]

[15] Physicians are able to charge a reasonable fee for copying and transferring medical records in accordance with CPSO's *Medical Records Management* policy.
[16] For further information, refer to CPSO's *Medical Records Management* policy.

ADVICE TO THE PROFESSION: ENDING THE PHYSICIAN-PATIENT RELATIONSHIP

Advice to the Profession companion documents are intended to provide physicians with additional information and general advice in order to support their understanding and implementation of the expectations set out in policies. They may also identify some additional best practices regarding specific practice issues.

An effective physician-patient relationship is essential for the provision of quality medical care and is based on the mutual trust and respect of the physician and the patient. While this relationship is of central importance to the practice of medicine, circumstances may arise that lead either the physician or the patient to end the physician-patient relationship.

This advice document is intended to help physicians interpret the expectations set out in the *Ending the Physician-Patient Relationship* policy and to provide guidance about how these expectations can be met.

Where the patient ends the physician-patient relationship

This policy does *not* apply when the patient ends the physician-patient relationship. The expectations in this policy apply only when a *physician* wishes to end a physician-patient relationship (prior to its normal or expected conclusion).

When a patient wishes to end a physician-patient relationship, physicians may want to discuss with the patient why they are choosing to do so. These discussions can help the physician understand any concerns the patient may have about the care they are receiving and can help the physician resolve the situation.

The physician remains responsible for documenting in the patient's medical record the patient's reasons for ending the relationship (if known) and any steps they have undertaken to try to resolve the situation. To prevent confusion, physicians may also consider providing the patient with a written notification that their physician-patient relationship has ended.

Significant breakdowns in the physician-patient relationship

Physicians will need to use their professional judgment to determine what constitutes a "significant breakdown." A breakdown in the physician-patient relationship can occur when trust and respect between a physician and their patient has been lost and/or the therapeutic relationship has deteriorated. Situations that can lead to a breakdown in the physician-patient relationship include, but are not limited to, those in which a patient:

- Commits prescription-related fraud;
- Behaves in an abusive, or disruptive manner;
- Frequently misses appointments without providing appropriate cause or notice; or
- Refuses to pay outstanding fees without providing a reasonable justification for non-payment.[1]

Resources for managing difficult patient encounters

For information on ending the physician-patient relationship and managing challenging encounters, see the external resources linked below:

- *When physicians feel bullied or threatened* (CMPA)
- *How to manage conflict and aggressive behaviour in medical practice* (CMPA)

[1] Reasonable justification for non-payment could include evidence of financial hardship. For more information on billing issues, see CPSO's *Uninsured Services: Billing and Block Fees* policy and *Advice to the Profession: Uninsured Services*.

- *Challenging patient encounters: How to safely manage and de-escalate* (CMPA)
- *Physician Safety: How to Protect Against Threats or Risk of Harm by Patients FAQ* (OMA)

The Ontario College of Family Physicians also has a Peer Connect Mentorship program which supports physicians in skillfully responding to mental health issues and addressing substance use disorders and chronic pain challenges in their practice.

Patient complaints

Patients may contact CPSO for help addressing an issue with their physician and/or to initiate a complaint. Depending on the nature of the issue, CPSO may contact the physician to try to help resolve the situation.

Often, patient concerns can be resolved when the issue is brought to the physician's attention, and the physician-patient relationship can be repaired. Physicians should not automatically end their relationship with a patient in response to the patient's contact with CPSO. If, however, a physician believes that their patient's concerns or complaints indicate a broader loss of mutual trust and respect and they feel they cannot maintain an effective therapeutic relationship with the patient, it may be appropriate to end the physician-patient relationship.

Situations where physicians may no longer be able to provide quality care

There are many reasons why physicians may feel they can no longer provide quality care to a patient including, but not limited to:

- The patient has been absent for a long period of time;
- The patient has relocated far from the physician's practice and is unable to attend in-person appointments, where necessary; or
- The physician develops a conflict of interest with the patient.

Considerations for deciding to end the physician-patient relationship

There may be specific factors to consider and/or steps to take prior to ending the relationship, depending on a physician's reasons for wanting to end their relationship with a patient. For example:

Where the patient has been absent from the practice for an extended period, the physician can:

- Make a good-faith effort to determine whether the patient would prefer to maintain the relationship.
- Send a letter of inquiry to the patient's last known address (residential or email).

Where the patient's behaviour is abusive or disruptive, the physician can:

- Consider whether the patient's behaviour is an isolated incident or part of a larger pattern.
- Consider whether there are underlying factors that may be contributing to the patient's behaviour (e.g., mental illness).
- Inform the patient of any expectations or clinic policies related to patient conduct.

Where the patient has refused to pay an outstanding fee, the physician can:

- Consider the financial burden that paying the fee could place on the patient.
- Consider waiving the fee or allowing flexibility with respect to repayment, especially if the patient is unable to pay due to personal circumstances.

Where the patient has relocated far from the physician's practice, the physician can:

- Determine whether the patient is willing and able to travel to the clinic for necessary in-person care and/or whether care can appropriately be provided virtually.[2]
- Discuss with the patient how their relocation could impact their ability to receive the care they need.

[2] See CPSO's *Virtual Care* policy and *Advice to the Profession: Virtual Care* for more information.

Where the physician wishes to decrease their practice size[3], the physician can:

- Make sure to select patients with whom to end the physician-patient relationship in a fair, transparent, and compassionate way.
- Ensure that patients with high or complex care needs are not discharged disproportionately.
- Consider each patient's medical needs and their ability to find alternative care in a timely manner.

Where the physician has a conflict of interest with a patient, the physician can:

- Inform the patient of how the conflict of interest impacts their ability to provide quality care.
- Assist the patient in finding another provider to take over their care.

Outside use and de-rostering patients

When patients who are part of a rostered practice seek care outside of that practice (e.g., by going to a walk-in clinic), there can be a financial impact on the physician. For this reason, some physicians may want to de-roster that patient and see them instead on a fee-for-service basis.

Physicians need to be conscious of the difference between *ending* a physician-patient relationship and *de-rostering* a patient, and ensure this distinction is made clear to patients. To avoid any potential confusion when de-rostering a patient, physicians may want to discuss with patients directly what de-rostering entails and why they are being de-rostered, while also making clear to them that they will not lose access to care.

It would not be reasonable for a physician to end the physician-patient relationship solely because the patient sought care outside of their rostered practice. However, there may be instances where de-rostering is not possible, or where the physician feels that the patient continually seeking care outside of the practice has led to a breakdown in their relationship or has impacted their ability to provide quality care to the patient. In these circumstances, the physician needs to do the following before ending the relationship:

- Consider the factors that may have led the patient to seek care outside the practice (including the physician's own availability),
- Provide the patient with clear information about the patient's obligations within the rostered practice,
- Provide the patient with appropriate warning, and
- Undertake reasonable efforts to resolve the situation in the best interests of the patient.

Providing written notification

Providing patients with a written notification indicating the reasons for ending the physician-patient relationship during an appointment, or sending the notification by registered mail or courier can help ensure that the patient has received it. It may also be appropriate and acceptable for a physician to inform a patient of their decision to end the physician-patient relationship using an online platform (e.g., patient portal or email) provided the physician typically uses this platform to communicate with the patient.

No matter how a physician provides written notification to their patients, they will need to ensure that patient confidentiality is maintained.

Sample termination letter

Physicians may use the following sample letter to inform their patients that they have ended the physician-patient relationship. Physicians can customize this letter to suit their needs and to help ensure that the patient can understand it.

[3] Physicians who plan to retire will need to do so in accordance with the expectations outlined in CPSO's *Closing a Medical Practice* policy.

Dear [patient's name]:

As we discussed at your appointment on [*insert date*], my first obligation as a medical doctor is to provide quality care to all my patients. To do this, you and I must cooperatively and respectfully work together towards your health and well-being.

Due to [*if appropriate, indicate reason*], it is no longer possible for me to continue our physician-patient relationship.

I urge you to obtain another physician or primary health-care provider as soon as possible. With your consent, I will be pleased to provide them with a copy or summary of your medical records [*include any additional steps, the process for obtaining a copy of their medical records and any associated fees*]. I will also ensure appropriate follow-up on all laboratory and test results still outstanding and provide interim care for [*include time period here, minimum three months*].

For primary care physicians: For assistance in locating another physician, you may wish to register with Health Care Connect which can refer you to a family physician or nurse practitioner in your area accepting new patients. You can also contact primary care clinics within your community to determine if any physicians are accepting new patients. Some physicians, including those who are new to an area or who are beginning to establish a practice, may advertise locally that they are accepting new patients.

Yours truly,

[*Signature of physician*]

MARCH 2025

Title:	Final Approval: *Consent to Treatment* policy (For Decision)
Main Contacts:	Tanya Terzis, Manager, Policy & Governance Laura Rinke-Vanderwoude, Policy Analyst
Attachments:	**Appendix A:** Revised Draft *Consent to Treatment* Policy **Appendix B:** Revised Draft *Advice to the Profession: Consent to Treatment* **Appendix C:** Revised Draft *Guide to the Health Care Consent Act*
Question for Board:	Does the Board of Directors approve the revised draft *Consent to Treatment* policy as a policy of CPSO?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- A draft *Consent to Treatment* policy (**Appendix A**) and associated *Advice to the Profession* (*"Advice"*) (**Appendix B**) and *Guide to the Health Care Consent Act* (**Appendix C)** have been revised based on consultation feedback.

- The Board is provided with an overview of the key revisions made to the drafts and asked whether the revised draft policy can be approved as a policy of CPSO.

- Enabling physicians to understand their responsibilities regarding consent to treatment protects patients and supports CPSO's public interest mandate.

Current Status & Analysis

- The draft *Consent to Treatment* policy was released for consultation following the September 2024 Board meeting. The consultation received 51 total responses. All of the written comments can be viewed on the consultation webpage and an overview of the feedback was provided to the Board in the November 2024 Policy Report. The draft policy was also discussed by the Board in the November 2024 meeting.

- The revised draft policy, *Advice*, and *Guide to the Health Care Consent Act* have now been revised in response to consultation feedback, Board feedback, and input from the Policy Working Group. Feedback was generally very positive.

- The revised draft policy now clarifies the definitions of "informed" and "valid" consent, while other changes to the revised draft policy are minor. The revised draft policy retains the expectation that physicians obtain express consent for intimate examinations and, based on feedback from Obstetricians and Gynecologists, also retains that consent is not required to be documented in such instances.

- The revised draft *Advice* has been updated to address feedback from the Board and Policy Working Group, including adding new content regarding:

    - Consent to withdraw life-sustaining treatment;
    - The use of technology in interpretation;
    - Minors and capacity to consent to treatment;
    - What to do if a physician cannot contact a patient's Substitute Decision-Maker; and
    - The Consent and Capacity Board.

- Given the nature of the resource, no substantive changes were made to the revised draft *Guide to the Health Care Consent Act*.

CONSENT TO TREATMENT POLICY

Policies of the College of Physicians and Surgeons of Ontario (the "College") set out expectations for the professional conduct of physicians practising in Ontario. Together with the *Practice Guide* and relevant legislation and case law, they will be used by the College and its Committees when considering physician practice or conduct.

Within policies, the terms 'must' and 'advised' are used to articulate the College's expectations. When 'advised' is used, it indicates that physicians can use reasonable discretion when applying this expectation to practice.

Definitions

Treatment: Anything that is done for a therapeutic, preventative, palliative, diagnostic, cosmetic, or other health-related purpose, and includes a course of treatment, plan of treatment, or community treatment plan. It does not include, among other things, a capacity assessment, health history-taking, assessment or examination of a patient to determine the general nature of their condition, communication of an assessment or diagnosis, admission to a hospital or other facility, personal assistance service, or treatment that poses little or no risk of harm to the person.[1]

Capacity: A person is capable with respect to a treatment if they are able to understand the information that is relevant to making a decision and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision. Capacity to consent to a treatment can change over time and a patient can be capable with respect to some treatments and incapable with respect to others.

Substitute decision-maker (SDM): A person who may give or refuse consent to a treatment on behalf of a patient who is incapable with respect to treatment.

Express consent: Agreement that is direct and explicit. Express consent can be given orally or in writing.

Implied consent: Agreement that is understood from the words or behaviour of the patient or the circumstances under which the treatment is given.

Informed consent: Express or implied consent that is provided by a patient after understanding the information provided and having the opportunity to ask questions about the nature of the treatment, its expected benefits, its material risks relevant to their specific circumstances that a

[1] See section 2(1) of the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A. and sections 1(1) and 33.7 of the *Mental Health Act*, R.S.O. 1990, c. M.7 for further information.

reasonable person would want to know, alternative courses of action, and the likely consequences of not having the treatment.

Valid Consent: Consent that meets all the requirements of the *Health Care Consent Act, 1996 (HCCA)*. This includes that the consent be informed, be provided by a capable patient or SDM, and be given voluntarily and not under duress.[2]

Policy

This policy sets out expectations of physicians in obtaining and documenting consent to treatment, in addition to meeting the requirements of the *HCCA*. Further information about the *HCCA*'s requirements is set out in the *Guide to the Health Care Consent Act* companion document.

Obtaining Consent

1. Physicians **must** comply with all of the requirements in the *HCCA*, including obtaining valid consent[3] before treatment is provided.

    a. While consent can generally be either express or implied, physicians **must** obtain *express* consent in situations where the examination or treatment is:
        - an intimate examination[4];
        - carries appreciable risk;
        - is a surgical procedure or an invasive investigative procedure; or,
        - will lead to significant changes in consciousness.

    b. A physician proposing treatment may request another health-care provider obtain consent from the patient, but they **must** be assured that the health-care provider has the knowledge, skill, and judgment required to obtain consent. The physicians involved in the treatment are ultimately responsible for the consent being obtained.

2. Physicians **must** engage in a dialogue with the patient or the SDM and answer any questions they may have about the treatment prior to obtaining consent to ensure that the patient's consent is informed.

[2] For further information about the requirements of valid consent, see the *Guide to the Health Care Consent Act* companion document.
[3] The HCCA sets out the elements that are required for obtaining valid consent, as well as guidance for emergencies where valid consent cannot be obtained. For further information, see the *Guide to the Health Care Consent Act* companion document.
[4] An intimate examination includes breast, pelvic, genital, perineal, perianal and rectal examinations of patients. Additional guidance around consent for examinations is set out in CPSO's *Advice to the Profession: Maintaining Appropriate Boundaries* document.

3. If physicians believe that consent is not being freely given, they **must** take reasonable steps to ensure that there has been no coercion and that the patient is not under duress.

4. Physicians **must** consider and address language and communication issues that may impede a patient's ability to give valid consent.

    a. Physicians **must** use their professional judgment to determine whether it is appropriate to use a patient's family members or friends as interpreters and only do so where it is in the patient's best interests.

Incapable Patients and Substitute Decision-Making

Treatment can only be provided where the patient is capable with respect to the treatment and has given consent, or, where the patient is incapable, the SDM has given consent on the patient's behalf.[5]

5. Where a patient is incapable with respect to a treatment, physicians **must**, where possible, inform the incapable patient that an SDM will assist them in understanding the proposed treatment and will be responsible for the final decision.

    a. Where a patient disagrees with the finding of incapacity, physicians **must** advise them that they can apply to the Consent and Capacity Board (CCB) for a review of the finding.

    b. Where a patient disagrees with the involvement of the designated SDM, physicians **must** advise them that they can apply to the CCB to appoint an SDM of their choice.

    c. When appropriate, physicians **must** involve the incapable patient, to the extent possible, in discussions with the SDM.

Documenting Consent

6. Physicians **must** comply with all relevant legislation related to medical record-keeping[6] and the expectations set out in CPSO's *Medical Records Documentation* policy.

7. Physicians **must** document information in the patient's medical record about consent to treatment where the examination or treatment:
    - carries appreciable risk;
    - is a surgical procedure or an invasive investigative procedure; or,
    - will lead to significant changes in consciousness.

[5] There are some exceptions to the consent to treatment requirements in emergencies. Please see the *Guide to the Health Care Consent Act* for more information about consent to treatment in emergencies.
[6] Including the *Medicine Act,* General Regulation, Part V.

ADVICE TO THE PROFESSION: CONSENT TO TREATMENT

Advice to the Profession companion documents are intended to provide physicians with additional information and general advice in order to support their understanding and implementation of the expectations set out in policies. They may also identify some additional best practices regarding specific practice issues.

The College's *Consent to Treatment* policy and *Guide to the Health Care Consent Act* companion document set out physicians' professional and legal obligations with respect to obtaining consent to treatment. This *Advice to the Profession: Consent to Treatment* document is intended to help physicians interpret these obligations and provide guidance around how they may be effectively discharged.

Obtaining Consent

What is the difference between implied consent, express consent, and written consent?

As stated in the policy, implied consent is understood from the words or behaviour of the patient or the circumstances (e.g., holding out an arm to have a wound sutured), whereas express consent is direct and explicit. Written consent is a form of express consent (express consent can also be given orally).

Do I have to obtain consent to withdraw a life-sustaining treatment?

Yes. The *Decision-Making for End-of-Life Care* policy provides guidance about withdrawing treatment in end-of-life scenarios. Physicians can consult the Canadian Medical Protective Association or legal counsel to ensure they have complied with their legal obligations regarding consent in these situations.

What should I consider in determining whether it is appropriate to use a patient's family members or friends as interpreters?

In many cases, using a patient's family members or friends as interpreters could be the most accessible, convenient, practical, and comfortable option for patients. At the same time, using family members or friends as interpreters can present challenges, such as language limitations, difficulty understanding medical terms, inter-family dynamics and conflict, or important information being deliberately or accidentally omitted. As a result, particularly for higher risk or complex treatment plans, physicians can consider a formal or third-party interpretation service, where available.

You must also have consent to share the patient's personal health information with any interpreter, regardless of whether the interpreter is a family member or a third party.[1]

What should I consider when using technology to assist in interpretation for patients?

Technology (e.g., Google Translate) may help physicians to translate for patients in some cases, particularly where no other reliable method of interpretation is available. However, use of technology may come with the risk of inaccurate translation or a privacy breach and physicians need to consider any potential accuracy and privacy issues before using such technology. Even when using technology, physicians are ultimately responsible for ensuring that patients have provided informed, valid consent to treatment.

What do I do if a patient wants a family member or friend to consent on their behalf or if they want to provide consent without hearing about the risks of the treatment?

A patient may ask that you obtain consent from a family member or friend, even where they are capable. In other cases, the patient may feel anxious about the proposed treatment and want to provide consent without hearing about the risks.

However, a capable patient cannot ask someone else to provide consent on their behalf. The law requires that consent be obtained by a capable patient directly or, where they are incapable, the SDM. It also requires that consent be informed. As such, you are required to provide information about the nature of the treatment, its expected benefits, its material risks and material side effects, alternative courses of action, and the likely consequences of not having the treatment. If a patient refuses to hear this information, their decision will not be informed and their consent will not be valid.

You may want to sensitively explain this requirement to the patient and emphasize the importance of understanding the risks. You may also want to give patients time to process the information, gather family or friends if they need additional support, and try to arrange for an opportunity to continue the dialogue at a later date if time permits.

Can a patient's family members or friends be involved in the consent discussion?

Yes, it is appropriate and often helpful to involve others in the consent discussion, provided you have the patient's consent to share their personal health information and the patient makes the final decision regarding treatment. Minors capable of consenting to treatment can also choose whether they wish to have their parents or others involved in discussions about their care or treatment.

It may be helpful to ask at the beginning of the patient encounter how the patient prefers to hear information about their condition (e.g., prognosis), and who they want to be present with them while they receive the information.

[1] For more information, see CPSO's *Protecting Personal Health Information* policy.

Does a signed consent form constitute informed consent?

Not necessarily. The requirement for informed consent will not be met where the patient simply signs a consent form or receives written education materials or pamphlets without an informed consent discussion. This includes a discussion of the nature of the treatment, the expected benefits and material risks, alternative courses, of action and likely consequences of not having treatment, in addition to the patient having an opportunity to ask any questions they may have.

It is important to consider the patient's particular circumstances when determining whether a risk is material. The information to be discussed must be determined on a case-by-case basis so that it relates to the specific patient and is neither over- or under-inclusive.

What steps can I take to help my patients understand the information being provided when obtaining consent?

You may want to be mindful of the factors that can limit patient comprehension, as well as the tools that can help support comprehension. Some of these include:

- Using language appropriate for the patient's comprehension of concepts like probability and medical terminology.
- Considering the impact of pain, mental illness, and biases when communicating information.

Other tools can be found in the CMPA document "Helping patients make informed decisions."

Remember that patients or substitute decision-makers (SDMs) may need time to review and understand any information you provide prior to giving or refusing consent to a treatment. Consider "pacing" the information you provide so that the patient or SDM has an opportunity to reflect on it and any questions they wish to ask.

In order to obtain informed consent, I need to provide certain information, including the "material risks" associated with the treatment. What are "material" risks, and which risks do I have to disclose?

Courts have defined a "material" risk as a risk about which a reasonable person in the same circumstances as the patient would want to know in order to make a decision about the treatment. This includes but is not limited to risks that the physician believes may lead the patient to refuse or withhold consent to treatment.

The material risks that must be disclosed are risks that are common and significant, even though not necessarily grave, and those that are rare, but particularly significant. Generally speaking, the more frequent the risk, the greater the obligation to inform the patient about it. In addition, risks of great potential seriousness, such as paralysis or death, must likely be disclosed even if uncommon.

Determining Capacity

Are minors capable of consenting to treatment?

Minors are sometimes capable of consenting to treatment. In Ontario, there is no minimum age for capacity to consent to treatment. The *HCCA* says that all people are presumed capable of consenting to treatment, which also applies to minors. Physicians can use their professional judgment to consider whether there are reasonable grounds to believe that a minor is incapable, as they would for any other patient.[2]

Can I assume that once a patient is considered capable with respect to a treatment, they will always be capable regarding that treatment or will be capable for all other treatment decisions?

No. Capacity is fluid; it can change over time and is treatment-specific, meaning it could depend on the nature and complexity of the specific treatment decision.

For this reason, consent may need to be revisited after it has been obtained in case there are any significant changes in the patient (e.g., their health status, health-care needs, specific circumstances, capacity, etc.) or treatment (e.g., the nature, expected benefits, material risks and material side effects, etc.). The passage of time may also increase the risk that these changes will arise and that consent may need to be obtained again.

It may be appropriate to involve the future SDM(s) in ongoing consent discussions, with the patient's permission, so that if the patient does lose capacity and the SDM is required to start making treatment decisions, those decisions can be made in accordance with the patient's stated wishes and/or best interests.

My patient is refusing to consent to a treatment that I think they should have. Does this mean they are incapable?

Not necessarily. Patients have the legal right to refuse or withhold consent. Patients may sometimes make decisions that are contrary to the physician's treatment advice, and you cannot automatically assume in these cases that they are incapable of making that decision.

In some cases, however, a patient's decision may cause you to question whether the patient has the capacity to make the decision (e.g., they understand the information relevant to the decision and the consequences of not proceeding with the treatment). Where this is the case, you may want to consider doing a more thorough investigation of the patient's capacity to confirm the patient's decision is informed and valid. This could start with questions about their reasons for refusing treatment and/or the information they are relying on in making their decision.

[2] For further information about minors and consent to treatment, including the test for capacity to treatment, see the *Guide to the Health Care Consent Act* companion document.

It is important to remember that it is inappropriate for a physician to end the physician-patient relationship solely because the patient chooses not to follow the physician's treatment advice (for more information, see the CPSO's *Ending the Physician-Patient Relationship* policy).

Incapable Patients and Substitute Decision-Makers

Where a patient expresses a desire to apply to the Consent and Capacity Board (CCB) for review of a decision involving capacity or the identity of the SDM, you can provide the contact information for the Law Society of Ontario's Referral Service.

What do I do if the patient is incapable and I cannot contact an SDM?

The *HCCA* provides exceptions to consent requirements for emergencies.[3] In all other cases, consent must be provided by an SDM identified by the hierarchy set out in the *HCCA*[4] prior to providing treatment. If there is no SDM that meets the requirements, the Public Guardian and Trustee (PGT) will make the decision.

Physicians may wish to consult with legal counsel and/or the Canadian Medical Protective Association if they have questions about what to do when they cannot contact an SDM.

What do I do if the SDMs disagree on whether to give or refuse consent?

Because the *HCCA* permits two or more people within the same rank to jointly act as an SDM, you may encounter a situation where equally ranking SDMs disagree about whether to give or refuse consent.

Although the patient may not be capable of making treatment decisions, the patient may be capable of choosing an SDM by creating or updating their Power of Attorney for Personal Care. Alternatively, one of the SDMs or another person may apply to the CCB for the right to make the decision as the patient's representative.

Ultimately, if two equally ranking SDMs disagree, the Public Guardian and Trustee (PGT) will make the decision as a last resort. More information about how to involve the PGT may be obtained from the Treatment Decisions Unit. Physicians may want to consult legal counsel if they have questions.

How can a patient communicate their wishes to the SDM?

The SDM is required to give or refuse consent in accordance with the wishes of the patient, provided the patient was, at the time the wishes were expressed, capable and 16 years or older.

Wishes can be expressed in writing, orally, or in any other manner. Written wishes may involve advance care planning documents, commonly known as an 'advance directive' in a power of

[3] For more information about emergencies, see the *Guide to the Health Care Consent Act* companion document.
[4] The *Guide to the Health Care Consent Act* companion document provides more information about the SDM hierarchy.

attorney, or some other form. For more information about advance care planning, see the CPSO's Decision-Making for End-of-Life Care policy.

Later wishes expressed while capable, whether written, oral, or any other manner, prevail over earlier wishes.

I have a legal obligation to ensure that SDMs understand the requirements for giving or refusing consent as set out in the HCCA. What steps can I take to fulfill this obligation?

First, you need to determine how familiar the SDM is with the HCCA requirements. Some SDMs may not know what the HCCA requirements are, so you may need to tell them. You may want to consider referring SDMs to existing substitute decision-making resources that outline the requirements, such as the Hamilton Health Sciences' *Making Decisions for Others: Your Role as a Substitute Decision Maker* education document.

Other SDMs may be very familiar with the requirements, as they may have had to give or refuse consent on behalf of an incapable patient before. In these circumstances, you may not need to tell SDMs what the requirements are. Instead, you must be satisfied that the SDM understands what the HCCA requirements are when you are obtaining consent to a treatment from an SDM.

What if I am concerned that the SDM is not acting in accordance with the patient's wishes or best interests?

If you believe that the SDM is not acting in accordance with the patient's wishes[5] or best interests, you can apply to the CCB to determine how to proceed.

What is the role of the Consent and Capacity Board? How do I find more information?

The CCB is an expert tribunal comprised of lawyers, psychiatrists, and members of the public. The CCB can convene hearings quickly. Among many other things, the CCB has authority to review findings of capacity to make treatment decisions and authorize the appointment of a representative to make treatment decisions on behalf of an incapable patient. The CCB can also provide direction when a physician believes an SDM is not complying with their obligations,[6] or if clarity about a patient's wishes is needed. They can also grant permission to depart from prior wishes in very limited circumstances.

The CCB's website has information regarding their services. Physicians can contact the CCB directly or seek assistance from legal counsel at their institution, if applicable, or from the Canadian Medical Protective Association.

For more information about this process, see the CCB website or the Ontario Hospital Association's *A Practical Guide to Mental Health and the Law in Ontario*.

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[5] This may include written advanced care planning directives provided by the patient while capable. The *Decision-Making for End-of-Life Care* policy and *Advice to the Profession: End-of-Life Care* companion document provide some guidance around end-of-life scenarios that may involve advanced care planning.
[6] See section 21 of the *HCCA* for the principles for giving or refusing consent that apply to SDMs.

Documentation

What do I need to consider when documenting consent discussions?

Proper documentation can help physicians demonstrate that valid consent was obtained if an issue arises after treatment. Therefore, while the policy only *requires* physicians to document consent discussions in specific circumstances, it is a best practice to document consent discussions in all circumstances.[7]

You need to use your professional judgment when documenting the encounter and include enough information to provide an accurate summary of your discussion with your patient.

You are expected to capture any written consent (e.g. a signed consent form) in the patient's medical record.[8]

[7] As set out in the *Consent to Treatment* policy, express consent is required for all intimate examinations. It is strongly recommended that physicians document consent discussions for intimate exams, including that the physician gave the patient the option of having a third party present during an intimate examination. See the CPSO's *Boundary Violations* policy for more information about offering to have a third party present during intimate examinations.

[8] See CPSO's *Medical Records Documentation* policy.

GUIDE TO THE HEALTH CARE CONSENT ACT

This document sets out the requirements for obtaining consent to treatment that are set out in the *Health Care Consent Act* and related case law (judge-made law). Although some of the language is taken directly from the legislation, the requirements have been restated and presented in a way that speaks directly to physicians.

Physicians may want to seek independent legal advice if they have questions about meeting the legal requirements. The obligation to ensure that valid consent is obtained always rests with the physician proposing the treatment. In the case of any inconsistency between this document and any applicable legislation, the legislation will prevail.

General Principles for Obtaining Valid, Informed Consent

The *Health Care Consent Act* (*HCCA*) requires physicians to obtain valid, informed consent before providing treatment.

Before treatment is administered, physicians must believe the patient is capable with respect to treatment and has given consent.

If the physician believes that the patient is not capable of making decisions about their treatment, then the consent must be obtained from the Substitute Decision Maker (SDM).[1]

Patients and SDMs have the legal right to refuse, withhold, or withdraw consent to a treatment, and physicians must respect this decision even if they do not agree with it.[2]

Elements of Valid Consent

Consent is valid when:

- It relates to the proposed treatment;
- It is informed;
- It is given voluntarily; **and,**
- It was not obtained through misrepresentation or fraud.

Identifying Informed Consent

Consent is informed when a physician:

[1] If a physician becomes aware of an application or potential application to the Consent and Capacity Board (CCB), physicians should review section 18 of the *HCCA* regarding when treatment may begin.
[2] If a physician thinks a SDM has not complied with the *HCCA*, they can apply to the CCB.

- Has provided information about the nature of the treatment, its expected benefits, material risks and side effects, alternative courses of action, and the likely consequences of not having the treatment;
- Has responded to requests for additional information; and,
- Is satisfied that the patient or their SDM understood the information provided, which includes taking reasonable steps to facilitate that understanding.

The information provided to the patient or their SDM must include information that a reasonable person in the same circumstances would require in order to make a treatment decision. This must include information about material risks that are relevant for both a broad range of patients and the specific patient.

Scope of Valid, Informed Consent

Unless the circumstances make it unreasonable to do so, physicians are entitled to presume that consent to treatment includes:

- consent to variations or adjustments in the treatment when the nature, expected benefits, and material risks and side effects are not significantly different than the original treatment; and
- consent to the same treatment's continuation in a different setting, if the change in setting will not significantly change the expected benefits or material risks or side effects of the treatment.

Capacity, Incapacity, and Minors

A person is capable with respect to a treatment if they are able to understand the information that is relevant to making a decision, and appreciate the reasonably foreseeable consequences of a decision or lack of decision.

Capacity to consent to a treatment can change over time, and a patient can be capable with respect to some treatment decisions and incapable for others. Therefore, physicians must consider the patient's capacity at various points in time and in relation to the specific treatment being proposed.

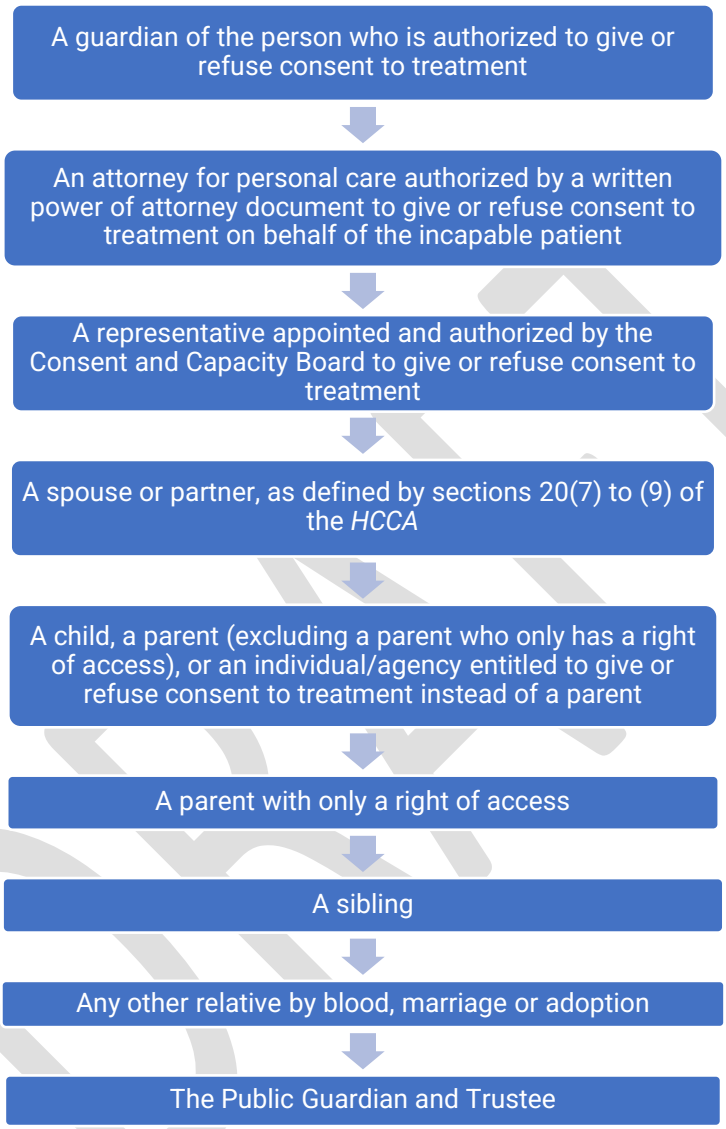
A person is presumed to be capable with respect to treatment unless there are reasonable grounds to believe otherwise (e.g., something in a patient's history or behaviour raises questions about their capacity to consent to the treatment).

Minors and Capacity

In Ontario, the presumption of capacity applies to everyone, including minors. If a minor is capable with respect to a treatment, the physician must obtain consent from the minor directly, even if the minor is accompanied by their parent or guardian.

Identifying the Substitute Decision-Maker

The *HCCA* sets out a hierarchy of the individuals and agencies who may give or refuse consent on behalf of an incapable patient as follows:



Using the Hierarchy

Where a patient is incapable with respect to treatment, physicians must obtain consent from the SDM identified by the hierarchy. The SDM is the highest-ranking person in the hierarchy set out in the *HCCA* who is also:

- capable with respect to the treatment (the test for capacity applies equally to both patients and SDMs);
- at least 16 years old, unless they are the incapable person's parent;

- not prohibited by a court order or separation agreement from having access to the incapable patient or from giving or refusing consent on their behalf;
- available to communicate consent or refuse consent within a time that is reasonable in the circumstances; and
- willing to assume the responsibility of giving or refusing consent.

If a higher-ranking person in the hierarchy does not satisfy the requirements

If a higher-ranking person in the hierarchy does not satisfy all of the requirements for substitute decision-making under the *HCCA*, physicians must move to the next-highest person in the hierarchy who meets the requirements.

Once an SDM is Identified

Once an SDM is identified, the HCCA requires that they give or refuse consent in accordance with the most recent and known wish expressed by the patient while they were capable and at least 16 years old.

If no valid wish is known or the wish is impossible to comply with, the SDM must act in the patient's best interests.

Physicians are responsible for taking reasonable steps to ensure that SDMs understand these requirements.

Determining an Incapable Patient's Best Interests

To determine the incapable patient's best interests, the SDM must consider:

- any values and beliefs the patient held while capable that the SDM believes they would still act on if capable;
- any wishes the patient expressed that the SDM is not legally required to follow (e.g., because the wish was expressed when the patient was not capable or was under the age of 16); and
- the following factors:
    - whether the treatment is likely to:
        - improve the incapable patient's condition or well-being;
        - prevent their condition or well-being from deteriorating; or,
        - reduce the extent or rate of their condition or well-being's deterioration;
    - whether, without the treatment, the incapable person's well-being is likely to improve, remain the same, or deteriorate;
    - whether the expected benefit of the treatment outweighs the risk of harm; and,
    - whether a less restrictive or less intrusive treatment would be as beneficial.

Emergency Treatment

Under the *HCCA*, an emergency is a situation where the patient is apparently experiencing severe suffering or is at risk of sustaining serious bodily harm if the treatment is not administered promptly.

In emergencies, physicians must obtain consent from a patient who is apparently capable with respect to the treatment unless, in the opinion of the physician, all the following are true:

- the communication required to obtain consent cannot take place because of a language barrier or a patient's disability;
- reasonable steps in the circumstances have been taken to find a practical means of enabling communication but were not successful;
- the delay required to find a practical means of communication will prolong the patient's apparent suffering or put them at risk of sustaining serious bodily harm; and,
- there is no reason to believe that the patient does not want the treatment.

If a Patient Previously Wished to Refuse Consent to the Treatment

Physicians must not provide treatment in emergencies if they have reasonable grounds to believe that the patient, while capable and at least 16 years of age, expressed a wish to refuse consent to the treatment that would be applicable in the circumstances.

Contacting SDMs in Emergencies

In an emergency where the patient is incapable with respect to the treatment, physicians must obtain consent from the incapable patient's SDM unless, in the opinion of the physician, the delay required to establish consent or refusal:

- will prolong the suffering that the patient is apparently experiencing; or,
- will put the patient at risk of sustaining serious bodily harm.

If an SDM Refuses to Consent to a Treatment in an Emergency

Where an SDM refuses to consent to a treatment in an emergency, the physician must respect this decision unless, in the physician's opinion, the SDM has not complied with the substitute decision-making requirements outlined in section 21 of the *HCCA*.

If the SDM has not complied with the *HCCA* requirements, the treatment may be administered despite the refusal.

If a Patient Becomes Capable During an Emergency

If, in the opinion of the physician, the patient becomes capable with respect to the treatment during emergency treatment, the physician must seek the patient's consent. The capable

patient's decision to give or refuse consent to the continuation of the treatment supersedes the SDM or physician's decision.

After Administering Emergency Treatment Without Consent

After administering treatment in an emergency without consent, the physician must promptly note in the patient's record the physician's opinions at the time of treatment that they relied on in administering the emergency treatment under the HCCA.

Duration of Emergency Treatment

Treatment in an emergency may continue only for as long as is reasonably necessary to:

- find a practical means of enabling communication with the capable patient; or,
- find the incapable patient's SDM.

Physicians must ensure that reasonable efforts are made to enable communication or find the SDM.

Board Motion

Motion Title	Final Approval: *Consent to Treatment* Policy
Date of Meeting	March 7, 2025

It is moved by_____, and seconded by_____, that:

The Board of Directors[1] of the College of Physicians and Surgeons of Ontario approves the revised policy "*Consent to Treatment*" as a policy of the College (a copy of which forms Appendix " " to the minutes of this meeting).

[1] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulated Health Professions Act*) and the *Medicine Act*.