



Board of Directors Meeting

Annual Financial Meeting

May 29 and 30, 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 May 29 and 30, 2025, in the CPSO Boardroom at 80 College Street, 3rd Floor, Toronto, Ontario. This is the Annual Financial Meeting of the Board.

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 May 26. Details on this process are available on the [CPSO's website](#).

The meeting will convene at 1:00 p.m. on Thursday, May 29, 2025, and at 10:30 a.m. on Friday, May 30, 2025.

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

May 8, 2025

Board Meeting Agenda

Annual Financial Meeting

May 29 and 30, 2025



THURSDAY, MAY 29, 2025

Item	Time	Topic and Objective(s)	Purpose	Page No.
1	1:00 pm (10 mins)	Call to Order and Welcoming Remarks (S. Reid) <ul style="list-style-type: none"> Note regrets and declare any conflicts of interest 	Discussion	N/A
2	1:10 pm (5 mins)	Consent Agenda (S. Reid) <ul style="list-style-type: none"> 2.1 Approve Board meeting agenda 2.2 Approve the draft minutes from the Board meeting held on March 6 and 7, 2025 2.3 Committee Appointments and Re-appointments Consent Agenda Motion 	Approval (with motion)	7-15 16 17-18
3	1:15 pm (5 mins)	Items for information: <ul style="list-style-type: none"> 3.1 Executive Committee Report – No 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 2026 Q1 Updates and Q2 Meeting Dates 	Information	- 19-22 23 24-27 28-31 32-35 36
4	1:20 pm (75 mins)	CEO/Registrar’s Report (N. Whitmore)	Discussion	N/A
*	2:35 pm (15 mins)	NUTRITION BREAK		
5	2:50 pm (15 mins)	Board Chair’s Report (S. Reid)	Discussion	N/A
6	3:05 pm (50 mins)	Governance and Nominating Committee Report (P. Safieh) <ul style="list-style-type: none"> 6.1 2025 Board Election 6.2 Executive Committee Elections for 2025/26 6.3 Executive Committee Appointments for 2025/26 	Information Decision (with motion) Decision (with motion)	- 37-44 45
7	3:55 pm (25 mins)	Governance and Nominating Committee Elections for 2025/26 (P. Safieh) <ul style="list-style-type: none"> The Board elects the 2025/26 Governance and Nominating Committee members 	Decision (with motion)	46-52

Item	Time	Topic and Objective(s)	Purpose	Page No.
8	4:20 pm (10 mins)	Updated Board Letter of Commitment (C. Allan) <ul style="list-style-type: none"> The Board is asked to consider approving the updated Board Letter of Commitment 	Decision (with motion)	53-55
9	4:30 pm (10 mins)	Draft Policy for Public Consultation: Closing a Medical Practice (T. Terzis) <ul style="list-style-type: none"> The Board is asked to consider approving the draft policy to be released for public consultation 	Decision (with motion)	56-64
10	4:40 pm (10 mins)	Draft Policy Amendments for Consultation: Delegation of Controlled Acts (T. Terzis) <ul style="list-style-type: none"> The Board is asked to consider approving draft amendments to the policy to be released for public consultation 	Decision (with motion)	65-74
11	4:50 pm	Adjournment Day 1 (S. Reid)	N/A	N/A

Item	Time	Topic and Objective(s)	Purpose	Page No.
12	10:30 am (5 mins)	Call to Order (S. Reid) <ul style="list-style-type: none"> Note regrets and declare any conflicts of interest 	Discussion	N/A
13	10:35 am (40 mins)	Revised Draft Policies for Final Approval - <ul style="list-style-type: none"> The Board is asked to consider approving the revised draft policies as policies of the College 		
		13.1 Accepting New Patients (T. Terzis)	Decision (with motion)	75-81
		13.2 Ending the Physician-Patient Relationship (C. Brown)	Decision (with motion)	82-90
		13.3 Treatment of Self, Family Members and Others Close to You (T. Terzis)	Decision (with motion)	91-100
*	11:15 am	Motion to Move In-Camera	Decision (with motion)	101
14	11:15 am (45 mins)	In-Camera Session		Materials provided under separate cover
*	12:00 pm (60 mins)	LUNCH		
15	1:00 pm (40 mins)	Finance and Audit Committee Report (N. Novak, S. Califaretti)		
		15.1 Draft 2024 Audited Financial Statements (S. Califaretti, N. Kuhanandan)	Decision (with motion)	102-203
		15.2 For Approval: Audited Financial Statements for the fiscal year ended December 31, 2024		204
		15.3 Audit Findings Report (Guest: M. Rooke – Tinkham LLP)	Information	205-213
		15.4 For Approval: Appointment of the Auditor for 2025 fiscal year (N. Novak, S. Califaretti)	Decision (with motion)	214-215
16	1:40 pm (20 mins)	By-law Amendments: Business Practices (S. Califaretti, C. Silver, M. Cooper) <ul style="list-style-type: none"> The Board is asked to consider approving the By-law Amendments relating to business practices 	Decision (with motion)	216-220
17	2:00 pm (30 mins)	Regulatory Amendments: Provisional Class of Registration and Retired Class of Registration (S. Tulipano, S. Sulevani) <ul style="list-style-type: none"> The Board is asked to consider approving the regulatory amendments (effective in 2026) for circulation 	Decision (with motion)	221-228
*	2:30 pm (20 mins)	NUTRITION BREAK		

Item	Time	Topic and Objective(s)	Purpose	Page No.
18	2:50 pm (20 mins)	By-law Amendments for fees relating to the Retired Class of Registration (S. Tulipano, M. Cooper, C. Silver) <ul style="list-style-type: none"> The Board is asked to consider approving the proposed By-law amendments for circulation to the profession 	Decision (with motion)	229-232
19	3:10 pm (20 mins)	By-law Amendments: Emeritus Status (S. Tulipano, M. Cooper) <ul style="list-style-type: none"> The Board is asked to consider approving the proposed By-law amendments for circulation to the profession 	Decision (with motion)	233-236
20	3:30 pm	Close Meeting - Day 2 (S. Reid) <ul style="list-style-type: none"> Reminder that the next meeting is scheduled on September 25 and 26, 2025 	N/A	N/A
*	3:30 pm	Meeting Reflection Session (S. Reid) <ul style="list-style-type: none"> Share observations about the effectiveness of the meeting and engagement of Board Directors 	Discussion	N/A

DRAFT PROCEEDINGS OF THE MEETING OF THE BOARD
March 6 and 7, 2025

Location: Boardroom, 80 College Street, Toronto, Ontario

March 6, 2025

Attendees:

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

Regrets:

Dr. Baraa Ahtar
Mr. Jose Cordeiro
Dr. Ian Preyra

Guests:

Ms. Deanna Williams, Governance Consultant, Dundee Consulting Group Ltd.

1. Call to Order and Welcoming Remarks

S. Reid, Board Chair, called the meeting to order at 11:30 am. The Board Chair welcomed Directors and staff to the Board meeting and acknowledged members of the public attending in person.

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

The Board Chair welcomed new Director, V. Roth, to her first Board meeting. Meeting regrets were noted.

Conflicts of interest on day 1 were noted for K. Tzanetos for item 6 Governance and Nominating Committee – New Item under the Governance and Nominating Committee (GNC) Report: Academic Director Appointments (Decision).

2. Consent Agenda

S. Reid provided an overview of the items listed on the Consent Agenda for approval. She noted that an addendum to the package was distributed on March 4, 2025 for a new agenda item, Academic Director Appointments, to be included under the GNC Report.

01-B-03-2025 – For Approval: Consent Agenda

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

The Board of Directors¹ 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, as amended;**
- 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.

CARRIED

3. For Information

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

- 3.1 Executive Committee Report
- 3.2 Ontario Physicians and Surgeons Discipline Tribunal Cases
- 3.3 Government Relations Report
- 3.4 Policy Report
- 3.5 Medical Learners Reports – Ontario Medical Students Association (OMSA) and Professional Association of Residents of Ontario (PARO)
- 3.6 Update on Board Action Items
- 3.7 Q1 2026 Meeting Dates
- 3.8 2024 College Performance Measurement Framework

4. Board Chair Report

S. Reid, Board Chair, presented her report to the Board providing an update noting that she attended the Federation of Medical Regulatory Authorities of Canada (FMRAC) conference and highlighted the keynote speaker presentation, "Leading in a (Volatile, Uncertain, Complex, Ambiguous) VUCA World". She recognized staff for their work on enhancing the Annual Report noting that the report clearly articulates the work done in 2024.

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*.

The work of the GNC was highlighted, noting that the GNC has been working to implement a skills-based and balanced Board through the Board elections and Academic Director appointment processes. The Board Chair noted that L. Becker, M. Ghandikota, F. Sherman and A. Srivastava were re-appointed to the Board as Public Directors.

The Executive Committee Report to the Board was highlighted and sets out the decisions made by the Executive Committee on behalf of the Board in between Board meetings. The Executive Committee met virtually in January to brainstorm and plan for the year ahead including planning for Board education opportunities. An update was provided on Committee appointments.

An update was provided on the Board Chair's one-to-one meetings with each of the Directors. A summary of key takeaways was shared.

There will be an opportunity for Board Directors interested in Board leadership roles to participate in Board leadership coaching, including sessions with D. Williams, Governance Consultant.

Other updates were provided on the mentorship program for new Directors and policy work that will be coming to the Board over the next two days.

5. Chief Executive Officer/Registrar's Report

N. Whitmore, Chief Executive Officer and Registrar, presented her report to the Board noting that all key performance indicators for 2024 were met. An overview of the CPSO's mission, vision and values was shared.

She provided an update on the 2025 key performance indicators, targets, and metrics.

An update of the following departments and programs was provided:

- Registration and Membership Services - Annual Renewal launched April 7;
- Quality Improvement / Quality Assurance - Building and piloting QI 2.0 program and a pilot QI program for Out of Hospital Premises (OHP) Medical Directors;
- OHP Inspection Program;
- Communications – an update was provided on e-Dialogue and the launch of the enhanced Annual Report;
- Patient & Public Help Centre;
- Legal;
- Ontario Physicians and Surgeons Discipline Tribunal (OPSDT) – including an update on the Health Professions Discipline Tribunal project;
- Policy – New Members of the Policy Working Group (PWG) were announced noting that M. Azad is the new Chair of the PWG.
- Government Relations and stakeholder collaboration;

- Board – An opportunity for Board Leadership Development will be offered by the CPSO to Board Directors who are interested in leadership roles.

Updates were provided on various CPSO operational and staff activities.

K. Tzanetos departed the meeting due to a conflict of interest.

6. Governance and Nominating Committee Report

P. Safieh, Chair of the GNC, provided the GNC Report to the Board, including an update on the 2025 Province-Wide Election process and on GNC meetings held since the last Board meeting. Following the 2025 Board Election, a plan-do-check-act cycle will occur, and learnings from the cycle will be shared with the Board at a future meeting. The Board asked questions on the interest expressed and the process for dispute should it occur. It was noted that more details on the Board Election will be provided in due course.

As highlighted in the Board Chair's Report, Public Director Updates were shared with the Board. The GNC Chair congratulated L. Becker, M. Ghandikota, F. Sherman and A. Srivastava on their re-appointments to the Board.

It was noted that appointments for the Executive Committee Member Representatives and elections for Board Chair and Board Vice-Chair are upcoming. The deadline to submit an application for these positions is March 26th, and the appointments and election will take place at the May 29 and 30 Board meeting.

The Committee received an overview of the 2025 Academic Director Appointment process and noted that the Board is being asked to consider the GNC's recommendation to appoint Dr. Claire Kendall, Dr. Roy Kirkpatrick, and Dr. Katina Tzanetos as Academic Directors for a one-year term.

02-B-03-2025 – For Approval: Appointment of Academic Directors

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

The Board of Directors¹ of the College of Physicians and Surgeons of Ontario selects and appoints Dr. Claire Kendall, Dr. Roy Kirkpatrick and Dr. Katina Tzanetos as Academic Directors for a one-year term commencing as of the close of the Annual Organizational Meeting of the Board in 2025 and expiring at the close of the Annual Organizational Meeting of the Board in 2026.

CARRIED

K. Tzanetos rejoins the meeting.

7. Review Feedback and Board Discussion: Treatment of Self, Family Members, and Others Close to You Draft Policy

T. Terzis, Manager, Policy provided an overview of the draft Treatment of Self, Family Members and Others Close to You Policy that was released for consultation after the September 2024 Board meeting and the feedback received from the policy consultation. Key changes to the

draft policy were highlighted, noting that feedback from the consultation supports exceptions in communities with limited treatment options. The Board was given an opportunity to discuss the draft policy and provide input. There was discussion relating to the treatment of minor conditions and whether the policy was in line with right-touch regulatory principles, amongst other topics. The PWG will consider the feedback and bring the final version back to the Board for approval at the May Board meeting.

Motion to move in-camera

03-B-03-2025 – Motion to Go In-Camera

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

The Board of Directors¹ 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

8. In-Camera Session

The Board of Directors of the College of Physicians and Surgeons of Ontario entered into an In-Camera session at 4:20 pm and returned to the open session at 5:00 pm.

9. Adjournment - Day 1

S. Reid, Board Chair, adjourned day 1 of the Board Meeting at 5:00 pm.

Board Chair

Recording Secretary

DRAFT PROCEEDINGS OF THE MEETING OF THE CPSO BOARD OF DIRECTORS
March 7, 2025

Attendees:

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

Regrets:

Dr. Baraa Ahtar
Mr. Jose Cordeiro
Dr. Ian Preyra

10. Call to Order

S. Reid, Board Chair, called the meeting to order at 11:30 am. She welcomed everyone back to the Board meeting and noted regrets.

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

S. Tulipano, Director, Registration and Membership Services provided an overview of the By-law amendments regarding the PA Register and Fees for Emergency Class Certificate of Registration, noting that the amendments were circulated to the profession and no feedback was received.

04-B-03-2025 – For Approval: By-law Amendments re PA Register and Fees for Emergency Class Certificate of Registration

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

The Board of Directors¹ 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

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 21.2.1 of 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;

CARRIED

12. Alternative Pathways to Registration for Physicians Trained in the United States Directive

S. Tulipano, Director, Registration and Membership Services provided an overview of the Alternative Pathways to Registration for Physicians Trained in the United States Directive. It was noted that the proposed directive aligns with the CPSO's strategic plan for continuous improvement. Benefits of the proposed directive were highlighted, including cost savings and expedited processing of applications. Following questions and discussion, the Board expressed support for approving the directive.

05-B-03-2025 – For approval: Registration Policy Directive – “Alternative Pathways to Registration for Physicians Trained in the United States”

The following motion was moved by J. Fisk, seconded by L. Becker and carried, that:

The Board of Directors¹ 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 “A” to the minutes of this meeting).

CARRIED

Item 15 Final Approval: Consent to Treatment Policy moved up to facilitate flow

15. Final Approval: Consent to Treatment Policy

P. Malette, Board Director and Policy Working Group member and T. Terzis, Manager, Policy presented the “Consent to Treatment” policy that was released for consultation after the November Board meeting. It was noted that this was the first policy to undergo the new Board feedback process on policies. An overview was provided on the consultation feedback and key revisions made to the draft policy and advice document. It was noted that one of the key changes made was separating legal obligations into a companion resource the Guide to the *Health Care Consent Act*. Following questions and discussion, the Board expressed support to approve the revised draft as a policy of the College.

06-B-03-2025 – Final Approval: Consent to Treatment Policy

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

The Board of Directors¹ 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 “B” to the minutes of this meeting).

CARRIED

13. Review Feedback and Board Discussion: Accepting New Patients Draft Policy

T. Terzis, Manager, Policy provided an overview of the draft “Accepting New Patients” Draft Policy that was released for consultation after the November Board meeting and the feedback received from the policy consultation. Key changes to the draft policy were highlighted including emphasizing the principles of fairness and transparency to inform how physicians accept new patients and clarifying expectations related to introductory meetings. The Board was given the opportunity to discuss the draft policy and provide input. There was a discussion relating to changing references from meet and greet to intake, amongst other topics. The PWG will consider the feedback and bring the final version back to the Board for approval at the May Board meeting.

14. Review Feedback and Board Discussion: Ending the Physician-Patient Relationship Draft Policy

C. Brown, Team Lead, Policy provided an overview of the draft “Ending the Physician-Patient Relationship” Draft Policy that was released for consultation after the November Board meeting and the feedback received from the policy consultation. Key changes to the draft policy were highlighted, including making the draft more clear, succinct, high-level, and principle-based. The Board was given the opportunity to discuss the draft policy and provide input. There was a discussion relating to the three-month timeline for physicians to provide necessary medical services to patients, amongst other topics. Following discussion, the Board agreed that three months was reasonable and fair for providing necessary care. The PWG will consider the feedback and bring the final version back to the Board for approval at the May Board meeting.

16. Close Meeting - Day 2

07-B-03-2025 – Close Meeting

The following motion was moved by J. Fisk, seconded by A. Srivastava and carried, that:

The Board of Directors¹ of the College of Physicians and Surgeons of Ontario close the meeting.

CARRIED

The next Board meeting is scheduled on May 29 and 30, 2025.

Board Chair

Recording Secretary

Title:	Committee Appointments and Re-appointments (For Decision)
Main Contacts:	Cameo Allan, Director, Governance Caitlin Ferguson, Governance Coordinator
Questions for Board:	<ol style="list-style-type: none"> 1. Does the Board of Directors (Board) approve the request for Exceptional Circumstances for the individual as laid out in this briefing note? 2. Does the Board wish to appoint the individuals as laid out in this briefing note?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- The Board is asked to make one new committee appointment and seven re-appointments, including one request for Exceptional Circumstances.
- Ensuring that CPSO committees have qualified and diverse members allows the College to carry out its strategic objectives and fulfill its mandate to serve in the public interest.

Current Status & Analysis

Exceptional Circumstances Request

- The Quality Assurance Committee (QAC) is requesting the re-appointment of Dr. Tina Tao under the Exceptional Circumstances provision laid out in section 7.6.8 of the CPSO By-laws.
- Dr. Tao will reach her 9-year term limit for the QAC on July 26, 2025, and Exceptional Circumstances have already been approved by the Board to allow her to serve until the 2025 Annual Organizational Meeting (AOM).
- Dr. Tao is currently the Vice-Chair of the QAC, and Exceptional Circumstances are being requested again to allow her to serve until the 2026 AOM. This request is being made to allow her to serve another year in a leadership role while Committee Support staff work to develop future leaders for the QAC.

Quality Assurance Committee Re-Appointments

- The QAC is requesting to re-appoint all current members. The members being requested for re-appointment are: Dr. Mohammad Keshoofy, Dr. Charles Knapp, Dr. Ken Lee, Dr. Gina Neto, Dr. Ashraf Sefin, Dr. Astrid Sjodin, and Dr. Tina Tao.
- These re-appointments would start upon the close of the 2025 AOM and would last until the close of the 2026 AOM.

New Ontario Physicians and Surgeons Discipline Tribunal (OPSDT) Appointment

- The OSPDT and the Fitness to Practise Committee (FTP) request the appointment of Dr. Roy Kirkpatrick.
- Dr. Kirkpatrick previously served on the OPSDT and FTP from 2020 to 2024. He has also been appointed as an Academic Director on the CPSO Board of Directors for the 2025 – 2026 year.
- The OPSDT and FTP are requesting that Dr. Kirkpatrick be appointed as a Registrant member, with his appointment beginning May 30, 2025, lasting until the close of the 2025 AOM.

Board Motion

Motion Title	For Approval: Consent Agenda
Date of Meeting	May 29, 2025

It is moved by _____, and seconded by _____, that:

The Board of Directors¹ 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 May 29 and 30, 2025;**
- 2.2 The draft minutes from the Board meeting held on March 6 and 7, 2025;**
- 2.3 Committee Appointments and Re-appointments**

Exceptional Circumstances Request

The Board of Directors¹ of the College of Physicians and Surgeons of Ontario approves the application of the exceptional circumstances provision in Section 7.6.8 of the CPSO By-laws in respect of Dr. Tina Tao for an additional one year term on the Quality Assurance Committee when the term of her current appointment expires at the close of the 2025 Annual Organizational Meeting of the Board.

Quality Assurance Committee Re-Appointments

The Board of Directors¹ of the College of Physicians and Surgeons of Ontario re-appoints the following individuals to the Quality Assurance Committee for a one-year term commencing as of the close of the AOM of the Board in 2025 until the close of the Annual Organizational Meeting in 2026:

Member Name
Dr. Mohammad Keshoofy
Dr. Charles Knapp
Dr. Ken Lee
Dr. Gina Neto
Dr. Ashraf Sefin
Dr. Astrid Sjodin
Dr. Tina Tao

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*.

New Ontario Physicians and Surgeons Discipline Tribunal and Fitness to Practise Committee Appointment

The Board of Directors¹ of the College of Physicians and Surgeons of Ontario appoints Dr. Roy Kirkpatrick to the Ontario Physicians and Surgeons Discipline Tribunal and the Fitness to Practise Committee effective May 30, 2025, and expiring at the close of the Annual Organizational Meeting of the Board in 2025.

Title:	Ontario Physicians and Surgeons Discipline Tribunal Report of Completed Cases February 16, 2025 – May 9, 2025 by (For Information)
Main Contact:	Dionne Woodward, Tribunal Counsel

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- This report summarizes reasons for decision released between February 16, 2025 – May 9, 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 & Analysis

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

- 9 sets of reasons on findings (liability) and penalty
- 1 set of reasons on a motion
- 1 set of reasons on case management issues

Findings

Liability findings included:

- 1 finding of sexual abuse
- 8 findings of disgraceful, dishonourable or unprofessional conduct
- 2 findings of failing to maintain standard of practice
- 2 findings of failing to cooperate with College’s investigation
- 2 findings of failing to respond within a reasonable time period to a written inquiry of the College
- 1 finding of contravening a term, condition or limitation on the physician’s certificate of registration
- 1 finding of having been found guilty of an offence relevant to suitability to practise

Penalty

Penalty orders included:

- 2 revocations
- 4 suspensions
- 7 reprimands
- 4 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 (February 16, 2025 – May 9, 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 15	Parajian	May 7, 2025			X		- Found guilty of offence relevant to suitability to practise
2025 ONPSDT 14	Kilian	May 2, 2025			X		- Failed to cooperate with College investigation - Failed to respond within a reasonable time period to a written inquiry of the College.
2025 ONPSDT 11	Duic	March 18, 2025				X	
2025 ONPSDT 10	Kadlubowska	March 18, 2025			X		
2025 ONPSDT 9	Richards	March 13, 2025			X		
2025 ONPSDT 8	Prabhu	March 6, 2025	X		X		
2025 ONPSDT 7	Kustka	March 5, 2025		X	X		- Failed to cooperate with College investigation - Failed to respond within a reasonable time period to a written inquiry of the College.
2025 ONPSDT 6	Slataroff	March 4, 2025			X		
2025 ONPSDT 5	Sharma	March 3, 2025			X	X	

TABLE 2: TRIBUNAL DECISIONS – PENALTIES (February 16, 2025 – May 9, 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 15	Parajian	May 7, 2025	Revocation, reprimand		\$6000
2025 ONPSDT 11	Duic	March 18, 2025	Suspension, reprimand, TCL	3 months	\$6000
2025 ONPSDT 10	Kadlubowska	March 18, 2025	Suspension, reprimand, TCL	14 months	\$6000
2025 ONPSDT 9	Richards	March 13, 2025	Reprimand <i>*Registrant undertook to resign College membership and not re-apply for registration in Ontario or anywhere else in Canada.</i>		\$6000
2025 ONPSDT 8	Prabhu	March 6, 2025	Revocation, reprimand, reimbursement for complainant's therapy and counselling		\$6000
2025 ONPSDT 6	Slataroff	March 4, 2025	Suspension, reprimand, TCL	5 months	\$6000
2025 ONPSDT 5	Sharma	March 3, 2025	Suspension, reprimand, TCL	10 months	\$6000

TABLE 3: TRIBUNAL DECISIONS - MOTIONS AND CASE MANAGEMENT
(February 16, 2025 – May 9, 2025)

Citation and hyperlink to published reasons	Physician(s)	Date of reasons	Motion/Case management outcome	Nature of motion/case management issue
2025 ONPSDT 13	MacDonald	April 24, 2025	The registrant, who is alleged to have accessed and possessed child pornography, brought a motion asking the Tribunal to order the College to provide more detailed information about the allegations against him. The Registrant sought specifics about when, where, and how the material was allegedly accessed, along with detailed information about the digital files involved. The Tribunal dismissed the motion.	In dismissing the motion, the Tribunal explained that a request for particulars is meant to clarify what a party intends to prove—not to challenge the type of evidence the party has chosen to rely on. The hearing panel will determine, after considering all the evidence, whether the College has met its burden of proof.
2025 ONPSDT 12	Ola	March 19, 2025	In a case management direction, the Tribunal ruled that: the registrant could file a written statement of particulars; the College could supplement its affidavit evidence with oral testimony; and a formal waiver of Rule 14.3.4, which provides that a registrant who pleads no contest may not call evidence on the merits, was not required for the registrant to clarify which allegation he did and did not contest.	This case involves allegations of improper OHIP billing and boundary violations. While the registrant does not dispute certain key facts, the parties could not agree on how to present them in a joint statement. As a result, they agreed that the College would present its evidence in writing, and the registrant would testify orally, with some facts possibly set out in an affidavit. Three outstanding procedural issues were ruled on by the case management chair.

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

Legislative Update

- On February 27, Doug Ford's Progressive Conservatives were re-elected with a third consecutive majority government. Sylvia Jones was reappointed as Deputy Premier and Minister of Health.
- The legislative session began on April 14, followed closely by a Throne Speech that mainly reiterated earlier promises to ease barriers for skilled health-care workers; invest over \$1.8 billion to ensure every Ontarian is connected to primary care; expand medical education and residency positions; fund hospital and long-term care infrastructure; and streamline emergency and surgical care to reduce wait times.

Issues of Interest

- **Bill 2, the [Protect Ontario Through Free Trade Within Canada Act, 2025](#):** among other things, this legislation sets out a framework for reducing interprovincial barriers and an expanded as-of-right registration regime for professions across various sectors.
 - A companion [regulatory proposal](#) was subsequently released, along with an [accompanying technical briefing document](#). Of specific relevance to CPSO, government plans to expand as-of-right registration to American-licensed physicians and removing the current restrictions on practice settings (which are currently limited to public hospitals, long-term care homes, and the Ottawa Heart Institute).
- **Bill 13, the [Primary Care Act, 2025](#):** new legislation was introduced on May 7 sets out six objectives that the government must have in its design, implementation and maintenance of Ontario's publicly-funded primary care system (connectivity, convenience, inclusivity, etc.).
 - The legislation also requires Minister of Health to report annually on metrics, including the percentage of insured Ontarians with an "ongoing relationship" with a primary care clinician or team.
 - At the same time, an additional \$300M in funding was announced for new and expanded community-based primary care teaching clinics.
- **Federal election update:** Mark Carney continues as Prime Minister following a federal election at the end of April that saw the Liberal party forming a minority government.
 - While the Conservatives performed well in the 905 region and western Canada, Pierre Poilievre lost his own seat. He plans to stay on as Conservative leader and pursue a seat in rural Alberta, where a Conservative MP has volunteered to step down.
 - Through the campaign, both the Liberal and Conservative parties made commitments in support of national licensure of physicians and nurses.
- **Public member update:** CPSO continues to be in a good position with 14 public members. The next public member term expiry is not until December 31, 2025, providing an extended window of continuity. As always, CPSO is in regular contact with the Ministry and the Minister's Office to ensure that they are aware of CPSO's needs.

Title:	Policy Report (For Information)
Main Contact:	Tanya Terzis, Manager, Policy
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

- Two policy consultations launched following the March 2025 Board meeting:

Consultation Feedback Overview¹	
Preliminary: Boundary Violations² <ul style="list-style-type: none"> • Most respondents found the existing policy helpful, clear, and indicated that it met their needs. Physician respondents reported commonly referring to the policy for guidance regarding intimate exams, especially with respect to communication and the use of third parties. • Survey respondents indicated it can be challenging to establish and enforce boundaries around appropriate patient-to-physician contact, especially with respect to texting, email contact, or contacting physicians on social media. • Some of the feedback received related to issues around treating family members and friends in small communities, which are addressed in CPSO’s Physician Treatment of Self, Family Members, and Others Close to Them policy. • Physician respondents requested additional clarity on non-sexual boundary violations, especially issues that may be categorized as “minor violations” or “boundary crossings,” such as accepting small gifts. • There was a series of coordinated responses suggesting the section on non-sexual boundaries be expanded to include expectations related to “Political Boundaries/Discrimination.” Respondents suggested the policy prohibit displays of political partisanship by physicians on social media and in-person, including prohibiting physicians from displaying divisive political symbols via clothing or posters. Respondents characterized such displays of partisanship (i.e., Anti-Zionism) as discriminatory and harmful to patient trust, safety, and neutrality in care. 	81 responses received³
Preliminary: Delegation of Controlled Acts <ul style="list-style-type: none"> • While the majority of respondents agreed that the existing policy is clear and easy to understand, many felt that it does not address all the relevant issues related to delegating controlled acts. Suggestions included clarifying onsite supervision requirements and adding more examples. • Most respondents expressed that delegating controlled acts is appropriate when it facilitates access to care and in emergencies. • Several respondents highlighted the challenges encountered with medical directives and indicated that the information required to be included in directives was too onerous. • Some respondents raised concerns about the misuse of medical directives in aesthetic medicine and for monetary gain and requested stricter oversight of med-spas. 	161 responses received⁴

¹ As of the Board submission deadline.

² A preliminary consultation refers to consulting on an existing policy and a general consultation refers to consulting on a draft policy.

³ Organizational respondents included the College of Nurses of Ontario (CNO), Ontario Medical Association (OMA), Ontario Trial Lawyers Association (OTLA), and Professional Association of Residents of Ontario (PARO).

⁴ Organizational respondents included the Coalition of Aesthetic Medical Providers, CNO, OMA, Durham Region Health Department, OTLA, PARO, and York Region Public Health.

- Three preliminary consultations will launch following the May 2025 Board meeting:
 - [Providing Physician Services During Job Actions](#): This policy was last comprehensively reviewed in 2014 and sets out expectations for physicians who are contemplating or undertaking a job action.
 - [Public Health Emergencies](#): This policy was last comprehensively reviewed in 2018 and sets out expectations for physicians during a public health emergency.
 - [Uninsured Services: Billing and Block Fees](#): This policy was last comprehensively reviewed in 2017 and sets out expectations for physicians who bill for services not covered by the Ontario Health Insurance Plan (OHIP), commonly referred to as “uninsured services.”
- 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**).

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		
<u>Public Health Emergencies</u>	May-25	✓						2026	
<u>Uninsured Services: Billing and Block Fees</u>	May-25	✓						2026	
<u>Providing Physician Services During Job Actions</u>	May-25	✓						2026	
<u>Delegation of Controlled Acts</u>	Mar-25		✓					2026	
<u>Boundary Violations</u>	Mar-25		✓					2026	
<u>Closing a Medical Practice</u>	Sep-24			✓				2025	
<u>Accepting New Patients</u>	Feb-24						✓	2025	
<u>Ending the Physician-Patient Relationship</u>	Feb-24						✓	2025	
<u>Physician Treatment of Self, Family Members, or Others Close to Them</u>	Dec-23						✓	2025	The draft has been retitled <i>Treatment of Self, Family Members, and Others Close to You.</i>

Table 2: Policy Review Schedule

Policy	Reviewed	Policy	Reviewed
<u>Consent to Treatment</u>	2025	<u>Professional Responsibilities in Medical Education</u>	2021
<u>Reporting Requirements</u>	2024	<u>Third Party Medical Reports</u>	2021
<u>Essentials of Medical Professionalism</u>	2024	<u>Advertising</u>	2020
<u>Infection Prevention and Control for Clinical Office Practice</u>	2024	<u>Medical Records Management</u>	2020
<u>Professional Behaviour</u>	2024	<u>Medical Records Documentation</u>	2020
<u>Conflicts of Interest and Industry Relationships</u>	2024	<u>Protecting Personal Health Information</u>	2020
<u>Medical Assistance in Dying</u>	2023	<u>Disclosure of Harm</u>	2019
<u>Human Rights in the Provision of Health Services</u>	2023	<u>Prescribing Drugs</u>	2019
<u>Decision-Making for End-of-Life Care</u>	2023	<u>Availability and Coverage</u>	2019
<u>Dispensing Drugs</u>	2022	<u>Managing Tests</u>	2019
<u>Virtual Care</u>	2022	<u>Transitions in Care</u>	2019
<u>Social Media</u>	2022	<u>Walk-in Clinics</u>	2019
<u>Complementary and Alternative Medicine</u>	2021	<u>Ensuring Competence: Changing Scope of Practice and Re-entering Practice</u>	2018

Ontario Medical Students' Association CPSO Council Update May 29 and 30, 2025

Maxim Matyashin, President
Zoe Tsai, President-Elect



Thank you once again to the CPSO for inviting representatives from the Ontario Medical Students Association (OMSA) to observe and participate in your Council meeting. Now wrapping up the 2025 academic year, 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. **A Provincial Medical Education Standards Document** - We are currently finalizing our analyses of Professionalism, Mistreatment, and Appeals policies and recommendations. Thereafter, we will begin bringing this forth to each medical school faculty for implementation and would greatly appreciate the CPSO's support.

New Updates:

1. **OMSA Day of Action on the Family Medicine Crisis**- We held our OMSA Day of Action (medical students' equivalent of Queens' Park Day) in March with this year's topic being the Family Medicine Crisis on March 22-24th and was attended by 100 medical students across the province. Our team has secured new partnerships and connections at the OMA SGFP for future advocacy in the realm of family medicine, especially regarding the drastic decrease of CMG's interest in family medicine as per the 2025 CaRMS Forum Match Data, with potential for a joint statement. We would appreciate support from our colleagues at the CPSO on this matter as much as possible.
2. **Thunder Bay OMSA Council Meeting** - We successfully held OMSA's first northern outreach event in Thunder Bay in April to further understand the healthcare systems and landscapes of the Northern/Rural Ontario regions. This was met with enthusiasm from local news outlets and hospital facilities. We are aiming to further expand this event in coming years to increase medical students' exposure and outreach to Northern/Rural Ontario.
3. **OMSA Council Executive Elections** - Elections will be held on May 11th, 2025 for our incoming 2025-2026 OMSA Executive Council. We look forward to introducing you to the new members of the team!

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
President, OMSA
president@omsa.ca

Zoe Tsai
President-Elect, OMSA
president_elect@omsa.ca



PARO Update to CPSO May 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.

PARO Site Teams

We are extremely proud at PARO of the incredible groundbreaking work our PARO Site Teams have done to deliver on our strategic plan and I am happy to share some of that work with you.

Toronto

- During Resident Doctor Appreciation Week over 500 virtual cards of gratitude were delivered to residents; 34% of which came from staff physicians, program directors and admin.
- Toronto Safe Ride Home pilot program launched on January 13th and the resident feedback has been positive. This is a fantastic example of how we build on successes across the sites. Since its inception at NOSM, we now have Safe Ride Home Programs rollout across the province.

Queen's:

- The Queen's team hosted several exciting events including a free coffee/tea day for Resident Doctor Appreciation Week, a spin class, a bouldering night and skating event at Market Square.
- The team held a Talk for Family Medicine residents interested in applying to enhanced skills programs.
- The team is working on optimizing the rollout of the new EMR system at their hospital sites.

Ottawa:

- Thanks to the collaborative efforts of the GC team, PGME, and The Ottawa Hospital, part-time parking passes are now available for residents, and access to a new parking lot has been granted.
- The team's advocacy for a PGME-wide safe ride home program has been successful and a pilot program is on the way.
- Our Ottawa team has hosted several exciting events including ice cream rounds, fitness sessions, skating on the Rideau Canal and a full PARO Wellness Half Day on April 28th.

McMaster

- The GC team has been working with the hospitals to improve call rooms availability for residents.
- The McMaster GC held many exciting events including an OHL Ice Dogs hockey game, play with clay, free coffee/tea during Resident Doctor Appreciation Week, a skate night and a talk for resident parents.
- The team is advocating for a more inclusive scrub and gown sizes, improved call rooms and access to 24/7 food options at all of the hospital sites, including healthy food options.

NOSM

- The NOSM team has been working with hospitals to roll out new cell phone paging applications at their hospital sites
- NOSM held an excellent variety of events including an indoor golf event, cross country skiing and snowshoe event and filling snack cupboards in resident lounges to help with the lack of food options at smaller rural hospital sites.
- The team continues to advocate for improving housing access and resources for NOSM residents.

Western

- The team worked to decrease the number of modules and workplace safety training for residents at different hospital sites, decreasing unnecessary administrative burden on residents.
- The team is working on an audit of all call rooms at Western, with the goal of ensuring there are always enough call rooms available for the residents who need them. As well they continue to advocate for improvements to the EMR system.
- The Western team held many successful events including an escape room, a hockey game, and a zumba event. Almost 300 residents participated in their Resident Doctor Appreciation Week events.

This local work is at the heart of what PARO does.

PARO Board of Directors

We are pleased to announce that for the 2025-2026 academic year Dr. Steph Mercier, PGY4, RCPSC Medical Oncology at Ottawa will be our President and Dr. Connor Brenna, PGY2, RCPSC Anesthesia at Toronto our Treasurer. The rest of the Board will be elected at our next PARO General Council meeting on June 6th.

PARO Awards

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

PARO celebrated the recipients of the 2025 PARO Awards at the Award Banquet on May 9th and winners of each award can be found on the [PARO website](#).

MAY 2025

Title:	Update on Board Action Items (For Information)
Main Contacts:	Carolyn Silver, Chief Legal Officer Cameo Allan, Director of 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 March 6 and 7, 2025. The motions carried, and the implementation status of the decisions are outlined in Table 1.

Table 1: Board Decisions from the March 6 and 7, 2025 meeting

Reference	Motions Carried	Status
<u>01-B-03-2025</u>	<p><u>Consent Agenda</u></p> <p>The Board of Directors¹ 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:</p> <p style="padding-left: 40px;">2.1 The Board meeting agenda for March 6 and 7, 2025, as amended; 2.2 The draft minutes from the Board meeting held on November 28 and 29, 2024; 2.3 Committee Appointment</p> <p>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.</p> <p style="text-align: center;"><u>CARRIED</u></p>	Completed.

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*.

Reference	Motions Carried	Status
<u>02-B-03-2025</u>	<p><u>For Approval: Appointment of Academic Directors</u></p> <p>The Board of Directors¹ of the College of Physicians and Surgeons of Ontario selects and appoints Dr. Claire Kendall, Dr. Roy Kirkpatrick and Dr. Katina Tzanetos as Academic Directors for a one-year term commencing as of the close of the Annual Organizational Meeting of the Board in 2025 and expiring at the close of the Annual Organizational Meeting of the Board in 2026.</p> <p style="text-align: center;"><u>CARRIED</u></p>	Completed.
<u>03-B-03-2025</u>	<p><u>Motion to Go In-Camera</u></p> <p>The Board of Directors¹ 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).</p> <p><i>Exclusion of public</i></p> <p>7(2) Despite subsection (1), the Council may exclude the public from any meeting or part of a meeting if it is satisfied that,</p> <p>(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;</p> <p>(d) personnel matters or property acquisitions will be discussed.</p> <p style="text-align: center;"><u>CARRIED</u></p>	Completed.
<u>04-B-03-2025</u>	<p><u>For Approval: By-law Amendments re PA Register and Fees for Emergency Class Certificate of Registration</u></p> <p>The Board of Directors¹ of the College of Physicians and Surgeons of Ontario amends the CPSO By-laws (By-law No. 168) as set out below:</p> <p>1. Paragraph (d) of Section 17.1.1 of the CPSO By-laws is revoked and substituted with the following paragraph (d):</p> <p>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:</p> <p style="padding-left: 20px;">...</p> <p style="padding-left: 20px;">(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;</p>	Completed.

Reference	Motions Carried	Status
	<p>2. Paragraph (c) of Section 18.1.2 of the CPSO By-laws is revoked and substituted with the following paragraph (c):</p> <p>18.1.2 Annual fees as of June 1, 2018, are as follows:</p> <p>...</p> <p>(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</p> <p>3. Section 21.1.1 of the CPSO by-laws is revoked and substituted with the following:</p> <p>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.</p> <p>4. Paragraphs (e) and (h) of Section 21.2.1 of the CPSO By-laws are revoked and substituted with the following paragraphs (e) and (h):</p> <p>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:</p> <p>...</p> <p>(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;</p> <p>...</p> <p>(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;</p> <p>5. Paragraph (b) of Section 23.1.3 of the CPSO By-laws is revoked and substituted with the following paragraph (b):</p> <p>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</p>	

Reference	Motions Carried	Status
	<p>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:</p> <p>...</p> <p>(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;</p> <p style="text-align: center;"><u>CARRIED</u></p>	
<u>05-B-03-2025</u>	<p><u>Alternative Pathways to Registration for Physicians Trained in the United States Directive</u></p> <p>The Board of Directors¹ of the College of Physicians and Surgeons of Ontario approves the new registration policy directive, “<i>Alternative Pathways to Registration for Physicians Trained in the United States</i>”, as a directive of the College (a copy of which forms Appendix “A” to the minutes of this meeting).</p> <p style="text-align: center;"><u>CARRIED</u></p>	Completed.
<u>06-B-03-2025</u>	<p><u>Final Approval: Consent to Treatment Policy</u></p> <p>The Board of Directors¹ of the College of Physicians and Surgeons of Ontario approves the revised policy “<i>Consent to Treatment</i>” as a policy of the College (a copy of which forms Appendix “B” to the minutes of this meeting).</p> <p style="text-align: center;"><u>CARRIED</u></p>	Completed.
<u>07-B-03-2025</u>	<p><u>Close Meeting</u></p> <p>The Board of Directors¹ of the College of Physicians and Surgeons of Ontario close the meeting.</p> <p style="text-align: center;"><u>CARRIED</u></p>	Completed.

Title:	2026 Q1 Updates and Q2 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 2026 CPSO meeting dates for Q1 (updated since last circulated) and Q2.

Current Status & Analysis

- Starting in 2024, CPSO Board dates have been shared quarterly on a rolling basis. This gives Board Directors and staff advance notice of the upcoming Governance & Nominating Committee (GNC), Finance & Audit Committee, Executive Committee (EC) and Board of Directors meetings.
- At its March meeting, the Board was provided Q1 2026 meeting dates. GNC meetings were tentatively scheduled as the Governance Office gathered learnings from the first province-wide election cycle. As the Election has concluded, the Governance office has updated the GNC meeting schedule for Q1.
 - The February 3 GNC meeting has been moved to February 17 and the March 10 GNC meeting has been removed.
 - The March 3 EC ad-hoc meeting is scheduled in case a dispute is submitted regarding the Slate of Nominees; the meeting will be held virtually if required.
 - The March 31 EC will be virtual instead of in-person.
- The meetings below are the 2026 Q1 and Q2 meeting dates:

Q1

Jan-2026

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

Q2

Apr-2026

M	T	W	T	F
		1	2	3
		Passover (Apr 2-3)		Good Friday
6	7	8	9	10
	GNC-V			
13	14	15	16	17
20	21	22	23	24
	GNC-V			
27	28	29	30	
	FAC-V			

BOD	Board of Directors
EC	Executive
EC-V	Executive-Virtual
GNC-V	Governance & Nominating-Virtual
FAC-V	Finance & Audit-Virtual
	Stat/religious holidays/Marbreak

Feb-2026

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

May-2026

M	T	W	T	F
				1
4	5	6	7	8
	EC			
11	12	13	14	15
18	19	20	21	22
	Victoria's Day			
25	26	27	28	29
			BOD	BOD

Mar-2026

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

Jun-2026

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

Title:	Executive Committee Elections and Appointments (For Decision)
Main Contacts:	Cameo Allan, Director, Governance Christina Huang, Team Lead, Governance
Attachment:	Appendix A: 2025-2026 Executive Committee Nomination Statements and Forms
Questions for Board:	<ol style="list-style-type: none"> 1. Does the Board of Directors (Board) elect Dr. Patrick Safieh as Board Chair? 2. Does the Board elect Dr. Andrea Steen as Board Vice-Chair? 3. Does the Board appoint Dr. Marie-Pierre Carpentier, Ms. Joan Fisk, Dr. Lydia Miljan (PhD) and Mr. Rob Payne as four Executive Member Representatives?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- The Board is asked to elect the Board Chair and Board Vice-Chair and approve four Executive Member Representative appointments as prescribed in the CPSO By-laws section 5.1 and 9.1.2.
- Appropriate governance of committees of the Board aligns with CPSO’s public interest mandate.

Current Status & Analysis

- At the May 2025 CPSO Board meeting, the Board will determine the 2025-26 Executive Committee. This involves electing a Board Chair and Vice-Chair and appointing four Executive Member Representatives.
- On March 5, 2025, the Registrar sent a memo to Board Directors informing them of the application and selection process for the 2025-26 Executive Committee.
- As per CPSO By-laws section 9.1.1, the Executive Committee shall be composed of 6 members, at least 3 Physician Directors and 2 Public Directors.
- It is a CPSO convention that:
 - the current Board Vice-Chair is to progress to Board Chair;
 - the next Board Vice-Chair is currently serving, or has served, on the Executive Committee; and
 - nominations must be made in advance of the May Board meeting as they will not be accepted from the floor.
- All candidates submitted a Nomination Statement by March 26 at 4 pm to be considered; candidates for Chair and Vice-Chair positions will be given an opportunity to address the Board for two minutes about their candidacy for the position.
- Nomination Statements have been attached in **Appendix A:**
 - Dr. Patrick Safieh (Chair)
 - Dr. Andrea Steen (Vice-Chair)
 - Dr. Marie-Pierre Carpentier (Executive Member Representative)
 - Ms. Joan Fisk (Executive Member Representative)
 - Dr. Lydia Miljan (PhD) (Executive Member Representative)
 - Mr. Rob Payne (Executive Member Representative)
- The GNC reviewed all candidates and confirmed they meet the eligibility criteria as approved by the Board.
 - Since there is only one candidate for the Board Chair and Vice-Chair position, the candidates will be acclaimed.
 - The Board is asked to appoint Executive Member Representatives.
- The 2025-26 Executive Committee term will start upon the close of the 2025 AOM until the close of the following AOM.

Executive Committee Elections



Nomination Statement & Form: Dr. Patrick Safieh

Dr. Patrick Safieh, Physician Director

Nominated For:

Board Chair

Board of Director Terms:

2017-2020

2020-2023

2023-2026

CPSO Involvement:

Board Vice-Chair	2024 – 2025
Executive Committee	2023 – Present
Governance and Nominating Committee	2022 – 2023, 2024 – Present
Quality Assurance Committee	2008 – 2022
Policy Working Group	2018 – 2020

Nomination Statement:

Thank you for considering me for the position of Board Chair. I have a long history with the CPSO as well as multiple hospital leadership roles which enables me to be an effective, experienced and knowledgeable member of the Executive Committee.

I have recently Chaired our GNC and navigated the Governance modernization initiatives for elections and appointments. I have been involved with the CPSO as a Peer Assessor (2000-2008), a non-Board member (2008-2017, three of which as co-chair), member of the Executive Committee, QI Coach, and as a Board Member (since 2017), as well as being Chief of Family Medicine at two hospitals, Chief of Emergency Medicine and Chief of Staff. I have introduced a new Family Medicine Teaching Unit at Humber River Hospital, while also continuing active clinical practice (both in my busy and diverse family practice & in Emergency). In addition to my formal leadership positions, I have acted as a mentor and provided encouragement to my colleagues, including during the challenges of the pandemic.

Personally, I am married to a family physician for 33 years and have four adult children. I handle crises well and am considered to be well balanced with a calm demeanour.

Nomination Statement & Form: Dr. Andrea Steen

Dr. Andrea Steen, Physician Director

Nominated For:

Board Vice-Chair

Board of Director Terms:

2022-2025

CPSO Involvement:

Executive Committee

2024 – Present

Nomination Statement:

I am writing to express my interest to stand for the nomination of Vice Chair position of the Board. The depth of experience of the Directors, and talent and expertise of the staff, make it an absolute pleasure to belong to this Board. Although I am new to the executive committee, I have experience with leadership, Board positions, governance, and a keen desire to continue the work of this high functioning Board and organization. My leadership style is collaborative, respectful and thoughtful. I see these values aligning with the culture created with our current Board. I would strive to continue the work of the very competent Vice Chairs who have been role models and mentors. Also, with coaching from our governance consultant, I would be open to improving my communication and effectiveness to be a successful and valuable Vice Chair. I appreciate your consideration for this important position.

Nomination Statement & Form: Dr. Marie-Pierre Carpentier

Dr. Marie-Pierre Carpentier, Physician Director

Candidate For:

Executive Member Representative

Board of Director Terms:

2022 – 2025

CPSO Involvement:

Policy Working Group	2025 – Present
Ontario Physicians and Surgeons Discipline Tribunal	2022 – Present
Fitness to Practise Committee	2022 – Present

Nomination Statement:

I am honoured to submit my nomination for a position on the Executive Committee, bringing a strong commitment to governance, leadership, and public service. With a solid understanding of professional regulation, I am confident in my ability to contribute meaningfully to the Executive Committee’s objectives.

My tenure as a CPSO Board Director, member of the OPSDT, and participant in the CPSO Policy Working Group has deepened my insight into regulatory processes and reinforced my dedication to the College’s mandate. Additionally, my seven years as a CPSO peer assessor in emergency medicine have given me firsthand experience in upholding professional standards.

As a francophone emergency physician with 25 years of clinical experience—including leadership roles as chief of the emergency department and president of the Medical Staff Association—I bring a well-rounded perspective to the Board. My work in the emergency department has strengthened my commitment to EDI in healthcare.

As a candidate, I approach challenges with patience and tact. My leadership is rooted in collaboration, and a commitment to achieving meaningful outcomes. It would be an honour to serve on the Executive Committee and contribute to the CPSO’s strategic vision, ensuring the Board reflects the dynamic healthcare landscape it serves.

Executive Committee Application



Nomination Statement & Form: Ms. Joan Fisk

Ms. Joan Fisk, Public Director

Candidate For:

Executive Member Representative

Board of Director Terms:

2017 – 2020

2020 – 2023

2023 – 2024

2024 – 2026

CPSO Involvement:

Executive Committee	2020 – Present
Inquiries, Complaints and Reports Committee	2017 – Present

Nomination Statement:

I am putting my name forward as a candidate for the Executive Committee.

I have enjoyed being part of the progressive changes the board has undergone for the last 4 years, and would welcome the opportunity to continue in this capacity for the next year.

I am now experienced in the role this committee has in the governance of the College of Physicians and Surgeons of Ontario.

My involvement on the ICRC committee has given me insight into the important role of the regulation of the profession, and I am honoured to act on behalf of the public, to ensure that they are protected. It is also important to be able to contribute to the evolving efficiency of the College through knowledge and experience I have gained over the past years.

Thank you for your support and welcome your continued endorsement of my role on the Executive committee.

Executive Committee Application



Nomination Statement & Form: Dr. Lydia Miljan (PhD)

Dr. Lydia Miljan (PhD), Public Director

Candidate For:

Executive Member Representative

Board of Director Terms:

2020 – 2023

2023 – 2025

CPSO Involvement:

Executive Committee	2022 – Present
Inquiries, Complaints and Reports Committee	2020 – Present
Governance Committee	2021 – 2022
Policy Working Group	2020 – 2023

Nomination Statement:

As a researcher and advocate for political engagement, I bring a unique perspective and skill set that makes me an excellent member of the committee. As a member of Executive Committee for the past 2 years I have increased my knowledge of professional and occupational regulation as well as health system knowledge and risk oversight.

I have skills competencies in most of the areas identified by CPSO. Of the key attributes I believe the ones that align best with my background in public policy are governance and leadership.

Throughout my career, I have dedicated myself to advancing knowledge and understanding of political systems and the role of citizens within them. I have published extensively on topics ranging from electoral reform to public policy (including health care) and my work has been widely recognized for its contributions to the field. I have a strong grasp of the complex legal and ethical considerations involved in regulatory decision-making.

I bring my expertise in research and analysis, and my commitment to the public to the table. I am confident that I can continue to make valuable contributions to the committee's work and help advance the mission of CPSO.

Executive Committee Application

Nomination Statement & Form: Mr. Rob Payne



Mr. Rob Payne, Public Director

Candidate For:

Executive Member Representative

Board of Director Terms:

2020 – 2021

2021 – 2024

2024 – 2027

CPSO Involvement:

Governance and Nominating Committee	2022 – Present
Finance and Audit Committee	2020 – Present
Ontario Physicians and Surgeons Discipline Tribunal	2020 – Present
Fitness to Practise Committee	2020 – Present

Nomination Statement:

I'm honoured to submit my nomination for the role of Executive Member. As a dedicated, active and engaged member of the Board and the Ontario community, I'm committed to supporting and governing the affairs of the CPSO in fulfilling its duty to serve the public interest.

My experience in local government, marketing communications, wealth management & finance, governance, adjudication and community engagement has equipped me with a strong understanding of governance and the importance of my fiduciary responsibilities. This experience, spanning thirty-six years, has prepared me to contribute and support College staff with the development and delivery of major communications, government relations, and outreach initiatives to the profession, the public and other stakeholders, consistent with the College's strategic plan.

As a Public Director, I'm committed to the duty of care & loyalty, consulting with the Board to foster transparency and accountability, while taking a respectful and responsive approach. I'm also resolved to continue the great work to enhance the trust between our dedicated healthcare professionals and the public. I'm excited about the opportunity to work alongside other Executive Members in serving the people of Ontario through effective regulations of our medical doctors. Thank you for considering my nomination.

Motion Title	For Approval: 2025-26 Executive Committee Elections
Date of Meeting	May 29, 2025

It is moved by _____, and seconded by _____, that:

The Board of Directors¹ of the College of Physicians and Surgeons of Ontario appoints:

Dr. Patrick Safieh (as Board Chair), and

Dr. Andrea Steen (as Board Vice-Chair),

to the Executive Committee for the year that commences with 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*.

Motion Title	For Approval: 2025-26 Executive Committee Appointments
Date of Meeting	May 29, 2025

It is moved by _____, and seconded by _____, that:

The Board of Directors¹ of the College of Physicians and Surgeons of Ontario appoints:

Dr. Marie-Pierre Carpentier,

Ms. Joan Fisk,

Dr. Lydia Miljan (PhD), and

Mr. Rob Payne,

as Executive Member Representatives to the Executive Committee for the year that commences with 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*.

Title:	Governance and Nominating Committee (GNC) Elections (For Decision)
Main Contacts:	Cameo Allan, Director, Governance Christina Huang, Team Lead, Governance
Attachment:	Appendix A: 2025-2026 GNC Nomination Statements and Forms
Question for Board:	Who does the CPSO Board of Directors (the Board) elect to the GNC, upon the close of the 2025 Annual Organizational Meeting (AOM)?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- The CPSO Board of Directors (Board) is asked to elect the GNC members for 2025-26, as prescribed in the CPSO By-laws section 9.4.3
- Appropriate governance of committees of the Board aligns with CPSO's public interest mandate.

Current Status & Analysis

- On April 1, 2025, the Registrar sent a memo to Directors informing them of the process for the 2025-26 GNC elections.
- All candidates submitted a completed Nomination Statement by May 2 at 4 pm to be considered and will be given an opportunity to address the Board for two minutes about their candidacy for the position.
- It is CPSO convention that nominations must be made in advance of the Board meeting when GNC elections will be held and will not be accepted from the floor.
- Nomination statements have been attached in **Appendix A:**
 - Dr. Madhu Azad (Physician Director)
 - Ms. Lucy Becker (Public Director)
 - Dr. Vincent Georgie (PhD) (Public Director)
 - Dr. Sarah Reid (Physician Director)
 - Mr. Fred Sherman (Public Director)
- As per the CPSO By-laws section 9.4.1, the GNC is composed of the Board Vice-Chair (who is Chair of GNC), 2 Physician Directors and 2 Public Directors (where these Directors are not members of the Executive Committee).
 - The Board Vice-Chair will be appointed as Chair of the GNC.
 - There will be an election for the 2 Public Director positions. The CPSO will use the same electronic ballot process for voting as in previous years, which will require Board Directors to have their CPSO laptop.
 - Given that there are 2 candidates for 2 Physician Director positions, they will be acclaimed.
- The 2025-26 GNC term of will start upon the close of the 2025 AOM until the close of the following AOM.

Governance and Nominating Committee Elections



Nomination Statement & Form: Dr. Madhu Azad

Dr. Madhu Azad, Physician Director

Nominated For:

Member, Governance and Nominating Committee

Appointed Board of Director Terms:

2022-2024

2024-2027

CPSO Involvement:

Governance and Nominating Committee	2023-Present
Policy Working Group	2023-Present
Ontario Physicians and Surgeons Discipline Tribunal	2022-Present
Fitness to Practice Committee	2022-Present

Nomination Statement:

Dear Colleagues,

With great responsibility and pride, I seek re-election for the Governance and Nomination Committee. Having served on the GNC from 2023-2025, I remain dedicated to the role of enhancing a trustworthy GNC.

My Immersive experience in Policy, OPDST and GNC has significantly expanded my organizational knowledge, adding to insights and skills in adaptive leadership from leadership roles in hospital and primary care.

Having worked in three different countries, with lived experiences as an International Medical Graduate and a BIPOC Family Physician, working within health inequities of the North, I bring a clear intersectional lens.

My qualifications include an International Masters in Healthcare Leadership (McGill) and ongoing education as a member of the Institute of Corporate Directors.

The CPSO strives to excel, this drives the evolving GNC culture, enabling important counter conversations. Good can be great, and I commit at the CPSO to asking "How can we do better?"

Thank you for your consideration.

Governance and Nominating Committee Elections



Nomination Statement & Form: Ms. Lucy Becker

Ms. Lucy Becker, Public Director

Nominated For:

Member, Governance and Nominating Committee

Appointed Board of Director Terms:

2021 - 2024

2024 - 2025

CPSO Involvement:

Governance and Nominating Committee	2024 - Present
Ontario Physicians and Surgeons Discipline Tribunal	2021 - Present
Fitness to Practise Committee	2021 - Present

Nomination Statement:

As a public affairs, policy and communications executive with extensive leadership and governance experience in various professional regulatory sectors, I feel I can contribute more to modernizing the CPSO governance model.

As the Chair of the Bereavement Authority of Ontario Governance and Nominations Committee (GNC) and as a member of both the Don Valley Community Legal Services and National NewsMedia Council's GNCs, I bring governance best practices and lessons learned to the CPSO.

My professional and regulatory background includes over 25 years of regulating lawyers, investment firms and advisors, and retirement homes. It also encompasses strong risk and financial management and oversight. As the co-chair of the Financial Services Regulatory Authority's Consumer Advisory Panel, I am a champion for financial literacy, consumer engagement and consumer-centric outcomes.

My leadership style is open, collaborative and inclusive, focused on relationship-building and leveraging diverse unique perspectives/insights and lived experiences of others.

It would be an honour to be re-elected for another term alongside such dedicated and inspiring colleagues who are committed to enhancing the public's trust and confidence through modern, effective and efficient regulation that serves the public interest. Thank you for your continued support.

Governance and Nominating Committee Elections



Nomination Statement & Form: Dr. Sarah Reid

Dr. Sarah Reid, Physician Director

Nominated For:

Member, Governance and Nominating Committee

Board of Director Terms:

- 2018 – 2021
- 2021 – 2024
- 2024 – 2027

CPSO Involvement:

Board Chair	2024 – 2025
Board Vice-Chair	2023 – 2024
Executive Committee	2022 – Present
Finance & Audit Committee	2024 – Present
Quality Assurance Committee	2019 – 2024
Governance and Nominating Committee	2021 – 2022, 2023 – 2024
Policy Working Group	2020 – 2024

Nomination Statement:

This is a critical time for the CPSO Board as we operationalize our recent bylaw changes and make our governance modernization efforts a reality. The 2025 Governance and Nominating Committee worked tirelessly to deliver our first province-wide election. We will need to continue to iterate this process to ensure the desired richness of experience, skills and attributes is reflected on our Board in the future.

I have been a pediatric emergency physician in Ottawa for over 20 years and have developed a keen understanding of the complexity of our health care system and the challenges faced by patients and their families. I am deeply committed to patient experience and the CPSO's vision of Trusted Doctors Providing Great Care.

As your Chair, I recognize the need to continue to develop the conditions required to support a robust election/appointment process for Board committees. I have put my name forward to ensure that our 2026 GNC is constituted according to our bylaws. Given the importance of the work of our GNC, I believe that my leadership and governance experience on the CPSO Board and committees will allow me to help support our shared goals. I appreciate your consideration.

Governance and Nominating Committee Elections



Nomination Statement & Form: Dr. Vincent Georgie (PhD)

Dr. Vincent Georgie (PhD), Public Director

Nominated For:

Member, Governance and Nominating Committee

Appointed Board of Director Terms:

2024 - 2027

CPSO Involvement:

Ontario Physicians and Surgeons Discipline Tribunal	2025 – Present
Fitness to Practice Committee	2025 – Present

Nomination Statement:

I would be honoured to serve on the GNC.

I might be new to CPSO, but I am not new to Boards, Executive Searches, Governance or Organizational Leadership, or to operating in complex regulatory environments. In fact, it is one of the reasons I was appointed to the CPSO Board.

I come from both the Film Industry and Higher Education. I believe I can provide a critical, practical and outside-the-box lens in this role. There is strong value in diversity of perspective especially as a public actor.

For several years, I have provided strategic counsel to the President and Vice-Chancellor of the University of Windsor, am frequently called upon to provide similar counsel to governmental actors at all three levels, and have served on numerous Senates, Boards of Governors, Boards of Directors and Advisory groups across Ontario.

I have Chaired, Co-Chaired or been a member of numerous searches in both public and private sectors for Board-level, Executive-level and Senior-level appointments and re-appointments.

I am a strong communicator, a highly collaborative leader and consensus-builder, have a strong work ethic and critical lens.

I am a francophone based in Windsor, and I hope to bring my language and regionality to the table.

Governance and Nominating Committee Elections



Nomination Statement & Form: Mr. Fred Sherman

Mr. Fred Sherman, Public Director

Nominated For:

Member, Governance and Nominating Committee

Appointed Board of Director Terms:

2021 - 2022

2022 - 2025

2025 - 2028

CPSO Involvement:

Policy Working Group	2021 - Present
Inquiries, Complaints and Reports Committee	2021 - Present

Nomination Statement:

It continues to be my true honour to serve over the last four-plus years on behalf of Ontario residents, alongside colleagues striving to deliver on the mission of Trusted Doctors Providing Great Care. I wish to put my name forward as a Public Director candidate for the Governance and Nominating Committee (GNC).

I was humbled by the opportunity to bring to the CPSO a breadth of public affairs and corporate governance experience which began decades ago as a student leader managing a multi-million-dollar health plan for 10,000 beneficiaries, while concurrently serving on various university governance boards. These skills were honed on successive public and private boards.

My on-going service on both the CPSO Inquiries, Complaints and Reports (ICR) Committee and the Policy Working Group have allowed me to develop strong relationships and buttressed my participation in our regulatory governance modernization work.

Beyond the College, I am a Director of the Province of Ontario's Ottawa Convention Centre where I chair the Finance and Audit Committee.

Throughout my service, I have understood the significance of what I bring, including the lived experience as a person of colour.

If elected, I will serve with distinction, integrity and collegiality.

Motion Title	For Approval: 2025-26 Governance and Nominating Committee (GNC) Elections
Date of Meeting	May 29, 2025

It is moved by _____, and seconded by _____, that:

The Board of Directors¹ of the College of Physicians and Surgeons of Ontario appoints:

Dr. Andrea Steen (as GNC Chair),

Dr. Madhu Azad (as Physician Director, GNC member),

Dr. Sarah Reid (as Physician Director, GNC member),

_____ (as Public Director, GNC member), and

_____ (as Public Director, GNC member),

to the Governance and Nominating Committee for the year that commences with 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*.

MAY 2025

Title:	Updated Board Letter of Commitment (For Decision)
Main Contacts:	Cameo Allan, Director, Governance Caitlin Ferguson, Governance Coordinator
Attachment:	Appendix A: Updated Letter of Commitment
Question for Board:	Does the Board of Directors (Board) approve the updates to the Letter of Commitment?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- The Board is asked to review and approve updates to the Letter of Commitment (Letter), which is signed annually by all Board Directors.
- Ensuring that all Directors understand the norms they are expected to follow before, during and between meetings allows the Board to work more efficiently and remain focused on serving the public interest.

Current Status & Analysis

- The Letter was initially adopted at the May 2024 Board meeting and is now signed annually along with the Declaration of Adherence package. It is also the basis of the Board Norms slides that are displayed at the start and end of each Board meeting.
- Based on ongoing learnings since the Letter was adopted, the Governance Office is proposing some minor changes.
- The proposed changes include:
 - Increased specificity about the process Directors should follow to raise questions or concerns regarding CPSO business between meetings.
 - Clarification around external presentations and the requirement to seek authorization before agreeing to an engagement.
- The blacklined version of the Letter is attached as **Appendix A**.

CPSO Board of Directors Letter of Commitment (2025)

The goal of this letter is to ensure that Directors understand the norms and behaviours that lead to effective Board of Directors (Board) meetings. As a Director on the Board of the College of Physicians and Surgeons of Ontario (CPSO), I acknowledge that the CPSO's duty is to serve in the public interest. I will abide by all obligations described in the Declaration of Adherence and Code of Conduct. This letter highlights some, not all, obligations in the Declaration of Adherence and the Code of Conduct, along with some additional obligations that are specific to Directors. I understand that some of these obligations will remain after I cease being a Director.

Prior to Board Meetings:

- I will endeavour to attend all Board meetings and will give notice to the Board Chair if I am unable to attend.
- I will review all materials (including any motions) before the meeting to ensure I understand them. If I have significant concerns or require clarification regarding the materials, I will discuss them with the Board Chair before the meeting.
- I will proactively disclose any actual or potential Conflicts of Interest in accordance with the Declaration of Adherence and CPSO By-Laws.

During Board Meetings:

- I recognize that my role as a Director is to govern the affairs of the CPSO in fulfilling its duty to serve the public interest, rather than to be involved in CPSO operations (the Board addresses the What and the Why, not the How).
- I will participate in a professional manner in Board discussions and interactions with CPSO staff.
- I will be engaged and focused on Board work during meetings, sharing my valuable insights. I will refrain from sidebar conversations and reduce distractions from electronic devices as much as possible.
- I will endeavour to ask questions that contribute to and advance the discussion.
- I will listen actively to ensure everyone's voice is respectfully heard.

Between Board Meetings:

- Once the Board has come to a decision, I will adhere to and support the decision ("speak with one voice").
- I will not communicate directly with CPSO staff. I will send any questions or concerns to the Governance Office, who will then review and direct my request as required. All questions or concerns must be directed to the Governance Office, who will triage my request; I will not communicate directly with individual CPSO staff.
- I will refer any questions from the public or media to the Governance Office.
- I will not speak on behalf of CPSO (including giving presentations in my role as Director or on a CPSO-related topic) unless explicitly authorized by the Communications Office., and I will refer any questions from the public or media to the Governance Office.
- I will only engage on social media in accordance with the Code of Conduct.
- I will check my CPSO email at least twice weekly between Board meetings.
- I will only use my CPSO-issued laptop and CPSO email address for CPSO work and communications in accordance with the Declaration of Adherence.

I confirm that I have read, understand and accept my duties and responsibilities as a Director of CPSO.

Printed Name: _____ Signature: _____ Date: _____

Motion Title	For Approval: Board Letter of Commitment
Date of Meeting	May 29, 2025

It is moved by _____, and seconded by _____, that:

The Board of Directors¹ of the College of Physicians and Surgeons of Ontario approves the revised Board Letter of Commitment (a copy of which forms Appendix "XX" 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*.

MAY 2025

Title:	Draft Policy for Public Consultation – <i>Closing a Medical Practice</i> (For Decision)
Main Contacts:	Tanya Terzis, Manager, Policy Lynn Kirshin, Senior Policy Analyst Mike Fontaine, Senior Policy Analyst
Attachments:	Appendix A: Draft <i>Closing a Medical Practice</i> policy Appendix B: Draft <i>Advice to the Profession: Closing a Medical Practice</i>
Question for Board:	Does the Board of Directors approve releasing the draft <i>Closing a Medical Practice</i> policy for public consultation?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- A draft *Closing a Medical Practice* policy (**Appendix A**) and associated *Advice to the Profession* (“*Advice*”) (**Appendix B**) have been developed. The Board is asked whether the draft policy can be released for public consultation.
- Clarifying the expectations for physicians that arise from closing their practice will help minimize disruptions in continuity of care for patients and aligns with CPSO’s public interest mandate.

Current Status & Analysis

- The current [Closing a Medical Practice](#) policy¹ and *Advice* have been revised in response to preliminary consultation feedback² and input from the Policy Working Group.
- While many elements from the current policy have been retained in the draft, some revisions have been made, including the following:
 - The current expectation related to facilitating access to ongoing care has been removed to address concerns raised about the physician shortage. The draft policy is more principle-based and requires physicians to make reasonable efforts to minimize disruptions to continuity of care for patients (**Provision 1**).
 - The current expectation that physicians proactively plan for unexpected closures has been removed from the policy and has been reframed as a best practice in the *Advice*.
 - Physicians’ obligations with respect to providing prescription renewals and following up on outstanding tests have been clarified, as concerns were raised that the existing obligations were overly vague (**Provisions 4 to 6**).
 - The expectations around medical records have been streamlined in the draft policy and state that physicians must comply with the [Medical Records Management](#) policy and legislation (**Provision 7 and 8**).
 - In response to concerns that the current policy does not address unexpected practice closures, the draft policy includes an explicit exception for unexpected closures stating that, where physicians are suddenly and unexpectedly required to close their practice, physicians are required to comply with the policy to the best of their ability and as soon as it is practical to do so (**Provision 11**).
 - The draft now clearly sets out specific expectations for physicians whose certificates of practice have been suspended or revoked (**Provision 12**).

¹ The *Closing a Medical Practice* policy was last reviewed in 2019.

² A preliminary consultation on the draft policy received 48 total responses. All of the written comments can be viewed on the [consultation webpage](#), and a feedback overview was provided to the Board in the [November 2024 Policy Report](#).

CLOSING A MEDICAL PRACTICE

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

Practice closure: Occurs when a physician ceases to practise (due, for example, to retirement, resignation, revocation, suspension, illness or death) or continues to practise but at a new location (i.e., relocation).

Policy

This policy applies to all physicians who are closing a medical practice, including those who work in group practices or institutional settings, regardless of practice area or specialty.

1. Physicians **must** make reasonable efforts to minimize disruptions to continuity of care for patients. The minimum requirements for what constitutes reasonable efforts are set out in the policy below.

Notifying patients of practice closures

2. Physicians **must** notify patients¹ whose care is being actively managed² of a planned practice closure as early as possible, and at least three months before the practice closure.
 - a. In instances where a successor will be in place to take over the practice, the notice period may be shortened, but physicians **must** use their professional judgment to determine an appropriate timeframe for notifying patients.
3. Physicians **must** notify patients of the practice closure directly, either in writing (e.g., by mail, secure e-mail, or a portal message), by telephone,³ or in person at a scheduled appointment and **must** provide the following information:
 - a. The date of the closure;
 - b. Whether a successor is taking over part or all of the practice, and options for patients if no successor is available or they choose not to continue with the planned successor; and
 - c. Information about how to access or request transfer of their medical records including, whether or not medical records are being transferred to another person or entity.

¹ Or substitute decision-maker where the patient is incapable.

² Please see the *Advice to the Profession: Closing a Medical Practice* for more information on who may be a patient whose care is being actively managed.

³ Caution should be exercised when leaving messages on voicemail or with a third party due to concerns regarding patient confidentiality and privacy rights. For more information, please see the CPSO’s policy on [Protecting Personal Health Information](#).

32 **Prescription renewals**

- 33 4. During the notice period, physicians **must** provide prescription renewals when requested by patients and
34 where it would be clinically indicated.
- 35 a. Physicians **must** use their professional judgment to determine an appropriate timeframe for the
36 renewal.
- 37 b. Physicians **must** inform patients that prescription renewals written prior to the date they resign their
38 certificate of registration are not valid after the date of resignation.⁴

39 **Outstanding test results**

- 40 5. Physicians **must** continue to comply with the expectations set out in the [Managing Tests](#) policy, including
41 those related to tests that have a high risk of being clinically significant⁵.
- 42 6. Physicians **must** inform patients:
- 43 a. That standing orders for laboratory or other tests are not valid after the date of resignation; and
- 44 b. Of any arrangements that have been made regarding outstanding test results that will be received
45 after their practice closure.⁶

46 **Medical records**

- 47 7. Physicians **must** ensure that patients have continued access to their medical records following a practice
48 closure.
- 49 a. Physicians with custody of the medical record **must** notify all patients if they intend to transfer
50 custody of the medical record.⁷
- 51 8. Physicians **must** ensure that medical records, whether paper or electronic, are retained in accordance with
52 legislation⁸ and the [Medical Records Management](#) policy.⁹

53 **Notifying CPSO and others of practice closures**

- 54 9. Physicians who are closing a medical practice for the purposes of relocation **must** notify CPSO of a
55 change in their practice address within 30 days of the change.¹⁰
- 56 10. Physicians **must** use their professional judgment to determine whether to notify other health-care
57 providers involved in their patients' care of their practice closure.

⁴ For more information on prescription renewals, please see the *Advice to the Profession: Closing a Medical Practice*.

⁵ A clinically significant test result is a test result determined by a physician to be one which requires follow-up in a timely fashion, urgently, if necessary. Physicians determine the clinical significance of a test result using their clinical judgment and knowledge of the patient's symptoms, previous test results, and/or diagnosis.

⁶ For more information on arranging appropriate follow-up on outstanding test results, please see the *Advice to the Profession: Closing a Medical Practice*.

⁷ The *Personal Health Information Protection Act, 2004* states that where it is not reasonably possible to notify patients in advance of a transfer of records, physicians must notify patients as soon as possible after the transfer has occurred (S. 42(2)).

⁸ O. Reg. 114/94, General, enacted under the *Medicine Act, 1991*; c. 30, s. 19.

⁹ In addition to retention requirements, the *Medical Records Management* sets out storage and security requirements for medical records.

¹⁰ Physicians can consult the [CPSO's website](#) for information on how to report this change.

58 **Unexpected closures**

59 11. In situations where physicians are suddenly and unexpectedly required to close their practice, physicians
60 or their designate **must**, to the best of their ability and as soon as it is practical to do so, take steps to
61 fulfill the expectations set out above.¹¹

62 **Practice closures due to suspension or revocation of certificate of registration**

63 12. Physicians who close their practice due to the suspension or revocation of their certificate of registration
64 **must**:

- 65 a. Notify patients as soon as possible after learning of the need for a practice closure in accordance
66 with **Provisions 2 and 3** of this policy;
- 67 b. Notify others of the practice closure in accordance with **Provision 10** of this policy;
- 68 c. Notify CPSO of the arrangements they have made for storing medical records;
- 69 d. Inform patients that prescription renewals written prior to the date of suspension or revocation are
70 not valid after the date of suspension or revocation;
- 71 e. Inform patients that standing orders for laboratory or other tests are not valid after the date of
72 suspension or revocation;
- 73 f. Inform patients that they are not able to interpret test results, prepare reports,¹² or provide follow-up
74 care; and
- 75 g. Inform patients about how they can get their prescriptions renewed and/or how to follow up on tests
76 performed or results received after the date of suspension or revocation.

¹¹ For resources on facilitating an unexpected practice closure, see the *Advice to the Profession: Closing a Medical Practice*.

¹² Only administrative work required to finalize an outstanding report can be completed during the suspension period or following resignation or revocation. Administrative work includes editing draft reports, summarizing conclusions or signing reports completed prior to resignation, revocation or suspension.

ADVICE TO THE PROFESSION: CLOSING A MEDICAL PRACTICE

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

This document is intended to help physicians interpret their obligations as set out in the *Closing a Medical Practice* policy and provide guidance around how these obligations may be met.

Contingency planning for unexpected practice closures

Contingency plans for unexpected closures can help ensure that patients and others, (e.g., family members and colleagues) are not negatively impacted should you have to unexpectedly close your practice. This can involve identifying a designate who can assist with fulfilling the policy expectations should an unexpected closure occur (e.g., notifying patients about the closure, etc.).

Patients whose care is being actively managed

Physicians are required to notify patients whose care is being actively managed of any practice closure. A patient's care can be considered actively managed when:

- The physician sees the patient on a regular basis (even annually);
- The patient is rostered to a physician's practice and is counted as part of the physician's contract; and/or
- The physician provides prescriptions or renewals to the patient.

Similarly, patients whose care would not be considered actively managed include:

- Patients whose involvement with a physician (specialist) has reached its natural or expected conclusion; and/or
- Patients who were provided episodic care (e.g., at a walk-in clinic or emergency room).

However, it is also important for physicians to use their professional judgment to determine whether there may be other patients who would benefit from being notified of the practice closure.

Additional patient notification methods

It may be difficult to determine whether all your patients are aware of your practice closure. In addition to notifying patients directly about a practice closure, you can also inform your patients by:

- Posting printed notices in your office;
- Providing notice on your office voicemail message; and/or
- Posting a notice on a website.

33 **Notifying CPSO about practice closures**

34 If you are closing your practice because you are resigning from membership, you can submit a service request
35 in the Member Portal.¹

36 **Retaining a certificate of registration when closing a practice**

37 Some physicians may retain their certificate of registration after they have closed their practice to help ensure
38 timely follow-up on test results and so that patients can continue to fill their prescriptions while they find
39 another health-care provider (as prescriptions are not valid after a physician's resignation). If physicians
40 choose to do this, it is important for them to provide their contact information and be available to answer
41 questions about test results and prescription medications during this time.

42 **Prescription refills following a resignation**

43 Once a physician resigns their certificate of registration, prescriptions written prior to their date of resignation
44 are no longer valid. This can present challenges for patients who rely on prescription refills to manage their
45 care needs.

46 In its [Fact Sheet on Prescriber Registration Status Changes](#), the Ontario College of Pharmacists states that the
47 decision to dispense a prescription or prescription refill after a prescriber's registration status has changed and
48 the patient is no longer under their care should be made on a case-by-case basis. In most cases, prescription
49 refills are considered invalid once a physician is no longer registered with the College. In these situations,
50 however, the pharmacist may decide to honour the refill request based on their [assessment of the patient](#) and
51 the circumstances at hand in the best interest of the patient.

52 **Arranging appropriate follow-up on outstanding test results**

53 In some cases, the results of laboratory tests and/or diagnostic imaging reports that you have ordered may
54 only be available after your practice has closed. As such, you have a responsibility to make arrangements to
55 ensure appropriate follow-up on results (for tests you have ordered) that will be received after the practice
56 closure.

57 The type of arrangements that are needed will depend on the nature and urgency of the outstanding test
58 results, and physicians will need to use their professional judgment to determine what arrangements for
59 tracking and follow-up are necessary. These arrangements could include advising patients to contact the
60 facility that administered the test to obtain a copy of their results and to follow-up with another health-care
61 provider.

62 It is important to recognize that the higher the risk of receiving a clinically significant test result, the more
63 important it is to track and follow-up on these test results. The [Managing Tests](#) policy sets out that, where an
64 outstanding test result has a high risk of being clinically significant, your obligations include:

- 65 • Ensuring that the results are tracked;
- 66 • Arranging for another health-care provider to communicate the results with the patient once they are
67 received and provide appropriate follow-up, as needed.

68 **The Medicine Act and medical records retention requirements**

69 The requirements for medical record retention outlined in the policy are mandated by [Ontario Regulation,
70 114/94, General, enacted by the Medicine Act, 1991](#). Appropriately retaining medical records facilitates
71 continuity of care by ensuring that patients have access to their medical records following a practice closure.

¹ For further information, see [CPSO's website](#).

72 Medical records may also be relevant in future legal proceedings. For additional guidance on maintaining
73 patient medical records, see CPSO's [Advice to the Profession: Medical Records Management](#).

74 **Providing medical records to successors**

75 The [Personal Health Information Protection Act, 2004 \(PHIPA\)](#) permits physicians who are custodians of
76 medical records to disclose patients' personal health information to a potential successor for the purpose of
77 allowing the potential successor to assess and evaluate the physician's practice. However, there will need to be
78 an agreement to keep the information confidential and secure.²

79 **Responsibility for patients' medical records following a physician's death**

80 If a physician dies, the estate trustee of the physician is deemed to be the custodian of patients' medical
81 records until custody and control of the records pass to another person who is legally authorized to hold
82 them.³

83 Where there is uncertainty about who is responsible for the medical records of a deceased physician, the
84 CMPA can provide assistance. More information about medical records and practice closure can be found in
85 the resources listed below.

86 **Transferring medical records**

87 When transferring medical records, it is good practice to have a written agreement documenting:

- 88 • The location of the records;
- 89 • The responsibility of notifying the transferring physician if the records are moved to a different location
90 or transferred to a different physician;
- 91 • The transferring physician's right of access to the records in the event of a civil claim or CPSO
92 complaint;
- 93 • Patients' right of access to the records;
- 94 • The length of time for which the records must be retained;
- 95 • The obligation to protect the confidentiality of the records; and
- 96 • Obligations regarding the destruction of the records.

97 If you are transferring custody of patients' medical records you can contact the CMPA to ensure that the
98 arrangements you make for record transfer and retention comply with your obligations under the *Medicine Act*,
99 *1991* with respect to records and *PHIPA*.

100 **Resources for closing a medical practice**

101 The information below provides additional guidance with respect to closing a medical practice including:
102 planning for an unexpected closure (e.g., due to death or illness), planning for an expected closure (e.g., due to
103 retirement), managing patient medical records, notifying patients, meeting privacy obligations and managing
104 other office issues.

105 *Ontario Medical Association*

- 106 • [Closing a Practice: A Guide for Physicians](#) (includes a practice closure checklist and sample patient
107 notification letters)

² *PHIPA*, s. 42 (1)

³ *PHIPA*, s. 3 (12)

- [Closing your Practice Due to Retirement?](#)
- [Closing a practice: When the unexpected happens](#) (for families or estate executors who are facilitating a practice closure when a physician dies or stops practising medicine suddenly due to illness)

Canadian Medical Protective Association

- [Closing or Leaving a Practice: Tips for Primary Care Physicians](#)
- [Electronic Records Handbook](#)

Information and Privacy Commissioner of Ontario

- [Succession Planning to Help Prevent Abandoned Records](#)
- [Avoiding Abandoned Health Records: Guidance for Health Information Custodians Changing Practice](#)
- [Frequently Asked Questions: Personal Health Information Protection Act](#), (See in particular, the question “What are the requirements for the treatment of personal health records in the event of a change in practice?” on page 15).

Ministry of Health and Long-Term Care

- HealthForceOntario: [Transition Out of Practice: A Guide for Physicians](#)

DRAFT

Board Motion

Motion Title	Draft Policy for Consultation: <i>Closing a Medical Practice</i>
Date of Meeting	May 29, 2025

It is moved by _____, and seconded by _____, that:

The Board of Directors¹ of the College of Physicians and Surgeons of Ontario engage in the consultation process in respect of the draft revised policy, "*Closing a Medical Practice*," (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*.

MAY 2025

Title:	Draft Policy Amendments for Consultation: <i>Delegation of Controlled Acts</i> (For Decision)
Main Contacts:	Anil Chopra, Associate Registrar Tanya Terzis, Manager, Policy Stephanie Sonawane, Policy Analyst
Attachment:	Appendix A: Draft Amendments to the <i>Delegation of Controlled Acts</i> policy
Question for Board:	Does the Board of Directors approve releasing the draft amendments to the <i>Delegation of Controlled Acts</i> policy for public consultation?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- Amendments to the [Delegation of Controlled Acts](#) policy are proposed to address challenges identified by the Inquiries, Complaints, and Reports Committee (ICRC) and the Investigations and Resolutions Department in enforcing the policy. The Board is asked whether the draft amendments to the policy can be released for public consultation.
- Clarifying appropriate delegation enables effective inter-professional collaboration and helps ensure patient safety, in line with CPSO’s public interest mandate.

Current Status & Analysis

- ICRC has seen a number of cases involving physicians who are delegating inappropriately. These cases involve circumstances where there is insufficient physician involvement in patient care, and where delegates are essentially operating independently.
- The current *Delegation of Controlled Acts* policy may be providing too much flexibility for physicians who are delegating and is enabling delegation in the absence of a physician-patient relationship in more instances than intended. Feedback suggests that the current policy is not giving ICRC the tools necessary to take action where they feel inappropriate delegation is occurring.
- In response to this issue, the following changes to the policy are proposed:
 - **Provisions 7 and 8:** clarifying what an “anticipated” physician-patient relationship means in practice and requiring a clinical assessment by the physician within 48 hours (for the first encounter with the patient).
 - **Provisions 7 and 8:** removing the “patient’s best interest” exception which is being read too broadly and enabling delegating in the absence of physician involvement. Instead, the draft policy sets out a specified list of appropriate exceptions (see below for more information).
 - **Footnote to Provision 7:** moving the list of circumstances where physicians can delegate in the absence of a physician-patient relationship to a new appendix, updating the list to better reflect the circumstances where this may be appropriate, and making the list exhaustive.
 - **New footnote:** adding a footnote that highlights that physician services, such as assessments, counselling, therapy, consultations and diagnostic service interpretations cannot be delegated to a non-physician for OHIP payment purposes. These services must be personally rendered by the physician to be paid by OHIP.
- As this work is being undertaken, the *Delegation of Controlled Acts* policy is also being reviewed more broadly, and the review will continue as planned outside of these specific proposed changes.

DELEGATION OF CONTROLLED ACTS

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

Controlled Acts¹: Controlled acts are specified in the *Regulated Health Professions Act, 1991 (RHPA)* as acts which may only be performed by authorized regulated health professionals.²

Delegation: Delegation is a mechanism that allows a regulated health professional (e.g., a physician) who is authorized to perform a controlled act to temporarily grant that authority to another person (whether regulated or unregulated) who is not legally authorized to perform the act independently.

For the purposes of this policy, delegation does **not** include:

- Assignments of tasks that do not involve controlled acts (e.g., taking a patient’s history, obtaining informed consent, administering a test that does not involve a controlled act, taking vitals, etc.); or
- Orders that authorize the initiation of a controlled act that is within the scope of practice of another health care professional (e.g., nurses are legally authorized to “administer a substance by injection” when the procedure has been ordered by a specified regulated health professional (e.g. a physician). Therefore, a nurse would require an order to perform this procedure, but this would not be considered delegation).³

Direct Order: Direct orders are written or verbal instructions from a physician to another health care provider or a group of health care providers to carry out a specific treatment, procedure, or intervention for a specific patient, at a specific time. Direct orders provide the authority to carry out the treatments, procedures, or other interventions that have been directed by the physician and generally take place after a physician-patient relationship has been established.

¹ See Appendix A for a list of controlled acts defined under subsection 27 (2) of the *Regulated Health Professions Act, 1991, S.O. 1991, c. 18 (RHPA)*.

² Although the *RHPA* prohibits performance of controlled acts by those not specifically authorized to perform them, it permits performing controlled acts if the person performing the act is doing so to render first aid or temporary assistance in an emergency, or if they are fulfilling the requirements to become a member of a health profession and the act is within the scope of practice of the profession and is performed under the supervision or direction of a member of the profession (*RHPA*, s. 29(1)(a,b)).

³ For additional information about what is not considered “delegation” as defined in the policy, see the [Advice to the Profession: Delegation of Controlled Acts](#) document.

29 **Medical Directive**⁴: Medical directives are written orders by physician(s) to other health care provider(s) that
30 pertain to any patient who meets the criteria set out in the medical directive. When a medical directive calls for
31 acts that need to be delegated, it provides the authority to carry out the treatments, procedures, or other
32 interventions that are specified in the directive, provided that certain conditions and circumstances exist.

33 Policy

34 Delegation is intended to provide physicians with the ability to extend their capacity to serve patients by
35 temporarily authorizing an individual to act on their behalf. Delegation is intended to be a physician extender,
36 not a physician replacement. Physicians remain accountable and responsible for the patient care provided
37 through delegation.

38 When to Delegate

39 *In the patient's best interest*

- 40 1. Physicians **must** only delegate controlled acts when doing so is in the best interest of the patient. This
41 includes only delegating when the act can be performed safely, effectively, and ethically. Therefore,
42 physicians **must** only delegate when:
- 43 a. the patient's health and/or safety will not be put at risk;
 - 44 b. the patient's quality of care will not be compromised by the delegation; and
 - 45 c. delegating serves at least one of the following purposes:
 - 46 i. promotes patient safety,
 - 47 ii. facilitates access to care where there is a need,
 - 48 iii. results in more timely or efficient delivery of health care, or
 - 49 iv. contributes to optimal use of healthcare resources.

50 *When not to delegate*

- 51 2. Physicians **must not** delegate where the primary reasons for delegating are monetary or physician
52 convenience.
- 53 3. Physicians **must not** delegate the performance of a controlled act to:
- 54 a. a health professional whose certificate of registration is revoked or suspended at the time of the
55 delegation⁵; or
 - 56 b. unregistered practitioners⁶ (i.e., individuals who have claimed to be or have posed as a
57 physician).
- 58 4. Physicians **must not** delegate the controlled act of psychotherapy.⁷

59

⁴ For examples of prototype medical directives, please consult the Emergency Department Medical Directives Implementation Kit which has been developed jointly by the Ontario Hospital Association (OHA), the Ontario Medical Association, and the Ministry of Health and is available on the OHA website.

⁵ For additional information about determining the status of a health professional's certificate of registration, see the [Advice to the Profession: Delegation of Controlled Acts](#) document.

⁶ For a list of individuals identified by the CPSO see [CPSO's website](#).

⁷ This does not prohibit health care professionals who are authorized to perform the controlled act of psychotherapy from doing so, including nurses of all classes, psychologists, occupational therapists, social workers, and registered psychotherapists.

60 What to Delegate

- 61 5. Physicians **must** only delegate the performance of controlled acts that they can personally perform
62 competently (i.e., acts within their scope of practice).⁸

63 How to Delegate

64 Use of direct orders and medical directives

- 65 6. Physicians **must** delegate either through the use of a direct order or a medical directive that is clear,
66 complete, appropriate, and includes sufficient detail to facilitate safe and appropriate implementation
67 (see the *Documentation* section of this policy for more information).

68 In the context of a physician–patient relationship

- 69 7. Physicians **must** only delegate in the context of an existing or anticipated physician-patient relationship
70 (i.e., a clinical assessment by the physician will take place within 48 hours), unless an exception applies
71 (see Appendix B for the list of exceptions) a patient's best interest dictates otherwise (e.g., public
72 health or public safety measures).⁹
- 73 8. Physicians **must** perform a clinical assessment prior to delegating or as soon as possible afterward
74 (i.e., within 48 hours)¹⁰, unless one of the exceptions set out in Appendix B applies a patient's best
75 interest dictates otherwise.
- 76 9. Where, in the context of a physician-patient relationship, delegation is occurring on an ongoing basis,
77 physicians **must**:
- 78 a. ensure that patients are informed of who the delegating physician is and that they can make a
79 request to see the physician if they wish to; and

⁸ O. Reg. 865/93, *Registration*, enacted under the *Medicine Act, 1991*, S.O. 1991, c.30, s. 2(5) requires physicians to only practise in the areas of medicine in which they are trained and experienced. For more information see the College's *Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice* policy and the *Advice to the Profession: Delegation of Controlled Acts* document.

⁹ Generally, a patient's best interests will be served by delegation that occurs in the context of an existing or anticipated physician-patient relationship. However, in some instances a patient's best interests might be served by receiving care in the absence of a traditional physician-patient relationship. For example, in instances where access would otherwise be compromised to the point of risking patient safety, or where patient or public safety might be otherwise compromised. Examples of appropriate circumstances in which delegation may occur in the absence of a traditional physician-patient relationship include, but are not limited to:

- the provision of care by paramedics under the direct control of base hospital physicians or within community paramedicine programs;
- the provision of primary care in remote and isolated regions of the province by registered nurses acting in expanded roles;
- the provision of public health programs, such as vaccinations;
- postexposure prophylaxis following potential exposure to a blood-borne pathogen or the provision of the hepatitis B vaccine in the context of occupational health medicine;
- hospital emergency departments for routine protocols; and
- lay person first responders performing controlled acts for the purposes of first aid in an emergency.

¹⁰ The Ontario Medical Association (OMA) provides guidance on the OHIP provisions related to delegated services. The guidance sets out that physician services, such as assessments, counselling, therapy, consultations and diagnostic service interpretations cannot be delegated to a non-physician for OHIP payment purposes. These services must be personally rendered by the physician to be paid by OHIP. See the OMA's *Billing for Delegated Services Guide* for more information.

- b. periodically re-assess¹¹ the patient to ensure that delegation continues to be in the patient's best interest (e.g., when there is a change in the patient's clinical status or treatment options).

Ensure consent to treatment is obtained

10. Physicians **must** ensure informed consent is obtained and documented, in accordance with the *Health Care Consent Act, 1996* and the College's [Consent to Treatment](#) policy, for any treatments that are delegated.¹²

- a. In circumstances where the delegation takes place pursuant to a medical directive, physicians **must** ensure the medical directive includes obtaining the appropriate patient consent.¹³

Quality Assurance

Identifying and mitigating risks

11. Prior to delegating, physicians **must** identify significant or common risks associated with the delegation and mitigate them such that patient safety is at no greater risk than had the act not been delegated.

- a. Physicians **must** only delegate controlled acts if the necessary resources and environmental supports are in place to ensure safe and effective delegation.

Evaluating delegates and establishing competence

12. Physicians **must** be satisfied that individuals to whom they delegate have the knowledge, skill, and judgment to perform the delegated acts competently and safely. Prior to delegating physicians **must**:

- a. review the individual's training and credentials, unless the physician is not involved in the hiring process and it is reasonable to assume that the hiring institution has ensured that its employees have the requisite knowledge, skill, and judgment¹⁴; and
- b. observe the individual performing the act, where necessary (e.g., where the risk is such that observation is necessary to ensure patient safety).

Ensuring delegates can accept the delegation

13. Physicians **must** only delegate to individuals who are able to accept the delegation.¹⁵ In particular, physicians **must not**:

¹¹ In some circumstances, an assessment might take the form of a chart review or consultation with the delegate rather than an in-person assessment.

¹² Please see the *Health Care Consent Act, 1996* and the College's [Consent to Treatment](#) policy for more information.

¹³ Obtaining informed consent includes providing the patient with information about the individual who will be providing the treatment and their role and/or credentials. Obtaining informed consent also includes the provision of information and the ability to answer questions about the material risks and benefits of the procedure, treatment or intervention proposed. If the individual who will be enacting the medical directive is unable to provide the information that a reasonable person would want to know in the circumstances, the implementation of the medical directive is inappropriate.

¹⁴ In some cases, the physician may not personally know the individual to whom they are delegating. For example, medical directors at base hospitals delegating to paramedics or in hospital settings, where the hospital employs the delegates (nurses, respiratory therapists, etc.) and the medical staff is not involved in the hiring process. For additional guidance about ensuring competence when a physician has not personally employed a delegate, see the [Advice to the Profession: Delegation of Controlled Acts](#) document.

¹⁵ In addition to the limitations set out in the *RHPA*, some regulatory colleges in Ontario place limits on the types of acts that their members may be authorized to carry out through delegation. The delegate is responsible for informing the delegating physician of any regulations, policies, and/or guidelines of their regulatory body that would prevent them from accepting the delegation.

- a. delegate to an individual if they become aware the individual is not permitted to accept the delegation; or
- b. compel an individual to perform a controlled act they have declined to perform.

Supervision and support of delegates

14. Physicians **must** provide a level of supervision and support that is proportionate to the risk associated with the delegation and that is reflective of the following factors:

- a. the specific act being delegated;
- b. the patient's specific circumstances (e.g., health status, specific health-care needs);
- c. the setting where the act will be performed and the available resources and environmental supports in place; and
- d. the education, training and experience of the delegate.

15. If on the basis of the risk assessment onsite supervision is not necessary, physicians **must** be available to provide appropriate consultation and assistance (e.g., in person, if necessary, or by telephone).

16. Physicians **must** be satisfied that the individuals to whom they are delegating:

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

17. Physicians **must** ensure that the individuals to whom they are delegating accurately identify themselves and their role in providing care to patients and that patients with questions about the delegate's role are provided with an explanation.

Managing adverse events

18. Physicians **must**:

- a. have protocols in place to appropriately manage any adverse events that occur;
- b. be available to provide assistance in managing any adverse events, if necessary;
- c. be satisfied that the delegate is capable of managing any adverse events themselves, if necessary; and
- d. have a communication plan in place to keep informed of any adverse events that take place and any actions taken by the delegate to manage them.

Ongoing monitoring and evaluation

19. Where acts are routinely delegated, physicians **must** have a reliable and ongoing monitoring and evaluation system for both the delegate(s) and the delegation process itself.

20. As part of this system, physicians **must**:

- a. confirm currency of the delegate's knowledge and skills; and
- b. evaluate the delegation process to ensure it is safe and effective; and
- c. review patient medical records to ensure the care provided through delegation is appropriate and meets the standard of practice.
 - i. What is necessary will depend on the specific acts being delegated and the other quality assurance processes in place to ensure safe and effective delegation.

143 Documentation

144 **Medical Directives**

- 145 21. Physicians **must** ensure the following information is included in the medical directive¹⁶:
- 146 a. The name and a description of the procedure, treatment, or intervention being ordered;
 - 147 b. An itemized and detailed list of the specific clinical conditions that the patient must meet before
148 the directive can be implemented;
 - 149 c. An itemized and detailed list of any situational circumstances that must exist before the
150 directive can be implemented;
 - 151 d. A comprehensive list of contraindications to implementation of the directive;
 - 152 e. Identification of the individuals authorized to implement the directive;¹⁷
 - 153 f. A description of the procedure, treatment, or intervention itself that provides sufficient detail to
154 ensure that the individual implementing the directive can do so safely and appropriately;¹⁸
 - 155 g. The name and signature of the physician(s) authorizing and responsible for the directive and the
156 date it becomes effective; and
 - 157 h. A list of the administrative approvals that were provided to the directive, including the dates and
158 each committee (if any).
- 159 22. Each physician responsible for the care of a patient who may receive the proposed treatment,
160 procedure, or intervention **must** review and sign the medical directive each time it is updated.¹⁹

161 **Medical Records**

- 162 23. Physicians **must** ensure that:
- 163 a. the care provided through delegation is documented in accordance with the College's [Medical](#)
164 [Records Documentation](#) policy, including that each entry in the medical record is identifiable and
165 clearly conveys who made the entry and performed the act;
 - 166 b. it is clear who the authorizing physician(s) are (e.g., the name(s) of the authorizing physician(s)
167 are captured in the medical record); and
 - 168 c. verbal direct orders are documented in the patient's medical record by the recipient of the direct
169 order and are reviewed or confirmed at the earliest opportunity by the delegating physician.²⁰

170

171

¹⁶ A comprehensive guide and toolkit was developed by a working group of the Health Profession Regulators of Ontario (HPRO) in 2006 and is posted on their website.

¹⁷ The individuals need not be named but may be described by qualification or position in the workplace.

¹⁸ The directive may call for the delegate to follow a protocol that describes the steps to be taken in delivering treatment if one has been developed by the physician or the institution.

¹⁹ It is acceptable for physicians working at institutions with multiple directives to receive copies of each directive and sign one statement indicating that they have read and agreed with all the medical directives referred to therein. This can be done as part of the annual physician reappointment process.

²⁰ Physicians practising in hospitals may be subject to additional requirements under the *Public Hospitals Act, 1990*.

172 Appendix A

173 Controlled Acts under the *RHPA*

- 174 1. Communicating to the individual or his or her personal representative a diagnosis identifying a disease
175 or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably
176 foreseeable that the individual or his or her personal representative will rely on the diagnosis.
- 177 2. Performing a procedure on tissue below the dermis, below the surface of a mucous membrane, in or
178 below the surface of the cornea, or in or below the surfaces of the teeth, including the scaling of teeth.
- 179 3. Setting or casting a fracture of a bone or a dislocation of a joint.
- 180 4. Moving the joints of the spine beyond the individual's usual physiological range of motion using a fast,
181 low amplitude thrust.
- 182 5. Administering a substance by injection or inhalation.
- 183 6. Putting an instrument, hand or finger,
 - 184 i. beyond the external ear canal,
 - 185 ii. beyond the point in the nasal passages where they normally narrow,
 - 186 iii. beyond the larynx,
 - 187 iv. beyond the opening of the urethra,
 - 188 v. beyond the labia majora,
 - 189 vi. beyond the anal verge, or
 - 190 vii. into an artificial opening in the body.
- 191 7. Applying or ordering the application of a form of energy prescribed by the regulations under the *RHPA*.
- 192 8. Prescribing, dispensing, selling or compounding a drug as defined in the *Drug and Pharmacies*
193 *Regulation Act*, or supervising the part of a pharmacy where such drugs are kept.
- 194 9. Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye
195 glasses other than simple magnifiers.
- 196 10. Prescribing a hearing aid for a hearing impaired person.
- 197 11. Fitting or dispensing a dental prosthesis, orthodontic or periodontal appliance or device used inside the
198 mouth to prevent the teeth from abnormal functioning.²¹
- 199 12. Managing labour or conducting the delivery of a baby.
- 200 13. Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response.
- 201 14. Treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an
202 individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory
203 that may seriously impair the individual's judgement, insight, behaviour, communication or social
204 functioning.

²¹ This is the only controlled act that physicians are not authorized to perform.

205 **Appendix B**

206 In some exceptional circumstances, a patient may receive care without an existing or anticipated physician-
207 patient relationship. These circumstances are listed below:

- 208 • the provision of care by paramedics under the direct control of base hospital physicians or within
209 community paramedicine programs;
- 210 • the provision of primary care in remote and isolated regions of the province by registered nurses acting
211 in expanded roles;
- 212 • the provision of public health programs, such as vaccinations, **or the delivery of urgent care during a**
213 **public health emergency declared by a public health authority;**
- 214 • postexposure prophylaxis **or vaccination** following potential exposure to a blood borne pathogen ~~or the~~
215 ~~provision of the hepatitis B vaccine in the context of occupational health medicine;~~
- 216 • **care provided in a hospital (e.g., emergency departments) under medical directives or protocols for**
217 ~~routine protocols;~~ and
- 218 • lay person first responders performing controlled acts for the purposes of first aid in an emergency.

DRAFT

Board Motion

Motion Title	Draft Policy for Consultation: <i>Delegation of Controlled Acts Policy</i>
Date of Meeting	May 29, 2025

It is moved by _____, and seconded by _____, that:

The Board of Directors¹ of the College of Physicians and Surgeons of Ontario engage in the consultation process in respect of the draft revised policy, "*Delegation of Controlled Acts*", (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*.

Title:	Final Approval: <i>Accepting New Patients</i> Policy (For Decision)
Main Contacts:	Tanya Terzis, Manager, Policy Mike Fontaine, Senior Policy Analyst Kaitlin McWhinney, Junior Policy Analyst
Attachments:	Appendix A: Revised Draft <i>Accepting New Patients</i> policy Appendix B: Revised Draft <i>Advice to the Profession: Accepting New Patients</i>
Question for Board:	Does the Board of Directors approve the revised draft <i>Accepting New Patients</i> policy as a policy of CPSO?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- The draft *Accepting New Patients* policy (**Appendix A**) and associated *Advice to the Profession* (“*Advice*”) (**Appendix B**) have been revised. The Board is provided with an overview of the key changes and is asked whether the revised draft policy can be approved as a policy of CPSO.
- Setting appropriate expectations for accepting new patients aligns with CPSO’s public interest mandate by supporting equitable access to care for patients.

Current Status & Analysis

- The draft *Accepting New Patients* policy was released for public consultation following the November 2024 Board meeting. The consultation received 107 responses¹. All of the written feedback can be viewed on the [consultation webpage](#), and an overview of the feedback can be found in the [March 2025 Policy Report](#). The drafts were also discussed at the [March 2025 Board meeting](#).
- Much of the draft policy and *Advice* content has been retained in the revised drafts. Key updates that have been made in response to the feedback² include:
 - The existing expectation that physicians refer patients to other providers for care that is outside their clinical competence and/or scope of practice has been removed, given that this is well-established among physicians.
 - The sentiment that primary care providers who provide comprehensive care have few reasons to refuse new patients on the basis of scope has been retained in the “Accepting patients with a history of opioid use” section of the *Advice*.
 - The expectations related to “introductory meetings” have been reframed. These initial meetings are now called “intake appointments” to signal that the intended outcome of these encounters is that the patient will be accepted into the practice.
 - The policy also now indicates that *only on rare occasions* would a physician be justified in refusing a new patient following an “intake appointment” (**Provision 7**). Should a physician refuse to accept a patient following an intake appointment, they must comply with the policy’s transparency and communication requirements (e.g., ensure that the reasons for refusal are not discriminatory and inform the patient why they were not accepted).
 - A section has also been added to the *Advice* that provides additional guidance on “intake appointments” and how they ought to be used.
 - The policy now clarifies that physicians whose practices are closed are not required to inform patients seeking care of any criteria for accepting patients.

¹ 24 responses were received through the online discussion page, and 83 responses were received via the online survey. An additional 24 survey responses were received via targeted engagement of the [Citizen Advisory Group](#).

² Including from internal engagement, the public consultation, and the Board.

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.¹ Discrimination may be direct, indirect, intentional, or unintentional.

Good faith: A legal term that means a sincere intention to act in an honest, fair, and decent manner 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.

Policy

1. Physicians are permitted to decide:

- a. Whether their practice is accepting new patients;² 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** refuse to accept patients based on any of the prohibited grounds of discrimination set out in the Ontario *Human Rights Code*.³

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

- a. High, complex, or chronic health-care needs;
- b. A history of prescribed opioids and/or psychotropic medication;⁴
- c. Needs that require additional time to manage;

¹ For more information, see the Ontario [Human Rights Code, R.S.O. 1990, c H.19](#).

² The expectations set out in this policy apply broadly to physicians 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.

³ Prohibited grounds of discrimination (also referred to as “protected grounds”) include age; ancestry, colour, race; citizenship; ethnic origin; place of origin; creed; disability; family status; marital status; gender identity; gender expression; receipt of public assistance; record of offences; sex; and sexual orientation. For more information, see the [Human Rights Code \(“Code”\)](#) and CPSO’s [Human Rights in the Provision of Health Services](#) policy.

⁴ Physicians are advised to consult CPSO’s [Prescribing Drugs](#) policy for further information on blanket ‘no narcotics’ prescribing policies.

- 30 d. A physical or mental health condition or disability⁵ that may require the physician to prepare and
31 provide additional documentation or reports; and/or
32 e. Beliefs or ideologies which do not align with the physician's own and which may impact the
33 patient's therapeutic choices.⁶
- 34 4. Physicians are permitted to establish criteria for accepting new patients. These criteria **must**:
- 35 a. Be directly relevant to the physician's clinical competence, scope of practice, and/or focused
36 practice area;⁷
37 b. Comply with the terms and conditions of the physician's certificate of registration and associated
38 practice restrictions, if applicable;
39 c. Be fair and promote equitable access to health-care services;
40 d. Be clearly communicated to prospective patients seeking care;⁸ and
41 e. Be shared with CPSO, on request.
- 42 5. Where physicians refuse to accept a patient, they **must**:
- 43 a. Do so in good faith;
44 b. Clearly communicate the reasons for the refusal to the patient; and
45 c. Document the reasons for the refusal.
- 46 6. Physicians are permitted to prioritize patients with high or complex care needs, family members of current
47 patients⁹, and those belonging to priority populations. Physicians **must** use their professional judgment to
48 determine whether prioritizing patients is appropriate, taking into account the patient's health-care needs
49 and any known social factors that may influence the patient's health outcomes (e.g., social determinants of
50 health¹⁰).
- 51 7. Physicians may determine, on rare occasions, that they are unable to accept a patient into their practice
52 after an intake appointment has taken place.¹¹ In these situations, physicians **must**:
- 53 a. Ensure that their reasons for refusing the patient are not discriminatory, in accordance with
54 **Provisions 2-3** of this policy;
55 b. Inform patients, as soon as possible, that they have not been accepted into the practice;
56 c. Clearly communicate the reasons for the refusal to the patient, in accordance with **Provision 5b** of
57 this policy; and
58 d. Document the reasons for the refusal, in accordance with **Provision 5c** of this policy.
59

⁵ Physicians should be aware that under the *Code*, the term 'disability' is interpreted broadly and covers a range of conditions. 'Disability' encompasses any degree of 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.

⁶ This could include, for example, the decision to refrain from being vaccinated or the decision to have an abortion.

⁷ 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 who are not accepting patients or whose practice is closed to new patients are not required to inform patients of any criteria they use or have used for accepting patients.

⁹ 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.

¹⁰ The [Public Health Agency of Canada](#) defines "social determinants of health" as a specific group of social and economic factors (within the broader determinants of health) which relate to an individual's place in society such as income, education, or employment. For more information, see [Social Determinants of Health and Health Inequalities](#).

¹¹ For more information on intake appointments, see *Advice to the Profession: Accepting New Patients*.

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 [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 a sincere intention to act in an honest, fair, and decent manner with others.

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

- Closing their practice when it has reached capacity, and 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 high or complex health-care needs;
- Prioritizing access to care because a patient truly has high or complex health-care needs, and not because a patient is believed to have easy-to-manage care needs and/or requires less time or resources; and
- Not using medical questionnaires or other screening tools to unfairly vet prospective patients.

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 health services. While priority populations may differ 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 limited access to care;
- People experiencing homelessness;
- People experiencing severe and persistent mental illness;
- Indigenous people;
- Black, 2SLGBTQI+, and other marginalized people;¹
- Refugees, asylum seekers, and migrants;
- People with substance use disorders; 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.

39 ***Communicating physician criteria for accepting new patients***

40 To promote patients' understanding and ensure that decisions to accept new patients are equitable,
41 transparent, and non-discriminatory, physicians are encouraged to inform patients of any criteria they have for
42 accepting new patients at the earliest opportunity, for example, when the patient first inquires whether the
43 practice is accepting patients.

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

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

53 ***Informing patients that they will not be accepted into a practice***

54 Some individuals may interpret refusal as discrimination even when the physician's reasons for refusing to
55 accept the patient are non-discriminatory. Effective communication which promotes patient understanding can
56 help dispel perceived discrimination. The Canadian Medical Protective Association's (CMPA) [Patient-centred](#)
57 [communication](#) offers guidance to physicians on how to communicate effectively with patients to optimize
58 their care.

59 ***Accepting patients with a history of opioid use***

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

- 62 • Responsibly prescribing narcotics and controlled substances is part of good clinical care, and refusing
63 to prescribe these drugs altogether (e.g., "no narcotics" policies) may lead to inadequate management
64 of some clinical problems and leave some patients without appropriate treatment.
- 65 • There are relevant resources and clinical practice guidelines that can assist in managing the care of
66 patients with a history of prescription opioid use. For example, the Centre for Addiction and Mental
67 Health (CAMH) has developed the [Canadian Opioid Use Disorder Guideline](#), a national clinical guideline
68 for Canadian prescribers of opioid agonist therapy.²
- 69 • Where elements of a patient's care needs are legitimately outside a physician's clinical competence
70 and/or scope of practice, the patient will need to be referred to a provider for those elements of care
71 that they are unable to manage directly.
- 72 • Given the broad scope of practice of primary care physicians who provide comprehensive care, there
73 are few occasions where scope of practice would be an appropriate ground to refuse a prospective
74 patient, and determinations about whether a patient's health-care needs fall within their clinical
75 competence and/or scope of practice must be made in good faith.

76 ***Defined catchment areas and patients who live a significant distance away from a practice***

77 CPSO recognizes that, depending on their practice structure, physicians may have agreements (e.g., with the
78 Ministry of Health) that require them to accept patients who reside within specific catchment areas or
79 geographical boundaries. Nothing in the *Accepting New Patients* policy prohibits physicians from accepting
80 patients on this basis, provided the policy expectations are otherwise met.

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.

81 Likewise, patients may inquire whether a physician would consider accepting them into their practice even
82 though they live a significant distance away from that practice. In these cases, physicians can use their
83 professional judgment to determine whether they will be able to provide quality care to the patient despite the
84 significant geographical distance between them.³ When determining whether to accept a patient who lives far
85 away from their practice, physicians can discuss with the patient how the geographical distance between them
86 could impact the patient's ability to receive the care they need.

87 ***Using waitlists***

88 Physicians who use self-managed waitlists in their practice need to use them cautiously and carefully manage
89 patient expectations by clearly communicating the expected waiting period.

90 Resources such as CMPA's [Wait times when resources are limited](#) contain additional guidance for physicians
91 who use waitlists.

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

95 ***Intake appointments***

96 Physicians may use intake appointments for a number of reasons, including:

- 97 • Gathering a patient's personal health information;
- 98 • Taking a medical history;
- 99 • Sharing information about the practice;
- 100 • Disclosing information about their scope of practice or focused practice area; and/or
- 101 • Determining in collaboration with the patient whether there is a good foundation for an effective
102 therapeutic relationship.

103 Typically, an intake appointment will result in the establishment of a physician-patient relationship, and patients
104 can reasonably assume they have been accepted into the physician's practice following an intake appointment.
105 Sometimes, however, physicians may determine during (or soon after) the intake appointment that they are
106 unable to accept a patient into their practice. In these rare cases, physicians are responsible for complying with
107 the obligations set out in the *Accepting New Patients* policy relating to informing patients that they will not be
108 accepted into the practice, communicating to them the reasons why they will not be accepted, and
109 documenting the reasons for the refusal.

³ 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. 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. 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.

Board Motion

Motion Title	Revised Policy for Final Approval: <i>Accepting New Patients</i>
Date of Meeting	May 30, 2025

It is moved by _____, and seconded by _____, that:

The Board of Directors¹ of the College of Physicians and Surgeons of Ontario approves the revised policy “*Accepting New Patients*” 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*.

Title:	Final Approval: <i>Ending the Physician-Patient Relationship</i> policy (For Decision)
Main Contacts:	Tanya Terzis, Manager, Policy Courtney Brown, Team Lead, Policy
Attachments:	Appendix A: Revised Draft <i>Ending the Physician-Patient Relationship</i> policy Appendix B: Revised Draft <i>Advice to the Profession: Ending the Physician-Patient Relationship</i>
Question for Board:	Does the Board of Directors approve the revised draft <i>Ending the Physician-Patient Relationship</i> policy as a policy of CPSO?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- The draft *Ending the Physician-Patient Relationship* policy (**Appendix A**) and associated *Advice to the Profession* (“Advice”) (**Appendix B**) have been revised. The Board is provided with an overview of the key changes and is asked whether the revised draft policy can be approved as a final policy of CPSO.
- Setting expectations that support fair and transparent decision-making when ending the physician-patient relationship aligns with CPSO’s public interest mandate.

Current Status & Analysis

- The draft *Ending the Physician-Patient Relationship* policy was released for public consultation following the November 2024 Board meeting. The consultation received 262 total responses¹. All of the written feedback can be viewed on the [consultation webpage](#), and an overview of the feedback can be found in the [March 2025 Policy Report](#). The drafts were also discussed at the [March 2025 Board meeting](#).
- Much of the draft policy and *Advice* content has been retained in the revised drafts. However, some key updates were made in response to feedback², including:
 - Making the draft policy more principle-based by reverting back to the existing requirement that physicians provide necessary medical services for a *reasonable period of time* following the end of a physician-patient relationship. Three months has now been provided as an example instead of a requirement in all instances.
 - Removing conflicts of interest with patients from the list of examples in the draft *Advice* where a physician may no longer be able to provide quality care to a patient. Consultation respondents found this example unclear, and the issue of physicians treating individuals who they have a personal or close relationship with is covered in the *Physician Treatment of Self, Family Members, and Others Close to Them* policy.
 - Updating the draft *Advice* section on patient complaints (now titled *Patient Concerns*) to better reflect and highlight that not all patient contact with CPSO constitutes a complaint.
 - Amending the draft *Advice* to clarify that de-rostering a patient will not result in the patient losing access to care, and that physicians need to be clear about this with patients.

¹ 50 responses were received through the online discussion page, and 212 responses were received via the online survey. An additional 24 survey responses were received via targeted engagement of the [Citizen Advisory Group](#).

² Including from internal engagement, the public consultation, and the Board.

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, including specialists, **must** comply with the expectations set out in this policy when ending a physician-patient relationship *prior* to reaching the natural or expected conclusion of a patient’s care. This policy does not apply when:
 - a. a physician’s relationship with a patient reaches its natural or expected conclusion (for example, because treatment has concluded), or
 - b. 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

Circumstances where physicians may end the physician-patient relationship

2. 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^{2,3}

Circumstances where physicians cannot end the physician-patient relationship

3. Physicians **must not** end a physician-patient relationship based on a prohibited ground of discrimination⁴ or where otherwise prohibited by legislation.⁵

¹ For more information on physician retirement, relocation, or disciplinary action, see CPSO’s [Closing a Medical Practice](#) policy. For more information on leaves of absence see CPSO’s [Availability and Coverage](#) 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 *Advice to the Profession: Ending the Physician-Patient Relationship*.

³ For more information on circumstances where physicians may end the physician-patient relationship, see *Advice to the Profession: Ending the Physician-Patient Relationship*.

⁴ The *Ontario Human Rights Code* (“Code”) provides that every person has a right to equal treatment without discrimination in the provision of health services, including discrimination on the grounds of age, gender, marital status, national or ethnic origin, physical or mental disability, race, religion, and sexual orientation.

⁵ 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*. Where physicians are unsure about their legal obligations, they can contact the Canadian Medical Protective Association or seek legal advice.

- 29 4. Physicians **must** respect patient autonomy with respect to lifestyle, healthcare goals, and treatment
30 decisions, and **must not** end a physician-patient relationship solely because a patient:
- 31 a. Does not follow medical advice;⁶
 - 32 b. Suffers from an addiction or dependence, or is on a high dose of a prescribed controlled drug
33 and/or substance;⁷ or
 - 34 c. Seeks treatment to which the physician objects for reasons of conscience or religion.⁸

35 **Expectations when ending the physician-patient relationship**

- 36 5. Prior to ending a physician-patient relationship, physicians **must**:
- 37 a. Make reasonable efforts to resolve the situation in the best interest of the patient, where they
38 feel it is safe to do so;⁹
 - 39 b. Apply good clinical judgment and compassion to determine the most appropriate course of
40 action; and
 - 41 c. Consider the patient's specific circumstances and vulnerabilities, as well as the consequences
42 of ending the relationship for the patient.
- 43
- 44 6. When ending a physician-patient relationship, physicians **must**:
- 45 a. Inform the patient of the reasons why they are ending the physician-patient relationship, where
46 they feel it is safe to do so;¹⁰
 - 47 b. Notify the patient in writing of their decision to end the physician-patient relationship and of
48 the importance of seeking ongoing care;¹¹
 - 49 c. Retain a copy of the written notification and any confirmation of receipt in the patient's
50 medical record;
 - 51 d. Document the reasons for ending the physician-patient relationship and all the steps that have
52 been undertaken to attempt to resolve the issue(s) in the patient's medical record;
 - 53 e. Inform appropriate staff and the patient's other health-care providers, where necessary, that
54 they are no longer providing care to the patient, unless the patient has expressly restricted the
55 physician from sharing this information;¹²

⁶ 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.

⁷ Controlled drugs and substances are defined in the *Controlled Drugs and Substances Act*, 1996.

⁸ 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.

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 make efforts to resolve the situation with the patient prior to ending the physician-patient relationship.

¹⁰ 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.

¹¹ 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 *Advice to the Profession: Ending the Physician-Patient Relationship*.

¹² 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.

- 56 f. Provide necessary medical services¹³ for a reasonable period of time (e.g., three months) after
57 ending the physician-patient relationship,¹⁴ where they feel it is safe to do so;¹⁵
58 g. Provide care in an emergency, where it is necessary to prevent imminent harm;¹⁶
59 h. Inform the patient that they are entitled to a copy of their medical records and the process for
60 obtaining a copy;¹⁷ and
61 i. Ensure the timely transfer of a copy or summary of the patient's medical records, if
62 requested.¹⁸
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¹³ 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.

¹⁴ 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(17)).

¹⁵ 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.

¹⁶ For example, where the physician is working in an Emergency Department.

¹⁷ Physicians are able to charge a reasonable fee for copying and transferring medical records in accordance with CPSO's [Medical Records Management](#) policy.

¹⁸ 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.

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.

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 can 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 towards the physician, other members of the clinical team or office staff;
- Frequently misses appointments without 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

Physicians have a right to be free from violence in their workplace. There are many challenging situations that may arise during physician interactions with patients, and ultimately physicians are permitted to end relationships where they feel their safety, or the safety of others, is threatened.

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)
- [*Challenging patient encounters: How to safely manage and de-escalate*](#) (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](#).

- [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. Nonviolent Crisis Prevention & Intervention Training which focuses on prevention and teaching individuals how to safely de-escalate anxious, hostile, or violent behavior may also be helpful.

Patient concerns

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

Often, patient concerns can be resolved when the issue is brought to the physician's attention and are not indicative of a breakdown in the therapeutic relationship. Physicians need to consider the specific circumstances of each situation, the factors that may have led the patient to contact CPSO and/or make a complaint, and make reasonable efforts to resolve the situation, where possible.

If, however, a physician believes that a patient's concerns or complaints indicate a broader loss of mutual trust and respect and they feel they cannot maintain an effective therapeutic relationship, 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; or
- The patient has relocated far from the physician's practice and is unable to attend in-person appointments, where necessary.

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:

- Consider how long the patient has been absent, and the likelihood that the patient has sought care elsewhere.
- 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 a pattern of behaviour.
- 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.

Where the physician wishes to decrease their practice size³, 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.

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. This is distinct from ending the physician-patient relationship.

Physicians need to be conscious of the difference between *ending* a physician-patient relationship and *de-rostering* a patient, and make clear to the patient that if they are de-rostered, 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.

Dear [patient's name]:

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

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.

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

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

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

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

136 Yours truly,

137 *[Signature of physician]*

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Board Motion

Motion Title	Revised Policy for Final Approval: <i>Ending the Physician-Patient Relationship</i>
Date of Meeting	May 30, 2025

It is moved by _____, and seconded by _____, that:

The Board of Directors¹ of the College of Physicians and Surgeons of Ontario approves the revised policy “*Ending the Physician-Patient Relationship*” 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*.

MAY 2025

Title:	Revised Draft Policy for Approval: <i>Treatment of Self, Family Members, and Others Close to You</i> (For Decision)
Main Contacts:	Tanya Terzis, Manager, Policy Lynn Kirshin, Senior Policy Analyst Laura Rinke-Vanderwoude, Policy Analyst
Attachments:	Appendix A: Revised Draft <i>Treatment of Self, Family Members, and Others Close to You</i> Policy Appendix B: Revised Draft <i>Advice to the Profession: Treatment of Self, Family Members, and Others Close to You</i> Appendix C: Draft <i>Legal Requirements: Treatment of Sexual and/or Romantic Partners</i>
Question for Board:	Does the Board of Directors approve the revised draft <i>Treatment of Self, Family Members, and Others Close to You</i> policy as a policy of CPSO?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- A newly-titled revised draft *Treatment of Self, Family Members, and Others Close to You* policy (**Appendix A**) and associated *Advice to the Profession* (“*Advice*”) (**Appendix B**) have been revised. The Board is provided with an overview of the key changes and is asked whether the revised draft policy can be approved as a final policy of CPSO.
- Setting appropriate expectations for physicians with respect to treating themselves, family members, and others close to them promotes quality care and supports CPSO’s public interest mandate.

Current Status & Analysis

- The draft *Treatment of Self, Family Members, and Others Close to You* policy¹ was released for public consultation following the November 2024 Board meeting. The consultation received 138 responses.² All of the written feedback can be viewed on the [consultation webpage](#), and a feedback overview can be found in the [March 2025 Policy Report](#). The drafts were also discussed at the [March 2025 Board meeting](#).
- A few substantive updates were made to the drafts in response to the feedback.³ Key changes to the draft policy include:
 - Removing the requirement that treatment for minor conditions and emergency treatment only be provided when no other qualified health-care professional is readily available;
 - Reintroducing two expectations from the current policy:
 - **Provision 2** sets out an expectation that if ongoing care is necessary, physicians must transfer care to another professional as soon is practical;
 - **Provision 3** sets out an expectation that physicians cannot provide recurring episodic treatment to family members and others close to them;
 - Referencing Indigenous communities in the policy to clarify that the exceptions for communities with limited treatment options apply to them;
 - Creating a separate *Legal Requirements* document (**Appendix C**) to explain how the sexual abuse provisions apply to spouses and romantic partners; and,
 - Allowing prescribing or administering controlled drugs and substances in emergencies.
- The draft *Advice* has been updated to include guidance about pressure to provide treatment by family members and others close to a physician and to identify the factors that reasonably affect a physician’s professional judgment that were previously outlined in the draft policy.

¹ The policy was renamed from *Physician Treatment of Self, Family Members, or Others Close to Them*.

² 40 responses were received through the online discussion page, and 96 responses were received via the online survey. An additional two responses were received via targeted engagement with Indigenous stakeholders.

³ Including public consultation responses and Board feedback.

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 act¹; ordering and performing tests (including blood tests and diagnostic imaging); providing a course of treatment, plan of treatment, or community treatment plan.²

Emergency Treatment: Treatment that is necessary in a timely manner to prevent significant harm, suffering and/or deterioration.

Minor Condition: A health condition that can be managed with minimal, short-term treatment and usually does not require ongoing care or monitoring.

Family Member: An individual with whom the physician has a familial connection **and** with whom the physician has a close and/or personal relationship, where the relationship is of such a nature that it would reasonably affect the physician’s professional judgment.³ This includes but is not limited to the physician’s spouse or partner, parent, child, or sibling.

Others Close to Them: Individuals who have a close and/or personal relationship with the physician where the nature of the relationship could reasonably affect the physician’s professional judgment.

Policy

Treating Family Members and Others Close to You

1. Physicians **must not** provide treatment for themselves, family members, or others close to them except for:
 - a. Treatment for minor conditions;

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*.

³ For information about why close relationships may affect a physician’s professional judgment, see the *Advice to the Profession: Treatment of Self, Family Members, and Others Close to You* companion document.

- 33 b. Emergency treatment; or
34 c. Other treatment permitted by Provisions 5 to 7 of this policy.
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36 2. Where additional or ongoing treatment is necessary, physicians **must** make every reasonable effort
37 to transfer care to another qualified health-care professional as soon as is practical.
38
39 3. Physicians **must not** provide recurring episodic treatment to themselves, family members, or others
40 close to them for the same disease or condition, or provide ongoing management of a disease or
41 condition, even where the disease or condition is minor.

42 **Treating Spouses or Sexual/Romantic Partners**

- 43 4. Physicians **must** be mindful that providing treatment to a spouse, partner, or anyone else with whom
44 they are sexually or romantically involved may give rise to a physician-patient relationship and that
45 providing treatment that exceeds the circumstances set out in this policy may give rise to a
46 physician-patient relationship such that the sexual abuse provisions⁴ of the *Regulated Health*
47 *Professions Act, 1991* would apply. For more information, see the *Legal Requirements: Treatment of*
48 *Sexual and/or Romantic Partners* document.

49 **Practising in Communities with Limited Treatment Options**

- 50 5. CPSO recognizes that in some small communities⁵, there may be family members or others close to
51 the physician who do not have alternative options for treatment. When determining if a person does
52 not have alternative options for treatment, physicians **must** consider:
53
54 a. Whether the treatment is within another available qualified health-care professional's scope
55 of practice;
56 b. The geographical distance and/or the person's ability to travel to other treatment options;
57 c. Whether virtual care can be used to provide treatment; and
58 d. Any personal factors that would present a significant barrier to obtaining treatment⁶ from
59 another available qualified health-care professional.
60
61 6. If a person does not have alternative treatment options and is not a physician's sexual or romantic
62 partner, the physician may provide treatment beyond emergency treatment or treatment for minor
63 conditions and **must** document the circumstances in the patient's medical record, including why
64 treatment was provided.
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⁴ The *Health Professions Procedural Code* and O. Reg. 260/18 under the *Regulated Health Professions Act* only allows physicians to treat their sexual or romantic partners in emergency circumstances or where the treatment is minor in nature, and only when the physician has taken reasonable steps to transfer care or where there is no reasonable opportunity to transfer care.

⁵ This includes Indigenous communities who may have a deep and pervasive mistrust of the medical profession. Further guidance on this provision's application to Indigenous communities can be found in the *Advice to the Profession: Treatment of Self, Family Members and Others Close to You* document.

⁶ 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.

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7. Despite Provision 6, physicians **must not**:

- a. Provide intimate examinations⁷ outside of emergency treatment to family members; and/or
- b. Provide psychotherapy to family members.

Prescribing or Administering Drugs

8. Physicians **must not** prescribe or administer narcotics⁸ and/or controlled drugs and substances⁹ for themselves, family members, or others close to them except if providing emergency treatment¹⁰.

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.



⁷ Intimate examinations include breast, pelvic, genital, perineal, perianal and rectal examinations of patients.
⁸ 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.
⁹ 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.
¹⁰ 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. 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*.

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.

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.¹

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.

Objectivity and Factors Affecting Professional Judgment

A relationship can reasonably affect a physician's professional judgement in a number of ways. For example, a physician may:

- feel uncomfortable discussing sensitive issues such as sexual history, mental health, substance use, abuse or neglect.
- feel 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.
- have difficulty recognizing the need to obtain informed consent and to respect the individual's decision-making autonomy.
- have 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.
- be reluctant to make a mandatory report.
 - For example, an impairment affecting the individual's ability to drive, or a suspicion of child abuse.

Physicians need to consider if the relationship may affect the individual's openness to disclose important information, raise concerns about proposed treatment, or take appropriate next steps after treatment. This includes the individual:

- 39 • being uncomfortable discussing sensitive issues like substance use, sexual history,
40 mental health, abuse, or neglect;
- 41 • feeling obligated to accept a physician's treatment recommendations; and
- 42 • being reluctant to make a complaint, or pursue legal options.

43 ***Pressure to Provide Treatment***

44 Physicians may feel pressured by family members or others close to them to provide treatment
45 even when they don't feel it would be appropriate. Physicians can explain to the person seeking
46 treatment that this policy sets out professional expectations that they must uphold, which
47 includes not providing treatment beyond the exceptions set out in the policy.

48 ***Treating Sexual and Romantic Partners***

49 Ontario legislation defines who is a patient for the purpose of determining whether sexual
50 abuse has occurred². If a physician provides treatment to a patient where there was or is a
51 sexual or romantic relationship, a physician can be found to have committed sexual abuse.

52 For more information about providing treatment to sexual and romantic partners, please see the
53 *Legal Requirements: Treatment of Sexual and/or Romantic Partners* document.

54 ***Minor Conditions***

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

- 56 • Minor skin conditions;
- 57 • Minor uncomplicated infections; and
- 58 • Minor injuries.

59 Patient-specific factors include but are not limited to:

- 60 • Age;
- 61 • Past medical history; and
- 62 • The severity of the symptoms.

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

66 ***Alternative Treatment Options***

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

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

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

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

81 ***Indigenous Communities***

82 CPSO recognizes that physicians practising in Indigenous communities may be interconnected
83 with or related to the entire community. Additionally, systemic inequality has deeply affected the
84 trust many Indigenous people have in the health-care system. For Indigenous patients, this may
85 mean they do not have an alternative treatment option that they perceive as culturally safe.

86 This policy supports physicians practising in Indigenous communities to provide care beyond
87 emergency treatment and treatment for minor conditions in accordance with the policy.

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>
- 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*.

² O. Reg. 260/18 under the *Regulated Health Professions Act*

LEGAL REQUIREMENTS: TREATMENT OF SEXUAL AND/OR ROMANTIC PARTNERS

This document is intended to assist physicians in understanding their legal obligations and limitations when treating a sexual and/or romantic partner, which are set out in the *Health Professions Procedural Code (Code)* and O.Reg. 260/18 under the *Regulated Health Professions Act (RHPA)* and in case 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 should seek independent legal advice if they have questions about the legal requirements and limitations. In the case of any inconsistency between this document and any applicable legislation, the legislation will prevail.

Overview: Sexual Abuse and a Physician's Sexual and/or Romantic Partners

If a physician provides treatment to an individual where there was or is a sexual or romantic relationship, a physician may be found to have committed sexual abuse – even if the person they are treating is a spouse or long-term romantic partner.

However, a physician *can* provide treatment to a current or past sexual or romantic partner for minor conditions or in emergency circumstances. In these cases the physician has to take reasonable steps to transfer care of the individual to another physician, where possible¹.

For more information on the requirements in the *Health Professions Procedural Code (Code)*, please see below.

Definition of “Patient” for the Purposes of Determining Sexual Abuse

For the purposes of determining whether sexual abuse has occurred, a person is defined as a patient when any one of the following occur:

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

This means that essentially all treatment provided by a physician will make the person a patient under the law.

¹ O. Reg. 260/18 under the *Regulated Health Professions Act*

Exceptions

The legislation provides an exception to the definition of patient, which permits treatment of a sexual or romantic partner in specified circumstances. A sexual or romantic partner will *not* be considered a patient if all three of the following criteria are met:²

- there is a sexual relationship between the person receiving treatment and the physician at the time the treatment is provided;
- the treatment was provided in emergency circumstances or where the treatment is minor; and
- the physician has taken reasonable steps to transfer care of the individual to another physician, or there is no reasonable opportunity to transfer care.

Duration of the Physician-Patient Relationship

Under the *Code*³, a person will be considered a physician's patient until a year after the physician stopped providing treatment or otherwise had a physician-patient relationship.

Sexual Abuse Provisions in the Code

The *Code*⁴ states that sexual abuse has occurred if a physician has:

- Sexual intercourse or other forms of physical sexual relations with a patient,
- Touched a patient in a sexual manner; or
- Engaged in any behaviour or remarks of a sexual nature towards a patient.

There is no exception for spouses or romantic partners.

Consequences for Treating Sexual or Romantic Partners

The *Code*⁵ sets out mandatory penalties for engaging in professional misconduct by sexually abusing a patient. These penalties include revocation and/or suspension.

The law requires these mandatory penalties to be applied, even if there are mitigating factors or a physician was in a consensual relationship.⁶

² [O. Reg. 260/18](#) Patient Criteria under Subsection 1(6) of the [Code](#).

³ S. 1(6) of the [Code](#), schedule 2 to the RHPA.

⁴ S. 1(3) of the [Code](#), Schedule 2 of the RHPA

⁵ S. 51(5) of the [Code](#) sets out mandatory orders for sexual abuse proceedings.

⁶ Decisions and reasons for Ontario Physicians and Surgeons Discipline Tribunal findings can be found on their [website](#).

Board Motion

Motion Title	Revised Policy for Final Approval: <i>Treatment of Self, Family Members, and Others Close to You</i>
Date of Meeting	May 30, 2025

It is moved by _____, and seconded by _____, that:

The Board of Directors¹ of the College of Physicians and Surgeons of Ontario approves the revised policy "*Treatment of Self, Family Members, and Others Close to You*", formerly titled "*Physician Treatment of Self, Family Members, or Others Close to Them*" 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*.

Board Motion

Motion Title	Motion to Go In-Camera
Date of Meeting	May 30, 2025

It is moved by _____, and seconded by _____, that:

The Board of Directors¹ 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*.

Title:	Draft 2024 Audited Financial Statements (For Decision)
Main Contacts:	Nathalie Novak, Chief Operating Officer Sandra Califaretti, CPA, CA, Corporate Controller Michael Rooke, CPA, CA, LPA, Engagement Partner, Tinkham LLP
Attachments:	Appendix A: Draft 2024 Audited Financial Statements of the College of Physicians and Surgeons of Ontario Appendix B: Glossary of Financial Terms Appendix C: A Guide to Financial Statements of Not-for Profit Organizations Appendix D: Audit Findings Report: Results of the audit examination of the financial statements for the year ended December 31, 2024 Appendix E: Adjusting Journal Entries for 2024 Statements Appendix F: Reclassifying Journal Entries for 2024 Statements
Question for Board:	Is the Board of Directors in agreement to approve the College's draft audited financial statements for the year ended December 31, 2024?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- The Chief Operating Officer (COO) and the Corporate Controller (Controller) are pleased to present the draft 2024 audited financial statements to the Board, along with a presentation that highlights key performance metrics for the 2024 financial position and financial performance.
- Tinkham LLP performed an audit of the financial statements of the College for the year ended December 31, 2024. At the completion of the audit, Tinkham provides the Audit Findings Report which provides insight into audit considerations, materiality, audit procedures and other findings related to the College's presentation of their financial position and performance.
- Included with the Audit Findings Report are appendices which contain adjustments to the financial statement amounts identified during the audit process. Management has reflected these adjustments in the draft audited financial statements submitted for approval.
- Appendix B: Glossary of Financial Terms, and Appendix C: A Guide to Financial Statements of Not-for-Profit Organizations are provided to the Board to be consulted as required while reviewing the Audited Financial Statements.

Current Status & Analysis

- Finance staff prepare the annual financial statements in accordance with Not-For-Profit Accounting Standards (ASNPO) based on recognition of the College's financial transactions for the fiscal year. The College's external auditors, Tinkham LLP, perform audit procedures to provide an audit opinion on the fair presentation of the annual financial statements.
- The College's draft audited financial statements present the College's financial position as at December 31, 2024, in addition to financial performance for the 2024 fiscal year. There has been no change to accounting policies used to present the draft financial statements and estimates and assumptions are based on historical trends or supported by actuarial reports. The draft audited financial statements include an allocation of the 2024 net surplus of \$9.2M to the Operating Reserve Fund in the Net Assets balance.
- The COO and Controller are pleased to share that the auditors have provided an unqualified opinion on the 2024 draft audited financial statements. The 2024 draft financial statements are presented to the Board for approval.
- Michael Rooke, Engagement Partner from Tinkham LLP is present at the Board meeting to answer any questions from the Board related to the Audit Findings Report.



Financial statements of the

**COLLEGE OF PHYSICIANS AND
SURGEONS OF ONTARIO**

December 31, 2024

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INDEPENDENT AUDITOR'S REPORT

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

We have audited the accompanying financial statements of the College of Physicians and Surgeons of Ontario ("College"), which comprise the statement of financial position as at December 31, 2024 and the statements of operations and changes in unrestricted net assets and cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the College as at December 31, 2024, and the results of its operations and its cash flows for the year then ended in accordance with Canadian accounting standards for not-for-profit organizations.

Basis for Opinion

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

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

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

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

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

Auditor's Responsibilities for the Audit of the Financial Statements

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

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

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

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

TORONTO, Ontario
May __, 2025

Licensed Public Accountants

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Statement of Financial Position

As at December 31	Notes	2024	2023
Assets			
Current			
Cash		\$ 61,063,936	\$ 22,812,508
Investments	3	15,055,301	45,404,942
Accounts receivable		1,105,807	328,989
Prepaid expenses		3,004,254	3,607,174
		80,229,298	72,153,613
Investments	3	51,419,192	51,056,692
Capital assets	4	11,834,913	12,517,505
		\$ 143,483,403	\$ 135,727,810
Liabilities			
Current			
Accounts payable and accrued liabilities		\$ 7,809,292	\$ 9,672,271
Current portion of obligations under capital leases	7	898,759	554,881
		8,708,051	10,227,152
Deferred revenue	5	31,278,376	30,280,179
		39,986,427	40,507,331
Obligations for post-employment benefits other than pension	6	512,786	412,662
Accrued pension cost	6	4,414,470	4,424,193
Obligations under capital leases	7	839,563	642,885
		45,753,246	45,987,071
Net assets			
Internally restricted			
Invested in capital assets		10,096,591	11,319,739
Building Fund		30,700,276	30,700,276
Technology and Information Management Fund		12,805,097	12,805,097
Operating Reserve Fund		44,128,193	34,915,627
Pension remeasurements		(794,872)	(686,721)
Unrestricted		794,872	686,721
		97,730,157	89,740,739
		\$ 143,483,403	\$ 135,727,810

Contingencies (Note 8)

The accompanying notes are an integral part of these financial statements.

Approved on behalf of the Board:

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Statement of Operations

Year ended December 31	Notes	2024	2023 (Note 10)
Revenue			
Membership fees			
General and educational	5	\$ 73,159,150	\$ 70,629,766
Penalty fee		600,107	412,166
		73,759,257	71,041,932
Application fees		9,369,826	8,980,475
OHPIP annual and assessment fees	5	1,487,337	1,397,211
IHF annual and assessment fees	5	514,654	2,356,038
OHPIP, IHF application fees and penalties		93,871	83,885
Cost recoveries and other income		1,495,814	2,037,104
Interest and investment income		4,638,696	4,412,880
		91,359,455	90,309,525
Expenses			
Staffing costs		56,249,812	56,120,154
Per diems		6,351,544	7,959,436
Other costs		9,780,368	10,797,089
Professional fees		3,820,334	3,994,563
Amortization of capital assets		4,558,479	4,386,157
Occupancy		2,501,349	2,493,214
		83,261,886	85,750,613
Excess of revenue over expenses for the year		\$ 8,097,569	\$ 4,558,912

The accompanying notes are an integral part of these financial statements.

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Statement of Changes in Net Assets

Year ended December 31	Invested in Capital Assets	Building Fund	Technology and Information Management Fund	Operating Reserve Fund	Pension Re- measurement	Unrestricted	2024 Total	2023 Total
Balance, beginning of year	\$ 11,319,739	\$ 30,700,276	\$ 12,805,097	\$ 34,915,627	\$ (686,721)	\$ 686,721	\$ 89,740,739	\$ 85,143,418
Excess (deficiency) of revenue over expenses	(4,558,479)	-	-	-	-	12,656,048	8,097,569	4,558,912
Purchase of capital assets	2,546,038	-	-	-	-	(2,546,038)	-	-
Payment of capital lease obligations	789,293	-	-	-	-	(789,293)	-	-
Actuarial remeasurement for pensions	-	-	-	-	(108,151)	-	(108,151)	38,409
Transfer to Operating Reserve Fund	-	-	-	9,212,566	-	(9,212,566)	-	-
Balance, end of year	\$ 10,096,591	\$ 30,700,276	\$ 12,805,097	\$ 44,128,193	\$ (794,872)	\$ 794,872	\$ 97,730,157	\$ 89,740,739

The accompanying notes are an integral part of these financial statements.

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Statement of Cash Flows

Year ended December 31	2024	2023 (Note 10)
Cash flows from operating activities:		
Excess of revenue over expenses for the year	\$ 8,097,569	\$ 4,558,912
Amortization of capital assets	4,558,479	4,386,157
	12,656,048	8,945,069
Net change in non-cash working capital items:		
Accounts receivable	(776,818)	643,084
Prepaid expenses	602,920	(509,622)
Accrued interest receivable	557,713	(1,394,115)
Accounts payable and accrued liabilities	(1,862,979)	1,570,463
Deferred revenue	998,197	(2,708,872)
Obligations for post-employment benefits other than pension	100,124	412,662
Pension cost	(117,874)	(80,214)
Cash provided by operating activities	12,157,331	6,878,455
Cash flows provided (used) by investing activities:		
Proceeds from redemption of investments	66,186,893	14,000,000
Purchase of investments	(36,757,465)	(58,373,327)
Purchase of capital assets	(2,546,038)	(1,481,794)
Cash provided (used) by investing activities	26,883,390	(45,855,121)
Cash flows used by financing activities:		
Payment of capital lease obligations	(789,293)	(586,057)
Net increase (decrease) in cash	38,251,428	(39,562,723)
Cash, beginning of year	22,812,508	62,375,231
Cash, end of year	\$ 61,063,936	\$ 22,812,508

The accompanying notes are an integral part of these financial statements.

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Notes to the Financial Statements

December 31, 2024

1 Organization

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

As a not-for-profit organization, the College is exempt from income taxes under subsection 149(1) of the Income Tax Act (Canada).

2 Significant accounting policies

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

(a) Financial instruments

(i) Measurement

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

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

(ii) Impairment

Where there is a permanent loss in value, the financial instrument value is written down to recognize the loss, with the corresponding write-down reflected in the Statement of Operations.

(b) Cash

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

(c) Investments

Guaranteed investment certificates (GIC) are carried at amortized cost.

(d) Capital assets

The cost of a capital asset includes its purchase price and all direct costs including financing interest incurred to prepare the asset for its intended use.

When a capital asset no longer provides future economic benefit or contributes to the College's ability to provide services, the net carrying amount is written down to its fair value or replacement value.

(i) Tangible assets

Tangible assets are measured at cost less accumulated amortization.

Amortization begins when the asset is placed in service and is provided for on a straight-line basis over the estimated useful life as follows:

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

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Notes to the Financial Statements

December 31, 2024

2 Significant accounting policies (continued)

(d) Capital assets (continued)

(ii) Intangible assets

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

Amortization begins when the asset is placed in service and is provided for on a straight-line basis over the estimated useful life of four years.

(e) Employee future benefits

(i) Healthcare of Ontario Pension Plan

Most of the College's active employees receive post-retirement benefits through the Healthcare of Ontario Pension Plan (HOOPP), which is a multi-employer defined benefit pension plan providing post-employment benefits based on best five consecutive year average pay.

The College accounts for its participation in this plan as a defined contribution plan. The College does not recognize any share of the pension plan surplus based on the fair market value of the HOOPP assets, as this is a joint responsibility of all participating employers and their employees. As a result, contributions are expensed when due.

(ii) CPSO Retirement Savings Plan 2019

CPSO Retirement Savings Plan 2019 is a legacy defined contribution plan providing post-retirement benefits to a small, designated group of active and inactive members. Contributions are expensed when due.

The College also sponsors a supplementary plan for select members of the CPSO Retirement Savings Plan 2019 to supplement pension benefits payable to these employees which are subject to the maximum contribution limits under the Canadian Income Tax Act. Withdrawals of these amounts by employees are funded from the College's general assets.

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

The College maintains a closed (1998) defined benefit pension plan and supplementary arrangements for certain designated former employees; defined benefit obligations are based on services rendered when the individuals were in active service with the College. The retirement benefits of these designated employees are provided through a funded plan and an unfunded supplementary plan.

The defined benefit obligation at the Statement of Financial Position date is determined using the most recent actuarial valuation report prepared for accounting purposes. The value of the plan assets and the defined benefit obligation are measured at the College's Statement of Financial Position date.

In its year-end Statement of Financial Position, the College recognizes the defined benefit obligation, less the fair value of plan assets, adjusted for any valuation allowance in the case of a net defined benefit asset. The plan cost for the year is recognized in the College's Statement of Operations. Past service costs for the year resulting from changes in the plan are recognized immediately in the College's Statement of Operations at the date of the changes.

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

(iv) Obligations for post-employment benefits other than pension

The College pays certain medical and dental benefits on behalf of eligible retired employees. The College recognizes these post-employment costs in the period in which the employee's services were rendered. The post-employment benefit plan other than pension is valued using an actuarial valuation.

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Notes to the Financial Statements

December 31, 2024

2 Significant accounting policies (continued)

(f) Revenue recognition

(i) Members' fees and application fees

Membership and application fees are set annually. Fees are received in advance and recognized as revenue in the Statement of Operations proportionately over the fiscal year.

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

IHF and OHPIP annual and assessment fees are cost recoveries and recognized at the same rate as the related costs are expensed. Unearned fees are recognized as deferred revenue.

(iii) Cost recoveries

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

(iv) Other income

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

(v) Interest and investment income

Interest income is comprised of interest on cash deposits held in an interest-bearing account at a major financial institution. Investment income is comprised of income on other investments.

Interest and investment income are recognized when earned.

(g) Management estimates

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

(h) Internally restricted reserves (Net Assets)

The Board has approved the following internally restricted reserves:

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

(ii) Building Fund, restricted for future building requirements;

(iii) Technology and Information Management Fund, restricted for future information and technology infrastructure development and improvements; and

(iv) Operating Reserve Fund, restricted to provide sufficient financial resources to continue operations in the case of a significant adverse event.

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Notes to the Financial Statements

December 31, 2024

3 Investments

As at December 31	2024	2023
Guaranteed Investment Certificates (GIC)		
Short-term:		
Bank of Nova Scotia Non-Redeemable GICs, yielding interest at 3.81% (maturity April 7, 2025) and 4.01% (maturity May 6, 2025) (2023 – 5.89% to 6.27%; maturity January 5, 2024 to August 8, 2024)	\$ 14,943,899	\$ 44,373,327
Accrued interest	111,402	1,031,615
	\$ 15,055,301	\$ 45,404,942
Long-term:		
Bank of Montreal (BMO) Extendible GIC	\$ 25,000,000	\$ 25,000,000
National Bank of Canada (NBC) Canadian Banks Portfolio Flex GIC	25,000,000	25,000,000
Accrued interest	1,419,192	1,056,692
	\$ 51,419,192	\$ 51,056,692

The BMO Extendible GIC earns interest at 1.45% and has a final maturity date of August 1, 2027, however, contains call features that allow the issuer to exercise its option to mature the GIC every six months. The GIC is not redeemable at the option of the College. At maturity the principal amount of \$25,000,000, plus accrued interest, is guaranteed. The fair market value of the GIC as at December 31, 2024 is \$25,000,000 (2023 - \$25,000,000).

The NBC Canadian Bank Portfolio Flex GIC matures on January 29, 2026, and earns a return determined at maturity based on the percentage change in price of an equally weighted portfolio of five Canadian bank's shares. At maturity the principal amount of \$25,000,000 is guaranteed. The fair market value of the GIC as at December 31, 2024 is \$25,290,000 (2023 - \$22,947,500).

4 Capital assets

As at December 31	2024		2023	
	Cost	Accumulated Amortization	Cost	Accumulated Amortization
Tangible assets				
Land	\$ 2,142,903	\$ -	\$ 2,142,903	\$ -
Building and building improvements	22,293,885	18,244,139	21,380,121	17,684,056
Furniture and fixtures	4,865,339	4,472,287	4,677,993	4,383,663
Computer and other equipment	5,460,495	5,273,294	5,046,148	4,991,552
Computer equipment under capital lease	3,567,315	1,828,993	2,455,354	1,257,588
Intangible assets				
Computer application software	14,934,856	11,611,167	13,695,269	8,563,424
	53,264,793	41,429,880	49,397,788	36,880,283
Net book value		\$ 11,834,913		\$ 12,517,505

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Notes to the Financial Statements

December 31, 2024

5 Deferred revenue

Deferred revenue consists of membership fees received in advance for the next year as well as unearned fees related to the Out of Hospital Premises Inspection Program (OHPIP). The Independent Health Facility (IHF) program was transferred to Accreditation Canada effective April 26, 2024. The change in the deferred revenue accounts for the year is as follows:

	Membership Fees	IHF	OHPIP	2024 Total	2023 Total
Balance, beginning of year	\$ 30,111,850	\$ 164,434	\$ 3,895	\$ 30,280,179	\$ 32,989,051
Amounts billed during the year	74,325,676	350,220	1,483,442	76,159,338	71,674,143
Less: Recognized as revenue	(73,159,150)	(514,654)	(1,487,337)	(75,161,141)	(74,383,015)
Balance, end of year	\$ 31,278,376	\$ -	\$ -	\$ 31,278,376	\$ 30,280,179

6 Employee future benefits

(a) Designated Employees' Retirement Plan and Supplementary Arrangements

- (i) Reconciliation of plan assets and accrued pension obligation (funded and unfunded) of the defined benefit pension plan to the amount in the Statement of Financial Position:

Defined Benefit Plan	Funded Plan	Unfunded Plan	2024 Total	2023 Total
Plan assets at fair value	\$ 1,671,781	\$ -	\$ 1,671,781	\$ 1,843,339
Accrued pension obligations	(2,808,451)	(3,277,800)	(6,086,251)	(6,267,532)
Funded status deficit	\$ (1,136,670)	\$ (3,277,800)	\$ (4,414,470)	\$ (4,424,193)

- (ii) Pension plan assets

Defined Benefit Plan	Funded Plan	Unfunded Plan	2024 Total	2023 Total
Fair value, beginning of year	\$ 1,843,339	\$ -	\$ 1,843,339	\$ 2,053,650
Interest income	84,794	-	84,794	102,683
Return on plan assets (excluding interest)	92,930	-	92,930	31,937
Employer contributions	-	321,386	321,386	307,355
Benefits paid	(349,282)	(321,386)	(670,668)	(652,286)
Fair value, end of year	\$ 1,671,781	\$ -	\$ 1,671,781	\$ 1,843,339

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Notes to the Financial Statements

December 31, 2024

6 Employee future benefits (continued)

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

(iii) Accrued pension obligations

Defined Benefit Plan	Funded Plan	Unfunded Plan	2024 Total	2023 Total
Balance, beginning of year	\$ 2,911,552	\$ 3,355,980	\$ 6,267,532	\$ 6,596,466
Interest cost on accrued pension obligations	133,931	154,375	288,306	329,824
Benefits paid	(349,282)	(321,386)	(670,668)	(652,286)
Actuarial (gains) losses	112,250	88,831	201,081	(6,472)
	\$ 2,808,451	\$ 3,277,800	\$ 6,086,251	\$ 6,267,532

The most recent actuarial valuation of the pension plan for funding purposes was made effective December 31, 2024. The next required actuarial valuation for funding purposes must be as of a date no later than December 31, 2027.

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

Defined Benefit Plan	Funded Plan	Unfunded Plan	2024 Total	2023 Total
Interest cost on accrued pension obligations	\$ 133,931	\$ 154,375	\$ 288,306	\$ 329,824
Interest income on pension assets	(84,794)	-	(84,794)	(102,683)
Pension expense recognized	\$ 49,137	\$ 154,375	\$ 203,512	\$ 227,141

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

Defined Benefit Plan	Funded Plan	Unfunded Plan	2024 Total	2023 Total
Actuarial (gains) losses	\$ 112,250	\$ 88,831	\$ 201,081	\$ (6,472)
Return on plan assets (excluding interest)	(92,930)	-	(92,930)	(31,937)
Charge (recovery) to net assets	\$ 19,320	\$ 88,831	\$ 108,151	\$ (38,409)

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

Year ended December 31	2024	2023
Funded defined benefit plan	\$ 49,137	\$ 51,519
Unfunded supplementary defined benefit plan	154,375	175,621
Defined contribution plan	513,844	521,505
Healthcare of Ontario Pension Plan	3,636,106	3,573,341
	\$ 4,353,462	\$ 4,321,986

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Notes to the Financial Statements

December 31, 2024

6 Employee future benefits (continued)

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

(vii) Actuarial assumptions

A discount rate of 4.45% (2023 - 4.60%) was used to measure the accrued pension obligations as at December 31, 2024.

(b) Healthcare of Ontario Pension Plan

Employer contributions made to the plan during the year total \$3,636,106 (2023 - \$3,573,341). These amounts are included in staffing costs in the Statement of Operations.

Each year an independent actuary determines the funding status of HOOPP by comparing the actuarial value of invested assets to the estimated present value of all pension benefits that members have earned to date. The most recent actuarial valuation of the Plan as at December 31, 2024 indicates the Plan is 109% funded. HOOPP's consolidated Statement of Financial Position as at December 31, 2024 disclosed total pension obligations of \$112.5 billion with net assets at that date of \$123 billion indicating a surplus of \$10.4 billion.

(c) Obligations for post-employment benefits other than pension

The College has an accrued benefit obligation as at December 31, 2024, of \$512,786 (2023 - \$412,662). The benefit obligation and related expense for the year ended December 31, 2024, was determined by actuarial valuation using a discount rate of 4.70% (2023 - 4.60%). There are no assets in the plan and, therefore, the plan is unfunded.

(d) Restructuring benefits

The College continues to restructure its affairs during the year for the purpose of achieving long-term savings, which resulted in termination benefits to employees in the amount of \$2,973,152 (2023 - \$4,462,782), which has been included in staffing costs.

7 Obligations under capital leases

The College has entered into capital leases for computer equipment. The maturity dates range from September 2025 to December 2027 with fixed interest rates ranging between 8.30% to 10.30%. The following is a schedule of the future minimum lease payments over the term of these leases:

2025	\$	898,759
2026		634,025
2027		205,538
		<hr/>
		1,738,322
Less: current portion		898,759
		<hr/>
	\$	839,563
		<hr/>

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Notes to the Financial Statements

December 31, 2024

8 Contingencies

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

9 Financial instruments

General objectives, policies and processes

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

Credit risk

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

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

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

Liquidity risk

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

Market risk

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

(i) Currency risk

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

(ii) Interest rate risk

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

(iii) Equity risk

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

Changes in risk

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

10 Comparative figures

Certain comparative figures have been reclassified to conform with the financial statement presentation adopted in the current year.

Glossary of Financial Terms

Accounting Framework and Assurance Definitions

Generally Accepted Accounting Principles (GAAP): Is the term used to refer to the standard framework of guidelines for financial accounting used in any jurisdiction. GAAP includes the standards, conventions and rules accountants need to follow in recording and summarizing transactions and in the preparation of financial statements.

Accounting Standards for Not-For-Profit Organizations (ASNPO): Represent the accounting framework established by the Accounting Standards Board of CPA Canada for not-for-profit organizations and used to develop and present a not-for-profit organization's financial statements. Not for Profit organizations must present financial statements following ASNPO and are audited against these standards by external auditors.

Accounting Policies: Specific procedures and rules implemented within an organization and used to prepare its financial statements; accounting policies are based on the organization's accounting framework and include any accounting methods, measurement systems and procedures for presenting disclosures. Accounting policies help ensure consistency and comparability in financial reporting between different organizations and assist users in analyzing comparative financial performance and financial position across organizations.

Financial Audit: The purpose of a financial audit is to provide an objective independent examination of an organization's financial statements, which increases the value and credibility of the financial information and statements produced by management. The financial audit process analyzes an organization's financial records and determines if they are accurate and that there is no misstatement or financial misrepresentation. Financial audits performed by independent, external auditors increase user confidence in the financial statements, mitigate investor or stakeholder risk and can contribute to reducing the cost of capital or increasing investor confidence.

Auditor or Audit Firm: Auditors and their audit firms are independent professional accountants that provide assurance that financial statements produced by an organization accurately reflect and represent operational and financial results and comply with accounting standards for the audited organization. Auditors provide an opinion on the financial statements, providing some assurance that the financial position and results as presented in the financial statements are free from misleading information and fraud. An auditor's report will be issued based on the results of the audit, including any recommendations for improvement to internal control processes.

Unqualified Audit Opinion: Another term is clean opinion, which means that in the auditor's opinion, based on an assessment of internal controls and audit procedures that include testing of sample financial transactions, the financial statements present fairly in

all material respects, the financial position, and results of operations of the organization. An unqualified, or clean opinion, means that readers of the financial statements can rely on the information provided by management. A “qualified” audit opinion indicates that the financial statements may contain material misstatements or omissions, informing readers that they should regard the statements with caution.

Recognition: Is an accounting term that stipulates how and when revenues and expenses are to be recorded in the general ledger and represented in the financial statements. ASNPO outline revenue and expense recognition criteria that stipulates when a financial event is recorded as an accounting transaction. Recognition of a financial transaction differs from cash inflow or outflow associated with the transaction.

Accrual accounting: Is a method of accounting recognition, required by GAAP and ASNPO, that records financial transactions, revenues and expenses, when they are incurred rather than when cash is received, or payments are made. Accrued revenues and expenses are typically recognized as accounts receivable or accounts payable until money is exchanged/received as settlement to the financial transaction.

Accounting estimates/areas of judgement: Refers to the use of management’s discretion in the preparation of its financial statements, based on information available for valuation purposes and the application of accounting policies based on accounting standards that may have a significant impact on the organization’s financial statements. Where significant estimates have been made or judgement applied, disclosure is required in the Notes to the Financial Statements to ensure that the reader has relevant information necessary to make informed decisions about the financial statement presentation.

Financial Compliance: Refers to the continual process of meeting mandatory internal and external governance, policy, statutory and regulatory by-laws, legislation, regulations, and policies as outlined by the organizations that developed and mandated those policies. Examples of financial compliance would include adherence to Board by-laws for investments made, approval of expenditures by individuals with actual and not delegated authority, compliance with Canada Revenue Agency tax deduction, remittance and reporting legislation and meeting pension administration requirements as set out by FSRA (Financial Services Regulatory Authority of Ontario).

Financial Reporting Definitions

Financial Statements: Reports that contain and summarize financial and accounting information about an organization, providing information about its financial position, its financial performance, the sources, and uses of cash and accompanying disclosures (Notes) that provide additional information relevant for the reader. Financial statements are presented at a point in time, for a specific period, such as a fiscal year.

Statement of Financial Position (Balance Sheet): One of several important statements that make up an organization's Financial Statements; the balance sheet communicates an organization's worth or "book value". This financial statement outlines an organization's Assets (what is owned), Liabilities (what is owed) and Accumulated Surplus (Excesses earned over previous fiscal years that represent equity to the organization) or Accumulated Deficit. The accumulated surplus balance incorporates the value of reserves built up from excesses of revenues over expenses which are set aside to be used for future investment or revenue shortfalls. The Statement of Financial Position is presented at a point in time, typically at the end of a fiscal year.

Statement of Operations (Income Statement): One of several important statements that make up an organization's Financial Statements; the income statement summarizes an organization's annual financial performance, its revenues, expenses and surplus or deficit recognized over the fiscal year or reporting period.

Statement of Cash Flows: One of several important statements that make up an organization's Financial Statements; the cash flow statement summarizes the amount of cash flowing into and out of an organization based on operating, investing and financing activities, recognized over a fiscal year or reporting period.

Notes to the Financial Statements: The notes to the financial statements communicate information necessary for the fair presentation of financial position and results of operations that is not readily apparent from, or not included in, the financial statements themselves.

Going Concern: An accounting term used to describe an organization that is financially stable enough to meet its obligations and continue its business/mandate for the foreseeable future. Financial Statements are prepared using the going concern principle, which assumes that during and beyond the next fiscal period, the organization will complete its current plans, use its existing assets and continue to meet its financial obligations. Management is required to make specific disclosures and/or defer financial transaction recognitions if going concern is in doubt.

Internal Controls over Financial Reporting: Is the process that enables organizations to manage risk related to finances and reliably compiled accurate financial statements; specifically includes the daily control policies and procedures, such as commitment and expense approval, reconciliations, proper segregation of duties, that exist across the organization in relation to financial transactions.

Financial Transaction Definitions

General Ledger (G/L): An organization's general ledger, commonly referred to as a G/L, refers to the book of accounts which summarizes all financial transactions incurred

within the organization during the accounting period. Financial transactions are categorized using a Chart of Accounts, which divided financial transactions as follows:

- By Cost Centre, which represents the department accountable for the financial transaction, and,
- By Cost Element, or G/L Account, which represents a categorization by type or nature of transaction, such as revenues and expenses. Common cost elements/accounts are Membership Fees, Interest Income, Salaries and Wages, Benefit Expense, Pension Expense, Meals and Entertainment, Technology Subscriptions, Legal Fees and Depreciation Expense.

Assets: Items that are owned, either through purchase or capital lease arrangements, that provide future benefits to the organization, such as cash, real estate, technology or accounts receivable; assets can be classified as follows:

- Current Assets: Assets which can be converted into cash within the fiscal year, such as bank account holdings, short term investments and accounts receivable,
- Fixed or Capital Assets: Tangible assets that support operations, revenue processes and provide long term sustainable benefits, such as buildings and technology infrastructure, and,
- Long Term Assets: Assets that are held for longer than one year and can't be converted easily into cash, such as long-term investments.

Liabilities: Amounts owed to other parties for goods and/or services provided to an organization; liabilities can be classified as follows:

- Current Liabilities: short term amounts owing that are due in the next year, and,
- Long Term Liabilities: financial obligations that can be paid off over a longer period than a year.

Revenues: Revenues represent earnings from services provided to customers; revenues are recognized at the time, or over the period, that the service is provided, not when the cash is received. Revenues can also be recognized/earned from interest or investments, from amounts recovered from third parties for costs incurred or from grants, donations or funding provided by third parties such as government entities.

Expenses: Expenses represent costs incurred to run and manage operations within an organization, including salaries and benefits, technology subscriptions, property taxes, building maintenance and insurance and depreciation. Expenses are recognized when they are payable, representing financial obligations to the organization, not when they are paid. Certain expenses such as depreciation never require an outflow of cash when recognized as they represent allocations of cash outflows made in prior periods.

Surplus/Deficit: Represents the difference between Revenues and Expenses during a fiscal period; a surplus is generated when the difference is positive whereas a deficit is generated with the difference is negative; a surplus or deficit is calculated for a reporting period, such as a fiscal year.

Depreciation/Amortization: Is an accounting term whereby the cost to acquire or develop a fixed asset is spread over the period the asset provides benefit to the organization (the useful life). Depreciation/amortization recognizes the reduction in the value of a fixed/capital asset over the span of several years due to usage, passage of time, wear and tear, technological obsolescence, depletion, inadequacy, rot, rust, decay, or other such factors before the asset needs significant upgrading or updating.

Asset allocation: Refers to how an organization chooses to spread money over different investment types, known as asset classes, which include:

- Cash and Cash Equivalents: Any asset that is in the form of cash or which can be converted to cash easily, and,
- Bonds: Any asset where funds have been “loaned” to another organization; periodic interest is received or accrued and paid at the time the bond matures, at a defined term when the bond is redeemed, and the amount of the loan and accrued interest are repaid.

Accounts Receivable: Represents the value of money that is owed to the organization by customers that have been provided a service but have not paid for it yet.

Accounts Payable: Represents the value of money that the organization owes a third party, such as an employee, vendor, or contractor, for services received, but not yet paid for.

Defined Benefit Pension Plan: Represents a retirement income plan where an organization commits to pay employees in the plan a set amount, typically based on average salary/wages and years of service, at the time of retirement either for a set number of years or to end of life. The financial obligation created by a defined benefit pension plan must be recognized as a liability to the organization that is satisfied with future revenues and cash flows.

Defined Contribution Pension Plan: Represents a retirement income plan where the amount of pension income is not guaranteed; such plans define the amount of required contribution, typically made by the employee and organization, with no promise of set income when the employee chooses to retire.

Accounting Cut-off: Refers to the end of a fiscal or reporting period, such as a month, quarter or fiscal year. A cut-off date marks the last date to enter transactions in the general ledger and financial statements for the reporting period. Management should have practices in place to ensure that the timing of revenue recognition and expense reporting meets fiscal period cut-off requirements; proper cut-off ensures that transactions are recognized appropriately and reflected accurately in the financial statements.

Financial Management Definitions

Cash flow: Refers to the net balance of cash moving in and out of the organization at a specific point in time, broken down as follows:

- Operating Cash Flow: Net cash generated from normal business operations,
- Investing Cash Flow: Net cash generated from investing activities such as bonds, GICs and the purchase or sale of fixed/capital assets, and,
- Financing Cash Flow: Net cash related to business financing, such as debt payments and accumulated surplus/equity.

Liquidity: Describes how quickly assets can be converted into cash that is used to pay for goods and/or services required for operations.

Return on Investment (ROI): Is a calculation used to determine the expected or actual return of a project or activity when compared to the cost of the investment, typically shown as a percentage. This measure is often used to evaluate whether a project or investment is worthwhile for the organization to pursue.

Working Capital: Represents the difference between an organization's current assets and current liabilities; it is the money available for daily operations, the value of which can help determine an organization's operational efficiency and short-term financial health.

Cash burn: The burn rate represents the pace at which an organization that's not generating profits consumes cash reserves; it represents the speed at which an organization spends the money that is available to it when it is not making more money than it spends.

Budgeting: A term to explain a financial planning process that outlines the resources required to manage operations in quantitative terms and the income that is required to fund those plans. A budget is typically prepared in advance of a fiscal year, based on past trending, and future expectations and plans, formalizing management's plans, anticipated results, and actions required to achieve stated goals. Good budgeting promotes financial and operational sustainability within organizations.

Forecasting: Is a method of making informed predictions by using historical data and trends as main inputs to determining the course of future events. This tool is essential to predicting future financial performance, therefore is an important activity in the financial management process.

Financial Ratios: Are mathematical relationships between financial numbers that assist in providing insight into an organization's financial health and performance; analyzing financial ratios can provide organizations with valuable insights into profitability, liquidity, efficiency, and other factors, providing visualization of how the organization has performed over a given period.

Funding Source: Refers to the origins of an organization's money/cash balances, for example, operating revenues, operating surplus, reserve balances, borrowed funds such as debt, used to offset expenses/expenditures.

Reserves: Refers to prior year surpluses that have been set aside in the future; reserves can be restricted meaning that they have been appropriated for specific use such as specific capital investments, or unrestricted meaning that the amounts are available for any use or purpose. The existence of reserves allows for capital or operating expenditures to be made at a future date that do not require a corresponding revenue to be earned when the expenditure is made.



A Guide to Financial Statements of Not-for-Profit Organizations

QUESTIONS FOR DIRECTORS

SECOND EDITION



DIRECTORS' BRIEFING SERIES

A Guide to Financial Statements of Not-for-Profit Organizations

Questions for Directors

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Preface

The Corporate Oversight and Governance Board (COGB) of the Chartered Professional Accountants of Canada (CPA Canada) has developed this guide to help directors of not-for-profit organizations (NFPs) understand the financial statements of the organization they serve. Although boards may delegate the detailed aspects of financial oversight to a board committee, all directors have a personal responsibility for ensuring that they understand the financial information provided to them and the financial implications of their decisions and actions. Directors are expected to probe and question until they are satisfied with their organization's financial information and the direction in which the organization is moving. An understanding of financial statements is a prerequisite for effective oversight of the financial affairs of the organization.

Financial statements in the NFP sector can involve accounting methodologies not found in the for-profit sector. NFPs are very diverse and range from small all-volunteer groups to large highly sophisticated enterprises. Some, but not all, have charitable status. This document is directed to NFPs that are of a sufficient size to require a management team and engage the services of an external auditor.

The guide will assist NFP directors to understand:

- the role and responsibilities of the board, management and the auditor in financial reporting
- the concepts and terminology of financial reporting in the NFP sector
- the ways in which contributions (i.e., donations) to the organization can be accounted for
- the various financial statements they will encounter in their role as an NFP director

Directors of government-sponsored NFPs and NFPs that operate “social enterprises” may find this guide helpful; however, they face particular financial reporting issues that are not covered in this briefing.

Throughout the guide, there are sections entitled “Items for directors to watch for and questions to ask.” These sections are intended to assist directors to undertake their governance oversight role in an effective manner. Directors are encouraged to frame additional questions in the particular circumstances they face.

The COGB acknowledges the author, Deryck Williams, as well as William G. Wolfson and William Harper, the authors of the previous edition of this publication. The COGB also thanks the members of CPA Canada's Not-for-Profit Organizations Committee for their invaluable input and direction, and the CPA Canada staff who provided support for the project.

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Introduction

The Importance of the Sector and the Role of Directors in Oversight of Financial Affairs

It is estimated that 12.7 million Canadians volunteer with not-for profit organizations (NFPs). Many of these volunteers serve as members of their organization's board of directors.¹ NFP boards are responsible for overseeing the affairs of organizations that constitute about 8.5% percent of Canada's GDP, generate economic activity of approximately \$169 billion and provide 2.4 million jobs for Canadians.² Being a director in the NFP sector is a vitally important role.

Board members in the NFP sector have a wide variety of skills and interests. Some may feel uncomfortable reviewing financial information and may be poorly equipped to provide the required oversight of the financial affairs of the organizations which they have been elected to govern. This gap presents a threat to the sustainability of the organization. It may also expose individual board members themselves to legal liability. The bottom line is that overseeing the financial affairs of NFPs is a key responsibility of the board, and of every member of the board.

Directors have a "fiduciary duty" to their not-for-profit organization to act honestly and in good faith in the best interests of the organization. This responsibility is sometimes referred to as the "duty of loyalty," but it is much broader than just loyalty. It speaks to concepts such as the duty of confidentiality and not participating in decisions in which the director may have a personal interest. Directors also have a "duty of care" that requires them to act with the care, diligence and skill that a reasonably prudent person would exercise in comparable circumstances. This obligation means that directors must diligently apply their skill, expertise, education and intelligence to the job of being a director to make reasonable business decisions.

Directors have fiduciary responsibilities to take steps to ensure that funds are spent in accordance with donors' or funders' criteria, that statutory obligations are fulfilled, such as payroll deductions being remitted to the Canada Revenue Agency, and that internal

1 Statistics Canada (2013) *Survey of Giving, Volunteering and Participating*.

2 Statistics Canada (2017) *Satellite Account of Nonprofit Institutions and Volunteering*.

controls are in place to avoid the occurrence of fraudulent transactions within the organization. A proper understanding of the financial statements and information provided to the directors assists the directors in fulfilling these responsibilities.

A board can delegate the work to prepare financial information, but the board as a whole is ultimately responsible for financial reporting. Indeed, one of the fundamental roles of the board of directors is stewardship of the organization's resources. This duty includes the responsibility to protect the organization's assets and to oversee its financial affairs. Financial statements are the primary means of communicating information about the organization's financial position (at a point in time) and financial results of its operations (over a period of time).

Though financial information is not the only information required to develop an understanding of the organization, it is a key component. Financial information is typically measurable, objective, comparable over time, sometimes comparable across organizations, and can provide an indicator of organizational health. Board members require the ability to understand various financial statements in order to discharge their stewardship responsibility to the organization.

Each board member does not need to have financial expertise, or to be a financial expert, but all directors should develop a basic level of financial literacy. This guide for NFP Directors aims to provide a practical tool to help board members understand financial concepts and comprehend financial statements. Most importantly, this guide will help directors focus on certain elements in the financial statements and understand how they can use that information to critically assess and oversee their organization's financial affairs.

Some Common Barriers Impeding Full Board Participation in Financial Oversight

We have an experienced accountant on our board — why should I have to deal with this?

Financial experts such as accountants bring a valuable skill set to the board table, along with their field experience and their professional mindset. They are in a strong position to help their board peers deepen their understanding of financial matters. Organizations with a financial professional on the board are fortunate and should use that person as a resource. Further, that director should expect to play a key role in the oversight of financial affairs, perhaps by becoming a member of the audit or finance committee of the board. (In some NFP organizations, the functions of these two committees are combined into one board committee.) However, as noted above in the “duty of loyalty,” board members cannot

abdicate their responsibility or transfer it to another board member. Each and every board member must fulfill their obligations for the oversight of financial matters to the best of their ability.

Shouldn't the board be focusing on our organization's mission?

The ultimate goal of every not-for-profit organization, and hence every organization's board, is the achievement of its mission. Consequently, a significant portion of the board's time and energy needs to be focused on the organization's mission and progress in achieving it. However, the organization must protect its assets, pay its bills, compensate its employees, receive and manage donations, and undertake a host of other financial activities. Doing so in an efficient and effective manner is critical to achieving its mission. An organization that is not financially secure cannot focus on achieving its mission, as efforts of the board and management are directed to financial survival.

Accounting is just too complex for me!

Accounting is indeed a complex subject. There are various financial concepts and accounting principles. However, all board members do not need to be accounting experts. Directors should strive to acquire a basic understanding of financial matters, and a basic ability to read, assess and question financial statements and other financial information. Turning to experts for assistance and advice is entirely appropriate, but making final decisions within the context of the organization's total financial picture is the responsibility of every member of the board.

Isn't this the job of the auditor³ or of management?

The auditor and management both have important and distinct roles to play in ensuring fair and complete financial reporting for the organization. So does the board of directors. Management is responsible for selecting the organization's accounting policies and preparing, presenting and acting on financial information. The board is responsible for overseeing management and the processes for preparing financial information, and for satisfying itself that the resulting information reasonably reflects the organization's reality. The auditor, on the other hand, is responsible for providing an independent professional opinion on the fair presentation of the organization's financial position and its financial results. These three parties to financial reporting are inter-dependent: Each relies on the other, but each has its own role and responsibilities.

³ Depending on the legislation governing an NFP in the jurisdiction where it is incorporated, the organization may have options regarding the engagement of an auditor. These options are beyond the scope of this guide.

Outline of this Guide

This guide is designed to help directors of not-for-profit organizations to fulfill their fiduciary duties. Many NFPs have charitable status which brings additional reporting obligations and oversight duties for directors.

The guide outlines the process of financial reporting and the various roles and responsibilities within an NFP for financial reporting. It describes the concepts and terminology used in financial reporting, providing both definitions and examples. With that foundation in place, the guide describes two key financial reports that directors will encounter most frequently:

- statement of financial position (sometimes called the “balance sheet”)
- statement of operations (sometimes called the “statement of activities” or “income statement”)

This guide will use the terminology of statement of financial position and statement of operations; NFPs are free to use other designations. [Appendix 1](#) and [Appendix 2](#) provide descriptions and analysis of other financial concepts and statements that NFP directors may encounter, depending on the operations of their organization.

There is particular emphasis in the guide on questions directors might consider asking about various financial processes and statements that they will encounter in their oversight role.

The Process of Financial Reporting

Financial reporting must serve both the interests of internal users and the interests of external stakeholders.

Internal Financial Reporting

Internally, staff members of the organization are both creators and users of financial reports. Finance staff collect the appropriate data, manage the associated information systems and create financial reports. Managers responsible for financial integrity, risk, quality, program delivery and other key internal responsibilities use these reports in fulfilling their job responsibilities.

Certain financial reports are submitted to the board and/or board committees.

Financial reporting to the board of an NFP tends to follow a natural cycle:

- the budget for the coming year (prepared by management, usually influenced by, but not identical to, management's year-end estimates from the preceding year and other information)
- the audited financial statements for the previous year (issued usually in the first or second quarter of the next fiscal year, upon completion of the external auditor's work on the NFP's financial statements)
- internal in-year financial statements to report on actual results compared to the budget, often including projected results to year-end (prepared by management)

Directors can expect to review each of these types of financial reports at various points in time. The dates in the "calendar year" depend on the NFP's fiscal year-end. The fiscal year is the 12 month period used for calculating the figures in an annual financial statement. The fiscal year may not coincide with the calendar year. For those organizations with a December 31 year-end, directors can expect the following:

- budget review in the fall
- draft audited financial statements in the spring
- internal in-year financial reports at least every quarter (and in some organizations, every month or bi-monthly)

External Reporting to Stakeholders

Not-for-profit organizations have many stakeholders and each one has an interest in the financial affairs of the organization. All stakeholders have a common interest in areas such as:

- the protection of the assets entrusted to the organization
- the efficient and effective use of the organization's resources in furtherance of its purpose

Some stakeholders have quite specific interests. For example:

- Funders (e.g., governments or foundations) want assurances that their contributions to the organization have been used in accordance with the funding submission and subsequent approval.
- Donors (particularly major donors) want assurances that their contributions have been applied according to their wishes.
- Members have an interest in how their fees have been deployed and more generally in how the organization is performing.
- The Canada Revenue Agency (CRA) requires all NFPs to submit an annual filing that includes financial information.⁴

The organization, through its management, has a reporting duty to all of these stakeholders. Financial statements and other financial reports are communication tools that the organization uses to meet the information needs of its stakeholders.

Common information requirements are usually met through the issuance of general purpose audited annual financial statements, supported by the organization's annual report. These are good tools for communicating to a variety of audiences about the organization's financial affairs. However, they may not answer all the questions of certain stakeholders. Special purpose reports are used to supplement audited financial statements to answer these additional questions. For example, many funders require reporting about the use of "their" funds, in specific formats, as a condition of granting the funding to the organization.

4 An NFP that is not a registered charity and has assets over \$200,000 or receives certain investment income over \$10,000 must file Form T1044 annually. If an NFP is incorporated but not a registered charity, it must file a T2 Corporate Tax Return annually. Charitable NFPs file Form T3010 and do not file T2s or T1044s. Certain financial information submitted by charities is made available to the public on the CRA website.

The Roles and Responsibilities Associated With Financial Reporting

A Three-Way Arrangement

Responsibility for an organization's financial reporting is shared among three parties — management, the board and the external auditor — as follows:

- management, which is responsible for preparing financial reports
- the board, which is responsible for overseeing management and its financial reporting processes and satisfying itself as to the appropriateness of financial reports for those outside the organization
- the auditor, who is responsible for making an independent assessment of the financial statements, and giving a professional opinion on whether they give a fair presentation of the organization's financial position and results of operations⁵

Each party relies on the work of the other two in discharging its own responsibilities. Each one brings a unique perspective to the preparation of financial reports:

- Management has an intimate understanding of the organization's activities and plans; management also exercises judgment on how certain items are accounted for in the financial reports.
- The board offers a high-level, strategic view of the organization, coupled with due diligence duties with respect to internal policies, procedures and processes, and an accountability to external stakeholders.
- The auditor brings a different level of financial expertise that may not exist within the organization; more importantly, the auditor brings an outside, independent perspective on the organization's financial affairs

5 The auditor examines the general purpose financial statements of a not-for-profit organization prepared in accordance with generally accepted accounting principles (GAAP) as determined by the Accounting Standards Board (AcSB) and published in the *CPA Canada Handbook — Accounting*. Under GAAP, NFPs have the choice of applying International Financial Reporting Standards (IFRS® Standards) or Accounting Standards for Not-for-Profit Organizations (ASNPO). As most NFPs report using ASNPO, this guide is based on that accounting framework. Some NFPs are not required to engage the services of an auditor; nevertheless, this guide will still be helpful to directors of those organizations.

Management is responsible for preparing financial reports. The perspectives provided by the auditor and the board could not exist without management first preparing the reports for these two other parties to consider.

Management is also responsible for developing internal financial controls. Robust internal controls are essential to the integrity of financial reporting. The board has an obligation to pay close attention to the details of management's approach to internal controls and to satisfy itself that all appropriate areas have been covered to minimize the risk of financial mismanagement or fraud.

In the process of performing the independent external audit, the auditor will expect management to sign a "representation letter." This letter confirms, among other things, that the financial information provided to the auditor is, to the best knowledge of the signatories, complete and that there has been full disclosure of all material financial matters.

The Relationship Between the Board and the Auditor

A significant underpinning of external financial reporting is that the information be credible. Users must have a strong level of assurance that financial information is a fair presentation of the organization's affairs. The annual audited financial statements provide a key measure of accountability and control for not-for-profit organizations. The auditor, with a mandate to directly inspect the books and records of the organization, provides an important check on the presentation of financial information by management.

The choice of the auditor and the reporting relationship for the auditor are therefore key considerations. The board selects the auditor and recommends the appointment of the auditor for approval of the organization's members at the Annual General Meeting. Governance best practices for not-for-profit organizations dictate that the auditor reports directly to a committee of the board (in some organizations, directly to the board). The auditor is also expected as a matter of best practices to meet *in camera* (see [Appendix 5](#)) with the board committee (or the board as a whole), without management present.

Understanding Financial Statements

There are two key types of financial statements that directors will encounter most frequently, whether as part of the budgeting process, in-year monitoring of results or the review of the external auditor's formal financial statements. These are:

- *statement of operations* for a period of time
- *statement of financial position* at a point in time

Two other financial statements are included in the audited financial statements at year-end: *statement of changes in net assets* and *statement of cash flows*. These two statements are discussed in [Appendix 1](#). The main body of this guide focuses on the two statements above that directors will review on a regular basis. When reviewing these statements, directors should pay special attention to the cash position of the organization, as healthy cash balances are key to long-term viability.

The Time Frame

The first thing to keep in mind is the difference between figures presented on the statement of operations, which are “cumulative sums over time,” with those on the statement of financial position, which are “at a point in time.”

- Financial figures calculated as *cumulative sums over time* show the total financial value of an activity during a fixed period of time, such as a full year or a quarter of a year, ending at the reporting date. For example, fees for service is the sum of all fees earned by the organization over the specified period. Another example is salaries and benefits paid in the period.
- Some financial figures are calculated at *a point in time*: in other words, as at a particular reporting date. For example, the accounts payable figure is the total dollar amount owed by the organization to suppliers at the specified date. Another example is the value of investments held by the organization at the specified reporting date.

There is a relationship between the two concepts. The “point in time” figures on the statement of financial position are the net result of all the transactions over time. As an example, the investment balance (a “point in time” figure) is the result of all transactions

that have cumulatively impacted the balance over time, which include gains, losses, dividends and interest. Each of the latter appear on the statement of operations (cumulative sums over time) in the period when they occur.

Accrual Accounting vs. Cash Accounting

An important consideration in measuring and recording revenues and expenses, as well as assets and liabilities, is when to record a transaction. Transactions need not involve cash. In these circumstances, the accounting question is when to record the event in the books of the organization (and thereby in the financial reports).

- *Accrual accounting* records transactions when they occur, regardless of when money actually changes hands between the organization and third parties. Examples are a fee-for-service delivered and invoiced but where payment has not yet been received by the NFP (this would be included in revenues and accounts receivable) or a purchase of office supplies using a credit card where payment has not yet been made (this would appear as an expenditure and account payable).
- *Cash accounting* records transactions only when there is an exchange of cash. Under this system, the sample transactions above would not be recorded until the fee-for-service was received (an increase in revenues) and until the NFP paid its credit card bill (an increase in expenditures).

Accrual accounting provides a more accurate record of financial activities because it records the economic substance of transactions, whether or not cash has been received or paid. Compliance with GAAP requires that NFPs use the accrual method.

The Statement of Operations

The primary purpose of a statement of operations is to communicate information about changes in the organization's economic resources and obligations for the period. It does this by providing a summary of the organization's revenues and expenditures over the period of time. It also shows the net balance between the two periods: in other words, the excess (or deficiency) of revenues over expenditures for the period.

Sample Statement of Operations

The following is an example of an *internal* statement of operations for a simple not-for-profit organization. We will review the statement to understand the information it is providing for decision-making. It is "internal" because it also includes the budget for the year, which is not usually included in the external financial statements. Internal financial statements are intended for board and management review.

NOT-FOR-PROFIT ORGANIZATION STATEMENT OF OPERATIONS For the 12 months ended December 31 A			
	Budget	Current year	Prior year
Revenues			
Government Grants	8,700	8,700	8,150
Fees for Service	950	975	920
Investment Income	35	35	35
Interest and Other	12	10	15
Total Revenues B	9,697	9,720	9,120

**NOT-FOR-PROFIT ORGANIZATION
STATEMENT OF OPERATIONS
For the 12 months ended December 31 A**

	Budget	Current year	Prior year
Expenditures			
Salaries and Benefits	6,822	6,940	6,560
Rent and Building Occupancy	1,845	1,845	1,600
Office	450	490	440
Depreciation of Capital Assets G	24	24	30
Other	4	5	4
Total Expenditures B	9,145	9,304	8,634
Excess of Revenues Over Expenditures B	552	416	486

Using a “big picture first” approach, the reader of the statement of operations looks first at four key items: the time frame, total revenue, total expenditures and the excess or deficiency of revenue over expenditures.

- A. What is the period over which these numbers have been accumulated? The answer shown in the statement’s title (**A**) is that it is for the 12 months ended December 31. External financial statements are commonly presented for a 12-month fiscal period. However internal financial statements may show shorter periods, such as monthly or quarterly and so on, providing year-to-date information as the organization progresses to its 12-month fiscal year-end.
- B. What are total revenues, expenditures and the excess or deficiency between them? In this case, looking at the column for the current year, observe (**B**) that total revenues of \$9,720 exceeded total expenditures of \$9,304 by \$416. The reader can draw an initial big-picture conclusion that the organization had an acceptable year. Now, drill down to understand this further.
- C. What are the major components of revenues and expenditures? Government grants are 90% (8,700/9,720) of total revenues. This organization is therefore critically dependent on government funding. Observe that as in many not-for-profit organizations, staffing

costs are by far the largest cost component, at about 75% (6,940/9,304) of total expenditures. The excess of revenues over expenditures is about 4% of total revenues (416/9,720). A low percentage of excess or deficiency is normal for an NFP.

- D. Drill down further through comparisons. This sample statement allows comparisons with both the prior twelve months and the current twelve-month budget. In NFP's, because their objective is to maximize mission rather than profit, budgets are a particularly important benchmark for understanding how well the organization did financially.
- E. Total revenues increased over last year by \$600. As a percentage this is $9,720/9,120 = 6.6\%$. They also were higher than budget by \$23. Looking at the items that add up to the total, note that the largest part of the increase is government grants, from \$8,150 to \$8,700. The organization budgeted for this increase. So, the unexpected component of the increase is fees for service, which are \$25 higher than budget. The reader can conclude that this is the main reason total revenues are up over budget.
- F. Total expenditures increased over last year by \$670. As a percentage, this is $9,304/8,634 = 7.8\%$. They were also higher than budget by \$159. Looking at the items that add up to the total, note that the largest part of the increase is salaries and benefits, increasing from \$6,560 to \$6,940. The expenditure is also significantly over budget by \$118. Observe that office expenditures were up over last year's and over budget by \$40. A director would expect explanation from management for these unplanned increases and discussion of whether the trend will continue.
- G. The term "depreciation of capital assets" (**G**) bears special explanation. Depreciation (used interchangeably with the term "amortization") is the expensing of the cost of an asset spread out over its useful life. Capital assets are assets held for use on a continuing basis in the ordinary course of operations (see a full definition in the [Glossary](#)).

For example, suppose the organization purchases a van for use in carrying out its operations, and it estimates that it will have a useful life of six years. The van is a capital asset. The portion of the original cost of the van that is expensed in each of the six years is its depreciation expense for the year, which is shown in the statement of operations. If the organization had purchased the van for cash, its depreciation expense for that first year would be considerably lower than the cash paid for its purchase. However, at the end of the six years the cumulative depreciation expense would equal the full cost of the van (net of any estimated value on disposition).

- H. How much detail should be in the statement of operations?

Based on the NFP's chart of accounts,⁶ the statement of operations organizes revenues and expenditures in various categories, usually listed from largest dollar value to smallest.

⁶ A chart of accounts is a way of organizing the many hundreds — indeed likely thousands — of transactions an NFP engages in every year. See [Appendix 1](#) for more details.

Revenues are organized according to their type (e.g., grants, contributions, fees, sales, interest).

Expenditures are grouped together in meaningful categories and may be classified by object (e.g., salaries, rents, supplies), by function (e.g., program delivery, administration, fundraising) or by program (e.g., children's programs, youth programs, adult programs).

Management needs to develop an expenditure listing that is both short enough to digest (typically less than one page) and long enough to provide insight into the major types of revenues and expenditures. External financial statements will normally have less detail than internal statements. Materiality is a useful concept to apply in determining the amount of detail on external financial statements.

Note that when expenditures are organized by function or program, this means that expense objects, such as salaries and rent and amortization, have been allocated on a consistent basis to regroup them by function or program. GAAP requires that the basis for the allocation of fundraising and general support expenses be disclosed in the accounting policies and, where material, that a chart be provided in the notes to the financial statements showing these allocations. It is good governance for the directors to review the amount and basis for these allocations.

The Statement of Financial Position

The statement of financial position is a financial snapshot taken at a point in time. This statement is sometimes called the “balance sheet” because it shows that total assets equal (i.e., balance) the sum of liabilities and net assets.

How is it that the statement of financial position balances? The net assets (N) of an NFP are defined as its assets (A) minus its liabilities (L): $A - L = N$, which is known as the “balance sheet equation.” The statement of financial position shows this equation in a rearranged form: $A = L + N$. This proof of balance (“the books are balanced”) is important because it shows that what has been entered in the underlying accounts is complete. (However, it does not prove that everything that should have been entered has been.) An important extension of this balancing principle is that the excess or deficiency of revenues over expenditures for the period between two statements of financial position must be the same in the statement of operations as it is in the final statement of financial position. If it is not, then at least one of the statements is in error.

Sample Statement of Financial Position

The following is an example of a statement of financial position for the same not-for-profit organization at the December 31 current year-end, with comparison to the previous year-end. NFP directors can expect that their organization might use different terminology and additional categories, but the fundamental relationships within the statement of financial position will be the same as shown here.

**NOT FOR PROFIT ORGANIZATION
STATEMENT OF FINANCIAL POSITION
as at December 31 of current year**

	Current year	Previous year
ASSETS		
Current Assets		
Cash and Cash Equivalents	2,370	2,005
Grants Receivable	100	65
Accounts Receivable	25	20
Prepaid Expenses	42	35
	2,537	2,125
Investments	500	500
Capital Assets (Property and Equipment)	1,126	1,150
Total Assets	4,163	3,775
LIABILITIES AND NET ASSETS		
Current Liabilities		
Bank Indebtedness	85	115
Accounts Payable	122	87
Government Remittances Payable	65	48
Current Portion of Mortgage Payable	75	75
	347	325

**NOT FOR PROFIT ORGANIZATION
STATEMENT OF FINANCIAL POSITION
as at December 31 of current year**

	Current year	Previous year
Mortgage Payable	825	900
Other	65	40
	890	940
Net Assets	2,926	2,510
Total Liabilities and Net Assets	4,163	3,775

The statement of financial position organizes assets and liabilities based on how close each is to cash (liquidity). Consequently, in the assets section, current assets are shown first followed by assets not expected to become cash in the next twelve months — investments and capital assets. Similarly, in the liabilities section, current liabilities expected to be paid within twelve months are shown first, followed by longer-term items — in this case the balance of the mortgage payable.

Shown below liabilities is the result of subtracting the liabilities from assets, which is normally “net assets.” If the result is negative, it is titled “net deficiency.”

Using a “big picture first” approach, the reader of the statement of financial position looks first at four key items: the time frame, total assets, total liabilities and the net assets or deficiency.

- A. What is the point in time of the statement? The answer in the title (A) is that it is prepared as at December 31 with the first column showing the current year and, for comparison, the second column showing the balances as they were twelve months prior.
- B. What are the total assets, liabilities and their net? The assets are \$4,163, the liabilities are \$347 plus \$890 = \$1,237. When the liabilities are subtracted from the assets, the result is net assets of \$2,926. It is essential to understand that the net asset balance is not another type of asset. It is simply the arithmetical result of subtracting the liabilities from the assets. That said, it is a very important figure. A large net asset balance usually indicates that the organization is financially strong and, conversely, a net deficiency

(where liabilities exceed assets) usually indicates the organization is in financial difficulty. In this case, the reader can draw an initial big-picture conclusion that the organization is in a very strong financial position. Now, drill down to understand this further.

- C. What are the major components of the assets? The major current asset is “cash and cash equivalents” with a balance of \$2,370. Cash equivalents are short-term highly liquid investments that are readily convertible to cash. Note that the organization is in a strong cash position because cash is 93% ($2,370/2,537$) of current assets, and a portion of that cash is earning income.

There are some grants and accounts due to be received, but they are proportionately small. The balances are higher than the previous year, which might prompt a question as to why. When receivables grow in amount, it can be a sign of difficulty in collecting. In this case, it could be a sign of the increase in fees for service revenue over last year. Prepaid expenses are expenses paid in advance, very often including insurance and rent.

The investment balance stayed the same, meaning there were no withdrawals or new investments. In particular, this means that the amount earned on investments of \$35, (shown on the statement of operations), was not reinvested. Observe that the capital assets amount went down by \$24, which is the amount of the amortization shown on the statement of operations.

- D. Drilling down on current liabilities, note that their total (\$347) is well within the means of the organization to be paid, given its cash balance. The bank indebtedness has decreased and accounts payable have increased by similar amounts. These changes may be due to later payments to suppliers compared to last year. Government remittances, which include employee tax withholdings, have increased. This may partly be due to the increase in salaries shown on the statement of operations. However, the size of the increase, which is greater than the percentage increase in salaries, might prompt a question as to why.

The largest item in long-term liabilities is the mortgage payable. Note that it went down as expected by the amount due in the year. A reader would look in the financial statement notes to see when the full balance will come due.

Restricted Contributions, a Special Type of Revenue

NFP organizations often receive donations from their supporters. For some NFPs, especially charitable organizations, the amounts can be significant. The accounting term for donations is contributions.

Contributions are a type of revenue unique to not-for-profit organizations. The main characteristic of a contribution that sets it apart from other types of revenue is that it is a non-reciprocal transfer. In other words, the contributor does not receive anything in exchange for the contribution. Government funding to an NFP is considered to be a contribution.

A not-for-profit organization typically has multiple goals, and its supporters may choose to support one or another of these goals or place some other restriction on the use of the contributions they provide. For example, a restriction might be to use the contribution only for one particular program, or to purchase a capital asset, or it may be that the contribution is not to be used at all, but rather invested as an endowment with the income from the invested funds to be used for a particular program. Accepting such restricted contributions places an obligation on the organization to respect those restrictions, and to use those monies only in accordance with donors' wishes.

Accordingly, there are three types of contributions:

1. An *unrestricted contribution* has no externally imposed conditions and the NFP is free to use the funds in any manner it chooses. (It is neither a restricted contribution nor an endowment contribution.)
2. A *restricted contribution* is a contribution subject to externally imposed stipulations as specified by the donor.
3. An *endowment contribution* is a special type of restricted contribution requiring that the resources contributed be maintained permanently.

Accounting for Contributions

NFPs are required to distinguish between contribution revenues and other revenues, and to report on them and on unspent restricted contributions in their financial statements. As each of the three types of contributions has different stipulations as to their use, each one needs to be tracked separately and reported on separately.

There are two methods of revenue recognition for contributions:

1. the *deferral method* (the default method)
2. the *restricted fund method*

An NFP typically makes a choice of revenue recognition policy early in its existence, when contributions are first received. Altering the method after that is a significant accounting change which would need to be disclosed in the audited financial statements as a change in accounting policy.

The two methods can result in significant differences in the amount of revenue recognized each year and in presentation of the related balances on the statement of financial position. Each method has advantages in the information it provides for decision-making. Choosing the method most suitable for a particular organization requires careful consideration.

Below we discuss the application of each method to the sample financial statements.

Deferral method of accounting for restricted contributions

The overall concept of the deferral method is that restricted contributions are recognized as revenue on the statement of operations in the same period that the related expenditures are recognized. Until the related expenditures are recognized, the restricted contributions are recorded on the statement of financial position.

To achieve this, the accounting treatment depends on which type of contribution is made and the nature of the item it is intended to be spent on.

- An unrestricted contribution is taken into revenue in the period it is received.
- An externally restricted contribution for which the related expenditures are made in the current period is also included in the current period revenue.
- Where the related expenditures of an externally restricted contribution are not made in the current period, the contribution is recorded on the statement of financial position as a *deferred contribution*. In a future period when the related expenditure is made, the deferred contribution balance is reduced and revenue on the statement of operations is increased by the corresponding amount.
- If the externally restricted contribution is for the purchase of a capital asset, (e.g., a building or a vehicle), as the related capital asset is amortized into expenditures, the deferred contribution is amortized at the same rate, meaning that it is reduced and revenue increased by the corresponding amount.
- In the sample statement of operations below, the contribution revenues of \$270 and \$180 are a combination of any unrestricted, current-year restricted and previously deferred restricted contributions. Since any restrictions on these revenues are fulfilled in the current year, the term “restricted” is not required.
- A special situation occurs when there will never be a corresponding expenditure for a restricted contribution:
 - An endowment contribution, which is essentially an asset contribution to be held in perpetuity, is never recognized in revenue. Instead it is recorded on the statement of financial position as an increase in a category within net assets called *net assets restricted for endowments*.
 - An externally restricted contribution for the purchase of land is also never recognized in revenue but is instead recorded on the statement of financial position as a direct increase in net assets.

NOT-FOR-PROFIT ORGANIZATION
STATEMENT OF OPERATIONS (deferral method)
For the 12 months ended December 31

	Current year	Previous year
Revenues		
Government Grants	8,700	8,150
Fees for Service	975	920
Contributions	270	180
Investment Income	35	35
Interest and Other	10	15
Total Revenues	9,990	9,300
Expenditures		
Salaries and Benefits	6,940	6,560
Rent and Building Occupancy	1,845	1,610
Office	490	440
Depreciation of Capital Assets	24	30
Other	5	4
Total Expenditures	9,304	8,644
Excess of Revenues Over Expenditures	686	656

Despite any underlying complications in computing which portion of deferred contributions should be recognized in the statement of operations, as shown above the statement using this method is typically quite concise.

The deferral method has the effect of reducing swings in excess or deficiency of revenues over expenditures that can occur, for example, when a major restricted contribution is received in one year and spent in the subsequent year. If instead the restricted contribution had not been deferred, then the organization would show a large excess in the first year and a large deficiency in the subsequent year when the expenditure is made.

Because of the way it reduces swings in net results, this method is popular with organizations that receive government funding for programs, where there is a requirement to report a matching of program revenues and expenditures. Examples would be community care organizations and municipally and federally supported arts organizations.

A disadvantage of the deferral method is that the contributions reported on the statement of operations can be very different from the total amount of restricted contributions the organization received in the year. The amount of restricted contributions received can be found in a note to the financial statements, explaining the changes in the deferred contributions balances.

NOT FOR PROFIT ORGANIZATION
STATEMENT OF FINANCIAL POSITION (deferral method)
as at December 31 of current year

	Current year	Previous year
ASSETS		
Current Assets		
Cash and Cash Equivalents	2,585	1,938
Restricted Short-Term Investment	75	50
Grants Receivable	100	65
Accounts Receivable	25	20
Prepaid Expenses	42	35
	2,827	2,108

NOT FOR PROFIT ORGANIZATION
STATEMENT OF FINANCIAL POSITION (deferral method)
as at December 31 of current year

	Current year	Previous year
Investments	330	350
Restricted Investments	170	150
Capital Assets (Property and Equipment)	1,126	1,150
Total Assets	4,453	3,758
LIABILITIES AND NET ASSETS		
Current Liabilities		
Bank Indebtedness	85	115
Accounts Payable	122	87
Government Remittances Payable	65	48
Current Portion of Mortgage Payable	75	75
Deferred Contributions	75	50
	422	375
Mortgage Payable	825	900
Other	65	40
Deferred Contributions — Capital Assets	35	43
	925	983

NOT FOR PROFIT ORGANIZATION
STATEMENT OF FINANCIAL POSITION (deferral method)
as at December 31 of current year

	Current year	Previous year
Net Assets		
Net Assets Restricted for Endowments	170	150
Unrestricted Net Assets	2,936	2,250
	3,106	2,400
Total Liabilities and Net Assets	4,453	3,758

Above are new line items that can result on the statement of financial position with the deferral method of accounting for restricted contributions. Notice the new line for deferred contributions, being restricted contributions that have not yet been expended. In this statement they are divided into two groups: those in current liabilities, which are expected to be expended within the next twelve months (\$75 and \$50), and the restricted contributions accumulated to pay for capital assets (\$35 and \$43), which are expected to be drawn down over a period of years and so have been grouped with long-term liabilities.

While the presentation above, splitting the deferred contributions into current and long-term, is common practice, its level of detail is not strictly required. The applicable accounting standard simply requires that deferred contributions balances be presented outside of net assets. The standards do require that the changes in the balances of deferred contributions be reported. The change information is typically provided in a note to the financial statements showing opening balances plus receipts and less expenditures, to equal the closing balances for each significant type of deferred contribution. The receipts total in this note is the amount of restricted contributions given to the organization in the year.

Notice the new line showing net assets restricted for endowments. The reader can see that the increase for the year was \$20. Detail on changes in this balance would be included in the statement of changes in net assets, which is described further in [Appendix 1](#).

A concern with the deferral method disclosure on the statement of financial position is that it does not make clear where the assets are that will be used to fund the expenditures required by the deferred contributions. In this example, the organization has followed a best

practice of restricting the cash (into short-term investments) of \$75 that will be needed to meet the requirements of the current deferred contributions. Similarly, it has disclosed the \$170 restricted portion of the investments that provide the endowment.

This additional disclosure is not always provided. A discerning director will investigate whether sufficient funds have been set aside to meet restrictions, particularly in situations where the organization liquidity is low.

Restricted fund method of accounting for restricted contributions

The overall concept of the restricted fund method is that restricted contributions are accumulated in funds. The funds are then drawn down when expenditures compliant with their restrictions are made. The method is particularly useful to organizations that have long time horizons for spending and receive contributions where the eventual timing of their expenditure is flexible and varying in amount. It is useful for educational institutions, hospital foundations and many faith-based organizations.

The restricted fund method is a specialized use of fund accounting (see [Glossary](#)). A sure sign of fund accounting is when the statement of operations consists of multiple columns showing the results for the current year (rather than a single column). Under the restricted fund method, the organization reports a *general fund* (sometimes called an *operating fund*) and at least one *restricted fund* and, if it receives endowment contributions, an *endowment fund*. Each of these funds is displayed as a column on the statement of operations, or it may have its own page. Depending on the organization and usually based on the complexity of the funds, the statement of financial position may (if complex) also have multiple columns for the current year. However, all funds and their totals must be included within the statement of financial position.

Once again, the accounting treatments of restricted contributions differ depending on the type of contribution and the nature of the item it is intended to be spent on:

- An unrestricted contribution is taken into revenue in the period it is received.
- An externally restricted contribution is immediately reported as revenue of its corresponding restricted fund. Note that if there is *no* restricted fund corresponding to the nature of the restriction of the contribution, the contribution is recognized in the general fund using the deferral method.
- An endowment contribution is reported as revenue of the endowment fund.

An illustration of financial statements using the restricted fund method can be found in [Appendix 2](#).

The Concept of Materiality

The figures in financial statements may not be perfectly accurate for a variety of reasons including inadvertent omission of entries, accounting coding errors that place an amount in the wrong account, or other similar factors. *Materiality* is the term used to describe the significance of financial statement information to decision-makers. Misstatements of financial information are said to be material if they (individually or in aggregate with other misstatements) could reasonably be expected to influence the economic decisions of users of the organization's financial statements.

Materiality is a matter of professional judgment in the particular circumstances where misstatements are identified. If the misstatements are not material, there is no requirement under Canadian accounting standards to correct the financial statements. Nevertheless, management is encouraged to correct discovered errors.

The auditor's application of their professional judgment in determining materiality can be a complex process. An auditor of an NFP may begin their determination by considering differing percentage ranges applied to benchmarks, such as total assets, gross revenue or total expenses. The results will be very different, for example, for an asset-rich but low-transaction foundation, compared to an organization running many programs from a low asset base. Consequently, some benchmarks may be much more relevant than others in particular circumstances.

To these benchmark ranges, the auditor will consider many matters such as:

- the volatility of the benchmark
- the overall financial strength of the organization
- its nature
- trends in its economic environment
- the question of whether there are items of particular focus to the financial statement users
- the specific nature of the types of revenue, expense, assets and liabilities
- their risk of misstatement

It follows that the auditor's determination of materiality may quite reasonably be different for two organizations that initially appear similar. It also follows that, in order to make a sound judgment of materiality, it is important that the auditor have sufficient knowledge and experience of the nature of the activities and environment of the organization being audited, including access to relevant experts.

Items for Directors to Watch for and Questions to Ask

Oversight of the Two Key Financial Statements

The statement of operations and the statement of financial position are inextricably linked. For instance, investment income shown on the operations statement is linked to the size and return on investment assets shown on the financial position statement. Consequently, oversight review and questioning by directors may well arise on essentially the same topic from either of the two statements.

Nevertheless, presented below are some possible questions directors may wish to ask based on the major categories in each statement. The statement of financial position traditionally comes first in audited financial statements, and hence it comes first below.

Questions to ask about the statement of financial position

- What are the components of *cash and cash equivalents*? Are any of these at risk of losing value?
- Who owes us the *accounts receivable*? What is the age profile of these accounts? Is there likely to be a problem in collecting these amounts? Has any provision been taken for uncollectable amounts?
- What are the components of *prepaid expenses*? (These often arise from amounts paid for services before they are rendered, like insurance or rent.) Do we have any choice about paying in advance?
- What are the major types of *invested assets (investments)* we hold? Do we have an investment policy? Are the investments in accordance with that policy? What are the prospects for future changes in value and income from these investments? What are the risks associated with these types of investments? Are the risks appropriate for our organization at this time?⁷ What happens to these assets if we wind down the organization?

7 If the organization has significant investments, the board may establish an investment committee and engage professional investment advisors. In their oversight role, board members still need to review the major elements of the investment portfolio.

- What are the *capital assets* we own? Where in the organization are they used? How are these assets depreciated or amortized? That is, how do we record the “consumption” or use of these assets over time to reflect their declining useful life and utility to the organization? Does this charge reflect reality? Do we have plans to replace these assets as needed? Are we building a replacement fund to pay for replacements? Do we have appropriate insurance on these assets in case they are damaged or lost?
- To whom do we owe *accounts payable*? Do we pay these amounts on a timely basis, and specifically, in accordance with the payment terms that suppliers or others have specified in order to avoid further costs?
- Are government remittances being paid promptly? In certain circumstances, directors can be held liable for non-payment of government remittances.
- What is the renewal date for the *mortgages or loans* outstanding? What new interest rates can be anticipated and how do they compare to the rates we are currently paying? We have a large cash balance — what are the penalties, if any, involved in paying down the mortgage? Should we consider doing so, or do we have plans for the use of the cash balance in the future?
- What is included in *other liabilities*? To whom are these owed and why? When will these amounts come due, and will we have the cash resources to pay them?

Directors will want to have a keen eye for comparing the figures for the current year compared to the previous year. Significant changes over time (both increases and decreases) may well spark questioning. Directors can themselves undertake simple calculations for items not shown directly on the statement such as the working capital ratio (see [Glossary](#)), the percentage change in the value of invested assets, or the percentage change in capital assets.

Questions to ask about the statement of operations

The questions that apply to *revenues* raised to support operations tend to be identical for the many potential sources. They are:

- Who provides each category of revenue to the organization and why? Are there restrictions on how these revenues are used?
- Where the organization conducts fundraising, what are the costs associated with raising this kind of revenue? Is the effort of raising these funds worthwhile? Are there opportunities to increase this type of revenue?

- What are fundraising expenditures as a percentage of funds raised?⁸ How does this compare with similar charitable NFPs?⁹ Are the fundraising costs warranted, relative to the benefits received? Do we have fundraising protocols that provide guidance to management?
- Who are our competitors for these revenues? Do they represent possible collaborators?
- Have we remained true to our mission in pursuing funding for specific programs, or have we focused too much on acquiring the revenues, even if the activities funded blur our focus (so-called “mission creep”)?
- Are there revenues devoted for a specific program, project or activity? Do these revenues include funding to sustain the organization’s overhead (so-called “core funding”)? If not, how is infrastructure to be funded as the program, project or activity places greater stress on it?
- How do we go about soliciting these revenues? Are we adhering to board policies or standards around ethical fundraising activities?
- How secure is each source of revenue for future periods?

There may be additional questions related to certain components of revenues:

- What is the source of *investment income*? What is our target return on investments? Is this achievable in the current economic climate?
- What is included in *other income*? Should any of these components be reported separately?

Here are some potential questions related to the major components of expenditures:

- What lies behind the expenditures on *salaries and benefits*? Where in the organization are employees deployed? What is our compensation policy? When did we last award raises and when is the next scheduled change? What benefits do we provide our employees? How do we handle vacations and vacation pay? How does our compensation stack up in the marketplace? How senior is our staff group? What costs would we incur if we had to lay off staff?
- What explains *rent and occupancy* costs? What spaces do we rent (or own)? What are they used for? Are they sufficient? What are the major lease or rental terms? How long until we have to move or negotiate a new lease?
- What is the nature of our *marketing and communication* costs? How do we select communications channels to use, especially new, digital media channels? How do we identify, select and reach our target audiences?

8 As this percentage may not be evident from the financial statements, management may have to prepare a separate report.

9 As noted earlier, certain financial information provided by charitable NFPs is publicly available on the CRA website. Also available on the CRA website is *Guidance on Fundraising by Registered Charities* (Document CG-013); among other topics it includes a section on the CRA’s concerns when the ratio of fundraising costs to revenue exceeds 35%.

- What is the policy for *amortization of capital assets*?
- What is included in *other expenses*? Should any of the items be disclosed separately?

As with the statement of financial position, directors will want to compare the figures in the statement of operations for the current year to the previous year. Significant changes over time (both increases and decreases) may well spark questioning. Directors will have particular interest in comparing the results to budget. Since the budget is based on the organization's mission, variances in the budget are signals of how well the organization is achieving its mission.

Directors are encouraged to undertake their own calculations of certain items not appearing directly on the statement of operations, such as the percentage of total revenues each revenue source represents. Some organizations, for instance, are heavily dependent on government grants (and, indeed, in some cases, government grants from a single source). Other organizations may be heavily dependent on donations, which in turn are dependent on the state of the economy.

Oversight at Points in Time

At various points in time — during the budgeting process, when monitoring the internal in-year financial statements, and later when reviewing and approving the audited statements — there are certain additional things directors should watch for.

When approving the budget as a forward-looking financial statement

A budget is a powerful and useful tool to help boards discharge their fiduciary responsibilities. By satisfying itself that budgets reflect appropriate and prudent uses of an organization's funds, boards are well on their way to meeting their responsibility for overseeing the effective use of the organization's assets.

Directors should be familiar with their organization's plans. It is often the case that they have been directly involved in strategic planning toward achieving the organization's mission. Plans provide the roadmap directing the NFP's efforts toward achieving its mission. The budget is the financial dimension of an approved organizational plan.

A budget is also a prediction. It is based on various assumptions about the future. There is obviously uncertainty about how the future will unfold, and it may be prudent for management to produce various draft budgets based on different scenarios (e.g., inflation rates, government funding renewals, donation levels) for review by the board before one version is selected as the approved budget for the coming year.

Here are some questions that directors may wish to ask during the budget review and approval process:

- What are the key assumptions behind the estimates of revenues and the estimates of expenditures for the coming year?
- Are there significant differences between the current year-end projections and the budget estimates for the upcoming year? If so, what are the explanations for these differences?
- What is the plan for staffing levels and staff compensation for the coming year?
- Are there any significant changes planned for programs and services inherent in the budget?
- Is the budget fully in accord with our strategic plan?
- What “scenarios” have been considered in the budget planning process?
- How much of a cushion do we have against unanticipated adverse events?

It is important to note that operational plans can change during the year as situations crystalize. On that basis, budgets can also change. However, best practice is to maintain a single budget, once approved, and monitor the effect of changed plans on the actual results. Any changes in budgets should be approved by the board.

When monitoring the internal financial statements

The internal financial statements prepared by management during the fiscal year will show budget figures versus actual results, and will show the difference between the two, called the *variance*. As noted above, a budget is a prediction. It would be rare if everything unfolds as assumed; consequently, budgets are unlikely to be precisely achieved, as shown by the variances. When actual results have significant variance to budget, good practice is to include reporting of projected results to year-end and compare them to the year-end budget. Directors and management can then see the extent of remedial action necessary.

By carefully monitoring activities against the plan — and financial results against the budget — boards can assess the effectiveness of the organization’s use of its resources and can determine whether any in-year alterations in the operational plan are warranted. Here are some questions that may assist in that regard:

- Are the variances related to revenues or to expenditures or to both?
- What is the explanation for the significant variances (both “over” and “under”)?
- Are variances arising from external factors beyond the organization’s control (e.g., an unanticipated increase in utility usage or utility rates)?
- What are management’s plans for responding to the variances?

- How realistic are the projections to year-end? What are the assumptions that underpin those projections?
- Is there a need for action now related to our operations to deal with the variances and/or projections to year-end?

In extreme circumstances, the board may need to consider a change to the strategic plan in order to respond to a financial crisis as evident from large variances from budget projections.

When reviewing and approving the year-end audited financial statements

The audit offers a key measure of accountability and control for not-for-profit organizations. The auditor, with a mandate to directly review the books and records of the organization, provides an important check on the activities of management.

Very simply put, an auditor reviews what an organization's finance staff creates. This checking is referred to as "gathering audit evidence," which means that auditors look for evidence that the accounting information audited is correct. This "audit trail" may be well documented within organizations. However, some organizations sponsor events where significant cash or cheques are collected, possibly by a single volunteer. This situation is problematic for the auditor, since it may be impossible to be satisfied that all the cash has been collected, deposited and recorded properly in the organization's accounts. Some charitable organizations go to great lengths to implement procedures and controls regarding cash and cheque donations, thereby providing documentation that the auditor can review.

The auditor will also assess internal controls and procedures in the organization, to the extent that this might impact the assessment of the validity of information recorded in the accounts.

In very small organizations, controls and procedures may be extremely limited due to lack of formal systems and limited resources available to implement them. On the other hand, in a very large organization, there might be extensive documentation of accounting policies and procedures, the use of computer systems and internal controls. If these systems are determined to be strong and well-functioning, the auditor might be able to reduce the other evidence needed to be gathered to form the audit opinion.

The auditor will also analyze much of the information in the accounts to see whether it is consistent with the organization's activities. Finally, the auditor will look at the financial statements and the accounting policies used by the organization.

In view of all the information the auditor has gathered about the organization, and with all of the auditor's professional experience, the key question the auditor will answer is: *Do the financial statements paint a picture that is a fair presentation of the organization's financial position and results of operations?* At the end of the auditor's engagement, the auditor communicates that opinion to financial statement users through the auditor's report.

The report contains both the audited financial statements with accompanying notes and the auditor's opinion. The notes provide additional important information that support certain figures in the audited statements. Notes are often essential to clarify or further explain the items in the financial statements. They have the same significance as if the information or explanations were set out in the body of the statements themselves.

The opinion can be unqualified or qualified, the latter situation most often due to the auditor's inability to verify the completeness of donations. See [Appendix 3](#) for samples of the auditor's report addressed to the board of directors, one illustrating an unqualified opinion and one illustrating a qualified opinion.

When reviewing the draft audited statements, directors may wish to consider these questions of the auditor:

- Did the auditor initiate any significant changes to management's year-end financial information prior to issuance of the audit opinion and approval of the financial statements? (In the language of accountants, did the auditor require significant adjustments through "journal entries" to the statements originally prepared by management?)
- Are the audited financial statements consistent with the results shown in the internal financial statements that have been monitored by board members during the year? Internal financial statements should be more detailed than external financial statements but consistent with them. If not, then their reliability for decision-making is in question.
- Did the auditor find any weaknesses in internal controls or accounting policies?
- Did the auditor have any concerns about the activities of the organization that have impacted on the financial results?
 - Did management make significant estimates in the financial statements and did the auditor have any concerns about them?
 - Were there any issues that might have caused the auditor to issue a qualified report?
 - Was there an *in camera* meeting with the auditor (without management present) and an *in camera* meeting with management (without the auditor present)?

Once satisfied with the audited financial statements, the board will approve them and make them available for wider distribution.

Conclusion

The board of directors is obliged to fulfill its stewardship responsibilities on an ongoing basis. It will do so by regular reviews of financial information prepared for that purpose, by engaging in thorough questioning and probing of the information presented and by continuing to do so until satisfied with the answers to questions. Directors should pay particular attention to variances between budget and actual figures, to major differences between the current year figures and the previous year results, and to consistency between the various statements (operations, financial position, changes in net assets, cash flows).

Questioning and probing by the board serves many purposes, including helping directors to develop a sound understanding of the organization's operations and of both the accounting treatment and the choice of accounting policies in financial statements. It also serves as a jumping-off point for substantive debates about the organization's strategies, tactics, plans, policies and risks. There is a time and place for each type of questioning. A comprehensive understanding of the financial state of the organization will be developed over time, rather than in a single, marathon session.

Boards typically review financial reports, including at least a statement of operations and a statement of financial position, at a minimum quarterly. However, the exact frequency and level of detail of such reviews will be influenced by many factors, including the adequacy of internal financial processes, the level of expertise of management in financial matters, the complexity of the organization, the financial position of the organization, and the involvement of board committees such as the audit or finance committee.

The board needs to satisfy itself that general purpose reporting documents (audited financial statements and supporting annual reports) are fair and balanced communications of the affairs of the organization, and that the reports address the common questions that many stakeholders may have. The board will do this by reviewing drafts of these reports including any note disclosures and accompanying narrative commentary, comparing them to the more detailed internal reports that the board has used, and by satisfying itself that the financial reporting is sufficient to inform stakeholders who do not have access to the detailed information available to the board.

The board will oversee the process for preparing other specialized reports, satisfying itself as to the adequacy of this process, and will review, as appropriate, specific reports to stakeholders. Where many reports to different funders are prepared, based extensively on financial data that the board has already reviewed (i.e., where the preparation is essentially

reformatting rather than new reporting), the board may choose to rely upon management for preparation of these reports. On the other hand, extensive new reporting, or reporting that is critical to the ongoing operations of the organization, may well be reviewed directly by the board or one of its committees before issuance. The board may choose to establish protocols to determine which reports require its review prior to release. Although there may be a number of specialized reports prepared, there is only one set of complete financial statements for an organization, and specialized reports must be consistent with the figures in the financial statements.

As noted earlier, the board may delegate some or all of these tasks to an audit or finance committee. Doing so can be particularly effective. The board can rely in good faith on the work of its committees. However, the board cannot delegate its ultimate responsibility; the entire board remains responsible for the work delegated to its committees.

In sum, the board of directors of a not-for-profit organization has serious duties with respect to oversight of the organization's financial affairs. Directors do not need to be financial experts, but they do need to have an understanding of how financial information is presented. They need to actively review what is presented and participate in the discussions. They need to be able to question and probe management and the auditor, until they are satisfied that their issues have been addressed. In the end, it is the board of directors that holds ultimate accountability for the financial affairs of the organization.

APPENDIX 1

Other Financial Concepts and Statements

1. Other Financial Concepts

This appendix deals with certain additional concepts and statements that NFP directors are likely to encounter.

Accounts and chart of accounts

Even a small organization can have hundreds or perhaps even thousands of transactions every year. All this information needs to be recorded in one place, historically in a set of ledger books and now, almost without exception, in a computerized accounting system. Every organization needs someone assigned to collect and input every financial transaction.

Keeping track of all this activity in a way that allows for the preparation of many different kinds of reporting requires careful organization of the basic data.

- The *account* is the fundamental unit of organization for all this information. Accounts are established for every type of asset, liability, net assets, revenue and expense that the organization is likely to encounter, and in as much detail as practical, to allow for maximum flexibility in reporting later on. An ordinary, mid-sized NFP can easily have hundreds of accounts to record all its different activities.
- The *chart of accounts* is a highly structured document that shows all accounts, organized in various ways. The chart delineates accounts within the major categories and sub-categories of assets and liabilities, revenues and expenditures, and also, for example, by program or activity or by type of transaction. It is the structure of the chart of accounts that is the key to all subsequent summarization, analysis and reporting of financial information.

It is management's responsibility to develop and maintain a coherent chart of accounts. Directors see the product of the chart of accounts as financial reports are provided to them showing various categories, based on the organization's chart of accounts.

2. Other Financial Statements

Two additional statements will appear in the audited financial statements. These two are not typically included by management in budgets or in-year internal reports:

- statement of changes in net assets
- statement of cash flows

Statement of changes in net assets

The statement of changes in net assets provides details about what has happened to the balance of net assets over a period of time (usually a year). Net assets are disaggregated into categories, and the statement will identify the changes that have taken place in each category. We have previously seen two categories within net assets on the statement of financial position: “net assets restricted for endowments” and “unrestricted net assets.” Two other categories that are sometimes shown within net assets are “invested in capital assets” and “internally restricted net assets.”

The purpose of showing “invested in capital assets” (which is an optional disclosure) is to separate within net assets the portion that is illiquid. This amount is calculated by subtracting from the net balance of capital assets any related debt or deferred contributions. In the case of the sample financial statements, this is $\$1,126 - \$75 - \$825 - \$35 = \$191$. This portion of net assets would not be available to the organization in liquid form unless the organization sold or financed the capital assets.

Internally restricted assets occur when the board decides to set aside a portion of net assets for a special purpose. It is called “internally restricted” because the action is done by the board and can be undone by the board. Normally the purpose of doing so is to signal to readers a key intention, such as setting aside net assets for a contingency. Corresponding assets also need to be set aside to provide the actual funds required. Note that increases or decreases in internally restricted funds have no impact on the statement of operations.

Sample statement of changes in net assets (deferral method)

The following is a sample statement of changes in net assets. This NFP has received endowment contributions during the year. It has created an internally restricted fund, and it has chosen to show the amount invested in capital assets.

NOT-FOR PROFIT ORGANIZATION
STATEMENT OF CHANGES IN NET ASSETS (deferral method)
For the current year ended December 31

	Current Year					Previous Year
	Invested in Capital Assets	Endowment	Internally Restricted For Special Projects	Unrestricted	Total	\$000
Balance, Beginning of Year	132	150	315	1,803	2,400	1,744
Excess (Deficiency) of Revenues Over Expenditures	-16*			702	686	656
Endowment Contributions		20			20	
Mortgage Principal Payment	75			-75		
Transfer to Internally Restricted Fund			15	-15		
Balance, End of Year	191	170	330	2,415	3,106	2,400

NOT-FOR PROFIT ORGANIZATION
STATEMENT OF CHANGES IN NET ASSETS (deferral method)
For the current year ended December 31

	Current Year					Previous Year
	\$000					\$000
	Invested in Capital Assets	Endowment	Internally Restricted For Special Projects	Unrestricted	Total	Total
*Consists of:						
a) Revenue From Amortization of Deferred Capital Contributions	8					
b) Depreciation Expense for Capital Assets	-24					
	-16					

A review of this sample statement of changes in net assets generates the following observations:

- The end of year balance totals of net assets are identical to the values shown in the net asset section in the statement of financial position (\$3,106 and \$2,400).
- The excess of revenues over expenditures for the current year of \$686 is shown in the current year total column and equals the amount in the sample statement of operations. Note the \$20 below the \$686. This is the total of endowment contributions received for the year, which (in accordance with the deferral method) are not included in the statement of operations, but nevertheless increase total assets, as shown here.
- The mortgage principal payment of \$75 has the effect of increasing the net amount invested in capital assets and decreasing the unrestricted net asset balance.
- The transfer into the internally restricted fund for special projects of \$15, which would have required a board resolution, has the effect of decreasing unrestricted net assets by the same amount.

We have provided an explanatory calculation for the portion of the change in the amount invested in capital assets resulting from operations. The amount invested decreases by the depreciation of \$24, which is shown as an expense on the statement of operations, but this is offset by the amortization of the deferred contributions made to fund capital assets, which is \$8, and is included in contributions on the statement of operations. This explanatory calculation would not normally be provided with the financial statements.

For simplicity, this sample statement does not include new capital asset purchases. Had there been any, paid out of current funds, their amount would show in exactly the same manner as the mortgage principal payment. Invested in capital assets would increase by the value of the purchases, and unrestricted net assets would decrease by the same amount. If a portion of the purchase was funded by debt secured by the capital assets, thereby increasing debt, then the statement would show a decrease in invested in capital assets, by the amount of the debt, and a corresponding increase in unrestricted net assets.

Statement of cash flows

The statement of cash flows provides additional information that explains how cash has been used or generated by the organization from operations, through investments and through financing.

As an example, suppose during the year an organization had a significant increase in revenue and excess of revenue over expenditure, yet now found itself short of cash to pay its bills. One reason this could happen would be that payment of the fees for the revenue had not been received. Accounts receivable had greatly increased, which accountants think of as a use of cash. A reader could detect this change from the comparative statement of position. However, on the statement of cash flows it is specifically highlighted, as the statement directly shows the increase in accounts receivable as using up cash.

The statement of cash flows identifies cash provided by, or used in, three areas over the year:

- operations (i.e., cash generated by an operating surplus; cash used to fund an operating deficit); operations includes working capital items (see [Glossary](#)) such as accounts receivable, prepaid expenses, accounts payable and similar items)
- investing activities (i.e., using cash to acquire investments; generating cash from selling investments)
- financing activities (i.e., generating cash through borrowing; paying cash to repay borrowing)

There are two methods for presenting the statement of cash flows:

- The direct method focuses on cash transactions: Cash acquired increases the cash balance; cash expended decreases the cash balance. Under the direct method, the equation that underpins the statement of cash flows is *Ending cash balance = Opening cash balance + Cash acquired – Cash expended*.

- The indirect method focuses on the operating surplus derived from the statement of operations and makes certain adjustments to that figure. As this method is used by most NFPs, it is described in more detail below.

For an NFP that did not engage in any investing activities or financing activities during the year, the fundamental equation for a statement of cash flows under the indirect method is: *Opening cash balance + Surplus from operations + Adjustments for operating items not requiring cash + Changes in non-cash working capital = Ending cash balance.*¹⁰

Under this method, the statement of cash flows is typically presented in a “reconciliation” format, starting with the excess (deficiency) of revenues over expenditures, then adjusting for the non-cash items in operations and the changes in non-cash working capital items, to arrive at cash provided by (or used in) operations. In equation form, this mode of presentation involves two equations:

1. *Surplus from operations + Adjustments for operating items not requiring cash + Changes in non-cash working capital = Change in cash balance*
2. *Ending cash balance = Opening cash balance + Change in cash balance during the year*

Although this formula appears more complicated than the one for the direct method, it is typically easier to prepare and — because it ties directly into the changes in the statement of financial position — it is often more useful to the reader.

Sample statement of cash flows

The following sample statement of cash flows is based on the reconciliation method, starting with the excess (or deficiency) of revenues over expenditures, as taken from the statement of operations for the same not-for-profit organization.

¹⁰ If the organization did engage in investing and financing activities, the equation becomes: *Opening cash balance + Surplus from operations + Adjustments for operating items not requiring cash + Changes in non-cash working capital + Investing activities + Financing activities = Ending cash balance.*

**NOT-FOR-PROFIT ORGANIZATION
STATEMENT OF CASH FLOWS
For the current year ended December 31**

	Current year	Previous year
Operating Activities		
Excess of Revenues Over Expenditures	686	656
Add (deduct) Items Not Involving Cash:		
Depreciation of Capital Assets	24	30
Amortization of Deferred Capital Contributions	-8	-10
	702	676
Change in Non-Cash Working Capital Balances		
Grants Receivable	-35	5
Accounts Receivable	-5	10
Prepaid Expenses	-7	-1
Accounts Payable	35	-20
Government Remittances Payable	17	
Deferred Contributions	25	5
	30	-1
Cash (Used in) Provided by Operating Activities	732	675
Investing Activities		
Restricted Short-Term Investments	-25	12
Purchase of Restricted Investments	-20	-85

NOT-FOR-PROFIT ORGANIZATION STATEMENT OF CASH FLOWS For the current year ended December 31		
	Current year	Previous year
Sales of Investments	20	85
Endowment Contributions	20	5
Deferred Contributions – Capital assets	-	10
Purchase of Capital Assets	-	-250
	-5	-223
Financing Activities		
Bank Indebtedness	-30	-60
Mortgage Payment	-75	-75
Other	25	-2
	-80	-137
Net Increase (Decrease) in Cash During the Year	647	315
Cash Balance, Beginning of Year	1,938	1,623
Cash Balance, End of Year	2,585	1,938

The statement of cash flows is perhaps the most difficult one for directors to “decode,” most likely because positive and negative entries can occur within the same category.

Further, a positive entry in one year can become a negative entry in the next year and vice-versa. Always note that the amounts in this statement are changes that occurred during the year. In reviewing this sample statement of cash flows, directors can determine the following:

- The “end of year” cash balance of \$2,585 for the current year as shown above is identical to that amount shown on the statement of financial position.
- The cash balance increased from the previous year by \$647, even though the excess of revenue over expenditures for the year was \$687.
- One of the drivers of the increase in cash was donor contributions since deferred contributions for operations increased by \$25. In other words, certain new contributions were received during the current year but were not used during the year. The unspent balance was added to deferred contributions, leading to an increase of \$25.
- New endowment contributions of \$20 were also received during the year. They were invested in restricted investments.
- Another source of cash was a significant increase in accounts payable of \$35; this amount was included in expenditures but cash was not yet expended in the current year to pay for these obligations.
- On the other hand, grants receivable in the current year increased by \$35 and accounts receivable increased by \$5. In total, \$40 was added to revenues related to these two items, but cash was not received for them in the current year.
- Cash of \$75 was expended in both years to pay mortgage obligations.

3. Items for Directors to Watch for and Questions to Ask

The statement of changes in net assets and the statement of cash flows provide an opportunity for the board to review in detail its trusteeship over restricted contributions, to understand the prior year cash flows and anticipate any upcoming cashflow concerns.

Questions to ask about the statement of net assets

- For each category, what caused the change in net asset value? What changes are anticipated in the coming year?
- Is the amount invested in capital assets appropriate for the needs of organization? It is a common problem that NFPs run down their assets, without sufficient replenishment. Is there any repayment risk of the long-term debt associated with the capital assets?

- Are the investments corresponding to the endowment fund prudently invested? Have the terms of the endowment specified by the donors been honoured? Have the calculations of endowment principal and amounts available for expenditure been correctly computed?
- Is the amount being accumulated in the internally restricted fund sufficient for its intended purpose? Have the corresponding assets been set aside? Has the purpose and progress of the internally restricted fund been clearly communicated to the stakeholders of the organization?
- One of the most significant accumulated balances of an NFP is its unrestricted net asset balance, as this is a clear indicator of its net financial strength and ability to withstand downturns. After reviewing the balance within the context of the statement of net assets, do the directors have any concerns about the financial strength of the organization?

Questions to ask about the statement of cash flows

- What is the explanation for any significant differences, year to year, in the entries on this statement?
- Are there any concerning trends in working capital (see [Glossary](#)) as shown by the cash used in or provided by operations? Is surplus cash idle? Should it be employed in the organization's mission?
- Where "invested in capital assets" is not separated out of net assets, these questions could be triggered from review of the statement of cash flows: Is the amount invested in capital assets appropriate for the needs of organization?
- Are the investments prudent (neither too conservative nor too risky or illiquid)? Is the organization earning returns commensurate with market results? Is there a long-term investment strategy? Are knowledgeable board members exercising appropriate oversight of significant investments?
- Are there any major financing activities anticipated in the near future? Are cash resources sufficient for debt repayments?

APPENDIX 2

Fund Accounting

1. The Use of Fund Accounting

How fund accounting works

When an organization presents its financial statements using fund accounting, the statement of operations shows columns containing revenue and expenditures for each fund, with a column cross totalling all the funds. For example, a sports organization may choose to have a column for its youth programs, one for adult programs, one for its property including facility fees and expenses, another for bursaries, and an administration column. This presentation provides readers with the ability to rapidly see which revenues and expenditures are trending up or down and the degree of cost recovery of each area generated from its associated fees and sponsorships.

However, to be a true application of fund accounting, the funds *must carry forward their balances* on the statement of financial position. In this example, the organization chooses that the net balance of the property fund (capital assets less associated debt) will be carried forward with accumulated earnings and that the bursary fund balance is carried forward. The other programs' excess or deficiency are closed out (added together) into the net asset balance.

The property and bursary fund balances would appear separately within net assets (now called the fund balances). Alternatively, the statement of financial position could be presented with a full column for each of these two balances, one for all the other items, and a cross total. This level of detail would only make sense if there were many items associated with the balances, such as segregated cash and investments, accounts receivable and payable, and capital assets and related debt. It is fairly common for NFPs to show columns on the statement of operations, but much less common for them to also do so on the statement of financial position.

Restricted fund accounting

As noted earlier, restricted fund accounting is a specialized type of fund accounting. It is designed with a focus of making clear to readers what restricted funds have been received, how they are being managed and how expended. It applies a revenue recognition policy — the

restricted fund method (in which restricted contributions may be recognized in revenue when received rather than deferred from revenue until expended), with the use of fund accounting to show the receipt, expenditure and carryforward balances of restricted contributions.

Restricted funds on the statement of financial position may be shown in detailed columns or as balances within the “fund balances” section (which has replaced the “net assets” section) along with note disclosure of restrictions. In the sample we provide below, the funds are shown in full-column format.

Restricted funds in the statement of operations will always be shown as separate columns. A key difference between the restricted method and regular fund accounting is that there is no requirement to cross add the columns of the statement of operations (although this is common practice). The basis for this exemption is that it is sometimes not meaningful to cross add the revenue and expenditures of operating activities with those of restricted fund contributions, earnings and expenditures.

Sample statements using restricted fund accounting

Under fund accounting, the statement of changes in fund balances can often be conveniently combined with the statement of operations, resulting in only three financial statements:

- statement of financial position
- statement of operations and changes in fund balances
- statement of cash flows

As discussed above, the statement of financial position may utilize columns, and the statement of operations will do so. It is common practice to show the statement of cash flows on a total basis, without separation into funds.

The sample set of statements shown below demonstrating restricted fund accounting includes three funds for the not-for-profit organization, defined as follows:

1. an operating fund, which holds the accumulated unrestricted operating surpluses, the internally restricted funds (in this example for special projects), and any restricted amounts for which there is no applicable restricted fund
2. a property fund, which is an externally restricted fund to provide capital assets
3. an endowment fund, which is an externally restricted fund for endowment contributions from donors

The three sample statements that follow are based on the same financial information presented in the previous sample statements.

Comparative balances

Note that for each of the statements of financial position and operations and fund balances shown below, there are five columns: one for each of the three funds, one for the current year total and one for the previous-year total.

It can be helpful for the user of the financial statement to instead be presented with the current-and prior-year results for each column. This would result in two columns for each of three funds and one column for each of the two total funds, for a grand total of eight columns.

It is a matter of judgment whether the additional detail provided is helpful to the user of the financial statement. Many comparative changes may be readily determinable from the five-column presentation. Users may find an eight-column presentation to be overwhelming in its size. On the other hand, important details of comparative changes may otherwise be hidden in the five-column presentation.

NOT-FOR-PROFIT ORGANIZATION STATEMENT OF FINANCIAL POSITION As at December 31 of current year					
	Current year				Previous year
	Operating Fund	Property Fund	Endowment Fund	Total	Total
ASSETS					
Current Assets					
Cash and Cash Equivalents	2,585	33		2,618	1,938
Restricted Short- Term Investments	75			75	50
Grants Receivable	100			100	65
Accounts Receivable	25			25	20
Prepaid Expenses	42			42	35
	2,827	33	-	2,860	2,108

NOT-FOR-PROFIT ORGANIZATION STATEMENT OF FINANCIAL POSITION As at December 31 of current year					
	Current year				Previous year
	Operating Fund	Property Fund	Endowment Fund	Total	Total
Investments	330		170	500	500
Capital Assets (Property & Equipment)		1,126		1,126	1,150
	330	1,126	170	1,626	1,650
	3,157	1,159	170	4,486	3,758
LIABILITIES AND FUND BALANCES					
Current Liabilities					
Bank Indebtedness	85			85	85
Accounts Payable	122			122	135
Government Remittances Payable	65			65	
Mortgage Payable		75		75	75
Deferred Contributions	75			75	
	347	75	-	422	295
Mortgage Payable		825		825	900
Other	65			65	40
	65	825	-	890	940

**NOT-FOR-PROFIT ORGANIZATION
STATEMENT OF FINANCIAL POSITION
As at December 31 of current year**

	Current year			Total	Previous year
	Operating Fund	Property Fund	Endowment Fund		Total
Fund Balances					
Unrestricted	2,415			2,415	1,803
Internally Restricted Special Project Fund	330			330	315
Externally Restricted Property Fund	-	259		259	175
Endowment	-		170	170	150
	2,745	259	170	3,174	2,443
	3,157	1,159	170	4,486	3,758

**NOT-FOR-PROFIT ORGANIZATION
STATEMENT OF OPERATIONS AND CHANGES IN FUND BALANCES
For the current year ended December 31**

	Current Year			Total	Previous year
	Operating Fund	Property Fund	Endowment Fund		Total
Revenues					
Government Grants	8,700			8,700	8,150
Fees for Service	975			975	920

NOT-FOR-PROFIT ORGANIZATION					
STATEMENT OF OPERATIONS AND CHANGES IN FUND BALANCES					
For the current year ended December 31					
	Current Year				Previous year
	Operating Fund	Property Fund	Endowment Fund	Total	Total
Contributions	262	33	20	315	180
Investment Income	35			35	35
Interest and Other Income	10			10	15
<i>Total Revenues</i>	<i>9,982</i>	<i>33</i>	<i>20</i>	<i>10,035</i>	<i>9,300</i>
Expenditures					
Salaries and Benefits	6,940			6,940	6,560
Rent and Building Occupancy	1,845			1,845	1,610
Office	490			490	440
Depreciation of Capital Assets		24		24	30
Other	5			5	4
<i>Total Expenditures</i>	<i>9,280</i>	<i>24</i>	<i>-</i>	<i>9,304</i>	<i>8,644</i>
Excess of Revenues Over Expenditures	702	9	20	731	656
Fund Balances, January 1	2,118	175	150	2,443	1,787
Transfer to Fund Mortgage Payment	-75	75			

NOT-FOR-PROFIT ORGANIZATION
STATEMENT OF OPERATIONS AND CHANGES IN FUND BALANCES
For the current year ended December 31

	Current Year			Previous year
	Operating Fund	Property Fund	Endowment Fund	Total
Transfer to Internally Restricted Special Project Fund	15			
Transfer From Unrestricted Fund	-15			
Rent and Building Occupancy	1,845			1,610

NOT-FOR-PROFIT ORGANIZATION
STATEMENT OF CASH FLOWS
For the current year ended December 31

	Current year	Previous year
Operating Activities		
Excess (Deficiency) of	731	656
Revenues Over Expenditures		
Add (Deduct) Items Not Involving Cash:		
Depreciation of Capital Assets	24	30
	755	686
Change in Non-Cash Working Capital Balances		
Grants Receivable	-35	5

**NOT-FOR-PROFIT ORGANIZATION
STATEMENT OF CASH FLOWS
For the current year ended December 31**

	Current year	Previous year
Accounts Receivable	-5	10
Prepaid Expenses	-7	-1
Accounts Payable	35	-20
Government Remittances Payable	17	-
Deferred Contributions	25	5
	30	-1
Cash (Used in) Provided by Operating Activities	785	685
Investing Activities		
Restricted Short-Term Investments	-25	12
Purchase of Restricted Investments	-20	-85
Sales of Investments	20	85
Purchase of Capital Assets	-	-250
	-25	-238
Financing Activities		
Bank Indebtedness	-30	-60
Mortgage Payment	-75	-75
Other	25	-2
	-80	-137
Net Increase (Decrease) in Cash During the Year	680	310

**NOT-FOR-PROFIT ORGANIZATION
STATEMENT OF CASH FLOWS
For the current year ended December 31**

	Current year	Previous year
Cash Balance, Beginning of Year	1,938	1,623
Cash Balance, End of Year	2,618	1,938

We now review each of the statements to see how the results contrast with those of the same statements previously presented using the deferral method of revenue recognition.

The reader is presumed to have read the explanations of the meanings of the accounting terms as well as the explanation of the two revenue recognition methods, which are provided in the main body of this document.

Observations about the statement of financial position

- When readers unfamiliar with fund-based statements are first introduced to them, they often find the increased level of detail challenging to absorb. However, once they are used to the format, they find a clarity resulting from the accountability inherent within the method.
- To compare the sample statement balances with the previously presented deferral method statements, focus first on the total column, and then work back through each of the fund columns.
- The endowment column shows investments of \$170 that match the endowment fund balance at the bottom of the statement. Contrast this with the deferral statement where the \$170 investment is optionally segregated and shown as restricted. Had that not been done, a reader of those statements would not know whether the endowment investments were in fact segregated. This is an example of the increased accountability provided by the restricted fund method. In fact, were the assets of the endowment fund being used by another fund in order to balance the restricted fund method, it would force presentation of an amount due from that fund to show in the endowment fund column. Since such a borrowing of endowment funds would likely be improper, it would encourage corrective action.

- The property fund column shows the arithmetic that results in the fund balance and makes clear that as the mortgage is paid off, the fund balance increases. For illustration, we have added a restricted contribution of \$33 received in the year. The presentation makes clear that the contribution is held in the fund but has not yet been expended on capital asset purchases.
- The operating fund column contains all other assets and liabilities. Note that it also contains a deferred contribution balance of \$75. This means that an externally restricted contribution has been received that is intended for a purpose other than property or endowment. As previously stated, where a restricted contribution is received for which there is no corresponding restricted fund, it is presented in the operating (or general) fund with the deferral method.
- Note also in this column that the board has created an internally restricted fund of \$330 for special projects. The balance has been extracted from the unrestricted fund balance.

Observations about the statement of operations and fund balances

- Once again, the reader will find it beneficial, when contrasting these statements with the previously presented deferral method statements, to focus first on the total column and then work back through the fund columns.
- The endowment fund column shows revenue of \$20 being the contributions given to the fund in the year. Under the deferral method, this amount is recorded as a direct increase in net assets and included in the statement of changes in net assets.
- Note that while in this example there is a single endowment fund, it is not uncommon for the funds presented on the statements to be the aggregate of many underlying funds of the same nature (e.g., endowment or externally restricted) but with different restrictions on their expenditure. The notes to the financial statements will usually provide additional detail on the underlying funds.
- The property fund shows \$33 in revenue (as mentioned above this is included for illustration, it was not included in the deferral statements). It also shows the depreciation of \$24, which does appear on the deferral statements. However, note that contributions in the operating fund have gone down by \$8 from \$270 to \$262. Recall that under the deferral method, the restricted contributions for capital assets were being amortized into revenue over the estimated useful of the associated capital assets that they originally funded. This type of amortization does not occur in the restricted fund method. Consequently, the contribution revenue is lower by the amount of the amortization. Note that in the year the restricted contribution was made, revenue would have been higher, in the same way the property fund revenue has been increased by \$33 this year, even though the contribution has not been expended on a capital asset.

- An item of particular note is the transfer to fund the mortgage payment that is shown in the second last row of the statement. Each fund within this statement is a self-balancing set of accounts. What this means is that the movement of assets or liabilities between the funds must be accounted for. Such a movement is a transaction, and it will either result in an amount payable or receivable between the funds or be satisfied by a board authorized transfer between the funds.
- In this example, the annual mortgage repayment of \$75 has been paid by the operating fund. Rather than show this as an amount receivable by the operating fund from the property fund the board has chosen to transfer a corresponding amount out of the unrestricted fund balance of the operating fund to the property fund balance.
- Finally, note that the excess of revenue over expenditures is different between the two methods. Under the restricted fund method of revenue recognition, the \$20 endowment fund contribution is included in revenue but not included under the deferral method. And the amortization of deferred capital contributions of \$8 is not included in revenue under the restricted fund method but is included under the deferral method. In this example, the difference in the excess of revenue over expenditures between the two is not large, but there are many instances where it can be.¹¹
- Canada is the only accounting jurisdiction where NFPs may choose between revenue recognition methods that produce differing results. There are many who consider this problematic, and a research project is in progress at the Accounting Standards Board to determine if a single method can be developed that meets the different needs of users.

2. Items for Directors to Watch for and Questions to Ask Related to Fund Accounting

Fund accounting is a different way of organizing and presenting the same financial information for an NFP. Consequently, most of the questions directors might have about the statement of financial position and statement of operations and changes in balances and the statement of cash flows are the same as in the main body of the guide and are not repeated here. However, as the example for the same not-for-profit organization has shown, fund accounting does give prominence to each of the fund categories, leading to additional questions directors might wish to ask:

- Is the use of fund accounting still warranted in the current circumstances?
- For each externally restricted fund, has the use of the monies been in accordance with the restrictions imposed by the donors?

¹¹ For those interested in reconciling the two amounts, beginning with the \$686 excess or revenue over expenditures on the deferral statements, subtract the \$8, add the \$20 and add the \$33 contribution, which was added for illustration, to equal the \$731 excess of revenue over expenditures on the restricted fund statements.

- For each internally restricted fund, has the use of monies been in accordance with the restrictions created by the board?
- Have all the inter-fund transfers as shown on the statement of operations and changes in fund balances been approved by the board?
- Are the summary categories for reporting on restricted funds and unrestricted funds the most appropriate ones?

APPENDIX 3

Samples of the Auditor's Report Addressed to the Board of Directors – Unqualified and Qualified Opinions

As mentioned in the discussion of [the roles and responsibilities associated with financial reporting](#), responsibility for an organization's financial reporting is shared among three parties – management, the board and the external auditor. Considerable effort is applied to clearly express the auditor's opinion of the organization's audited financial statements. The auditor's report details management and the auditor's responsibilities and the limitations that must be applied when relying on the auditor's opinion.

Below is an auditor's report of an NFP, prepared in accordance with Canadian accounting standards for not-for-profit organizations and containing no qualification to the opinion. It is well worth careful reading by members of the board and management. Auditors will always welcome discussion and clarification of the meaning of the report.

INDEPENDENT AUDITOR'S REPORT

To the board of directors of "NFP Society"

Opinion

We have audited the financial statements of NFP Society (the Society), which comprise the statement of financial position as at December 31, 20X1, the statements of operations, changes in net assets and cash flows for the year then ended and the notes to the financial statements, including a summary of significant accounting policies.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the Society as at December 31, 20X1, and its financial performance and cash flows for the year then ended in accordance with Canadian accounting standards for not-for-profit organizations.

Basis for opinion

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

Responsibilities of management and those charged with governance for the financial statements

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

In preparing the financial statements, management is responsible for assessing the Society's ability to continue as a going concern and for disclosing, as applicable, matters related to going concerns; management must also use the going concern basis of accounting unless they intend to either liquidate the Society or to cease operations or unless they have no realistic alternative but to do so.

Those charged with governance are responsible for overseeing the Society's financial reporting process.

Auditor's responsibilities for the audit of the financial statements

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

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

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

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

City
Date

Name of Licensed Public Accountant

Qualified Audit Opinion

It is common for auditors to qualify their opinion of the financial statements of charities that receive substantial revenue through donations. This results from the auditor being unable to verify the completeness of some or all of the types of donation revenues being received.

A contribution is a non-reciprocal transfer to a not-for-profit of cash or other assets. Its non-reciprocal nature means that it is not generated by a service or sale and has not been invoiced by the charity. This means the charity may have no way of determining the *completeness* of the contributions it is to receive. A contribution may be received but not recorded, may be discovered well after its intended delivery, or may go astray or be misappropriated.

When the auditor is unable to verify the completeness of contributions, the auditor will qualify their opinion. The qualification means that the organization revenue may have been higher or lower than shown in the current and prior year, and consequently the cash flows and assets may have been different than shown.

Note that there is a trend for charities to reduce the scope of the qualification to only specific types of revenue and, at times, to eliminate the qualification altogether. This is coming about through a combination of additional internal controls and opportunities provided by the increasing use of digital methods to make donations.

Below is an example of the first two paragraphs of the independent auditor's report containing a qualification with respect to the completeness of contribution revenue. The remaining paragraphs of the auditor's report would be substantially the same as the example above.

INDEPENDENT AUDITOR'S REPORT

To the board of directors of "NFP Society"

Qualified opinion

We have audited the financial statements of NFP Society (the Society), which comprise the statement of financial position as at December 31, 20X1, the statements of operations, changes in net assets and cash flows for the year then ended and the notes to the financial statements, including a summary of significant accounting policies.

In our opinion, except for the possible effects of the matter described in the *Basis for Qualified Opinion* section of our report, the accompanying financial statements present fairly, in all material respects, the financial position of the Society as at December 31, 20X1, and its financial performance and cash flows for the year then ended in accordance with Canadian accounting standards for not-for-profit organizations.

Basis for qualified opinion

In common with many not-for-profit organizations, the Society derives revenue from fundraising activities, the completeness of which is not susceptible to satisfactory audit verification. Accordingly, verification of these revenues was limited to the amounts recorded in the records of the Society. Therefore, we were not able to determine whether any adjustments might be necessary to donations revenue, excess of revenues over expenses, and cash flows from operations for the years ended December 31, 20X1 and December 31, 20X0, current assets as at December 31, 20X1 and December 31, 20X0 and net assets as at December 31, 20X1 and December 31, 20X0. Our audit opinion on the financial statements for the year ended December 31, 20X0 was modified accordingly because of the possible effects of this limitation in scope.

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

APPENDIX 4

Contributed Materials and Services, Pledges, Bequests, Gifts of Life Insurance and Annuities

There are several other types of contributions that create special accounting considerations.

Recognizing Contributed Materials and Services

Organizations may receive substantial contributed materials and services. In these situations, recognition of the fair value of these contributions may provide useful information. Examples include contributed food for food banks and gifts of clothing and construction materials for certain charities. Fair values can be determined from published prices, by industry trading values and through appraisals.

Judgment is required in determining the practicality and cost of the record keeping required to determine the fair values and the cost of its audit against the benefit of the recognition. For example, it is normally impractical to recognize a fair value for the work of volunteers because valuing the hours worked is difficult.

Where the fair value of contributed materials and services can be reasonably estimated, the organization may want to establish a policy to record the amount on the financial statements.

Recognizing a Pledge

Whether collection of a pledge is reasonably assured determines whether it can be recognized. Since its collection depends on factors outside the organization's control, such as changing economic conditions and the continued goodwill and the donor's ability to pay, in almost all cases pledges do not meet the criteria for recognition. They are therefore not recognized until the pledge is actually received. Arguments have been made for recognizing certain pledge agreements that are enforceable in law when the organization would be willing to go to court to enforce them. However, recent jurisprudence has increased the uncertainty of collection, even in these cases.

There is an exception to the above non-recognition of pledges. Certain organizations that have large annual fundraising campaigns are able to provide a reasonable estimate of how many pledges will be received, based on their previous annual experience and the high volume of individual low-value pledges. For these organizations, the ability to compare campaign revenues has a high value to the readers, justifying the effort in calculating the estimate of the net pledges to be received.

Recognizing a Bequest

Although the trustee of an estate may signal to the organization that they have been included in a bequest, there remains uncertainty with when the bequest will be received and the amount that will be received. It is increasingly common for gifts in large estates to be litigated, leading to further uncertainty. Organizations should not record bequests until they know the timing and amount of the gift with reasonable certainty.

Recognizing Life Insurance Policies and Gifts of Annuities

Financial planning for gifts can involve many tax and accounting complexities and is best undertaken by professionals trained in the field. Gifts of life insurance and the creation of gift annuities are two examples of these types of gifts. The amount and timing of revenue recognition will depend on the specific terms of the gift and the associated financial instrument. For example, for life insurance, it will depend on whether the policy is whole life or term and who is paying the premiums. Annuities will typically require the cost of an annual independent valuation.

Organizations should accept these types of gifts only when they have a full understanding of both the net amount of the gift and any risks involved. For example, there have been situations with gift annuities where financial results over time have been a net loss to the receiving organization.

APPENDIX 5

Glossary of Financial Terms

The following definitions are taken from the *CPA Canada Handbook* and other sources, as appropriate.

Accounting policies are the specific principles, bases, conventions, rules and practices applied by an entity in preparing and presenting financial statements.

Accounts payable are amounts owed by an organization.

Accrual accounting records transactions when they occur, regardless of when money actually changes hands between the organization and third parties.

Amortization is the writing off of the cost of an asset, less any residual value, in a rational and systematic manner over its useful life. Depreciation accounting is a form of amortization applied to tangible capital assets.

Assets, in general, are possessions having value. In accounting, assets are resources owned, or in some cases controlled, by an individual or organization as a result of transactions or events from which future economic benefits are expected to flow to that individual or organization.

Capital assets, comprising tangible properties, such as land, buildings and equipment, and intangible properties, are identifiable assets that meet all of the following criteria:

- They are held for use in the provision of services, for administrative purposes, for production of goods or for the maintenance, repair, development or construction of other capital assets.
- They have been acquired, constructed or developed with the intention of being used on a continuing basis.
- They are not intended for sale in the ordinary course of operations.

Cash accounting records transactions only when there is an exchange of cash.

Contributions are non-reciprocal transfers to a not-for-profit organization of cash or other assets or non-reciprocal settlements or cancellations of its liabilities. Government funding provided to a not-for-profit organization is considered to be a contribution.

Current assets are those assets that are in the form of cash or expected to become cash within the coming year.

Current liabilities are those obligations that have to be paid within the coming year.

Deferral method Under the deferral method of accounting for contributions, restricted contributions related to expenses of future periods are deferred and recognized as revenue in the period in which the related expenses are incurred. Endowment contributions are reported as direct increases in net assets. All other contributions are reported as revenue of the current period. Organizations that use fund accounting in their financial statements without following the restricted fund method would account for contributions under the deferral method.

Deferred contribution is a restricted contribution received or receivable but carried forward to be taken into income in future periods as the related restrictions are met.

Endowment contribution is a type of restricted contribution subject to externally imposed stipulations specifying that the resources contributed be maintained permanently, although the constituent assets may change from time to time.

Endowment fund is a self-balancing set of accounts which reports the accumulation of endowment contributions. Under the restricted fund method of accounting for contributions, only endowment contributions and investment income subject to restrictions stipulating that it be added to the principal amount of the endowment fund would be reported as revenue of the endowment fund. Allocations of resources to the endowment fund that result from the imposition of internal restrictions are recorded as interfund transfers.

Expenditures / Expenses are decreases in economic resources, either by way of outflows or reductions of assets or incurrences of liabilities, resulting from an entity's ordinary activities.

Fair value is the amount of the consideration that would be agreed upon in an arm's length transaction between knowledgeable, willing parties who are under no compulsion to act.

Fiscal year is the twelve month period designated by the organization for its "business year."

Fund accounting comprises the collective accounting procedures resulting in a self-balancing set of accounts for each fund established by legal, contractual or voluntary actions of an organization. Elements of a fund can include assets, liabilities, net assets, revenues and expenses (and gains and losses, where appropriate). Fund accounting involves an accounting segregation, although not necessarily a physical segregation, of resources.

General fund is a self-balancing set of accounts which, under the restricted fund method of accounting for contributions, reports all unrestricted revenue and restricted contributions for which no corresponding restricted fund is presented. The fund balance represents net assets that are not subject to externally imposed restrictions.

In-camera is a legal term taken from the Latin for “in a chamber” and means “in private.” A board of directors would normally meet along with management at least annually with its auditors. It is best practice for time to be set aside for the board to meet in-camera with the auditors — i.e., without management present. It is also common for boards to arrange time to meet simply in-camera as a board.

Internal controls are all measures taken to safeguard assets, check the accuracy and reliability of accounting data, promote operating efficiency and ensure compliance with the organization’s policies and legislation under which it operates.

Liabilities, a synonym for debt, represent amounts that it is expected will require settlement in the future as a result of events and transactions that occurred prior to the accounting date, or obligations for future delivery of goods or services for which payment has already been received.

Long-term assets (or capital assets) are not expected to be converted to cash within a year.

Long-term liabilities are obligations to make payments in the future, beyond one year.

Materiality is the quality of being important. As a general rule, in the context of financial reporting, materiality may be judged in relation to the reasonable prospect of an item or aggregate of items being significant to financial statement users in making decisions.

Net assets, sometimes referred to as equity or fund balances, is the residual interest in a not-for-profit organization’s assets after deducting its liabilities. Net assets may include specific categories of items whose use may be either restricted or unrestricted.

Not-for-profit organizations are entities, normally without transferable ownership interests, organized and operated exclusively for social, educational, professional, religious, health, charitable or any other not-for-profit purpose. A not-for-profit organization’s members, contributors and other resource providers do not, in such capacity, receive any financial return directly from the organization.

Note disclosure is explanatory or supplementary information that elaborates on data summarized in the main body of the financial statements or provides additional information that is important to understanding the situation being reflected in the statements.

Related parties exist when one party has the ability to exercise, directly or indirectly, control, joint control or significant influence over the other. Two or more parties are related when they are subject to common control, joint control or common significant influence. Two not-for-profit organizations are related parties if one has an economic interest in the other. Related parties also include management and immediate family members.

Related party transaction is a transfer of economic resources or obligations between related parties, or the provision of services by one party to a related party, regardless of whether any consideration is exchanged. The parties to the transaction are related prior to the transaction. When the relationship arises as a result of the transaction, the transaction is not one between related parties.

Restricted contribution is a contribution subject to externally imposed stipulations that specify the purpose for which the contributed asset is to be used. A contribution restricted for the purchase of a capital asset or a contribution of the capital asset itself is a type of restricted contribution.

Restricted fund is a self-balancing set of accounts, the elements of which are restricted or relate to the use of restricted resources. Under the restricted fund method of accounting for contributions, only restricted contributions, other than endowment contributions, and other externally restricted revenue would be reported as revenue in a restricted fund. Allocations of resources that result from the imposition of internal restrictions are recorded as interfund transfers to the restricted fund.

Restricted fund method of accounting for contributions is a specialized type of fund accounting which involves the reporting of details of financial statement elements by fund in such a way that the organization reports total general funds, one or more restricted funds and an endowment fund, if applicable. Reporting of financial statement elements segregated on a basis other than that of use restrictions (e.g., by program or geographic location) does not constitute the restricted fund method.

Restrictions are stipulations imposed that specify how resources must be used. External restrictions are imposed from outside the organization, usually by the contributor of the resources. Internal restrictions are imposed in a formal manner by the organization itself, usually by resolution of the board of directors. Restrictions on contributions may only be externally imposed. Net assets or fund balances may be internally or externally restricted. Internally restricted net assets or fund balances are often referred to as “reserves” or “appropriations.”

Revenues are increases in economic resources, either by way of inflows or enhancements of assets or reductions of liabilities, resulting from the ordinary activities of an entity.

Statement of changes in net assets provides information about changes in the portions of net assets attributable to endowments, internal and external restrictions, and unrestricted net assets.

Statement of cash flows provides information about the sources and uses of cash by the organization in carrying out its operating, financing and investing activities for the period.

Statement of financial position presents the organization's economic resources, obligations and net assets as at the reporting date.

Statement of operations presents information about changes in the organization's economic resources and obligations for the period.

Unrestricted contribution is a contribution that is neither a restricted contribution nor an endowment contribution.

Working capital is the difference between current assets and current liabilities.

Working capital ratio describes how many dollars of current assets are on hand for each dollar of current liabilities.

Where to Find More Information

CPA Canada Publications on Not-for-Profit Governance

Available at www.cpacanada.ca/nfpgovernance

About the Author

Deryck Williams, FCPA, FCA

Although he had no idea what the word “auditor” meant, Deryck was inspired at a young age to follow in the footsteps of his uncle, a Chartered Accountant. Then, while studying accounting at Queen’s University, Deryck inadvertently discovered a passion for not-for-profit work and became intensely involved — to the detriment of his marks — as a volunteer in a charity that takes kids in trouble with the law on ten-day wilderness canoe trips. And the rest, as they say, is history! Deryck met and married a fellow volunteer, and together they now have five wonderful children. His wife spent her entire career teaching troubled youth while he exclusively audited and primarily consulted with NFPs including some of Canada’s largest, as well as a great many that are not so large. Along the way, they both served as volunteers and board members in a variety of different charities and not-for-profit organizations.

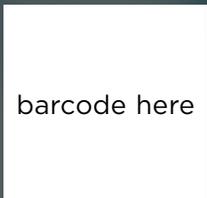
Deryck has long been present in the halls of CPA Canada and its predecessor organization, advocating for the not-for-profit sector. He has travelled the country delivering seminars and helping organizations troubleshoot. He has always enjoyed helping leaders of NFPs to achieve excellence — for on their shoulders rests the quality of life for millions of Canadians. At the time he retired, Deryck was the national leader of the not-for-profit sector practice of Grant Thornton and a member of both the Not-for-Profit Advisory Committee of the Accounting Standards Board and the Not-for-Profit Organizations Committee of the CPA Canada Corporate Oversight and Governance Board.



CPA

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Board Motion



Motion Title	For Approval: Audited Financial Statements for Fiscal Year 2024
Date of Meeting	May 30, 2025

It is moved by _____, and seconded by _____, that:

The Board of Directors¹ of the College of Physicians and Surgeons of Ontario approves the audited financial statements for the fiscal year ended December 31, 2024, as presented (a copy of which form Appendix "X" 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*.

TINKHAM LLP | CHARTERED PROFESSIONAL ACCOUNTANTS

D C Tinkham FCPA FCA CMC LPA
P J Brocklesby CPA CA LPA
M Y Tkachenko CPA CA
M W G Rooke CPA CA LPA
A C Callas CPA CA LPA
G P Kroepflin CPA
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TINKHAMCPA.COM

March 13, 2025

Mr. Rob Payne, Chair, Finance and Audit Committee
College of Physicians and Surgeons of Ontario
80 College Street
Toronto ON M5G 2E2

To the Members of the Finance and Audit Committee

We are pleased to report to the Finance and Audit Committee of the College of Physicians and Surgeons of Ontario ("College") on the results of our audit examination of the financial statements for the year ended December 31, 2024. In our view, a direct line of communication between our firm and the Finance and Audit Committee is essential to the proper exercise of our respective responsibilities.

The purpose of this letter is to review our responsibilities as auditors in accordance with the terms of our audit engagement, and in the attached memorandum we report on the year end and various elements of the audit examination.

We have performed our audit examination of the College's financial statements for the year ending December 31, 2024 in accordance with Canadian generally accepted auditing standards. We have performed the audit to obtain reasonable assurance about whether the financial statements present fairly, in all material respects, the financial position, results of operations and cash flows in accordance with Canadian Accounting Standards for Not-for-Profit Organizations.

We have also considered the College's internal control over the financial reporting solely for the purpose of determining the nature, extent, and timing of auditing procedures necessary for expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the College's internal control. Our work does not provide assurance on the internal control structure and does not necessarily consider all control systems upon which management may be relying.

The detailed terms of our engagement are outlined in our engagement letter. Also, as part of our audit engagement, we have requested a letter of representation from the College's management confirming representations made to us orally during our audit as well as representations implicit in the College's records.

Our appointment as auditors involves the responsibility on our part to call to your attention any significant matters, which we believe may require your consideration. We report in the attached memorandum on the results of our audit for the year ending December 31, 2024, including the following:

- Audit Report;
- Engagement Team and Statement on Independence;
- Audit Approach;
- Materiality;
- Significant Accounting Policies;
- Significant Management Judgments and Estimates;
- Related Party Transactions;
- Recommendations Arising from the Audit Examination;
- Management Co-operation;
- Adjusting Journal Entries;
- Summary of Audit Differences;
- Details of all Audit and Non-audit Services;
- Developments in Accounting Standards; and
- Canada Revenue Agency – Update.

The accompanying report is intended solely for the use of the Finance and Audit Committee, Board, and management, and presents information regarding our audit examination, which we believe will be of assistance.

As always, our audit of the annual financial statements provides the objectivity and independence that the College expects.

Yours very truly,

A handwritten signature in blue ink, appearing to be 'A. [unclear] LLP', written in a cursive style.

Tinkham LLP

Encl.

**College of Physicians and Surgeons of Ontario
Report to the Finance and Audit Committee
December 31, 2024**

Audit Report

We will issue our unqualified audit opinion following approval of the financial statements by the Board of Directors and completion of the following outstanding audit items:

- Motions to approve transfers between unrestricted and internally restricted net assets;
- Receipt of the signed representations letters;
- Receipt of the responses to the legal enquiry letters; and
- Completion of the subsequent events review up to the date of our audit report.

Engagement Team and Statement on Independence

We continue to serve you with a team of professionals who offer both industry expertise and many years of professional audit experience. We believe that the following professionals have provided responsive, innovative, and forward-looking service and we note the high level of expertise engaged on your audit:

Michael Rooke, CPA, CA, LPA
Dale C Tinkham, FCPA, FCA, CMC, LPA
Himmat Grewal, CPA

Engagement Partner
Concurring Partner
Engagement Principal

It is a fundamental principle that auditors providing assurance services be objective with unimpaired professional judgment in the eyes of a reasonable observer. We confirm that we are independent with respect to the College within the meaning of the CPA Ontario Code of Professional Conduct Rule 204.

Audit Approach

Our audit approach is a risk-based approach that focuses on your operations, the associated risks, and their potential effects on financial statement accounts. We also reviewed and considered management's formal assessment of the internal control environment. Our audit process continually enhances our understanding of the College's business, the risks it faces and the process to manage them.

The audit included examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation.

Our approach also focuses on the identification and testing of the internal controls. We have reviewed and evaluated the overall internal control environment, assessed the computer environment, and the specific internal controls upon which we place reliance in expressing our opinion on the financial statements.

In the current year, we identified and tested internal controls for the purchases, payables, and payments; revenue, receipts and receivables and payroll transactions streams to obtain evidence that key controls were operating as expected and were effective.

Based on the results of our testing, we modified our audit plan for the year end to reduce substantive work where the tests of internal controls justify reliance and reduced our year end substantive testing in these areas.

We employed a combination of control testing and substantive audit procedures on year end balances for assets, liabilities, revenues, and expenses. In addition, we have confirmed the College's cash and investment balances. We have also requested legal enquiry letters from a sample of lawyers retained by the College to confirm the status of any lawsuits or claims filed against the College.

Our audit was carried out in accordance with our original plan.

Materiality

Our evaluation of areas of audit significance is made relative to materiality. An understanding of what is significant or material in relation to the overall results of the College is critical to the performance of an effective and efficient audit. An item is considered material if its impact might reasonably be expected to affect the decisions of a reader of the financial statements.

Our assessment of materiality considers the CPA Canada quantitative guidelines of up to 2% of gross revenues but is also affected by the size and nature of potential misstatements, as well as our knowledge of the College's business. We have set quantitative materiality for the purposes of this examination at \$2,300,000 or 2.5% of gross revenues.

Significant Accounting Policies

Our audit also includes assessing accounting policies used by the College. The preparation of financial statements may require management to select from more than one acceptable approach to accounting.

There were no changes in accounting standards applicable to the College this year and there were no changes in accounting policies used by the College.

Please refer to the significant accounting policies in the notes to the financial statements for a detailed description of the accounting policies used. The accounting policies are appropriate for the College's reporting purposes and reflect best practices.

Significant Management Judgments and Estimates

The preparation of financial statements requires the use of accounting estimates. Certain estimates are particularly sensitive due to their significance to the financial statements and the possibility that future events may differ significantly from management's expectations. Management is responsible for applying sound judgment in preparing estimates and disclosures and assessing the impact of misstatements on the fair presentation of the financial statements.

Charges for amortization of capital assets are based on the estimated useful lives of the tangible and intangible assets which are disclosed in the detail of the notes to the financial statements.

The College relies on the actuarial calculations for pension assets and liabilities, and obligations for post-retirement benefits other than pensions. The full cost of pensions and post retirement benefits expense are reflected in the financial statements. In consultation with the actuaries, management determines the discount factor used in the actuarial calculations.

There is no allowance for doubtful accounts recorded as at December 31, 2024. It is management's judgement that any accounts receivable not subsequently collected would be insignificant and no allowance is required.

The College estimates the amount of deferred revenue based on parameters established by management.

The College has accrued an estimate of \$1,340,000 (2023 - \$1,210,000) representing management's best estimate of the College's obligation to fund patients who are approved by the Patients Relations Committee (PRC) through the Survivors' Fund. The accrued amount is based on the unpaid but awarded amount totaling \$2,174,000 (2023 - \$2,031,000) reduced for historical claim experience.

Based on our audit procedures, we have concluded the estimates and judgments made by management are reasonable in the context of the financial statements when taken as a whole. Financial results as determined by actual future events could differ from those estimates and it is reasonable to assume such differences may be material.

Related Party Transactions

During our audit, we conduct various tests and procedures to identify transactions considered to involve related parties. Related parties exist when one party has the ability to exercise, directly or indirectly, control, joint control or significant influence over the other. Two or more parties are related when they are subject to common control, joint control, or common significant influence. Two not-for-profit organizations are related parties if one has an economic interest in the other. Related parties also include management, directors and their immediate family members and companies with which these individuals have an economic interest.

Related party transactions identified during the audit consisted of remuneration and reimbursements of College related expenses to Board members. It is management's opinion that these transactions have occurred in the normal course of operations and therefore separate financial statement disclosure is not necessary.

Management has advised us that no other related party transactions have occurred and that all transactions have been disclosed to us. The Finance and Audit Committee is required to advise us if it is aware of or suspects any other related party transactions have occurred, which may be required to be disclosed in the financial statements.

Recommendations Arising from the Audit Examination

We have not identified any significant deficiencies in internal controls or accounting routines, nor developed any recommendations as a result of the application of our year-end audit procedures. Findings arising from our interim audit examination are reported separately in our interim reporting letter, dated January 9, 2025, addressed to the Finance and Audit Committee.

Additional recommendations aimed at strengthening the College's internal and information technology controls have been reported separately to management.

Management Co-operation

We received the full co-operation from management and staff in the conduct of our audit. There have been no disagreements with management on any issues. There were no restrictions placed on the approach to or extent of our work. We were provided complete and timely access to all books and records, documents, and other supporting data that we required.

Adjusting Journal Entries

Adjustments, which were below the level of materiality, made to the records of the College and approved by management during the audit, were to adjust prepaid expenses.

There was one additional audit adjustment at the request of management for financial statement presentation.

Summary of Audit Differences

During our audit, we found no misstatements or unadjusted items, nor have we found significant misstatements that would likely cause future financial statements to be materially misstated.

Details of all Audit and Non-Audit Services

We have not provided any additional services in the year other than the issuance of our audit opinion on the financial statements of the College.

It is our understanding that the Corporation Income Tax Return (T2) and Non-Profit Organization (NPO) Information Return (T1044) will be prepared by management for submission to the CRA.

Developments in Accounting Standards

There are no developments in accounting standards that are not yet effective that would be expected to have a material impact to the College's financial statements.

Canada Revenue Agency – Update

Effective spring 2025, the Canada Revenue Agency (“CRA”) will transition to online mail through the CRA’s online portal (“My Business Account”) as the default method of delivering business notices and other correspondence, instead of by mail.

The change applies to existing businesses registered for My Business Account and businesses who have a representative that accesses the CRA’s services on their behalf.

Canadian businesses will need to sign into My Business Account and ensure the business email is up to date to receive correspondence, including notice of assessments and most other statements and letters.

The College of Physicians and Surgeons of Ontario

Year End: December 31, 2024

Adjusting journal entries

Date: 2024-01-01 To 2024-12-31

Number	Date	Name	Account No	Referer	Debit	Credit	
1	2024-12-31	Prepaid Expenses-	13000	L1	166,382.10		
1	2024-12-31	Insurance-Occupancy	54110-8000	L1		166,382.10	
		To adjust for prepaid insurance amounts at year-end.					
					166,382.10	166,382.10	

Net Income (Loss) 8,097,570.68

2025-03-24
4:21 PM

Completed by	Reviewed by	Reviewed by	Reviewed by
<p style="text-align: center;">HG</p> <p style="text-align: center;">2025-03-12</p>		<p style="text-align: center;">DCT</p> <p style="text-align: center;">2025-03-22</p>	<p style="text-align: center;">MR</p> <p style="text-align: center;">2025-03-13</p>

The College of Physicians and Surgeons of Ontario

Year End: December 31, 2024

Reclassifying Journal Entries

Date: 2024-01-01 To 2024-12-31

Completed by	Reviewed by	Reviewed by	Reviewed by
HG 2025-03-12		DCT 2025-03-22	MR 2025-03-13

5G

Number	Date	Name	Account No	Reference	Debit	Credit	Recurrence	Misstatement
RE1	2024-12-31	Capital Lease Obligation Current Portion-	21040	DD3		343,877.23		
RE1	2024-12-31	Capital Lease Obligation	2290-1-00-00-0000-0	DD3	343,877.23			
		To allocate between current and LT portion of Cap. Leases.						
					343,877.23	343,877.23		
		Net Income (Loss)	8,097,570.68					

Title:	Appointment of the Auditor (For Decision)
Main Contacts:	Nathalie Novak, Chief Operating Officer Sandra Califaretti, CPA, CA, Corporate Controller
Question for Board:	Is the Board of Directors in agreement with the re-appointment of Tinkham LLP, Chartered Accountants as the College’s auditors for the 2025 fiscal year?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- Section 6.1.4(b) of the CPSO By-laws requires that the Board appoint one or more auditors who are duly licensed under the *Public Accounting Act, 2004, S.O. 2004, C.8* to hold office until the next Annual Financial Meeting.
- The Board of Directors is requested to approve the re-appointment of Tinkham LLP as the College’s 2025 financial statement auditors.

Current Status & Analysis

- Tinkham LLP was selected as the College’s financial statement auditor through a limited competitive process, first auditing the College in 2007.
- During this time, Tinkham LLP has remained independent, incorporating regular lead partner and senior staff rotations every few years as a best practice.
- The audit team has worked cooperatively with management across the organization to complete the audit and present the financial statements to the Board for approval.
- Although certain jurisdictions recommend the rotation of an audit firm every ten years, the College has benefited from Tinkham’s tenure through their enhanced knowledge of business operations and the internal control and financial environment, understanding of accounting policies and relationship with previous and current management. The 2024 audit was executed in an efficient and timely manner with no issues or concern raised by management.
- It is therefore recommended that the Board of Directors re-appoint Tinkham LLP as the College’s financial statement auditors for the 2025 fiscal year.

Board Motion



Motion Title	For Approval: Appointment of Auditors for Fiscal Year 2025
Date of Meeting	May 30, 2025

It is moved by _____, and seconded by _____, that:

The Board of Directors¹ of the College of Physicians and Surgeons of Ontario appoints Tinkham LLP, Chartered Professional Accountants, as the College's auditors to hold office until the next Annual Financial Meeting of the Board.

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*.

Title:	By-law Amendments: Business Practices (For Decision)
Main Contacts:	Sandra Califaretti, CPA, CA, Corporate Controller Carolyn Silver, Chief Legal Officer Marcia Cooper, Senior Corporate Counsel
Attachment:	Appendix A: Proposed By-law Amendments to Business Practices
Question for Board:	Does the Board of Directors approve the proposed By-law amendments to Business Practices?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- Article 14 of the CPSO By-laws, included since before 2002, outlines provisions related to business practices, including responsibility over investment decisions, borrowing limits and delegation of authorities to make commitments and payments on behalf of the CPSO.
- The creation of new roles in the College, process automation through an updated financial system, and the need for flexibility in making financial and investment decisions, and executing financial transactions, has resulted in a review of these provisions and associated recommendations.

Current Status & Analysis

- Several provisions of Article 14 Business Practices of the CPSO By-laws, first incorporated prior to 2002, were recently reviewed considering changes to the oversight and management of the finance function, modernization of financial streams and processes, and market and economic volatility and uncertainty that require agile financial decision-making.
- Changes made to several provisions of Article 14 are intended to:
 - Bring clarity to the management of investment decisions for excess cash, and borrowing limits related to possible cash flow and working capital shortfalls,
 - Allow greater flexibility in the delegation of commitment and spending authority when operationally reasonable to do so,
 - Streamline approval processes related to cash disbursements where upstream controls have been built into system workflows, and,
 - Separate operational responsibilities from commitment authorities to meet operational needs.
- The initial implementation of the College's financial system (F&O) coupled with the current review of financial processes has enhanced the College's control environment. Through redesigned financial processes, the College has reallocated accountability for financial commitments and disbursement controls, reducing the relevance of downstream approvals. In addition, the creation of the COO position allows for focused oversight of the College's financial environment that aligns with overarching strategic goals and management of operations. Operational efficiencies have contributed to positive cash flows, giving the College the opportunity to manage investments more proactively in the current economic environment.
- The proposed By-law changes contribute to the streamlined financial environment that continues to mitigate financial risk and maximizes effective financial management practices.

APPENDIX A: PROPOSED AMENDMENTS

PART 7 – BUSINESS AND ORGANIZATIONAL MATTERS

ARTICLE 14 BUSINESS PRACTICES

14.4 Investment

- 14.4.1 Funds of the College that are not immediately required may be invested by an investment dealer selected by, and acting in accordance with criteria or parameters given by, the Finance and Audit Committee, only in the following:
- (a) bonds, debentures or other evidences of indebtedness of, or guaranteed by, the Government of Canada;
 - (b) deposit receipts, deposit notes, certificates of deposit, acceptances and other similar instruments issued or endorsed by a bank listed in Schedule I to the *Bank Act*, S.C. 1991, c. 46; or
 - (c) investment-grade money market funds previously approved for the purpose by the Finance and Audit Committee.
- 14.4.2 The Executive Committee may by resolution approve the investment or reinvestment of funds of the College that are not immediately required in any investments not listed in Section 14.4.1 -which the Executive Committee considers advisable ~~, and two Signing Officers shall implement the decision.~~

14.5 Borrowing

- 14.5.1 The Board may by resolution:
- (a) borrow money on the credit of the College, except that a Board resolution is not required for the College to borrow amounts not exceeding \$250,000 in total;
 - (b) limit or increase the amount or amounts to be borrowed; and
 - (c) secure any present or future borrowing, or any debt, obligation, or liability of the College, by charging, mortgaging, hypothecating or pledging all or any of the real or personal property of the College, whether present or future.
- 14.5.2 The Board or the Executive Committee may by resolution borrow money on behalf of the College for periods of six months or less secured only by investments of the College of the type set out in Section 14.4.1.
- 14.5.3 Two Signing Officers shall sign documents to implement a decision made under Section 14.5.1 or Section 14.5.2.
- 14.5.4 Despite Sections 14.5.1 and 14.5.2, a resolution of the Board or the Executive Committee is not required for the issuance and use of College credit cards or for entering into equipment leases.

14.6 Signing of Contracts and Other Documents and Approval of Expenditures

14.6.1 The signing officers of the College shall be any of the following (the “**Signing Officers**”): the Registrar, the Chief Operating Officer, the Corporate Controller and the Corporate Accountant.

14.6.2 If Signing Officers are not reasonably available, the Registrar or the Chief Operating Officer may delegate signing authority for one or more contracts, agreements, instruments and other similar or related documents, and for authorizations for Obligations, to a College staff person ~~who is an officer (including a deputy or associate Registrar) or director~~ (each, a “**Delegated Signatory**”). ~~Such, such~~ delegation ~~shall to~~ be in writing and saved in College systems. Despite the foregoing, the Registrar and the Chief Operating Officer may not delegate signing authority for any documents or authorizations contemplated in Section 14.5.3, ~~Section 14.6.7~~ or for cheques in Section 14.6.10.

...

14.6.6 Budgeted Expenses: Contracts, agreements, instruments and any other documents requiring signature by the College, and any other authorization (excluding purchase orders and invoices), for expenditures or expenses (for greater certainty, whether for procurement of goods and services or for a non-procurement purpose) (collectively, “**Obligations**”) included or authorized in a budget approved by the Board shall be signed or authorized by a Signing Officer or Delegated Signatory.

...

14.6.10 Two Signing Officers shall sign each cheque. ~~or authorize each electronic transfer of funds.~~ A Signing Officer shall not sign a cheque ~~or authorize an electronic transfer of funds~~ payable to such Signing Officer. Each electronic transfer of funds shall be authorized by one Signing Officer, or if Signing Officers are not reasonably available, a Delegated Signatory. Such delegation shall be in writing and saved in College systems.

Motion Title	For Approval: By-law Amendments - Business Practices
Date of Meeting	May 30, 2025

It is moved by _____, and seconded by _____, that:

The Board of Directors¹ of the College of Physicians and Surgeons of Ontario amends the CPSO By-laws (By-law No. 168) as set out below:

1. Section 14.4.2 of the CPSO By-laws is revoked and substituted with the following:

14.4.2 The Executive Committee may by resolution approve the investment or reinvestment of funds of the College that are not immediately required in any investments not listed in Section 14.4.1 which the Executive Committee considers advisable.

2. The following is added as Section 14.5.4 of the CPSO By-laws:

14.5.4 Despite Sections 14.5.1 and 14.5.2, a resolution of the Board or the Executive Committee is not required for the issuance and use of College credit cards or for entering into equipment leases.

3. Section 14.6.2 of the CPSO By-laws is revoked and substituted with the following:

14.6.2 If Signing Officers are not reasonably available, the Registrar or the Chief Operating Officer may delegate signing authority for one or more contracts, agreements, instruments and other similar or related documents, and for authorizations for Obligations, to a College staff person (each, a **"Delegated Signatory"**). Such delegation shall be in writing and saved in College systems. Despite the foregoing, the Registrar and the Chief Operating Officer may not delegate signing authority for any documents or authorizations contemplated in Section 14.5.3, Section 14.6.7 or for cheques in Section 14.6.10.

4. Section 14.6.6 of the CPSO By-laws is revoked and substituted with the following:

14.6.6 Budgeted Expenses: Contracts, agreements, instruments and any other documents requiring signature by the College, and any other authorization (excluding purchase orders and invoices), for expenditures or expenses (for greater certainty, whether for procurement of goods and services or for a non-procurement purpose) (collectively, **"Obligations"**) included or authorized in a budget approved by the Board shall be signed or authorized by a Signing Officer or Delegated Signatory.

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*.

5. Section 14.6.10 of the CPSO By-laws is revoked and substituted with the following:

14.6.10 Two Signing Officers shall sign each cheque. A Signing Officer shall not sign a cheque payable to such Signing Officer. Each electronic transfer of funds shall be authorized by one Signing Officer, or if Signing Officers are not reasonably available, a Delegated Signatory. Such delegation shall be in writing and saved in College systems.

Title:	Regulatory Amendments: <i>Provisional Class of Registration and Retired Class of Registration (For Decision)</i>
Main Contacts:	Samantha Tulipano, Director, Registration and Membership Sayran Sulevani, Legal Counsel Heather Webb, Manager, Communications Mike Fontaine, Senior Policy Analyst
Attachment:	Appendix A: Draft Regulatory Amendments: <i>Provisional Class of Registration and Retired Class of Registration</i>
Question for Board:	Does the Board of Directors approve the proposed regulatory amendments for circulation?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- Amendments are proposed to [Ontario Regulation 865/93 \(Registration\)](#) under the *Medicine Act, 1991*, in order to establish two new classes of registration: a Provisional Class and a Retired Class. The Board is provided with an overview of the proposed classes and is asked whether the regulatory amendments can be approved for circulation.
- The proposed amendments help to ensure that physicians' certificates of registration accurately reflect both the nature of the terms, conditions, and limitations under which they practise and their status as practising (or non-practising) physicians.

Current Status & Analysis

A) *Provisional Class of Registration*

Current Status

- Under the current regulation, a certificate of registration of any class that is subject to terms, conditions, or limitations ("TCLs") imposed by a CPSO committee (including the Registration Committee) is deemed to be a restricted certificate.
- The "restricted" class is set out in the regulation and includes physicians with both registration-related restrictions (e.g. scope-based restrictions) and restrictions relating to practice concerns and/or disciplinary action.
- In many cases, restricted certificates are granted to physicians who are not eligible for an independent practice certificate but who are otherwise eligible to practise in Ontario through a pathway created by a Registration Committee policy (e.g. [Restricted Certificate of Registration for Exam Eligible Candidates](#)).
 - Indeed, many physicians holding a "restricted" certificate may practise fully independently, with only a scope-based restriction.
 - When applied to these applicants, the "restricted" designation has led to confusion among physicians and the public because of its potentially negative connotation.

Proposed Provisional Class

- The proposed regulatory amendment establishing a provisional class of registration would differentiate between restricted certificates of registration arising out of registration policies with no other terms, and certificates with additional restrictions imposed by CPSO committees (e.g., ICRC, Discipline, QAC).
 - Once the regulatory amendment comes into force, certificates of registration granted under a registration policy designated by the Board¹, with no other terms, will be deemed to be provisional certificates of registration.

¹ Under the proposed regulatory amendment, Board-designated registration policies under which physicians may be granted a provisional certificate of registration will be known as "exemption policies."

- Restrictions that are imposed in addition to those set out in the relevant registration policies will result in the certificate of registration being “restricted” rather than “provisional.”
- Moreover, under the proposed regulatory amendment, physicians holding a provisional certificate of registration will be eligible to apply for an independent practice certificate (“IP”) provided:
 - they have held a provisional certificate of registration for five continuous years; and
 - during the five-year period immediately preceding the application:
 - they have practised continuously in Ontario; and
 - the only TCL on their certificate is that they practise within their scope.
- Physicians holding a provisional certificate who apply for an IP will be exempt from certain requirements set out in the regulation.

Next Steps

- Once the regulatory amendment comes into force and the Board has designated exemption policies, physicians currently holding a restricted certificate of registration under one of the designated exemption policies will automatically be transferred to the provisional class.
- Likewise, physicians who have held a restricted certificate for a continuous period of five years where the only restriction is that they practise limited to their scope will immediately be eligible to apply for an IP.
 - The Registration Committee will assess all applicants requesting to transfer to an IP to ensure they meet all necessary standards and qualifications.
- Prior to the regulatory amendments coming into force, the Board will need to identify which existing registration pathways qualify for a provisional certificate and designate them as exemption policies.

B) Retired Class of Registration

Current Status

- In the current regulation, there is no class of registration specifically for physicians who are retired.
 - As a result, physicians who want to remain registered with CPSO but who may not wish to continue practising must maintain their registration and continue to fulfill all relevant requirements (e.g., continuing professional development). These physicians also appear on the Physician Register without indication that they are not actively practising.

Proposed Retired Class

- The proposed regulatory amendment would establish a retired class of registration which would be available to physicians holding an IP or a provisional certificate authorizing independent practice where the only TCL is a scope-based restriction.
- Physicians registered in this class would not be permitted to practise medicine or provide any health-care services, would be exempt from completing other requirements set out in the registration regulations (e.g., continuing professional development), and would pay a reduced membership fee.
- Physicians wishing to transfer from the retired class back into independent practice would be permitted to do so provided they have been in the retired class for less than two years, are not the subject of an investigation, have no restrictions related to their practice, and meet all other requirements for registration.
- Physicians registered in the retired class for more than two years would be able to apply for a new practice certificate following the typical process and may be subject to additional requirements under the [Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice](#) policy.

- In addition to enabling retired physicians to maintain their connection with CPSO, registering physicians in the retired class will enable CPSO to more accurately track the number of physicians actively practising in the province.

C) Next Steps

- Should the Board approve the proposed regulation amendments, they will be circulated for 60 days in accordance with Section 22.21 and Section 95(1.4) of the *Health Professions Procedural Code*.
- Following the circulation period, the proposed regulation amendments will be brought to the Board for final approval to submit to the Ministry.

Regulatory Amendments – Proposed Language

RESTRICTED CERTIFICATE

10. (1) A licence that is in effect on the day this Regulation comes into force and which is subject to terms, conditions or limitations imposed by a committee under a predecessor of the Act is deemed to be a restricted certificate of registration under the Act subject to the imposed terms, conditions and limitations. O. Reg. 865/93, s. 10 (1).

(2) A certificate of registration of any class upon which a committee imposes terms, conditions or limitations is deemed to be a restricted certificate of registration under the Act subject to the imposed terms, conditions and limitations. O. Reg. 865/93, s. 10 (2).

(3) **Subject to subsection 10.1(1),** a certificate of registration of any class issued by reason of an order of the Registration Committee directing the Registrar to impose terms, conditions or limitations on the certificate is deemed to be a restricted certificate of registration under the Act subject to the imposed terms, conditions and limitations. O. Reg. 865/93, s. 10 (3).

(4) A holder of a restricted certificate of registration may practise medicine only in accordance with the terms, conditions and limitations of the certificate. O. Reg. 865/93, s. 10 (4).

PROVISIONAL CERTIFICATE (Proposed New Section)

“exemption policy” means a policy designated by Council as an exemption policy for the purposes of section 10.1 of this regulation.

10.1(1) A certificate of registration of any class issued by order of the Registration Committee:

1. pursuant to an exemption policy directing the Registrar to impose terms, conditions or limitations on the certificate; or
2. pursuant to subsection 22.18(7)2(i) of the Health Professions Procedural Code which authorizes the member to practice independently limited to a specified scope of practice as ordered by the Registration Committee,

is deemed to be a provisional certificate of registration under the Act subject to the imposed terms, conditions and limitations, if no other terms, conditions or limitations are

imposed on the certificate of registration, by any other Committee including the Registration Committee.

(2) A holder of a provisional certificate of registration may practise medicine only in accordance with the terms, conditions and limitations of the certificate.

(3) A holder of a provisional certificate of registration who applies for an independent practice certificate is exempt from the standards and qualifications required under paragraphs 2, 3 and 4 of subsection 3(1), if the member satisfies the following standards and qualifications:

1. The member has held a provisional certificate of registration continuously for a period of at least five years, including the period of time the member held a restricted certificate of registration before section 10.1(1) came into force and which was deemed provisional by operation of section 10.1(1), and, during the five-year period immediately preceding the application:
 - a. No terms, conditions or limitations are imposed on the certificate of registration, by any other Committee, including the Registration Committee, other than the term, condition and limitation imposed by order of the Registration Committee authorizing the member to practice independently limited to a specified scope of practice; and
 - b. The member has practised continuously in Ontario.

RETIRED CLASS (Proposed New Section)

s.13.1 (1) The standards and qualifications for a certificate of registration in the retired class are as follows:

1. The applicant is a member who holds a:
 - (i) certificate of registration authorizing independent practice; or
 - (ii) provisional certificate of registration, with terms, conditions and limitations imposed by order of the Registration Committee authorizing independent practice limited to a specified scope of practice as ordered by the Registration Committee, and no other terms;
2. The applicant is not engaged in active practice in any jurisdiction;

3. The applicant is not in default of any obligation to the College, including, but not limited to, the payment of any outstanding fees, penalties or any other amount owing to the College.

(2) The following are terms, conditions and limitations of a certificate of registration in the retired class:

1. The member shall not engage in the practice of medicine and/or provide any health care services.

(3) A member in the retired class is exempt from completing the continuous professional development and self-assessment requirements set out in section 29 of the General Regulation O.Reg 114/94.

(4) A member who holds a certificate of registration in the retired class for less than two years may, upon application for reinstatement, be issued a certificate of registration of the class they held on the day prior to issuance of their certificate of registration in the retired class, if the member fulfils all of the following requirements:

1. The member submits a completed application in the form provided by the College;
2. The member pays the applicable fee;
3. The member is not in default of any obligation to the College, including but not limited to the payment of any outstanding fees, penalties or any other amount owing to the College;
4. The member meets the registration requirements in subsection 2(2)(a), (b), (d) and (e);
5. The member meets the non-exemptible standards and qualifications in subsection 2(1). Without limiting the foregoing, for the purposes of this provision, the member is deemed not to have met this requirement if the member is the subject of allegations of professional misconduct, incompetence, and/or incapacity, under investigation by the College or any body that regulates a profession inside or outside Ontario, and/or is subject to an order of any committee of the College;

6. The member has engaged in the practice of medicine in Ontario within two years prior to the date of the application for reinstatement under this section.

s.13.2 Notwithstanding subsection 13.1(4), a member who holds a certificate of registration in the retired class may make a new application for a certificate of registration under the Health Professions Procedural Code.

DRAFT

Board Motion

Motion Title	Draft Regulation Amendments for Consultation: Provisional Class of Registration and Retired Class of Registration
Date of Meeting	May 30, 2025

It is moved by _____, and seconded by _____, that:

The Board of Directors¹ of the College of Physicians and Surgeons of Ontario (a) release for external consultation and engage in the notice and consultation process in accordance with Section 22.21 of the Health Professions Procedural Code, in respect of the draft provisional class of registration and retired class of registration regulatory amendments to the Ontario Regulation 865/93 (Registration) under the *Medicine Act*, 1991, and (b) circulate such draft regulatory amendments to stakeholders pursuant to Section 95(1.4) of the Health Professions Procedural Code, (a copy of which amendments form 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*.

MAY 2025

Title:	By-law Amendments for fees relating to the Retired Class of Registration (For Decision)
Main Contacts:	Samantha Tulipano, Director, Registration and Membership Carolyn Silver, Chief Legal Officer Marcia Cooper, Senior Corporate Counsel and Privacy Officer
Attachment:	Appendix A: Proposed By-law Amendments
Question for Board:	Does the Board approve circulation of the proposed By-law amendments?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- By-law amendments are proposed to set the fees for the proposed Retired Class Certificate of Registration.
- The proposed By-law amendments will facilitate and support the establishment of the proposed Retired Class certificate of registration.

Current Status & Analysis

- Earlier in this meeting, the Board was presented with a proposal to make a regulatory amendment to establish a Retired Class certificate of registration.
- The proposed By-law amendments establish the fees applicable to the Retired Class of registration.
 - a) It is proposed that there be no application fee for physicians applying for the Retired Class.
 - b) The annual fee is proposed to be 50% of the standard annual fee for certificates of registration (i.e., 50% of \$1725 = \$862.50).
- No amendments to the fee By-laws are needed for the Provisional Class certificate of registration as the fees will be the same as for current Restricted certificates.
- Note that enactment of the proposed By-law amendments will be conditional on approval of the regulatory amendments for the Retired Class certificate of registration by the Board and the government.
- These By-law amendments must be circulated to the profession before they can be approved by the Board.
- If the Board approves, the proposed By-laws will be circulated to the profession. After circulation, the proposed amendments will be brought back to the Board for final approval.

APPENDIX A: PROPOSED BY-LAW AMENDMENTS FOR RETIRED CLASS FEES

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, except that no application fee applies to a person who submits an application for a certificate of registration in the retired class. The application fees are as follows: ...

18.1 Annual Fees

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

- (a) \$1,725 for a holder of a certificate of registration other than a certificate of registration authorizing postgraduate education, a certificate of registration authorizing supervised practice of a short duration, a certificate of registration authorizing temporary independent practice, a certificate of registration in the retired class, or a certificate of registration authorizing practice as a physician assistant;
- (b) for a holder of a certificate of registration authorizing postgraduate education applying to renew the holder's certificate of registration, 20% of the annual fee set out in Section 18.1.2(a);
- (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~~
- (d) despite Sections 18.1.2(a), (b) and (c), where the holder of a certificate of registration will be taking parental leave for a period of four months or longer during the membership year for which the annual fee applies because the holder is pregnant, has recently given birth or will be caring for their newborn or newly adopted child, the annual fee for such membership year is 50% of the annual fee applicable to the holder of the certificate of registration as set out in Sections 18.1.2(a), (b) and (c), so long as the holder applies to the College for this parental leave reduced annual fee prior to the close of the annual renewal period for such membership year. If an application for the parental leave reduced annual fee is received after the close of such annual renewal period, the parental leave reduced annual fee will be applied to the following membership year. The parental leave reduced annual fee is not available for holders of a certificate of registration authorizing supervised practice of a short duration. This Section 18.1.2(d) only applies to annual fees for membership years commencing on or after June 1, 2020; and
- ~~(e)~~(e) for a holder of a certificate of registration in the retired class, 50% of the annual fee set out in Section 18.1.2(a).

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

Motion Title	For Approval: By-law Amendments for Fees relating to the Retired Class of Registration
Date of Meeting	May 30, 2025

It is moved by _____, and seconded by _____, that:

The Board of Directors¹ of the College of Physicians and Surgeons of Ontario proposes to amend the CPSO By-laws (By-law No. 168) as set out below, after circulation to stakeholders:

1. Section 17.1.1 of the CPSO By-laws is amended by deleting the first sentence thereof and substituting it with the following:

A person who submits an application for a certificate of registration or authorization shall pay an application fee, except that no application fee applies to a person who submits an application for a certificate of registration in the retired class.

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

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

- (a) \$1,725 for a holder of a certificate of registration other than a certificate of registration authorizing postgraduate education, a certificate of registration authorizing supervised practice of a short duration, a certificate of registration authorizing temporary independent practice, a certificate of registration in the retired class, or a certificate of registration authorizing practice as a physician assistant;
- (b) for a holder of a certificate of registration authorizing postgraduate education applying to renew the holder's certificate of registration, 20% of the annual fee set out in Section 18.1.2(a);
- (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;
- (d) despite Sections 18.1.2(a), (b) and (c), where the holder of a certificate of registration will be taking parental leave for a period of four months or longer during the membership year for which the annual fee applies because the holder is pregnant, has recently given birth or will be caring for their newborn or newly adopted child, the annual fee for such membership year is 50% of the annual fee applicable to the holder of the certificate of registration as set out in Sections 18.1.2(a), (b) and (c), so long as the holder applies to the

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*.

College for this parental leave reduced annual fee prior to the close of the annual renewal period for such membership year. If an application for the parental leave reduced annual fee is received after the close of such annual renewal period, the parental leave reduced annual fee will be applied to the following membership year. The parental leave reduced annual fee is not available for holders of a certificate of registration authorizing supervised practice of a short duration. This Section 18.1.2(d) only applies to annual fees for membership years commencing on or after June 1, 2020; and

- (e) for a holder of a certificate of registration in the retired class, 50% of the annual fee set out in Section 18.1.2(a).

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

Title:	By-law Amendments: Emeritus Status (For Decision)
Main Contacts:	Samantha Tulipano, Director, Registration and Membership Carolyn Silver, Chief Legal Officer Marcia Cooper, Senior Corporate Counsel and Privacy 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

- By-law amendments are proposed to phase out the emeritus status program.
- As emeritus status only applies to former members, the status does not contribute to the public interest.

Current Status & Analysis

- Under the By-laws, former members who meet certain requirements may apply for emeritus status. If granted, the status is subject to annual renewal.
- Emeritus status was previously described on the CPSO website as “a distinction granted to physicians who were members in good standing” and who meet the other specified criteria. The reference to “in good standing” comes from the old Regulation 577/75 under the *Health Disciplines Act*. “Good standing” is no longer a term that the College uses.
- The value of emeritus status to former members is not clear. Those with emeritus status receive College publications (i.e. Dialogue). The emeritus status is indicated on the public register beside the former member’s current status: “Expired: Emeritus status as of <date>”.
- While there is no risk of harm to the public in granting emeritus status to a former member who had serious conduct or practice concerns, there may be a risk to the reputation and credibility of the College in granting a distinction to a member who is not seen by the public as appropriate based on their history with the College.
- It is proposed that the emeritus status program be phased out such that no new grants of emeritus status would be made as of the effective date of the By-law amendment. Those who already have emeritus status will maintain their status without the need to renew annually. However, if any of the conditions that were required for granting and renewing the status are not met (see Appendix A), the College may terminate that status on 30 days’ notice.
- Practically, the College has not been actively offering emeritus status to former members, and has been waiving the annual renewal process for those with the status, for about five years. It was very rare for a person’s application to renew their emeritus status to be denied, which called into question the purpose of the resource expenditure associated with the annual renewal process.
- It is preferable for the By-laws to be amended to reflect the state of the program for transparency and clarity. See **Appendix A** for the proposed By-law amendments (redlined).
- The proposed By-law amendments do not need to be circulated to the profession prior to approval by the Board. However, there will need to be communication to the profession about the changes.
- The Board is asked to approve the proposed By-law amendments.

APPENDIX A

PROPOSED BY-LAW AMENDMENTS FOR EMERITUS STATUS

ARTICLE 24 EMERITUS STATUS

24.1 Emeritus Status

24.1.1 ~~As of [DATE BY-LAW AMENDMENT APPROVED], no person shall be eligible for a new grant of emeritus status, whether by the Registrar or by the Registration Committee. may grant emeritus status to a former holder of a certificate of registration.~~

~~24.1.2 A person who has emeritus status as of [DATE BY-LAW AMENDMENT APPROVED] shall continue to have emeritus status, without any need to apply for renewal of such status, provided that if any of the following conditions are not met at any time, the person's emeritus status shall terminate 30 days after written notice by the College: of any class who applies therefore and who:~~

~~has held a certificate of registration authorizing independent practice, a General licence under Part III of the *Health Disciplines Act* or the equivalent licence under a predecessor of such Act, or some combination of them, continuously for 25 years;~~

- (a) ~~the person~~ has not been the subject of a finding of professional misconduct or incompetence that has been entered in the Register;
- (b) ~~at the time of application, the person~~ is not:
 - (i) in default of payment of any fee payable to the College;
 - (ii) in default of providing to the College any information required by or under an Act or regulation; and
 - (iii) is not the subject of proceedings for professional misconduct or incompetence; and

~~(c) the person~~ is fully retired from the practice of medicine.

~~24.1.2 The Registration Committee may grant emeritus status to a former holder of a certificate of registration of any class who applies therefore and complies with Sections 24.1.1(c) and 24.1.1(d).~~

24.1.3 A person with emeritus status may not practise medicine.

~~24.1.4 A Registrant who was designated as a life member under section 43 of Ontario Regulation 577/75 or a predecessor thereof shall be deemed to continue as a person with emeritus status but a life member who continues to meet the requirements of section 43 of Ontario Regulation 577/75 may elect to maintain their life membership.~~

24.2 Expiry and Renewal of Emeritus Status

~~24.2.1 The Registrar shall provide an application for renewal to each person with emeritus status and each life member at the person's last known address or e-mail address before April 15 in each year, together with notification that the person's emeritus status or life membership will expire unless the completed application for renewal is received by the Registrar by the following May 31.~~

~~24.2.2 An emeritus status and a life membership expire unless the Registrant's completed application for renewal is received by May 31 of each year.~~

~~24.2.3 The Registrar shall, and the Registration Committee may, renew the emeritus status of a person whose emeritus status has expired on the same basis as the Registrar or the Registration Committee may grant emeritus status under Section 24.1.~~

~~24.2.4 A life membership which expires may not be renewed, but a life member whose membership has expired is entitled to emeritus status.~~

Motion Title	For Approval: By-law Amendments - Emeritus Status
Date of Meeting	May 30, 2025

It is moved by _____, and seconded by _____, that:

The Board of Directors¹ of the College of Physicians and Surgeons of Ontario amends the CPSO By-laws (By-law No. 168) as set out below:

1. Article 24 of the CPSO By-laws is revoked and substituted with the following:

ARTICLE 24 EMERITUS STATUS

24.1 Emeritus Status

- 24.1.1 As of **[DATE BY-LAW AMENDMENT APPROVED]**, no person shall be eligible for a new grant of emeritus status, whether by the Registrar or by the Registration Committee.
- 24.1.2 A person who has emeritus status as of **[DATE BY-LAW AMENDMENT APPROVED]** shall continue to have emeritus status, without any need to apply for renewal of such status, provided that if any of the following conditions are not met at any time, the person's emeritus status shall terminate 30 days after written notice by the College:
 - (a) the person has not been the subject of a finding of professional misconduct or incompetence that has been entered in the Register;
 - (b) the person is not:
 - (i) in default of payment of any fee payable to the College;
 - (ii) in default of providing to the College any information required by or under an Act or regulation; and
 - (iii) is not the subject of proceedings for professional misconduct or incompetence; and
 - (c) the person is fully retired from the practice of medicine.
- 24.1.3 A person with emeritus status may not practise medicine.

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*.