CPSO

Meeting of Council

September 10 & 11, 2020

CPSO

NOTICE

OF

MEETING OF COUNCIL

A virtual meeting of the College of Physicians and Surgeons of Ontario (CPSO) will take place on Thursday, September 10 and Friday, September 11, 2020. Due to the current pandemic situation, an in-person meeting at a physical location will not be held.

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

The meeting will convene at 12:00 Noon.

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

(Revised September 1, 2020)

Council Meeting Agenda

September 10-11, 2020

Thursday, September 10, 2020

Item	Time	Topic and Objective(s)	Purpose	Page
1	12:00pm	**Call to Order and Welcoming Remarks** (B. Copps) • Welcome Council members and guests, conduct roll call and declare any conflicts of interest	Discussion	N/A
2	12:05pm	**Consent Agenda** (B. Copps) **2.1 Approve of Council meeting agenda** **2.2 Approve minutes from Council held May 28, 2020** **2.3 Items for information:** • Discipline Committee Report • Governance Equity, Diversity and Inclusion Initiative • Executive Committee Report • Government Relations Report • Policy Report • Office of the Chief Forensic Pathologist • Reserve Fund Policy	Approval	**3** **7** **9** **18** **25** **30** **32** **36** **41** **43**
3	12:10pm	**Quality Improvement Program - Motion** (B. Copps) • Consider for approval a motion regarding the Quality Improvement Program	Decision	**46**
*	12:20pm	**LUNCH**		
4	1:20pm	**Staff Introductions** (B. Copps) • Facilitate introductions of senior leaders and other key staff	Discussion	N/A
5	1:45pm	**Registrar's Report** (N. Whitmore) • Receive key updates from the Registrar/CEO and learn about the progress being made in key CPSO initiatives	Discussion	N/A
6	2:45pm	**President's Report** (B. Copps) • Receive key updates from the President and learn about any issues that may be relevant for Council	Discussion	N/A

Item	Time	Topic and Objective(s)	Purpose	Page
7	**3:00pm**	**Governance Committee Report** (P. Poldre) **7.1** Committee Chair/Vice-Chair Model **7.2** Election of 2020-2021 Academic Representatives on Council **7.3** 2020-2021 Chair Appointments **7.4** Request for Exceptional Circumstances **7.5** Committee Appointment	 Decision Decision Decision Decision Information	**49**
*	**3:25pm**	**NUTRITION BREAK**		
8	**3:45pm**	**Overview of Policy Process** (C. Roxborough) • Review CPSO's policy development and review process	Information	**N/A**
9	**3:50pm**	**Telemedicine Policy Review Kick-off** (T. Terzis) • Engage early in CPSO's process to review and update the Telemedicine policy	Discussion	**67**
10	**4:10pm**	**Members Topics** (B. Copps) • Discuss any issues that Council members have raised in advance of the meeting	Discussion	**N/A**
11	**4:25pm**	**Council Award Presentation** (D. Rouselle) • Celebrate the achievements of Dr. Stephanie Milone and Dr. Stephen Milone from Orangeville	Discussion	**71**
*	**4:40pm**	**Adjournment Day 1** (B. Copps) • Remind Council members of the start time for the second meeting day of Council	Discussion	**N/A**

Friday, September 11, 2020

Item	Time	Topic and Objective(s)	Purpose	Page
12	**9:00am**	**Call to Order** (B. Copps) • Participate in roll call and declare any conflicts of interest	Discussion	**N/A**
13	**9:05am**	**Guest Presentation: Physician Burnout** (K. Milne) • Engage in a dynamic discussion with Dr. Ken Milne about physician burnout in Ontario. Dr. Milne is the Chief of Staff at South Huron Hospital Association and Adjunct Professor in the Department of Medicine and Department of Family Medicine at the Schulich School of Medicine and Dentistry	Discussion	**N/A**
14	**10:05am**	**Third Party Medical Reports** (E. Everson) • Consider whether the draft policy can be released for external consultation and engagement	Decision	**73**
*	**10:35am**	**NUTRITION BREAK**		
15	**10:55am**	**Executive Committee Elections** (P. Poldre) • Participate in the process to select the members of the 2021 Executive Committee (Council members will need to have access to their CPSO email to vote)	Decision	**103**
16	**11:15am**	**Delegation of Controlled Acts** (B. Copps) • Consider whether the draft policy can be released for external consultation and engagement	Decision	**113**
17	**11:45am**	**Council Award Presentation** (A. Turner) • Celebrate the achievements of Dr. Nicole Laferriere from Thunder Bay	N/A	**137**
18	**12:00pm**	**Motion to Go In Camera** • Consider for approval a motion to move in camera	Decision	**138**
*	**12:05pm**	**IN CAMERA**		
*	**12:30pm**	**LUNCH**		

Item	Time	Topic and Objective(s)	Purpose	Page
19	**1:30pm**	**CPSO Presidential Compensation** (P. Pielsticker) • Consider for approval the Finance and Audit Committee's recommendations regarding the compensation framework for the CPSO President	Decision	**139**
20	**1:45pm**	**Application of Blood Borne Viruses Policy to Emergency Medicine Physicians** (J. Wilson) • Discuss and consider for approval proposed amendments to the policy	Decision	**146**
21	**2:05pm**	**Reduced Membership Fees for Parental Leaves** (S. Tulipano) • Consider for approval the Finance and Audit Committee's recommendations regarding the reduction in membership fees for physicians on parental leave	Decision	**151**
*	**2:20pm**	**NUTRITION BREAK**		
22	**2:40pm**	**By-Law Amendments to Reflect Solis Processes** (N. Novak) • Discuss and consider for approval proposed by-law amendments to facilitate the implementation of Solis	Decision	**157**
23	**2:50pm**	**Enterprise System Release 1 Preview** (Deloitte) • Preview CPSO's exciting new enterprise system in advance of the launch in mid-September	Information	**N/A**
24	**3:35pm**	**Professional Responsibilities in Medical Education** (J. Van Vlymen) • Consider whether the draft policy can be released for external consultation and engagement	Decision	**165**
*	**4:05pm**	**Adjournment Day 2** (B. Copps) • Reminder that the next meeting scheduled for December 3-4, 2020	Discussion	**N/A**
*	**4:10pm**	**Meeting Reflection Session** (B. Copps) • Share observations about the effectiveness of the meeting and engagement of Council members	Discussion	**N/A**

Council Motion

Motion Title: Council Meeting Consent Agenda

Date of Meeting: September 10-11, 2020

It is moved
by_____,

and seconded by_____,
that:

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

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

or

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

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

With the following corrections:

DRAFT PROCEEDINGS OF
THE MEETING OF COUNCIL
OF
THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
MAY 28, 2020

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

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

Regrets:
Ms. Ellen Mary Mills

1. Call to Order and Welcoming Remarks

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

B. Copps then gave a traditional land acknowledgement statement as a demonstration of recognition and respect for Indigenous peoples.

B. Copps conducted a roll call, and named staff attending. She introduced norms for the virtual meeting. No conflicts were declared. It was noted that due to the Covid-19 pandemic, the presentation of the Council Award would be deferred to a future meeting of Council.

2. Consent Agenda

01-C-05-2020

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

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

- Meeting agenda for May 28, 2020
- Meeting minutes of Council held on March 6, 2020
- For information items:
    - Discipline Committee Report
    - Executive Committee Report
    - Governance Committee Report
    - Policy Report

CARRIED

3. Covid-19 Update on Strategic Activities in Response to the Pandemic

Fiona Hill-Hinrichs, Director of Communications and Media, outlined the communications and policy activities that have been completed in response to the pandemic, including providing physician and patient resources, ventilator procurement and critical care triaging, registration, licensure and health human resources.

Craig Roxborough, Manager of Policy, provided an overview of Directive #2 which was amended and allows for gradual resumption of non-essential care, and noted that CPSO posted guidance for patients and physicians on the website.

4. Registrar/CEO Report

Dr. Nancy Whitmore shared that organization has been nimble in responding to the pandemic. Under the leadership of the Transformation Office, CPSO successfully transitioned staff to work remotely within five days. Some non-critical work has been put on hold while innovation has accelerated as some areas are finding ways to operate more efficiently in the virtual environment. For example, Discipline Hearings are being held virtually and the College will be having its first contested hearing.

Despite the pandemic, the organization has been meeting the key performance indicator targets that Council approved. Notably:

- The number of ongoing cases dropped by almost two-thirds (62%) since the start of 2018

- We have more than halved the amount of time to complete an investigation since Q1 of 2019.
- The time it takes to write an ICRC decision dropped by 89% since June 2018, from 26.4 weeks to 2.86 weeks.
- We are contacting complainants more quickly upon receipt of a complaint; it took 21 business days to contact a complainant in the first half of 2018 and only two days by the first half of 2019.
- 85% of participants in our Quality Improvement pilot project found the program valuable for learning and identifying areas of improvement.
- There are currently 1,290 family physicians participating in the Quality Improvement Program.

It is unclear how long the pandemic will last so there is a degree of flexibility that needs to be maintained regarding expectations in meeting all the key performance indicator targets.

N. Whitmore highlighted how CPSO has maintained communications with the profession, being mindful of the frequency, tone and topic of the messages. Council members shared that feedback from the profession has been positive overall and that physicians appreciate CPSO's consideration to their role in responding to Covid-19.

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

5. President's Report

B. Copps shared feedback from the last meeting's evaluation and highlighted the improvements that have been made in response to Council member suggestions. She noted the move by the Executive Committee to virtual meetings, the postponed CPSO Council elections; annual renewal process, government outreach and work underway to develop the patient-facing Continuity of Care Companion document.

6. Audit and Financial Statements for 2019

02-C-05-2020

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

The Council appoints Tinkham LLP, Chartered Accountants, as auditors to hold office until the next financial meeting of the Council.

CARRIED

03-C-05-2020

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

The Council approves the financial statements for the fiscal year ended December 31, 2019 as presented (a copy of which form **Appendix "B"** to the minutes of this meeting).

CARRIED

7. By-Law Amendments to Reflect New System Processes

04-C-05-2020

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

The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 136:

By-law No. 136

(1) Subsection 51(3.1) of the General By-law is revoked and the following is substituted:

3.1 (a) In this section "premises" and "procedure" have the definitions that are set out in s.44(1) of Ontario Regulation 114/94 made under the *Medicine Act 1991*;

b) Every member who performs a procedure in a premises subject to inspection under Part XI of Ontario Regulation 114/94 shall report to the College, in writing or electronically as specified by the College, within 24 hours of learning of any of the following events:

(i) Death within the premises;

(ii) Death within 10 (ten) days of a procedure performed at the premises;

(iii) Any procedure performed on wrong patient, site, or side; or

(iv) Transfer of a patient from the premises directly to a hospital for care.

(c) In addition to reporting the event, the member shall provide all information underlying the event to the College in writing or electronically as specified by the College and in an Adverse Events Reporting form approved by the College.

(2) Section 51b of the General By-law is revoked and the following is substituted:

51b. Every health profession corporation that holds a certificate of authorization from the College shall provide the Registrar with notice, in writing or electronically as specified by the College, of any change in the shareholders of such corporation, who are members of the College, within fifteen (15) days following the occurrence of such

change. The notification shall include the identity of the shareholder who has ceased to be a shareholder, and the identity of any new shareholder(s), and the date upon which such a change occurred. The notification shall be signed by a director of the health profession corporation. The notification may be sent (i) electronically as specified by the College, or (ii) in printed form by regular mail, courier or personal delivery addressed to the Registrar, in care of the Registration Department of the College, re: Notice of Shareholder Change. The Registrar may from time to time approve one or more standard forms (printed and/or electronic) for the purposes of providing the notice required by this section and where any such form has been approved, the notice shall be submitted in the applicable approved form.

(3) Subsection 53(1) of the General By-law is revoked and the following is substituted:

Expiry and Renewal of Emeritus Status

53. (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.

CARRIED

By-law Amendments to Reflect New CPSO System Processes (By-law No. 137)

05-C-05-2020

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

The Council of the College of Physicians and Surgeons of Ontario proposes to make the following By-law No. 137, after circulation to stakeholders:

By-law No. 137

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

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

(a) his or her home address;

(b) an e-mail address for communications from the College and the address of all locations at which the member practices medicine;

(c) a description or confirmation of the services and clinical activities provided at all locations at which the member engages in medical practice;

(d) the names, business addresses and telephone numbers of the member's associates and partners;

(e) information required to be maintained on the register of the College;

(f) information respecting the member's participation in continuing professional development and other professional training;

(g) the types of privileges held at each hospital at which a member holds privileges;

(h) information that relates to the professional characteristics and activities of the member that may assist the College in carrying out its objects, including but not limited to:

(i) information that relates to the member's health;

(ii) information about actions taken by other regulatory authorities and hospitals in respect of the member;

(iii) information related to civil lawsuits involving the member;

(iv) information relating to criminal arrest(s) and charge(s); and

(v) information relating to offences.

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

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

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

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

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

CARRIED

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

By-law Amendments to Reflect New CPSO System Processes (By-law No. 138)

06-C-05-2020

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

The Council of the College of Physicians and Surgeons of Ontario proposes to make the following By-law No. 138, after circulation to stakeholders:

By-law No. 138

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

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

CARRIED

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

8. Member Topics

Council Observers OMSA and PARO

Ms. Sharon Yeung from the Ontario Medical Students Association (OMSA), discussed her involvement with OMSA. She described OMSA's positive collaboration with CPSO, citing a review of the CPSO policy on undergraduate medical education and conversations about the registration process, including mental health disclosure. She shared feedback from students on registration issues.

Dr. Catherine Brown from the Professional Association of Residents of Ontario (PARO) discussed work that PARO has done to support physicians, including training and work hours and thanked the CPSO for its work and flexibility in helping facilitate graduating residents, transitioning to practice, and more.

Remarks from Council Members

Dr. Elizabeth Samson asked the College to reduce the 2020 annual fee for physicians by 25 to 50% in consideration of the challenges facing the profession at this time.

9. Motion to Go In Camera

07-C-05-2020

It is moved by R. Smith and seconded by L. Miljan that:

The Council exclude the public from the part of the meeting immediately after this motion is passed, under clause 7(2)(d) of the *Health Professions Procedural Code*.

CARRIED

10. Exceptional Circumstances

08-C-05-2020

It is moved by J. Fisk and seconded by D. Hellyer that:

Council approves, in principle, that the exceptional circumstances clause in Section 37(8) of the General By-law be applied in respect of the following members of the Committees listed below when their appointments expire at the Annual General Meeting of Council in December 2020:

Inquiries, Complaints and Reports Committee:

- Dr. Stephen Whittaker
- Dr. Anil Chopra
- Dr. Haig Basmajian
- Dr. Robert Hollenberg

Registration Committee:

- Dr. Bob Byrick
- Dr. Barbara Lent

Discipline Committee:

- Dr. Pamela Chart
- Dr. Melinda Davie
- Dr. Robert Sheppard
- Dr. Eric Stanton
- Dr. Dennis Pitt
- Dr. Steven Bodley

Fitness to Practise Committee:

- Dr. Steven Bodley

CARRIED

11. Council Elections

Laurie Cabanas, Director of Governance and Policy, discussed the postponement of the 2020 Council Elections for Districts 5 and 10 from spring to September due to the COVID pandemic.

09-C-05-2020

It is moved by R. Smith and seconded by L. Miljan that:

The Council approves the 2020 district election date set out below:

Districts 5 and 10 - September 29, 2020

CARRIED

12. Adjournment

B. Copps adjourned the meeting at 2:45 pm.

_____

Dr. Brenda Copps, President

_____

Alexandra Wong, Recording Secretary

CPSO

Council Briefing Note

September 2020

TOPIC: Discipline Committee Report of Completed Cases – May 11, 2020 to August 21, 2020

FOR INFORMATION

ISSUE:

This report covers the 13 discipline cases completed (i.e., the written decision and reasons on finding and, if applicable, penalty have been released) between May 11, 2020 and August 21, 2020.

BACKGROUND:

The report consists of two tables:

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

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

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

- The Committee's decision is available for viewing from the physician's public register profile on the College's website. It contains the full text Discipline Committee's decision and reasons document.
- If you experience any difficulty opening a hyperlink, please use "Control-click" or right click on the blue text and select "open hyperlink".

- Physicians' names in the first column of each table are hyperlinked to let you navigate back and forth from the liability findings in Table 1 to the penalty findings in Table 2, for each physician.

SUMMARY:

In the period reported, the Discipline Committee released 13 decisions and reasons (D&Rs)

- 9 D&Rs set out findings on liability and the Committee's penalty order
- 0 D&Rs set out findings on liability and a penalty hearing is to be scheduled
- 3 D&Rs set out the Committee's penalty order (cases where findings were made previously)
- 1 D&R set out the Committee's decision on a Reinstatement application.

In the 12 D&Rs that included a penalty order, the Committee's orders included:

- 10 reprimands
- 7 suspensions
- 6 impositions of Terms, Conditions or Limitations on the physician's Certificate of Registration
- 2 revocations.

The Committee imposed a costs order on the physician in 10 D&Rs.

DECISION FOR COUNCIL:

- This item is for information

Contact: Moira Calderwood (Counsel HPP), ext. 370
Elaine Stone (Manager), ext. 479

Date: August 28, 2020

TABLE 1: DISCIPLINE DECISIONS (MAY 11 – AUGUST 21, 2020) – FINDINGS

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

PHYSICIAN NAME (Click the Hyperlink to see Table 2 for Penalty Details)	DECISION Release Date and Link to CPSO Public Profile	FINDINGS							
		With Penalty or Both	Sexual Abuse	Incompetence	Found guilty of offence relevant to practice	Failing to maintain the standard of Practice	DDU	Conduct Unbe-oming	Contravened a TCL on Certificate of Registration
Jamal, Abida Sophie (Reinstatement)	May 11 2020	n/a							
Khan, Farooq Ali	May 29 2020	Penalty only							
Yazdani Boroujeni, Fereshteh	June 9 2020	Both					✓		✓
Shamji, Mohammed Farid	June 9, 2020	Both			✓				
Raddatz, Elaine	June 24, 2020	Both					✓		

Dhanoa, Avtar Singh	June 26, 2020	Both			✓		✓		
Martinez, Lionel Gines	July 6, 2020	Both				✓	✓		
Singh, Kunwar Raj	July 6, 2020	Both							✓
Uzoh, Chizoba Christopher	July 8, 2020	Both					✓	✓	
Nadon, Fernand Gaston Vincent	July 14, 2020	Both	✓		✓		✓		
Islam, Md Ashiqul	July 7, 2020	Penalty only							
Rabiu, Adegbenga Olusaseun	July 29, 2020	Penalty only							
Smith, Edward James	August 21, 2020	Both						✓	

TABLE 2: DISCIPLINE DECISIONS (MAY 11 – AUGUST 21, 2020) – PENALTIES

Physician Name (Click the Hyperlink to Return to Table 1 For Findings)	**Revocation**	**Suspension/ Length**	**Reprimand**	**TERM, CONDITION, LIMITATION**			**Costs/ Comment**
				Clinical supervision	**Prescribing restrictions**	**Other**	
Jamal, Abida Sophie (Reinstatement)							Order granted reinstatement with TCLs including clinical supervision; no costs of hearing ordered
Khan, Farooq Ali							No penalty or costs ordered. (Decision under appeal)
Yazdani Boroujeni, Fereshteh		✓ **6 months**	✓			✓	Costs: $6000
Shamji, Mohammed Farid	✓		✓				No costs order
Raddatz, Elaine		✓ **6 months**	✓			✓	Costs: $6000

Physician Name (Click the Hyperlink to Return to Table 1 For Findings)	Revocation	Suspension/ Length	Reprimand	TERM, CONDITION, LIMITATION			Costs/ Comment
				Clinical supervision	Prescribing restrictions	Other	
Dhanoa, Avtar Singh		✓ 5 months	No			✓	Costs: $6000
Martinez, Lionel Gines		✓ 12 months	✓	✓		✓	Costs: $6000
Singh, Kunwar Raj			✓				Costs: $6000
Uzoh, Chizoba Christopher		✓ 9 months	✓				Costs: $10,390
Nadon, Fernand Gaston Vincent	✓		✓				Costs $6,000, plus $786,940 (to reimburse the College for funding provided to patients under section 85.7 of the Code)
Islam, Md Ashiqul		✓ 4 months	✓			✓	Costs $31,110

Physician Name (Click the Hyperlink to Return to Table 1 For Findings)	Revocation	Suspension/ Length	Reprimand	TERM, CONDITION, LIMITATION			Costs/ Comment
				Clinical supervision	Prescribing restrictions	Other	
Rabiu, Adegbenga Olusaseun		✓ 4 months	✓			✓	Costs: $29,036
Smith, Edward James			✓				Costs: $6,000.00

Council Briefing Note

September 2020

TOPIC: **Governance Equity, Diversity and Inclusion Initiative**

FOR INFORMATION

ISSUE:

- In June, the Governance Committee directed staff to consider opportunities for increasing diversity on CPSO Council and Committees.
- Staff brought an initial plan to the Governance Committee in July and further work is now being considered.
- Council is provided with a summary of the relevant background, work undertaken so far and possible next steps.

BACKGROUND:

- In advance of the 2020 Council elections and the fall recruitment for new Committee Members, the Governance Committee discussed strategies for encouraging physicians to run/apply for these positions, and specifically, how CPSO could work to increase the diversity of our Council and Committees.
- The Governance Committee directed staff to target outreach to groups and associations with memberships that are underrepresented on Council and to develop a Diversity and Skills Matrix to support this diversification and act as a natural starting place for any equity, diversity, inclusion work at CPSO.

CURRENT STATUS:

Outreach

- Following the direction of the Governance Committee, staff sought to identify diverse physician groups and associations that could be targeted for outreach for the upcoming Council elections.
- Research revealed that there are few active organizations of this kind in Ontario; the main active organization is the Black Physicians Association of Ontario.
- A letter was sent to the Black Physicians Association of Ontario with a request to share information about our Council elections and Committee appointments with their membership.
- An initial conversation between CPSO and the Black Physicians Association of Ontario staff occurred which was very positive and future opportunities for collaboration are being explored.

Research

- In part due to the limited opportunities for outreach to diverse physician groups, and also to support broader equity, diversity and inclusion work, staff undertook an initial scan of the relevant research and best practices at regulators and non-corporate boards in order to determine what an equity, diversity, and inclusion initiative could entail for CPSO.
- This research revealed numerous examples of equity, diversity and inclusion work at other regulatory organizations and governing boards and underscored a relatively substantial body of research and best practices related to this work.
- A main takeaway of this research was that in order to not fall into tokenism, we must move beyond a diversity of representation, into equity and inclusion and that we must see this work as long-term and achieved in stages.
- Our work has been guided by this research and its findings.

Governance Education Session

- The Governance Committee, as part of this work, invited Dr. Javeed Sukhera to facilitate an education session at their July 27th meeting.
- Dr. Sukhera is Associate Professor of Psychiatry and Paediatrics at the Schulich School of Medicine and Dentistry, Western University. In addition to his practices in the Paediatric Chronic Pain, Child and Adolescent Mental Healthcare and Transcultural Mental Health Programs at London Health Sciences Centre, he also runs an interdisciplinary research program exploring novel approaches to stigma reduction and bias recognition and management in health professionals. Dr. Sukhera also works with organizations on equity, diversity, and inclusion and is regularly invited to deliver workshops, keynotes, and lectures.
- Dr. Sukhera gave a talk that focused on foundational concepts related to diversity, equity and inclusion and shared his research on bias and creating a culture of belonging. He challenged the Committee to engage in critical self-reflection and explained the vital importance of empathy.
- The Governance Committee found Dr. Sukhera's talk informative and thought-provoking and continue; based on positive feedback Dr. Sukhera has been invited as a guest speaker to the December meeting of Council.

Diversity and Skills Matrix

- Also, at the July 27th Governance Committee meeting, staff gave the Committee an overview of research and findings to-date and presented the Committee with a draft Diversity and Skills Matrix that can be used for Council and Committees.
- A Diversity and Skills matrix is a multi-faceted tool and a good governance practice used by boards across many different sectors,[1] and it can provide a comprehensive snapshot of current Council/Committee members' and Committee applicants' skills and perspectives.
- The Maytree Foundation argues that surveying the demographics of board/committee members and applicants by using a Diversity and Skills Matrix can help to "build an applicant pool that

[1] See for example: Vancouver Airport Authority Board of Directors; New York City Comptroller's Board Accountability Project 2.0 which included many large public corporations adopting the use of a Diversity and Skills Matrix; Harbourfront Centre (see Maytree Foundation, *Diversity in Governance: A Toolkit for Nonprofit Boards*, 2011 [Maytree Report]); and Family Services Toronto (see Maytree Report).

better reflects the diversity of the population you serve and who will bring the range of perspectives and experience needed to govern well."[2]

- The matrix asks applicants and current Council/Committee members to rank their skill-level/experience on a high-to-low scale in areas such as legal skills, French proficiency, technological adeptness, risk management, among others.
- In addition to collecting professional information—i.e. year of medical school graduation, specialty, practice setting and locale, etc.—the "Identity/Background" component of the drafted matrix aims to gather information on a Council/Committee member or applicant's ethno-cultural background and lived experiences through the optional self-identification categories.
- A matrix can help identify any gaps among the current Council and Committee composition and allow staff to consider making appointments, or targeting outreach for applicants, to better represent those areas. In this way, a matrix is an initial step towards creating a culture of inclusion and belonging both at the College governance-level and in the profession writ large.
- The matrix aligns with our current Governance Modernization initiative to move to a competency-based board selection process.[3]
- Staff will be using this matrix in the upcoming Committee recruitment process and further consideration will be given as to how it could be used to support diversification of Council.

Coordination Among Health Regulatory Colleges

- The Health Professions Regulators of Ontario has established a working group focused on diversity, equity and inclusion; an initial meeting took place to learn about the various initiatives underway and identify common approaches.
- A Terms of Reference for the working group is being developed; CPSO is represented on the working group and additional information about the outputs of the group will be shared as they become available.

NEXT STEPS:

- Education/training sessions for the Senior Management Team, Executive Committee, and staff need to be considered as do opportunities to expand equity, diversity, and inclusion work at CPSO, beyond governance.
- Staff will continue to identify best practices and work up potential next steps in an equity, diversity, inclusion strategy for CPSO.
- The topic of equity, diversity, and inclusion is being incorporated into the December meeting of Council.

Contact: Miriam Barna, ext. 557
Laurie Cabanas, ext. 503

Date: August 21, 2020

[2] Maytree Report at 12.
[3] See CPSO submission to government to reduce red tape.

Attachments:

Appendix A: Draft Diversity and Skills Matrix for Council and Committees

Appendix A

Instructions:

1. Please feel free to fill in the Identity/Background* options in any manner that you are most comfortable with or best describes your identity/experience (e.g. by simply placing a checkmark in the appropriate option, or by providing specifics on your cultural/ethnic background or gender, etc.). You may also leave the options blank if they are not applicable to you or if you prefer not to self-identify.

2. For Practice Setting and Locale**, the please fill in the number(s) and letter(s) that best captures your practice setting (e.g. 1A & 2D):

   1) Urban Centre 2) Mid-size City 3) Rural 4) Northern

   A. Hospital B. Solo Practice C. Group Practice D. Community Setting E. Specialty F. Academic

3. For Skills/Knowledge/Experience***, please check the number that best represents your skill/expertise in the specified area. This section is mandatory. The numbers are ranked as follows:

   1) None 2) Low 3) Medium 4) High

Name	**Professional Information**				**Identity/Background***						**Skills/Knowledge/Experience*** (Will vary by Committee)																				
	CPSO District	Specialty	Year of MD Graduation	Practice Setting & Locale**	Gender Identity	Ethnic/Cultural Identity	Indigenous	Person with Disability	2SLGBTQ+	Other[1]	Adult Learning & Education	Anti-Racism/Oppression Training	Board & Governance	Business Skills	Experience Working w/Equity-seeking Groups	Finance & Accounting	French Proficiency	Govt & Govt Relations	Health System Knowledge	Human Resources/People Management	Leadership	Legal Skills	Policy Development	Professionalism & Ethics	Professional Regulation	Risk Management	Strategic Planning	Technological Proficiency	Other
											1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
											2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	
											3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	
											4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	

[1] Examples: immigration status; language(s) spoken; low-income; etc.

CPSO

Council Briefing Note

September 2020

TOPIC: Executive Committee Report

FOR INFORMATION

- The Executive Committee met on June 23, 2020.

- Sheila Laredo, Chief Medical Advisor, and Shandelle Johnson, Director, Quality Management Division, discussed in detail the Quality Improvement program.

- Brenda Copps, Chair of the Executive Committee, highlighted some concerns raised by Quality Assurance Committee members regarding the transition from the Quality Improvement pilot to the Quality Improvement program.

- Two motions were passed by the Quality Assurance Committee at its June 12, 2020 meeting that were provided to the Executive Committee for consideration which were:
    - that the former PATHWAYS program be used as a data set to assess the concordance of peer assessment and self-assessment, and the results reviewed by the Quality Assurance Committee; and
    - that random peer assessment for physicians under 70 years of age resume immediately, as a parallel program to the current QI Program.

- Executive Committee Executive Committee members discussed a number of issues including: considerations regarding the use of peer assessments, enhanced communication regarding the Quality Improvement program, the roles of Medical Advisors and Quality Improvement Coaches, data collection and comparison of the Quality Assurance and Quality Improvement programs and the importance of continuing to work collegially together to serve the interest of the public.

- Following consideration of the two Quality Assurance Committee motions, and discussion regarding the Quality Assurance Committee's concerns, the Executive Committee determined that: the motions would not be forwarded to Council, as Council has already provided its strategic direction; and that B. Copps would, on behalf of the Executive Committee, communicate this and additional feedback to the Quality Assurance Committee, at its next meeting.

3-EX-June-2020• Upon a motion by P. Poldre and seconded by P. Pielsticker and CARRIED, the Executive Committee directed that, in response to the motions raised by the Quality Assurance Committee, B. Copps will attend the Quality Assurance Committee meeting in advance of Council to convey that the motions would not be forwarded to Council, provide more information to the Committee about the Quality Improvement program, and confirm that staff would communicate and deliver Quality Improvement data in a consistent and timely way.

- Peeter Poldre, Chair of the Governance Committee, provided the report from the Governance Committee.

5-EX-June-2020• Upon a motion by P. Poldre and seconded by J. Plante and CARRIED, the Executive Committee appoints Dr. Trevor Bardell, to the Inquiries, Complaints and Reports Committee for a three-year term.

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

Date: August 25, 2020

Council Briefing Note

September 2020

TOPIC: Government Relations Report

FOR INFORMATION

1. Update on the Ontario Legislature
2. Issues of Interest
    a) Governance Modernization
    b) BC Health System investigation
    c) Physician Assistant Regulation
    d) Long-Term Care COVID-19 Commission
3. Interactions with Government

---

1. UPDATE ON THE ONTARIO LEGISLATURE

- The extended spring/session of the Legislature ended on July 21. The Legislature is scheduled to reconvene on September 14.
- With the emergence of the COVID-19 pandemic, the previous legislative session was anything but typical. Between the middle of March and end of May, the legislature met sporadically to enact legislation responding to the pandemic.
- However, in June and July, the Legislature met more regularly and, in addition to continuing to pass legislation related to the pandemic, government turned its attention back to passing legislation introduced prior to the emergence of the pandemic.
- In total, 18 pieces of legislation were passed since the House reconvened in February. These bills were a mix of responses to the COVID-19 pandemic and legislation that drove the government's broader agenda with regard to: home and community care services, tenants and housing, and changes to the justice system, including legal aid and process improvement changes at the Law Society. None of the Bills passed this session will have a direct impact on CPSO.
- Two Bills have garnered particular attention: Bill 184, Protecting Tenants and Strengthening Community Housing Act and Bill 195, Reopening Ontario (A Flexible Response to COVID-19) Act.
- Bill 184 changes the way that disputes between landlords and tenants are handled and will enable the Landlord and Tenant Board to issue eviction orders without a hearing as well as provide new avenues to collect unpaid rent from current and past tenants. The government has argued that the bill will benefit tenants, however numerous housing groups and Toronto City Council have opposed the legislation. On July 29, Toronto City Council voted 22-2 to initiate legal action to stop the provisions related evictions.

- Bill 195 extends some of the government's emergency powers for up to two years. Premier Ford has called Bill 195 "absolutely critical" but critics of the Bill have noted that it will allow the Premier to impose emergency orders outside of a state of emergency and without the oversight of the Legislative Assembly.
- PC MPP Belinda Karahalios (Cambridge) voted against the Legislation which she described as an "unnecessary overreach on our parliamentary democracy"; she was ousted from the PC Caucus for voting against the Bill and now sits as an Independent.
- MPP Karahalios' departure from the PC Caucus is the fourth for the Ford government, with both Randy Hillier and Jim Wilson ousted from Caucus and now sitting as Independents and Amanda Simard resigning from the PC party to sit as a Liberal MPP.
- There are now 12 Independent MPPs in the Legislature including eight Liberals and the Green Leader. Despite these changes, the PCs still have a strong majority with 72 of 124 seats.

2. ISSUES OF INTEREST

a) Governance Modernization

- As Council will recall, CPSO made a submission to the Minister of Health in Mach 2019 that recommended a series of legislative changes to reduce red tape and bring forward governance modernization at CPSO.
- Since then, staff have engaged government decision-makers in conversations about the importance of bringing forward these changes.
- A presentation summarizing our governance modernization proposal and outlining the efforts to garner government support for these changes will be shared at the September Council meeting.
- Additionally, as part of CPSO's work related to governance modernization, staff have been monitoring the external environment for related developments.
- There are a few recent developments in other provinces including new legislation in Alberta and changes to health professional regulatory colleges in British Columbia.
- Alberta's Bill 30, the Health Statutes Amendment Act, 2020 was introduced by the Minister of Health, Tyler Shandro on July 6, 2020 and received Royal Assent on July 29th. This Bill amended nine pieces of legislation that span across the provincial health care system.
- Although the Bill has received the most attention for the amendments that alter the current salary options for physicians and allow patients to access care through private facilities; Bill 30 also made some notable governance changes to health professional regulatory colleges.
- The amended provisions to the *Health Professions Act* state that public appointees must make up 50% of the Council and committees' membership, which was previously set at 25%. The Colleges will need to revise their by-laws that set out their Council and committee composition in order to meet the new statutory requirement.
- Critics have noted that these changes do not enforce any sort of diversity or competency framework into the selection process for public member appointments, which heightens the potential for greater political influence in the government's future appointments to the Colleges.
- Additionally, the provisions do not provide any guidance with respect to increasing or decreasing the size of their Council in order to meet the composition requirements, leaving this matter at the discretion of the Colleges.
- As the Bill is specific to the Alberta health care system, CPSO is not directly affected by the proposed legislative amendments. However, the Bill is relevant as it aligns with one of the CPSO's governance modernization recommendations to increase the representation of public members on the CPSO Council

to 50% of the total composition. This kind of governance transformation also follows the proposed reforms for the regulation of health professions in British Columbia.[1]

- Staff have been closely monitoring the proposals for regulatory governance reforms that have come out of British Columbia's review led by Harry Cayton and the subsequent Legislative steering committee.
- Although the more substantive proposals for regulatory reform have not moved forward, some more modest changes are currently underway.
- As of August 31, 2020, BC's podiatric surgeons will be regulated under the College of Physicians and Surgeons of BC (CPSBC). On September 1, 2020, an amalgamated BC College of Nurses and Midwives (BCCNM) will be in operation.
- These amalgamations will reduce BC's regulatory health colleges to from 21 to 19, in line with the recommendations for reform.
- The amalgamations were proposed and championed by the four affected Colleges – with a specific request to amalgamate originating from the Councils of the four Colleges – and approved by the Minister of Health.
- Whether BC moves forward with broader reforms to health regulatory colleges remains to be seen. CPSO staff will continue to monitor for developments.

b) BC Health System investigation

- In June 2020, the British Columbia government announced an investigation into allegations of racist behaviours by emergency room healthcare workers towards Indigenous patients. These allegations include ER doctors and nurses playing a "game" where they would guess the blood-alcohol of incoming patients who they presumed to be Indigenous.
- Health Minister Adrian Dix appointed Mary Ellen Turpel-Lafond as the independent investigator. She is a lawyer and law professor at UBC's Peter Allard Law School and a member of Saskatchewan's Muskeg Lake Cree Nation.
- According to its Terms of Reference,[2] the investigation will examine and make recommendations to eliminate Indigenous-specific racism within the BC healthcare system.
- The investigation will include consideration of specific allegations of racism and examination of the institutions in which they took place.
- Most relevant for CPSO, the investigation will also look at any acts or omissions by regulatory authorities and individuals in leadership that may have contributed to systemic racism in the healthcare system, and the scope and effectiveness of any initiatives by those players to address the existence of systemic racism in health professions.
- The investigation's potential recommendations include implementing measures to uphold human rights afforded to Indigenous peoples as articulated in international declarations and national inquiries and commissions,[3] providing both public and professional education to address bias and discrimination towards Indigenous peoples, regulating areas of the healthcare sector that may be relevant to protecting the exercise of Indigenous peoples' human rights, among many others.
- The investigation's final report will be submitted to the BC Minister of Health no later than December 31, 2020.
- This investigation may have far-reaching consequences for the health care system and regulators and could provide important insight as CPSO considers opportunities related to equity, diversity and inclusion initiatives.
- CPSO staff will monitor developments on this file.

[1] See Recommendation 1 under "Governance, conduct and probity" in Harry Cayton, *An Inquiry into the performance of the College of Dental Surgeons of British Columbia and the Health Professions Act* (2018) at 7.1 [Cayton Report].
[2] See https://engage.gov.bc.ca/addressingracism/investigation-details/.
[3] See United Declaration on the Rights of Indigenous Peoples, the Truth and Reconciliation Commission of Canada, and the Missing and Murdered Indigenous Women and Girls Inquiry Calls for Justice.

c) Physician Assistant Regulation

- Council will recall that CPSO has been in conversation with this government, and the previous Liberal government, about the question of regulating physician assistants.
- Council was last updated about this issue in March following an indication from government that they remained committed to moving forward with some form of physician assistant regulation.
- Additional information about physician assistant regulation under CPSO will be provided to Council at its September meeting.

d) Long-Term Care COVID-19 Commission

- On July 29, the government launched an independent commission into COVID-19 and long-term care following more than 1,800 resident deaths and a Canadian Armed Forces report that detailed resident neglect and abuse.
- The Commission will investigate "how COVID-19 spread within long-term care homes, how residents, staff, and families were impacted, and the adequacy of measures taken by the province and other parties to prevent, isolate and contain the virus."
- Three commissioners have been appointed: Frank N. Marrocco, a Superior Court justice, is the Chair; Dr. Jack Kitts, former head of the Ottawa Hospital; and Angela Coke, former senior executive of the Ontario Public Service, have also been appointed.
- While the Premier has stressed that the Commission will be independent from the government, and include powers to compel people, including any Minister or the Premier himself, to testify and produce evidence; questions have been raised about the integrity of the inquiry as the recommendations will not be legally binding.
- The Commission is expected to deliver their report by April 2021.

3. INTERACTIONS WITH GOVERNMENT

- We are now two years into the Ford Government's mandate and significant progress has been made in establishing relationships with the various players.
- Over the course of the COVID-19 pandemic, we have worked to support government initiatives and communications and have been responsive to any inquiries coming from the Ministry, the Minister of Health's office, and individual MPPs.
- With the return of the Legislature in the fall, government relations staff will explore opportunities to re-start our MPP meetings (virtually) in order to support ongoing contact and relationship building with Queen's Park.

Contact: Miriam Barna, ext. 557
Laurie Cabanas, ext. 503

Date: August 21, 2020

CPSO

Council Briefing Note

September 2020

TOPIC: Policy Report

FOR INFORMATION

UPDATES:

1. Policy Consultation Update

    I. *Advertising*
    II. *Social Media – Appropriate Use by Physicians*

2. Policy Status Table

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1. Policy Consultation Update:

I. *Advertising*

- In March 2020 Council approved the draft *Advertising* policy for release for public consultation. As a result of the pandemic, the consultation was initially put on hold only launching in June 2020 with acknowledgement of the unprecedented circumstances but a commitment to the need to resume operating within a "new normal."

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

- The consultation garnered a total of 150 responses: 25 through written feedback and 125 via the online survey.[1] The majority of respondents were physicians.

[1] Organizational responses included: Ad Standards; Canadian Academy of Facial Plastic and Reconstructive Surgery (CAFPRS); Canadian Medical Protective Association (CMPA); College of Physicians and Surgeons of Alberta (CPSA); Kirsten Foss Coaching; Ontario Medical Association (OMA); OMA Section: Eye Physicians and Surgeons of Ontario (EPSO); OMA Section on Plastic Surgery and the OMA Section on Otolaryngology – Head & Neck Surgery; Ontario Trial Lawyers Association (OTLA); and Professional Association of Residents of Ontario (PARO).

- The majority of the feedback received was supportive of and affirmed many of the expectations set out in the draft policy, including the shift to permit the use of before and after photos.

- Notwithstanding this, most respondents also provided constructive suggestions or identified specific concerns. While many of the issues raised relate to obligations set out in the regulation, key issues identified include:

    - The subjective nature of the concepts contained in some expectations (e.g., good taste, dignified, provocative, etc.);

    - The paternalistic nature of prohibiting the advertising of incentives;

    - The use of testimonials and the inability to counter negative reviews on third party websites;

    - The restrictiveness of not be able to be associated with any product or service other than their own medical services; and

    - The limitations or restrictions on the use of before and after photos.

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

II. *Social Media – Appropriate Use by Physicians*

- Following the March 2020 Council meeting, a preliminary consultation on CPSO's *Social Media – Appropriate Use by Physicians* statement was set to begin. As a result of the pandemic, the consultation was initially put on hold only launching in July 2020 with acknowledgement of the unprecedented circumstances but a commitment to the need to resume operating within a "new normal."

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

- As of the Council submission deadline, the consultation received 262 responses: 19 through written feedback and 243 via the online survey. The majority of respondents were physicians.

- Overall, the majority of respondents were supportive of the guidance provided and found the current statement to be clear and comprehensive.

- Notwithstanding this, many respondents provided constructive suggestions and identified areas of concern. Key issues identified included:

    - Clarifying the concepts of “professionalism” and “unprofessionalism” (while avoiding being too prescriptive or too vague, and recognizing that views on “professionalism” are diverse and may inadvertently impact certain groups);

    - Distinguishing between personal vs. professional uses and public vs. private uses of social media;

    - Limiting physicians commenting outside their area of expertise or sharing misinformation (e.g., by ensuring statements are evidence-based);

    - Dealing with unprofessional and negative comments from others; and

    - Using specific and concrete examples of what constitutes inappropriate behavior and elaborating on the consequences of violating these guidelines.

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

2. Policy Status Table:

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

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

DECISION FOR COUNCIL:

1. This item is for information.

Contact: Craig Roxborough, Ext. 339

Date: August 21, 2020

Attachments:

Appendix A: Policy Status Table

Appendix A

Table 1: Current Reviews

Policy	Launch	Stage of Policy Review Cycle						Target Comp.	Notes
		Prelim. Consult	Drafting	Approval to Consult	Consult on Draft Policy	Revising Draft Policy	Final Approval		
Telemedicine	Sep-20	✓						**2022**	A review is underway to review and update the policy.
***Social Media: Appropriate Use by Physicians* (Statement)**	Apr-20		✓					**2021**	A review is underway to review and update the statement.
Statements & Positions Redesign	Jan-20		✓					**2021**	All CPSO *Statements & Positions* are being evaluated for relevance, currency, and potential updates.
Professional Responsibilities in Postgraduate Medical Education* & *Undergraduate Medical Education	Dec-19			✓				**2021**	A joint review is being undertaken and the current policies have been combined into a new draft policy.
Medical Expert* & *Third Party Reports	Dec-19			✓				**2021**	A joint review is being undertaken and the current policies have been combined into a new draft policy.
Advertising	May-19					✓		**2020**	A *new* draft policy has been developed to provide guidance on and set parameters within an existing legislative framework.
Complementary / Alternative Medicine	Mar-19		✓					**2020**	A review is being undertaken to review and update the policy.
Delegation of Controlled Acts	Mar-19			✓				**2020**	A review is being undertaken and a new draft policy has been developed.

Table 2: Policy Review Schedule

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

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

CPSO

Council Briefing Note

September, 2020

TOPIC: Office of the Chief Forensic Pathologist

FOR INFORMATION

ISSUE:

- The Office of the Chief Forensic Pathologist has approached the College for assistance with its oversight of forensic pathologists and to enhance information sharing with the College. The College is developing a Memorandum of Understanding (MOU) to achieve these goals.

BACKGROUND:

- The Goudge inquiry, which was a systemic review of pediatric forensic pathology in Ontario, resulted in changes to the *Coroner's Act* in 2008. These changes created the Office of the Chief Forensic Pathologist and the requirement that the Chief Forensic Pathologist create and maintain a registry of forensic pathologists. To practice as a forensic pathologist in Ontario, a physician must be on the Pathologists' Register. The Chief Forensic Pathologist must ensure that physicians are appropriately trained and credentialed to be added to the register, and also decide when to remove physicians from the register.

- The Office of the Chief Forensic Pathologist is seeking the College's assistance with respect to its oversight of forensic pathologists and seeking to enhance information sharing between the College and the Office of the Chief Forensic Pathologist.

CURRENT STATUS:

- To achieve the goals of collaboration, assistance and information sharing using existing CPSO tools and processes, we have proposed the following, which will be formalized in an MOU:

    - **Office of the Chief Forensic Pathologist Credentialing Process**: Upon request, the College will issue a Certificate of Professional Conduct (CPC) to the Office of the Chief Forensic Pathologist in respect of a College member.

The content of CPCs are described in Federation of Medical Regulatory Authorities of Canada's Policy on Disclosure of Personal Information.

- **Investigations:** Where the College is investigating a forensic pathologist, the College will share information with the Office of the Chief Forensic Pathologist to the greatest extent possible. CPSO will also make efforts to have select investigators assigned, enabling them to develop expertise and to streamline communication between the two organisations.

- **Joint Investigations**: Joint investigations in select cases could result in more efficient, cost effective and comprehensive investigations. Collaboration may also assist the Office of the Chief Forensic Pathologist and the College in maintaining the integrity of concurrent investigations. Further, where practical and reasonable, the Office of the Chief Forensic Pathologist and the College will seek to share technical resources and, where appropriate, may enter into cost-sharing agreements.

- **Quality of Care:** The College will provide a point of contact and collaborate with and assist the Office of the Chief Forensic Pathologist in quality of care measures as appropriate.

CONSIDERATIONS:

- The Office of the Chief Forensic Pathologist has approached the College for assistance. The College will use existing tools to work with the Office of the Chief Forensic Pathologist, which will be set out in an MOU. Forensic pathologists are a very small group of specialists in Ontario and it is not anticipated that there will be significant costs associated with implementing this MOU.

NEXT STEPS:

- The College will prepare an MOU for discussion with the Office of the Chief Forensic Pathologist.

DECISION/DISCUSSION FOR COUNCIL:

1. This item is for information

Contact: Sayran Sulevani, ext. 510.

Date: August 20, 2020

CPSO

Council Briefing Note

September 2020

TOPIC: Reserve Fund Policy

FOR INFORMATION

ISSUE:

- Reserve Fund Policy

BACKGROUND:

- The Finance and Audit Committee reviewed the attached policy for the Reserve Fund and is recommending to Council the adoption of this policy.

FOR COUNCIL:

For information.

Contact: Nathalie Novak, Chief Transformation Officer, ext. 432
Douglas Anderson, Corporate Services Officer, ext. 607

Date: August 19, 2020

Attachments:

Appendix A: Reserve Fund Policy

Appendix A

RESERVE FUND POLICY

Responsibility: Operations Department

Approval: Date:

Effective: Date:

Amendments: To be reviewed every three years by the Finance and Audit Committee or as circumstances warrant determining whether amendments are necessary in response to internal and external changes.

Purpose

The purpose of the reserve fund is to ensure the College has sufficient financial resources to continue operations if there is a significant negative event, e.g. legislative change, natural disaster, economic disaster, pandemic, etc. The goal is to provide an internal source of funds that offers stability for the programs, employees, and ongoing operations of the College for a sufficient period of time. The reserve fund is an unrestricted balance set aside in the event of unforeseen expenses unanticipated loss in funding, or uninsured losses. The reserve may also be used for one-time, nonrecurring expenses that will ensure long-term capacity, such as staff development or investment in infrastructure.

Definitions and Goals

The reserve fund is defined as unrestricted, designated funds set aside at the direction of Council. The minimum balance is an amount sufficient to maintain ongoing operations and programs for a set period of time.

Establishing the Target Minimum Reserve Balance

Establishing a reserve fund is a key part of organizational risk management. Before determining the amount of reserves needed, an analysis of potential risks should be considered.

Potential risks:

- legislative change, potentially causing the College to wind-down
- natural disaster; e.g. earthquake, floods, etc.
- economic disaster, financial system collapse, stock market crash
- pandemic
- act of war

- litigation
- other event

The severity of these potential risks suggests the target minimum reserve balance can range from as little as a few months to twenty-four (24) months or more.[1] Management considers different scenarios when recommending the target reserve balance to the Finance and Audit Committee.

Accounting for Reserves

The reserve fund balance will be recorded in the financial records as an Internally Restricted Fund.

Funding of Reserves

The reserves will be funded with surplus unrestricted operating funds. Once the reserve fund is accounted for, any surplus from future operational years will be used to fund future expenditures incurred by the College or to offset fee increases.

Use of Reserves

Use of the Operating Reserves requires three steps:

1. Identification of appropriate use of reserve funds.
   Management identifies the need to access reserve funds and confirms that the use is consistent with the purpose of the reserve as described in this Policy. This step requires analysis of the reason for the shortfall, the availability of any other source of funds before using reserves, and an evaluation of the time period that the funds will be required before replenishment.

2. Authority to use the reserve
   Management will submit a request for the use of the reserve to the Finance and Audit Committee. The request will include an analysis of the use of funds and plans for its replenishment. If satisfied with the request, the Finance and Audit Committee will review the request and if in agreement will recommend approval to Council.

3. Reporting and monitoring
   Management is responsible for ensuring that the reserve fund is maintained and used only as described in this Policy. Upon approval for the use of these funds, management will maintain records of its use. Regular reports of progress to restore the fund to the target amount will be provided to the Finance and Audit Committee.

Recommendation

It is recommended that the College sets its reserve requirement to approximately twelve months of operating costs.

[1] Article: Operating Reserves with Nonprofit Policy Example. https://www.propelnonprofits.org/resources/nonprofit-operating-reserves-policy-examples/

Council Motion

Motion Title: Quality Improvement Program

Date of Meeting: September 10, 2020

It is moved by_____,

and seconded by_____, that:

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

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

REGISTRAR'S REPORT

(No materials)

PRESIDENT'S REPORT

(No materials)

Council Motion

Motion Title: Committee Chair/Vice-Chair Model

Date of Meeting: September 10, 2020

It is moved by_____,

and seconded by_____, that:

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

Council Motion

Motion Title: 2020-2021 Chair Appointments

Date of Meeting: September 10, 2020

It is moved by_____,

and seconded by_____, that:

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

Committee	Proposed Chair for 2021	Term (years)
Discipline	Mr. David Wright *(N/C)*	2
Executive	Dr. Judith Plante	1
Finance & Audit	Dr. Thomas Bertoia *(N/C)*	2
Fitness to Practise	Dr. Deborah Hellyer	2
Governance	Dr. Brenda Copps	1
Inquiries, Complaints and Reports	Dr. Anil Chopra *(N/C)*	2
	Proposed 2021 Specialty Chairs	
	Dr. Brian Burke, *(N/C)* Settlement	2
	Ms. Joan Fisk, General	2
	Dr. Rob Gratton, Obstetrical	2
	Dr. Andrew Hamilton, *(N/C)* Surgical	2
	Dr. Thomas Faulds, *(N/C)* Family Practise	2
	Dr. Anita Rachlis, *(N/C)* Internal Medicine	2
	Dr. Lesley Wiesenfeld, *(N/C)* Mental Health & HIP	2
Patient Relations	Ms. Sharon Rogers, *(N/C)*	2

Premises Inspection	Dr. Gillian Oliver, *(N/C)*	2
Quality Assurance	Dr. Janet van Vlymen	2
Registration	Dr. Barbara Lent, *(N/C),* Acting Chair	1

Council Motion

Motion Title: Exceptional Circumstances

Date of Meeting: September 10, 2020

It is moved by_____,

and seconded by_____, that:

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

Inquiries, Complaints and Reports Committee

Dr. Jerry Rosenblum

CPSO

Council Briefing Note

September 2020

TOPIC: Governance Committee Report

FOR DECISION:

1. **Committee Chair/Vice-Chair Model**
2. **Election of 2020-2021 Academic Representatives on Council**
3. **2020-2021 Chair Appointments**
4. **Request for Exceptional Circumstance**

FOR INFORMATION:

5. **Committee Appointment**

FOR DECISION:

1. Committee Chair/Vice Chair Model

ISSUE:

- As part of its efforts to implement good governance practices, the Governance Committee has introduced the implementation of a Chair/Vice-Chair model for Committees for the term beginning in December 2020.

BACKGROUND:

- Based on the table below, CPSO Committees have 3 types of governance structures:
    - Chair + Vice-Chair, where the Vice-Chair transitions to the Chair role;
    - Chair, where the Chair is appointed annually; and
    - Co-Chairs, where the Co-Chair appointments are staggered to promote continuity.

Committee	Type of Chair
Discipline	Chair/Vice-Chair
Executive	Chair/Vice-Chair
Finance and Audit	Chair
Fitness to Practice	Chair
Governance	Chair/Vice-Chair
Inquiries, Complaints and Reports	2 Co-Chairs
Patient Relations	Chair
Premises Inspection	Chair
Quality Assurance	2 Co-Chairs
Registration	Chair

- It is critical that CPSO Committee Chairs understand their role, responsibilities and fiduciary duty to the organization; lack of clarity results in risk to the Committee's ability to carry out its mandate and can negatively impact the organization in meeting its strategic objectives.

- At the Education Day earlier this year, Dr. Richard Leblanc recommended that we implement the Chair/Vice-Chair model for our Committees for the following reasons:
    - Clarifies roles, responsibilities and accountabilities within the Committee
    - Supports succession planning as the Vice-Chair moves into the Chair role
    - Allows for mentoring between the Chair and Vice-Chair and can be used as a way to mentor other Committee members who wish to eventually move into a leadership role

- In keeping with good governance practices and to assist Chairs and Vice-Chairs with understanding their leadership roles, role descriptions were designed and approved by the Governance Committee for the Chair and Vice-Chair positions (Appendices A and B).

- CPSO has also identified core competencies for Committee members, which should be taken into consideration when considering Chairs and Vice-Chairs (Appendix C).

- Feedback from Committee members and Committee support staff suggest that at least one (1) year of experience on the Committee should be required prior to being eligible for a Vice-Chair role.

- While the Nomination Guidelines suggest that the term of a Chair be no more than three (3) years, to facilitate effective succession planning and remain inclusive of those who may be a couple of years into their Committee experience, the Governance Committee recommends that a two (2) year term for each of the Chair and Vice-Chair positions would be ideal (other than for certain committees, as outlined below).

- Based on the requirement of one (1) year experience, and taking into consideration the applicable term limits for Committees, the succession and associated timeframe could resemble the following over a five (5) year period:

- Discussions about Chair nominations have taken place with the current Committee Chairs and those nominees will go to Council in September for approval.

- The concept of the Chair/Vice-Chair model has been discussed informally with some Committees, and positive feedback has been received about the model.

NEXT STEPS:

- The Committee Chairs selected for 2021 will be involved in recommending Vice-Chairs to the Governance Committee at the October meeting, Executive Committee in November and Council in December.

- Communications will be disseminated to Committees for a 2-year term for the Chair and Vice-Chair, including the role descriptions for the Chair and Vice-Chair.

- The Governance department is planning a Committee Chairs' Orientation to take place in the Fall once all Committee Chairs have been selected.

DECISION FOR COUNCIL:

1. Does Council approve the new Chair/Vice-Chair model as presented and support its implementation effective December 2020?

---

2. Election of 2020-2021 Academic Representatives on Council

- The Deans of the six medical schools were asked to appoint their academic representative for the 2020/2021 session of Council. The following representatives have been appointed for either a one-year term or three-year term as per the General By-Law, s(25):

  Dr. Janet van Vlymen, (Queen's University) 1-year term
  Dr. Mary Jane Bell, (University of Toronto) 1-year term
  Dr. Terri Paul, (Western University) 1-year term
  Dr. Karen Saperson, (McMaster University) 3-year term
  Dr. Paul Hendry, (University of Ottawa) 1-year term
  Dr. Roy Kirkpatrick (NOSM) new 3-year term

- The academic representatives will meet prior to the September Council meeting and recommend three voting academic representatives for the 2020/2021 session of Council.

- The three voting representatives the for 2020-2021 Council term will commence their role following the induction of new Council members at the annual meeting of Council on December 4, 2020.

_____

DECISION FOR COUNCIL:

1. Does Council accept the recommended slate of 2020-2021 voting academic representatives at its September meeting? [If the slate is not approved, a vote will be held at the September meeting of Council in which all members of the academic advisory committee are placed on a ballot].

_____

3. 2020-2021 Chair Appointments

ISSUE:

- The proposed 2021 roster of Chair nominations is presented to Council to make Chair appointments that commence, following the December AGM.

BACKGROUND:

- Committee Chairs and ICRC Specialty Chairs[1] will be determined at the September Council meeting. These appointments will take effect following the December 3 and 4, 2020 AGM.

- In considering nominations for these leadership positions, the Governance Committee followed the newly developed Chair role/competency description approved by the Governance Committee. (See Appendices A and C)

- Most Chair terms will be 2-year terms, with the exception of the Executive Committee, Governance Committee and Registration Committee Acting Chair position which will be for 1 year.

- The Governance Committee agreed that Dr. Judith Plante will resume the role of Registration Committee Chair following her 2021 term as President.

- The recommendations for the Committee Chairs for 2020-2021 will be shared with Council members in advance of the meeting (Appendix D).

DECISION FOR COUNCIL:

1. Does Council approve the recommended slate of 2020-2021 Chairs?

---

[1] The Governance Committee agreed to rename ICRC Vice Chairs of Specialty Panels as ICRC Specialty Chairs.

4. Request for Exceptional Circumstances

ISSUE:

- At its June meeting, the Executive Committee considered and approved a request to apply the exceptional circumstances provision to Jerry Rosenblum; it is now forwarding the request to Council for approval.

BACKGROUND:

- Due to Covid-19 and the unexpected changes in workload and availability of Committee members, the Inquiries Reports and Complaints Committee have identified a need to extend Jerry Rosenblum's appointment for one more year to help maintain stability and effective functioning for the Committee.

- This request is in addition to the requests that were made and approved by Council at the March meeting.

DECISION FOR COUNCIL:

Does the Council approve, in principle, the request to apply the exceptional circumstances clause in Section 37 (8) of the General By-Law to Dr. Jerry Rosenblum, member of the Inquiries, Complaints & Reports Committee, when his appointment expires at the Annual General Meeting of Council in December 2020?

FOR INFORMATION:

5. Council and Committee Appointments

- The Executive Committee appointed Dr. Trevor Bardell to the ICR Committee at the June 23rd 2020 meeting.

- Shannon Weber was appointed as a public member of Council on August 13, 2020 for one year (Appendix E).

Contact: Peeter Poldre, Chair, Governance Committee
Laurie Cabanas, Ext. 503
Debbie McLaren, Ext. 317
Marcia Cooper, Ext. 546

Date: September 8, 2020

Appendix A: Role Description – Chair
Appendix B: Role Description – Vice Chair
Appendix C: Core Competencies for Committee Members
Appendix D: Proposed Chairs for 2020-2021
Appendix E: Order In Council (Shannon Weber)

Appendix A: Chair Role and Responsibilities

Chair Role:

The role of a Chair on a Committee, Working Group or Advisory Group is to provide leadership and direction to members of the Committee, Working Group or Advisory Group so that they can successfully achieve the objectives set out in their respective Terms of Reference.

Chair Selection:

Chairs are appointed by Council, based on a recommendation from the Governance Committee and informed by current Committee leadership and staff.

Potential Chairs should be identified based on a variety of considerations, including but not limited to:

- eligibility with respect to applicable term limits
- demonstration of core leadership competencies
- leadership experience
- subject matter expertise necessary to fulfill the mandate of the Committee, Working Group or Advisory Group
- knowledge and support of the regulatory and/or statutory obligations of the Committee, Working Group or Advisory Group (if applicable)
- interest and availability

Chair Responsibilities:

- In addition to providing leadership and guidance in support of the objectives and mandate of the Committee, Working Group or Advisory Group are met as outlined in the Terms of Reference and legislation where applicable, Chairs are also responsible for leading and managing activities which include but are not limited to:
    - Acting as the principal spokesperson for the Committee in reporting to Council and interfacing with other Committees
    - Striving to ensure adherence of group members to CPSO expectations outlined in the Declaration of Adherence
    - Working with staff to plan, organize and chair meetings and panels (where applicable)
    - Facilitating meaningful discussion among group members and encouraging all members to share ideas and views
    - Gaining consensus during the decision-making process in a respectful way
    - Introducing strategies to resolve conflicts that may arise
    - Collaborating with staff to provide orientation to new members
    - Overseeing the development of reports to Council
    - Identifying learning needs of the group or individual members as appropriate

- Monitoring performance of individual members and providing feedback to enhance performance
- Liaising with the Governance Committee on issues such as recruitment, mentoring and succession planning of members
- Participating in a self-assessment with the Chair of Governance Committee to obtain feedback and identify opportunities to enhance performance

For Discipline, Fitness to Practice and Inquiries, Complaints and Reports Committees, key duties also include:

- Working with staff to select members to lead and participate in panels
- Providing advice and support to members participating in panels, drawing where appropriate on staff support and other legal advice
- Monitoring panel activities and decisions to ensure alignment with legislative requirements and CPSO policies/procedures

The Chair plays a key role in identifying members who demonstrate strong leadership skills and who may be suitable for a Vice-Chair role as part of succession planning.

Appendix B: Vice-Chair Role and Responsibilities

Vice-Chair Role:

The role of a Vice-Chair on a Committee, Working Group or Advisory Group is to support the Chair in providing leadership and direction to members of the Committee, Working Group or Advisory Group so that they can successfully achieve the objectives set out in their respective Terms of Reference.

Vice-Chair Selection:

Vice-Chairs are appointed by Council, based on a recommendation from the Governance Committee and informed by current Committee leadership and staff.

Potential Vice-Chairs should be identified based on a variety of considerations, including but not limited to:

- eligibility with respect to applicable term limits
- demonstration of core leadership competencies
- leadership experience or potential
- subject matter expertise necessary to fulfill the mandate of the Committee, Working Group or Advisory Group
- knowledge and support of the regulatory and/or statutory obligations of the Committee, Working Group or Advisory Group (if applicable)
- interest and availability

Vice-Chair Responsibilities:

- In addition to supporting the Chair in leading the Committee to achieve the objectives and mandate of the Committee, Working Group or Advisory Group are met as outlined in the Terms of Reference and legislation where applicable, Vice-Chairs are also responsible for activities which include but are not limited to:
    - Acting as the delegate for the Chair (where necessary) in reporting to Council and interfacing with other Committees where necessary
    - Modeling CPSO expectations outlined in the Declaration of Adherence
    - Working with staff and the Chair to plan, organize meetings and panels (where applicable)
    - Assisting the Chair with resolving conflicts that may arise
    - Supporting orientation for new members
    - Participating in the development of reports to Council
    - Identifying learning needs of the group or individual members as appropriate
    - Informing the Chair regarding the performance of individual members
    - Participating in a self-assessment with the Chair of Governance Committee to obtain feedback and identify opportunities to enhance performance

Appendix C: Core Competencies

Continuous Learning: Involves taking actions to improve personal capability and includes the ability to quickly understand and apply information, concepts, and strategies. Demonstrates an interest in continuous personal learning.

Creativity: Is generating new solutions, developing creative approaches, and implementing new approaches that lead to improved performance. It requires the ability to anticipate and lead change that contributes to organizational success.

Effective Communication: Is willing and able to see things from another person's perspective. Demonstrates the ability for accurate insight into other people's/group's behaviour and motivation and responds appropriately. It is the ability to accurately listen, understand, and respond effectively with individuals and groups.

Planning & Initiative: Recognizes and acts upon present opportunities or addresses problems effectively. Displays effective use of time management skills. Is able to plan and organize workflow and meetings in an efficient manner to address the opportunity or problem.

Relationship Building: Is working to build or maintain ethical relationships or networks of contacts with people who are important in achieving Committee/Working Group/Advisory-related goals in support of CPSO's mandate.

Results Oriented: Makes specific changes in own work methods or systems to improve performance beyond agreed standards (i.e., does something faster, at lower cost, more efficiently; improves quality; stakeholder satisfaction; revenues, etc.).

Stakeholder Focused: Desires to help or serve others, meets the organization's goals and objectives. It means focusing one's efforts on building relationships and discovering and meeting the stakeholders' needs. Partnerships between internal colleagues within the College are essential to meet external stakeholders' needs.

Strategic Thinking: Understands the implications of decisions and strives to improve organizational performance. It requires an awareness of organizational issues, processes, and outcomes as they impact key stakeholders and the organization's strategic direction.

Teamwork: Demonstrates cooperation within and beyond the College. Is actively involved and "rolls up sleeves". Supports group decisions, even when different from one's own stated point of view. Is a "good team player", does his/her share of work. Compromises and applies rules flexibly and adapts tactics to situations or to others' response. Can accept setbacks and change own immediate behaviour or approach to suit the situation. Is candid about opinions and raises justified concerns.

Appendix D: Proposed CPSO Committee Chairs for 2020-2021

Committee	Proposed Chair for 2021	Term (years)
Discipline	Mr. David Wright *(N/C)*	2
Executive	Dr. Judith Plante	1
Finance & Audit	Dr. Thomas Bertoia *(N/C)*	2
Fitness to Practise	Dr. Deborah Hellyer	2
Governance	Dr. Brenda Copps	1
Inquiries, Complaints and Reports	Dr. Anil Chopra *(N/C)* **Proposed 2021 Specialty Chairs** Dr. Brian Burke, *(N/C)* Settlement Ms. Joan Fisk, General Dr. Rob Gratton, Obstetrical Dr. Andrew Hamilton, *(N/C)* Surgical Dr. Thomas Faulds, *(N/C)* Family Practise Dr. Anita Rachlis, *(N/C)* Internal Medicine Dr. Lesley Wiesenfeld, *(N/C)* Mental Health & HIP	2 2 2 2 2 2 2 2
Patient Relations	Ms. Sharon Rogers, *(N/C)*	2
Premises Inspection	Dr. Gillian Oliver, *(N/C)*	2
Quality Assurance	Dr. Janet van Vlymen	2
Registration	Dr. Barbara Lent, *(N/C),* Acting Chair	1

N/C = Non-council committee member

Appendix E

Ontario

Executive Council of Ontario
Order in Council

On the recommendation of the undersigned, the Lieutenant Governor of Ontario, by and with the advice and concurrence of the Executive Council of Ontario, orders that:

Conseil exécutif de l'Ontario
Décret

Sur la recommandation de la personne soussignée, le lieutenant-gouverneur de l'Ontario, sur l'avis et avec le consentement du Conseil exécutif de l'Ontario, décrète ce qui suit :

PURSUANT TO clause 6(1)(b) of the *Medicine Act, 1991,* **Shannon Weber** of Waterloo, be appointed as a part-time member of the Council of the College of Physicians and Surgeons of Ontario to serve at the pleasure of the Lieutenant Governor in Council for a period not exceeding one year, effective the date this Order in Council is made.

EN VERTU DE l'alinéa 6 (1) b) de la *Loi de 1991 sur les médecins,* **Shannon Weber** de Waterloo, est nommée au poste de membre à temps partiel du Conseil de l'Ordre des médecins et chirurgiens de l'Ontario, pour exercer son mandat à titre amovible à la discrétion du lieutenant-gouverneur en conseil, pour une période maximale d'un an à compter du jour de la prise du présent décret.

Christine Elliott

Recommended: Minister of Health
Recommandé par : La ministre de la Santé

Concurred: Chair of Cabinet
Appuyé par : Le président | la présidente du Conseil des ministres

Approved and Ordered:
Approuvé et décrété le : AUG 13 2020

Lieutenant Governor
La lieutenante-gouverneure

O.C. | Décret : 1205/2020

OVERVIEW OF POLICY PROCESS

(No materials)

CPSO

Council Briefing Note

September 2020

TOPIC: *Telemedicine* – Policy Review Kick-off

FOR DISCUSSION

ISSUE:

- The College's *Telemedicine* policy is in the beginning stages of the policy review process. In an effort to increase Council's engagement in the policy review process and to capitalize on Council's expertise, Council is being asked for feedback at this early stage to help shape and inform the direction of the review.

- Council is provided with an overview of the current policy, the current telemedicine landscape, and discussion questions meant to inform the review.

BACKGROUND:

- The current *Telemedicine* policy was last reviewed and approved by Council in 2014. It defines "telemedicine" as:

    - *Both the practice of medicine and a way to provide or assist in the provision of patient care (which includes consulting with and referring patients to other health-care providers, and practising telemedicine across borders) at a distance using information and communication technologies such as telephone, email, audio and video conferencing, remote monitoring, and telerobotics.*

- The current policy takes a principle-based approach, setting out general expectations about the use of telemedicine and an overarching statement that the practice of telemedicine is the practice of medicine. Key expectations include requirements to:

    - Continue to meet the existing legal and professional obligations that apply to care that is provided in person (e.g., consent to treatment, confidentiality of personal health information, prescribing drugs, medical records, etc.); and

    - Consider the appropriateness of telemedicine in each instance.

- The companion *Advice to the Profession* document addresses frequently asked questions including those related to the appropriateness of delegating and prescribing via telemedicine and issues related to security and privacy. An existing Patient Information Sheet addresses frequently asked questions for patients.

CURRENT STATUS:

- As a result of the pandemic, the health care system and the way that care is delivered has undergone significant and rapid transformation. COVID-19 has vastly increased the use of virtual care, especially within primary care.

    - A recent OntarioMD blog post highlights data indicating that usage of virtual care went from about 7% before the pandemic to about 80% of all visits happening virtually during the pandemic and as high as 89% among primary care physicians.

- Historically challenges to implementation have been around licensing, compliance with privacy and security requirements, and the availability of remuneration from the Ministry, but the current climate has created opportunities to overcome some of these barriers.

- This systemic shift has highlighted virtual care's potential and established it as a legitimate and potentially necessary option for patient care. Research and feedback suggest that both physicians and patients are having positive experiences with virtual care, that it can improve access and convenience, and that it can enable the provision of safe and effective care during a public health crisis.

- As this transformation continues and the system reflects on the learnings that have been afforded by this experience, consideration will need to given to challenges such as equitable access, remote or marginalized communities with poor internet access, and issues related to security and privacy, training, and licensing.

- While the system reflects on this transformation, so too can the CPSO examining the role of regulation and the regulator to both enable and shape what quality virtual care looks like. To support this work, discussion questions for Council have been set out below.

NEXT STEPS:

- A public consultation on the current policy will begin after September Council.

- Consultation and engagement activities will include efforts to solicit feedback from stakeholders that represent or advocate for the interests of diverse and/or vulnerable

groups, to help ensure the draft policy is specifically reviewed with a diversity, equity and inclusion lens.

- Feedback received as part of these activities will be shared with the Executive Committee and Council at a future meeting and will inform the development of a new draft policy and *Advice*.

DISCUSSION FOR COUNCIL:

1. What has your experience been providing or receiving care virtually?

    a. How has this changed as a result of the pandemic?
    b. What barriers to implementation have you experienced, and have those been overcome?

2. What are the advantages you see to providing care virtually? What are the disadvantages or risks that need to be managed?

3. How can the College best enable and yet regulate this space? What issues do you think the profession is looking for guidance/expectations on the most?

Contact: Tanya Terzis, Ext. 545
Craig Roxborough, Ext. 339

Date: August 21, 2020

MEMBER TOPICS

(No materials)

Council Briefing Note

September 2020

TOPIC: Council Award Recipients

FOR INFORMATION

ISSUE:

- At the September 10 meeting of Council, **Dr. Stephanie Milone** and **Dr. Stephen Milone** (both from Orangeville) will receive the CPSO Council Award.

BACKGROUND:

- The CPSO Council Award recognizes physicians who demonstrate the ideal qualities that are required to effectively meet the health care needs of the people they serve. These abilities are articulated in the Royal College of Physicians and Surgeons of Canada's CANMEDS Framework which consist of seven roles:
    - The physician as medical expert (the integrating role)
    - The physician as communicator
    - The physician as collaborator
    - The physician as leader
    - The physician as health advocate
    - The physician as scholar
    - The physician as professional

- A competent physician seamlessly integrates the competencies of all seven CPSO Council Award qualities.

CURRENT STATUS:

- Council member Dr. David Rouselle will present the award.

Contact: Laurie Cabanas, ext. 503

Date: August 27, 2020

GUEST PRESENTATION

“PHYSICIAN BURNOUT”

Guest Speaker: *Dr. Ken Milne*

(No materials)

CPSO

Council Motion

Motion Title: *Third Party Medical Reports* – Draft for Consultation

Date of Meeting: September 11, 2020

It is moved
by_____,

and seconded by_____,
that:

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

CPSO

Council Briefing Note

September 2020

TOPIC: *Third Party Medical Reports* – Draft for Consultation

FOR DECISION

ISSUE:

- The College's *Third Party Reports* and *Medical Expert: Reports and Testimony* policies are currently under review. These policies have been combined into a new draft *Third Party Medical Reports* policy and a new companion *Advice to the Profession* document has been developed.

- Council is asked if the draft policy can be released for external consultation and engagement.

BACKGROUND:

- The current *Third Party Reports* policy was last reviewed and approved by Council in 2012[1], and the current *Medical Expert: Reports and Testimony* was approved by Council in 2012.

- The draft policy was developed with direction from the standing Policy Review Working Group, consisting of Brenda Copps (Chair), Ellen Mary Mills, and Janet Van Vlymen, as well as Medical Advisors Angela Carol and Keith Hay. Additional support was provided by Edward Everson (Medical Advisor), and Amy Block and Ruth Ainsworth (Legal Counsel).

- Preliminary research was undertaken in accordance with the usual policy review process.[2] In addition, feedback on the current policies was solicited through a preliminary consultation that was held from December 2019-February 2020.

[1] Minor updates were made to the policy in May 2018 to accurately reflect the provisions in Bill 87, the *Protecting Patients Act, 2017*, that came into force on May 1, 2018.
[2] This included: a literature review of scholarly articles and research papers; a jurisdictional review of Canadian and international medical regulatory authorities and Ontario health profession regulators; a review of relevant statistical information regarding matters before the Inquiries, Complaints, and Reports Committee (ICRC), and relevant case examples from ICRC and Discipline; and feedback on the current policies from the College's Public and Physician Advisory Service.

- Efforts were made to invite organizational stakeholders representing or advocating for the interests of diverse and/or vulnerable groups, in addition to our typical stakeholders.

- The consultation garnered a total of 210 responses: 52 through written feedback and 158 via the online consultation survey. An overview of the feedback and a full breakdown of consultation respondents was provided in the Policy Report to Council in March 2020.

- In addition to hearing from patients, physicians and other key stakeholder organizations, feedback was received from the following organizational stakeholders representing or advocating for the interests of diverse and/or vulnerable groups: Acquired Brain Injury Survivor Solutions, Canadian Life and Health Insurance Association Inc., FAIR Association of Victims for Accident Insurance Reform, Injured Workers Community Legal Clinic, and Ontario Trial Lawyers Association.

- Relevant findings and themes from the research and the preliminary consultation are provided below, as key updates are outlined.

CURRENT STATUS:

- A draft *Third Party Medical Reports* policy (**Appendix A**) and companion *Advice to the Profession* document (**Appendix B**)[3] have been developed in response to the research and preliminary consultation feedback.

- The draft policy combines both the current *Third Party Reports* and *Medical Expert: Reports and Testimony* policies given the significant overlap between the policies.[4]

    - This has resulted in one clear and concise policy that is more user-friendly than going to two separate policies on related issues.

    - It is notable that the draft policy retains the existing content from the current policies and addresses new issues, while achieving a 22% reduction in word count.

- The draft policy expectations are largely consistent with those of the current policies, but many updates have been made to enhance clarity and address the research and preliminary consultation feedback.

[3] While the *Advice* document is provided for Council's review and feedback, and will be distributed as part of the consultation, it is intended to be a nimble communications tool which does not require Council approval in the same way a policy requires approval.
[4] The current policies both relate to physician participation in third party processes.

- This briefing note captures the most significant updates and highlights the areas where the Working Group had the most discussion, but other updates that were made include: updating the terminology, using more precise language, referencing relevant College policies and regulations, and ensuring the consolidated expectations reflect the range of physician participation in third party processes (from treating physicians filling out forms for their patients to physicians providing testimony as medical experts).

- An overview of the key updates made in the draft *Third Party Medical Reports* policy and *Advice* document is set out below.

Physician Participation in Third Party Processes

- To address a gap in the current policy, the draft policy builds on the existing requirement for treating physicians to provide third party medical reports for their patients (Provision #3) by adding a new requirement for treating physicians to provide testimony about their patients (Provision #4).

    - This mirrors the requirement to provide written information and/or opinions about patients, reflects physicians' legal obligation to respond to subpoenas or summons, and addresses the questions raised with the College's Public and Physician Advisory Service.

- To address questions regarding the qualifications needed to conduct IMEs and act as medical experts, the draft policy retains the position that physicians are not obligated to provide these services and now requires that the following conditions be met before doing so: physicians must have an active certificate of registration, and must have actively practiced within the requisite scope of practice and area of expertise within the past two years (Provision #5).

    - The Working Group added the requirement to currently have an active certificate of registration because it is consistent with the College's *Closing a Medical Practice* policy.

    - The Working Group discussed the requirement to have actively practiced within the requisite scope of practice and area of expertise within the past two years at great length and ultimately decided to include it in light of the preliminary consultation feedback,[5] and because it ensures physicians would

[5] Via the survey. Respondents provided a range of views regarding whether actively practicing medicine (which was defined in the survey as including the provision of clinical care) should be required in order to conduct IMEs and/or act as medical experts. Some respondents felt actively practicing medicine is necessary in order for physicians to maintain the clinical knowledge and expertise required for IMEs and/or medical expert work, and other respondents felt it may not be necessary for physicians to be actively practicing medicine.

only provide these services when they have the relevant competency to do so.

- The Working Group worded the active practice requirement in such a way that it could allow a physician's scope of practice and area of expertise to be IMEs and/or medical expert work. As such, the draft policy does not prevent physicians from exclusively conducting IMEs and/or doing medical expert work provided that is the scope of practice and area of expertise the third party request requires, and they have actively practiced within that scope of practice and area of expertise within the past two years.

- To clarify the draft policy requirements, the *Advice* document addresses what retired physicians who no longer have an active certificate of registration can do with respect to third party requests, and what qualifies physicians to act as medical experts.

Consent

- The current policies do not specify whether express[6] or implied[7] consent is required for the collection, use and disclosure of personal information for a third party process, and for conducting an examination for a third party process. The draft policy now clarifies that express consent is required for both (Provisions #9 and 10).

  - The Working Group came to this decision after much discussion and consideration of the following: the federal and provincial privacy legislation, the College's *Advice to the Profession: Maintaining Appropriate Boundaries* document (which describes express consent for examinations as best practice), and the general confusion subjects have regarding physicians' role in third party processes.

- The *Advice* document clarifies that physicians can rely on consent obtained by someone else and pre-signed consent forms.

Transparency

- To minimize confusion regarding the physician's role in responding to third party requests and whether anyone else was involved in fulfilling the request, the draft policy now requires that physicians clearly identify who assisted them in conducting the IME and/or who contributed to the third party medical report (Provision #25).

[6] Express consent is direct, explicit, and unequivocal, and can be given in writing or orally.
[7] Implied consent is inferred from words or behaviour, or the surrounding circumstances, such that a reasonable person would believe that consent has been given, although no direct, explicit, and unequivocal words of agreement have been given.

- The issue of whether physicians should get assistance with IMEs and/or third party medical reports is contentious.[8] By adding this requirement, the Working Group wanted to acknowledge that it may be appropriate for physicians to get assistance with the IME and/or report, and they just have to be transparent about it. This approach was recommended by some preliminary consultation respondents.[9]

Timely

- To address concerns regarding the time taken (i.e., the full 60 days currently permitted) by some physicians to complete fairly simple or straightforward third party medical reports, that are sometimes urgently needed, the draft policy has been updated with a more nuanced requirement.

- Recognizing the need for physicians who are not acting as medical experts to complete third party medical reports in a timely manner, the Working Group decided to set an expectation that IMEs and third party reports must be completed in a timely manner while retaining the 60 day timeframe as the maximum for IMEs, which tend to be more complex, and shortening the maximum timeframe for other third party medical reports that do not require IMEs to 45 days (Provision #29).

- The Working Group also felt it was important to clarify that complexity and urgency would dictate what is considered "timely" and specified this in footnote #32 and the *Advice* document.

    - The Working Group's approach to require the completion of third party medical reports in a timely manner is consistent with feedback from the College's Public and Physician Advisory Service, and the specific timeframes were supported by some preliminary consultation respondents.[10]

- To address a gap in the current policy identified by the College's Public and Physician Advisory Service, the current requirement to provide medical expert testimony without unreasonable delay has been broadened to capture testimony provided by any physician, and it clarifies that physicians must respond to any

[8] This practice is referred to as "ghostwriting" and those who are critical of it believe physicians should conduct the IME and/or write the third party medical report themselves, instead of having an unidentified person doing some or all of it for them.
[9] Including the Ontario Trial Lawyers Association, the FAIR Association of Victims for Accident Insurance Reform, and some respondents via the survey. Other respondents felt physicians should conduct IMEs and/or write third party medical reports themselves.
[10] Via the survey. Respondents provided a range of views regarding the timeframes for IMEs and third party medical reports. Some respondents felt the timeframe should be less than 30 days, some felt 30 or 60 days would be reasonable, and some felt the timeframe should be longer than 60 days. Some respondents proposed not quantifying the timeframe and instead basing it on the complexity or urgency of the request.

requests or orders (e.g., subpoenas or summons) to provide testimony in a timely manner (Provision #32).

Clinically Significant Findings

- To align the expectations in the current policies and ensure there is appropriate disclosure and management of clinically significant findings, the following new requirements were added to the draft policy: to disclose the finding to the subject's primary health-care provider (if they have one) and determine who will assume responsibility for providing any necessary care and follow-up; and if the subject doesn't have a primary health-care provider, advise the subject to see a health-care provider for any necessary care and follow-up, or if the subject is at imminent risk of serious harm and requires urgent medical intervention, ensure any necessary care and follow-up is provided (Provision #36).

    - The Working Group discussed the new requirements extensively and ultimately decided on including them because they are generally consistent with other medical regulators,[11] and the preliminary consultation feedback.[12]

Documentation, Retention & Access

- The documentation and retention expectations in the current policies were not clear, and they were particularly confusing with respect to non-treating physicians. Unlike the current policies, the draft policy specifies what information must be documented (Provision #38), how that information must be documented (e.g., legible, accurate, etc.) (Provision #39), and what related materials must be retained (e.g., contract, recordings, etc.) (Provision #40).

    - The Working Group wanted to be explicit about what must be documented and retained and that these requirements apply to all physicians (treating and non-treating), as the current policies are not clear. These additions also address the preliminary consultation feedback received.[13]

NEXT STEPS:

- Subject to Council's approval, the draft policy will be released for external consultation and engagement.

[11] Collège des Médecins du Québec, College of Physicians and Surgeons of Alberta, College of Physicians and Surgeons of Manitoba, and Yukon Medical Council.
[12] Including from the Ontario Trial Lawyers Association, the FAIR Association of Victims for Accident Insurance Reform and respondents via the survey.
[13] From the Ontario Medical Association.

- Consultation and engagement activities will include efforts to solicit feedback from stakeholders that represent or advocate for the interests of diverse and/or vulnerable groups, to help ensure the draft policy is specifically reviewed with a diversity, equity and inclusion lens.

- Feedback received as part of these activities will be shared with the Executive Committee and Council at a future meeting and used to further refine the draft.

DECISION FOR COUNCIL:

1. Does Council approve the draft policy for external consultation and engagement?

Contact: Michelle Cabrero Gauley, Ext. 439

Date: August 21, 2020

Attachments:

Appendix A: Draft *Third Party Medical Reports* policy

Appendix B: Draft *Advice to the Profession: Third Party Medical Reports*

Appendix A

Third Party Medical Reports

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

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

Definitions

Third party processes: Processes that relate to insurance benefits, workplace issues, attendance in educational programs, legal proceedings, etc. Physicians participate in these processes by conducting independent medical examinations and providing third party medical reports and testimony.

Independent medical examinations (IME): Examinations which are conducted strictly for third party processes and *not* for the provision of health care. IMEs can include a file review[1] and/or examination[2] of the subject. IME findings are communicated by physicians in third party medical reports and/or testimony.

Third party medical reports and testimony: Information and/or opinions that are provided by physicians[3] in writing and/or orally for a third party process and *not* for the provision of health care.

Subjects: Patients or individuals[4] who are the subject of an IME, third party medical report and/or testimony.

Medical experts:[5] Physicians who, by virtue of their medical education, training, skill and/or experience, have specialized knowledge and expertise on medical issues.

[1] The file review could include reviewing medical records, reports, etc.

[2] The examination could be physical, psychological, functional, etc.

[3] Both treating and non-treating physicians may provide third party medical reports and testimony. For example, treating physicians may complete forms on behalf of their patients, and non-treating physicians may report on the findings of the independent medical examinations they conduct on individuals.

[4] The College will consider individuals who are the subject of an IME, third party medical report or testimony to be patients for the purposes of the sexual abuse provisions set out in the *Health Professions Procedural Code* (*Regulated Health Professions Act, 1991*, S.O. 1991, c.18., Sched. 2).

[5] 'Expert witnesses' and 'litigation experts' are other terms commonly used to describe physicians who are retained by a party in a legal proceeding to act as medical experts. This is different than treating

Policy

1. Physicians **must** act with the same high level of integrity and professionalism when participating in third party processes, as they would when delivering health care.

2. Physicians **must** comply with the expectations set out in this policy and any other specific legal principles and requirements that may apply to the third party process.[6]

Physician Participation in Third Party Processes

3. When requested, treating physicians **must** provide third party medical reports about their current and former patients in accordance with the 'Consent' section of this policy, unless they no longer have an active certificate of registration.[7]

4. When requested or ordered (e.g., by subpoena or summons), treating physicians **must** provide testimony about their current and former patients.[8]

5. Physicians are not obligated to conduct IMEs or act as medical experts, and **must** only accept a request to conduct an IME or act as a medical expert if they:
    a. currently have an active certificate of registration;

physicians who may also be required to give evidence in a legal proceeding regarding the treatment they provided to their patients, symptoms their patients' reported etc., or regarding reports they prepared in their capacity as treating physicians (known as 'participant experts'). See the Advice to the Profession document for more information.

[6] For example, this can include, but is not limited to: the principles of solicitor-client and litigation privilege; requirements found in the *Personal Health Information Protection Act, 2004,* S.O. 2004, c.3, Sched A.(*PHIPA*), and the *Personal Information Protection and Electronic Documents Act,* SC 2000, c 5 (*PIPEDA*); requirements found in the *Courts of Justice Act*, R.S.O. 1990, c. C.43, the *Insurance Act*, R.S.O. 1990, c. I.8, the *Workplace Safety and Insurance Act, 1997*, S.O. 1997, c.16, Sched. A., and the *Occupational Health and Safety Act*, R.S.O. 1990, c.O.1; and the relevant regulations enacted under these Acts. Physicians may want to seek independent legal advice regarding the specific legal principles and requirements that apply to the third party process they are participating in.

[7] The College's *Closing a Medical Practice* policy states that "following a resignation, revocation, or suspension, physicians **must not**…prepare reports... 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".

[8] A subpoena or summons does not grant physicians the authority to speak to anyone about the patient or disclose their medical records without the patient's (or their substitute decision-maker's) consent, unless permitted or required by law (e.g., court order). For more information, see: Canadian Medical Protective Association. (2009). *Subpoenas-What are a physician's responsibilities*.

b. have the requisite scope of practice and area of expertise and have actively practiced within that scope and area of expertise within the past two years;[9] and
c. have disclosed to the requesting party any perceived or potential conflicts of interest[10] and the physician and requesting party determined no conflict exists.[11]

6. In discharging provision 5c, physicians **must not** disclose any personal health information[12] about a patient without their consent, unless permitted or required by law.[13]

7. Before participating in a third party process, physicians **must**:
   a. know who the requesting party is (i.e., the third party that requested the IME,[14] third party medical report, and/or testimony);
   b. understand what they are being asked to do,[15] and specifically, what questions they are being asked to answer; and
   c. ensure any contracts with the requesting party (e.g., outlining scope, purpose, timelines, fee arrangements, etc.,) comply with the expectations set out in this policy.

[9] Conducting IMEs and acting as medical experts reasonably require current or recent experience practicing in the requisite scope of practice and area of expertise.

[10] An example of where a conflict of interest may arise is when physicians have a personal or professional relationship with one of the parties involved in the third party process. For more information on conflicts of interest, see the Advice to the Profession document.

[11] It may be possible to proceed notwithstanding a conflict if the following conditions are met:

- the conflict has been disclosed to all parties;
- all parties expressly waive the conflict; and
- the physician has determined the conflict would not affect their objectivity or impartiality.

[12] Even the fact that the physician has or had a treating relationship with a patient is considered personal health information.

[13] See the College's *Protecting Personal Health Information* policy and *Mandatory and Permissive Reporting* policy for circumstances in which disclosures of personal health information are permitted or required by law.

[14] Some examinations may be ordered. For example, see Rule 33 of the *Rules of Civil Procedure,* O. Reg. 194, enacted under the *Courts of Justice Act*, R.S.O. 1990, c. C.43 for information regarding court-ordered examinations.

[15] For example, this could include understanding the scope of the physician's role and responsibilities, such as whether the requesting party expects the physician will:

- conduct an IME;
- provide a third party medical report;
- clarify or expand on the information and/or opinions in the third party medical report after the report is submitted, if necessary; and/or
- provide testimony.

Physician Role in Third Party Processes

8. Physicians **must** understand and communicate the nature of their role in the third party process to subjects[16,17] they interact directly with, which includes that their role:
    a. is to *provide* information and/or opinions to the third party involved in the process and not to *decide* the outcome[18] of the third party process or provide health care;
    b. may involve collecting, using, and disclosing personal information (which may include personal health information)[19] for a third party process; and
    c. if applicable, may involve conducting an examination for a third party process.

Consent

9. Physicians **must** ensure express[20] consent to collect, use or disclose the subject's personal information for a third party process has been obtained from the subject, unless physicians are permitted or required by law to collect, use and disclose that information.[21]

10. Physicians **must** ensure express consent for conducting an examination for a third party process has been obtained from the subject, which includes explaining the purpose, scope, and rationale of the examination.

11. The consent process will vary depending on the circumstances of each case; however, at minimum, physicians **must** ensure the following points are conveyed:
    a. consent can be withdrawn at any time; however, this may prevent the physician from completing the IME and/or third party medical report and providing testimony;

[16] Throughout this policy, where "subject" is referred to, it should be interpreted as "subject or substitute decision-maker" where applicable.

[17] Patients may be confused about the nature of the physician's role in the third party process when it is their own treating physician that is involved in the process.

[18] The final outcome (for instance, decisions regarding eligibility for benefits) is not determined by the physician but rather by the relevant decision makers in the third party process.

[19] In most cases, physicians who participate in the third party processes will be subject to *PIPEDA*, the legislation which establishes requirements for the collection, use and disclosure of "personal information" about individuals in the course of commercial activities. "Personal information" is defined broadly as "information about an identifiable individual" and includes "personal health information".

[20] Express consent is direct, explicit, and unequivocal, and can be given in writing or orally.

[21] Depending on the circumstances, consent requirements for collection, use and disclosure are contained in *PIPEDA* and/or *PHIPA*.

b. limits may be placed on the information that physicians can disclose in writing and/or orally; however, such limitations may prevent the physician from participating in the third party process; and
c. if consent is withdrawn or limited by the subject, physicians may still be permitted or required by law to collect, use and disclose the subject's personal information or personal health information.[22]

Fees for Physician Participation in Third Party Processes

12. Physicians **must** discuss any requirements or arrangements with respect to fees (including cancellation fees for missed appointments) with the requesting party before participating in third party processes.

13. Physicians **must** comply with any specific legal requirements in relation to fees for their participation in third party processes.[23]

14. In the absence of any specific legal requirements, physicians **must** ensure their fees are reasonable in accordance with the College's *Uninsured Services: Billing and Block Fees* policy and regulation.[24]

Requirements for Independent Medical Examinations, Third Party Medical Reports and Testimony

15. Physicians **must** conduct IMEs and provide third party medical reports and testimony that are:
    a. within their scope of practice and area of expertise;
    b. comprehensive and relevant;
    c. fair, objective and non-partisan;
    d. transparent;

[22] See Division 1, Section 7 of *PIPEDA* for circumstances in which physicians are permitted or required by law to collect, use and disclose personal information, and the College's *Protecting Personal Health Information* policy and *Mandatory and Permissive Reporting* policy for circumstances in which disclosures of personal health information are permitted or required by law.

[23] For example, the regulations under the *Coroner's Act,* R.S.O. 1990, c. C.37, set out the fee payable for each day of attendance of an expert witness who has been summoned to provide evidence at an inquest, as well as the fees payable for conducting a *post mortem* examination. Depending on the context, different proceedings may have rules in place governing how the fees payable to witnesses for attendance at a hearing or to medical experts for the preparation of reports will be determined (e.g., in the regulations under the *Courts of Justice Act,* R.S.O. 1990, c. C.43 and regulations under the *Administration of Justice Act,* R.S.O. 1990, c. A.6.).

[24] Section 1(1), paragraphs 21 and 22 of *Professional Misconduct*, O. Reg., 856/93, enacted under the *Medicine Act, 1991*, S.O. 1991, c. 30.

e. accurate;[25]
f. clear; and
g. timely.

Additional information relating to each requirement is set out below.

Within Scope of Practice & Area of Expertise

16. Physicians **must:**
    a. accurately represent their scope of practice and area of expertise, including their qualifications in accordance with relevant College policy and regulation;[26] and
    b. restrict their IMEs, statements and/or opinions to matters that are within their scope of practice and area of expertise.

Comprehensive & Relevant

17. Physicians **must** take reasonable steps to obtain[27] and review all relevant clinical information and opinions relating to the subject that could impact their statements and/or opinions.

18. Physicians **must** clearly identify any limitations on the comprehensiveness of the IMEs they conduct and the third party medical reports and testimony they provide, including:
    a. if they are unable to fulfil an element of the third party's request because the information and/or opinion requested is beyond their scope of practice and area of expertise;
    b. if they are unable to obtain all relevant clinical information and opinions after taking reasonable steps;
    c. if they do not have enough information to arrive at a recommendation or conclusion on a particular point;
    d. if consent has been withdrawn; and
    e. if limits have been placed by the subject on the information that can be disclosed to the third party.

[25] Section 1(1), paragraph 18 of *Professional Misconduct*, O. Reg., 856/93, enacted under the *Medicine Act, 1991*, S.O. 1991, c. 30. states that signing or issuing, in the member's professional capacity, a document that the member knows or ought to know is false or misleading is an act of professional misconduct.

[26] College's registration policy on *Specialist Recognition Criteria in Ontario* (also see the *Cosmetic Surgery FAQ* and *Advertising FAQ*); and section 9(1) of *General*, O. Reg 114/94, enacted under the *Medicine Act, 1991*, S.O. 1991, c. 30.

[27] Indirectly via medical records or reports and/or directly via examination of the subject.

19. In discharging provision 18, physicians **must** clearly indicate what impact the limitations have on the statements and/or opinions they provide in third party medical reports and testimony.[28]

20. Physicians **must not** deliberately leave out relevant information and/or opinions in any third party medical reports and testimony they provide.

21. Physicians **must** only provide the third party with the information and/or opinions that are relevant to the request and necessary for answering the questions asked.

22. Physicians **must not** make any unrelated or unnecessary comments during IMEs and in third party medical reports and testimony.

Fair, Objective & Non-Partisan

23. Physicians **must**:
    a. provide statements and/or opinions that are reasonable, balanced, and substantiated by fact, scientific knowledge and evidence, and sound clinical judgment;
    b. ensure the statements and/or opinions they provide are not influenced by prejudice and bias[29], the party who requests or pays for their services, or the potential outcome of the third party process; and
    c. provide any additional assistance that a court or tribunal may reasonably require.

Transparent

24. Physicians **must** be clear about who the requesting party was and what has been requested of them (i.e., what questions they were asked to answer).

25. Physicians **must** clearly identify who assisted them in conducting the IME and/or who contributed to the third party medical report.

26. For any third party medical reports and testimony provided, physicians **must**:
    a. Describe the basis and rationale for their statements and/or opinions, including:
        i. the facts their statements and/or opinions are based on;

[28] For example, if the limitation prevents them from arriving at a recommendation or conclusion on a particular point.

[29] Some types of bias include: implicit, affective, cognitive, framing, hindsight or outcome, and learned intuition.

ii. what clinical information and opinions they obtained and reviewed and who the source was; and
iii. any research or literature they relied upon.[30]

b. Indicate where their statements and/or opinions stand in relation to the profession (e.g., if there is a range of opinions on an issue, and if their statements and/or opinions are contrary to the accepted views of the profession).

Accurate

27. For any third party medical reports and testimony provided, physicians **must**:
    a. ensure their statements and/or opinions are accurate; and
    b. communicate any errors they become aware of, and any changes to their statements and/or opinions to the third party in a timely manner.

Clear

28. Where possible, physicians **must** use language and terminology that will be readily understood by the audience.
    a. When physicians use abbreviations and medical or technical terminology, they **must** explain the meaning.

Timely

29. Absent a specific legal requirement,[31] physicians who are not acting as medical experts **must** conduct IMEs and/or provide third party medical reports in a timely manner,[32] but no later than:
    a. 60 days after receiving the request to conduct an IME and report on the findings; and

[30] If acting as a medical expert, see Rule 53.03(2.1) of the *Rules of Civil Procedure,* O. Reg. 194, enacted under the *Courts of Justice Act*, R.S.O. 1990, c. C.43 for specific information required in an expert report.
[31] There may be specific timelines for providing third party medical reports set out in legislation. For example, see section 68.1 of the *Statutory Accident Benefits Schedule – Effective September 1, 2010*, O. Reg.34/10, enacted under the *Insurance Act*, R.S.O. 1990, c. I.8, together with sections 32.1 and 42 of the *Statutory Accident Benefits Schedule – Accidents on or after November 1, 1996*, O.Reg. 403/96, enacted under the *Insurance Act*, R.S.O. 1990, c. I.8.
[32] What is considered timely will depend on the nature of the request, taking into consideration the complexity and urgency of the request. For example, third party medical reports that relate to income or the necessities of life would need to be completed urgently.

b. 45 days after receiving the request to provide a third party medical report.

30. If physicians are not able to meet the timeframes set out in provision 29, physicians **must** discuss the matter with the requesting party and reach an agreement for a reasonable extension.[33]

31. Physicians who are acting as medical experts in the context of a legal proceeding **must:**
    a. reach an agreement with the requesting party regarding the timeframe for providing third party medical reports;
    b. reach an agreement with the requesting party for a reasonable extension if they are not able to meet the original timeframe; and
    c. provide third party medical reports within the agreed upon timeframe.

32. Physicians **must** respond to any requests or orders (e.g., subpoenas or summons) to provide testimony in a timely manner.

Independent Medical Examinations

Presence of Observers & Audio/Video Recordings

33. Physicians **must** comply with any legal requirements regarding the presence of observers[34] and recordings that apply to the examination being conducted.

34. In the absence of any legal requirements, physicians **must** ensure:
    a. any arrangements with respect to observers or recordings are mutually agreeable to all the parties involved; and
    b. consent with respect to observers or recordings has been obtained from all the parties involved.[35]

[33] Section 1(1), paragraph 17 of O.Reg. 856/93, *Professional Misconduct*, enacted under the *Medicine Act, 1991*, S.O. 1991, c.30 states it is an act of professional misconduct to fail, without reasonable cause, to provide a report or certificate relating to an examination or treatment performed by the member to the patient or his or her authorized representative within a reasonable time after the patient or his or her authorized representative has requested such a report or certificate.

[34] For example, for court-ordered examinations, Rule 33.05 of the *Rules of Civil Procedure,* O. Reg. 194, enacted under the *Courts of Justice Act*, R.S.O. 1990, c. C.43 states that observers shall not be present during examinations, unless the court orders otherwise.

[35] For more information on observers and recordings, see the Advice to the Profession document.

35. If an observer is present, physicians **must** inform the observer that they cannot interfere or intervene in any way during the examination.

Clinically Significant Findings

36. If physicians are conducting an IME and become aware of a clinically significant finding[36] that may not have been previously identified, they **must** determine if the subject is at imminent risk of serious harm and requires urgent medical intervention.
    a. If yes, physicians **must**:
        i. disclose the finding to the subject; and
        ii. if the subject has a primary health-care provider, communicate the finding to them[37] after obtaining the subject's consent to do so and determine who will be responsible for providing any necessary care and follow-up; or
        iii. if the subject doesn't have a primary health-care provider,
            (a) provide any necessary care that is within the physician's scope of practice and coordinate the provision of any follow-up; or
            (b) direct the subject to another health-care provider that is available to provide any necessary care and follow-up.
    b. If no and the IME is not being conducted in the context of a legal proceeding or the subject hired the physician to conduct the IME,[38] physicians **must:**
        i. disclose the finding to the subject; and
        ii. if the subject has a primary health-care provider, communicate the finding to them[39] after obtaining the subject's consent to do so and determine who will be responsible for providing any necessary care and follow-up; or
        iii. if the subject doesn't have a primary health-care provider, advise the subject to see a health-care provider for any necessary care and follow-up.

[36] An unexpected clinically significant finding, a condition which raises serious concern, or a symptom or condition which requires essential intervention. This includes, but is not limited to, undiagnosed conditions and conditions for which immediate intervention is required.
[37] Physicians must use their professional judgment to determine how to communicate the finding to the primary health-care provider (e.g., by phoning them directly or sending a written note), taking into consideration the nature of the finding.
[38] If the subject (or their representative) hired the physician to conduct an IME in the context of a legal proceeding, there are no impediments to disclosure (such as legal privilege).
[39] See footnote 37.

c. If no and a third party (not the subject) hired the physician to conduct the IME,[40] physicians **must**:
    i. seek independent legal advice regarding the disclosure of the finding; and
    ii. consult with the third party to determine whether the third party waives any impediment to disclosure.

37. If the clinically significant finding is disclosed, physicians **must** only provide clinical information that is directly relevant to the finding.

Documentation, Retention and Access

38. Physicians **must** document the following for all professional encounters or services provided for a third party process, where applicable:
    a. identification of the subject and their contact information;
    b. identification of the requesting party;
    c. date of professional encounter or service;
    d. consent that has been obtained for the collection, use and disclosure of information;
    e. consent that has been obtained for examinations;
    f. information regarding the IMEs that have been conducted;
    g. consent that has been obtained with respect to the presence of observers and/or recordings of examinations; and
    h. any clinically significant findings and any action taken with respect to the findings.

39. Physicians' documentation of the information in provision 38 **must** be:
    a. legible;
    b. accurate;
    c. complete and comprehensive;
    d. identifiable, containing a signature or audit trail that identifies the author;
    e. written in either English or French; and
    f. organized in a chronological or systematic manner.

40. In addition to documenting the information in provision 38, physicians **must** retain any related materials including, where applicable:

[40] If a third party (not the subject) hired the physician to conduct an IME in the context of a legal proceeding, legal privilege may apply and may be an impediment to disclosure when the subject is not at imminent risk of serious harm and does not require urgent medical intervention. The purpose of seeking independent legal advice is to determine to whether any such impediment to disclosure exists in the circumstances.

a. contracts with the requesting party (e.g., outlining scope, purpose, timelines, fee arrangements, etc.);
b. clinical information or opinions not created by the physician, which the physician relied upon;
c. audio or video recordings of examinations; and
d. third party medical reports.

41. Physicians **must** retain and provide access to the information and related materials in provisions 38 and 40 in accordance with the legal requirements that apply to the specific circumstances.[41]

[41] For example, retention requirements would depend on whether or not the information or related materials are retained as part of a patient's medical record, and access requirements would depend on whether the examination/report was conducted for a commercial purpose and is subject to *PIPEDA*, or a health-care purpose and is subject to *PHIPA*.

Appendix B

Advice to the Profession: Third Party Medical Reports

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 play an important role when participating in third party processes by conducting independent medical examinations (IMEs) and providing third party medical reports and testimony. Expectations regarding this role are set out in the College's *Third Party Medical Reports* policy. This document is intended to help physicians interpret their obligations in this policy and to provide guidance around how these obligations may be effectively discharged.

What is the difference between a 'participant expert' and an 'litigation expert' in a legal proceeding? And does the policy apply to both?

Yes, the policy applies to participant and litigation experts as they both provide information and/or opinions for a third party process.

Participant experts are treating physicians who have personal, first-hand knowledge about the matter at issue and who form expert opinions based on their participation in the underlying events. The participant expert forms their opinions in the ordinary exercise of their skill, knowledge, training and/or experience while observing or participating in the underlying events.

Participant experts may be asked or ordered (e.g., by subpoena or summons) to provide information, including the opinions they formed, in a legal proceeding. This may include factual information, such as: what symptoms the patient reported, what examinations were undertaken, and what observations the physician made, and may include opinions, such as: what the diagnosis was, and what advice or treatments were offered. In some cases, participant experts may be examined and cross-examined under oath about the information recorded in their medical records and/or provided in third party medical reports.

Litigation experts are engaged by or on behalf of a party to provide opinion evidence in relation to a legal proceeding. They are independent and would not have had a prior involvement in the underlying events at issue. The opinion may be about an individual, or about broader topics within their scope of practice and area of expertise, such as an area of medical practice, or a medical condition. The purpose of the opinion is to assist those involved in the legal proceeding understand the medical issues.

Litigation experts can provide opinions in writing (i.e., third party medical report) and/or orally (i.e., testimony). Litigation experts may also be examined and cross-examined under oath about information they provided in third party medical reports.

Physician Participation and Role in Third Party Processes

Can I participate in a third party process if I am retired?

It depends.

If treating physicians are retired and no longer have an active certificate of registration, they cannot start preparing new reports for third party processes. However, retired physicians may provide the third party with a copy or summary of the patient's medical record with the patient's (or their substitute decision-maker's) consent, as this would likely be administrative in nature.

Retired physicians who no longer have an active certificate of registration cannot conduct IMEs and/or act as medical experts.

However, all physicians may still be required to testify even if they no longer have an active certificate of registration. This may occur in circumstances where the physician has an active certificate of registration and conducts an IME and/or provides a third party medical report, then retires and is called to testify on that report months or years later.

Do treating physicians have an obligation to provide third party medical reports and testimony about patients in circumstances when they know patients won't be successful in the third party process?

At times, physicians may suspect their patients may not meet the eligibility criteria for a third party process, or may be unsuccessful in their claim for a third party process. However, treating physicians still have an obligation to provide the third party medical report and testimony because their role is to *provide* information and/or opinions to the third party involved in the process, and not to *decide* the outcome of the third party process.

Do family physicians have an obligation to provide third party medical reports and testimony about patients when the information relates to care provided by a specialist?

If the third party is requesting information about care provided by a specialist, the family physician may not have the information, or the information may be outside of the family physician's scope of practice and area of expertise. As such, family physicians would

only be obligated to provide the third party with the relevant information they have, and the information that is within their scope of practice and area of expertise.

In these circumstances, it may be in the patient's best interest for the family physician and specialist to discuss how to proceed with the request. Providing the requested information may require some collaboration between the family physician and specialist: the family physician may be able to provide some of the information, and the specialist may provide the rest of the information.

What if the specialist's consultation report back to the family physician specifically says that the report is not to be shared with a third party? Does the family physician have an obligation to provide information regarding the consultation report to the third party despite the specialist's instructions?

At times, specialists may indicate on their consultation reports back to family physicians that the report is not to be shared with a third party. Specialists may do this because if a third party is requesting information about care provided by a specialist, the specialist may want to provide that information directly to the third party.

In these circumstances, family physicians may need to contact the specialist to tell them that a third party has requested information regarding the consultation report and the family physician and specialist can discuss how to proceed with the request. As treating physicians, both family physicians and specialists have an obligation to respond to these types of requests.

What knowledge and expertise is required to conduct an IME or act as a medical expert? What qualifies a physician to act as a medical expert?

The specific knowledge and expertise required to conduct an IME or act as a medical expert would vary and depend on the nature of the case. As stated in the policy, physicians must only act within their scope of practice and area of expertise, and it is important that they have proficient knowledge of the relevant clinical practice guidelines in place at the material time.

In a legal proceeding, an expert is someone with demonstrated specialized knowledge beyond that of the ordinary person. Specialized knowledge may be gained through academic study, professional qualification, training and/or experience. Whether or not a physician qualifies as a medical expert in general terms may depend on a number of factors, including:

- the education and training they have completed (e.g., residency, fellowship training, including specialty and subspecialty training, etc.);

- any additional qualifications they hold (e.g., certification by national professional association or other relevant clinical society, etc.);
- the experience and proficiency they have in performing the relevant aspects of their practice (e.g., number of times they have completed a relevant procedure);
- the length of time they have been actively practicing in the requisite scope of practice and area of expertise;
- teaching roles they have held;
- the relevant research, articles, and/or textbooks they have published and presentations they have given;
- the awards or other recognition they have received;
- the uniqueness of their scope of practice and area of expertise (e.g., they are the only physician who treats a rare condition);
- the complaints and/or discipline history they have with the College; and
- the civil and/or criminal actions against them.

The above factors would have to be applied to the specific circumstances of the physician and the matter at issue in the legal proceeding. For example, physicians' lack of experience may be a factor in qualification, or may impact the weight that is attached to their opinion. However, there may be some circumstances where a physician has practiced for a limited period but is one of the only physicians with experience performing a new procedure or treating a rare condition. As such, this physician may be qualified to act as a medical expert, and significant weight may be attached to their opinion.

Physicians who act as medical experts in the context of a legal proceeding must be qualified as an 'expert' by the adjudicative body using the *Mohan/White Burgess* framework[1] before they are permitted to offer opinion evidence in the legal proceeding. If the physician is qualified as an expert, the adjudicative body will typically set parameters on the scope of the expert opinion that is admissible in the legal proceeding.

What kind of situations would constitute a conflict of interest?

Examples of situations where conflicts of interest arise include:

- the physician is currently treating one of the parties involved in the third party process;
- the physician acted as a treating physician to one of the parties involved in the third party process;
- the physician has a personal interest in the case;

[1] R. v. Mohan, [1994] 2 S.C.R. 9 and White Burgess Langille Inman v. Abbott and Haliburton Co., 2015 SCC 23 (CanLII), [2015] 2 SCR 182.

- the physician previously discussed the case with another party (depending on the circumstances); or
- the physician has or had a personal or professional relationship with any of the parties involved (depending on the circumstances).

Consent

Can I rely on consent obtained by someone else? Can I rely on pre-signed consent forms?

Consent to collect, use or disclose the subject's personal information, or consent to conduct an examination, may be obtained by someone else (e.g., a lawyer, employer, insurer, etc.). In addition, physicians can rely on pre-signed consent forms if they are satisfied that the consent applies to and authorizes the full spectrum of acts they will conduct in order to prepare the third party medical report (e.g., to collect, use and disclose personal information, to conduct an examination).

If physicians have any doubts as to the validity or scope of the consent obtained by someone else or the pre-signed consent form, they can raise their concern with the requesting party and consider obtaining consent from the subject directly.

Is consent time-limited? Do I need to ensure consent has been obtained again if some time has passed since consent was first obtained?

Consent does not expire after a certain period of time, but it can be withdrawn.[2] Some third party processes may take a long time and it is recommended that physicians make a reasonable effort to ensure that the consent obtained at the beginning of the third party process is still valid and hasn't been withdrawn.

For example, if physicians are asked to provide an addendum report some time after the initial third party medical report was provided, they may want to confirm whether consent is required for the physician to use and disclose the subject's personal information in the addendum report, and if so, confirm whether there consent to do so.

Fees

[2] Clause 4.3.8, Schedule 1 of the *Personal Information Protection and Electronic Documents Act,* SC 2000, c 5 and section 19, of the *Personal Health Information Protection Act, 2004,* S.O. 2004, c.3, Sched A.

What requirements and considerations are there when charging for third party medical reports?

As per the College's *Uninsured Services: Billing and Block Fees* policy, physicians must consider the patient's ability to pay when charging for uninsured services. Providing third party medical reports is considered an uninsured service.

When patients are paying out-of-pocket for the third party medical report, physicians may want to consider the type of report they are being asked to provide when determining fees and whether prepayment is required. For example, if the report is related to income or the necessities of life, it may be a financial burden for the patient to pay for the report, particularly if payment is required before they receive any benefits. Physicians may want to discuss this with patients to help them determine the patient's ability to pay for the third party medical report.

Requirements for Independent Medical Examinations, Third Party Medical Reports and Testimony

What steps do I have to take to obtain and review all relevant clinical information and opinions relating to the subject?

What steps are reasonable would depend on the specifics of the case, but could include something as simple as asking the third party what relevant clinical information and opinions they are expected to obtain and review. The third party may provide the physician with a copy of the medical records and that may be sufficient. If, however, physicians notice that something relevant is missing (e.g., test results or a consultation report is missing from the medical record), physicians could raise this with the third party and take reasonable steps to obtain a copy.

Alternatively, taking reasonable steps to obtain and review relevant clinical information and opinions could include the physician directly getting this information by examining the subject themselves and reviewing it in the context of preparing the third party medical report.

What does it mean to be fair, objective and non-partisan?

Being fair, objective and non-partisan means not being influenced by your personal feelings, prejudices or biases, or by the party who retains or pays you. It means the statements and/or opinions provided in third party medical reports and testimony are based on facts and would not change regardless of who retained or paid you for your services. The statements and/or opinions you provide are not directed at securing or obtaining a certain result in the third party process. Physicians cannot be "hired guns" for any party in a third party process.

Even though physicians may be asked to be medical experts by a party involved in the legal proceeding (e.g., Crown prosecutor in a criminal case), medical experts are not advocates for either side. Their duty is solely to the adjudicative body. A medical expert's role is to assist the adjudicative body by providing a fair, objective and non-partisan opinion.

Any medical expert called in a civil proceeding under the Rules of Civil Procedure[3] must complete a form[4] acknowledging their duty to provide evidence in relation to the proceeding as follows:

- To provide opinion evidence that is fair, objective and non-partisan;
- To provide opinion evidence that is related only to matters that are within their area of expertise; and
- To provide such additional assistance as the court may reasonably require to determine a matter in issue.

Further, medical experts must acknowledge that the duty referred to above prevails over any obligation which the expert may owe to any party by whom or on whose behalf they are engaged.

How quickly do IMEs and/or third party medical reports need to be completed?

The policy states that when physicians are not acting as medical experts, they must conduct IMEs and/or provide third party medical reports in a timely manner and specific maximum timeframes are set out for both.

What is considered timely will depend on the nature of the request, taking into consideration the complexity and urgency of the request. For example, third party medical reports that relate to income or the necessities of life would need to be completed urgently.

Non-urgent IMEs and/or third party medical reports must be completed no later than the maximum timeframes set out in the policy. However, if it is a fairly simple and straightforward third party medical report that does not require an IME, physicians may want to consider whether they can provide it sooner than 45 days.

What should I do if the requesting party does not give me a reasonable extension?

[3] *Rules of Civil Procedure* R.R.O. 1990, Reg. 194, enacted under the *Courts of Justice Act*, R.S.O. 1990, c. C.43.

[4] Form 53 of the *Rules of Civil Procedure* R.R.O. 1990, Reg. 194, enacted under the *Courts of Justice Act*, R.S.O. 1990, c. C.43 - Acknowledgement of Experts Duty.

If the requesting party does not provide a reasonable extension for an IME, physicians could decline to conduct the IME.

If the requesting party does not provide a reasonable extension for a third party medical report and physicians do not have an obligation to provide the third party medical report (i.e., they are not treating physicians), they could decline to provide the third party medical report.

If physicians do have an obligation to provide the third party medical report (i.e., they are treating physicians), they could consider whether they are able to provide a 'preliminary' report within 45 days, as long as they are clear about the nature of the report, its limitations, and that their statements and/or opinions could change in the final report.

Independent Medical Examinations

Who are possible observers in an examination?

In the absence of any legal requirements with respect to observers,[5] possible observers in an examination include the following:

- The subject of the examination may wish to have an observer present, which may include the subject's friend, family member or lawyer.
- The requesting party may wish to have an observer present, which may include the third party's representative.
- The physician may require assistants or may have of practice of employing chaperones in examinations.

When might an observer be present during an examination? When might the examination be recorded?

In the absence of any legal requirements with respect to observers,[6] physicians may want to consider having an observer present and/or recording the examination in circumstances where the subject is particularly vulnerable (e.g., if they are cognitively impaired or are a child) and consent has been obtained.

What should I do if an agreement with respect to observers and/or recordings cannot be reached?

[5] See footnote 34 in the policy.
[6] See footnote 34 in the policy.

If the physician disagrees about whether a court-ordered examination is recorded, the physician could decline to conduct the examination and a different physician could be sought to conduct the examination.

If the parties disagree about whether an examination that is not court-ordered will be conducted in the presence of an observer, or whether it will be recorded, physicians can postpone the examination until these matters can be discussed further so that a resolution can be reached. If a resolution can't be reached after further discussion, the physician could decline to conduct the examination and a different physician could be sought to conduct the examination.

To prevent possible disagreements that may delay the examination, physicians may want to consider making arrangements with respect to observers and/or recordings in advance of the examination. This would give all parties an opportunity to consider the matter and if necessary, discuss it with someone (e.g., family member, friend, lawyer, etc.) before the subject attends the examination.

Is it appropriate to form a physician-patient relationship with an individual who is the subject of an IME?

It depends.

Physicians may want to wait until after the third party process concludes to form a physician-patient relationship with the individual, as forming a physician-patient relationship could compromise the physician's independence and may disqualify them from participating in the third party process. However in some cases, it may be appropriate to begin treating the individual before the third party process concludes if no other physician is available. In these cases, it is recommended that the physician notify the requesting party of any change in status of their relationship with the individual's consent.

Regardless of whether or not a treating relationship is formed, it is important for physicians to clearly communicate with the individual what the nature of the physician's role will be (e.g., if they will solely do an IME and/or will form a treating relationship).

Documentation, Retention and Access

Do I need to document if the subject is not a patient?

Yes. As stated in the policy, physicians must document information for all subjects (patients and individuals).

Resources

There are a number of different resources to assist physicians who participate in third party processes. Please see the following for more information:

Canadian Medical Protective Association (CMPA):

CMPA. (2019). *Treating physician reports, IME reports, and expert opinions: The way forward*.

CMPA. (2018). *Providing access to independent medical examinations*.

CMPA. (2018). *Testifying-What it involves and how to do it effectively.*

CMPA. (2016). *Medical-Legal Handbook for Physicians in Canada.*

CMPA. (2012). *eLearning Modules.*

CMPA. (2012). *Overcoming bias in medical practice*.

CMPA. (2011). *Independent Medical Evaluations: Be prepared*.

CMPA. (2009). *Subpoenas-What are a physician's responsibilities*.

Canadian Society of Medical Evaluators (CSME):

CSME. (2013). *Guide to Third Party Medical Evaluation*.

There are also some other resources regarding bias and using professional and inclusive language when communicating. Please see the following for more information:

Canadian Public Health Association. (2019). *Language Matters-Using respectful language in relation to sexual health, substance use, STBBIs and intersecting sources of stigma*.

National Institute for Health and Care Excellence. (2019). *NICE style guide: Talking about people, including deaf and blind, age, faith, family origin, gender*.

O'Sullivan, E.D., & Schofield, S.J. (2018). Cognitive bias in clinical medicine. *Journal of the Royal College of Physicians of Edinburgh, 48*(3), 225-232. https://www.rcpe.ac.uk/sites/default/files/jrcpe_48_3_osullivan.pdf

CPSO

Council Motion

Motion Title: Executive Committee Elections

Date of Meeting: September 11, 2020

It is moved by_____,

and seconded by_____, that:

The Council appoints _____ (as President),

_____ (as Vice President),

_____ (as Executive Member Representative),

_____ (as Executive Member Representative),

_____ (as Executive Member Representative),

and Dr. Brenda Copps (as Past President), to the Executive Committee for the year that commences with the adjournment of the annual general meeting of Council in December 2020.

Council Briefing Note

CPSO

September 2020

TOPIC: Executive Committee 2021 Elections

FOR DECISION

ISSUE:

- There are upcoming vacancies for the President, Vice President, and Executive Member Representative positions on the Executive Committee for 2021. A vote will take place at the September 10-11 meeting of Council to fill these upcoming vacancies.

BACKGROUND:

- The current composition of the 2020 Executive Committee includes:
    - Dr. Brenda Copps, President
    - Dr. Judith Plante, Vice President
    - Ms. Ellen Mary Mills, Executive Member Representative
    - Mr. Peter Pielsticker, Executive Member Representative
    - Dr. Peeter Poldre, Executive Member Representative
    - Dr. Janet van Vlymen, Executive Member Representative

- Executive Committee members are expected to demonstrate the Key Behavioural Competencies for Council and Committee members (Appendix A)

- Nomination statements for the vacant positions of President, Vice President, and Executive Member Representative have been received from: (See Appendix B)
    - Dr. Judith Plante, for President
    - Dr. Janet van Vlymen, for Vice President
    - Dr. Robert Gratton, for Executive Member Representative
    - Ms. Joan Fisk, for Executive Member Representative
    - Mr. Peter Pielsticker, for Executive Member Representative

- Nominees will be given the opportunity to address Council prior to the election.

- Where there is only one candidate for a position, the candidates will be acclaimed; where there is more than one candidate for a position, an election will be held using an electronic voting software that facilitates secret ballot voting (ElectionBuddy). All

Council members must have access to their CPSO email during the voting period to access the voting link.

- As per the General By-Law, the term for Executive Committee members is one year and Dr. Brenda Copps will serve as Past President for the 2021 Executive Committee.

DECISION FOR COUNCIL:

1. Election for 2021 Executive Committee positions; 1 President, 1 Vice President, and remaining Executive Member Representatives of Council.

Contact: Dr. Peeter Poldre, Chair, Governance Committee
Laurie Cabanas, ext. 503
Debbie McLaren, ext. 371
Laura Rinke-Vanderwoude, ext. 454

Date: August 20, 2020

Attachments:

Appendix A: Key Behavioral Competencies of Council Members
Appendix B: Nomination Statements

Continuous Learning
Involves taking actions to improve personal capability and includes the ability to quickly understand and apply information, concepts, and strategies. Demonstrates an interest in continuous personal learning.

Creativity
Is generating new solutions, developing creative approaches, and implementing new approaches that lead to improved performance. It requires the ability to anticipate and lead change that contributes to organizational success.

Effective Communication
Is willing and able to see things from another person's perspective. Demonstrates the ability for accurate insight into other people's/group's behaviour and motivation, and responds appropriately. It is the ability to accurately listen, understand, and respond effectively with individuals and groups.

Planning & Initiative
Recognizes and acts upon present opportunities or addresses problems. Displays effective use of time management skills. Is able to plan and organize workflow and meetings in an efficient manner to address the opportunity or problem.

Relationship Building
Is working to build or maintain ethical relationships or networks of contacts with people who are important in achieving Council-related goals and the College mission.

Results Oriented
Makes specific changes in own work methods or systems to improve performance beyond agreed standards (i.e., does something faster, at lower cost, more efficiently; improves quality; stakeholder satisfaction; revenues, etc.).

Stakeholder Focused
Desires to help or serve others, meets the organization's goals and objectives. It means focusing one's efforts on building relationships and discovering and meeting the stakeholders' needs. Partnerships between internal colleagues within the College are essential to meet external stakeholders' needs.

Strategic Thinking
Understands the implications of decisions and strives to improve organizational performance. It requires an awareness of organizational issues, processes, and outcomes as they impact key stakeholders and the organization's strategic direction.

Teamwork
Demonstrates cooperation within and beyond the Council or the College. Is actively involved and "rolls up sleeves". Supports group decisions, even when different from one's own stated point of view. Is a "good team player", does his/her share of work. Compromises and applies rules flexibly and adapts tactics to situations or to others' response. Can accept setbacks and change own immediate behaviour or approach to suit the situation. Is candid about opinions and raises justified concerns.

Continuous Learning
Involves taking actions to improve personal capability and includes the ability to quickly understand and apply information, concepts, and strategies. Demonstrates an interest in continuous personal learning.

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Strategic Thinking
Understands the implications of decisions and strives to improve organizational performance. It requires an awareness of organizational issues, processes, and outcomes as they impact key stakeholders and the organization's strategic direction.

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Demonstrates cooperation within and beyond the Council or the College. Is actively involved and "rolls up sleeves". Supports group decisions, even when different from one's own stated point of view. Is a "good team player", does his/her share of work. Compromises and applies rules flexibly and adapts tactics to situations or to others' response. Can accept setbacks and change own immediate behaviour or approach to suit the situation. Is candid about opinions and raises justified concerns.

Appendix B: Nomination Statements

President

DR. JUDITH PLANTE

District 7 Representative
Pembroke, Ontario

Principal Area of Practice: Family Medicine

Elected Council Terms:
December 4, 2015 – December 7, 2018
December 7, 2018 – December 3, 2021

CPSO Committees and Other CPSO Work:

Executive Committee:	2019, Vice President - 2020
Finance and Audit Committee:	2020
Governance Committee:	2020
Inquiries, Complaints and Reports Committee:	2015 - 2020, Vice Chair, Family Practice, 2019 - 2020
Registration Committee:	2016 - 2020, Chair, 2020
Policy Working Groups: *Medical Records*	Chair: April 2018 – March 2020

STATEMENT:

So much has changed since I joined the Executive one year ago! Who could have predicted that we would be working entirely remotely and helping to lead the profession and the broader health care system through a pandemic?

We have managed this while continuing with our core functions and our commitment to Right Touch Regulation. The challenges of implementing a new QI program, making changes to our Discipline processes, and regulating Physician Assistants are all on the horizon.

I have contributed this year to many discussions and decisions about the above issues (just to name a few) and have gained a broader understanding of 'what goes on behind the scenes' to make our organization run. I have enjoyed working with and learning from all the fantastic people, both staff and members, who are engaged in this work.

I believe I am ready for a year as President and ask for your support. I know that a great team surrounds me, and I look forward to another interesting/challenging year… who knows what it will bring!

Sincerely,

Judith

Vice-President

DR. JANET van VLYMEN

Queen's University Academic Representative
Kingston, Ontario

Principal Area of Practice: Anesthesiologist

Appointed Council Terms:
December 2, 2016 – December 3, 2021

CPSO Committees and Other CPSO Work:

Education Committee:	2016 - 2019
Executive Committee:	2020
Education Advisory Group:	2020 (Chair)
Quality Assurance Committee:	2016 - 2020
Policy Working Group: *Prescribing Drugs*	March 2018 – December 2019
Policy Review Working Group: *(formerly Policy Redesign Working Group)*	2019 - present

STATEMENT:

Thank you for considering me for the Executive Committee and Vice President for 2021. I am an anesthesiologist with over 20 years' experience at Queen's University. Early in my career, I was appointed Director of Pre-Surgical Screening where I created a stream-lined, patient-centred program to prepare patients for surgery. As Deputy Chief, I continued to develop policies and procedures to improve patient safety. I am now the Program Medical Director for Perioperative Services with accountability for the quality of care for all patients, throughout their surgical experience.

I first worked with the CPSO as an investigator and medical expert for ICRC and PIC. In 2016, I was appointed as the Academic Representative for Queen's University and joined the QAC and Education Committees. I have been fortunate to be involved in a variety of policy working groups and am now Chair of the Education Advisory Group. As a strong advocate for high-quality patient care, I am grateful for the opportunity to work with the diverse group of physician and public members on Council. If elected to the Executive Committee as Vice President, I have the support of my Chair to allow me more time away from my Department and also of the support of our new Dean to continue working on Council without the risk of losing my position during a re-election.

Executive Member Representatives

DR. ROBERT (ROB) GRATTON

District 2 Representative
London, Ontario

Principal Area of Practice: Obstetrics/Gynecology

Elected Council Terms:
December 2, 2016 – December 6, 2019
December 6, 2019 – December 2, 2022

CPSO Committees and Other CPSO Work:

Finance and Audit Committee:	2018 - 2020
Inquiries, Complaints and Reports Committee:	2015 - 2020, Vice Chair, Obstetrics, 2019 - 2020
Policy Working Groups: *Medical Records*	2018 - 2020

STATEMENT:

Thank you for considering my candidacy for the Executive Member Representative. I have had the privilege of serving on Council since 2016, recently reelected for a second term representing District 2.

I have 5 years of experience on the complaints/investigation side of the College serving on the Inquiry, Complaints and Reports Committee since 2015 and as Vice Chair Obstetrics since 2019. I am currently serving for a second year on the Finance and Audit Committee, which has given me a much broader understanding of the College and it's many functions.

The mission of "serving the people of Ontario through effective medical regulation" is anchored in the priorities of "continuous improvement and meaningful engagement of the public and the profession". To this end, the new strategic priorities for the next 5 years (2020-2025) have been developed. The Council and the CEO/Registrar have committed to the principles of "Right Touch Regulation". The many issues involved in governance reform are being actively considered. It has been an exciting time to be a member of Council.

I believe that my experience on Council, the Finance and ICRC Committees and my involvement in the strategic planning process, has positioned me well to contribute to the Executive Committee.

MS. JOAN FISK

Public Member of Council
Cambridge, Ontario

Occupation: Chief Executive Officer

Appointed Council Terms:
November 1, 2017 – October 31, 2020
Reappointment Status: Pending

CPSO Committees and Other CPSO Work:

ICR Committee:	2017 - 2020

STATEMENT:

I am seeking support to join the Executive Committee of CPSO. I have learned a great deal during my 3 years serving the ICRC. I would like to be able to help with the modernization of the College.

My background is varied, with experience as a CEO in a Textile and Apparel Manufacturing Company (Tiger Brand Knitting Company, 30 years), CEO of the Greater Kitchener Waterloo Chamber of Commerce, Chair of the Waterloo Wellington Local Health Integration Network, and currently as CEO of the United Way Waterloo Region Communities. I have served on 13 boards, including Hospital, University, College, Insurance, Symphony, and other Community and Federal Task Force groups.

I have a Governance designation from Queens University. In addition, I have taken 5 Rotman School of Management courses related to Governance and Finance. I am an enthusiastic participant in my commitments and would welcome this opportunity to guide the College as it moves forward.

Thank you for considering my application.

Joan

MR. PETER PIELSTICKER, CA, CPA

Public Member of Council
Tehkummah, Ontario

Occupation: Financial Consulting

Appointed Council Terms:
March 18, 2015 – March 17, 2018
March 18, 2018 – December 31, 2018
January 1, 2019 – June 30, 2019
July 1, 2019 – June 30, 2022

CPSO Committees and Other CPSO Work:

Discipline Committee:	2015 - 2020
Executive Committee:	2019 - 2020
Finance and Audit Committee:	Chair: 2017 - 2020, Member: 2015 - 2017
Staff Pension Committee:	2018 - 2020
Premises Inspection Committee:	2015 - 2020
Quality Assurance Committee:	2015 - 2020

STATEMENT:

I am seeking your support in being re elected as a public member to the Executive Committee. Since my appointment to CPSO in 2015 I have been very active on numerous committees as outlined above.

As an accounting and finance professional I bring a unique perspective to Council and the Executive Committee. I am well versed in the oversight functioning of CPSO and would like to continue to offer my experience and expertise to the Executive Committee.

CPSO has taken on a special meaning in my life. The role of CPSO to the medical profession is vital to the effective functioning of the health care system in Ontario. I am proud to have been part of that and honoured to be part of the outstanding CPSO organization with its very capable and competent staff.

CPSO is going through some exciting changes. We are in the midst of a 5-year strategic plan, we are transitioning into a new enterprise system, we are recommending to government legislative changes that will totally revise governance. These are all matters with which I have prior business experience and where I can continue to make a contribution.

With COVID 19 we have all experienced unprecedented times. CPSO has managed well under the leadership of our CEO and President. I want to continue to be part of that team and humbly ask for your support in being re elected to the Executive Committee.

Council Motion

Motion Title: *Delegation of Controlled Acts* – Draft Policy for Consultation

Date of Meeting: September 11, 2020

It is moved
by_____,

and seconded by_____,
that:

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

CPSO

Council Briefing Note

September 2020

TOPIC: *Delegation of Controlled Acts* – Draft for Consultation

FOR DECISION

ISSUE:

- The College's *Delegation of Controlled Acts* policy is currently under review. A new draft policy has been developed along with a companion *Advice to the Profession* document.

- Council is asked if the draft policy can be released for external consultation and engagement.

BACKGROUND:

- The current *Delegation of Controlled Acts* policy was last reviewed and approved by Council in 2012.

- The draft policy was developed with direction from the standing Policy Review Working Group, consisting of Brenda Copps (Chair), Ellen Mary Mills, and Janet Van Vlymen as well as Medical Advisors Angela Carol and Keith Hay. Additional support was provided by Jessica Amey (Legal Counsel).

- Preliminary research was undertaken in accordance with the usual policy review process.[1] In addition, feedback on the current policy was solicited through a preliminary consultation that was held in the Spring of 2019.

    - Efforts were made to invite organizational stakeholders representing or advocating for the interests of diverse and/or vulnerable groups, in addition to our typical stakeholders.

[1] This included a literature review of scholarly articles and research papers; a jurisdictional review of Canadian medical regulatory authorities and Ontario health profession regulators; relevant statistical information regarding matters before the Inquiries, Complaints, and Reports Committee (ICRC); and feedback on the current policy from the College's Public and Physician Advisory Service (PPAS).

  - The preliminary consultation garnered a total of 888 responses: 83 through written feedback and 805 via the online consultation survey. An overview of the feedback was provided in the Policy Report to Council in May 2019.

- Relevant findings and themes from the research and the preliminary consultation are provided below, as key updates are outlined.

CURRENT STATUS:

- A draft *Delegation of Controlled Acts* policy (**Appendix A**) and companion *Advice to the Profession* document (**Appendix B**)[2] have been developed in response to the research and preliminary consultation feedback. An overview of the key features in each of the drafts is set out below.

A. Draft *Delegation of Controlled Acts* Policy

- The draft policy expectations are largely consistent with those of the current policy. This briefing note captures the most significant updates and highlights the areas where the Working Group had the most discussion, but other updates that were made to enhance clarity and expand on key concepts including: updating the terminology, using more precise language, referencing relevant College policies and regulations, and re-organizing the draft policy into sections that address: when to delegate (in the patient's best interest), what to delegate (acts within a physician's scope of practice), how to delegate (in the context of an established physician-patient relationship), quality assurance (mitigating risk and appropriate supervision), and documentation (medical records and medical directives).

Patient Best Interests

- The "best interests of the patient" is a core tenet of the current policy that required clarification to better support appropriate implementation of the concept. To clarify this concept (Provision #1), the draft policy:

  - Retains the requirement that delegation of controlled acts only occur when doing so is in the best interest of the patient and specifies that this includes only delegating when the act can be performed safely, effectively, and ethically; and

  - Sets out appropriate reasons for delegating, requiring that delegation serve one or more of the following purposes: promotes patient safety, facilitates access to care where there is a need, results in more timely or efficient delivery of health care, or contributes to optimal use of health-care resources.

[2] While the *Advice* document is provided for Council's review and feedback, and will be distributed as part of the consultation, it is intended to be a nimble communications tool which does not require Council approval in the same way a policy requires approval.

- While the current policy prohibits the delegation of controlled acts solely for monetary or convenience reasons, the College continues to see concerns regarding these issues. To strengthen this provision the draft prohibits physicians from delegating *primarily* for monetary reasons or physician convenience (Provision #2).

Delegating in the Context of an Established Physician-Patient Relationship

- In response to a lack of clarity regarding the circumstances under which delegation can happen outside of an existing physician-patient relationship, the draft policy specifies the limited circumstances where this would be permissible (i.e., patient best interests and/or public health/public safety initiatives) (Provisions #7 and #8).

    - In response to the Working Group's feedback that a physician-patient relationship is not always formed when delegating in a hospital setting, a new exception has also been included in the draft policy permitting the absence of a physician-patient relationship in hospital Emergency Departments, for routine protocols (Provision #8).

    - The *Advice* reinforces that delegating prior to a physician-patient relationship is the exception not the rule and clarifies existing misconceptions about the spirit or intent of the current policy (Lines 132 – 150).

Where Delegation is Ongoing

- In response to frequent instances of patients only being seen by delegates, the draft policy has been strengthened with the inclusion of new provisions to address situations where delegation is ongoing. In particular, the draft policy now requires:

    - Physicians to ensure patients are informed of who the delegating physician is and that they can speak with the physician if they wish (Provision #9); and

    - Physicians to re-assess patients in specific circumstances, to ensure that delegation continues to be in their best interest (i.e., where there is a change in clinical status/treatment options or upon patient request) (Provision #10).

- These revisions are consistent with the existing expectation that physicians have current knowledge of a patient's clinical status prior to delegating and that delegation must be in the patient's best interest.

    - The Working Group debated this matter in detail, aiming to strike a balance between permitting appropriate delegation while respecting patient choice and ensuring that physicians are not effectively replacing themselves through delegation.

Obtaining Consent to Treatment

- The current policy lacks clarity about whether consent is required for the delegation itself or just the treatment being delegated. The draft policy clarifies that in keeping with the *Health Care Consent Act*, informed consent must be obtained for the treatment provided but does not require consent to be obtained for the delegation itself (Provisions #11).

    - Delegation is a technical concept and the current policy requirement that patients be provided with an explanation about how the delegate has obtained authorization to perform the controlled act upon request is impractical and does not align with a team-based approach to care. Instead, revisions have been made to clarify the information that must be shared about the delegate (e.g., their role in providing care) (Provisions #19).

- In response to instances where delegates have misrepresented themselves or held themselves out to be physicians, a new provision has been included developed requiring physicians to ensure delegates are accurately representing themselves and are responding to patients who have questions about the delegate's role in providing care (Provision #19).

Evaluating Delegates and Establishing Competence

- In response to preliminary consultation feedback that suggests the current policy is not clear about the actions physicians should take to establish a delegate's competence, the draft policy has been updated to set out specific actions that must be taken to establish competence (i.e., reviewing the individual's training and credentials, and observing the individual performing the act, where necessary) (Provision #14).

Appropriate Supervision

- While the current policy does not permit physicians to leave delegates unsupervised, the College regularly receives questions or concerns regarding appropriate supervision and whether delegating physicians need to be onsite. As a result and in line with right-touch regulation, the draft policy specifies that the level of supervision must be proportionate to the level of risk associated with the act being delegated, outlining factors that determine the nature of supervision required (Provision #16).
- The draft clarifies that 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) (Provisions #17). The *Advice* emphasizes that it is not appropriate to leave a delegate to manage a practice on their own, and on-site supervision can help ensure the policy requirements are fulfilled (Lines 184 – 198).

- The Working Group considered this expectation at great length, ultimately determining that it was not possible or necessary in many instances of delegation to require physicians to be onsite when supervising (e.g., delegation occurring in rural areas, long-term care settings, paramedicine).

- Instead, they sought to set an objective standard that supervision must be proportionate to the circumstances, providing committees with the tools they need where they see inadequate supervision and providing physicians with a flexible structure that reflects the realities and variations in practices.

- The issues seen by committees are predominantly one of compliance rather than a gap in the current policy expectations and concerns related to inadequate supervision often involve a complete lack of physician involvement. Nonetheless, the draft policy contains new expectations that effectively prohibit physicians from leaving delegates unsupervised (i.e., reviewing medical records, delegate re-assessments where delegation is ongoing, etc.).

- Additional revisions were made to ensure delegates understand the extent of their responsibilities and know when and who to ask for assistance when necessary (Provisions #18).

Ongoing monitoring and evaluation

- To address frequent questions about appropriate monitoring and evaluation of delegates and the delegation process, the draft policy retains but expands on the current requirements[3] by requiring physicians to also review patient medical records to ensure appropriate care is being provided through delegation[4] (Provision #22).

Documentation

- The draft policy largely retains the current requirements pertaining to documentation in medical records and medical directives. The draft, however, does not retain the requirement to capture the name and number of medical directives in medical records. The Working Group viewed this as being predominantly applicable to hospital settings and not reflective of the realities of practice more broadly. It is now captured in the *Advice* document as a best practice.

B. Draft *Advice to the Profession* Document

[3] The current requirements include ensuring currency of a delegate's knowledge and skills and periodically evaluating the delegation process

[4] The draft policy states that 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.

- The draft *Advice to the Profession* companion document (**Appendix B**) sets out guidance on specific issues related to delegation, answers frequently asked questions, and is meant to facilitate a better understanding of the technical components of delegation (e.g., distinction between delegation as defined in the policy, “delegating” or assigning tasks that are not controlled acts, and ordering the initiation of a controlled act that is within the scope of practice of another regulated health professional).

NEXT STEPS:

- Subject to Council’s approval, the draft policy will be released for external consultation and engagement.

- Consultation and engagement activities will include efforts to solicit feedback from stakeholders that represent or advocate for the interests of diverse and/or vulnerable groups, to help ensure the draft policy is specifically reviewed with a diversity, equity and inclusion lens.

- Feedback received as part of these activities will be shared with the Executive Committee and Council at a future meeting and used to further refine the draft.

DECISION FOR COUNCIL:

1. Does Council approve the draft policy for external consultation and engagement?

Contact: Tanya Terzis, Ext. 545

Date: August 21, 2020

Attachments:
Appendix A: Draft *Delegation of Controlled Acts* policy
Appendix B: Draft *Advice to the Profession: Delegation of Controlled Acts*

Appendix A

Delegation of Controlled Acts

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

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

Definitions

Controlled Acts[1]: 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 independently authorized to perform the act.

For the purposes of this policy, delegation does not include assigning a task that does not involve a controlled act (e.g., taking a patient's history), nor does it include ordering the initiation of a controlled act that is within the scope of practice of another health care professional. For example, 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

[1] See the *Advice to the Profession: Delegation of Controlled Acts* 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.

been directed by the physician and generally take place after a physician-patient relationship has been established.

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

Policy

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

When to Delegate

In the patient's best interest

1. Physicians **must** only delegate controlled acts when doing so is in the best interest of the patient. This includes only delegating when the act can be performed safely, effectively and ethically. Therefore, physicians **must** only delegate when:

    a. the patient's health and/or safety will not be put at risk;
    b. the patient's quality of care will not be compromised by the delegation; and
    c. delegating serves one or more of the following purposes:
        i. promotes patient safety,
        ii. facilitates access to care where there is a need,
        iii. results in more timely or efficient delivery of health care, or
        iv. contributes to optimal use of health-care resources.

When not to delegate

2. Physicians **must not** delegate where the primary reasons for delegating are monetary or physician convenience.

3. Physicians **must not** delegate the performance of a controlled act to a person whose certificate to practise any health profession is revoked or suspended at the time of the delegation.

[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.

4. Physicians **must not** delegate the controlled act of psychotherapy.[5]

What to Delegate

5. Physicians **must** only delegate the performance of controlled acts that they can personally perform competently (i.e., acts within their scope of practice).[6]

How to Delegate

Use of direct orders and medical directives

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

In the context of an established physician−patient relationship

7. Physicians **must** only delegate in the context of an established physician-patient relationship and where they have current and sufficient knowledge of a patient's clinical status (i.e., following a clinical assessment[7]), unless a patient's best interests dictate otherwise (e.g., in a hospital emergency room, where it is common for some tests to be ordered before a physician has seen the patient).

8. Where a patient's best interest permits delegating prior to establishing a physician-patient relationship, physicians **must** assess the patient as soon as possible afterward, unless the delegation is occurring as part of a public health initiative, other public safety program, or as part of established protocols in a hospital setting.[8]

[5] This does not prohibit health care professionals who are authorized to perform the controlled act of psychotherapy from providing psychotherapy.

[6] 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 *Delegation of Controlled Acts*: *Advice to the Profession* document.

[7] Physicians who use telemedicine to conduct a clinical assessment prior to delegating must also comply with the College's *Telemedicine* policy.

[8] 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;
- 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 operated under the authority of a Medical Officer of Health, such as vaccinations;

9. Where delegation is occurring on an ongoing basis, physicians **must** ensure that patients are informed of who the delegating physician is and that they have the option of speaking with the physician if they wish to.

10. Where delegation is occurring on an ongoing basis, physicians **must** re-assess the patient to ensure that delegation continues to be in the patient's best interest, including when:

    a. there is a change in the patient's clinical status or treatment options; or
    b. the patient has requested to see the physician.

Ensure consent to treatment is obtained

11. 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.[9]

    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.[10]

Quality Assurance

Identifying and mitigating risks

12. Prior to delegating, physicians **must** identify any potential risks and mitigate them appropriately.

Resources and environmental supports

- post-exposure prophylaxis following potential exposure to a blood borne pathogen or the provision of the hepatitis B vaccine in the context of occupational health medicine; and
- hospital emergency room settings for routine protocols.

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

[10] Obtaining informed consent 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.

13. Physicians **must** only delegate controlled acts if the necessary resources and environmental supports are in place to mitigate any risks associated with the performance of the act.

Evaluating delegates and establishing competence

14. 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 judgment[11]; and
    b. observe the individual performing the act, where necessary (i.e., where the risk is such that observation is necessary to ensure patient safety).

Ensuring delegates can accept the delegation

15. Physicians **must** only delegate to individuals who are able to accept the delegation.[12] In particular, physicians **must not:**

    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

16. 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

[11] 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.

[12] 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.

d. the education, training and experience of the delegate.

17. 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).

18. 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.
        i. Where a medical directive is implemented, physicians **must** ensure an individual implementing the directive is able to identify the physician responsible for the care of the patient.

19. 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

20. Physicians **must** ensure that any adverse events that occur are managed appropriately and **must**:

    a. be available to provide assistance in managing any adverse events, if necessary;
    b. be satisfied that the delegate is capable of managing any adverse events themselves, if necessary; and
    c. 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 any adverse events.

Ongoing monitoring and evaluation

21. 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.

22. 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.

Documentation

Medical Directives

23. Physicians **must** ensure the following information is included in the medical directive[13]:

    a. The name and a description of the procedure, treatment, or intervention being ordered;
    b. An itemized and detailed list of the specific clinical conditions that the patient must meet before the directive can be implemented;
    c. An itemized and detailed list of any situational circumstances that must exist before the directive can be implemented;
    d. A comprehensive list of contraindications to implementation of the directive;
    e. Identification of the individuals authorized to implement the directive;[14]
    f. A description of the procedure, treatment, or intervention itself that provides sufficient detail to ensure that the individual implementing the directive can do so safely and appropriately;[15]
    g. The name and signature of the physician(s) authorizing and responsible for the directive and the date it becomes effective; and
    h. A list of the administrative approvals that were provided to the directive, including the dates and each Committee (if any).

24. Each physician responsible for the care of a patient who may receive the proposed treatment, procedure, or intervention **must** review and sign the medical directive each time it is updated.[16]

Medical Records

25. Physicians **must** ensure that:

[13] 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.
[14] The individuals need not be named but may be described by qualification or position in the workplace.
[15] 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.
[16] 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.

a. the care provided through delegation is documented in accordance with the College's *Medical Records Documentation* policy, including that each entry in the medical record is identifiable and clearly conveys who made the entry and performed the act;
b. it is clear who the authorizing physician(s) are (e.g., the name(s) of the authorizing physician(s) are captured in the medical record); and
c. verbal direct orders are documented in the patient's medical record by the recipient of the direct order and are reviewed or confirmed at the earliest opportunity by the delegating physician.[17]

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

Appendix B

Advice to the Profession: Delegation of Controlled Acts

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.

Introduction

Under Ontario law, certain acts, referred to as "controlled acts," may only be performed by authorized health professionals. Of the 14 controlled acts, physicians are authorized to perform 13 of them and under appropriate circumstances, physicians may delegate these acts to others.[1] While the term "delegation" can have multiple meanings, for the purposes of the policy, "delegation" is defined as 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 independently authorized to perform the act. Delegating controlled acts in appropriate circumstances can result in more timely delivery of health care, promote optimal use of healthcare resources and personnel, and increase access to care where there is a need.

The *Delegation of Controlled Acts* policy sets expectations for physicians about when and how they may delegate controlled acts, through either direct orders or medical directives. It also sets expectations about the use, development, and contents of medical directives. This companion *Advice* document is intended to help physicians interpret their obligations as set out in the *Delegation of Controlled Acts* policy and provide guidance around how these expectations may be effectively discharged.

Delegation Fundamentals

How do I know which acts are "controlled acts"?

Controlled acts are defined in the *Regulated Health Professions Act, 1991*[2] *(RHPA)* and include the following:

1. Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis.

[1] Physicians are not permitted to delegate the controlled act of psychotherapy.

[2] Controlled acts are defined under subsection 27 (2) of the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18 *(RHPA).*

2. Performing a procedure on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, or in or below the surfaces of the teeth, including the scaling of teeth.
3. Setting or casting a fracture of a bone or a dislocation of a joint.
4. Moving the joints of the spine beyond the individual's usual physiological range of motion using a fast, low amplitude thrust.
5. Administering a substance by injection or inhalation.
6. Putting an instrument, hand or finger,
    i. beyond the external ear canal,
    ii. beyond the point in the nasal passages where they normally narrow,
    iii. beyond the larynx,
    iv. beyond the opening of the urethra,
    v. beyond the labia majora,
    vi. beyond the anal verge, or
    vii. into an artificial opening in the body.
7. Applying or ordering the application of a form of energy prescribed by the regulations under the *RHPA*.
8. Prescribing, dispensing, selling or compounding a drug as defined in the *Drug and Pharmacies Regulation Act*, or supervising the part of a pharmacy where such drugs are kept.
9. Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses other than simple magnifiers.
10. Prescribing a hearing aid for a hearing impaired person.
11. Fitting or dispensing a dental prosthesis, orthodontic or periodontal appliance or device used inside the mouth to prevent the teeth from abnormal functioning.[3]
12. Managing labour or conducting the delivery of a baby.
13. Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response.
14. Treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning.

What should I do if I'm not sure whether a procedure, treatment, or intervention requires the performance of a controlled act?

Physicians with questions about whether a procedure, treatment or intervention involves the performance of a controlled act can consult the Canadian Medical Protective Association (CMPA) or seek an independent legal opinion.

What are some examples of instances that would <u>not</u> require delegation? In

[3] This is the only controlled act that physicians are not authorized to perform.

what circumstances does the policy not apply?

"Delegation" occurs only when a physician directs an individual to perform a controlled act that the individual has no statutory authority to perform. However, the term "delegation" is often used liberally to refer to instances that would not require delegation as defined in the policy. For example, the following would not require delegation as defined in the policy:

1) Assigning tasks to staff or other health care professionals that do not involve the performance of controlled acts (e.g., history-taking, administering a test that does not involve a controlled act, taking vitals, or obtaining consent).

2) Performing a controlled act in one of the permissible circumstances listed under the *RHPA*[4] (e.g., when providing first aid or temporary assistance in an emergency or when fulfilling the requirements to become a member of a health profession (e.g., medical students)).

3) Ordering the initiation of a controlled act that is within the scope of practice of another health professional (e.g., an order for a nurse to "administer a substance by injection" is not delegation as nurses are legally authorized to perform this act when ordered to do so by a physician).[5]

Considering and Evaluating Delegates

Can I delegate to individuals who are not members of a regulated health profession?

Yes. The policy permits delegating to individuals who are not members of a regulated health profession, provided the policy requirements are met. For example, Physician Assistants and Paramedics are skilled health care providers who regularly provide safe and effective care entirely through delegation.

[4] The *RHPA* sets out a number of exceptions that allow individuals who are not members of a regulated health profession to perform some controlled acts, in certain circumstances. A comprehensive list of the exceptions can be found under Section 29 (1) (2) of the *RHPA*.

[5] In order to determine whether an act requires delegation, physicians need to be aware of the scope of practice of the individual who will perform the act and whether it includes the controlled act in question. Regulated health professions have their own professional statutes (e.g., the *Nursing Act, 1991*), that define their scopes of practice and the controlled acts they are authorized to perform. Physicians with additional questions can consult the CMPA or obtain an independent legal opinion.

Physicians are ultimately responsible for the acts they delegate and must be satisfied that the individual to whom they are delegating has the requisite knowledge, skill, and judgment to perform the act(s).

Where can I find information about delegating to Physician Assistants (PAs)?

The Canadian Medical Association and the Canadian Association of Physician Assistants have developed a Physician Assistant Toolkit for Canadian physicians looking to delegate to PAs. The CMPA's article *Working with physician assistants: Collaborating while managing risks* also contains helpful information.

How do the policy expectations apply when delegating to International Medical Graduates (IMGs) who have credentials or licences obtained in other jurisdictions but who do not have certificates of registration in Ontario?

The same protocols that apply when delegating to any other individuals apply to IMGs. In particular, physicians cannot rely exclusively on credentials or licences obtained in other jurisdictions to ascertain whether an IMG has the requisite knowledge, skill, and judgment to safely perform a controlled act and must be equally diligent in evaluating and establishing the IMG's competence to perform the controlled acts.

What are my responsibilities for ensuring competence if I am not involved in the hiring of the individual to whom I will be delegating (e.g., in an institutional setting)?

As part of establishing and ensuring a delegate's competence the policy requires physicians to review the delegate'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 judgment. It is reasonable to rely on the diligence of the institution's process for hiring unless there are reasonable grounds to believe otherwise. Physicians must still be satisfied that the individuals to whom they are delegating have the knowledge, skill, and judgment to perform the delegated acts competently and safely and would need to take appropriate action if they had concerns about a delegate's competence (e.g., notifying the individual to whom the individual is accountable).[6]

[6] For additional information see the College's *Mandatory and Permissive Reporting* policy.

Scope of Practice

What does it mean to only delegate acts which are in my scope of practice? If I have a practice restriction, am I permitted to delegate?

Physicians are required by the policy to only delegate acts that they are competent to perform personally (i.e., those within their scope of practice). This means that physicians must only delegate acts that are within the limits of their knowledge, skill and judgment and any terms, limits, and conditions of their practice certificate. Physicians are not permitted to delegate acts that contravene their practice restrictions.

Delegating in the Context of an Established Physician-Patient Relationship

The policy requires delegating in the context of an established physician-patient relationship, while permitting some exceptions. Can you elaborate on the exceptions?

The policy permits delegating prior to establishing a physician-patient relationship where it would be in a patient's best interest and identifies a few circumstances in which delegation may occur in the absence of a traditional physician-patient relationship altogether. An example of when it would be in the patient's best interest to delegate prior to establishing a physician-patient relationship is in a hospital emergency room, where it is common for some tests to be ordered before a physician has seen the patient. In this case, the timely delivery of treatment is required to ensure patient safety and thus the patient's best interests will be served by having the controlled act performed prior to assessment by the physician.

Though the policy permits delegating in advance of a physician-patient relationship where it is in a patient's best interests to do so, delegating in this context is the exception not the rule. It is generally in a patient's best interest for a physician to conduct a clinical assessment and gather the necessary clinical information prior to delegating, so they can determine whether delegation is appropriate.

Physicians who are considering whether it would be appropriate to delegate prior to establishing a physician-patient relationship need to be prepared to justify delegating in this context and be able to illustrate why it is in the patient's best interest, should a complaint arise.

Is it appropriate to delegate a cosmetic procedure (e.g., botulinum toxin (Botox) and fillers) without first establishing a physician-patient relationship?

Generally, no. As the policy states, delegation must occur within the context of an existing physician-patient relationship and following a clinical assessment. The only exception to this is where the patient's best interests would dictate otherwise. As in all instances of delegation, a physician would have to justify why delegating in advance of a physician-patient relationship is in a patient's best interest and it is not clear that this exception would apply in the context of cosmetic procedures.

Assessment of Risk

What are the risks involved in delegating? How does risk factor into decisions related to delegation?

By law, controlled acts may only be performed by authorized regulated health professionals due to the potential harm that could result if performed by someone who does not have the knowledge, skill, and judgment to perform them. As such, the performance of any controlled act has been identified by the legislature as carrying some risk.

Risks vary depending on the specific acts being performed and the circumstances under which they are performed and thus must be considered prior to each instance of delegation and mitigated appropriately. Physicians must then only delegate if the patient's health and/or safety will not be put at risk by the delegation. Physicians who require additional assistance determining the appropriateness of delegating in a specific circumstance can contact the CMPA or obtain independent legal advice.

Appropriate Supervision and Support

Delegation is intended to be a physician extender, not a physician replacement. What does this mean and how can I apply this principle when delegating?

Delegation is intended to provide physicians with the ability to extend their capacity to serve patients by temporarily authorizing an individual to act on their behalf. It is meant to be a tool to extend physician services, where appropriate, as opposed to replacing the physician altogether. In accordance with the policy, this requires physicians to appropriately supervise and support delegates, and not allow a delegate to practise independently without any physician involvement or beyond the scope of their individual knowledge, skills, and judgement. Ensuring appropriate parameters are placed around what a delegate is permitted to do, that are based on the individual's education, training and experience is vital for safe and effective delegation.

I am required to appropriately supervise individuals to whom I am delegating. Am I required to be onsite when supervising a delegate?

Generally speaking, by fulfilling the requirements in the policy physicians will often already be onsite to supervise delegates. For example, when establishing a physician-patient relationship, providing an appropriate clinical assessment prior to delegating, re-assessing a patient as a result of a change in clinical status or treatment options, or when a patient has requested to see the physician.

Notwithstanding the above, the requirement to be onsite is case specific and dependent on the circumstances of the delegation. Supervision must be proportionate to the risks associated with the delegation and physicians need to be available to provide whatever support is required by the delegate. In some instances this will require you to be onsite, or to be available to come onsite if necessary, and in other instances you can provide assistance remotely, provided the right supports are in place in the setting where the delegation is occurring.

It is not appropriate for physicians to leave a delegate to manage a practice or their patient population on their own. Onsite supervision will help ensure the policy expectations are met.

What are some examples of circumstances where it might be appropriate to be offsite when supervising a delegate?

It may be appropriate for physicians to supervise delegates while offsite where the risk of the delegation is low, and/or the circumstances make it impractical or impossible to be onsite. For example, where delegation is occurring for the purpose of facilitating access to care where there is a need, it may not be possible for supervising physicians to be physically present at the location in which a delegate is providing care. Additionally, paramedicine is structured in a way that permits Base Hospital physicians to provide remote assistance where necessary and does not require onsite supervision. Lastly, physicians delegating in the context of long-term care homes may not always be onsite.

Ultimately, whether it is appropriate to be offsite at any given moment is case specific and physicians must be available to provide assistance to delegates, when necessary.

Quality Assurance

What are some best practices for monitoring and evaluating the delegation process?

Tracking or monitoring when medical directives are being implemented inappropriately or are resulting in unanticipated outcomes can help monitor the effectiveness of the delegation process.

Delegating Prescribing

Am I permitted to delegate the controlled act of prescribing?

Yes, where appropriate. As with the delegation of all controlled acts, physicians must consider whether it is in the patient's best interest to delegate prescribing, in the circumstances. Factors for consideration include the risk profile of the drug, the patient's specific condition, whether the drug has been previously prescribed (repeats or renewals)**,** whether the prescription requires adjustment, etc.

Can medical directives be used to implement orders for prescriptions?

Yes. Medical directives can be used to implement orders for prescriptions. Any prescriptions completed pursuant to a medical directive need to specifically identify the medical directive (name and number), the individual responsible for implementing the directive (name and signature), and the name of the prescribing physician, along with contact information to clarify any questions. If a request is received, a copy of the medical directive can be forwarded to further demonstrate the integrity of the order.

Documentation

How do I ensure appropriate documentation of delegation?

Medical records can provide indication of whether delegation is being done appropriately and in accordance with the policy. Therefore, in keeping with the principles and expectation of the College's *Medical Records Documentation* policy, it is important for the medical records of patients who received care through delegation to accurately and comprehensively reflect the care that was provided (e.g., evidence of an appropriate history-taking, any relevant assessments that were done prior to delegating, informed consent in accordance with the policy, etc.). Additionally, where medical directives are implemented, physicians may wish to capture the name and number of the directive in the medical record.

Liability and Billing

Are there liability issues that arise from delegation?

Physicians are accountable and responsible for the acts that they delegate. In particular, they are responsible for making the choice to delegate, and for ensuring that the delegation is taking place safely, effectively, and in accordance with the policy expectations.

Physicians with questions about liability or liability coverage can consult the CMPA.

If I am fulfilling the CPSO's expectations with respect to the delegation of controlled acts does that mean I have fulfilled the Ontario Health Insurance Plan (OHIP) billing requirements for delegated services?

No. Fulfilling the College's expectations with respect to the delegation of controlled acts does not entail that physicians have fulfilled Ontario Health Insurance Plan (OHIP) billing requirements for delegated services. Physicians who bill OHIP and who are considering delegating performance of controlled acts to others need to carefully review the provisions of the OHIP Schedule of Benefits. The Ontario Medical Association and the Provider Services Branch at OHIP can answer questions and give advice about such matters and a joint bulletin developed by the Ministry of Health and the OMA provides additional information on Payment Requirements for Delegated Services.

Council Briefing Note

September 2020

TOPIC: Council Award Recipient

FOR INFORMATION

ISSUE:

- At the September 11 meeting of Council, **Dr. Nicole Laferriere** of Thunder Bay will receive the CPSO Council Award.

BACKGROUND:

- The CPSO Council Award recognizes physicians who demonstrate the ideal qualities that are required to effectively meet the health care needs of the people they serve. These abilities are articulated in the Royal College of Physicians and Surgeons of Canada's CANMEDS Framework which consist of seven roles:
    - The physician as medical expert (the integrating role)
    - The physician as communicator
    - The physician as collaborator
    - The physician as leader
    - The physician as health advocate
    - The physician as scholar
    - The physician as professional

- A competent physician seamlessly integrates the competencies of all seven CPSO Council Award qualities.

CURRENT STATUS:

- Council member Dr. Andrew Turner will present the award.

Contact: Laurie Cabanas, ext. 503

Date: August 27, 2020

Council Motion

Motion Title: Motion to Go In Camera

Date of Meeting: September 11, 2020

It is moved by_____,

and seconded by_____, that:

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

Council Motion

Motion Title: CPSO Presidential Compensation

Date of Meeting: September 11, 2020

It is moved
by_____,

and seconded by_____,
that:

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

CPSO

Council Briefing Note

September 2020

TOPIC: CPSO Presidential Compensation

FOR DECISION

ISSUE:

- The Finance and Audit Committee is asked to look back and assess the recommendations made in 2017 for the Presidential annual stipend.
- After two years of collecting data in the new model and making changes to the expectations of Presidential deliverables, the proposal is to tweak the following:
    - Keep the annual increase in line with committees (i.e. 2%)
    - Remove the staff scheduled government relations meetings from the stipend and add it to functions covered by per diem claims as they are highly variable by year and can greatly swing the output
    - Increase the stipend to $45,000 to be reviewed on a three-year cycle.
        - It reflects the calculations of the 2018/2019 President experience
        - It allows for special circumstances that may include but are not limited to:
            - Pandemic or other emergency;
            - Oversight of Physician Assistants;
            - As President, a physician with an active practice may require more compensation

BACKGROUND:

- In 2017, the Finance and Audit Committee formed a working group to review the Council/Committee member compensation in order to develop recommendations for a sustainable compensation model for physician members of Committees and Council.
- The Physicians Compensation Working Group met five times from June 2017 – August 2018.

- The Committee considered:
    - An environmental scan of health regulators, medical regulators, and major medical organizations.
    - Internal cost analysis and trends of Council and Committee compensation
    - A survey of all Council and Committee members in January 2018
- In December 2017, CPSO Council approved a revised approach to the presidential compensation that included per diem/per hour compensation calculated using the regular physician member rate (in lieu of the previous higher per hour rate for the president) and a newly introduced annual presidential stipend, initially set at $30,000. It should be noted that the earlier presidential hourly rate was approximately $50 more than the regular member rate.

CONSIDERATIONS:

- In 2018/2019 the incoming President provided analysis and consideration to increase the stipend to $45,000 as a first-year marker, and without supporting data, $37,500 was the response to give an additional year for trending
- The role of the Presidency has been demanding, particularly recognizing the change mandate of the College over the past two years.
- Further validation of the importance of the Presidential role was outlined during the education session that was provided by Dr. Richard Leblanc, PhD earlier this year.
- It is the view of the Chief Transformation Officer fiscally responsible for the oversight of the financials, infrastructure and Key Performance Indicators (including process and efficiencies) that an increase in expenditures of $7,500 is a small investment in good governance.
- When analyzing the last 10 years of expenditures to the President’s compensation, the stipend was to adjust to a fluctuating payout to the correct amount and to ensure sustainability.
- On further analysis, a small increase will continue to provide a level set projection of the salary.

NEXT STEPS:

- The Finance and Audit Committee is recommending to Council that the President’s Stipend be increased to $45,000, should be reviewed on a three-year cycle (2020, 2021, 2022) and subject to inflationary increases effective 2020.

DECISION FOR COUNCIL:

Does Council approve the President's Stipend increase as presented?

Contact: Mr. Peter Pielsticker, Chair, Finance and Audit Committee
Nathalie Novak, Chief Transformation Officer, ext. 432
Douglas Anderson, Corporate Services Officer, ext. 607

Date: August 19, 2020

Attachments:

Appendix A: Presidential Compensation

Appendix A

CPSO Presidential Compensation

In December 2017, CPSO Council approved a revised presidential compensation approach that included per diem/per hour compensation calculated using the regular physician member rate (in lieu of the previous higher per hour rate for the president) and a newly introduced annual presidential stipend, initially set at $30,000. It should be noted that the earlier presidential hourly rate was approximately $50 more than the regular member rate.

For the purposes of this document, "per diem" assumes a maximum of 6 hours for a "full day" of CPSO activity. Activities that are less than 6 hours in duration are invoiced on an hourly basis. For the per diem functions listed below, additional claims can be made for travel time and expenses, preparation time, and tele/video-conference calls.

Functions covered by Per Diem claims:

- Council meetings
- Executive Committee meetings
- Governance Committee meetings
- Finance & Audit Committee meetings
- Any other statutory and by-law committees to which the President is appointed
- Any future ad hoc committee to which the President may be appointed or asked to chair (recent examples include joint chairs' meeting, the CEO selection committee, strategic planning committee)
- Any policy working group to which the President had been appointed prior to assuming the presidency
- CEO/Registrar performance evaluation process (includes the president, past-president, vice-president)
- Scheduled external stakeholder meetings (e.g. OMA, CMA, and their annual and special meetings)
- Scheduled meetings with College staff except for pre-scheduled agenda setting, debriefing and dry run meetings for Council and Executive meetings.
- Annual scheduled feedback session with each Council member (in person or by phone)
- Outreach and other speaking engagements under the auspices of/coordinated by the College
- Conference attendance in Canada (typically FMRAC) and internationally
- Other CPSO committee orientation activities:
    - Presidents will have variable past experience with key CPSO committees (Discipline, ICRC, QAC, PIC, Education, Registration) and must have an opportunity to become familiar with those committees on which she/he has not served in the past. At a minimum, the President should attend at least one business/policy meeting of each committee and perhaps one actual regular session. Such orientation may be invaluable when the President is involved in outreach activities.
    - Presidents are by tradition not re-appointed to one or more of the above committees during their presidential year but will likely return to the

committee once their term as President is complete. At her/his discretion, the President should attend the business meetings (maximum two per year) of such committees as part of their preparation to return to the committee.

Functions covered by the Annual Stipend:

- Pre-scheduled agenda setting, debriefing and dry run meetings for Council and Executive meetings
- General staff meetings (four annually)
- Casual, informal meetings with CPSO staff, including CEO/Registrar
- Scheduled government relations meetings (e.g. Premier, Ministers, staff)
- Alternate Dispute Resolution huddle (as an orientation activity)
- Media training
- Preparation and review of presidential submissions for *Dialogue*
- Preparation and review of CPSO correspondence that requires the President's signature
- Review and sign-off of financial authorizations within the President's responsibility
- Ad hoc phone calls and in person conversations with Council members (at office or home)
- Miscellaneous regular mail and email correspondence (at office or home)
- Miscellaneous phone calls (at office or home)

Considerations for Scheduling:

Previous Presidents have noted that one day of the week often seems preferred as the typical "President's day at the College" (not including Executive and Council meetings). Such an approach is clearly beneficial for Presidents who have a busy clinical practice to manage. Therefore, every effort should be made to continue such a scheduling approach. When this is not possible, and when travel is time-consuming and expensive, the President should strongly consider participating by tele/videoconferencing, especially for orientation activities.

Large gaps in "President's day" scheduling should be avoided but when such gaps do occur, the President should use such gap time in a "President's day" as preparation time for upcoming meetings.

Travel time and expenses will also be invoiced for functions covered by the annual stipend.

Re-assessment for Extenuating Conditions:

During or at the end of a President's term, unique circumstances may arise that may prompt a re-assessment of the presidential stipend and/or the list of functions listed above. Such a re-assessment should be initiated by the President and discussed with the

CEO/Registrar, the Chair of the Finance & Audit Committee and with staff assistance as required.

Respectfully submitted for consideration, December 20, 2018, revised January 9, 2019
Peeter Poldre, CPSO President 2018-2019

Council Motion

Motion Title: Application of *Blood Borne Viruses* Policy to Emergency Medicine Physicians

September 11, 2020

It is moved by_____,

and seconded by_____, that:

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

Council Briefing Note

CPSO

September 2020

TOPIC: Application of *Blood Borne Viruses* Policy to Emergency Medicine Physicians

FOR DECISION

ISSUE:

- The most recent version of the *Blood Borne Viruses* policy was approved by Council in December 2015 and applies to physicians who have the potential to perform exposure prone procedures[1] in the course of providing day-to-day care, with explicit reference to emergency medicine physicians.

- Since the policy was approved, there have been concerns raised about the application of the policy to emergency medicine physicians and specifically, the requirement to undergo routine testing, as it would be **extremely rare** for most emergency medicine physicians to perform an exposure prone procedure.

- Council is being asked to amend the policy to delete the example of emergency medicine physicians in order to address the above noted concerns.

BACKGROUND:

- The *Blood Borne Viruses* policy was first approved by Council in 1998 (but published in 2004) and revisions were approved by Council in 2005, 2012 and 2015, with the redesign being approved in 2019.

- The policy in place prior to 2015 only applied to physicians who perform and who assist in performing exposure prone procedures.

- As part of the 2015 policy review process, the scope of the policy was purposely revised to explicitly apply to physicians who have the potential to perform or assist in

[1] The Centers for Disease Control and Prevention (CDC) defines an exposure prone procedure as one which involves one or more of the following:

- digital palpation of a needle tip in a body cavity (a hollow space within the body or one of its organs) or the simultaneous presence of the health-care worker's fingers and a needle or other sharp instrument or object in a blind or highly confined anatomic site (e.g., during major abdominal, cardiothoracic, pelvic, vaginal and/or orthopaedic operations); or
- repair of major traumatic injuries; or
- manipulation, cutting or removal of any oral or perioral tissue, including tooth structures during which blood from a health-care worker has the potential to expose the patient's open tissue to a blood borne pathogen

performing exposure prone procedures. Emergency medicine physicians were also added as an explicit example. The scope of the policy was retained through the policy redesign process but is now articulated in Endnote #4 of the policy and in the Advice to the Profession (*Advice*) document.

    - The *Advice* provides a rationale for requiring emergency medicine physicians to be tested. It states that performing or assisting in performing exposure prone procedures is within an emergency physicians' scope of practice and that patients who require an exposure prone procedure could come to the emergency department even though this may not happen every day or even often.

- This change in scope and application of the policy was made to address concerns raised during the policy review process, where feedback from the preliminary consultation indicated that it was not clear to whom the policy applied. The revised wording reflected the advice the College had been giving, since at least 2012, to emergency medicine physicians who inquired as to whether the policy applied to them.

CURRENT STATUS:

Concerns Raised

- Over the past several years, the College's Medical Advisors have heard from a number of emergency medicine physicians who have said that the current testing requirements in the *Blood Borne Viruses* policy are not reasonable as the likelihood of them performing an exposure prone procedure is **extremely rare**.

- Practically speaking for the vast majority of emergency medicine physicians it would be incredibly rare to ever perform exposure prone procedures even if there is a potential. For example, an emergency medicine physician would need to be both in a place without surgical support and in a rare situation where a patient would need an exposure prone procedure to be performed in the emergency department. Feedback from the Medical Advisors indicated support for this analysis.

- Additionally, over the last 3 years, where it was determined that emergency medicine physicians working in full time pediatric emergency medicine or working in an urgent care track parallel to a full function emergency room did not have the potential to ever perform exposure prone procedures, these physicians were not required to undergo blood borne viruses testing[2].

Educational Requirements for Emergency Medicine Physicians

[2] This decision was made at an operational level.

- The educational requirements for emergency medicine physicians are predominantly focused on non-exposure prone procedures, with exposure prone procedures being a rare exception rather than the rule.

    - The 2014 Objectives of Training for the Royal College of Physicians and Surgeons of Canada (RCPSC) Emergency Medicine specialty does not list any procedures that could be considered as exposure prone procedures. Needle thoracentesis, needle thoracostomy, thoracostomy tube insertion are not exposure prone procedures.

    - The 2017 RCPSC Emergency Medicine Competencies lists thoracotomy and pericardiotomy (Clause 3.4.45 page 9) as required competencies which are exposure prone procedures. These procedures are rarely done in an ER and if done, are typically performed by consultant surgeons. In hospitals with active 24/7 trauma team availability, the emergency medicine physician would rarely be involved.

    - In both RCPSC documents, managing normal and complicated obstetric deliveries are listed as needed competencies (Clause 3.4.83 page 11). Although normal delivery is not an exposure prone procedure, the repair of an episiotomy, is an exposure prone procedure but this would rarely be something done by an emergency medicine physician and would depend on the circumstances of the delivery and resources available.

    - Emergency medicine physicians who come through the College of Family Physicians of Canada's Certificate of Added Competence program are not expected to do a thoracotomy during their training and it would be beyond their scope of practice to perform an exposure prone procedure in an emergency department.

Proposal to Amend Policy (with change in interpretation) to Address Concerns

- In response to the above, an amendment to the policy is proposed to delete the example of emergency medicine physicians (leaving in the "potential" wording) and, to provide further clarification in the *Advice* regarding who is captured by the policy.

    - More specifically, the example of "emergency medicine physicians" will be deleted in the sentence "….and also includes physicians who have the potential to perform or assist in performing exposure prone procedures in the course of providing day-to-day care (e.g., emergency medicine physicians) even though they may not be currently performing them" currently set out in endnote #4 of the policy.

- The advantages of this proposal are:
    - Would alleviate the concerns of emergency medicine physicians.

  - Among the emergency medicine specialty, those for whom the potential is more likely will continue to self-identify and conduct the appropriate routine testing.

- The disadvantages of this proposal are:
  - The “potential” wording which remains in the policy may cause confusion in the absence of reading the *Advice* or Annual Renewal Form.
  - There is a small possibility of increased risk to patients and physicians in the very rare circumstance that an emergency medicine physician who is not routinely being tested performs an exposure prone procedure.

CONSIDERATIONS:

- Emergency medicine physicians who also assist at surgery or do routine obstetrics, in addition to emergency medicine, would still need to be tested even if the policy is amended as they are performing exposure prone procedures.

- The policy is set to be reviewed in 2021 or 2022 depending on organizational priorities.

NEXT STEPS:

- Pending Council’s direction, any changes made to the policy will be clarified for next year’s annual renewal. Physicians will also be notified of any changes through *Dialogue*.

DECISION FOR COUNCIL:

1. Does Council want to amend the *Blood Borne Viruses* policy to delete the example of emergency medicine physicians?

Contact: Dr. James Wilson, Medical Advisor, ext. 434
Lynn Kirshin, Senior Policy Analyst, ext. 243

Date: August 21, 2020

Council Motion

Motion Title: Reduced Membership Fees for Parental Leaves

Date of Meeting: September 11, 2020

It is moved
by_____,

and seconded by_____,
that:

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

CPSO

Council Briefing Note

September 2020

TOPIC: Reduced Membership Fees for Parental Leaves

FOR DECISION

ISSUE:

- To consider reducing the membership fee for members who take an extended parental leave

BACKGROUND:

- The President and Executive Committee have asked the College to consider offering a reduced membership fee for members who disclose that they will be taking a parental leave.
- The Senior Management Team and Finance and Audit Committee have considered the matter and are supportive of the proposal.

CURRENT STATUS:

- Currently, member fees are issued based on an annual model (traditionally June 1 – May 31 for Independent Practice and July 1 – June 30 for postgraduate members).
- There is no proration or reduced fee applied for extended leaves, of any type and duration.
- The current postgraduate membership fee is $345/year while the membership fee for all other classes is $1,725/year.
- We do not formally collect/record information from the membership pertaining to parental leaves, although we do receive status updates for postgraduate members.
- There is also an added nuance that we will have members from both groups (and two different fees) applying for this discount which will have a different financial impact.

- A National Environmental Scan of registration fees and status types across Canada is included as Appendix A.
- Only one province (British Columbia) offers a reduced fee for members on extended leave (parental) while Quebec and Manitoba offer members to transfer to an inactive status.
- All 3 Medical Regulatory Authorities require additional payments to be re-instated at different intervals.
- Of the Ontario regulated professions who replied to our survey, five respondents indicated that they offer an option for reduced fees for members on extended leaves, with the College of Human Resources Professionals offering the most comprehensive plan which includes leaves for parental as well as illness and disability.
- The Royal College of Physicians and Surgeons of Canada offers an application for reduced membership fees which addresses loss of income, postgraduate training and leaves exceeding four months for family or health reasons.

ANALYSIS:

- Based on our data – we would estimate that no more than 100 postgraduate members take a parental leave exceeding four months in any given year.
    - Estimated annual revenue loss for this cohort: $345 / 2 x 100 = $17,250
- To estimate revenue loss for all other classes, the following metric was used: Female members* between the ages of 25 – 40 (8,813); having an average of two applicable leaves during this 15-year period at 50 % of the membership fee
    - Estimated annual revenue loss for this cohort: 8,813 x 2 x $862.50 = potential total revenue loss of $15,202,425 accumulated over a 15-year period;
    - If we divide this number over 15 years, the postgraduate estimated revenue loss is projected to be a revenue loss of about $1,013,437.50/year;

      *based on our data from the postgraduate cohort, parental leaves for males typically do not exceed the four month threshold so they are excluded from this estimate
- Based on the above, if we move forward with this initiative, the College could potentially see an annual loss of $1,030,687.50 of membership revenue.

CONSIDERATIONS:

- We have obtained legal advice that confirms that there is no legal barrier to recognizing leaves of absence related solely of a parental nature.
- As other Colleges/regulators have done, the College supports assigning a minimum duration to the length of the extended leave (e.g. four months or longer).

- We propose that individuals complete an application form requesting consideration for a fee reduction – and not to entrench this option as a question/selection in the renewal process.
- If, at the point of renewal, an individual applies for the fee reduction – they will receive a 50 % reduction in the annual membership fee for the year going forward.
- If an individual does not apply for the fee reduction at the time of annual renewal – but does so during the year and meets the criteria set out (i.e. parental leave of a period exceeding 4 months in duration) – the fee reduction will be attributed in the following year.
- The College does not have an inactive status option for the public register; physicians are either listed as Active, Expired, Revoked or Suspended.
- Currently, physicians who are on parental leave and enrolled in a postgraduate program maintain a status of “active” on the register. If the College moves forward with a reduced fee for parental leaves for all members, the recommendation is to maintain status quo and have the physicians maintain an “active” status on the public register.
- The issue of a differential fee for members has been considered by Council on a number of previous occasions, most recently in 2004 and 2013, wherein Council agreed to continue to require uniform annual fees for all certificates of registration and not introduce a fee structure that offers further fee differentials.

NEXT STEPS:

- The Finance and Audit Committee recommends to Council for approval, a reduction in membership fee for members taking parental leave effective June 1st, 2021.

DECISION FOR COUNCIL:

Does Council approve the policy as presented?

Contact: Samantha Tulipano, Ext. 709

Date: August 19, 2020

Attachments:

Appendix A: Environmental Scan of Reduced Fees

Appendix A - Reduced Membership Fees for Leaves:

From other Medical Regulatory Authorities:

British Columbia:

With respect to maternity/medical leave they charge $285.83 which is 1/6th of the current annual fee ($1,715). After 4 months leave the member must re-register and pay a $600 registration fee.

Manitoba:

Inactive license – $0 but must pay $1,816 if they want to keep their corporation active and $1,816 to return to the active register

Quebec:

Inactive license - $100 but must pay $1,595 to return to the active register (this is not specifically a leave license it was formerly a retired class)

From other Regulated Professions in Ontario:

College of Massage Therapists:

Inactive class - $200 renewal as opposed to full renewal at $785

Human Resources Professionals Association:

Parental Leave (first year) – fees reduced by 70%

Parental Leave (18 months) – fees reduced by 50%

Illness and Disability – member continues to work part time – fees reduced by 50%

Illness and Disability – member does not work – fees reduced by 100%

College of Chiropractors of Ontario:

Member moves to inactive and fees are prorated based on a monthly calculation

College of Audiologists and Speech Language Pathologists

No reduced fee if a member goes on leave during the year (meaning after the renewal period) – at renewal, if a member selects inactive practice, they pay half the membership fee.

Royal College of Physicians and Surgeons of Canada:

Temporary leave (exceeding four months) for personal or health reasons – 50% reduction in fees

Council Motion

Motion Title: **By-law Amendments to Reflect New CPSO System Processes (By-law No. 137)**

Date of Meeting: **September 11, 2020**

It is moved by_____,

and seconded by_____, that:

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

By-law No. 137

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

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

(a) his or her home address;
(b) an e-mail address for communications from the College and the address of all locations at which the member practices medicine;
(c) a description or confirmation of the services and clinical activities provided at all locations at which the member engages in medical practice;
(d) the names, business addresses and telephone numbers of the member's associates and partners;
(e) information required to be maintained on the register of the College;
(f) information respecting the member's participation in continuing professional development and other professional training;
(g) the types of privileges held at each hospital at which a member holds privileges;

(h) information that relates to the professional characteristics and activities of the member that may assist the College in carrying out its objects, including but not limited to:
    (i) information that relates to the member's health;
    (ii) information about actions taken by other regulatory authorities and hospitals in respect of the member;
    (iii) information related to civil lawsuits involving the member;
    (iv) information relating to criminal arrest(s) and charge(s); and
    (v) information relating to offences.

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

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

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

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

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

Council Motion

Motion Title: **By-law Amendments to Reflect New CPSO System Processes (By-law No. 138)**

Date of Meeting: **September 11, 2020**

It is moved by_____,

and seconded by_____, that:

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

By-law No. 138

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

FAILURE TO PROVIDE INFORMATION

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

CPSO

Council Briefing Note

September 2020

TOPIC: By-Law Amendments to Reflect SOLIS Processes

FOR DECISION

ISSUE:

- By-law amendments are needed to reflect new processes to be implemented in SOLIS for certain communications with members.

BACKGROUND:

- In May 2020, proposed By-law amendments were brought to Council for its consideration.
- The by-law amendments were intended to allow electronic communications for certain processes under the new CPSO enterprise system, SOLIS, and also to clarify the use of the member portal for communications more generally.
- Some of the By-law amendments had to be circulated to the profession before Council could approve them. Those that did not need to be circulated were approved by Council at the May meeting and became effective at that time.

CONSIDERATIONS:

- The By-law amendments that were circulated to the profession are now being brought back to Council for final approval.
- This set of By-law amendments includes amendments to the General By-law and to the Fees and Remuneration By-law. (See the proposed changes in Appendix A.)
- There were no comments submitted to CPSO on the proposed By-law amendments.

DECISION FOR COUNCIL:

1. Does Council approve the amendments to the General By-law and to the Fees and Remuneration By-law to reflect the new processes in Solis?

Contact: Marcia Cooper, x546
Cameo Allen, x573
Nathalie Novak, x432

Date: August 21, 2020

Attachments:

Appendix A: By-law Amendments

Appendix A

General By-Law

Notification Required by Members

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

(a) his or her home address;
(b) an e-mail address for communications from the College and the address of all locations at which the member practises medicine;
(c) a description or confirmation of the services and clinical activities provided at all locations at which the member engages in medical practice;
(d) the names, business addresses and telephone numbers of the member's associates and partners.
(e) information required to be maintained on the register of the College;
(f) information respecting the member's participation in continuing professional development and other professional training;
(g) the types of privileges held at each hospital at which a member holds privileges;
(h) information that relates to the professional characteristics and activities of the member that may assist the College in carrying out its objects, including but not limited to:

(i) information that relates to the member's health;
(ii) information about actions taken by other regulatory authorities and hospitals in respect of the member;
(iii) information related to civil lawsuits involving the member;
(iv) information relating to criminal arrest(s) and charge(s); and
(v) information relating to offences.

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

(7) Upon request of the College, a member shall provide to the College, in writing or electronically as specified by the College, acceptable documentation confirming

completion of continuing professional development programs in which the member has participated during a specified period of time.

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

Fee and Remuneration By-Law

FAILURE TO PROVIDE INFORMATION

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

ENTERPRISE SYSTEM

RELEASE 1 PREVIEW

(No materials)

CPSO

Council Motion

Professional Responsibilities in Medical Education – Draft for Consultation

September 11, 2020

It is moved by_____,

and seconded by_____, that:

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

CPSO

Council Briefing Note

September 2020

TOPIC: *Professional Responsibilities in Medical Education* – Draft for Consultation

FOR DECISION

ISSUE:

- The College's *Professional Responsibilities in Undergraduate Medical Education* and *Professional Responsibilities in Postgraduate Medical Education* policies are currently under review. These policies have been combined into a new draft *Professional Responsibilities in Medical Education* policy and a companion *Advice to the Profession* (*Advice*) document has been developed.

- Council is asked if the draft policy can be released for external consultation and engagement.

BACKGROUND:

- The current *Professional Responsibilities in Undergraduate Medical Education* policy and *Professional Responsibilities in Postgraduate Medical Education* policy were reviewed and approved by Council in 2012 and 2011, respectively.

- The draft policy was developed with direction from the standing Policy Review Working Group, consisting of Brenda Copps (Chair), Ellen Mary Mills, and Janet Van Vlymen as well as Medical Advisors Angela Carol and Keith Hay. Additional support was provided by Sayran Sulevani (Legal Counsel) and Nathan Roth (Medical Advisor).

- Preliminary research was undertaken in accordance with the usual policy review process.[1] In addition, feedback on the current policies was solicited through a preliminary consultation held from December 2019 to February 2020.

[1] This included a literature review of scholarly articles and research papers; a jurisdictional review of Canadian medical regulatory authorities, medical schools and relevant physician organizations; relevant statistical information and review of cases from the Inquiries, Complaints, and Reports Committee; and feedback on the current policies from the College's Public and Physician Advisory Service and the Education Advisory Group.

- Efforts were made to invite organizational stakeholders representing or advocating for the interests of diverse and/or vulnerable groups, in addition to inviting our typical stakeholders.

- The preliminary consultation garnered a total of 96 responses: 24 through the online discussion page, and 72 via the online survey. An overview of the feedback and a full breakdown of preliminary consultation respondents was provided to Council in March 2020 as part of the Policy Report.

- In addition to hearing from patients, physicians and other key stakeholder organizations, feedback was received from the following organizational stakeholders representing or advocating for the interests of diverse and/or vulnerable groups: #MedicineToo, Ontario Coalition of Rape Crisis Centres, and the Society for Canadians Studying Medicine Abroad.

- Relevant findings and themes from the research and the preliminary consultation are provided below, as key updates are outlined.

CURRENT STATUS:

- A draft *Professional Responsibilities in Medical Education* policy (**Appendix A**) and companion *Advice to the Profession* document (**Appendix B**) have been developed in response to the research and preliminary consultation feedback. An overview of the key features in each of the drafts is set out below.

A. Draft *Professional Responsibilities in Medical Education* Policy

- The draft policy expectations are largely consistent with those of the current policies; however, a number of revisions were made to enhance clarity and expand on key concepts. This briefing note captures the most significant changes and highlights those revisions where the Working Group had the most discussion, but other updates that were made include: using more precise language, and ensuring the consolidated expectations reflect the range of activities a Most Responsible Physician/supervisor or trainee may undertake in the medical education context.

Combining Current Policies: Enhancing Clarity and Utility

- The draft policy combines both the *Professional Responsibilities in Undergraduate Medical Education* and *Professional Responsibilities in Postgraduate Medical Education* given their significant overlap.

    - This has resulted in one clear and concise policy that is more user-friendly than having two separate policies on related issues.

    - It is notable that the draft policy retains the existing content from the current policies and addresses new issues, while achieving a 32% reduction in word count.

Availability of Most Responsible Physician (MRP) and/or Supervisor

- To address questions about what availability of MRPs/supervisors means, the draft policy expands on the expectations regarding availability of MRPs/supervisors that are currently only found in the postgraduate medical education policy (Provisions #5 and #6). The *Advice* also sets out guidance about whether an MRP/supervisor needs to provide direct supervision at all times.

    - Some preliminary consultation respondents commented on the need to clarify the degree of supervision and specifically the degree of supervision when on call and the Professional Association of Residents of Ontario suggested that the post-graduate medical education policy include a section on "on call interactions".

    - The draft policy is now more consistent with the policies of Canadian medical schools and one other Canadian medical regulator.

    - The issue of availability of supervisors is regularly seen at the College's Inquiries, Complaints and Reports Committee (ICRC) and the cases concern whether the supervisor properly supervised the medical student or resident and specifically whether the supervisor should have been more personally involved.

Violence/Harassment/Discrimination

- To address a gap in the current policies, the draft policy explicitly addresses violence, harassment, and discrimination against medical students and trainees, stating that physicians involved in medical education must not engage in these practices and must take reasonable steps to stop these practices if they see them occurring in the learning environment (Provision #10).

- Similarly, the draft policy also states that MRPs and/or supervisors must provide medical students and/or trainees with support and direction in addressing disruptive behaviour (including violence, harassment and discrimination) in the learning environment (Provision #11).

    - Preliminary consultation respondents, including the Professional Association of Residents of Ontario, wanted more explicit references to intimidation and harassment as they were concerned that the current policies do not address issues concerning students who are treated unprofessionally.

    - The ICRC has seen instances of inappropriate conduct by supervisors (including residents) towards residents/medical students. The inappropriate conduct included harassment (including sexual), intimidation, and discrimination.

- Although a number of medical schools have policies on these issues, the Working Group thought it was important for the College to make a statement on these issues.

Professional Relationships/Boundaries

- To address concerns that the existing policy might be too permissive in nature, the draft policy sets out a new expectation that prohibits MRPs and/or supervisors from entering into sexual relationships or relationships with medical students and/or trainees that could present a risk of conflict of interest, bias, or coercion (Provision #12) while directly or indirectly responsible for mentoring, teaching, supervising or evaluating the medical student and/or trainee.
    - Some preliminary consultation respondents, including the University of Ottawa Faculty of Medicine, felt that the current provisions seem to condone or encourage dating and two other Canadian medical regulatory authorities prohibit sexual relationships between supervisors and medical students/trainees.
    - The expectation is consistent with the philosophy of zero tolerance due to the nature of the power imbalance in such relationships and the Working Group felt that it was important to make this shift in the College's guidance to the profession.

Reporting Responsibilities

- To address a gap in the current postgraduate medical education policy, the draft policy contains new expectations with respect to reporting requirements in the context of postgraduate medical education and clarifies what must be reported, including when MRPs and/or supervisors engage in violence, harassment and discrimination against medical students/trainees (Provisions #14 and #15).
    - Currently, only the undergraduate medical education policy contains expectations regarding reporting, and it does not explicitly refer to violence, harassment and discrimination.
    - A Canadian national survey of recent medical graduates indicated that while many students identified experiencing or witnessing mistreatment during their training, actual reporting rates are very low as the students were worried that speaking up about bad behaviour will have consequences on their professional success. Feedback from medical students who participated in the preliminary consultation process aligned with these national results.

Obtaining Consent

- To address a gap in the current policies, the draft policy clarifies and expands upon the current policies' consent provisions.

- There is a new expectation requiring that express consent be obtained when medical students or trainees observe patient care, while allowing flexibility in terms of who must obtain the consent (Provisions #16). In addition, the draft policy requires MRPs and/or supervisors to use their professional judgment to determine whether consent is required for trainee participation in patient care (Provision #17).[2]

    - The Working Group discussed the issue of consent at length and agreed that the preliminary consultation feedback, polling conducted, and the literature reviewed supported the need to make these revisions – that is, patients should be informed when medical students/trainees observe or participate in their care, and that patient choice should be respected, while recognizing that as trainees come to the end of their training the need for consent for their participation in care diminishes.

B. Draft *Advice to the Profession* Document

- The draft *Advice* sets out guidance on specific issues related to professional responsibilities in medical education, and answers frequently asked questions.[3]

- The draft *Advice* also provides links to additional resources which may be helpful to medical students and/or trainees, including relevant Canadian Medical Protective Association articles, eDialogue, and the College's Professionalism and Practice program.

NEXT STEPS:

- Subject to Council's approval, the draft policy will be released for external consultation and engagement.

- Consultation and engagement activities will include efforts to solicit feedback from stakeholders that represent or advocate for the interests of diverse and/or vulnerable groups, to help ensure the draft policy is specifically reviewed with a diversity, equity and inclusion lens.

[2] The *Advice* sets out guidance for physicians about what factors to consider in making this determination, including the experience and competence of the trainee and the needs and wishes of the patient.
[3] While this document is provided for the Council's review and feedback, and will be distributed as part of the consultation, it is intended to be a nimble communications tool which does not require Council approval in the same way a policy requires approval.

- Feedback received as part of these activities will be shared with the Executive Committee and Council at a future meeting and used to further refine the draft.

DECISION FOR COUNCIL:

1. Does Council approve the draft policy for external consultation and engagement?

Contact: Lynn Kirshin, Ext. 243

Date: August 21, 2020

Attachments:

Appendix A: Draft *Professional Responsibilities in Medical Education* policy
Appendix B: Draft *Advice to the Profession: Professional Responsibilities in Medical Education*

Appendix A

Professional Responsibilities in Medical Education

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

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

Definitions

Undergraduate medical students ("medical students"): Students enrolled in an undergraduate medical education program. They are not members of the College of Physicians and Surgeons of Ontario.[1]

Postgraduate trainees ("trainees")[2]: Physicians who hold a degree in medicine and are continuing in postgraduate medical education. Commonly referred to as "residents" or "fellows" in most teaching sites. Trainees often serve in the role of supervisors but do not act as the most responsible physician for patient care. If trainees are supervisors, then the provisions of the policy regarding supervisors apply to them.

Most responsible physicians ("MRP"): Physicians who have overall responsibility for directing and coordinating the care and management of a patient at a specific point in time, regardless of the amount of involvement that a medical student or trainee has in that patient's care.

Supervisors: Physicians who have taken on the responsibility to observe, teach, and evaluate medical students and/or trainees. The supervisor of a medical student or trainee who is involved in the care of a patient may or may not be the most responsible physician for that patient.

[1] The *Regulated Health Professions Act, 1991*, S.O. 1991, c.18 (*RHPA*) permits students to participate in the delivery of health care by allowing them to carry out controlled acts "while 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 done under the supervision or direction of a member of the profession".

[2] The majority of trainees in Ontario hold a certificate of registration authorizing postgraduate education, but regardless of the class of certificate of registration held, postgraduate trainees cannot practise independently.

Policy

Identification of MRPs, Trainees and Medical Students

1. MRPs, supervisors, and/or trainees **must** ensure that patients[3] are informed:
    a. of the name and role of the MRP along with an explanation that the MRP is ultimately responsible for their care;
    b. about the medical students and/or trainees involved in their care, their roles on the health-care team and the fact that medical students are not physicians; and
    c. about the fact that patient care in teaching hospitals and other affiliated sites where medical education occurs relies on a collaborative, team-based approach.[4]

Supervision of Medical Students

2. MRPs and/or supervisors[5] **must** provide appropriate supervision to medical students. This includes:
    a. determining a medical student's willingness and competency to participate in patient care;
    b. closely observing interactions between medical students and patients to assess:
        i. a medical student's performance, capabilities, and educational needs;
        ii. whether a medical student has the requisite competence (i.e., knowledge, skill and judgment) to safely participate in a patient's care without compromising that care; and
        iii. whether a medical student demonstrates the requisite competence (i.e., knowledge, skill, and judgement) and expertise to interact with patients in circumstances where the supervisor is not present in the room;
    c. meeting at appropriate intervals with a medical student to discuss their assessments of patients and any care provided to them;
    d. ensuring that a medical student only engages in patient care based on previously agreed-upon arrangements with the MRP and/or supervisor;
    e. reviewing and providing feedback on a medical student's documentation, including any progress notes written by a student;

[3] Throughout this policy, where "patient" is referred to, it should be interpreted as "patient or substitute decision-maker" where applicable.
[4] Medical students could also provide the information contained in this provision.
[5] A trainee may also be a supervisor.

f. using their professional judgment to determine whether to countersign a medical student's documentation;
g. countersigning all orders written under the supervision or direction of a physician;[6] and
h. managing and documenting patient care, regardless of the level of involvement of medical students.

Supervision of Trainees

3. MRPs and/or supervisors **must** provide appropriate supervision to trainees. This includes:
    a. being familiar with individual learning plans and competencies, and program objectives;
    b. regularly evaluating a trainee's clinical competence and learning needs, and assigning graduated responsibility accordingly;
    c. determining that a trainee has the requisite competence (i.e., knowledge, skill, and judgment) to participate in a patient's care;
    d. ensuring that relevant clinical information is made available to a trainee;
    e. communicating regularly with a trainee to discuss and review their patient assessments, management, and documentation of patient care in the medical record; and
    f. directly assessing the patient as appropriate.

4. Trainees **must**:
    a. only take on clinical responsibility in a graduated manner in step with their demonstrated growing competency, although never completely independent of appropriate supervision;
    b. communicate with a supervisor and/or MRP and document:
        i. in accordance with the guidelines of their postgraduate program and/or clinical placement setting;
        ii. their clinical findings, investigations, and treatment plans;
        iii. when there is a significant change in a patient's condition;
        iv. when the trainee is considering a significant change in a patient's treatment plan or has a question about the proper treatment plan;
        v. about a patient discharge;
        vi. when a patient or family expresses concerns; or

[6] Prescriptions, telephone or other transmitted orders may be transcribed by the medical student but must be countersigned.

vii. in an emergency or when there is significant risk to the patient's well-being; and

c. identify the MRP or supervisor who has reviewed their consultation reports and indicate the MRP's or supervisor's approval of the report.

Availability of MRP and/or Supervisor

5. MRPs and/or supervisors **must** ensure that that they are identified and available to assist medical students and/or trainees when they are not directly supervising them (i.e., in the same room) or if unavailable, they **must** ensure that an appropriate alternative supervisor is available and has agreed to provide supervision.

6. The degree of availability of an MRP and/or supervisor and the means of availability (by phone, pager or in-person) **must** be appropriate and reflective of the following factors:
   a. the patient's specific circumstances (e.g., health status, specific health-care needs);
   b. the setting where the care will be provided and the available resources and environmental supports in place; and
   c. the education, training and experience of the medical student and/or trainee.

Professional Behaviour

7. MRPs and supervisors **must** demonstrate a model of compassionate and ethical care while educating and training medical students and trainees.

8. MRPs, supervisors, and trainees **must** demonstrate professional behaviour in their interactions with:
   a. each other,
   b. medical students,
   c. patients and their families,
   d. colleagues, and
   e. support staff.

9. MRPs, supervisors, and trainees **must not** engage in disruptive behaviour that interferes with or is likely to interfere with quality health-care delivery or quality medical education (e.g., the use of inappropriate words, actions, or inactions that interfere with a physician's ability to function well with others.[7])

[7] For more information, please refer to the College policy on *Physician Behaviour in the Professional Environment*, as well as the Guidebook for Managing Disruptive Physician Behaviour.

Violence, Harassment, and Discrimination

10. Physicians (including MRPs, supervisors, and trainees) involved in medical education and/or training **must not** engage in violence, harassment or discrimination against medical students and/or trainees.
    a. Physicians **must** take reasonable steps to stop violence, harassment or discrimination against medical students and/or trainees if they see it occurring in the learning environment and **must** take any other steps as may be required under applicable legislation[8], policies, institutional codes of conduct or by-laws.

11. MRPs and/or supervisors **must** provide medical students and/or trainees with support and direction in addressing disruptive behaviour (including violence, harassment and discrimination) in the learning environment, including but not limited to taking any steps as may be required under applicable legislation[9], policies, institutional codes of conduct or by-laws.

Professional Relationships/Boundaries

12. MRPs and supervisors **must not**:
    a. make sexual comments or gestures toward a medical student and/or trainee;
    b. enter into a sexual relationship with a medical student and/or trainee while directly or indirectly responsible for mentoring, teaching, supervising or evaluating the medical student and/or trainee; or
    c. enter into any relationship[10] with a medical student and/or trainee that could present a risk of conflict of interest, bias, or coercion while directly or indirectly responsible for mentoring, teaching, supervising or evaluating the medical student and/or trainee.

13. MRPs and/or supervisors (including trainees who are supervisors) **must** disclose any sexual or other relationship[11] between themselves and a medical student and/or trainee which pre-dates the mentoring, teaching, supervising or evaluating role of the MRP and/or supervisor to the appropriate member of faculty (e.g., the

[8] For example, the obligations set out in the *Occupational Health and Safety Act*, R.S.O. 1990, c.0.1 ("*OHSA*") and the *Human Rights Code*, R.S.O. 1990, c. H.19 (the "*Code*").
[9] Physicians may have other obligations under *OHSA* and the *Code* in regard to their own behaviour in the workplace, as well as specific obligations if they are employers as defined by *OHSA* or the *Code*.
[10] E.g., dating, business, etc.
[11] E.g., family, dating, business, etc.

department or division head or undergraduate/postgraduate program director) in order for the faculty member to decide whether alternate arrangements are warranted.

Reporting Responsibilities

14. Physicians (including MRPs, supervisors and trainees) involved in the education and/or training of medical students and/or trainees **must** report to the medical school and/or to the health-care institution, if applicable, when a medical student and/or trainee:
    a. exhibits behaviours that would suggest incompetence, incapacity, or abuse of a patient;
    b. fails to behave professionally and ethically in interactions with patients and their families, supervisors, and/or colleagues; or
    c. otherwise engages in inappropriate behaviour.

15. Physicians involved in administration at medical schools, or health-care institutions that train physicians **must** contribute to providing**:**
    a. a safe and supportive environment that allows medical students and/or trainees to make a report if they believe the MRP and/or their supervisor:
        i. exhibits any behaviours that would suggest incompetence, incapacity, or abuse of a patient;
        ii. fails to behave professionally and ethically in interactions with patients and their families, supervisors or colleagues; or
        iii. otherwise engages in inappropriate behaviour, including violence, harassment, and discrimination against medical students and/or trainees; and
    b. an environment where medical students and/or trainees will not face intimidation or academic penalties for reporting such behaviours.

Consent

While patient consent for treatment[12] must always be obtained, additional expectations apply in the medical education and training context.

16. The physician responsible for or who is providing care must obtain express consent[13] from the patient for:

[12] Obtaining informed consent includes the provision of information and the ability to answer questions about the material risks and benefits of the procedure, treatment or intervention proposed. For more information, please refer to the College's *Consent to Treatment* policy and also, the *Health Care Consent Act, 1996*, c. 2, Sched. A.
[13] Express consent is directly given, either orally or in writing.

a. medical student observation or participation in care, and/or
b. trainee observation of care.

17. MRPs and/or supervisors **must** use their professional judgment to determine whether to obtain express consent from patients when trainees participate in patient care.[14]

18. Where an examination, investigation and/or procedure is unrelated to or unnecessary for patient care[15], the MRP and/or supervisor **must** obtain express consent from the patient[16] and **must** be confident that the proposed examination or clinical demonstration will not be detrimental to the patient, either physically or psychologically.

Supervision of Medical Students for Educational Experiences not Part of an Ontario Undergraduate Medical Education Program

19. In addition to fulfilling the expectations set out above, physicians who choose to supervise medical students for educational experiences that are not part of an Ontario undergraduate medical education program **must**:
    a. comply with the *Delegation of Controlled Acts* policy,[17]
    b. ensure that they have liability protection for that student to be in the office,
    c. ensure that the student:
        i. is enrolled in and in good standing at an undergraduate medical education program at an acceptable medical school,[18]
        ii. has liability protection that provides coverage for the educational experience,
        iii. has personal health coverage in Ontario, and

[14] As trainees are physicians, it may not always be necessary to obtain express consent for their participation in patient care. See *Advice* for examples of when express consent may be needed for involvement of trainees in patient care.
[15] See *Advice* for examples.
[16] Regardless of whether or not the patient will be conscious during, for example an examination. For further information about medical students performing pelvic examinations, please see the Society of Obstetricians and Gynaecologists of Canada's *Guideline #246*.
[17] The College's Delegation of Controlled Acts policy applies to any physician who supervises:
1. an Ontario medical student completing an extra rotation that is not part of their MD program, and
2. a student from outside Ontario completing an Ontario educational experience where the student will be performing controlled acts.

[18] For the purposes of this policy, an "acceptable medical school" is a medical school that is accredited by the Committee on Accreditation of Canadian Medical Schools or by the Liaison Committee on Medical Education of the United States of America, or is listed in either the World Health Organization's Directory of Medical Schools: http://www.who.int/hrh/wdms/en/, or the World Directory of Medical School's online registry: https://www.wdoms.org/.

iv. ensure that the student has up-to-date immunizations.[19]

b. Where physicians do not have experience supervising medical students or are unable to fulfill the expectations outlined above, they **must** limit the activities of the medical student to the observation of patient care only.

[19] Please refer to the Council of Ontario Faculties of Medicine's Immunization policy: https://cou.ca/wp-content/uploads/2016/06/COFM-Immunization-Policy-2019.pdf.

Appendix B

Advice to the Profession: Professional Responsibilities in Medical Education

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 *Professional Responsibilities in Medical Education* policy sets out expectations for physicians involved in medical education and training, including most responsible physicians (MRPs), supervisors, and trainees. This *Advice to the Profession (Advice)* document is intended to help physicians interpret their obligations as set out in this policy and to provide guidance around how these obligations may be effectively discharged. In addition, this document provides resources for medical students and trainees.

Does an MRP and/or Supervisor need to provide direct supervision at all times?

An MRP and/or supervisor do not need to provide direct supervision at all times; however, as the policy states, MRPs and/or supervisors must ensure that they are identified and available to assist medical students and/or trainees when they are not directly supervising them (i.e. in the same room) or if unavailable, they must ensure that an appropriate alternative supervisor is available and has agreed to provide supervision.

If an MRP and/or supervisor is not available in person and they are called or paged, it is best practice to respond to these pages/phone calls within a reasonable length of time and be available to return to the hospital, or other training institution, if necessary. What is reasonable will depend on a number of factors including: the level of training and experience of the medical student and/or trainee, the nature of the patient's concerns, other available support, etc.

It may also be beneficial to ensure that on-call schedules be structured to provide continuous supervision to medical students. For trainees, it may be beneficial to provide guidance with respect to on-call interactions as sometimes residents are off-service and may not know what is expected of them. For example, it may be helpful to have a phone call/in-person meeting at the start of a shift to determine the trainee's PGY level, home program, how long they have been on the particular service, what procedures they have done, when staff would like to be called overnight, etc.

It is also important for medical students and trainees to develop awareness of their limitations and inform the MRP and/or supervisor and, seek appropriate assistance

when necessary if they are unable to carry out their duties. Good communication is vital to facilitating good supervision and optimal patient care.

How can physicians demonstrate a model of compassionate and ethical care to medical students and trainees?

Students and trainees often gain knowledge and develop attitudes about professionalism through role modeling. MRPs and supervisors have a duty to lead by example and to translate into action the principles of professionalism taught to medical students and trainees.

Characteristics of effective role models are well established. They include availability, clinical excellence, empathy, good communication skills, interest in teaching, self-reflection, transparency and respect for others.[1] Being an effective role model is not only beneficial to medical students and trainees, but it is also an important part of ensuring the best possible care for patients.

Engaging in favouritism of students and/or trainees is detrimental to the learning environment and affects all students. Similarly, predatory behaviour is unacceptable anywhere, but it is particularly problematic in a learning environment where medical students and trainees model the behaviour of their teachers. For these reasons, it is imperative that clinical teachers consistently uphold and display the highest values of the medical profession.

The policy requires physicians to not engage in disruptive behaviour including, violence, harassment, and discrimination against medical students and trainees. These behaviours are the antithesis to being a positive role model and physicians must not engage in them.

Is posting a sign informing patients that care in teaching hospitals may be provided by students and/or trainees sufficient?

Having a sign posted in a teaching hospital or other clinical placement setting where students and/or trainees are involved in care is helpful and promotes patient education and understanding, but it is not sufficient in terms of meeting the policy expectations.

The policy requires that express consent be obtained from patients when either medical students and/or trainees observe the care provided to patients and when medical

[1] *Canadian Family Physician*, Vol.66. February 2020, e55-61.

students participate in care. (See question below regarding express consent and trainee participation in care).

When should express consent be obtained for trainee participation in care?

The policy states that MRPs and/or supervisors **must** use their professional judgment to determine whether to obtain express consent from patients when trainees participate in the care of patients.

Trainees are medical doctors as they have obtained a certificate for postgraduate education, yet they are not permitted to practise independently. Obtaining express consent for participating in patient care is not needed in all cases, as it is for medical students. However, there may be circumstances where it may make sense to obtain consent for trainee participation in patient care. MRPs and/or supervisors can look to the experience and competency of the trainee. It may be appropriate to obtain express consent from patients when a less experienced trainee is providing care. It may be appropriate to obtain express consent in situations where a trainee is performing a procedure or examination for the first time or first few times or is providing a significant component of complex care. For those trainees who are transitioning to independent practice, it would be unlikely that express consent is necessary.

In addition, MRPs and/or supervisors can involve the patient in making this determination and look at the wishes and needs of the patient.

What are some examples of procedures/exams/investigations unrelated to patient care?

This happens often with learners, especially medical students - a physician performs a procedure/exam/investigation and then the medical student and/or trainee repeats it. For example, if a patient has an unusual heart murmur, a patient will be asked if the medical student can listen for educational purposes. Likewise, learners are asked to examine a skin rash, or check peripheral circulation, or do an eye or ear exam for their educational purposes. Intimate examinations (as defined by the medical schools) are also sometimes done by medical students and trainees and can be unrelated to patient care.

Resources

The information below provides additional information related to professional responsibilities in medical education as well as information that may be helpful to medical students and/or trainees. It is important for MRPs and/or supervisors to encourage medical students, who are not yet members of the CPSO, to become familiar with this information.

Medical schools and institutions where learning takes place also have relevant policies, guidelines, statements and procedures which are relevant to medical students and/or trainees. MRPs and/or supervisors are advised to be familiar with this information and direct their medical students and/or trainees to it.

Dialogue Articles

Dialogue, the College's quarterly publication for members, regularly addresses themes or issues relating medical education.

CPSO's Professionalism and Practice Program

How a physician delivers care is just as important as the care provided. To that end, the CPSO has partnered with medical schools across Ontario to develop modules on key professionalism topics. These modules include PowerPoint presentations, and case studies ground in real life issues and trends seen by the CPSO. They are also grounded in relevant frameworks, such as CanMEDs. We encourage medical students and trainees — and anyone else interested in medical professionalism — to visit the Professionalism and Practice area on our website and to download the modules.

***Canadian Medical Protective Association* (*CMPA*)**

The CMPA is a national organization and provides broad advice about a number of medico-legal issues. For Ontario specific information physicians are advised to look at the CPSO policy and advice document regarding professional responsibilities in medical education. However, the CMPA has a number of resources on the issues generally that physicians may find helpful.

For example:

Delegation and Supervision of Medical Trainees

Responsibilities of Physicians as Teachers