Engaged and Entrusted

Read how physicians – such as Dr. Alison Macarthur – employ their clinical expertise to keep self-regulation vital and relevant.

- Getting an Education in Palliative Care
- Connecting with an eHealth World
- Getting the Most Out of Your CPD
is the official publication of the College of Physicians and Surgeons of Ontario. The objective of this magazine is to provide clear policy direction and review pertinent legislative and disciplinary information, consult with the profession on issues of concern, and provide a forum for discussion and exchange of information and ideas. This publication does not accept unsolicited manuscripts.

REGISTRAR
Dr. Rocco Gerace

DIRECTOR, POLICY AND COMMUNICATIONS
Louise Verity

SENIOR EDITOR
Jill Heffey

MANAGING EDITOR
Elaine McNinch

ASSOCIATE EDITOR
Kathryn Clarke

DESIGN, LAYOUT AND PRODUCTION
Louise Musial

PHOTOGRAPHY & ILLUSTRATION CREDITS
Cover, p.5-13, 15, 16 (Graham), 17, 19-25, 29 (Downar), 30, 36, 40-43, 48, 52: D.W.Dorken, Toronto
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P. 18: Stephen Grimes
P. 29: David Cutler (Illustration)
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www.cpso.on.ca

The College of Physicians and Surgeons of Ontario is the licensing and regulatory body governing the practice of medicine in Ontario. The College is responsible for setting and maintaining medical standards, licensing physicians, investigating complaints about physicians on behalf of the public, and disciplining doctors found to have committed act(s) of professional misconduct.

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In Every Issue

5 Message from the President
In his farewell message, Dr. Bob Byrick reflects on how the proactive Out-of-Hospital Premises Inspection Program is an example of the evolving nature of medical self-regulation.

7 From the Registrar’s Desk
Dr. Rocco Gerace says a heartfelt thank you to the physicians who contributed their time to the activities of self-regulation.

8 Letters to the Editor
Readers provides further insight into the issues of opioid prescribing; the Canadian Orthopedic Association objects to the College’s Blood Borne Pathogen policy.

23 Reports from Council
We provide you with an overview of the decisions and discussions of our December Council meeting.

57 Discipline Summaries
Summaries of the following cases are included in this issue: Dr. C.N. Rathe; Dr. A.W. Redekopp; Dr. M.G.A. Salama; Dr. B. Sheffield; and Dr. L.W. Sokol.

Practice Partner

47 Doc Talk
Read of the 10 ways to increase your patients’ understanding of the medications you prescribe.

47 Patient Safety
An ISMP survey suggests that the difference in potency between hydromorphone and morphine may not be well understood by all health-care providers.

51 Getting the Most out of your CPD
We discuss the online opportunities available for the isolated physician.

52 Close-Up
Dr. Virginia Walley talks about her experience as a peer assessor.

53 QA Tips
The Quality Assurance Committee lists five ways to have top-notch records.

55 Practice Points
If your office was broken into, would your patient records be safe?

Policy Matters

16 Consolidated prescribing policy
We’ve brought together many of our expectations on different drug issues in one easy to use policy that provides detailed and explicit guidance.

17 Thinking of acting as a medical expert?
Make sure you read our policy and take our quiz to better understand the expectations of this important role.
We want your feedback

We are consulting on a number of different issues. Please visit our website at www.cpso.on.ca to provide your voice on the following matters:

- A proposed by-law that will increase the membership fee from $1530 to $1550. The proposed by-law is on page 24. Contact: msampson@cpso.on.ca
- A proposed by-law that will require physicians to have an email address for the purpose of receiving College communications. The proposed by-law and rationale are on page 26. Contact: msampson@cpso.on.ca

More information about the following can be found on the College website at www.cpso.on.ca under Policies and Publications>Consultations, and on page 27 of this issue.

- A draft statement to signal to physicians that some level of eHealth literacy will – before too long – be required in order to provide patients with quality care within an increasingly connected health-care system. Contact: ehealth@cpso.on.ca
- A draft statement about social media. Contact: socialmedia@cpso.on.ca
- A preliminary consultation on our telemedicine policy. Contact: telemedicine@cpso.on.ca

Mailing address: CPSO, 80 College Street, Toronto, Ontario M5G 2E2

For Your Information

9 College Leadership
Eric Stanton and Marc Gabel assume the roles of College President and Vice-President, respectively.

12 New Appointment
Dan Faulkner is named the College’s Deputy Registrar.

22 Election Results
The votes are counted. Four members have been returned to Council. They will be joined by two new members.

36 Future Leaders’ Day
They came. They saw. And now many of them want to participate in medical self-regulation.

43 Evaluation of Registration Routes
We are embarking on an initiative to determine if MDs differ in practice and performance based on the route of entry to practice.

56 Are You Ready?
When you renew your annual certificate this year, it will need to be done online. We provide some suggestions to help you.
Dear Colleagues

Reflecting on my experience with the College over my career, I did not realize how the College’s approach to professional regulation has evolved with time. There is a 150-year history of self-regulation in Ontario and throughout most of that period, the College was an insular organization with only one mechanism to influence professional behaviour, the discipline process. As medicine became more complex, clearly, the regulatory process needed to evolve as well.

In 1997, Geoffrey Bond, then President of the College, stated in Dialogue that “it seems that for the vast majority of bad outcomes, one can identify a series of system failures which made the individual mistake almost inevitable.” The public interest, he said, would be far better protected by the identification of those system errors and their rectification “than by any sort of individual denunciation and puniton of the person who, at the culmination of that system failure, committed the preordained mistake.” This approach ushered in a new approach to self-regulation and has formed the basis of the College’s quality assurance activities.

Several years ago, the College recognized that there was a gap in the regulation of out-of-hospital premises (OHPs) that put patient safety at risk. In response, the College developed and instituted a plan for OHPs that had one ultimate goal – to keep Ontario patients safer. Two years after the introduction of this program, the College has completed the inspection and assessment of more than 250 premises. The inspections focused on ensuring that the premises have the equipment and drugs needed for an appropriate response to an adverse event and that the physicians, nurses and other staff have the qualifications and experience to react to emergency situations appropriately, thereby preventing or mitigating patient injury. This program is an example of self-regulation moving to the next level – not only does the College recognize that system factors play an important role in adverse events, but that the regulator can play a proactive role in promoting a safe system of care.

This proactive role for a regulator in patient safety cannot be accomplished by the regulatory body acting autonomously. In my view, the College is an important and necessary part of a safe system, but not sufficient, by itself, to actually ensure safety. This requires active collaboration with professionals working in these premises. I thank the many colleagues who have devoted time and effort to this safety initiative over the past two years, including members who work in OHPs and have implemented the standards to provide safe care for their patients. During this period, we have developed a strong oversight body – the Premises Inspection Committee – and have built a skilled assessment team. There are now more than 75 physicians and
six nurses performing inspections and assessments. In fact, it was this team’s commitment which allowed us to meet the ambitious target of inspecting all of the OHPs operating in Ontario at the time the regulation came into force. And we did it within the first 24 months of the program’s inception— as was prescribed in the legislation.

One of the fundamental strengths of the Premises Inspection Committee is its willingness to continuously champion program improvements based on lessons learned from the operation of the program. The first two years of the Out-of-Hospital Premises Inspection Program (OHPIP) have helped us identify some gaps where no formal regulatory structure is in place. These need to be addressed to further enhance safety. For example, there are still a range of procedures performed outside of hospitals that are not captured under the OHPIP regulation. In addition, there are aspects of the program which can be improved. In my last letter in Dialogue, I outlined the need for a Quality Improvement program within OHPs to enhance learning and improvement from experience in these premises.

Please turn to page 38 for a further explanation of the challenges encountered, the milestones met, and the lessons learned from this important initiative. We also have a full status update on our program on the College website at www.cpso.on.ca.

OHPIP is just one example of a College tool, outside of disciplinary processes, to provide the public with assurance that the profession is regulated in the public interest. The challenge is to use these tools, such as remediation, peer assessments, and mandatory regulatory inspections, to optimal benefit.

In fact, as I look back on my last year as President, I can say emphatically that there is little about self-regulation that is not challenging. It is a balancing act of complex societal values: preserving individual privacy versus the need for public transparency; encouraging the intrinsic motivation of physicians to practise good medicine with the need to dictate good behaviour for doctors; and implementing remediation versus punitive correction when necessary. In doing so, we build upon and sustain the public’s trust while ensuring quality physicians are enabled to serve patients appropriately.

It has been a privilege to serve the public and the profession over the past year and I thank members of Council for giving me this opportunity.
Rising to the workload challenge

The demand for physician expertise never ebbs

Last year at the College, 2,668 Ontario physicians were assessed; 324 facilities were inspected; 152 opinions were provided on complaint matters. Over the same period, hundreds of matters on issues pertaining to quality assurance, policy development, discipline, registration, and complaints were considered. Clearly, the demand for physician expertise — the professional estimation of what is reasonable and fair and in the public interest — never ebbs.

Fortunately, physicians in Ontario continue to rise to meet the workload challenge. In doing so, they keep medical self-regulation viable and thriving.

In fact, the number of hours that physicians have contributed to the activities of medical self-regulation has more than doubled in the last six years. In 2011, nearly 58,000 hours were spent performing assessments, participating on committees, shaping policy and providing expert opinion. In 2006, we counted nearly 25,000 hours of physician participation. This commitment to action demonstrates that physicians understand the privilege of belonging to a self-regulating profession. It is no wonder, that in a world that is constantly changing, physicians continue to remain among the most trusted professionals in Canada. This happens because they care about the quality of care that patients receive.

In this issue, we take the opportunity to thank the approximately 1,100 physicians who actively participated in the regulatory process last year. I am very pleased to see so many physicians answer the call of their self-regulating body.

I am also heartened by the calibre of physicians who attended our recent Future Leaders’ Day event. This is the third year in which we have invited physicians, identified as leaders in their communities and hospitals, to come learn more about the College and its activities. These doctors are sharp, inquisitive and clearly committed to providing the best care to the patients in their communities. Many of them are interested in participating actively in self-regulation. And I look forward to working with them.

In closing, I would like to thank Bob Byrick for his excellent work as President of the College over the past year. His quick mind, integrity and engaging style served self-regulation very well. Thank you, Bob.
Dear Editor:

Re: Opioid Prescribing

I was pleased to see the ongoing discussions around the issue of opioid prescribing, in both the letters section and the article “The emergency room: not the right place for chronic pain management.” In responding, I hope to clarify a few points and advise CPSO members of some valuable resources in pain and addiction management.

Dr. Russell’s letter clearly outlines some of the difficulties with Ontario’s prescription monitoring system. However, lack of monitoring is not the only problem that leads to Ontario’s opioid problems. Practitioners remain very poorly trained in pain management and universal precautions in opioid prescribing. Since most chronic pain is managed by primary care physicians, we surveyed Canadian family medicine residency programs in 2010 for their content on non-end-of-life pain management: less than four hours over two years. A recent survey of family medicine residents at University of Toronto also found that a significant percentage of PGY-2s had a low knowledge in opioids, addiction, specialist referrals, use of narcotic contracts or urine drug screening. The College of Family Physicians has recognized this dilemma, and has formed a number of special interest program committees, including one for chronic pain, and another for addiction medicine. Our committees are working together closely to ensure that trainees and practising family physicians obtain sufficient competence in these areas to improve our patients’ and communities’ safety.

Dr. Blake’s review of the challenges of chronic pain patients visiting emergency departments was also very timely. Under-treated pain is a major source of health-care utilization and the E.R. is not the ideal place for assessing and managing these patients. Unfortunately the sample letter to a patient contained a common mistake: “...these drugs can very easily induce dependence and even addiction on the part of the patient.” Physical tolerance to many medications is common (beta-blockers, SSRIs), but does not equate to substance dependence. Addiction is a complex neurobiological disorder which results in craving, continued use despite harm, inability to cut down, and loss of control.

Screening for opiate risk can assist providers in recognizing those patients with higher rates of aberrant behaviours, and should be performed prior to opiate prescribing.

Meanwhile, physicians who are struggling with these complex issues might consider joining the Ontario College of Family Physicians’ Medical Mentoring for Addictions and Pain (MMAP) program which provides case discussion opportunities with regional pain/addiction consultants via a secure portal supported by McMaster University.

Ruth Dubin, MD
Kingston, ON
Chair of the Chronic Non-Cancer Pain Program Committee, CFPC

Re: Letter to the Editor, Dialogue, Issue 3, 2012

Dr. Leighton is against reconsidering “an informed decision to prescribe an opioid for severe pain” because, as he correctly notes, “the risk of abuse is about the same as among cancer patients.”

The point that he misses is so important that it is worth re-stating.

Down here in the addiction clinics we see patients whose lives are...

Continued on page 10...
New President, Vice-President

Dr. Eric Stanton, Dr. Marc Gabel elected to lead Council for 2012-2013 year

**DR. ERIC STANTON**

**PRESIDENT**

Dr. Stanton came to Council in 2007 as an elected member from Hamilton (District 4).

Dr. Stanton is an associate professor, Division of Cardiology, Department of Medicine at McMaster University. He has been working at McMaster since leaving Sault Ste Marie in 1987.

For several years, Dr. Stanton has been co-chairing the Quality Assurance Committee at the College.

In the coming year, Dr. Stanton will sit on the Governance and Finance Committees and chair the Executive Committee.

Find out more about Dr. Stanton in our Q and A on page 41.

---

**DR. MARC GABEL**

**VICE-PRESIDENT**

Dr. Gabel, a Toronto general practitioner practising in psychotherapy, first came to Council in 2002. He was re-elected in 2008 for a three-year term, and again in 2011 for another three-year term.

Before arriving at Council, Dr. Gabel was a peer assessor for several years.

Dr. Gabel has participated on the Governance, Methadone and Quality Assurance Committees. Between 2005-2008, Dr. Gabel co-chaired the Discipline Committee as a non-Council member.

Last year, Dr. Gabel chaired the working group that updated the Medical Records policy.

In the coming year, Dr. Gabel will be participating on the Discipline, Executive, Governance, Finance, and Fitness to Practise Committees. He will also be chairing the Outreach Committee.
being totally ruined by iatrogenic opiate addiction. Yes, cancer patients also get addicted, adding to their woes (but relieving their pain). Our patients don’t have life-threatening medical illness, but quite a few will die from the addiction. And some don’t even have pain—they have a relative with pain, who gets the pills.

Non-cancer patients have more to lose!

Tony Carr, MD

Hamilton, ON

Re: Annual testing concerns

I am writing on behalf of the Canadian Orthopedic Association’s Executive Board about our concerns regarding the CPSO Blood Borne Pathogens (BBP) policy.

There is no other Canadian provincial college that has implemented mandatory scheduled or annual testing for clear and scientifically supported reasons.

Our board supports the concept of routine voluntary testing, especially following an index exposure to a known seropositive patient. This is not only prudent for the physician, who then is able to seek immediate, appropriate treatment in the event of a seroconversion, but serves to protect the physician’s other patients and the physician’s family. Being that the risk to the patient, in the event of an exposure to a seropositive physician, is negligible, it is important to consider the rights of all members of the general public equally, including those of the physician.

We believe that physicians should be encouraged to test regularly and to report seroconversions when they occur. Testing will then be performed on a voluntary basis, and will more likely be done around the time of high-risk exposure, making unfortunate events, such as false positive tests, less common.

Tracy Wilson, MD

Thunder Bay, ON

The College responds:

We thank Dr. Wilson for her letter. The College is pleased to respond. The Blood Borne Pathogens policy requires routine annual testing for all physicians performing or assisting in exposure prone procedures. In arriving at this policy position, Council debated the issue extensively, and considered a range of arguments on each side of the issue, including those raised by stakeholders in our external consultation process. Council ultimately elected to require mandatory annual testing but has committed to review the policy again in two years in order to re-evaluate this position and the other elements of the policy.

The decision to require mandatory annual testing was based on a variety of factors. Council first concluded that relying on an ethical obligation for physicians to test for BBPs was not sufficient to protect the public and that mandatory testing was required.

All physicians performing exposure prone procedures have had an ethical obligation to know their serological status since 2004. The CPSO’s experience with respect to the annual renewal form, however, suggests that this ethical obligation has not resulted in physicians getting tested for BBPs. In 2009, when we added questions on BBPs, and physician testing to the annual renewal form, the responses indicated that a large proportion of physicians performing exposure prone proce-
dures had not been tested for BBPs since 2004.
Council concluded therefore, that a mandatory requirement for testing was necessary.

Council felt that annual testing represented a reasonable position.

Analysis of relevant evidence and the positions of other regulatory bodies indicate that currently there is no consensus about what interval of testing is warranted for health-care providers. Any interval of testing that Council specified would be considered unsupported by evidence. Council felt that the lack of consensus and the deficiencies in evidence could not be determinative in this instance: in the interests of patient safety it was Council’s responsibility to be proactive and to adopt a position on physician testing until such time as the body of evidence grows, and an evidence-based position is available.

Although the number of documented cases of physician-to-patient transmission of BBPs may be low, such transmission can and does occur. The consequences of a patient becoming infected with a BBP from his or her physician would be devastating not only to the individual patient and family, but also to the public at large, as it would undermine the trust patients have in the medical profession. Council felt that annual testing represented a reasonable position as it would provide both physicians and the CPSO with current information about physicians’ serological status, and would align with existing institutional requirements for annual hepatitis B virus testing.
This policy will be revisited in 2014.

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Online Renewal is on its Way!

Renewal of your annual certificate of registration must be completed online this year.
If you would like some help with the process, give us a call. We are happy to help make it as easy as possible.

Physician Advisory Service 416-967-2606 or 1-800-268-7096 ext. 606.
We also offer some suggestions on page 56.
Dan Faulkner appointed Deputy Registrar of the College

Dr. Rocco Gerace, College Registrar, is pleased to announce that Mr. Dan Faulkner has been appointed to the position of Deputy Registrar of the College.

Dan Faulkner joined the College in 1994 and shortly began assuming roles of increasing responsibility and scope in the Quality Management Division. Since 2007, he has been the Director and Associate Registrar of the Quality Management Division. In this role, he oversees strategy and operations for physician registration, practice assessment and enhancement (physicians and facilities), and research and evaluation. In this new position, Dan will continue to be accountable for the Quality Management Division and he also will assume oversight of the Information Technology (IT) Department.

Outside of the CPSO, Dan chairs the Working Group on Assessment and Supervision for the Federation of Medical Regulatory Authorities of Canada; is a member of the National Assessment Collaborative (NAC) Central Coordinating Committee of the Medical Council of Canada, and also chairs the Practice Ready Steering Committee of NAC; he is the CPSO representative on the Advisory Committee of the Quality Management Program – Laboratory Services in Ontario, and is the College representative to the Continuing Professional Development – Ontario (CPD-O) partnership.

Dan graduated from the University of Western Ontario, London (HBSc, Pharmacology and Toxicology) and McMaster University, Hamilton (MBA, Health Services Management).

New address?

Let us know within 30 days!

The College’s register must contain both your current mailing address and your primary practice address. At the back of each issue of Dialogue, a change of address form is provided to mail or fax in.

Your MAILING ADDRESS is the address you would prefer the College use to communicate with you and may be different from your practice address. It is NOT available to the public, unless you decide to use your primary practice address as your mailing address. Your PRIMARY PRACTICE ADDRESS is available to the public.

If you change either address, you must notify the College in writing within 30 days of the change.
Engaged and Entrusted
Physician participation in self-regulation is alive and well

The numbers are in. And they paint an encouraging picture of self-regulation.
The number of hours that physicians have contributed to the activities of medical self-regulation has more than doubled in the last six years. In 2006, nearly 25,000 hours were spent performing assessments, participating on committees, shaping policy and providing expert opinion.

Dr. George Arnold, an obstetrician-gynecologist in Markham, is a valued member of the Inquiries, Complaints and Reports Committee.
In 2011, we counted nearly 58,000 hours of physician participation. “This commitment to action demonstrates that physicians understand the privilege of belonging to a self-regulating profession,” said Dr. Rocco Gerace, College Registrar.

Dr. Bob Byrick, College President, agrees. “Doctors are busy people. In choosing to dedicate their time to activities that keep self-regulation vital and relevant, physicians are making it clear that this is a privilege that we value,” he said.

We’d like to thank the approximately 1,110 physicians who contributed their time during the June 1, 2011 to May 31, 2012 work year.
APPRECIATION

Dr. John L. Bowman
Dr. David K. Boyer
Dr. Keyna J. Bracken
Dr. Nicholas D.J. Braithwaite
Dr. Jack S. Brandes
Dr. Francisco Bravo
Dr. Calvin W. Breslin
Dr. Patrice M.J. Bret
Dr. Robert A. Brick
Dr. Harold T. Bridle
Dr. Donald P. Brisbin
Dr. Carol A. Brock
Dr. Gerald B. Brock
Dr. William F. Brodie-Brown
Dr. Lisa A. Bromley
Dr. Adrian H.R. Brown
Dr. Stephen H. Buchman
Dr. David N. Buckley
Dr. Howard M. Burke
Dr. Marcus J. Burnstein
Dr. Jacques Buteau
Dr. Michael W. Butters
Dr. Robert J. Byrick
Dr. James P. Caldwell
Dr. Paul M. Cameron
Dr. Alan D. Campbell
Dr. Paolo Campisi
Dr. Robert J. Cardish
Dr. Niels L. Carlsen
Dr. Wayne W. Carman
Dr. Angela M. Carol
Dr. Thomas J. Carr
Dr. Lesley K. Carr
Dr. Julia M. Carroll
Dr. Robert P. Carter
Dr. Paul G. Casola
Dr. Robert F.J. Casper
Dr. William Cass
Dr. Walter J. Cassidy
Dr. Saulo Castel
Dr. Christopher D.J. Chadwick
Dr. Gary A. Chaimowitz
Dr. Dean W. Chamberlain
Dr. Charles K.N. Chan
Dr. Edward Chan
Dr. Thomas T. Chan
Dr. Suryakant Chande
Dr. Ranjith D. Chandrasena
Dr. Karen D. Chang
Dr. Michael B.U. Chang
Dr. Kenneth R. Chapman
Dr. Jerry S. Chapnik
Dr. Pamela L. Chart
Dr. Sumeeta Chatterjee
Dr. Asim N. Cheema
Dr. Philip N. Cheifetz
Dr. Richard Y.Y. Chen
Dr. Benjamin H.P. Chen
Dr. Mary M.L. Cheng
Dr. Jordan W. Cheskes
Dr. Robert L.A. Chevrier
Dr. Lip K.J. Chin
Dr. John H.C. Chiu
Dr. Jagdish C. Chopra
Dr. Anil Chopra
Dr. Mabel Y.T. Chow
Dr. Stephen D. Chris
Dr. Dae-Gyun Chung
Dr. Mario V. Ciccone
Dr. Sharon L. Cironne
Dr. Maureen E.P. Cividino
Dr. Carole J. Clapperton
Dr. Luis F. Cleto
Dr. David K. Cochrane
Dr. John E. Cockburn
Dr. Charles I. Cohen
Dr. Charles J. Cohen
Dr. Allan L. Covens
Dr. Catherine A. Cowal
Dr. Ian G. Coxen
Dr. Michael D. Cox
Dr. Patrick G. Cox
Dr. Marilyn J. Crabtree
Dr. Gerard P. Craigen
Dr. John S.D. Davidson
Dr. Jan R. Davis
Dr. Ian R. Davis
Dr. Naveen R. Dayal
Dr. Anthony J. D’Angelo
Dr. Bahauddin H. Daniel
Dr. Faiz Daudi
Dr. Derek A. Davidson
Dr. John S.D. Davidson
Dr. Melinda J. Davie
Dr. Gregory A.L. Davies
Dr. Robert Di Cecco
Dr. Donato A. Di Giacomo
Dr. Gail A. Delaney
Dr. Walter Delpero
Dr. Jorge E. DeMaria
Dr. Susan F. Dent
Dr. John A. DePedi
Dr. Anoop Dev
Dr. Muhammad K. Dharidina
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Dr. Jagdish C. Chopra
Dr. Anil Chopra
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Dr. Anthony J. D’Angelo
Dr. Bahauddin H. Daniel
Dr. Faiz Daudi
Dr. Derek A. Davidson
Dr. John S.D. Davidson
Dr. Melinda J. Davie
Dr. Gregory A.L. Davies
Dr. Robert Di Cecco
Dr. Donato A. Di Giacomo

Dr. Alison Macarthur
Quality Assurance Assessor
Every year, hundreds of Ontario physicians, most with busy medical practices, make the time to help the College deliver on its mandate of responsible, professional, self-regulation. They sit on committees, do case reviews, participate in policy development, and make decisions about the quality of medical care delivered in this province. Without professional participation to ensure that standards are being met, self-regulation would not be possible.

We are currently looking for practising physicians to fill the following positions. For more information about time commitment, and qualifications please see our website at www.cpso.on.ca under Member Engagement.

**Position: Assessor**

Assessors review a physician’s practice to ensure that the physician is practising at an acceptable standard. Having assessors in each medical discipline ensures that physicians are reviewed by peers who understand the normal limitations of the practice and the difference between ideal and reasonable care.

In our Practice Assessment and Enhancement area, there is a particular need for assessors from the following disciplines: Addiction Medicine, Endocrinology, Anatomical Pathology, Radiology, Rheumatology, and Geriatrics.

**Contact:**
For more information, please contact the following individuals by email or at our toll-free number, 1-800-268-7096:

**Investigations & Resolutions:**
Alice Kuznir (akuznir@cpso.on.ca), ext. 761.

**Practice Assessment & Enhancement:**
Tracey Marshall (tmarshall@cpso.on.ca), ext. 223, and Christine Grusys (cgrusys@cpso.on.ca) ext. 261.

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**Dr. Ron Wexler**
Council Member
Position: Clinical Preceptor
The College is seeking members who are practising physicians to become clinical preceptors. Clinical preceptors serve as clinical teachers to guide, observe and assess the educational activities of a physician. This role typically involves assisting the physician in the initial development of an educational plan with specified learning objectives for the supervised timeframe.

Contact:
For more information, please contact the following individuals by email or at our toll-free number, 1-800-268-7096:
Practice Assessment & Enhancement:
Tracey Marshall (tmarshall@cpso.on.ca), ext. 223, and Christine Grusys (cgrusys@cpso.on.ca) ext. 261.

Registration:
Nathalie Novak (nnovak@cpso.on.ca), ext. 432.

Position: Clinical Supervisor
Clinical supervisors are individuals who inspect a physician’s practice at regularly prescribed intervals set by the College to ensure that the physician is meeting the expected standard of care and that patient safety is not being compromised. The clinical supervisor identifies physician enhancement opportunities to the supervised physicians. S/he may also assist physicians in learning about community resources to help meet patient needs.

Contact:
For more information, please contact the following individuals by email or at our toll-free number, 1-800-268-7096:
Practice Assessment & Enhancement:
Tracey Marshall (tmarshall@cpso.on.ca), ext. 223, and Christine Grusys (cgrusys@cpso.on.ca) ext. 261.

Registration:
Nathalie Novak (nnovak@cpso.on.ca), ext. 432.
ELECTION RESULTS

Two new members, four returning members win Council seats

Drs. Andrew Falconer, Peeter Poldre sit at Council table for first time

THE FOLLOWING PHYSICIANS WERE NAMED TO COUNCIL IN THE ELECTION HELD ON TUESDAY, OCTOBER 16TH

**District 6**
Counts of Frontenac, Haliburton, Hastings, Leeds and Grenville, Lennox and Addington, Northumberland, Peterborough, Prince Edward, and Victoria

Dr. Wayne J. Spotswood
Graduated from: Queen’s University
Principal area of practice: Emergency Medicine
Current hospital appointments: Kingston General Hospital
Dr. Wayne Spotswood returns to Council for a third term.
Dr. Spotswood currently serves on the Registration Committee and the Inquiries, Complaints and Reports Committee.

Dr. Dennis Pitt
Graduated from: Queen’s University
Principal area of practice: General Surgery
Current hospital appointments: Ottawa Hospital
Dr. Dennis Pitt returns to Council for a second term.
Dr. Pitt currently serves as a member of the Discipline Committee, the Fitness to Practise Committee and the Premises Inspection Committee.

**District 7**
Counts of Dundas, Glengarry, Lanark, Prescott, Renfrew, Russell and Stormont, and the Regional Municipality of Ottawa-Carleton

Dr. Andrew Falconer
Graduated from: University of Ottawa
Principal area of practice: Emergency Medicine
Current hospital appointments: Queensway Carleton Hospital
Dr. Andrew Falconer is a new member of Council.
He is the Chief of Staff at Queensway Carleton Hospital. Dr. Falconer has participated in the Champlain LHIN Regional Credentiaing initiative and is co-chair of the Champlain Orthopedic Program Planning initiative.

Dr. Steven Bodley
Graduated from: University of Western Ontario
Principal area of practice: Anesthesia
Current hospital appointments: North Bay Regional Health Centre
Dr. Steven Bodley returns to Council for a second term. Dr. Bodley has been active on the Premises Inspection Committee, a new committee which was developed to oversee the Out-of-Hospital Premises Inspection Program. He is also chair of the Methadone Committee and is a member of the Fitness to Practise Committee.

Dr. William McCready
Graduated from: Queen’s University of Belfast
Principal area of practice: Nephrology
Current hospital appointments: Thunder Bay Regional Health Science Centre
Dr. William McCready is returning to Council for a second term.
Dr. McCready currently serves on the Fitness to Practise Committee, which he currently chairs, the Discipline Committee and the Quality Assurance Committee. He also served on the working group that revised the prescribing policy and is a member of an advisory committee on information technology.

**District 8**
Territorial districts of Algoma, Cochrane, Manitoulin, Nipissing, Parry Sound, Sudbury, and Timiskaming

**District 9**
Territorial districts of Kenora, Rainy River and Thunder Bay

Dr. Peeter Poldre
Graduated from: University of Toronto
Principal area of practice: Clinical Hematology
Current hospital appointments: Sunnybrook Health Sciences Centre
Dr. Peeter Poldre became a new member of Council with this by-election. He had recently been appointed as a non-Council member of the Discipline Committee.
Dr. Poldre is a clinical hematologist and has been active in medical education throughout his career.
A comprehensive policy that addresses College expectations on matters of prescribing was approved by Council.

The Prescribing Drugs policy provides expectations on such matters as appropriate assessments, drug samples, what to do with unused drugs that have been returned by patients, refills, and opioid prescribing.

Notably, during the policy’s extensive consultation, the College heard repeatedly that more focus should be on preventing prescription drug abuse, and not implementing reactive measures.

Accordingly, while the policy does not attempt to curb the prescribing of narcotics and controlled substances for legitimate reasons, such as acute or chronic pain, it does reinforce the requirement that physicians prescribe narcotics and controlled substances in an appropriate manner.

We have a Q and A about the policy on page 33 and the policy is included with this issue of Dialogue.

The role of the medical expert

Much importance is paid to the opinion expressed by a medical expert – whether it is heard as testimony in court or stated in a written report. That is why it is so critical that physicians who are asked to serve as medical experts fully understand what is expected of them.

Council has just approved a new policy that sets expectations for physicians who act as medical experts.

You can test your knowledge of the role with a True and False quiz on page 37.

The policy is included with this issue.

Proposed increase of $20

Council approved the circulation of a proposed by-law that will increase the membership fee from $1,530 to $1,550.

The increase reflects the need to add resources to meet the increasing volumes of work in the registration and assessment areas. The budget also reflects costs to lease space in a nearby building. In its current configuration, the College’s office space has reached capacity. This additional space will be necessary until a longer-term solution is in place.

The proposed by-law is on page 24.

New expanded scope for pharmacists

In early October, new expanded scope regulations came into effect for pharmacists in Ontario. Among the changes is the ability of pharmacists, under their own authority and within specified parameters, to renew or adapt prescriptions for continuity of care and optimization of patient outcomes.
At the meeting, Marshall Moleschi, Registrar of the Ontario College of Pharmacists (OCP), discussed the practical implications of these legislative changes.

On page 45 we publish a joint statement from the College, the OCP, the Ontario Pharmacists’ Association and the Ontario Medical Association that clarifies aspects of the regulations and addresses several issues that are emerging in practice situations.

Consultation: A pricing strategy for IHFs and OHPs

Since the inception of the Out-of-Hospital Premises Inspection Program (OHPIP) in 2010 and with the transition to a new payment model for the Independent Health Facilities (IHF) program, the College decided it was time to review the approach to fees for both of these programs.

The College worked with experts to build a model that is consistent, fair and easy to implement for the two programs. Both programs operate on a full cost recovery basis.

Council reviewed the model and approved it for external consultation.

Partnership with Cancer Care Ontario

The College has undertaken a joint project partnership with Cancer Care Ontario (CCO) to reduce fragmentation within the system and improve patient outcomes.

Michael Sherar, CEO of CCO and Judy Burns, director of corporate projects for CCO, joined College staff to present the project to Council.

The plan is to develop and disseminate standards of care that will initially include pathology services, colonoscopy and mammography. The goal will then be to identify and monitor system and individual performance indicators using a systems approach to measure and improve quality.

A draft framework of the project will be presented to Council in February.

New by-law requires completion of conflict of interest form

Council approved a by-law amendment requiring district election candidates to complete a conflict of interest form.

The form asks candidates to acknowledge that they are familiar with the College’s principles of...

Fee Increase of $20 Proposed

At its December meeting, Council reviewed the budget for 2013 and agreed to circulate to the profession a proposed 1.3% increase in membership fees. This increase would bring the fee that a physician pays to renew a certificate of registration from $1,550 to $1,550. The proposed by-law amendment is as follows:

By-law No. 80

1. Subsection 4(a) of By-Law No. 2 (the Fees and Remuneration By-Law) is revoked and the following is substituted:

Annual Fees

4. Annual fees for the year beginning June 1, 2013, are as follows:

(a) $1,550 for holders of a certificate of registration other than a certificate of registration authorizing postgraduate education and other than a certificate of registration authorizing supervised practice of a short duration;

Providing Feedback

To provide feedback to the proposed by-law above, please email msampson@cpsso.on.ca or send your letter to: Mark Sampson, College of Physicians and Surgeons of Ontario, Proposed Fee By-law, 80 College Street, Toronto, ON, M5G 2E2. The deadline for comments is March 18, 2013.
Conflict of Interest – as set out in the General By-law and the policy. Signing such a form will ensure that candidates are aware of conflict of interest issues and broaden their understanding of the importance of the need to avoid conflicts.

Making the College more transparent
The College will review and assess its transparency practices in a multi-phase project.
In particular, the College will be looking at the information available to the public on the College website. The relative merits of adding various categories of information to the website will be explored.
The notion that organizations with a public interest mandate should aim to increase transparency has become increasingly widely-held across the broader public sector in recent years.

The evolving technological environment
Much of Council’s discussion focused on a series of initiatives that reflects the realities of an increasingly technological environment.
Council has approved the circulation of a proposed by-law that will require physicians to have an email address for the purpose of receiving College communications. The proposed by-law and the rationale is on page 26.

Council also approved a draft statement to signal to physicians that some level of eHealth adoption will – before too long – be required in order to provide patients with quality care within an increasingly connected health-care system.
A draft statement about social media was also approved by Council for circulation. The statement provides guidance about how best to engage in social media while protecting patient confidentiality and privacy, maintaining appropriate doctor-patient boundaries, avoiding conflicts of interest, and safeguarding the reputation of the medical profession.
And lastly, we are embarking on a preliminary consultation on our Telemedicine policy. The policy sets expectations for physicians using telecommunications technologies to create audio/visual linkages with patients in different locations, in actual or stored time.
More information about all these initiatives can be found on page 27. We are looking for your feedback.

Council Award presented to Drs. Charles Tator, Alan Elliott
Two physicians have been recognized with a Council Award for their contributions to medicine and the health-care of their patients.
Dr. Charles Tator, an internationally known and highly acclaimed neurosurgeon, was recognized for his work in spinal neurosurgery and traumatic brain injury.
“Dr. Tator’s contributions to neurosurgery, medicine and health care in Canada and around the world have been enormous,” said Dr. Michael Fehlings, director, Krembil Neuroscience Program.
And although he was not able to attend the meeting, Council recognized the achievements of Dr. Alan Elliott, a family physician. Dr. Elliott was singled out for his work with the less fortunate, which has seen him care for patients all over the world, including Afghanistan, Nepal, Africa and Hong Kong.
Today, Dr. Elliott practises in Northbrook, Ontario.
BY-LAW AMENDMENT

Proposed by-law requires members to provide an email address to College

Background
Every year, when we send out our annual renewal questionnaire, we ask members to provide us with their email address. However, in the current version of the questionnaire, a member can answer “not applicable” to the question. Currently, there are approximately 670 members who have not provided an email address to the College.

We are looking to change this with an amended by-law. From an operational perspective, requiring all members to provide the College with an email address would be tremendously beneficial. Email is an efficient, inexpensive and environmentally friendly communications vehicle. The College is increasingly using e-communications as a result of technological advancements. Further, eHealth is expanding rapidly and technical literacy is increasing in importance for physicians and other health-care professionals.

This change would also be consistent with our move to offer online renewal and other services online. Circulating by-laws, regulations and other communications by email would save time, reduce costs and improve communication with the membership.

PROPOSED BY-LAW:
The following (underlined) language would be added to section 51(1) of the General By-Law, if approved by Council following consultation, to expand this section to include email addresses:

51. (1) A member shall notify the College in writing or electronically as specified by the College of,
   (a) the member’s preferred addresses (both mailing and email) for communications from the College;
   (b) the address and telephone number of the member’s principal place of practice; and
   (c) the identity of each hospital and health facility in Ontario where the member has professional privileges.

In addition, to clarify that this information will be required on the annual renewal form, the College would add the following (underlined) language, if approved by Council, to section 51(3) of the General By-Law:

3. The College may forward to its members from time to time requests for information in a printed or electronic form approved by the Registrar. Each member shall accurately and fully 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 email address for communications from the College and the address of all locations at which the member practises medicine;
   (c) a description 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 law suits 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.
Logging on to a changing environment
Your feedback wanted on several technology-related issues

Before too long, all patient information will be managed electronically. Will you be ready?
Electronic communication was the focus of much of Council’s discussion at its most recent meeting. Now we want your feedback on matters of eHealth adoption, social media, email communications, and telemedicine.

An eHealth Statement
A draft statement has been developed to signal to physicians that some level of computer literacy will – before too long – be required in order to provide patients with quality care within an increasingly connected healthcare system.

At an earlier meeting, Council decided that the regulatory body had a role in promoting physician eHealth literacy, and encouraging the effective and appropriate use of technology by physicians to provide safe, quality care to their patients.

“Technology is evolving quickly; in the near future, consolidated, comprehensive lab and drug information about patients will be available to all physicians electronically,” reads the draft statement. “Eventually, all patient information will be managed electronically.”

The College, physicians and others in the health-care system have an obligation to respond to the changing environment, which will support and demand an unprecedented level of collaboration and information sharing.

The draft statement does not require physicians to adopt any particular eHealth technology, including an EMR. While the College working group that developed the draft statement believes that EMR use is important, the group members recognize that there is a continuum of physician eHealth use. The role of the physician is to keep learning and be open to any tools that will enable him or her to provide good care, and that includes learning how to connect with the larger health-care system.

eHealth adoption and use are not solely a physician responsibility, however. The statement makes clear that expectations exist for the College itself and its multiple partners — including system vendors, government, eHealth Ontario, and other health-care providers — to facilitate eHealth adoption and use to support quality patient care.

For example, the statement reads of the need for “availability of clinically useful and functional systems, those that are robust, flexible, upgradable, and able to effectively interface with other systems, regardless of size or scope.”

To read the draft statement, please go to our website at www.cpso.on.ca under Policies and Publications>Consultations.

Social Media Statement
Broadly speaking, the term “social media” refers to web and mobile technologies and practices that people use to share content, opinions, insights, experiences, and perspectives. Prominent examples of social media include Facebook and Twitter.

Like many others, physicians have come to see the appeal of participating in
such highly interactive dialogues. And besides being an enjoyable source of entertainment and information, social media can also be harnessed to advance good medical care and medical education.

The nature of these platforms, which are highly accessible, informal, and public, raise important questions, however, about the steps physicians should take in order to maintain professionalism while online.

That is why the College has developed draft guidance for physicians about how best to engage in social media while protecting patient confidentiality and privacy, maintaining appropriate doctor-patient boundaries, avoiding conflicts of interest, and safeguarding the reputation of the medical profession.

The draft document is not a policy; it does not establish any new expectations for physicians that are unique to the use of social media. Rather, it clarifies how existing professional expectations apply to behaviour in the social media sphere and provides advice on steps physicians can take to uphold those expectations.

To read the draft document, please go to www.cpso.on.ca under Policies and Publications>Consultations.

Email address for all physicians

If the College had your email address, we could send communications to you faster, more efficiently and less expensively than regular mailing.

For that reason, the College has approved the circulation of a proposed by-law that would require physicians to have an email address. The proposed by-law is published on page 26.

While the email addresses would be available to the College, they would not be available to the public on the College website.

Having your email address would allow the College to communicate with you in the event of a health emergency. An email address would also be used to send you such communications as proposed by-laws and regulations required to be circulated by legislation.

Currently, there are approximately 600 physicians who have not provided us with an email address.

This proposed by-law is consistent with our direction as an organization. In 2013, all physicians will be expected to renew online. (See article on page 56.)

Telemedicine policy preliminary consultation

In the five years since the Telemedicine policy was first published, telemedicine has evolved from a communication medium complementing traditional services, to a technology of automation and decision tools expanding the scope and range of health services available to patients. Telemedicine is being used with increased frequency in diverse contexts.

We are just embarking on a preliminary consultation of the policy to solicit feedback on the current policy. Let us know what new issues you think need to be addressed and what needs to be changed.

Please go to www.cpso.on.ca under Policies and Publications>Consultations.

Coming soon…..

We are actively exploring a move to online voting in district elections. This move will streamline and enhance the efficiency of our election process. The experience of other jurisdictions has shown that electronic voting results in greater voter participation. Stay tuned for more information in our next issue.
Getting an Education in Palliative Care

Increased training can make for better doctors – in any situation

By Stuart Foxman

In medical school, Dr. James Downar was asked to list the specialties that he was drawn to and those that held little interest. “The only thing I wrote down was ‘Don’t put me in palliative care,’” he recalls. He had gone into medicine to cure people, not to watch them die.

Today, Dr. Downar is a palliative care physician and intensivist at the University Health Network in Toronto. He explains that as he came to understand palliative care, he learned that it was more about life than death.

In fact, he suggests that every doctor, regardless of specialty, can benefit from more grounding in palliative care: “We all need a basic level of competency.”

Are physicians getting the training to provide quality end-of-life care? What methods are educating physicians on the nuances of palliative medicine? And how can this education help any physician to become more effective overall?

In this first of a five-part Dialogue series on palliative care, we’ll explore education and professional development.

The need for palliative care is growing. This care is no longer restricted to cancer patients; it now applies to people with other chronic conditions and illnesses. Canada needs more palliative care experts, especially given the aging population.

Some medical schools offer a one-year fellowship with added competence in palliative medicine, accredited by the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada. The Royal College has also proposed a two-year subspecialty in palliative medicine, with adult and pediatric training streams.

Last year, the College hosted a forum of experts in the end-of-life care field. We asked them what needed to change to meaningfully improve the last months, weeks and days of patients’ lives.

The experts describe a current environment where assumptions and misunderstandings – between physician and patient, among specialists and within families – replace informed discussion.

Given that lack of communication appears to be one of the biggest barriers to optimal end-of-life care, we’ve decided to launch a conversation. What is optimal care and what can be done to achieve it?

Over the next several issues, Dialogue will bring you the views of experts in palliative and end-of-life care, as well as lessons learned from patients’ experiences.

We are also taking the conversation online. Please visit us at www.cpso.on.ca/endoflife and share your thoughts and experiences.
There has also been a move to incorporate palliative concepts in medical curricula as central to every discipline. As a recent article in the *Canadian Medical Association Journal* noted, “End-of-life care should be as important to us as quality birthing care or quality care in the emergency department.”

Palliative care training in medical schools varies, but the curriculum generally focuses on managing pain and symptoms; responding to psychosocial and spiritual needs; assisting in end-of-life planning/decisions; effective communication with patients and families; interdisciplinary collaboration; and easing the suffering of terminally ill patients.

The issue isn’t just what’s taught but when. Often, palliative care education is confined to years one and two of medical school. Dr. Downar notes the stark contrast between what’s learned in the classroom and at the bedside. He’d like to see palliative care ingrained in later years of training, into residencies and fellowships.

“The clinical years should have exposure to palliative care as an obligatory rotation,” agrees Dr. José Pereira, head of the Division of Palliative Care, University of Ottawa.

To understand the gaps in palliative care training, consider this. All physicians will be expected to have training in CPR. However, how many will need to apply those skills? In contrast, hospital policies suggest that doctors routinely ask all patients about their care goal. “Yet, there is no standard training on how to talk about it, and in most cases no training at all,” says Dr. Downar.

Dr. Pereira, who is also Medical Chief, Palliative Medicine at Bruyère Continuing Care and The Ottawa Hospital, believes that palliative care training must be more robust. “It’s not just about end-of-life care, but a foundation of learning other competencies, like a patient-centred or holistic approach, bringing together the science and the humanism.”

A need to broaden exposure

Not every patient ends up seeing a palliative care specialist. Yet doctors in all fields see patients who can benefit from advance care planning and other palliative support. “How we manage end-of-life care is everyone’s responsibility,” says Dr. Downar.

Dr. Pereira is alarmed by some specialists who say “I don’t do palliative care,” even though they’ll see patients with incurable illnesses. “It behooves all clinicians to look in the mirror and ask if they have these skills or should get some fine tuning.”

Medical school faculty need to model the desired palliative care qualities and skills, Dr. Pereira adds: “If residents don’t see it, they won’t follow it.” He says that many faculty members should look at upgrading their own skills, with a program like LEAP (Learning Essential Approaches to Palliative and End-of-Life Care) a 13-hour educational program designed for physicians, nurses and pharmacists, across all sectors of care.

The medical literature identifies one big barrier to increased palliative care training – the culture of curative medicine. Dr. Downar mentions a survey of 600 oncologists, who were asked about their
most difficult conversation. It wasn’t telling someone they had cancer, but telling them their treatment wasn’t working.

“You’re aligning care with the goals of the patient.”

Hoping for the best and planning for the worst should always be an operating principle, Dr. Downar says. Why might doctors avoid conversations about end-of-life or use indirect terms? “Because they feel they’re taking away hope – but they’re really taking away truth,” he says.

Education must address some of the myths around palliative care, namely that palliative means death. As Dr. Pereira says, “It’s really about living as best as you can, as long as you can.”

He cites evidence regarding lung cancer patients who saw a palliative care team earlier in their illness (while receiving chemo or radiation). Says Dr. Pereira, “Not only did these patients have a better quality of life – less depression, less anxiety – but they lived on average three months longer than those who received palliative care only at end-of-life.”

Dr. Downar’s greatest education in palliative care came during his medical training in the ICU. He was “in love with technology and advanced procedures.” But meeting families of terminal patients had a dramatic impact on his career. “We knew the patient wasn’t going to get better but didn’t know how to talk about it,” Dr. Downar says. “Everything was about the cure, so making this transition was difficult. But when family meetings went well, it was the best I ever felt, far better than doing a procedure successfully or resuscitating someone. You realize the non-curative route is often what people want. You’re aligning care with the goals of the patient.”

To make that hit home, Dr. Downar has designed a novel program at Toronto General Hospital. Actors play family members of critically ill patients. Doctors who are in the last years of their sub-specialty training are then placed in these scenarios. The program aims to improve how these doctors interact with a family – with compassion and understanding – and help them make informed end-of-life decisions.

Conversations are difficult

Any training that makes these discussions more real is welcome. End-of-life conversations can be hard for all involved. That’s why Dr. Deanna Mercer feels strongly about broadening education on palliative care. Last year, the Ottawa psychiatrist had three family members die within two weeks, including her father and grandmother. Each case had issues regarding end-of-life care, not so much around quality of care but around the difficulty of having the needed discussions. Dr. Mercer says “the challenges families face in making...”

Join the conversation

We want to hear from you about your opinions, your experiences.

• Should palliative care training be a part of every medical student’s experience, regardless of discipline?
• How did palliative care training make you a better doctor to your healthy patients?
• Did a lack of palliative care training lead to some difficult experiences at patients’ bedside?

Join the conversation and let us know what you think: www.cpso.on.ca/endoflife
A recent national poll found that 86% of Canadians haven’t heard of advance care planning. In the next issue of Dialogue, we’ll continue our series on end-of-life care with a look at this important planning.

What tools are needed for physicians, patients and their families to actively engage in this process at an earlier stage, prior to the onset of serious illness? We invite our readers to share their thoughts on the series at: www.cpso.on.ca/endoflife.

end-of-life care

reasonable end-of-life decisions are compounded by physician unwillingness to have the conversations and beliefs about what is good care.”

Watching her loved ones struggle, she found it difficult to initiate those conversations even though she’s a physician. Dr. Mercer believes that all doctors – not just palliative care physicians – should learn how to confidently and competently broach sensitive issues with patients and their families, like withdrawing care and the value of comfort measures.

“I suspect that helping physicians address [these topics] will have a much larger overall impact on improving people’s experiences at the end of their lives,” says Dr. Mercer.

Dr. Erin O’Connor agrees that palliative care training is helping to round out her medical education. She didn’t receive any such training while studying medicine at Queen’s University, and chose this, her fourth year in a five-year emergency medicine residency, to do a one-year program in palliative care.

“In emergency, we see lots of people at end-of-life, whether suddenly due to a major trauma or because of something like end-stage cancer,” says Dr. O’Connor, who works at Ottawa Hospital and Elizabeth Bruyère Hospital. “Most of us choose medicine because we want to fix people. We feel that when we can’t we’ve failed the patient and their family. It’s not a failure. Even if you can’t make a person live longer, there’s still much more you can do. You can fix their pain, you can fix their suffering.”

While her special one-year program will serve her well in emergency medicine, Dr. O’Connor echoes the feeling that palliative care training can improve any doctor’s ability to deal with any patient. “Palliative care is very patient-focused,” she says. “It’s not focused on the disease or symptoms, but on what the patient wants and what’s best for them.”

Sometimes, that can get lost in solely treating an illness or condition. “I think that palliative care training is making me a more effective listener,” says Dr. O’Connor. “I’m better able to ask the right questions, and I’m more sensitive to patient symptoms and needs. And that’s making me a better doctor.”

www.cpso.on.ca/endoflife
At its last meeting, Council approved a consolidated policy that outlines expectations on many aspects of prescribing. In this issue, we provide answers to some Frequently Asked Questions on the Prescribing Drugs policy.

This is a comprehensive policy that appears to cover prescribing expectations on a whole range of issues. Did any of the expectations change in this new format?

A In consolidating seven different policies, we now have brought together our guidance on drugs and prescribing in one easy to use policy. Our expectations have remained largely consistent with what is stated in the previous policies, but we have added new expectations for other issues.

What do the new expectations address?

A We added new content on refills, drug samples, and redistributing unused drugs. We also addressed the use of technology when prescribing throughout the policy.

And we have a lot of new content (both in the policy and accompanying guidelines) about narcotics and controlled substances. Given the concerns regarding these drugs, and the many requests we receive to provide more guidance on this issue, we decided that more detailed expectations were necessary.

Overall, we have been more explicit and detailed to ensure that the College’s expectations are both clear and comprehensive.

The consultation lasted several months. What was the dominant issue heard from patients, physicians and other stakeholders?

A Many of the comments related to prescribing narcotics and controlled substances. In particular, concerns were expressed – by physicians and patients – about the inappropriate prescribing of these drugs.

We heard that more focus should be on preventing prescription drug abuse, not reactive measures. We have restructured the policy to put more emphasis on these measures such as highlighting the requirement to carefully consider whether prescribing narcotics is the most appropriate choice for the patient.
Treatment Agreement: 
Setting and managing patient expectations

If you decide that a patient will benefit from opioid therapy, it is recommended that you consider using a tool that fully allows your patients to understand under what conditions the drugs will be prescribed.

Treatment agreements are formal and explicit written agreements between physicians and patients that describe the conditions of ongoing opioid therapy.

A contract could state that:

• the physician will only prescribe if the patient agrees to stop all other narcotics and controlled substances;
• the patient will use the drug only as directed;
• the patient will not give the medication to anyone else; nor will the patient accept opioid medication from anyone else;
• the patient acknowledges that all risks of taking the drug have been fully explained to him/her; and
• the patient will use a single pharmacy of their choice to obtain the drug.

Having an agreement ensures patients are told what is expected of them when they receive a prescription and the circumstances in which prescribing will stop. The consequence for not meeting the terms of the contract would also be clear: the physician may decide not to continue to prescribing narcotics and controlled substances.

There is a sample agreement at the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain, (http://nationalpaincentre.mcmaster.ca/opioid/)

Are you concerned that the emphasis on preventative measures could lead physicians to second-guess their decisions to write a prescription for narcotics?

A No, physicians who have experience and expertise in opioid prescribing should not second guess their clinical decisions. This policy does not attempt to curb the prescribing of narcotics and controlled substances for legitimate reasons (i.e., acute or chronic pain, mental illness or addiction) but, yes, it does reinforce the requirement that physicians prescribe these drugs in an appropriate manner.

One of the risks when prescribing narcotics and controlled substances is the potential for prescription drug abuse. The non-medical use or abuse of prescription drugs is a serious and growing public health problem.

The policy makes it clear, however, that the College believes that narcotics are important tools and can play a role in safe, effective and compassionate treatment of acute or chronic pain, mental illness and addiction.

The policy does not provide details about how narcotics should be used. Why not?

A The policy cannot contain detailed clinical guidelines regarding when and how opioid therapy should be used (e.g., rec-
ommended dose, frequency, duration, etc.) because the intent of this policy, and College policies more generally, is to set out professional expectations. The policy references clinical guidelines that already exist (e.g., the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain [http://nationalpaincentre.mcmaster.ca/opioid]).

What does the policy require that I do before prescribing a drug?

A Physicians typically prescribe drugs within the context of a physician-patient relationship. In most cases, this means that an appropriate clinical assessment of the patient has been conducted, the physician has made a diagnosis or differential diagnosis and/or has a clinical indication based on the clinical assessment and other relevant information, informed consent has been obtained, and the physician prescribes a drug.

What does an appropriate clinical assessment consist of?

A An appropriate patient history, including the most complete and accurate list possible of drugs the patient is taking and any previous adverse reaction to drugs, and if necessary, an appropriate physical examination and/or any other examinations or investigations.

Can I rely on an assessment conducted by someone else?

A Yes, you may. We acknowledge that physicians often practise in a collaborative, interprofessional environment, where they often rely on assessments conducted by someone else. We wanted to ensure this was done appropriately, so physicians may rely on an assessment conducted by someone else if they meet the conditions set out in the policy. Ultimately, the prescribing physician is responsible for how they use the information from the clinical assessment, regardless of who conducts the assessment.

The policy does not allow physicians to redistribute unused drugs. Why not? Was this an issue during the consultation?

A Allowing physicians to redistribute unused drugs that have been returned by patients is inappropriate because the integrity of the drug cannot be ensured in all instances, and patient safety could be compromised.

This was definitely an issue in which we heard polarized views. Some respondents believed that returned drugs should not be redistributed given the patient safety concerns, others thought it should be allowed in some circumstances because patients may not otherwise be able to afford them. Ultimately, we agreed that it was a patient safety issue. 

DOC TALK

On page 47, we interview Dr. Barbara Lent, who chaired the working group for the prescribing policy. She discusses how conversations with patients can boost adherence to prescribed medications.
A closer look at self-regulation

In November, the College hosted its annual event designed to give physicians the opportunity to see themselves in a leadership role in medical self-regulation. Throughout the day-long event, two dozen physicians from across Ontario participated in debates on issues of regulation, discussed case studies and listened to doctors share their personal stories about how participation in medical self-regulation enriched their careers in medicine.
Much importance is paid to the opinion expressed by a medical expert – whether it is heard as testimony in court or stated in a written report. That is why it is so critical that physicians who are asked to serve as medical experts fully understand what is expected of them.

Recently, Council approved a policy that sets out professional expectations for physicians who choose to act as a medical expert. The policy is included with this issue. In the meantime, measure your knowledge by taking our true or false quiz.

Test your knowledge with this quiz...

1. When you provide an expert opinion, your first duty is to the individual who is instructing or paying you. True or false?

2. If a particular question or issue falls outside your area of expertise, you should provide your best guess. True or false?

3. Only leading specialists are qualified to act as a medical expert. True or false?

4. As a physician, you have an obligation to act as a medical expert, when asked. True or false?

5. You are asked to conduct a medical examination of an individual in your role as a medical expert. In doing so, you become aware of a suspicious finding which suggests the individual is at immediate risk of harm and requires urgent medical intervention. You can disclose this finding to the individual. True or false?

Quiz Answers

1. False. When you provide an expert opinion, your prevailing duty is to the adjudicative body (e.g., court). You must assist the adjudicative body by providing objective and impartial opinions. Physicians must not advocate for any party involved in the legal proceeding.

2. False. You must restrict your statements to areas in which you have expertise. If you do not know the answer to a question, you must clearly state this and decline to answer.

3. False. Any physician could be a medical expert by virtue of his or her knowledge and experience. The criteria is that the issue must fall within your area of expertise and that you do not have any conflicts of interest.

4. False. You do not have any such obligation.

5. True. In situations where the suspicious finding suggests that the individual is at imminent risk of significant harm and immediate medical care is required, physicians may not have time to seek independent legal advice, and must exercise their professional judgment to determine whether the patient’s current clinical status is urgent enough to warrant immediate disclosure to the individual.
More than ever before, medical procedures – including cosmetic surgery, colonoscopies, and interventional pain procedures – are performed in premises outside of hospitals. All signs indicate that this trend will grow in coming years. In fact, the government has confirmed its intention to move more procedures out of hospital settings and into the community.

Prior to 2010, no organization in Ontario had the authority to regulate these out-of-hospital premises. The College of Physicians and Surgeons of Ontario advanced the idea that these premises should be regulated in order to protect the public. The College worked hard with our partners in government to develop the Out-of-Hospital Premises Inspection Program (OHPIP), a program designed to protect patients by filling this significant gap in regulatory oversight.

Health premises currently regulated by OHPIP include those where certain levels of anesthesia are used and where a range of specified procedures are carried out as prescribed in regulation. Examples include premises where general anesthetic is administered and where surgical cosmetic procedures, colonoscopies, and interventional pain procedures are performed, as well as numerous other regulated procedures.

In the spring of 2012, the College met the critical milestone of inspecting all 209 out-of-hospital premises that existed when the regulation came into force. To date, the College has inspected more than 250 premises.

To mark the first two years of OHPIP, the College has released a report that provides an update of the program. The full report is available from the homepage at www.cpso.on.ca. Over the next several pages, we highlight a number of significant achievements from OHPIP’s first two years of operation as well as the opportunities for enhancing the program in the future.

**OHPIP’S FIRST TWO YEARS: The successes**

- **Bridged a gap in health-care regulation**
  - OHPIP filled a major gap in health-care regulation in Ontario and the program has helped to ensure that patients are receiving safe care in a wide array of out-of-hospital settings.
  - The OHPIP program has the authority to prevent high-risk procedures from being performed in premises that don’t meet the standards and also has the authority to prevent unqualified individuals from performing those procedures.

- **Established quality standards**
  - A working group at the College established standards for the provision of safe medical care and the core requirements for both the premises and the physicians who carry out procedures in these settings involving the use of anesthesia.
  - The College continuously revises and improves the standards document to ensure that the standards that underpin the OHPIP program reflect best clinical practices.
  - Two procedure-specific guidelines were developed for interventional pain medicine and colonoscopies.

- **Developed an oversight committee**
  - The program is overseen by the College’s Premises Inspection Committee, chaired by a physician member appointed by the College’s governing Council.
  - Each committee member brings relevant specialty expertise to the program in one of the relevant inspection/assessment areas. Public members of Council also sit on the Committee.
  - The mandate of the committee includes: ensuring appropriate individuals are appointed to perform inspections; ensuring that adequate inspections are carried out in a timely fashion; reviewing inspection reports
and determining whether premises “pass”, “pass with conditions”, or “fail” their inspections, specifying any relevant conditions on premises operations; establishing and reviewing costs of inspections.

✔ **Built a skilled inspection/assessment team**

- The College developed a team of highly competent peer assessors to administer the inspection program.
- More than 75 physicians and six nurses are carrying out inspections and assessments in out-of-hospital premises.

✔ **Inspected ALL existing OHP premises within ambitious target**

- In mid-2012, the College met a critical milestone for the OHPIP program; within the first 24 months of the program, we successfully inspected all 209 premises that entered into the program at the time the OHPIP regulation came into force.
- This milestone was prescribed in the OHP regulation passed by government.
- We have inspected 251 premises to date.

✔ **Established system for Inspection**

- All new OHPs must be inspected prior to opening.
- Once inspected, premises will receive a grade of pass, pass with conditions or fail. If a premises receives an inspection grade of ‘fail’, members of the College are prevented from performing regulated procedures at this OHP until the premises receives a pass or pass with conditions.

### Ensuring Public Protection: Program Results

Of the first 251 inspections, 178 premises passed, 64 passed with conditions and nine failed.

The public can be reassured that those premises that receive an inspection outcome of “pass” are meeting a high standard of practice. They are considered to have met all expectations outlined in the OHP standards and will be scheduled for a reassessment within five years – earlier, if additional procedures are done at the premises or a concern has been reported to the College.

Those premises that receive an inspection outcome of “pass with conditions” are safe to continue to serve the public; however, identified deficiencies must be corrected within a specified timeframe to meet OHP standards and to receive a grade of “pass.”

All of the premises which received a grade of “pass with conditions” are making the required adjustments to meet the standard.

If a premises receives an inspection grade of “fail” members of the College are prevented from performing the regulated procedures that could put the public at risk.

Examples of why an OHP may fail include: the staff, including physicians and nurses, do not have qualifications deemed appropriate; inadequate physical space; inadequate infection control practices; the OHP failed to have sufficient quantities of critical medication, such as cardiac resuscitation drugs on hand.

### Looking Forward

The first two years of OHPIP have helped the College to identify some gaps in this evolving regulatory structure. As these issues are resolved, we will further enhance public safety through this program.

**Pass with Conditions**

Premises who have received a Pass with Conditions outcome can remain operational; however any identified deficiencies must be corrected to meet the OHP standards. Examples of such deficiencies may include inadequate patient records; additional patient monitoring may be required; and or the maintenance of specified equipment.

**Fail**

Premises that have received an outcome of Fail have posed a definite threat to patient health and safety and must cease performing the regulated procedures at the premises. Examples may include a major breach of infection control, non-qualified personnel; and failure to meet procedural standards. Failed premises are required to have a reassessment when standards are met.
One of the identified program improvements is a mechanism to compel physicians in OHPs to report adverse events to the College. An adverse event can be defined as “an unexpected and undesired incident directly associated with the care or services provided to the patient” (J. Davies, Canadian Patient Safety Dictionary 2003).

“Such events can occur in all medical settings. Hospitals have evolved a mechanism of learning from adverse events. The OHPIP wants to ensure that the physicians and nurses working in OHPs also share experience and learn from such incidents to prevent adverse events and patient injury,” said Dr. Byrick.

Some identified program improvements, such as a requirement to report adverse events occurring in OHPs, are already in development.

Below are examples of program improvements that are currently underway or being planned to facilitate further public protection:

• Reporting adverse events to the College to protect patients and monitor quality improvements. A draft by-law for the reporting of sentinel events (Tier 1 events) was approved for consultation in September 2012. It is proposed that Tier 2 events be tracked by the premises for quality improvement purposes and be reported to the College annually.

• Collaborating with the Royal College of Dental Surgeons of Ontario (RCDSO) to facilitate assessment of physicians providing anesthesia care within dental clinics that are inspected and assessed by the RCDSO.

• Obtaining oversight of other procedures not currently covered by OHPIP regulation. This will ensure that all procedures performed in out-of-hospital premises that could pose risks to the public, are covered by the regulatory framework.

• Collaborating with Public Health Ontario to enhance and improve the implementation of standards related to infection control and other public health issues in these premises.

• Aligning standards between the OHPIP program and the government’s Independent Health Facilities Program to ensure consistency in quality and safety standards.

• Increasing transparency of the program by facilitating information sharing with the public regarding the results of premises inspections.

• Reviewing the need for additional standards and improving the core standards document for out-of-hospital premises, based on our experience. The committee has already developed two procedure-specific guidelines for interventional pain medicine and colonoscopies.

• Developing a fair and transparent fee model. The development of a fee structure to support this self-funded program has been challenging. The College has retained external expertise to guide the development of a sustainable cost-recovery fee model. Consultation will take place in 2013 to inform and guide the program fee structure.

• Updating the regulation to focus the program on the procedural risk rather than just anesthesia as a trigger for entering the program.

• Enhancing the College’s access to information about premises performing procedures captured under the regulation, currently the program relies on physician self-reporting.

“This program is a real success story for quality improvement and public protection in Ontario,” said Dr. Rocco Gerace, College Registrar. “We are very proud of the achievements of OHPIP, in particular, the advancements in patient safety and quality of care that the program has produced in its first two years,” he said.

1. Tier 1 events include: death within the premises; death within 10 days of the procedure performed at the premises; any procedure performed on wrong patient, site or side; and transfer of a patient from the premises directly to a hospital for care.

2. Tier 2 events include: the number and type of infections occurring in the premises; an unscheduled return to the procedure room for an unexpected event; an unplanned stay at the premises for medical reasons that is longer than 12 hours post-procedure; and an unscheduled treatment of a patient in a hospital within 10 days of a procedure performed at a premises.
At the December meeting of Council, Dr. Eric Stanton, a cardiologist from Hamilton, became President of the College.

Dr. Stanton recently sat down with Dialogue to discuss his passion for quality assurance and his hopes for the year ahead.

What led you to run for Council election?
I had been involved in the Ontario Medical Association as a board member and I felt that a number of issues that the OMA was dealing with were not incongruent with issues that the CPSO also struggled with. I just didn't think that the two organizations were as far apart as some thought. While the mandates of the two are quite different, ultimately the goals are the same: the best way to ensure patient safety is to support physicians in providing patient care in an environment that supports both patients and physicians. After several years on Council, I believe this more than ever.

You have been co-chair of the College’s Quality Assurance (QA) Committee for a number of years. You must get an earful in the doctor’s lounge every time a colleague gets a notice from the College that he or she will need to be assessed.

Sometimes, physicians will approach me and say they are nervous. I understand where they are coming from – I was nervous when I had my first peer assessment, before I became involved with the College. But I reassure them that assessments are done in the spirit of education and are not intended to be punitive. After the assessment, overwhelmingly, they will tell me that it was a positive experience. If they are practising great medicine, the assessor will confirm it. And that’s a nice feeling.

In those instances when more direction is needed, I think they understand that feedback is simply intended to be educational and supportive of their own desire to practise medicine to the expected standard.

Continued on page 43...
The College has embarked on an initiative to better understand whether any differences exist in the performance of physicians who achieve Ontario registration through alternative pathways and those who are registered through traditional pathways.

Over the years, the College has developed alternative registration pathways with the intention of improving patients’ access to medical care without compromising our registration standards. This evaluation will assess:

- Whether the alternative registration pathways and policies are achieving their intended purposes;
- Whether changes are required to the alternative registration pathways and policies (i.e., is the bar set too high; too low; or appropriate);
- Whether ongoing educational needs for physicians may differ depending on their route to registration (which, if so, will enable the development of appropriate quality improvement initiatives).

The evaluation will include both a retrospective analysis of complaints information received by the College and a records review traditionally used in assessments, complemented by the use of multisource feedback (MSF) to gain insight into the physicians’ communication and collaboration skills.

The data generated will assist us in understanding any differences in practice and performance based on the route of entry to practice, and will provide more information to inform Council about the potential broader use of MSF data within the peer assessment process, said Dan Faulkner, Deputy Registrar of the College.

**Piloting Multisource Feedback**

Before proceeding with the evaluation of our registration pathways and policies, pilot testing of the efficacy of the proposed MSF process will be conducted using more than 30 College peer assessor volunteers.

Between November 2012 and April 2013, the peer assessor volunteers will participate in a MSF process administered by an independent company specializing in client evaluation services.

Pivotal Research will interact directly with the volunteers and will facilitate the questionnaire process. In total, feedback will be obtained from eight physician and eight non-physician colleagues of the volunteers and 25 of their patients. The volunteers will also complete a self-assessment. Results from the MSF process will be shared with each volunteer and the College, and volunteers will be asked to provide feedback about their experiences with MSF processes and tools.

We will write more about this initiative in upcoming issues of Dialogue.
A recently amended Quality Assurance regulation now allows additional flexibility in how the College can conduct assessments. Why is that flexibility important?

The previous regulation was too restrictive in understanding practice issues and supporting the doctor in his or her improvement. This new regulation enables the Committee to choose the assessment tools most appropriate to the practice and the most appropriate for the assessment.

Can you provide an example?

In the case of a physician re-entering practice, for example, the Committee may wish to interview colleagues and co-workers who were involved with the physician during his or her retraining/supervision. In the instance of a physician who may not perform well on a traditional records-review assessment, the Committee may wish to have the physician observed in practice. If there are concerns seen during observation, it would then be easier to identify learning needs for the physician.

I don’t expect, however, that there will be many instances when we need to deviate from the traditional peer assessment process [a records review accompanied by an interview with the physician]. The process has worked well for a number of years and is well regarded and accepted by most physicians.

Can you explain how the assessor network is informing the evolution of our peer assessment program?

In creating the assessor network, the College recognized that the potential value of our experienced assessors goes well beyond the benefit they bring to the individual assessments they complete and that by organizing them into discipline-specific groups, we can gain from their collective wisdom and experience.

This is well demonstrated in our assessment re-visioning project where our assessors are supporting the creation of new assessment tools that are relevant and useful for each medical discipline. Their input to this project is unique in that they are working with College research and evaluation staff to improve the peer assessment program, not in a theoretical way, but through the lens of their experience with the peer assessment program.

As the co-chair of the QA Committee, are you beginning to see physicians embrace the concept of lifelong learning?

I definitely believe that physicians are committed to maintaining their knowledge and skills. I do believe that we all want to provide high quality care to our patients. This is easier said than done, however. The challenge is recognizing where improvements can be made, learning how to make them, and then doing so.

Does CPD need to evolve for this to happen?

Yes. I believe that physician education should engage actively with the real world in which the doctor practices. Resources need to be shifted, or increased, to create more opportunities for work-based learning. Many physicians still think of CPD as attendance at courses or conferences and, in fact, we know that the most effective forms of CPD are interactive and made meaningful when the content is directly applicable to the physician’s practice. Learning needs to be relevant to a physician’s work day.

We also need more opportunities to receive feedback – from other physicians, from our patients and from the nurses and other health-care professionals that we work with closely. We all have blind spots, after all. We may need others to bring them to our attention.
What do you find is your own most effective way to access continuous professional development?
I have always found that case discussions within small groups to be most rewarding. I like talking about the details of cases in a one-on-one scenario or within a small group. It feels real and relevant and immediate to me.

How do you think the College’s focus on continuous quality improvement has impacted on the complaints and discipline functions of the College?
I think there has been a shift away from the idea that we can only protect patients by removing physicians from practice. In fact, we protect patients by assisting physicians to improve and even excel in their practices. Of course, some issues, often behavioural ones, can only be addressed through a traditional disciplinary route.

However, the College generally believes that if a physician is capable of improving, we best serve the public by assisting that physician to stay in practice supported by other physicians who will guide his/her progress.

What do you hope your legacy is, as College President?
I would like to leave physicians with a better sense that their self-regulatory body is their partner in providing the best care possible. Every single doctor wants to be practising the very best medicine that he or she can – and we want to help them find the best ways to get there.

“Physician education should engage actively with the real world”

We want to hear what you think about our series on end-of-life care.

• Should palliative care training be a part of every medical student’s experience, regardless of discipline?
• How did palliative care training make you a better doctor to your healthy patients?
• Did a lack of palliative care training lead to some difficult experiences at patients’ bedsides?

Let us hear your voice: www.cpso.on.ca/endoflife

Join the Conversation
Dear Member:

On October 9, 2012, new expanded scope regulations came into effect for pharmacists in Ontario. Among the changes is the ability of pharmacists, under their own authority and within specified parameters, to renew or adapt prescriptions for continuity of care and optimization of patient outcomes.

The College of Physicians and Surgeons of Ontario (CPSO), the Ontario College of Pharmacists (OCP), the Ontario Medical Association (OMA), and the Ontario Pharmacists’ Association (OPA) have a long-standing history of supporting the principles that facilitate interprofessional care of patients and of educating our members regarding the practical implications of legislative change. This statement will clarify certain aspects of the regulations and address several issues that are emerging in practice situations.

Overriding Principles

The services included in the expanded scope regulation are part of ongoing medical care and a collaborative relationship between the pharmacist, the patient, and the patient’s primary health-care provider. The following overriding principles also apply:

• Pharmacists are accountable for practising within their scope of practice and in accordance with their knowledge, skills and judgment;

• Pharmacists adapt or renew prescriptions only for the benefit of the patient, based on clinical rationale (having distinguished patient’s best interest from patient or provider ‘convenience’); and

• Pharmacists assume full responsibility and liability for their decisions.

Renewals

The purpose of pharmacists’ renewals is to enable continuity of medication for patients with chronic conditions while ensuring appropriate monitoring and reassessment by the primary health-care provider.

Pharmacists may choose to renew prescriptions based upon the circumstances of the particular patient and will give consideration to the following:

• the medication to be continued is for a previously diagnosed chronic condition, and

• the patient has tolerated the medication without serious side effects.

The quantity of the drug renewed will not exceed the lesser of:

• the quantity that was originally prescribed, including any refills that were authorized by the original prescriber; or

• a six month’s supply.
INTERPROFESSIONAL COLLABORATION

Documentation in the pharmacy record and notification to the original prescriber within a reasonable time period is required for all prescription renewals.

Adaptations
Pharmacists may adapt prescriptions based upon the circumstances of the particular patient by adjusting the dose, dosage form, regimen, or route of administration to address the patient’s unique needs and circumstances. The pharmacist’s authority does not include therapeutic substitution.

All pharmacists’ adaptations require patients’ consent that must be documented along with the rationale for the adaptation and follow-up plan. Furthermore, if the adaptation is clinically significant, the original prescriber will be notified within a reasonable time period.

Pharmacists’ renewing or adapting authority excludes narcotics, controlled drugs, targeted substances and drugs designated as a monitored drug under the Narcotics Safety and Awareness Act.

Communication and Collaboration
Good communication between health-care professionals, particularly in a changing environment, is critical to ensuring the best care for patients. Physicians and pharmacists both have a role to play in optimizing medication management and educating patients on the importance of managing and maintaining continuity of care. All practitioners are urged to collaborate and communicate for the benefit of their mutual patients.

No Refill/No Adaptation
Some physicians have blanket ‘no refill/no adaptation’ policies, meaning they will not authorize refills/adaptations for any patient, any drug and in any circumstance. Such policies are inconsistent with patient-centred care and have no clinical basis. If there are situations where refills or adaptations may not be advisable for clinical reasons, we encourage open discussion between our two professions so that all professionals involved in the patient’s care are best positioned to exercise their professional judgment where necessary and appropriate.

The health-care system is undergoing considerable change. Collaboration and understanding among health-care professionals is critical to ensure that the focus remains on the patient. The CPSO, OMA, OCP and OPA will continue to maintain open and regular dialogue with their respective members and with each other to ensure a smooth transition in the evolving professional relationship between Ontario’s physicians and pharmacists.

Sincerely,

Rocco Gerace, M.D.
Registrar
College of Physicians and Surgeons of Ontario

Dennis A. Darby, P. Eng., ICD. D.
Chief Executive Officer
Ontario Pharmacists’ Association

Doug Weir, M.D., F.R.C.P. (C)
President
Ontario Medical Association

Marshall Moleschi, R.Ph., B.Sc.(Pharm), MHA
Registrar
Ontario College of Pharmacists
A Prescription to Talk About Medications

10 ways to increase understanding and adherence

Dr. Barbara Lent, a family physician in London, Ont., had a patient in his 70s with atrial fibrillation. She recommended a blood thinner, but knew from past encounters that this man hated taking any sort of medication. He also felt no compelling need given that he felt perfectly fine.

“I had to spend a lot of time, over a couple of years, explaining to him the risks and benefits of taking the medication or not,” recalls Dr. Lent.

In developed countries, according to the World Health Organization, 50% of patients simply don’t take their medications as prescribed. What accounts for this low rate? In studies of adherence, some of the leading factors include the patient’s lack of understanding of their condition, low health literacy, little input around their treatment, complex drug regimens, drug costs, and perceived benefits.

To Dr. Lent, much of the issue can be summed up in one word: com-

Identifying Knowledge gap for Hydromorphone

ISMP Canada has undertaken a survey to better understand the extent of health-care professionals’ knowledge deficits or gaps that could contribute to medication incidents with hydromorphone.

A review of hydromorphone incidents that have been reported to ISMP Canada, including mix-ups between hydromorphone and morphine, suggested to ISMP Canada analysts that the difference in potency between these two drugs may not be well understood by all health-care professionals.

Continued on page 49...
Dr. Lent, a Professor in the Department of Family Medicine at Western University, is also a Council member of the College and chaired the College’s working group for the recently approved and comprehensive Prescribing Drugs policy. It touches on everything from patient assessment to documentation to preventing medication errors, all with a goal to improve patient safety.

The reality is that for medication to be most effective, physician communication has to be effective too.

Issues with adherence are as old as medicine itself. Hippocrates himself wrote on the subject: “Keep a watch on the faults of the patients, which often make them lie about the taking of things prescribed. For through not taking disagreeable drinks, purgative or other, they sometimes die.”

The onus, however, don’t always rest on the patients. Eliminating barriers to adherence is a joint responsibility. Consider these 10 communication principles when prescribing.

1. Watch your language.
   This applies to any conversation with patients – cut the jargon, be straightforward, and ensure clarity about the prescription. Have patients repeat the key points to confirm understanding. “Do we say something too quickly or in language that’s too complex?” says Dr. Lent. “We have to double check and ensure that the patient got the message.”

2. Cover all the basics.
   That includes the name of the medication, its purpose, why it was picked, how often and how long to take it, possible adverse effects, and how the treatment plan may change if the medication isn’t right. In one study reported in the Archives of Internal Medicine, doctors left out at least one of these pieces in over 65% of the audiotaped cases analyzed. In another study, 42% of physicians said they had discussed the potential risks of the medication, yet only 3% actually did so based on videotapes of the consultation.

3. Slow down.
   How long do you think you take discussing prescriptions with patients? A study in Patient Education and Counseling analyzed 234 new medication prescriptions from family physicians, internists and cardiologists. The average length of time that physicians spent reviewing a medication: 49 seconds. That broke down to 26 seconds for guideline-recommended components and 23 seconds to cover all other aspects of the medication. Taking a little more time might avoid misunderstandings about the directions or the need for medication.

4. Don’t just communicate, collaborate.
   Engaging patients is as important as educating them. When prescribing, have you involved the patient in the discussion and decision? Weighed their beliefs and attitudes? For instance, some patients might balk at long-term medications. Others might have a hard time accepting a diagnosis, or believing the impact of a medication. Different patients have different priorities, goals and outlooks. “How family physicians provide information reflects what we know about the patient,” says Dr. Lent.

5. Ask the right questions to assess adherence.
   During visits, patients routinely note their medications. That doesn't mean they're taking them as directed, or at all. Ask probing questions in a non-judgmental way. Do you ever miss taking a medication? Have you experienced adverse effects? Have you stopped taking a medication for any reason? The answers will reveal much more than a list does.

Continued on page 50...
Available in oral and injectable forms, hydromorphone is about 4-7 times stronger than morphine; therefore, any confusion between these two drugs can have devastating consequences for the patient, including death.

Responses were received from every province and territory and represented health-care disciplines involved in the prescribing, dispensing, preparation, administration, and/or monitoring of hydromorphone.

The survey found that the majority of health-care providers in the nursing, pharmacy, and medicine categories (3,023 of 3,436 or 87.9%), in responding to a question related to the difference in potency, correctly identified hydromorphone 1 mg as approximately equal to morphine 5 mg. An even larger proportion of respondents (3,270 of 3,436 or 95.2%) correctly indicated that morphine and hydromorphone are “both opioid medications used to treat pain but are dosed differently.”

However, incorrect answers provided by the remaining respondents (166 of 3,436 or 4.8%) suggest that the relationship between morphine and hydromorphone is not universally understood. Specifically, 147 respondents (4.3%) answered “They are two completely different medications with different uses,” 10 (0.3%) answered that “hydromorphone is ‘watered-down’ morphine,” six (0.2%) answered that “Morphine is a brand name for hydromorphone,” and three (0.1%) answered that “hydromorphone is a brand name for morphine.”

There was no apparent pattern to these incorrect responses in terms of disciplines: all disciplines were represented in these incorrect answers. Other areas where scoring was lower were related to:

- ability to identify opioid tolerance (all disciplines);
- recognition that obese patients do not require higher doses of hydromorphone (all disciplines);
- recognition that patients with chronic obstructive pulmonary disease require lower doses of hydromorphone (all disciplines);
- recognition that patients who are taking a benzodiazepine require lower doses of hydromorphone (nursing and pharmacy);
- recognition that elderly patients require lower doses of hydromorphone (nursing and pharmacy);
- conversion factor for changing an oral dose of hydromorphone to an equianalgesic parenteral dose of hydromorphone (nursing);
- distinction between side effects and allergies (e.g., understanding that a side effect does not preclude the use of morphine) (all disciplines); and
- recognition of the signs and symptoms of an overdose (medicine).


This reminder is prompted by a recent case review by the Pediatric Death Review Committee, in which the physicians employed in a methadone clinic did not make a child protection referral even though the mother of a 10-month old had repeatedly tested positive for numerous illicit substances before the child’s death. The physicians did not contact the CAS even though they knew the society was actively involved with the family.

Physicians who are unsure of their obligations are encouraged to review the Mandatory and Permissive Reports policy on our website at www.cpso.on.ca.
6. Pay special attention to side effects.
Which ones are common? Which might be bothersome and which should resolve on their own? Which require a visit to the doctor? Concern about side effects (i.e., that they can outweigh the benefits) can be a huge factor in non-adherence. In one study of patients who stopped taking medication for hypertension, the possibility of side effects was the number one worry.

7. Remember that patients are making choices.
Applying blanket labels to patients – adherent or non-adherent, compliant or non-compliant – doesn’t help. Non-adherence might be due partly to poor communication, but it’s also a function of the patient’s experiences and perceptions; not taking the medication can be an active decision. Consider that the same patient who is non-compliant with certain prescriptions might be compliant in taking alternative therapies. Recognize the complexity of the situation. In talking to patients, don’t just provide the necessary information, but explore the patient’s motivation.

8. Show empathy.
Try to see through the patient’s eyes. If a patient is on multiple medications, you could say something like this: “I know that you’re on quite a few prescriptions, and I’m sure it can be hard to manage that every day. How are you doing with that?” Such an approach can strengthen the patient relationship and foster open discussions about taking medication.

9. Explore objections.
A counseling technique known as motivational interviewing can help you to pinpoint why patients might be reluctant to take their medication as prescribed. What obstacles might be in the way? What suggestions do you have to get around them? In a study of patients with hypertension, a group that participated in motivational interviewing – discussing their individual needs, constraints and preferences – were more likely to take their medications as prescribed than patients in the control group who received usual care.

10. Continue the conversation.
Canada’s Research-Based Pharmaceutical Companies (Rx&D) says the failure to take medicines correctly – overuse, underuse or misuse – costs Canada $7-9 billion a year. Improved medication adherence is associated with fewer hospitalizations and visits to emergency. Some surveys indicate that doctors overestimate the percentage of their patients take prescriptions as directed. If you don’t raise the topic, patients might assume it’s not important. And if patients don’t notice a real difference in their health, they might assume that they don’t need the medication anymore. Keep discussions of medication use high on the radar.

Overall, studies show that patients who report a strong relationship with their doctors have higher rates of adherence to prescriptions (as well as other treatments and recommendations). Communication is always going to be a critical part of forging that relationship.

Pharmacists certainly play a role too in providing counseling, and it’s important for doctors to rely on them, says Dr. Lent. “But doctors and patients have a special relationship,” she says. “We need to use that trust and power in a positive way to enhance patient compliance.” When it comes to prescribing, solid communication is a significant active ingredient to boosting patient education, adherence, and ultimately health and safety.
In this second installment of our series, Dr. James Watters, co-Chair of the Quality Assurance Committee (QAC) and Chair of the Education Committee, provides some further thoughts on CPD, including how isolated physicians can access the best CPD for their needs.

Can you address the challenges that a physician with a solo practice might face in accessing CPD?

Many of the physicians who are having difficulties are those who appear to be isolated in terms of interaction with colleagues. Often this means not only solo practice, but with no hospital privileges and few collegial interactions. Spending time with colleagues is vital in maintaining currency and competence. For the geographically isolated physician, this is a challenge. As well, it’s often difficult for such physicians to arrange coverage and leave their practices to meet up with colleagues for learning opportunities.

How would you counsel an isolated physician to access CPD?

There are increasing numbers of learning opportunities online that involve small group interaction that can help these physicians. Additionally, tele-networking is becoming more prevalent, which should help.

And there are many online resources where one can self-assess current knowledge. National specialty societies have objective exams/test materials. There are online and/or subscription based CPD programs that incorporate testing of knowledge and patient management.

What kind of role could statistical information play in defining CPD needs?

There is a huge need for relevant data, and I don’t think obtaining it is far off. For example, it would be very useful for a family physician to know the percentage of his or her patients who are receiving care at the standard indicated by clinical practice guidelines in such areas as preventive medicine, diabetes, asthma, and hypertension. How does that compare to his or her peers? Does the physician prescribe a comparable amount of antibiotics? Does she order a comparable volume of tests? And, how can this translate into a specific and focused CPD plan for them?

Physicians with an EMR can run specific queries such as frequency of prescriptions and diagnoses by type to review and get an idea of the most common drugs prescribed and diagnoses seen in a given period of time. Aggregate data on diabetes care and preventive screening measures is also made available to eligible physicians from the Ministry of Health and Long-Term Care of Ontario, which can provide insight into the physician’s practice and identify educational opportunities. I also understand that Alberta and Quebec have been able to provide data to groups of physicians for comparison, learning and improvement.

We always need to be careful with data and what it means, but waiting until the perfect dataset comes along, is not an option either.

In the next installment, we will explore some of the RCPSC initiatives available to physicians to support learning in practice, including Smartphone applications.
Peer Assessor Close-Up:
Virginia Walley

Name: Virginia M. Walley
Practice Location: Toronto
Specialty: Laboratory physician (pathologist)

Was there somebody who inspired you to go into medicine?
I grew up in Deep River which is a small town on the Ottawa River. I remember the doctors – Drs. Skelly, Park and Gasmann – were community leaders who worked hard and multi-tasked. They were generalists, back when GPs routinely performed small surgeries, helping each other with anesthesia and so on. It was clear that medicine was a noble calling, and one that would be interesting and allow the opportunity to really help people.

What attracted you to your specialty?
Laboratory medicine is immensely interesting; it provides the opportunity to understand the very basics of disease processes (whether through microbiology or biochemistry or tissue pathology, or any of the other laboratory medicine disciplines). A laboratory physician is the ‘doctors’ doctor’, investigating disease through laboratory tests to advise other physicians how best to proceed in their clinical care of patients.

What is the most effective way for you to participate in continuous professional development?
My most valuable CPD experiences have been ones where I have done mini-sabbaticals, working with an acknowledged expert in some field. It is such an excellent way to integrate lessons learned, and provides the opportunity for first-person discourse that is not possible in most other settings for CPD.

What has been a great moment for you as a peer assessor?
I have enjoyed the opportunity to speak to colleagues working in other settings, and to learn about their local means of dealing with various work situations and related quality management program essentials; there is always something to learn, and to bring back home to improve processes.

Becoming a Peer Assessor

I enjoy doing assessments because it allows me to see how my colleagues practise. I have definitely enhanced my practice as a result of picking up great tips from assessments I have conducted.

Dr. Iris Greenwald, Methadone Assessor

The College is looking for practising physicians with good interpersonal skills and a knowledge of continuing professional development and evidence-based medicine principles to become peer assessors.

If you’d like to learn more, please contact Tracey Marshall at: (416) 967-2600 ext. 223, toll free (800) 268-7096 ext. 223 or tmarshall@cpsq.on.ca.
Many physicians already recognize that good medical records are indispensable. Records need to provide comprehensive and accurate documentation of all the features of assessment, diagnosis, treatment and follow-up to ensure the patient’s story is conveyed. Yet record-keeping remains the primary area identified by peer assessment as needing improvement. The Medical Records policy was recently updated and includes new requirements for physicians, recommendations as to the best means of record-keeping to assist in providing patients with quality medical care, and many new resources to help physicians in all aspects of record-keeping.

The following are the top five recommendations made by the Quality Assurance Committee to physicians to assist them in improving their records.

1. **Implement and maintain Cumulative Patient Profile (CPP)**

Under the updated policy, a CPP is required for each patient’s family practice chart, including charts in walk-in clinics. While not required for specialists’ charts, a CPP is highly recommended for specialists who see patients on an ongoing basis.

A comprehensive and current CPP provides a handy overview of the significant items in a patient’s medical history, thereby enabling information to be distilled from the medical record more easily. It saves the physician time by eliminating the need to rewrite information in the progress notes and is helpful to the physician and any colleague or staff member who refers to the record.

Many samples of CPPs exist, and physicians are encouraged to customize the CPP to meet their needs (see Appendix E of the Medical Records policy).

2. **Keep medication list current**

A current medication list is a key component of a patient’s medical record. A review of the list with the patient at every visit ensures patient compliance and enables the physician to make any necessary adjustments and avoid prescribing a drug that will interact negatively with another one that the patient is taking, whether previously prescribed or over-the-counter.

The most appropriate location in the record to place a medication list is directly on, or proximate to, the CPP. The Committee often reminds physicians of the importance of recording the type, dose and duration of the medication prescribed. It is not safe to assume that another physician who refers to the record will know the details of the course prescribed. Also, patients themselves are sometimes unaware of the medications they are taking.

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**Top Five List**

1. Implement and maintain Cumulative Patient Profile
2. Keep medication list current
3. Include Flow Sheets
4. Use SOAP
5. Keep referring physicians in the loop
3. Include Flow Sheets

Flow sheets, such as those for health maintenance or chronic conditions, can tremendously facilitate and enhance a physician’s management of patients. They allow the physician to record important clinical information about the patient’s management over a period of time, thereby enabling the physician to see trends, which, in turn, means that an appropriate course of action or treatment plan can be identified.

See Appendix F of the Medical Records policy for samples.

4. Use SOAP

A recurrent finding in medical records is the omission of sufficient detail to accurately describe the patient and the physician’s encounters with them. Often, the Committee recommends that physicians provide more relevant detail with respect to medical history, functional inquiry, description of the symptoms (including the severity), and findings upon physical examination (significant negative and positive).

To assist physicians in meeting the challenge inherent in consistently recording enough detail, the Committee recommends the use of the Subjective Objective Assessment Plan format, commonly known as SOAP. There are many advantages to the SOAP format, not least of which is that it guides physicians to document the most relevant information about a patient encounter, thereby reducing unnecessary information and giving the note a recognizable structure. The updated policy provides guidance on information to be included in each element of SOAP.

5. Keep referring physicians in the loop

A recurrent finding in consulting physicians’ medical records is the need for more detailed notes and better consultation reports to the referring health professional (or family physician) to ensure appropriate communication and a shared understanding of responsibilities for follow-up and treatment.

The updated policy features a new section on procedural medicine, which outlines requirements regarding consultants’ records, consult notes for diagnostic and operative procedures, and discharge summaries. Physicians are encouraged to review this new section. Among the most significant changes is the requirement that consultants report to the referring health professional after completion of the initial assessment, with follow-up reports when there are new findings or changes made to the management plan.

New address?
Let us know within 30 days!

The College’s register must contain both your current mailing address and your primary practice address. At the back of each issue of Dialogue, a change of address form is provided to mail or fax in.

Your MAILING ADDRESS is the address you would prefer the College use to communicate with you and may be different from your practice address. It is NOT available to the public, unless you decide to use your primary practice address as your mailing address. Your PRIMARY PRACTICE ADDRESS is available to the public.

If you change either address, you must notify the College in writing within 30 days of the change.
If your office was robbed, would your patients’ health information be safe?

Physicians are ultimately responsible for ensuring that their patients’ medical records – both paper and electronic – are stored and maintained in a secure manner, according to legal requirements set out in Ontario’s health information privacy law (Personal Health Information Protection Act, 2004), and the principles set out in the College policies: Medical Records, and Confidentiality of Personal Health Information.

College policy sets expectations for physicians to ensure that patient information remains secure. Physicians must take appropriate measures to prevent loss, restrict access, and maintain the privacy of patients’ personal health information. This will include ensuring that electronic records are backed-up on a routine basis; copies are stored in a physically secure environment separate from where the original data are normally stored; identifiable personal health information accessed and/or stored on mobile devices (even temporarily) must be strongly encrypted. Hard copies of all patient records and data must be kept in restricted access areas or locked filing cabinets to protect against loss of information, damage to the records, and to prevent unauthorized people from viewing the information.

The College encourages physicians to capitalize on the advantages that electronic record-keeping and other technological advances have to offer, however, it is always the responsibility of the physician to ensure that appropriate security provisions have been made.

The significance of a loss or breach can be greater when multiple patient records are stored on a portable electronic device. Physicians must be particularly diligent in protecting records under these circumstances.

Further detail on physician obligations can be found in the CPSO’s Medical Records and Confidentiality of Personal Health Information policies at www.cpso.on.ca under Policies and Publications.

Feedback Wanted

We are about to undertake a review of the Confidentiality of Personal Health Information policy. As an initial step in that review process, we will be asking for feedback on the current policy; the comments received will be used to help inform the policy review process, and to highlight any specific issues that should be considered during the review. Please check the Consultations page on our website for details on that process in the coming months. We hope you’ll consider participating and sharing your views with us.
Are you ready for online renewal?
Physicians will need access to computer to complete annual renewal

By the end of April, you will have received your notice for annual renewal for 2013. Renewal of your annual certificate of registration must be completed online.

Your notice will provide all the information you will need to complete your renewal, including how to get started, how to set your password and more information specific to your renewal.

Most physicians have been renewing online for the past several years. And they have told us that they found the process to be easy and convenient. For those two hundred physicians who have never renewed online, we offer the following suggestions:

Uncomfortable with computers?
If you want us to walk you through the steps, just give us a call. We are happy to do it. Call us at 416-967-2606 or 1-800-268-7096 ext. 606.

No Computer?
• Drop by our building. We will have computers in our lobby for you to use during this period.
• Many libraries allow free access to computers.
• Ask a family member or a friend if you can use their computer.
• Ask a colleague, we’re sure they would be happy to help.

Nervous about paying online?
You do not have to submit your payment online. While our online payment options are very secure, you need not pay online. You can pay by cheque. Just select that option when you get to the end of your renewal form and make sure we receive payment before the deadline.

We are here to help
Our advisors have helped thousands of doctors in the past three years with annual renewal. If you have a problem, pick up the phone and they will help you sort it out. They’ve heard it all – from the simplest question to the most complex, they’ve got the answer.

Important dates to remember:

Last week of April
By the last week of April, you should have received a letter from the College with all the details about logging on to complete your renewal. Contact our Physician Advisors if you don’t receive your letter.

June 3rd
By June 3rd, you must have completed your renewal and made your payment to the College to avoid any late fees.

Blood Borne Pathogen Question
The College has a policy that sets out the circumstances under which physicians must be tested for Hepatitis B, Hepatitis C and HIV. For example, physicians who perform or assist in performing exposure prone procedures (EPPs) must be tested annually.

Please note that if you do perform or assist in performing EPPs, you will be asked, on the annual renewal form, whether you have been tested for these blood borne pathogens since April 1, 2012.

For more information, please visit our Blood Borne Pathogen policy online at www.cpsso.on.ca.
Discipline Summaries

The following pages contain summaries of the decisions of the Discipline Committee. To read the entire decision of a particular case, please go to wwwcpsoonca, select Doctor Search and enter the doctor’s name. A PDF of the decision is posted under Additional Details.

<table>
<thead>
<tr>
<th>NAME</th>
<th>HEARING DATES</th>
<th>NATURE OF PRACTICE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. LMN</td>
<td></td>
<td></td>
<td>58</td>
</tr>
<tr>
<td>Dr. C.N. Rathe</td>
<td>2009: June 15 to 18 2010: July 5 to 8, July 19,</td>
<td>General Practice</td>
<td>58</td>
</tr>
<tr>
<td></td>
<td>September 1, October 1, and October 25</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. A.W. Redekopp</td>
<td>November 21, 2011 December 19, 2011</td>
<td>General Practice</td>
<td>61</td>
</tr>
<tr>
<td>Dr. M.G.A. Salama</td>
<td>Oct 14, 2011</td>
<td>Family Medicine</td>
<td>62</td>
</tr>
<tr>
<td>Dr. B. Sheffield</td>
<td>June 20, 2011</td>
<td>General Practice</td>
<td>63</td>
</tr>
<tr>
<td>Dr. L.W. Sokol</td>
<td>November 16, 2011</td>
<td>Family Medicine</td>
<td>64</td>
</tr>
</tbody>
</table>
Dr. LMN

Allegation

It was alleged that Dr. LMN committed an act of professional misconduct, in that he has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional. Dr. LMN denied the allegation.

Facts and Evidence

The College alleged that Dr. LMN forced unwanted sexual touching and sexual intercourse upon Y, and that he has thereby committed an act of professional misconduct.

Both Dr. LMN and Y were employed at Hospital A. The unwanted sexual activity is alleged to have taken place in the hospital on an evening in 2006.

There was no dispute between the parties that sexual activity occurred at the time and place in question. The dispute hinged on the issue of consent. Dr. LMN stated that Y consented to sexual intercourse. Y stated that she did not consent, and that unwanted sexual activity, including sexual intercourse, was forced upon her in the manner of a sexual assault.

The Committee found several aspects of Y’s account inherently improbable.

The burden of proof is on the College and the standard of proof in discipline proceedings is a balance of probabilities based on clear, cogent and convincing evidence. The Committee was of the view that, although the multiple inherent improbabilities of course do not prove that the allegations against Dr. LMN are untrue, the cumulative effect was to cast sufficient doubt on the reliability of Y’s evidence.

The Committee concluded that the College did not prove its case. The allegation of professional misconduct against Dr. LMN was therefore dismissed.

Dr. Charles Nicholas Rathe

Practice Location: Belle River

Practice Area: General Practice

Date of Registration: Independent Practice, 1989

Hearing Information: Allegations Denied, Contested Hearing (11 days)

On May 31, 2011, the Discipline Committee found that Dr. Charles Nicholas Rathe committed an act of professional misconduct, in that he:

- failed to maintain the standard of practice of the profession with respect to his prescription of Ionamin to Patient 1;
- engaged in conduct unbecoming a physician by rude, inappropriate, hostile and/or aggressive behaviour at a school concert;
- engaged in disgraceful, dishonourable or unprofessional conduct by behaving in a rude and objectionable manner towards the son of Patient 2 during the course of an office visit by Patient 2 and her son; and by falsely representing that one of his patients (Patient 3) was employed as his office manager;
- sexually abused a patient, in that he had a sexual relationship, including sexual intercourse, with Patient 3; and,
- has been found guilty of an offence that is relevant to his suitability to practise, engaged in conduct unbecoming a physician and engaged in disgraceful, dishonourable or unprofessional conduct, in that he committed a criminal assault, arising out of a traffic incident, on a female victim by punching her in the face while enraged.

On June 23, 2011, Dr. Rathe appealed the decision of the Discipline Committee to the Superior Court of Justice (Divisional Court).

Reasons for Penalty

The Committee reviewed the multiple findings which it had made against Dr. Rathe.

The Committee concluded that, in the circumstances of this case, it should consider the totality of the findings
against Dr. Rathe in arriving at a decision on penalty. The Committee felt that to fragment and compartmentalize its findings would detract from the overall significance of the patterns of Dr. Rathe’s misconduct.

The Committee, in arriving at its decision on penalty, considered the need to protect the public, to address issues of specific and general deterrence, and to consider the remedial needs, if any, of the member.

Dr. Rathe has been found to have committed the most serious form of professional misconduct, namely, the sexual abuse of his patient. The Committee accepted the evidence of the complainant that Dr. Rathe carried on a sexual relationship with her for many months while she was his patient. The Committee found Dr. Rathe's behaviour in this regard to have entailed a most egregious violation of his professional obligations to his patient. Misconduct of this nature must be sanctioned in the strongest possible terms. The protection of the public, and maintenance of public confidence in the integrity of the profession, would, in the view of the Committee, compel the revocation of Dr. Rathe's certificate of registration, even if this were not mandated by statute.

The Committee was struck by the pattern of unacceptable conduct repeatedly demonstrated by Dr. Rathe over a period of almost 20 years, despite many previous attempts by the College to sanction his misbehaviour and to offer him opportunities for remediation. The

Full decisions are available online at www.cpso.on.ca. Select Doctor Search and enter the doctor’s name.

What does this mean?

We provide definitions for the legal terminology used in the discipline process

Admission
The physician admits that the facts alleged amount to professional misconduct and/or incompetence.

Plea of No Contest
The physician does not contest the facts. The College files a statement of facts as an exhibit at the hearing. The Discipline Committee can accept the facts as correct and make a finding of professional misconduct and/or incompetence. The physician does not admit to the facts or findings for the purpose of any other proceeding.

Agreed Statement of Facts
A statement of facts that are negotiated and agreed to by the College and the physician. It is filed as an exhibit at the hearing.

Joint Submission on Penalty
A penalty that is proposed to the Committee as an appropriate penalty by both the College and the physician. In law, the Discipline Committee must accept a joint submission on penalty unless it would be contrary to the public interest and bring the administration of justice into disrepute.

Contested Hearing
The physician denies the allegations. The College must prove the allegations on a balance of probabilities (the civil standard of proof) by calling evidence such as witnesses. If one or more of the allegations is proved, a penalty hearing is scheduled. The College and the physician may agree and jointly propose a penalty to the Committee or they may disagree and a contested penalty hearing takes place.
nature of his misconduct has included rude, objectionable, and abusive behaviour towards his patients and their families, dishonesty and deceit, poor anger control accompanied by unacceptable outbursts of rage, and failure to accept responsibility for his behaviour. Treatment and rehabilitative initiatives, when apparently pursued by Dr. Rathe in the past, have evidently been unsuccessful in addressing these distressing patterns of ongoing misconduct. Dr. Rathe has previously been before both the Complaints Committee, on several occasions, and the Discipline Committee, on account of issues of this nature. He has by his repeated conduct demonstrated overt disregard for the authority of the College. In the view of the Committee, the above factors are properly considered aggravating with respect to its decision on penalty.

The Committee accepted that, with the exception of the finding pertaining to the prescription of Ionamin, Dr. Rathe’s clinical skills and judgment were not at issue. The Committee, however, did not accept that the lack of harm to his patients was a mitigating factor. Firstly, the Committee heard no evidence with respect to the actual harm, or lack thereof, caused by Dr. Rathe's behaviour. Secondly, the Committee found that Dr. Rathe could well have caused serious harm to the patient he was found to have sexually abused. If conduct has the potential to cause harm to patients, it is not a mitigating factor that, perhaps by good luck, actual harm has not been caused. It is the exposure of patients to the potential for harm that is key. The protection of the public is the overriding principle that guided the Committee in its deliberation on penalty.

Revocation of Dr. Rathe's certificate of registration and a public reprimand are mandatory under s.51(5) of the Code. Even if this were not the case, the Committee was left with no doubt that, considering the totality of the multiple findings against Dr. Rathe and his previous history with the College, revocation of his certificate of registration was the only suitable penalty to address the protection of the public and to maintain public confidence in the integrity of the profession. General deterrence with respect to the membership is also addressed through a strong statement that the types of misconduct committed by Dr. Rathe will not be tolerated. The Committee did not consider specific deterrence to be a significant factor in Dr. Rathe’s case, as he has demonstrated through his conduct over the years to be undeterred by College sanctions. Similarly, despite occasional references in the evidence to Dr. Rathe’s mental health and addiction issues, the Committee heard no evidence in this regard and was, therefore, unable to make any findings on this matter or to incorporate rehabilitative or remedial considerations into its decision on penalty.

Order

The Committee ordered and directed that:
1. The Registrar revoke Dr. Rathe’s certificate of registration effective immediately;
2. Dr. Rathe appear before the Committee to be reprimanded;
3. Dr. Rathe reimburse the College for funding provided to his patient under the program required under section 85.7 of the Code, and that he post an irrevocable letter of credit or other security acceptable to the College, in the amount of $16,060, to guarantee the payment of any amount for funding provided under that program; and
4. Dr. Rathe pay costs to the College in the amount of $23,725.

On February 8, 2012, Dr. Rathe also appealed the penalty decision of the Discipline Committee to the Superior Court of Justice (Divisional Court).

In the circumstances, the Order of the Discipline Committee remains in effect despite the appeal.
On November 21, 2011, the Discipline Committee found that Dr. Alan Wayne Redekopp committed an act of professional misconduct, in that he failed to maintain the standard of practice of the profession in his record-keeping and documentation and in his prescribing of narcotics and controlled substances.

Reasons for Penalty
Counsel for the College and counsel for the member made a joint submission as to an appropriate penalty and costs order.

The Committee accepted and gave strong consideration and weight to the expert evidence, which concluded that Dr. Redekopp’s record-keeping and documentation failed to maintain the standard of practice. Further, the expert evidence was that there were serious concerns regarding Dr. Redekopp’s prescriptions of narcotics and controlled substances, which demonstrated a lack of skill, knowledge and judgment and a failure to maintain the standard of practice for family physicians prescribing opioids. There was concern with regard to combinations of drugs and excessive quantities prescribed. Following the death of his patient, Dr. Redekopp did not make any changes to his practice with respect to prescribing narcotics and controlled substances. The expert evidence indicated that Dr. Redekopp is “likely to expose his patients to harm or injury if he continues to prescribe opioids and other narcotics in this manner.” Accordingly, the Committee was of the view that any penalty to be handed down must seek to protect the public and minimize this risk.

Mitigating factors in this case include the fact that Dr. Redekopp acknowledged the concerns of the expert and admitted that he failed to maintain the standard of practice in his record-keeping and narcotic prescribing. Dr. Redekopp’s admission has saved the College the expense of a contested hearing. Furthermore, Dr. Redekopp has successfully completed the College Prescribing Course and has no previous history with the Discipline Committee.

In considering the proposed penalty, the Committee is cognizant of the relevant penalty principles. Dr. Redekopp will be prohibited from prescribing any narcotic or controlled substances, with the exception of testosterone, and the remainder of his practice will be under assessment to ensure that there are no other problem areas. This will serve to protect the public. Dr. Redekopp will post a sign in his office advising that he is restricted from prescribing narcotics and controlled substances and he will allow unannounced inspections by the College. This will further protect the public and will instill public confidence in the College’s ability to self-regulate. The College courses on prescribing and record-keeping will provide rehabilitation for Dr. Redekopp. The public reprimand will provide both specific and general deterrence.

The proposed penalty meets the requirements of public protection, maintaining public confidence in the College and rehabilitation of the member, and provides specific and general deterrence.

Order
The Committee ordered and directed that:

1. the Registrar place the following terms, conditions and limitations on Dr. Redekopp’s certificate of registration:
   a. Dr. Redekopp is prohibited from prescribing:
      (i) Narcotic Drugs;
      (ii) Narcotic Preparations;
      (iii) Controlled Drugs with the exception of testosterone; or
      (iv) Benzodiazepines/Other Targeted Substances.
   b. Dr. Redekopp shall post a clearly visible sign in his waiting room. For further clarity, this sign shall state as follows: “Dr. Redekopp has relin-
quished his prescribing privileges with respect to Narcotic Drugs, Narcotic Preparations and Controlled Drugs other than testosterone.”

c. Dr. Redekopp shall cooperate with unannounced inspections of his practice and such other steps as the College may take for the purpose of monitoring and enforcing his compliance with the terms of the Order.

d. Dr. Redekopp shall, at his own expense, participate in and successfully complete the following College course:

   (i) Medical Record-Keeping for Physicians.

2. Dr. Redekopp appear before it to be reprimanded.

3. Dr. Redekopp pay costs to the College in the amount of $3,650.

4. The results of this proceeding be included in the register.

At the conclusion of the hearing, Dr. Redekopp waived his right to an appeal and the Committee administered the public reprimand.

**Penalty and Reasons for Penalty**

Counsel for the College and counsel for the member made a joint submission as to an appropriate penalty and costs order.

In accepting the joint submission, the Committee was aware that Dr. Salama has no previous disciplinary history. The complainant was not his patient at any time. Whatever transpired between the complainant and Dr. Salama, the Committee was informed that no physical examination or touching occurred. As well, Dr. Salama stopped his involvement in the study soon after the events noted in the Agreed Statement of Facts occurred. Furthermore, Dr. Salama reimbursed the complainant for any expenses she incurred in the belief that she was to come to Ontario.

While these mitigating factors were taken into consideration, the Committee was aware that Dr. Salama was participating in a “study” that, as noted by the expert opinion, was shoddy in nature and in implementation. In his emails to the complainant, Dr. Salama lied about interviewing two previous male subjects. His wording and requests were unusual, and as the expert opinion noted, “provided a great deal of latitude for misunderstanding.” While Dr. Salama’s first language is not English, this does not excuse presenting to a “research subject” misleading and semi-salacious statements. The Committee was presented with the possibility that Dr. Salama may have been naïve in his participation in the project and in his communications with the complainant. The expert report notes this possibility, but comments, “the information conveyed is as important as the information itself.”

The Committee is presented with a physician who is, in the words of the College’s expert, “painfully unaware of the most basic requirements for conduction of clinical research and making decisions, initiating procedures and subverting an already faulty protocol.” In implementing the protocol from that position, Dr. Salama received very personal information of a sexual nature from the complainant that was unnecessarily intrusive. The Committee noted that, in accepting the allegation, Dr. Salama saved the complainant from having to travel from Newfoundland and having to testify to intimate details of her life.

**DR. MAGDY GAMIL ABDOU SALAMA**

Practice Location: Toronto
Practice Area: Family Medicine
Date of Registration: Independent Practice, 2007
Hearing Information: Agreed Statement of Facts and Admission, Joint Submission on Penalty and Costs

On October 14, 2011, the Discipline Committee found that Dr. Magdy Gamil Abdou Salama committed an act of professional misconduct, in that he failed to maintain the standard of practice of the profession in conducting research. While participating in a research study that was shoddy in nature and implementation, Dr. Salama provided misleading information to a research participant and his wording and requests provided a great deal of latitude for misunderstanding.
The proposed penalty meets the penalty criteria. It addresses specific deterrence in prohibiting Dr. Salama from doing research, addresses rehabilitation by having him enrol in and successfully complete an ethics course, and protects the public by the implementation of these aspects of the penalty. The reprimand expresses the profession’s disapproval of the behaviour and its expectation that members will uphold the standards of the profession.

**Order**

The Committee ordered and directed that:

1. The Registrar place the following terms, conditions and limitations on Dr. Salama’s certificate of registration:
   (i) Dr. Salama shall not participate in any research studies or activities of any kind at any time; and
   (ii) Dr. Salama shall, at his own expense, participate in and successfully complete an educational program in medical ethics and informed consent organized and approved by the College.

2. Dr. Salama appear before the panel to be reprimanded.

3. Dr. Salama pay costs to the College in the amount of $3,650.

4. The results of this proceeding be included in the register.

*At the conclusion of the hearing, Dr. Salama waived his right to an appeal and the Committee administered the public reprimand.*

**DR. BRIAN SHEFFIELD**

Practice Location: Richmond Hill  
Practice Area: General Practice  
Date of Registration: Independent Practice, 1972  
Hearing Information: Agreed Statement of Facts and Admission, Joint Submission on Penalty

On June 20, 2011, the Discipline Committee found that Dr. Brian Sheffield committed an act of professional misconduct, in that he has failed to maintain the standard of practice of the profession. Consistent and concerning patterns were identified in Dr. Sheffield’s assessment, diagnosis, treatment and follow-up care of patients, particularly with respect to his prescribing habits. Dr. Sheffield prescribed extremely excessive amounts of opioid medications, did not seem to pick up on drug-seeking behaviour, and was not making use of recommendations from pain specialists. For many of the patients reviewed by the College, they came seeking relief for pain and in the process developed a serious drug dependency.

In May 2010, Dr. Sheffield successfully completed the College’s prescribing course.

**Penalty and Reasons for Penalty**

Counsel for the College and counsel for the member made a joint submission as to an appropriate penalty and costs order.

In considering this joint submission, the Committee took into account that Dr. Sheffield’s act of professional misconduct took place over a long period of time. During this period, large dosages of narcotics and large quantities of narcotics were prescribed to a number of patients. Dr. Sheffield failed to appropriately assess patients before prescribing narcotics and failed to follow up in cases where narcotics were prescribed. He treated patients with narcotics without taking the necessary steps to monitor improvement or watch for dependence. He acknowledged that he had not been as skeptical as he should have been with respect to some patients.

The Committee considered the following specific concerns, which arose as a result of the medical inspection of Dr. Sheffield’s care and management of several patients:

- failure to provide adequate initial and ongoing assessment;
- failure to address addiction;
- failure to refer to addiction specialists; 

Full decisions are available online at [www.cpso.on.ca](http://www.cpso.on.ca). Select Doctor Search and enter the doctor’s name.
• failure to address drug-seeking behaviour;
• failure to refer to pain specialists;
• failure to follow recommendations by pain specialists to decrease opioids; and
• failure to propose alternative treatments for pain.

The Committee also considered the following mitigating factors:
• Dr. Sheffield admitted he fell below the standard of care and accepted responsibility for his serious misconduct;
• By his admission, Dr. Sheffield has saved the College the necessity of proceeding with a full contested hearing;
• Dr. Sheffield completed the College prescribing course of his own volition; and
• Dr. Sheffield has no prior history with the Discipline Committee.

The Committee concluded that the proposed penalty implements the principles of penalty that must be taken into account in the determination of an appropriate penalty. Under the jointly proposed order, Dr. Sheffield will be prohibited from prescribing narcotics, controlled substances and benzodiazepines; therefore, the public will be protected from future prescribing by a physician who has failed to maintain the standard of practice. Dr. Sheffield will post a sign in his office informing patients of the restrictions on his certificate of registration, and he will submit to unannounced inspections by the College and cooperate with the College in its monitoring of his compliance. This will provide further public protection and maintain public confidence in the College's ability to govern the practice of medicine in the public interest. The public reprimand will provide both specific and general deterrence. In addition, the Committee is of the opinion that this is an appropriate case to order costs for a one-day hearing at the tariff rate.

**Order**

The Committee ordered and directed that:

1. The Registrar impose the following terms, conditions and limitations on Dr. Sheffield’s certificate of registration:
   a) Dr. Sheffield shall not prescribe any drug that is:
      i) Narcotic drugs;
      ii) Narcotic preparations;
      iii) Controlled drugs; or
      iv) Benzodiazepines/other targeted substances.
   b) Dr. Sheffield shall post a sign that is clearly visible upon entering his offices. For further clarity, this sign shall state as follows: “Dr. Sheffield is prohibited from prescribing Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines and Other Targeted Substances”; and
   c) Dr. Sheffield shall cooperate with unannounced inspections of his practice and patient charts and such other steps as the College may take for the purpose of monitoring and enforcing his compliance with the terms of the Order.

2. Dr. Sheffield pay costs to the College in the amount of $3,650.

3. Dr. Sheffield appear before the Committee to be reprimanded.

At the conclusion of the hearing, Dr. Sheffield waived his right to an appeal and the Committee administered the public reprimand.

**DR. LORNE WAYNE SOKOL**

**Practice Location:** Toronto  
**Practice Area:** Family Medicine  
**Date of Registration:** Independent Practice, 1986  
**Hearing Information:** Agreed Statement of Facts and Admissions, Joint Submission on Penalty and Costs

On November 16, 2011, the Discipline Committee found that Dr. Lorne Wayne Sokol committed an act of professional misconduct, in that he has been found guilty of an offence that is relevant to his suitability to practise.

On or about December 14, 2009, Dr. Sokol pleaded guilty in the Ontario Court of Justice and was found guilty of submitting billings to the Ontario Health Insurance Plan (OHIP) that did not comply with the requirements of the Schedule of Benefits, thereby committing an offence under the *Health Insurance Act*. 
The conviction related to the period from approximately March 1, 2003 to February 15, 2007. In light of submissions made by the parties, and acknowledging that Dr. Sokol had made a significant repayment of the amount owing to the Workplace Safety and Insurance Board and to OHIP, totalling $3,511,356.62, the court imposed a sentence that included a fine of $25,000 plus the victim fine surcharge of $6,250, payable in seven days.

Reasons for Penalty
Counsel for the College and counsel for the member made a joint submission as to an appropriate penalty and costs order.

The Committee considered an Order of the Health Services Appeal and Review Board dated, December 7, 2000. This Order required Dr. Sokol to reimburse OHIP the amount of $77,295.76.

Counsel for the College submitted that Dr. Sokol's billing history was relevant for determining an appropriate penalty as it speaks to a prior occasion when he was alerted to problems with his billing, although the procedures at issue in that case were different from those in this case. The Committee believes it is significant that Dr. Sokol has been questioned about his billing practices and has been required to repay OHIP in the past. The Committee would have expected Dr. Sokol to have had a higher degree of vigilance to the appropriateness of his billing practices given this history. Unfortunately, there is no evidence that this was the case for Dr. Sokol. In addition, the Committee would be unduly fettered in considering measures to deal with the risk that a physician poses for similar behaviour in the future if prior history could not be considered in the penalty phase of the hearing.

The very large amount of money involved more than four years of billing OHIP and the Workplace Safety and Insurance Board (WSIB) for claims that did not comply with the Schedule of Benefits raised questions with the Committee. The fact that neither OHIP nor the WSIB caught the errors for years was beside the point.

The Committee stated that it is aware that the Ontario Court of Justice accepted Dr. Sokol's plea of guilty to committing an offence under the Health Insurance Act, contrary to section 44(1)(a) of the Act. That this offence did not involve fraudulent intent was a governing factor in the decision of this Committee in this case. Dr. Sokol repaid the money that was inappropriately remitted to him by reasons of his excessive billing, prior to his case being heard in court. That fact serves as a strong mitigating factor in the view of the Committee.

Other mitigating factors include the fact that Dr. Sokol has acknowledged his guilt and admitted his professional misconduct. His acceptance of responsibility has significantly reduced the time and cost that would have been involved in a lengthy hearing. He has also paid a fine and victim fine surcharge of $31,000 under the sentencing order of the Ontario court.

The penalty proposed by way of joint submission is appropriate, in our view, after consideration of previous similar cases.

In addition, the general principles to consider when looking at the penalty were examined to determine the appropriateness of the proposed order. Dr. Sokol will face a suspension that will serve as a specific deterrent to him and a general deterrent to the members of the profession as well. The public will be protected by the suspension and reprimand. Monitoring of Dr. Sokol's billing and unannounced visits to his practice will serve to address any residual risk he poses for repeating this behaviour and will also protect the public. An ethics course will address the rehabilitation of Dr. Sokol and contribute to public protection. The integrity of the profession will be maintained by the sanctions he is facing.

Justice is served by the Committee's acceptance of the joint submission. Dr. Sokol has repaid the money he owes and has cooperated with the process. Guiding principles for penalty have been met.
**Order**

The Discipline Committee ordered and directed that:

1. The Registrar suspend Dr. Sokol’s certificate of registration for a period of three months.
2. The Registrar impose the following specified terms, conditions and limitations on Dr. Sokol’s certificate of registration:
   a) Dr. Sokol shall, at his own expense, participate in and successfully complete an educational program in ethics approved by the College;
   b) For a period of one year, the College may request information from OHIP and/or the Ministry of Health and Long-Term Care in order for the College to monitor Dr. Sokol’s OHIP billings and to ensure his compliance with the *Health Insurance Act*;
   c) In order to facilitate the College’s monitoring, specified in paragraph 2(b), Dr. Sokol shall cooperate with unannounced inspections of his practice and patient charts by a College representative(s) for the purpose of monitoring and enforcing his compliance with the terms of this Order.
3. Dr. Sokol appear before the panel to be reprimanded.
4. Dr. Sokol pay costs to the College in the amount of $3,650.

*At the conclusion of the hearing, Dr. Sokol waived his right to an appeal and the Committee administered the public reprimand.*
As of November 1, 2012, 34 physicians continue to have their certificate of registration suspended for failure to complete the College’s 2012 annual renewal requirements by the deadline.

Many of the physicians listed below may be practising outside Ontario or have retired. It is in physicians’ best interest to officially resign from the College rather than let their membership lapse. Once a certificate of registration is suspended for non-completion of annual requirements, a permanent record of the suspension must be entered in the register. All institutional requests for a physician’s status with the College will include this information.

To resign from the membership, simply complete and return the resignation form that is provided with the annual fee invoice, or download one from the College's website.

The following list is provided as a public service announcement. Its main purpose is to alert the medical community, particularly health facilities and other employers, of physicians who are suspended and might be continuing to practise, unaware of their suspension. Past publication of this list has helped the College locate physicians who had lost contact with us and not known of the suspension of their registration.

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<tr>
<th>Name</th>
<th>CPSO Number</th>
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<tr>
<td>Nina Shneidman</td>
<td>18335</td>
<td>Diane Gayle Williamson</td>
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<td>22313</td>
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<td>Alexander Clark</td>
<td>23121</td>
<td>Maithili Rathnakar Shetty</td>
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<td>Barbara Evadne Clunes</td>
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<td>Derek Victor Andrew Fraser</td>
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<td>Michael Patrick Hogan</td>
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<td>Abdelrazak SA M Meliti</td>
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<td>Frederick Vincent</td>
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<td>52068</td>
<td>Laura Stacey MacLaren</td>
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<td>Fuad Ramadan</td>
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COUNCIL MEMBERS

ABOUT COUNCIL

council is the governing body of the College. The Regulated Health Professions Act stipulates that it consist of at least 32 and no more than 34 members including:

- 16 physicians elected by their peers on a geographical basis every three years;
- physicians appointed from among the six faculties of medicine (at the University of Western Ontario, McMaster University, University of Toronto, Queen’s University, University of Ottawa, and the Northern Ontario School of Medicine);
- no fewer than 13 and no more than 15 non-physician or ‘public’ members appointed by the provincial government for terms decided by the government.

Both medical faculty members and public members may be re-appointed at the end of their terms. Elected members may not serve more than three terms (nine consecutive years). The College President is elected from and by Council and serves a one-year term.

Council members sit on one or more committees of the College. Each committee has specific functions, most of which are governed by provincial legislation.

General Council meetings are held four times a year to review the activities of the College and debate and vote upon matters of general policy. Council meetings are open to the public and are held in the 3rd floor Council Chamber at 80 College Street, Toronto.

For more information about the actions, processes and structures by which the mandate of the College is fulfilled, please refer to the Governance Process Manual available at www.cpspo.on.ca under About Us>Council and Committees.

DISTRICT REPRESENTATIVES

1. Dr. Peter Tadros
Tecumseh, Ontario
2. Dr. Ronald Wexler
London, Ontario
3. Dr. Lynne Thurling
Fergus, Ontario
4. Dr. Eric Stanton
Hamilton, Ontario
5. Dr. Carol Leet
Brampton, Ontario
6. Dr. David Rouselle
Newmarket, Ontario
7. Dr. Preston Zuliani
St. Catharines, Ontario
8. Dr. Andrew Falconer
Ottawa, Ontario
9. Dr. Steven Bodley
North Bay, Ontario
10. Dr. Preston Zuliani
St. Catharines, Ontario

PUBLIC COUNCIL MEMBERS APPOINTED BY LIEUTENANT-GOVERNOR

Dr. El-Tantawy Attia, PhD
Mississauga, Ontario
Mr. Sudershen K. Beri
Richmond Hill, Ontario
Ms. Lynne Cram
London, Ontario
Ms. Susan Davis, LLB
Toronto, Ontario
Ms. Diane Doherty
Burlington, Ontario
Mr. Harry Erlichman, LLB
Toronto, Ontario
Mr. Martin Forget
Toronto, Ontario
Ms. Debbie Giampietri
Toronto, Ontario

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Toronto, Ontario
Ms. Debbie Giampietri
Toronto, Ontario

Mr. Robert Plain, LLB
Kingston, Ontario
Ms. Veena Pohani, LLB
Toronto, Ontario
Mr. Ron Pratt, MBA
Toronto, Ontario
Ms. Emile Therien
Ottawa, Ontario

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Kingston, Ontario
Ms. Veena Pohani, LLB
Toronto, Ontario
Mr. Ron Pratt, MBA
Toronto, Ontario
Ms. Emile Therien
Ottawa, Ontario

Ms. Manon Thompson
Ottawa, Ontario

UNIVERSITY REPRESENTATIVES

Dr. John Watts
McMaster University
Hamilton, Ontario
Dr. Bob Byrick
University of Toronto
Toronto, Ontario
Dr. John Jeffrey
Queen’s University
Kingston, Ontario
Dr. James Watters
University of Ottawa
Ottawa, Ontario
Dr. Barbara Lent
University of Western Ontario
London, Ontario
Dr. Michael Franklyn
Northern Ontario School of Medicine
Sudbury, Ontario
Change of Address Notification

This form is provided for members to notify the College of any change in address.

Each member is required by law to report the address of his or her primary place of medical practice. This address is a matter of public record in the College Register and must be reported promptly. In addition, a member may designate another address as their preferred mailing address for College communications. This second address is not available to the public.

If a member is not in active medical practice, he or she may so indicate by checking off the box in the practice address section; however, in that case the member must supply a mailing address.

If you have a change of address or information please mail or fax this completed form to:

Membership Services
College of Physicians & Surgeons of Ontario
80 College Street
Toronto, Ontario
M5G 2E2
Fax: (416) 967-2623

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Date of birth

Name of base hospital during your Internship (PGY1)

UPDATED ADDRESS INFORMATION (please print legibly)

CPSO Registration Number   ___   ___   ___   ___   ___
Surname
Given Names

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|                             | Email address |

Effective date
Signature

IMPORTANT FOR SECURITY – please provide the following information:

Date of birth

Name of base hospital during your Internship (PGY1)
Whom to Call at the College

To Dial Known Extensions ..................................................... (416) 967-2600
Toll Free ................................................................. (800) 268-7096
Recorded Information ..................................................... (416) 967-2620
General Inquiries .......................................................... (416) 967-2603
To Make a Complaint ..................................................... (416) 967-2603
Media Inquiries ............................................................ (416) 967-2611
Licensing Information ..................................................... (416) 967-2617
Physician Advisory Service .......................................... (416) 967-2606

Contact a Doctor at the College

Physicians on staff at the College are available if you need advice or direction. Here are the telephone extension numbers and e-mail addresses of the physicians you may wish to contact. When calling, dial (416) 967-2600, then touch the three digit extension number of the person you wish to speak to. If they are not available, you can leave a message on their voice mail or touch “0” to have someone assist you.

Dr. Eric Stanton – President: #406
Email: estanton@cpso.on.ca

Dr. Rocco Gerace – Registrar: #400
Email: rgerace@cpso.on.ca

Dr. Risa Bordman – Medical Advisor: #482
Email: rbordman@cpso.on.ca

Dr. Angela Carol – Medical Advisor: #288
Email: acarol@cpso.on.ca

Dr. Bill McCauley – Medical Advisor: #434
Email: bmccauley@cpso.on.ca

Dr. Patrick McNamara – Medical Advisor: #380
Email: pmcnamara@cpso.on.ca

Dr. Eugenia Piliotis – Medical Advisor: #453
Email: epiliotis@cpso.on.ca

Dr. Michael Szul – Medical Advisor: #299
Email: mszul@cpso.on.ca

Council Meeting Schedule

Council meetings are open to the membership and the public.
If you plan to attend, please contact the Communications Department at (416) 967-2611 or 1 (800) 268-7096 ext. 611.

2013 Council Meeting Dates:
February 26; May 30 & 31; September 9 & 10; December 5 & 6.