College of Physicians & Surgeons of Alberta

AGENDA
Council Meeting

May 30 and 31, 2019 **Council Chambers of the CPSA Offices – 2700, 10020 – 100 Street** **Teleconference** 1-855-436-3635 – Access Code 6961679		
Council Members: Dr. J. Bradley, President Dr. L. H. Francescutti, Vice President Ms. L. Louie, Executive Committee Member-at-Large Dr. P. Alakija Dr. G. Campbell Dr. C. Chan, PARA Observer Dr. R. Chee, Student Observer Dr. K. Jones Dr. D. Kunimoto Dr. J. Mannerfeldt	Dr. R. Martin Ms. L. McFarlane Dr. T. Motan Dr. J. O'Connor Dr. L. Savage Ms. L. Steinbach Ms. S. Strilchuk Dr. J. Stone Ms. K. Wood, Past President	**Additional Attendees:** Dr. S. McLeod, Registrar Dr. K. Mazurek, Deputy Registrar (Thursday only) Dr. J. Beach, Assistant Registrar Dr. M. Caffaro, Assistant Registrar Mr. S. Knight, Chief of Staff Dr. S. Ulan, Assistant Registrar Mrs. G. Jones, Senior Executive Assistant (Recording Secretary)
Guests: Rob Key – CEO of Professional Association of Resident Physicians of Alberta (PARA) - May 31 Micah Slavens and Jason Gilliland of Lift Interactive – May 31 Ed Jess and the staff from the Prescribing & Analytics Department – May 31		
Regrets: Dr. J. Meddings		

Thursday, May 30, 2019
0730 – Breakfast

Time Allotted			
0800 – 0900	**1.0**	**Call to Order for In-Camera Session (Council and Executive Team)**	
		1.1	Approval of Consent Agenda Items: • Approval of minutes, In-camera, February 28 and March 1, 2019 • Medical Facility Accreditation Committee Report • Standing Committee Reports • E-mail from Sexual Assault Centre of Edmonton **ACTION:** For information /approval (**MOTION**)

		1.2	Governance Committee (**Dr. Pauline Alakija**) • Proposal to Develop the Implementation Plan regarding the Watson Report • Physician Member Elections **ACTION:** For discussion/approval (**MOTION**)
		1.3	Finance and Audit Committee (**Dr. Graham Campbell)** • Compensation Philosophy **ACTION:** For discussion/endorsement (**MOTION**)
0900	**2.0**	**Call to Order for Public Session** (**Dr. John Bradley**) • Introduction of guests	
		2.1	Conflict of Interest Declaration (Real, Potential or Perceived)
		2.2	Approval of Agenda for May 30 and 31, 2019 and Approval of Consent Agenda items **CONSENT AGENDA:** *The Consent Agenda matters are proposed to be dealt with by unanimous consent and without debate. Committee members may seek clarification or ask questions without removing a matter from the consent agenda. Any committee member may request that a consent agenda item be moved to the regular agenda by notifying the Chair **prior** to the meeting. By approving the items on the consent agenda, any individual approvals such as those noted below are considered approved.* • Minutes, February 28 and March 1, 2019, Decision items from February 28 and March 1, 2019 in-camera session, March 15 and April 29, 2019 (Electronic votes) • Report from CARNA AGM (**Dr. John O'Connor**) • Report from APEGA AGM (**Ms. Levonne Louie**) • Finance and Audit Committee Report (**Dr. Graham Campbell**) • Governance Committee Report - (**Dr. Pauline Alakija**) ○ approval of Council Evaluation Policy • Unique identifier Information from March 1, 2019 Council meeting (**Dr. Susan Ulan**) **ACTION:** For Approval/Receive as Information (**MOTION**)
	3.0	**Reports**	
0915 0930		3.1	President's Report (**Dr. John Bradley)** **ACTION**: Receive as information
0930- 1015		3.2	Registrar's Report (**Dr. Scott McLeod**) KPIs – 2019, First Quarter Report **ACTION:** Receive as information
1015 – 1030	**COMFORT BREAK**		
1030 - 1045		3.3	Council KPI Update **(Dr. Louis Francescutti)** **ACTION:** For approval in principal (**MOTION**)

1045 - 1100		3.4	Competence Committee **(Dr. Richard Martin)** **ACTION:** Receive as information	
1100- 1115		3.5	2019 Council Retreat Report (**Dr. John Bradley**) **ACTION:** For discussion	
1115 - noon		3.6	Governance Committee (**Dr. Pauline Alakija**)	
			3.6.1	Committee Appointments (**Dr. Pauline Alakija**) **ACTION**: For approval (**MOTION**)
			3.6.2	2020 Retreat Planning **(Ms. Kate Wood)** **ACTION:** For approval (**MOTION**)
1200 – 1300	**LUNCH BREAK**			
	4.0	**Standards of Practice**		
1300 - 1315		4.1	Code of Ethics (**Ms. Chantelle Dick**) **ACTION:** For approval (**MOTION**)	
1315- 1345	**5.0**	**Bill 21 Updates (Dr. Karen Mazurek)** • Patient Relations Fund **ACTION:** For discussion		
1345- 1415	**6.0**	**Principles of Honorarium Payments (Dr. Graham Campbell)** **ACTION:** For discussion/endorsement (**MOTION)**		
1415- 1430	**COMFORT BREAK**			
1430- 1530	**7.0**	**Developing Council Policy Statements (Dr. John Bradley)** **ACTION:** For discussion		
1530- 1600	**8.0**	**In-Camera Meeting (Council and Registrar, by invitation)**		
		7.1	Letter from Member to Council President (**Dr. John Bradley**) **ACTION**: For discussion	

All Council Members are invited to tour the renovated office space following the Council Meeting. Refreshments will be served.

Friday, May 31, 2019
0730– Breakfast

0800 0830	**8.0**	**In-Camera (Council and Executive Team)**		
0900- 0915	**9.0**	**Call to Order of Public Session (Dr. John Bradley)**		
	10.0	**Communications Department**		
0915- 0935		10.1	Annual Report(**Ms. Dina Ovics**) **ACTION:** For approval (**MOTION)**	
0935- 1015		10.2	Brand Strategy – update (**Ms. Jessica McPhee and Ms. Morgan Hrynyk**) **ACTION**: For information	
			10.2.1	Presentation by Micah Slavens and Jason Gilliland of Lift Interactive **ACTION**: For discussion
1015 - 1030	**COMFORT BREAK**			
	11.0	**Presentations**		
1030- 1100		11.1	Presentation by the Professional Association of Resident Physicians of Alberta (PARA) (**Dr. Casey Chan & Mr. Rob Key, PARA CEO**) **ACTION:** For information	
1100 - 1130		11.2	Department Presentation: Prescribing & Analytics (**Mr. Ed Jess**) **ACTION:** For information	
1130 - 1230	**LUNCH BREAK**			
1230 - 1400	**12.0**	**Council Education –** CLEAR Introduction to Regulatory Governance: Module Two – Roles and Responsibilities of a Board Member **(Mr. Shawn Knight and Mr. Dale Cooney)** **ACTION:** For information and learning		
1400 1430	**13.0**	**In-Camera (Council, Registrar, Chief of Staff and Recording Secretary)**		
		13.1	**Presentation of Slate of Candidates for Executive Elections (Dr. Pauline Alakija, Dr. John O'Connor)** **ACTION:** Approval of Slate (**MOTION**)	
		13.2	**2020 Executive Elections (Ms. Kate Wood)** • **President** • **Vice-President** • **Member-at-Large** **ACTION**: Decision item by paper ballot	
1430 1500	**14.0**	**In-Camera (Council and Registrar, by invitation)**		
	15.0	**Adjournment**		

College of Physicians & Surgeons of Alberta

MINUTES
Council Meeting – Public Session

A meeting of the Council of the College of Physicians & Surgeons of Alberta was held in the Devonshire Room of the Union Bank Inn, 10053 Jasper Avenue, Edmonton, Alberta on 28 February and 1 March, 2019.

Council Members:		**Additional Attendees:**
Dr. J. Bradley, President Dr. L. H. Francescutti, Vice President Ms. L. Louie, Executive Committee Member-at-Large Dr. P. Alakija Dr. G. Campbell Dr. C. Chan, PARA Observer Dr. R. Chee, Student Observer Dr. K. Jones Dr. D. Kunimoto Dr. J. Mannerfeldt	Dr. R. Martin Ms. L. McFarlane Dr. J. O'Connor Dr. L. Savage Ms. L. Steinbach Ms. S. Strilchuk Dr. J. Stone Ms. K. Wood, Past President	Dr. S. McLeod, Registrar Dr. K. Mazurek, Deputy Registrar (Thursday only) Dr. J. Beach, Assistant Registrar Dr. M. Caffaro, Assistant Registrar Mr. S. Knight, Chief of Staff Dr. S. Ulan, Assistant Registrar Mrs. G. Jones, Senior Executive Assistant (Recording Secretary)

Regrets:
Dr. J. Meddings
Dr. T. Motan
Mr. D. Kay, Assistant Registrar, COO & Hearings Director

Thursday, 28 February 2019

1.0	**In-Camera Session (Council and Executive Team)**	
2.0	**Call to Order for Public Session** Dr. Bradley called the meeting to order at 9:06 a.m.	
	2.1	Approval of Agenda for 28 February and 1 March 2019 and Approval of Consent Agenda items **CONSENT AGENDA:** *The Consent Agenda matters are proposed to be dealt with by unanimous consent and without debate. Committee members may seek clarification or ask questions without removing a matter from the consent agenda. Any committee member may request that a consent agenda item be moved to the regular agenda by notifying the Chair prior to the meeting.* • Minutes, 28 & 29 November 2018, Decision items from in-camera sessions: 07 December 2018 and 21 December 2018 • Finance and Audit Committee Report (*including approval of Individual Practice Review Fees for 2019*) (Dr. Graham Campbell) • Medical Facilities Accreditation Committee (MFAC) Report • Governance Committee Report (Dr. Pauline Alakija) Council removed the Finance and Audit Committee from the Consent agenda for discussion as item 4.6. A

		request to have further discussion on the topic of diversity from the Governance Committee report was added after item 11.0. **<u>MOTION (C-02-19)</u>**: Moved and seconded that the agenda and items on the consent agenda be approved as amended such that the Finance and Audit Committee Report is discussed as item 4.6 and a discussion on Diversity is added following agenda item 11.0. Carried. For future agendas, Council asked that a link to the minutes from the Medical Facility Accreditation Committee be included with the report.
	2.2	Conflict of Interest Declarations (Real, Potential or Perceived) No conflicts were declared.
3.0	**Reports**	
	3.1	<u>President's Report</u> • <u>Councillor's Oath</u> • <u>Annual Conflict of Interest Declaration</u> • <u>Confidentiality and Non-disclosure Agreement</u> Dr. Bradley asked any Council members interested in participating on the committee to develop and monitor the key performance indicators for the College, to speak to Dr. Bradley, Dr. Francescutti or Dr. Mazurek. As part of his report, Dr. Bradley highlighted the importance of supporting the work done in Committees. Council members were encouraged to connect with Dr. Bradley or the Committee Chair directly if they had any questions or concerns related to Committee work.
	3.2	<u>Registrar's Report</u> • <u>Update: Key Performance Indicators (KPI)</u> Dr. McLeod highlighted a number of areas within his report, including: • Strategic Action Plan and the "Best Regulator" infographic – Dr. McLeod is to be held to account on the success of the plan. The plan should align to Council priorities and will set the direction of the College's work for the next five years. • College Brand Strategy – this work is progressing and will look at ensuring that how staff at the College communicate and how they do their job is consistent across the College and reflects the "brand". (It will not simply be the changing the CPSA logo.) • Standards of Practice – Mr. Knight, the Chief of Staff is working on a plan to update and review the Standards of Practice. • Professional Conduct – While the KPI report which was included in the agenda package indicates that the backlog in Professional Conduct will be reduced by 40%, Dr. McLeod suggested a more reasonable goal will be to reduce the backlog by 30%. He indicated that revising current processes in addition to the extra resources committed to this work will reduce the backlog. The ultimate goal, however, is to fix the root cause of the backlog and develop long term improvements. Responding to a question about the nature of the complaints, Dr. McLeod and Dr. Caffaro commented that there is a lot of complexity in the complaints coming forward and the time required to investigate is rising. It was also noted that once Bill 21 comes into full force, it is likely that more complaints will need to go to a hearing, rather than informal resolution and there will likely be more appeals. The importance of making sure the membership is aware of the provisions of Bill 21 was stressed. Dr. Caffaro advised that a member of the executive will present information during the intake sessions at the University

		of Alberta and the University of Calgary. Additionally, Dr. Mazurek shared that the College is working with the University of Calgary to develop some CPD courses around Bill 21. She will be delivering a "virtual town hall" message at the end of March and Dr. McLeod will be giving a presentation at the upcoming AMA Representative Forum. • Registration Department – The College is working with the Royal College to ensure the reporting of CPD by physicians to the CPSA is congruent with the records of the Royal College. Plans are being developed to manage discrepancies. Council discussed the work to ensure members move from the provisional register to the general register within the 6 years as provided in legislation. As previously reported a summative assessment has been developed for those members who are either unwilling or unable to secure Canadian credentials within the allotted time. Physicians wishing to use this route will need to pay for all costs incurred for the assessment which will likely be $12,000 to $15,000 for a family physician. Council was also provided with information about the rigor of the processes used when registering individuals on the provisional register. Council was advised that it is difficult to address all questions about registration in a general fashion as each case is different and is reviewed separately using specific criteria. • Federation of Medical Regulatory Authorities of Canada (FMRAC) – As noted in the written report, Dr. McLeod asked Council to provide some direction as to whether or not they would support continued exploration of the FMRAC Fast Track License Agreement and the FMRAC License Portability Agreement. As this idea has not been flushed out, a number of questions asked by Council will need to be addressed as the project progresses. Council gave its support for continued exploration of both agreements, but will require additional information before confirming the College's participation. • Telemedicine – Also through his work with FMRAC, Dr. McLeod advised Council that the medical regulators are looking to develop a shared Standard of Practice on Telemedicine. This has not been done previously and could be the first of other, shared Standards. There will be a consultation process with feedback being shared directly to FMRAC. Once the feedback is incorporated, the Standard will be brought forward to Council for approval. At that time, Council will not be able to wordsmith further and will need to determine if the Standard meets the intent. Dr. McLeod will also be discussing this with the Deputy Minister. Council gave tacit approval for continuing this work.
4.0	**Approval Items**	
	4.1	<u>Appointment of inspectors under Part 3.1 of the HPA</u> Dr. Mazurek presented information to Council detailing the current authority under the competence provisions of the Health Professions Act which permits inspectors to attend a physician's office unannounced. To date, this provision has never been used. However, recent situations have highlighted the value in being able to exercise this authority. Dr. Mazurek indicated that the proposal to delegate this authority to the Registrar would be more practical and expedient and allow the appointment of an inspector for a specific inspection based on the skills needed to perform the inspection. Council asked that, in order to ensure accountability, a reporting mechanism be created to bring awareness to Council of the use of this authority. **<u>MOTION (C-03-19):</u>** Moved by Dr. Martin and seconded by Ms. Louie that Council delegates authority to appoint inspectors under the Health Professions Act part 3.1 (Inspections), Section 53.1 (Inspectors) to the Registrar, effective immediately with the expectation that a report will be provided to Council through the Competence Committee at least annually. Carried.
	4.2	<u>Standard of Practice: Prescribing for Opioid Use Disorder</u> Dr. Monica Wickland-Weller, Senior Medical Advisor, brought forward the Standard of Practice which, if approved, will be implemented as of April 1, 2019. An Advice to the Profession was developed to accompany the Standard and consideration is being given to creating an Advice to Patients or an FAQ document as well. Council was advised that in areas where there is limited access to physicians with training

		in Opioid Agonist Treatment, online training is available. The Advice to the Profession has links to this program as well as a number of other resources a physician can access for assistance. **MOTION (C-04-19):** Moved by Dr. Martin and seconded by Dr. Francescutti that Council approves the new Safe Prescribing for Opioid Use Disorder Standard of Practice with the suggested revisions to ensure consistency in the requirement to have "access to Alberta prescription databases" for those who initiate Opioid Agonist Treatment and those who maintain Opioid Agonist Treatment. Carried.
	4.3	Standard of Practice: CMA Code of Ethics and Professionalism Ms. Chantelle Dick, Standards of Practice Coordinator, provided an overview of the request to approve taking the Canadian Medical Association's 2018 Code to members for consultation. While the College will not be able to modify the code, as per the Health Professions Act, there must be a consultation with members before this Code can be approved for use by the College. If Council does not wish to adopt this Code, the Code of Ethics from 2004 can continue to be used or Council could develop their own code of ethics. At this time, the 2018 Code has been adopted by 4 other provinces. Dr. McLeod added that FMRAC and CMPA were given opportunities to review the Code and have determined it to be acceptable. **MOTION (C-05-19):** Moved by Dr. Bradley and seconded by Ms. Louie that Council approves the Canadian Medical Association's 2018 Code of Ethics for consultation. Carried.
	4.4	Standard of Practice: Boundary Violations Mr. Shawn Knight, Chief of Staff, advised that with the development of a Standard of Practice related to the provisions of Bill 21, the Standard of Practice: Boundary Violations required some minor updates to remove any statements referring to sexual relationships with patients. Council suggested that the preamble make reference to the Sexual Abuse and Sexual Misconduct Standard of Practice so readers understand there is another standard to deal with sexual abuse and sexual misconduct with patients. Concerns were also shared about what is meant by a "close personal relationship". If that information is to be changed, the Standard would need to be sent for consultation again. Mr. Knight will add this to the work plan for reviewing and updating Standards of Practice. **MOTION (C-06-19):** Moved by Dr. Jones and seconded by Dr. Kunimoto that Council endorses the Boundary Violation Standard of Practice (SOP) as a standalone SOP and endorse the submission of the SOP to the Department of Health for consideration that section 133 of the HPA, requiring consultation has been met as none of the content remaining has changed. Carried. (One abstention). **ACTION:** The Standard of Practice will be considered for early review to develop a better definition of "close personal relationship".
	4.5	Update re: Bill 21 Implementation • Final approval of Bill 21 SOP Dr. McLeod indicated that the Sexual Abuse and Sexual Misconduct Standard of Practice was reviewed by the Minister's Office and they provided additional feedback which has been incorporated into the Standard. Mr. James Casey of Field Law has also reviewed the changes requested by the Ministry. Mr. Knight added that most of the changes are to provide clarity. Council suggested that, for consistency, the phrase "A regulated member who engages in the type of sexual acts described in the definition of "Sexual Misconduct" with a patient commits Sexual Misconduct" be added on page 4 of the Standard. Work is underway to develop an Advice to the Profession as well as an Advice to the Patient. If there are no additional revisions from the

		Minister's office, this Standard will be in effect on April 1, 2019. . **MOTION (C-07-19):** Moved by Ms. Louie and seconded by Dr. Jones that Council approves the updated standard of practice (SOP) for resubmission to the Minister of Health for her approval in March 2019 and that this approval will stand as approval for implementation of the SOP on April 1, 2019 if the SOP is returned to the CSPA approved by the Minister without changes. Carried. (One abstention). • Progress on Bill 21 Implementation Work Plan Dr. McLeod advised Council that work is progressing as planned to meet all required deliverables to implement the provisions of Bill 21. On the Implementation Checklist, "meeting any other functions as set out in Regulations" is not on track as it appears that the Regulations will not be available before April 1, 2019. This is considered low risk. • Request for feedback from Council regarding Criminal Record Checks Dr. Ulan indicated that as part of the requirements of Bill 21, the College is expected to obtain Criminal Record Checks from all applicants. To develop the proposed policy and procedure for this, Dr. Ulan's team did an environmental scan and determined there was no consistent practice. She engaged Field Law to assist in policy development, but requested feedback as follows: 1. Should physicians be required to provide CRCs when applying for a new registration category such as student→resident or resident→independent practice or provisional register→general register? o Council felt this is excessive and suggested only new applicants should be required to submit a CRC o Consideration will be given to sharing CRC's with other institutions such as the Universities o Ensure that it is clear on the RIF that if a physician lies regarding an attestation, it is a serious breach for which you could lose your permit. 2. When exceptional circumstances exist and the Registrar has granted an exemption (eg. unable to obtain CRC due to lack of infrastructure due to war or personal safety reasons?), should we require yearly CRC for a period of time once registered? o Suggested that the College will rely on the attestation and ask for a CRC once the candidate has been in Canada for three years. 3. At periodic intervals such as every 3 to 5 years once in independent practice? o Council suggested that all members will be required to have submitted a CRC in the next five years. Council also requested evidence and data be gathered as this work moves forward to understand the workload involved and what the work has yielded.
	4.6	Finance and Audit Committee Report Dr. Campbell presented the Finance and Audit Committee Report. The report included a note about the Investment Performance Review, which is a snapshot for a moment in time and is not indicative of the funds' performance over time. Regarding the fee schedule for the Individual Practice Reviews, Dr. Campbell advised that the previous practice of charging all costs of the review to the physician created a discrepancy for rural physicians. The set fee schedule will be an all-encompassing fee and allow rural physicians to pay the same fee as an Edmonton-based physician will pay. He added that this decision was not supported unanimously at the Committee. **MOTION (C-08-19)** Moved by Dr. Alakija and seconded by Ms. Louie that Council approves the revised Individual Practice Review fees for 2019: Standard review = $3,500 + GST

		Complex review = $7,000 + GST Carried.
5.0	**In-Camera (Council and Executive Team and Ms. Marian Stuffco)** • Government Relations – 2019 Provincial Election	
6.0	**Role of Council Members** Dr. Bradley led a discussion to hear everyone's perspectives on what the role of a Council member is or should be. No decisions were made on this matter and ideas were shared to develop a common understanding for all Councillors. The public session adjourned at 3:30 p.m.	
7.0	**In-Camera Meeting (Council and Registrar, by invitation)**	

Friday, 01 March 2019

8.0	**In-Camera (Council and Executive Team)**
9.0	**Call to Order of Public Session** Dr. Bradley called the public session to order at 8:15 a.m.
10.0	**Approval Item -** Physician Member Elections • Proposed Bylaw Amendment Dr. Alakija prefaced discussions of the proposed bylaw amendment by noting that the matter came to light during last year's physician member elections when a resident was permitted to run for a position on Council following receipt of a legal opinion which stated that the Bylaws did not preclude a resident from running. Many on Council felt that this was not the intent of the Bylaws; it was assumed that only practicing physicians were able to run. Council discussed the proposed Bylaw amendment and determined it would not be advisable to make a change at this time. Dr. Chan and Dr. Chee were thanked for providing their perspectives on the matter. Dr. Bradley added that he plans to speak further with the executive of PARA as well as the Medical Students Associations. He also plans to connect with the clinical and surgical assistants to discuss this topic further. **ACTION:** The Governance Committee will revisit this issue and further examine the risks involved if the proposed change is adopted at a later date.
11.0	**Proposed Bylaw Amendments** • Past President Dr. Alakija advised that the motion to formalize the position of Past President in the Bylaws was proposed at the Governance Committee and developed with the assistance of legal counsel. **MOTION (C-09-19)** Moved by Dr. Savage and seconded by Ms. Strilchuk that Council formally recognizes the past-president as a nonvoting member of Council by amending section 1 of the Bylaws as follows: 1(2) Council may invite the person who was president of Council in the year prior to the current president of Council to sit as a non-voting* member of Council and any committee of Council for a term of up to one year, until the current president finishes his/her term as president, or upon simple majority resolution of Council to

remove the past-president, whichever occurs first.
And to add the following provision to section 2 of the Bylaws:
2(2) The Council may permit the past-president sitting as a non-voting* member of Council or a committee of Council to claim expenses and per diem amounts as if a member of Council or a member of a committee of Council.
*the past president is a non-voting member of a committee unless otherwise stated in the committee's Terms of Reference.
Carried.

- Bill 21 Compliance (Sec 47. Publication, PART 4 – COMMUNICATION WITH THE PUBLIC, Section A – General)

A requirement of Bill 21 is the publication of information regarding discipline. With the assistance of legal counsel, revisions to the Bylaws have been proposed to reflect these requirements.

Counsel discussed the Bylaw revision and wondered if there was a risk for fraud if a physician's name and registration number are published. Administration committed to determining if there was another unique identifier that could be used to ensure there is no confusion when there is a possibility of more than one physician with the same name. A question was also raised about whether or not a decision would continue to be published if there was a successful appeal. Dr. Caffaro indicated that the hearing decision would likely remain available.

MOTION (C-10-19) Moved by Ms. Louie and seconded by Dr. Jones that the CPSA Bylaws be amended to revise section 47 as follows:

PART 4 – COMMUNICATION WITH THE PUBLIC

Section A - General

47. Publication

1. The Registrar may publish or distribute any information required or permitted to be disclosed pursuant to:

   (a) Any section of the Act,
   (b) The Regulations,
   (c) The *Personal Information Protection Act,* R.S.A. 2003, c. P-6.5,
   (d) Any other enactment that applies to the College, or
   (e) As otherwise permitted or required by law.

2. The information that the Registrar may publish or distribute includes, but is not limited to, the following:

   (a).Information on the College's register, including:
      i. The member's name and a unique identifier,
      ii. Whether the member's registration is restricted to a period of time and if so, the period of time,
      iii. Any conditions imposed on the member's practice permit,
      iv. The status of the member's practice permit, including whether it is suspended or cancelled,
      v. The member's practice specialization recognized by the college,
      vi. Whether the member is authorized to provide a restricted activity not normally provided by regulated members of the college,
      vii. Whether the member is not authorized to provide a restricted activity that is normally provided by regulated members of the college, and
      viii. Information described in s. 119(1) of the Act.

(b) Information described in s. 41 of the Regulations.
(c) Any direction made pursuant to s. 118(4) of the Act.
(d) Information regarding upcoming hearings or appeals.
(e) Any decision, order or direction made under Part 4, Division 4 and Division 5 of the Act, including written decisions issued by a hearing tribunal or council with respect to any matter.

3. The information described in this section may, subject to the Act, be published or distributed for the minimum period of time referred to in s. 42 of the Regulations, or such longer period as determined by the Registrar.

4. In determining what information should be distributed or published for the purposes of s. 119(1)(f) of the Act, the Registrar shall consider the following factors:

(a) whether publication or distribution is likely to cause harm to one or more persons,
(b) whether publication or distribution is relevant to the regulated member's suitability to practice,
(c) the public interest, including transparency of the College's discipline process,
(d) the education of regulated members, and
(e) any other factors that the Registrar considers relevant to this matter.

5. For the purpose of s. 119(1)(f) of the Act the Registrar may omit from publication or distribution any individually identifying information about any person identified in an order made by a hearing tribunal or the Council under Part 4 of the Act.

6. The information described above may, subject to the Act, be published or distributed for the minimum period of time referred to in s. 42 of the Regulations, or such longer period as determined by the Registrar.

Carried.

12.0 Diversity on Council

Dr. Alakija brought forward the topic to explore ways in which Council could encourage diversity. She suggested that Council should encourage people from diverse backgrounds to run and to vote. She commented that it may be necessary to provide some coaching to people from diverse backgrounds who are considering running for Council. Council should review whether or not barriers to diversity exist in Council policies and bylaws. Connecting with others and developing relationships was suggested as a means to encourage participation in the election process.

As a starting point, Dr. Alakija brought forward a motion to indicate Council's intentions with respect to diversity:

MOTION (C-11-19) Moved by Dr. Alakija and seconded by Dr. Francescutti with amendments moved by McFarlane and seconded by Savage that Council acknowledges that inclusion and increased diversity in Council membership will benefit Council and the public. Council commits to:

1) Encourage physicians from under-represented groups to run for council.
2) Ask government to continue to consider diversity in the public members appointed.
3) Strongly encourage physicians to vote in the Council elections, and consider diversity/inclusion.
4) Reach out to membership to ask what barriers exist for under-recognized physicians in obtaining council positions, and decrease those barriers within the CPSA control.
5) Review all bylaws, terms of reference, policies and communications with the intent to detect and eliminate barriers to diversity/inclusion on Council.

Carried.

13.0	**<u>Annual Report Preview</u>** Ms. Dina Ovic, Communications Advisor, presented the preview for the annual report, a document required by the Health Professions Act. In addition to fulfilling the College's mandated responsibility, the Communications team is using the annual report to engage members of the public as well as members of the profession. The annual report is being developed to explore how the College interpreted and responded to societal change this past year. The team will use stories to show how the College did this and how it continues to be relevant. Council viewed a video of Past President Kate Wood which will accompany the digital report went it is ready in April. The print report will be submitted to the Minister in June and will include approved financial statements. Responding to a question from Council, Ms. Ovic indicated that Communications will be able to track statistics regarding the digital report and will do a survey of those who receive print copies. Council did not raise any concerns with the proposed plans.
14.0	**<u>Physician Impairment</u>** Dr. Beach shared some ideas that could be considered in addressing concerns about factors that cause physician impairment. Previously, Dr. Monica Wickland-Weller had explored the topic of physician fatigue, but that work was put aside so as not to duplicate some of the work being done by the CMA at that time. Dr. Beach is exploring whether or not to revisit the subject and include other factors such as Cannabis use. This may require development of a functional capacity evaluation. Council added that it will require a change in culture and the College will need to partner with others to facilitate such changes. Council gave endorsement for Dr. Beach to explore the topic further.
15.0	**Department Presentations – Physician Health Monitoring** Dr. Beach provided an overview of the work undertaken by Physician Health Monitoring, noting that the program was developed to divert certain issues out of the complaints department and deal with the issues in a non-punitive manner. It was noted that many physicians resist coming forward with a problem as they fear they will lose their license. Statistics from the department indicate that 90% of physicians who enter the program return to practice. It was suggested that if this was communicated widely, more physicians may feel encouraged to seek assistance.
16.0	**<u>Council Education – CLEAR Introduction to Regulatory Governance: Module One</u>** As part of a commitment to ongoing governance training, Council will be reviewing these modules at each Council meeting in 2019. Mr. Dale Cooney, partner at BreakPoint Solutions and former Deputy Registrar for the Alberta College of Pharmacists, facilitated discussions for this interactive learning session. The public session adjourned at 3:00 p.m.
17.0	**In-Camera (Council and Registrar, by invitation)**

Gail Jones, Recording Secretary

College of Physicians & Surgeons of Alberta

Decision Items
In-Camera Meetings

To ensure transparency of the decision-making of the Council of the College of Physicians and Surgeons of Alberta, a report noting decisions passed during In-camera sessions will be brought forward to the next public meeting.

In-Camera Sessions: 28 February and 1 March 2019

Council met in-camera at various times during the 28 February and 1 March Council meeting to discuss sensitive issues.

The following motion was made:

MOTION: (C-01-19) Moved by Dr. Martin and second by Dr. O'Connor that the minutes from the in-camera sessions on 28 & 29 November 2018, 07 December 2018 and 21 December 2018 be approved as circulated. Carried.

Gail Jones

From: Gail Jones
Sent: Friday, March 15, 2019 2:11 PM
To: Council 2019
Cc: Scott McLeod; Karen Mazurek; Shawn Knight; Susan Ulan
Subject: APPROVED: Appointment of Hearings Director

Thank you everyone for your prompt replies. As we now have 11 responses approving the appointment, this e-mail is to confirm the following motion:

MOTION (C-12-19) Moved by Campbell and seconded by Martin that Council appoints Dr. Susan Ulan as the Hearings Director of the College of Physicians & Surgeons of Alberta, per section 14(1) of the Health Profession Act effective March 15, 2019. Carried.

Thanks,
Gail

From: Gail Jones
Sent: Friday, March 15, 2019 11:43 AM
To: Scott McLeod <Scott.McLeod@cpsa.ab.ca>; Louis Francescutti <lfrances@ualberta.ca>
Cc: Council 2019 <Council.2019@cpsa.ab.ca>; Karen Mazurek <Karen.Mazurek@cpsa.ab.ca>; Shawn Knight <Shawn.Knight@cpsa.ab.ca>; Susan Ulan <Susan.Ulan@cpsa.ab.ca>
Subject: RE: ACTION REQUIRED BY MARCH 22 (8 A.M.): Appointment of Hearings Director

I have also been asked about having this come forward with a mover and seconder. Graham has indicated he will move this motion and Richard is the seconder.

Gail

From: Scott McLeod
Sent: Friday, March 15, 2019 11:39 AM
To: Louis Francescutti <lfrances@ualberta.ca>
Cc: Gail Jones <Gail.Jones@cpsa.ab.ca>; Council 2019 <Council.2019@cpsa.ab.ca>; Karen Mazurek <Karen.Mazurek@cpsa.ab.ca>; Shawn Knight <Shawn.Knight@cpsa.ab.ca>; Susan Ulan <Susan.Ulan@cpsa.ab.ca>
Subject: Re: ACTION REQUIRED BY MARCH 22 (8 A.M.): Appointment of Hearings Director

Good Morning Louis,

There was no posting of this position because it's not a job competition. No one else can "apply". As we determine the future leadership needs of the organization we will determine if we have a competition.

Due to potential conflicts of interest for other ARs I determined that Susan was the best candidate.

The issue about does she have time is an issue that I manage with her.

I hope that helps.

Scott

Sent from my iPhone

On Mar 15, 2019, at 11:13 AM, Louis Hugo Francescutti <lfrances@ualberta.ca> wrote:

> Is there any background information about how this position is being filled?
>
> Was it posted? Internally or externally?
>
> Who else could apply?
>
> Does she have the time?
>
> Is there any conflicts with her current position?
>
> I hate to just rubber stamp this important decision with no background or discussion especially on a Friday afternoon.
>
> Louis Hugo Francescutti
> Physician & Storyteller
> 780-932-7187
>
> On Mar 15, 2019, at 9:40 AM, Gail Jones <Gail.Jones@cpsa.ab.ca> wrote:
>
> > Council members:
> >
> > Section 14(1) of the *Health Professions Act* requires Council to appoint a Hearings Director. The departure of Mr. Kay, the current Hearings Director (Motions C-60-16), requires the legislative position to be filled.
> >
> > The *Health Professions Act* prohibits the Hearings Director and Complaints Director (Dr. Michael Caffaro) from being the same person. The College must publish a directory with the contact information for the Hearings Director, which is currently done on our website.
> >
> > Therefore, please reply to this e-mail as soon as possible to indicate whether you approve of the following motion:
> >
> > ***It is recommended that*** **Council appoints Dr. Susan Ulan as the Hearings Director of the College of Physicians & Surgeons of Alberta, per section 14(1) of the Health Profession Act.**
> >
> > The effective date of this appointment will be the date the motion is passed by a majority of Council members.
> >
> > **Gail Jones, BComm**
> > **Senior Executive Assistant to Dr. Scott McLeod, Registrar**
> > T: 780-969-4970 | 1-800-561-3899 ext. 4970
> > F: 780-420-0651
> > 2700 Telus House, 10020-100 Street NW | Edmonton AB T5J 0N3
> > cpsa.ca

_____

College of Physicians & Surgeons of Alberta
Good Medical Practice – It's what we're all about

<image002.png>

Gail Jones

From: Gail Jones
Sent: Wednesday, May 1, 2019 8:37 AM
To: Kimberley Murphy; Dennis Kunimoto; Graham Campbell; Jaelene Mannerfeldt; James Stone; John Bradley; John O'Connor; Jon Meddings; Kate Wood; Kirsten Jones; Laurie Steinbach; Levonne Louie; Linda McFarlane; Louis Francescutti; Luke Savage; Pauline Alakija; R Martin; Stacey Strilchuk; Tarek Motan
Cc: Scott McLeod; Tracy Simons; Karen Mazurek; Shawn Knight; Valerie Gaul; Belinda Ibrahim; Casey Chan; Ryan Chee; Tina Giamberardino
Subject: RE: ACTION: Council email vote - 2019 Accreditation Fees

For the minute book, this motion will be recorded as follows:

> MOTION (C-13-19) Moved by Ms. Louie and seconded by Dr. Francescutti that the 2019 annual and assessment accreditation fees be approved effective April 1, 2019. Carried.

Thanks,
Gail

From: Kimberley Murphy
Sent: Tuesday, April 30, 2019 2:07 PM
To: Dennis Kunimoto <dkunimot@ualberta.ca>; Graham Campbell <gcampbell@canadadiagnostics.ca>; Jaelene Mannerfeldt <jmmannerfeldt@gmail.com>; James Stone <jastone@shaw.ca>; John Bradley <jsjbradley@sedmneph.ca>; John O'Connor <gramocroi@gmail.com>; Jon Meddings <meddings@ucalgary.ca>; Kate Wood <katewood@telus.net>; Kirsten Jones <kirstenejones@gmail.com>; Laurie Steinbach <ldsteinbach@hotmail.com>; Levonne Louie <levonne@levonnelouie.com>; Linda McFarlane <linda.mcfarlane@yahoo.com>; Louis Francescutti <lfrances@ualberta.ca>; Luke Savage <lcsavage@gmail.com>; Pauline Alakija <alakijap@me.com>; R Martin <kimnrich@telusplanet.net>; Stacey Strilchuk <stanbs@hotmail.com>; Tarek Motan <tmotan@ualberta.ca>
Cc: Scott McLeod <Scott.McLeod@cpsa.ab.ca>; Tracy Simons <Tracy.Simons@cpsa.ab.ca>; Karen Mazurek <Karen.Mazurek@cpsa.ab.ca>; Shawn Knight <Shawn.Knight@cpsa.ab.ca>; Gail Jones <Gail.Jones@cpsa.ab.ca>; Valerie Gaul <valerie.gaul@ualberta.ca>; Belinda Ibrahim <ibrahim@ucalgary.ca>; Casey Chan <caseychan0323@hotmail.com>; Ryan Chee <rchee@ualberta.ca>; Tina Giamberardino <Tina.Giamberardino@cpsa.ab.ca>
Subject: RE: ACTION: Council email vote - 2019 Accreditation Fees

Executive,

Please note, the following motion was passed today:

- ***It is recommended that Council approve the 2019 annual and assessment accreditation fees effective April 1, 2019.***

Thank you for your participation in this process.

Regards,

Kimberley Murphy
Executive Assistant to Dr. Karen Mazurek, Deputy Registrar
Continuing Competence
T: 780-392-3109 | 1-800-561-3899 ext. 3109
F: 780-424-5859
2700 – 10020 100 Street NW | Edmonton AB T5J 0N3

Kimberley.Murphy@cpsa.ab.ca | cpsa.ca

College of Physicians & Surgeons of Alberta
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From: Kimberley Murphy
Sent: April-26-19 3:37 PM
To: Dennis Kunimoto; Graham Campbell; Jaelene Mannerfeldt; James Stone; John Bradley; John O'Connor; Jon Meddings; Kate Wood; Kirsten Jones; Laurie Steinbach; Levonne Louie; Linda McFarlane; Louis Francescutti; Luke Savage; Pauline Alakija; R Martin; Stacey Strilchuk; Tarek Motan
Cc: Scott McLeod; Tracy Simons; K. Mazurek; Shawn Knight; Gail Jones; Valerie Gaul; Belinda Ibrahim; Casey Chan; Ryan Chee; Tina Giamberardino
Subject: ACTION: Council email vote - 2019 Accreditation Fees
Importance: High

Executive,

The Finance & Audit Committee (FAC) met on April 23, 2019 and reviewed and approved the revised annual and assessment fees for the accreditation of facilities. Please see documentation attached for further details.

The fees were to be sent to Council for approval at the May meeting, but the FAC is sending early to allow signing an agreement with Alberta Health Services (AHS) for accreditation of public facilities.

Please reply by 12 noon, Tuesday April 30, 2019 indicating "approve", "oppose" or "abstain" regarding the motion below:

- ***It is recommended that Council approve the 2019 annual and assessment accreditation fees effective April 1, 2019.***

NB: CPSA Council Executive are in agreement with conducting this vote by email. The Motion already has a mover (Levonne) and a seconder (Louis).

Thank you,

Kimberley Murphy
Executive Assistant to Dr. Karen Mazurek, Deputy Registrar
Continuing Competence
T: 780-392-3109 | 1-800-561-3899 ext. 3109
F: 780-424-5859
2700 – 10020 100 Street NW | Edmonton AB T5J 0N3
Kimberley.Murphy@cpsa.ab.ca | cpsa.ca

College of Physicians & Surgeons of Alberta
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It was my honour and pleasure to represent the CPSA at the CARNA Mini-Conference and AGM at the Oasis Centre in Edmonton on Mar 6 2019.

Attending the combined AGM and Conference was a cross-section of Registered Nurses, Nurse Practitioners, and Administrators, from across the province and from other jurisdictions. The day began before 8am, and was packed-I was reassured that this is typical for such CARNA events-this was my first!

Registration was efficient and smooth. I retrieved my badge, and was quickly involved in conversations and Qs & As about the College. The Opioid crisis seemed of prime interest. We had to be gently ushered in to take our seats, in mid-conversation. Everything starts sharply on time at CARNA!

Peter Brown, ex-CBC Radio Edmonton, speaker, author, impresario, comedian, scriptwriter, director, creator of Die-Nasty and The Irrelevant Show-to mention just a few of his achievements-was a fabulous and funny MC. He ran a tight ship.

Sarah Hoffmann, the then-Alberta Minister of Health, made a few opening remarks. She drew huge applause. Nothing really specific to say-just greetings and well done on a continuing great job.

The first Keynote Speaker was very interesting. Kathleen Bartholomew, a recognized national leader in nursing in the US, has evolved into somewhat of an expert on nurse-nurse and nurse-physician relationships, and dealing with lateral violence. She is especially hot on hospital culture, and healthy work environments. She spoke in a very engaging way about how interpersonal/interprofessional relationships impact patient-centred care. What I took from her eloquent words was what I inherently knew-open, honest, confident communication is ESSENTIAL. She had everyone's rapt attention. Her over an hour long address seemed to fly. No-one sat during her prolonged ovation! I was very impressed.

A short comfort break was followed by the AGM.

Several reports were presented. This was followed by resolutions, debates and votes. Both internal and broader, Canada-wide issues-nursing exams en Francais v en Anglais, for example, for French-speaking nurses. Animated debate took place-it made for a very interesting day. While there was agreement broadly on the various topics, when there was disagreement, further debate generally ended in an agreed modified approach. Very polite and so Canadian.

Lunch break was filled with several conversations around collaborative care, and AHS' role in either facilitating or obstructing its development. Asked for my input, I was very careful to state MY opinion based on experience! Altogether a fascinating but too-short-lived interaction. I made several contacts for future exchanges.

Greta Cummings, the Dean of Nursing at the University of Alberta, next took the stage, for her keynote, which concerned leadership in nursing. I had the chance to briefly meet her in the morning. She introduced the CNA President, Tim Guest, who spoke a few words of encouragement to the attendees.

At that point, I had several calls from my hospitalist group, and unfortunately had to excuse myself early to participate in a conference call, and exited the CARNA AGM.

I feel strongly that we-the CPSA-should officially attend CARNA's AGM annually, given the strong connections we as physicians have with our nursing team collaborators, and especially given our common challenges. It would support further our idea of Patient-Centric Care.

Submitted by Dr. John O'Connor

College of Physicians & Surgeons of Alberta

Report from Council Representatives Attending External Meetings

Important note: Please use your discretion and do not divulge any information that may be deemed confidential or sensitive.

Name of Council Representative: **Levonne Louie**

Name of External Meeting: Association of Professional Engineers and Geoscientists of Alberta (APEGA) Summit Awards and AGM

Date of Meeting: April 25 & 26, 2019

Were issues relevant to CPSA Council and its members? Yes. Like the CPSA, APEGA is a self-regulator. It regulates engineers, geoscientists, and the organization they practice under. A primary focus is protection of the public.

If applicable, please identify any non-confidential issues of current or potential special interest or concern to CPSA and its members.

- **In 2020, APEGA will be 100 years old as an association. They will be showcasing their expertise to the public as they don't feel that the public really understands all that they do. A comment was made that they need to better communicate the role that APEGA plays which should increase the level of trust. They are finding that self-regulation is harder to defend. However, they feel there is value to "Professionalism by Peer Review."**
- **APEGA is trying to position themselves as the engineering capital of the world.**
- **80% of the engineering work is being done offshore and they need to have the oversight function no matter where the work is being done. They are looking globally for best practices.**
- **They have 160 recommendations for the government to modernize their act which they believe will ultimately increase protection of the public.**
- **In increasing their competency system, they are also looking to increase competency for international graduates.**
- **They are addressing barriers to women in the profession and received a government grant to do some work in this area.**
- **A special committee was struck to review the current process and provisions for election of member candidates to Council.**
- **Results of their elections were announced. A President-Elect, Vice-President (2nd) (1 year terms) and 4 Councillors (3 year terms) were announced. New Council is 44% women and 4/5 of the Executive are immigrants. A 17 member Nominating Committee was appointed for 2019/2020 and the past president chairs the Nominating Committee.**

Should Council continue to attend these meetings?

Yes as it is interesting to learn about the governance structures of other self-regulating professions. Next AGM is in Edmonton on April 24, 2020.

Please provide any other comments here, if you wish.

CPSA was the only non-engineering special guest at the APEGA AGM. Of presence was acknowledged at both the Summit Awards and the AGM.

Thank you for representing Council at this meeting. Please complete and return this report to Shawn Knight, shawn.knight@cpsa.ab.ca within two weeks following the meeting. If you have any questions or concerns, please contact him at 780-969-4973

College of Physicians & Surgeons of Alberta

Submision to:	**Council**

Meeting Date:	Submitted by:		
May 30, 2019	Finance & Audit Committee		
Agenda Item Title:			
Action Requested:	☐ The following items require approval by Choose an item. See below for details of the recommendation.	☐ The following item(s) are of particular interest to Choose an item. Feedback is sought on this matter.	☒ The attached is for information only. No action is required.
AGENDA ITEM DETAILS			
Recommendation (if applicable) :	Not applicable.		
Background:	Report to Counci on the FAC meetings held on April 23, 2019.		
Next Steps:	n/a		
List of Attachments:			

1. FAC report to Council
2. CPSA Audited financial statements for the year ended December 31, 2019
3. Pension Fund for Employees of CPSA audited financial statements for the year ended December 31, 2019

College of Physicians & Surgeons of Alberta

FINANCE & AUDIT COMMITTEE

Report to Council
College of Physicians & Surgeons of Alberta
May 30, 2019

The Finance and Audit Committee (FAC) met on April 23, 2019 and addressed the following issues:

1. **Pension Investment Policy**
   The Committee approved changes to the Statement of Investment Policies and Procedures (SIPP) for the CPSA pension assets.

   The changes incorporated the following:
   - Removing references to governance activities already included in the Pension Governance policy.
   - Removing references to other governance activities already included in the CPSA Governance Policy Manual.
   - Updating benchmark index to new industry standard terms.
   - Changing the asset class minimum and maximum ranges for equities to align with the Connor, Clark & Lunn (CC&L) investment policy.

2. **2018 Financial Results**
   The FAC discussed a report from management regarding budget variances for the 2018 financial results. In 2018, the CPSA showed income from operations of $1,580,000 compared to a budgeted income from operations of $946,000, resulting in additional income, or positive variance, of $634,000.

	Actual	**Budget**	**Variance**	
Revenues	<30,470,000>	< 29,563,000>	907,000	3%
Operating Expenses	28,890,000	28,617,000	< 273,000>	<1%>
Operating Income	**<1,580,000>**	**<946,000>**	**634,000**	
Development Costs	684,000	500,000	< 184,000 >	<36%>
Income after Development Costs	<896,000>	<446,000>	450,000	
Non-operating activity	767,000	< 350,000>	< 1,117,000 >	
Net Income	< 129,000>	< 796,000>	< 667,000>	

Revenues shown in brackets; <negative variance> = less revenues or more expenses

College of Physicians & Surgeons of Alberta

Non-operating activity includes facility accreditation, interest for the building fund plus the fair value changes in investments.

The net assets (or accumulated surplus) at December 31, 2018 is $27.6 million. The breakdown between restricted and unrestricted is as follows:

Net Assets:	
Invested in capital assets	$ 3,913,000
Internally restricted building fund	7,851,000
Unrestricted	15,858,000
Total	$27,622,000

The total unrestricted surplus of $15,858,000 represents approximately 55% of one year's gross operating expenses.

The College's current policy on reserves targets for the unrestricted surplus is 60% of one year's gross operating expenses. The College is below the targeted surplus by 5% or $1,476,000.

3. Audited Financial Statements for 2018

Ms. Anna Coghill, Mr. Robert Newton and Mr. Ryan Hauser from PricewaterhouseCoopers (PwC) presented the Final Audit Findings to FAC, for the year ended December 31, 2018. As requested by FAC, PwC had also conducted a review of expense claims of a number of randomly selected executive, non-executive staff and Council members.

PwC reviewed their audit process and confirmed that this was a clean audit, with no outstanding issues. A detailed review of the selected expense claims revealed no issues.

FAC has approved the audited financial statements; a copy is appended to this report for Council's information.

2018 Financial Results

Excess of revenue over expenditures before other income	$726,000
Other income (losses)	(597,000)
Excess of revenues over expenditures	$129,000

Other income includes interest for the building fund plus the fair value changes in investments.

The College's summarized financial results will be included in the CPSA annual report.

4. Pension Fund Audited Financial Statements for 2018

The pension fund financial statements were prepared as a requirement of the Alberta Employment Pension Plans Act and reflect the assets of the College's registered pension plan.

College of Physicians & Surgeons of Alberta

Ms. Coghill, Mr. Robert Newton and Mr. Ryan Hauser from PwC reviewed the audit process and confirmed that this was a clean audit, with no outstanding issues.

The total net assets in the pension fund at the end of December are $34.5 million, up from $33.8 million at the end of 2017.

FAC approved the pension fund audited financial statements. The financial statements will be filed with Alberta Finance prior to the end of June.

5. Pension Sub-Committee Update

The FAC received a report on the pension project.

It is important to consider the "Total Compensation" that the CPSA offers its employees in its compensation package. Total compensation considers salary, benefits and pension.

The Pension Sub-Committee has had four meetings to keep apprised of the pension review project. Activity since February:

- Hugessen Consulting worked with the HR team to review general market salary, benefit and pension data to compare the CPSA benchmark positions.
- The HR team resumed the HR Philosophy project, rolling out the new HR philosophy to the leadership team and staff.

HR Philosophy

The CPSA HR team, with the assistance of Stoppler Hughes has developed the HR philosophy. It was rolled out to the CPSA leadership team, and was presented to staff during meetings in March.

The HR philosophy statement:

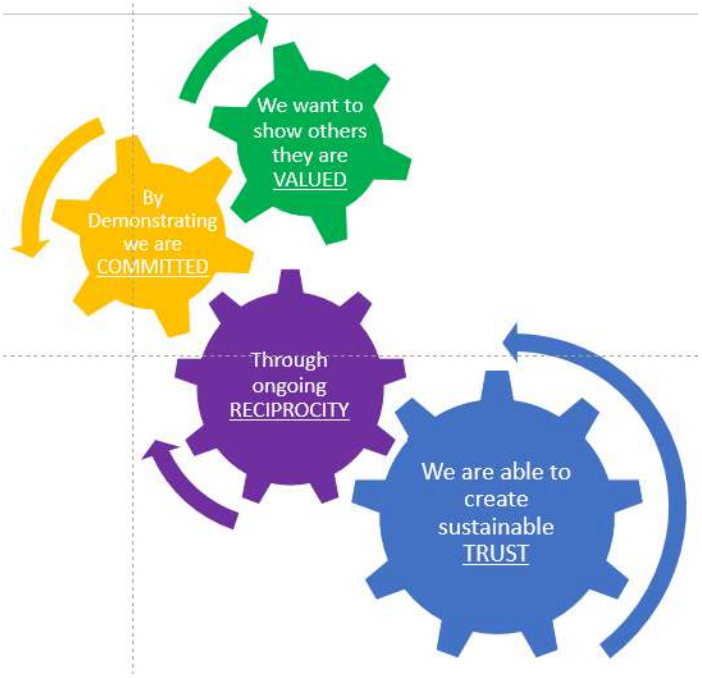
The philosophy of our people is to be intrinsically invested in our work, our teams, and each other.

The CPSA management will do this by

- performing
- supporting
- encouraging
- and developing

the following behaviors:

College of Physicians & Surgeons of Alberta



The philosophy tag line: **Build Together, Achieve More**

- The CPSA rebranded the "total reward" concept to "total compensation" to align with the HR Philosophy.
- Hugessen Consulting met on several occasions with the leadership team, and also with the working group (Scott McLeod, Karen Mazurek, David Kay, Tracy Simons, Janice Romanzin-Roy, HR Advisor) to finalize the CPSA Compensation Philosophy.
- Management (Scott McLeod, Tracy Simons & Janice Romanzin-Roy) led multi-session staff meetings to keep staff informed of possible changes coming for CPSA benefits and pensions, including the employee contribution amounts.
- Management and the Pension Sub-Committee developed a list of pension options to be evaluated.
- The initial calculation of costing for the pension options has been prepared and reviewed with the Pension Sub-Committee. The options have been reviewed using an employee lens and a financial lens.

Further analysis of the pension options is continuing.

The committee discussed and stressed the importance of providing the best quality of work over meeting the timelines of having a recommendation for June.

College of Physicians & Surgeons of Alberta

7. Criteria for Sole Source Contracts

The FAC received an initial draft report from management on criteria for sole sourcing contracts.

The Committee discussed the report and provided input. Management will incorporate the feedback into the criteria to be discussed at a future FAC meeting.

College of Physicians & Surgeons of Alberta

Financial Statements
December 31, 2018

Independent auditor's report

To the Members of College of Physicians & Surgeons of Alberta

Our opinion

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of College of Physicians & Surgeons of Alberta (the College) as at December 31, 2018 and the results of its operations and its cash flows for the year then ended in accordance with Canadian accounting standards for not-for-profit organizations.

What we have audited
The College's financial statements comprise:

- the statement of financial position as at December 31, 2018;
- the statement of revenues and expenditures for the year then ended;
- the statement of changes in net assets for the year then ended;
- the statement of cash flows for the year then ended; and
- the notes to the financial statements, which include a summary of significant accounting policies.

Basis for opinion

We conducted our audit in accordance with Canadian generally accepted auditing standards. Our responsibilities under those standards are further described in the *Auditor's responsibilities for the audit of the financial statements* section of our report.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Independence
We are independent of the College in accordance with the ethical requirements that are relevant to our audit of the financial statements in Canada. We have fulfilled our other ethical responsibilities in accordance with these requirements.

Supporting schedules

Without modifying our opinion, we draw attention to the accompanying schedules subsequent to the related notes, which have been provided for information purposes only. These schedules have not been subject to audit procedures.

PricewaterhouseCoopers LLP
Stantec Tower, 10220 103 Avenue NW, Suite 2200, Edmonton, Alberta, Canada T5J 0K4
T: +1 780 441 6700, F: +1 780 441 6776

Responsibilities of management and those charged with governance for the financial statements

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

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the College's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the College's ability to continue as a going concern. If

we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the College to cease to continue as a going concern.

- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

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

PricewaterhouseCoopers LLP

Chartered Professional Accountants

Edmonton, Alberta
April 23, 2019

College of Physicians & Surgeons of Alberta

Statement of Financial Position

As at December 31, 2018

	2018 $	2017 $
Assets		
Current assets		
Cash and cash equivalents	30,328,433	30,652,199
Accounts receivable	5,351,231	2,251,260
Accrued interest receivable	13,957	15,259
Prepaid expenses and other assets	808,815	589,537
	36,502,436	33,508,255
Investments (note 3)	22,775,953	22,774,152
Equipment and leasehold improvements (note 4)	3,913,412	691,429
	63,191,801	56,973,836
Liabilities		
Current liabilities		
Accounts payable and accrued liabilities	3,884,182	2,546,084
Deferred fee revenue	21,951,681	20,246,850
Deferred contributions (note 5)	128,001	193,829
Deferred leasehold inducements (note 6)	358,462	130,747
	26,322,326	23,117,510
Deferred leasehold inducements (note 6)	3,030,443	21,472
Employee future benefits (note 7)	6,216,615	3,589,218
Asset retirement obligation (note 8)	-	289,703
	35,569,384	27,017,903
Net assets		
Invested in equipment and leasehold improvements	3,913,413	675,864
Internally restricted (note 10)	7,850,583	7,759,473
Unrestricted	15,858,421	21,520,596
	27,622,417	29,955,933
	63,191,801	56,973,836

Commitments (note 9)

Approved by the Finance and Audit Committee

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

College of Physicians & Surgeons of Alberta

Statement of Revenues and Expenditures

For the year ended December 31, 2018

	2018 $	2017 $
Revenues		
Physician annual fees	22,810,798	22,145,901
Practice readiness fees	2,277,815	2,439,957
Professional corporation fees	1,405,350	1,405,550
Grant funding (note 5)	832,328	789,089
Physician registration fees	783,260	889,590
Investment income (note 3)	781,374	640,070
Miscellaneous	610,122	572,162
Recovery of investigation and hearing expenditures	539,679	236,059
Physician practice	238,539	120,315
Physician health monitoring fees	99,125	89,200
Rental income	92,129	100,337
	30,470,519	29,428,230
Expenditures (notes 11 and 13)		
Administration	5,171,251	4,654,235
Information technology	2,218,218	2,338,989
Governance	1,571,855	1,294,926
Office of the registrar	1,329,250	1,240,380
Communication	1,202,248	1,311,368
Amortization	583,499	586,385
College activities		
Professional conduct	4,231,043	3,642,928
Physician practice	3,469,429	2,975,554
Physician prescribing and analytics	2,725,890	2,241,523
Practice readiness	2,409,755	2,816,356
Registration	2,236,411	1,878,214
Physician health monitoring and practice conditions monitoring	1,741,274	1,559,624
	28,890,123	26,540,482
Excess of revenues over expenditures before other items	1,580,396	2,887,748
Developmental costs	684,162	742,432
Accredit Health Facilities		
Revenues	2,655,085	3,110,122
Expenses	(2,825,800)	(2,861,578)
(Deficiency) excess of revenues over expenditures for facilities	(170,715)	248,544
Excess of revenues over expenditures before other income	725,519	2,393,860
Other income (losses)		
Fair value changes in investments (note 3)	(687,937)	536,772
Investment income building fund	91,110	74,345
	(596,827)	611,117
Excess of revenues over expenditures for the year	128,692	3,004,977

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

College of Physicians & Surgeons of Alberta

Statement of Changes in Net Assets

For the year ended December 31, 2018

	Invested in equipment and leasehold improvements $	Internally restricted $	Unrestricted $	2018 Total $	2017 Total $
Net assets – Beginning of year	675,864	7,759,473	21,520,596	29,955,933	26,066,516
Excess of revenues over expenditures for the year	(579,052)	-	707,744	128,692	3,004,977
Remeasurement of employee future benefits	-	-	(2,462,208)	(2,462,208)	884,440
Net investment in equipment and leasehold improvements	3,816,601	-	(3,816,601)	-	-
Net investment in building fund (note 10)	-	91,110	(91,110)	-	-
Net assets – End of year	3,913,413	7,850,583	15,858,421	27,622,417	29,955,933

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

College of Physicians & Surgeons of Alberta

Statement of Cash Flows

For the year ended December 31, 2018

	2018 $	2017 $
Cash provided by (used in)		
Operating activities		
Cash received from fees	28,660,807	30,743,274
Cash paid to suppliers and employees	(27,038,902)	(29,773,091)
Cash received from grant funding	777,725	1,209,022
Cash received from investments	827,966	571,676
Cash received from other sources	1,006,957	896,945
	4,234,553	3,647,826
Investing activities		
Purchase of equipment and software and leasehold improvements	(3,816,600)	(247,876)
Proceeds on sale of equipment and software, leasehold improvements, and other assets	(4,540)	24
Proceeds on sale and maturity of investments	1,496,342	8,724,871
Purchase of investments	(2,233,521)	(9,584,885)
	(4,558,319)	(1,107,866)
(Decrease) increase in cash and cash equivalents during the year	(323,766)	2,539,960
Cash and cash equivalents – Beginning of year	30,652,199	28,112,239
Cash and cash equivalents – End of year	30,328,433	30,652,199
Cash and cash equivalents consist of		
Money market fund	12,501,201	12,316,401
Cash on deposit	17,699,231	18,141,969
Restricted cash on deposit	128,001	193,829
	30,328,433	30,652,199

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

1 Purpose and authority

The College of Physicians & Surgeons of Alberta (the College) is constituted under the authority of the Health Professions Act of the Province of Alberta. The College's principal function is the regulation of the practice of medicine in Alberta. As a not-for-profit organization under the Income Tax Act (Canada), the College is not subject to either federal or provincial income taxes.

2 Summary of significant accounting policies

These financial statements have been prepared in accordance with Canadian accounting standards for not-for-profit organizations (ASNPO). Significant accounting policies observed in the preparation of the financial statements are summarized below.

Measurement uncertainty

The precise determination of certain assets and liabilities is dependent on future events and the preparation of financial statements for a period necessarily involves identification of assets and liabilities that are subject to estimates and approximations. Actual results could differ from those estimates. Significant estimates include providing for amortization of equipment and leasehold improvements, defined benefit obligation and the collectibility of accounts receivable.

Investments

The College's investments consist of fixed income and equity-based instruments held primarily for trading purposes. The investment portfolios, managed by third party investment managers, are subject to an investment policy set by management and reviewed by the Finance and Audit Committee of the College. The College's primary investment objective is to maximize returns within a low to medium level of risk, with medium liquidity. Fixed income investments, consisting of federal, provincial and corporate bonds, are capable of prompt liquidation. The equity-based investments are widely held and diversified and are traded on a regular basis at the discretion of the investment managers.

Investments are recorded at fair value on the latest closing bid price, with the exception of the long-term deposit for the building fund, which is measured at amortized cost. This accounting treatment results in unrealized changes in the market value of the investment portfolio being reported as a component of fair value changes reported on the statement of revenues and expenditures.

Transaction costs on investments recorded at fair value are expensed when incurred. The purchase and sale of investments are recognized on the settlement date.

On occasion, investments may include cash intended for reinvestment purposes, which is excluded from operational cash.

Cash and cash equivalents

Cash and cash equivalents consist of cash on deposit and investments in money market instruments maintained for operational purposes. Restricted cash on deposit consists of grant funding received from the provincial government to fund specific College initiatives within various programs.

Equipment and leasehold improvements

Equipment and leasehold improvements are recorded at cost less accumulated amortization. The College provides amortization on its equipment and leasehold improvements using the straight-line method at the following rates:

	Rate
Computer equipment	3 – 5 years
Furniture and equipment	3 – 10 years
Software	5 years
Leasehold improvements	lease term

Initial leasehold improvements are amortized on a straight-line basis over the life of the initial lease. Subsequent improvements are amortized to the expiry of the lease term upon completion of leasehold improvements.

When equipment or leasehold improvements no longer contribute to the College's ability to provide services, its carrying amount would be written down to residual value, if any.

The College internally restricts net assets invested in equipment and leasehold investments. This internal restriction policy does not include the net book value or liability base of the asset retirement obligation or the corresponding obligation related to the deferred leasehold inducements.

Leasehold inducements

Tenant allowances and lease inducements are deferred and amortized on a straight-line basis as a reduction of rent expense over the term of the related lease. For lease contracts with escalating lease payments, total rent expense for the lease term is expensed on a straight-line basis over the lease term. The difference between rent expensed and amounts paid is recorded as an increase or deferral in unamortized lease inducements.

Asset retirement obligations

The College recognized asset retirement obligations when a legal obligation arose from the acquisition or use of a tangible asset. The obligation is measured based on management's best estimate of future cost. The College recorded an asset retirement obligation and cost for the removal of leasehold improvements and to provide general site restoration at the termination of the lease for office premises. The asset retirement obligation is estimated using a discounted cash flow approach using an estimate of the market risk-free interest rate. The asset retirement obligation is adjusted at the end of each year to reflect the passage of time and changes in the estimated future cash flows underlying the obligation. Changes due to the passage of time are

recognized in administration expenditures as an accretion expense. Changes in the obligation due to changes in estimated cash flows are recognized as an adjustment of the carrying amount of the related long-lived asset and obligation. The asset is amortized over the life of the office premises lease.

Deferred contributions

The College receives restricted contributions from the Government of Alberta and other organizations. The College uses the deferral method of accounting for restricted contributions. Contributions are recognized as revenue in the same period the related expenditures are incurred.

Employee future benefits

The College has a defined benefit pension plan for all permanent employees.

The College recognizes its defined benefit obligation as the employees render services giving them the right to earn the pension benefit. The defined benefit obligation at the statement of financial position date is determined using the most recent actuarial valuation report prepared for funding purposes. The measurement date of the plan assets and the defined benefit obligation is the College's statement of financial position date. The date of the most recent actuarial valuation prepared for funding purposes is December 31, 2017.

In its year-end statement of financial position, the College recognizes the defined benefit obligation, less the fair value of the plan assets, adjusted for any valuation allowance in the case of a net defined benefit asset. The plan cost for the year is recognized on the statement of revenues and expenditures.

Remeasurements and other items comprise the aggregate of the following: the difference between the actual return on plan assets and the return calculated using the discount rate; actuarial gains and losses; the effect of any valuation in the case of a net defined benefit asset; past service costs; and gains and losses arising from settlements and curtailments. The remeasurement costs are reflected in the statement of changes in net assets.

Revenue recognition

- Annual physician, professional corporation and facility fees

  Annual physician, professional corporation and facility fees are set annually by Council and are recognized as revenue in the fiscal year to which they relate. Fees are recognized when collectibility is reasonably assured. Fees received in advance are recognized as deferred fee revenue.

- Registration fees

  Registration fees are recognized when received or receivable and collectibility is reasonably assured.

- General and miscellaneous revenue

  Other general revenue is recognized when the related services are provided or goods are shipped and collectibility is reasonably assured.

- Investment income

  Investment income includes interest and dividends and is recognized when earned.

- Rental income

  Income from sublease rental is recognized when earned in accordance with the terms of the lease agreement and when collectibility is reasonably assured.

- Grant funding

  Grant funding is recognized in accordance with the terms of the grant agreement and when collectibility is reasonably assured.

Disclosure of allocated expenses

The costs of each College program include the costs of personnel and other expenses that are directly related to providing the program. The College also incurs a number of general support expenses that are common to the administration of the organization and each of its programs.

The College allocates certain general support expenses by identifying the appropriate basis of allocating each component expense and applies that basis consistently each year. The general support expenses are allocated on the following bases:

- Computer programming costs – proportionately on the basis of time allocated by staff in the program.
- Operating costs – proportionately on the basis of time allocated by staff in the program.
- Rent costs – proportionately on the basis of space occupied and time allocated by staff in the program.
- Salary and benefit costs – proportionately on the basis of time allocated by staff in the program.

Details on the amounts allocated can be found in note 11.

3 Investments

	2018 $	2017 $
Investments		
Cash	1,364,782	955,610
Term deposits – Building fund	7,850,566	7,542,066
Corporate bonds, at fair value, bearing yield rates of 3.31% to 4.55%, due 2026 to 2041	4,710,513	4,870,892
Provincial government, 1.55% to 4.10%, due 2019 to 2026	1,540,829	1,792,555
Government of Canada securities, at fair value, bearing yield rates of 1.25% to 2.35%, due 2021 to 2027	159,602	159,418
	15,626,292	15,320,541
Equities (including trust units) – at fair value		
Foreign	4,303,419	4,473,450
Domestic	2,846,242	2,980,161
	7,149,661	7,453,611
	22,775,953	22,774,152

Investment income comprises interest and dividends. Fair value changes in investments comprise the following:

	2018 $	2017 $
Unrealized gain (loss) on investments	(842,366)	514,002
Realized gain on investments	54,425	95,380
Foreign exchange gain (loss)	100,004	(72,610)
	(687,937)	536,772

4 Equipment and leasehold improvements

			2018
	Cost $	Accumulated amortization $	Net $
Leasehold improvements	5,015,256	1,694,181	3,321,075
Furniture and equipment	2,289,326	1,976,892	312,434
Computer equipment	1,733,426	1,496,040	237,386
Software	728,610	686,093	42,517
	9,766,618	5,853,206	3,913,412

Net Assets under construction totalling $3,272,000 are not being amortized at December 31, 2018.

	2017		
	Cost **$**	**Accumulated amortization** **$**	**Net** **$**
Leasehold improvements	3,647,491	3,285,323	362,168
Furniture and equipment	2,021,308	1,929,851	91,457
Computer equipment	1,490,182	1,323,235	166,947
Software	715,359	644,502	70,857
	7,874,340	7,182,911	691,429

5 Deferred contributions

During the year, the College received restricted contributions from the provincial government and other organizations to fund various College initiatives. Deferred contributions as at December 31, 2018 are as follows:

	Deferred contributions 2017 **$**	**Received** **$**	**Recognized as revenue** **$**	**Deferred contributions 2018** **$**
Physician prescribing analytics				
Triplicate Prescription Program	168,223	560,000	627,341	100,882
Triplicate Prescription Program – other sources	-	34,000	34,000	-
Physician Risk Identification Project	25,606	-	18,900	6,706
Physician Practice Opioid Tapering Course	-	6,100	1,600	4,500
Advisory Committee on the management of substance use in acute care settings	-	65,000	49,087	15,913
	193,829	665,100	730,928	128,001

Contributions recognized as revenue in the current year but not reflected in the above table and included in accounts receivable at year-end are as follows:

	2018 **$**	**2017** **$**
Triplicate Prescription Program	101,400	112,625

6 Deferred leasehold inducements

	2018 $	2017 $
Opening balance	152,219	282,693
Net amounts received or receivable	3,367,159	-
Recognized in net revenue	(130,473)	(130,474)
	3,388,905	152,219
Less: Current portion	358,462	130,747
	3,030,443	21,472

The existing deferred leasehold inducements are being amortized over the lease term to February 28, 2019. The amortization is recognized as a reduction of office facilities. Additional leasehold inducements of $3,367,159 for leasehold improvements in progress will commence amortization upon completion of the instalments in 2019.

7 Employee future benefits

The College has a defined benefit pension plan for all permanent employees. The benefits are based on years of service and the employees' final average earnings. The cost of this program is being funded currently.

The College accrues its obligations under the employee defined benefit plan as the employees render the services necessary to earn the pension.

The College measures its accrued employee future benefit obligation and the fair value of plan assets using the valuation for funding purposes as at December 31 each year. The most recent actuarial valuation of the pension plans for funding purposes was as at December 31, 2017, and the next required valuation will be as at December 31, 2020.

	2018		2017	
	Registered $	SERP $	Registered $	SERP $
Fair value of plan assets	34,549,858	-	33,762,740	-
Accrued benefit obligation	33,522,514	7,243,959	31,300,537	6,051,421
Plan surplus (deficit)	1,027,344	(7,243,959)	2,462,203	(6,051,421)

The net accrued benefit obligation is included in the College's statement of financial position as follows:

	2018 $	2017 $
Employee future benefits	(6,216,615)	(3,589,218)

The significant actuarial assumptions adopted in measuring the College's employee future benefit obligation are as follows:

	2018		2017	
	Registered	**SERP**	**Registered**	**SERP**
Discount rate	4.70%	4.70%	4.70%	4.70%
Rate of amortization increase	various	various	various	various

Total cash payments for employee future benefits for 2018, consisting of cash contributed by the College to the registered pension plan and cash payments directly to beneficiaries for the Supplementary Pension Plan for Employees of the College (SERP) benefit plan, were $2,570,783 (2017 – $2,965,097).

8 Asset retirement obligation

The College has recorded a liability for asset retirement obligation of $nil (2017 – $289,703). The asset retirement obligation represented the legal and contractual obligation associated with the removal of existing leasehold improvements and general site restoration at the termination of the lease for office premises.

A new lease was entered into during 2018 and there is no longer a contractual obligation to remove the existing leasehold improvements. The associated asset retirement obligation was settled in 2018 and as such, the settlement amount was recorded as an addition to the deferred leasehold inducements balance.

A reconciliation between the opening and closing asset retirement obligation balances is provided below:

	$
Balance – Beginning of year	289,703
Accretion included in administration expenses	4,447
Settlement	(294,150)
Balance – End of year	-

9 Commitments

The College is committed to a lease agreement related to its office premises until February 2029. The basic rental due in each of the next five years and thereafter is as follows:

	$
2019	644,461
2020	759,120
2021	759,120
2022	759,120
2023	830,288
Thereafter	4,649,610
	8,401,719

The College is committed to contractual arrangements with an external company to develop and maintain a database, provide user licences and analysis work for prescribing data, support the College's physician practice portal, maintain the Practices at Risk program, and to support peer-reviewed publications until March 2020. The fees due are $826,938 in 2019 and $63,375 in 2020.

The College is committed to a contractual arrangement with an external organization until April 2021 to organize assessment and personal development programs for physicians who have been identified as having practice concerns. The annual fees due are $93,500.

The College has committed to a contractual arrangement with an external organization until December 2020 to provide survey administrations. The estimated fees due are $168,500 in 2019 and $172,000 in 2020.

The College has committed to a joint funding arrangement with external organizations to contribute funds in 2020 and 2021 towards an initiative to help physician and patient conversations to avoid unnecessary tests, treatments and procedures. The annual fees are $40,000 in 2020 and $40,000 in 2021.

The College has committed to fund the treatment and counselling of patients in relation to complaints filed on or after April 1, 2019 relating to sexual abuse or sexual misconduct. The estimated annual fees are $67,500.

In the normal course of business, the College may become subject to litigation; losses, if any, are expected to be fully covered by the College's insurance. The results of such claims are not determinable at this time and therefore, no amounts have been accrued for in the financial statements.

10 Internally restricted net assets

The internally restricted fund reports interest earned on the funds that have been allocated for the Building Reserve Fund by the Council of the College.

During the year, the Council of the College internally restricted the net results of the accreditation program for the year ended December 31, 2018 and onward to be used by the accreditation department for future

development costs. As the net results of the accredit health facility operations was a deficit of revenue over expenditures, no amounts were internally restricted in net assets for the year ended December 31, 2018.

11 Allocation of expenses

The general support expenses, including programming costs, operating costs, rent and salary and benefits, have been allocated as follows:

	2018 $	2017 $
Professional conduct	2,900,596	2,791,856
Administration	2,656,054	2,214,341
Physician practice	2,622,971	2,165,855
Accreditation	1,860,127	1,673,639
Information technology	1,744,945	1,789,478
Registration	1,661,587	1,355,284
Physician prescribing and analytics	1,619,822	1,361,095
Physician health monitoring and practice conditions monitoring	1,075,376	962,429
Communication	1,031,185	1,146,552
Office of the Registrar	750,724	892,357
Governance	731,700	532,487
Practice readiness	641,971	846,930
Department costs	185,423	70,788
	19,482,481	17,803,091

12 Financial instruments

The College's financial instruments include cash and cash equivalents, accounts receivable, accrued interest receivable, investments and accounts payable and accrued liabilities. Cash and cash equivalents, accounts receivable and accrued interest are classified as loans and receivables and accounted for at amortized cost using the effective interest rate method. Loans and receivables are initially recorded at fair value. Accounts payable and accrued liabilities are classified as other liabilities and are accounted for at amortized cost using the effective interest rate method. Financial liabilities are initially recorded at fair value.

The fair value of financial instruments that are not recorded at fair value approximates their carrying amounts due to the short-term maturity of these instruments.

The College is exposed to various risks through its financial instruments. The following analysis provides a measure of the risks as at December 31, 2018.

Credit risk

Credit risk refers to the risk a counterparty may default on its contractual obligations resulting in a financial loss. The College's investment in bonds and interest accrued thereon is primarily with federal and provincial governments with a portion allocated to investment grade corporate bonds concentrated in Canada. Accounts

receivable consist of numerous parties operating primarily in the medical field, are of a short-term nature and no individual account receivable is significant to the College's financial position.

A portion of the assets held in the pension plan is exposed to credit risk, similar to the risks on the College's bond portfolio. In the event of loss in the pension plan, the College would be obligated to fund any deficiency that may arise. The balanced fund invests in a mix of government and investment grade corporate bonds.

Cash and cash equivalents and term deposits are maintained with a Schedule I financial institution. There has been no change to credit risk from the prior year.

Market and other price risk

The College's equity interests, including exchange traded funds, are primarily focused on the Canadian public market and are subject to fluctuations due to changes in market prices of individual securities, general market and industry trends, changes in interest rates and creditworthiness and foreign exchange rates. The College is also exposed to interest rate risk through its holdings of bonds. Market and other price risk is directly influenced by the volatility and liquidity in the markets in which the related underlying assets are traded. All investments are of large market entities regularly traded on the exchanges.

A portion of the assets held in the pension plan is exposed to market and other price risk, similar to the risks on the College's investment portfolio. In the event of loss in the pension plan, the College would be obligated to fund any deficiency that may arise. The balanced fund invests in a mix of large market entities or funds regularly traded on the exchanges.

The College holds assets denominated in the US dollar. It is therefore exposed to currency risk as the value of the financial instruments denominated in the US dollar will fluctuate due to changes in exchange rates.

There has been no change to these risks from the prior year.

Liquidity risk

Since inception, the College has primarily financed its liquidity through member dues, fees and investment income. The College expects to continue to meet future requirements through all of the above sources.

The College is not subject to any externally imposed capital requirements. The investments are subject to liquidity risk if the College is required to sell at a time that the market for investments is unfavourable. There have been no changes to the College's objectives and what it manages as capital since the prior year.

13 Nature of expenses

Supplemental information with respect to the nature of expenses included in the statement of revenues and expenditures is as follows:

	2018 $	2017 $
Salary and benefits	19,482,480	17,803,091
Consulting	5,066,455	5,082,529
Office facilities	1,781,025	1,883,803
Legal	1,068,809	735,625
Travel, meals and accommodation	844,502	791,660
Honoraria	818,510	818,047
Program costs	801,966	657,889
Other	681,260	449,624
Amortization	583,499	586,385
Bank and interest charges	559,680	551,992
Grants and scholarships	356,024	353,371
Printing and supplies	355,875	430,476
Total net expenditures	32,400,085	30,144,492

14 Comparative figures

Some of the comparative figures have been reclassified to conform to the current year's presentation.

College of Physicians & Surgeons of Alberta

Schedule A

Schedule of Administration

(Unaudited)

For the year ended December 31, 2018

	2018 $	2017 $
Staff costs		
Salaries	1,369,133	1,260,959
Pension and SERP	1,118,467	777,518
Benefits	216,294	251,531
Professional development	37,406	21,161
Membership fees and dues	21,090	28,800
Team building	1,455	3,875
	2,763,845	2,343,844
General expenditures		
Amortization	347,997	354,789
Audit and accounting	41,638	41,721
Bank fees	92,524	114,262
Conferences	12,470	4,964
Consulting fees	460,707	215,960
Furniture and equipment – net of gain/loss on disposal	77,660	79,618
Insurance	78,390	74,459
Legal	10,650	16,985
Lunchroom	29,504	23,169
Office expenses – net of internal recoveries	(82,902)	(31,833)
Travel, meals and accommodations	4,521	8,269
Recovery of costs	(96,119)	(102,908)
	977,040	799,455
Privacy		
Staffing costs	176,418	150,539
General expenses	1,113	508
	177,531	151,047
Office facilities		
Office rent	1,759,215	1,800,422
Recovery of rent	(177,200)	(165,100)
Maintenance	14,168	63,288
Accretion expense	4,649	16,068
	1,600,832	1,714,678
Net expense for the year	5,519,248	5,009,024

College of Physicians & Surgeons of Alberta

Schedule B

Schedule of Information Technology

(Unaudited)

For the year ended December 31, 2018

	2018 $	2017 $
Staff costs		
Salaries and benefits	1,947,039	1,990,759
Professional development	31,391	33,934
Team building	2,979	1,985
	1,981,409	2,026,678
General expenditures		
Amortization	230,010	227,202
Computer – external support	180,105	146,017
Computer supplies	86,321	137,202
Consulting fees	-	59,272
Consulting fees – server hosting	96,529	97,118
Furniture and equipment	5,157	5,535
Office expenses	18,207	13,715
Travel, meals and accommodations	295	477
Website maintenance and internet	86,660	90,176
	703,284	776,714
Recovery of programming and operating costs	(236,465)	(237,200)
Net expense for the year	2,448,228	2,566,192

College of Physicians & Surgeons of Alberta

Schedule C

Schedule of Governance

(Unaudited)

For the year ended December 31, 2018

	2018 $	2017 $
Staff costs		
Salaries and benefits	719,158	523,300
Professional development	9,249	8,891
	728,407	532,191
Council meetings and retreat	407,185	399,765
Elections	7,357	6,582
Strategic planning	-	29,166
Committees of council		
Council appeals committee	172,127	15,325
Ad Hoc – for council	77,311	66,512
Executive committee	15,289	26,627
Finance and audit committee	53,860	29,541
Medical informatics	19,740	51,891
Legislation committee	8,432	-
Competence committee	21,877	43,326
Governance committee	25,022	24,713
Presidential business	35,248	55,476
	428,906	313,411
Representatives to council	-	3,564
Net expense for the year	1,571,855	1,284,679

College of Physicians & Surgeons of Alberta

Schedule D

Schedule of Office of the Registrar

(Unaudited)

For the year ended December 31, 2018

	2018 $	2017 $
Staff costs		
Salaries and benefits	730,786	666,272
Professional development	15,594	11,493
	746,380	677,765
Registrar's office		
Registrar's administration	245,363	77,184
Executive search/resignation costs	-	249,446
Grants and scholarships	45,920	20,570
	291,283	347,200
Liaison		
AMA	4,828	342
CMA	1,036	36
FMRAC	173,031	178,223
MCC	4,320	(1,924)
National organizations	12,445	17,400
Provincial organizations	10,634	6,112
	206,294	200,189
Speaker's Bureau	1,331	-
Standards	72,487	5,615
Abandoned records	6,260	5,470
Alberta expert review panel	5,215	4,141
Net expense for the year	1,329,250	1,240,380

College of Physicians & Surgeons of Alberta

Schedule E

Schedule of Communication

(Unaudited)

For the year ended December 31, 2018

	2018 $	2017 $
Staff costs		
Salaries and benefits	1,020,451	1,123,383
Dues and assessments	4,065	1,000
Professional development	10,326	20,122
Team building	408	421
	1,035,250	1,144,926
General expenditures		
Conferences	-	4,185
Government relations	94,665	28,692
Office expenses	9,072	9,319
Public relations	38	571
Research and evaluation	25,805	13,598
Travel, meals and accommodations	2,079	921
	131,659	57,286
Annual report	8,563	8,282
Communication projects	14,976	51,098
Community relations	7,582	12,417
Internal communications	-	1,521
Media	2,363	8,259
Messenger	1,855	1,225
Regional tours		
Per diem	-	5,341
Sundry	-	1,492
Travel, meals and accommodations	-	19,521
	-	26,354
Net expense for the year	1,202,248	1,311,368

College of Physicians & Surgeons of Alberta

Schedule F

Schedule of College Activities

(Unaudited)

For the year ended December 31, 2018

	Schedule	2018 $	2017 $
CPSA activities			
Register physicians			
Registration	G	2,235,212	1,876,814
Practice readiness	H	131,939	376,398
		2,367,151	2,253,212
Investigate complaints			
Professional conduct	I	3,691,364	3,406,869
Support continuing competence			
Physician practices	J	3,229,291	2,766,854
Prescribing analytics	K	1,739,523	1,389,218
		4,968,814	4,156,072
Monitor physicians			
Physician health monitoring	M	1,458,228	1,298,144
Practice condition monitoring		183,923	171,447
		1,642,151	1,469,591
Accredit health facilities			
Accreditation programs	N	170,715	(248,544)
E-Accreditation project		5,492	4,394
		176,207	(244,150)
Total activity expenses		12,845,687	11,041,594

College of Physicians & Surgeons of Alberta

Schedule G

Schedule of Registration

(Unaudited)

For the year ended December 31, 2018

	2018 $	2017 $
General program expenditures		
Bank/credit card fees	467,157	437,729
Legal	14,961	34,198
Legal independent	46,704	7,980
Office expenses	16,957	18,218
Postage and courier	17,127	16,163
Travel, meals and accommodations	8,709	8,379
	571,615	522,667
Summative assessments		
Legal	2,713	-
Office expenses	239	-
Travel, meals and accommodations	24	-
	2,976	-
Staff costs		
Salaries and benefits	1,636,446	1,344,781
Dues and assessments	234	263
Professional development	24,379	10,503
Team building	762	-
	1,661,821	1,355,547
Registrar approvals	(1,200)	(1,400)
Net expense for the year	2,235,212	1,876,814

College of Physicians & Surgeons of Alberta

Schedule H

Schedule of Practice Readiness

(Unaudited)

For the year ended December 31, 2018

	2018 $	2017 $
Practice Readiness		
Revenue		
Practice readiness fees	(1,633,765)	(1,769,432)
Practice readiness assessment administration fee	(591,000)	(651,800)
Late payment fee	(900)	(2,550)
Therapeutics exam fees	(37,800)	-
	(2,263,465)	(2,423,782)
Practice readiness expenditures		
Consulting fees	1,613,711	1,927,868
Computer programing	31,175	35,925
Legal	10,960	2,689
Occupancy cost	43,700	33,800
Office expenses	1,797	5,653
Operating cost	68,100	60,900
Professional development	22,526	6,067
Salaries and benefits	476,469	710,237
Travel, meals and accommodations	5,250	31,956
Therapeutics exam administration fee	127,050	-
Total practice readiness expenses	2,400,738	2,815,095
Net practice readiness expenses	137,273	391,313
Other assessments		
Administration fee	(3,000)	(3,000)
Recovery costs	(11,350)	(13,175)
Consulting fees	9,000	1,260
Telephone and fax	16	-
	(5,334)	(14,915)
Net expense for the year	131,939	376,398

College of Physicians & Surgeons of Alberta

Schedule I

Schedule of Professional Conduct

(Unaudited)

For the year ended December 31, 2018

	2018 $	2017 $
Staff costs		
Salaries and benefits	2,856,394	2,746,774
Professional development and dues	49,559	40,177
Team building	1,102	1,444
	2,907,055	2,788,395
General program expenditures		
Casual labour	340	9,791
Consulting fees	38,963	-
Office expenses	23,395	19,511
Sundry	31	68
Legal	11,628	8,035
Travel, meals and accommodations	1,904	2,450
	76,261	39,855
Complaint expenditures		
Consulting fees/per diem	24,516	-
Office expenses	586	953
Travel, meals and accommodations	9,948	10,710
External file review	(4)	115
	35,046	11,778
Investigation expenditures		
Consulting fees/per diem	103,999	46,002
Legal	295,043	250,168
Office expenses	5,570	1,422
Travel, meals and accommodations	250	-
	404,862	297,592
Recovery of investigation costs – net of expenses	(179,310)	(99,158)
Recovery of external file review costs	(125,397)	(125,289)
Net investigation costs	100,155	73,145
Judicial review/court of appeal	64,331	102,541
Complaint review committee	179,496	154,065
Hearing tribunal	329,020	237,090
Net expense for the year	3,691,364	3,406,869

College of Physicians & Surgeons of Alberta

Schedule J

Schedule of Physician Practice

(Unaudited)

For the year ended December 31, 2018

	2018 $	2017 $
General program expenditures		
Conferences	13,824	7,178
Consulting fees	50	-
Dues	7,992	1,513
Legal	1,477	5,601
Office expenses	7,894	10,318
Professional development	213	124
Salaries and benefits	59,619	38,732
Travel, meals and accommodations	29,796	20,905
	120,865	84,371
Individual Practice Review (IPR)		
Recovery of Individual Practice Review costs	(181,039)	(79,315)
Practice visits administration fee	(57,500)	(41,000)
Consulting fees	298,811	155,546
Dues and assessments	838	1,247
Office expenses	9,796	1,843
Professional development	13,638	11,868
Salaries and benefits	1,249,182	929,224
Travel, meals and accommodations	29,650	27,239
	1,363,376	1,006,652
Group practice review program (GPR)		
Consulting fees	59,825	120,324
Office expenses	7,431	6,234
Professional development	5,270	3,345
Salaries and benefits	290,960	327,460
Travel, meals and accommodations	14,511	34,190
	377,997	491,553
Factors based IPR pilot		
Professional development	391	-
Salaries and benefits	179,692	-
	180,083	-
Practice review pilot development project		
Professional development	3,542	4,336
Salaries and benefits	141,347	231,474
	144,889	235,810
Clinic pre-open assessment pilot		
Professional development	486	-
Salaries and benefits	78,761	-
	79,247	-
Total practice review expenses	2,266,457	1,818,386

	2018 $	2017 $
Competency enhancement		
Recovery costs	(1,600)	(72,000)
Grants and scholarships	86,100	172,000
Office expenses	228	78
Professional development	1,114	865
Salaries and benefits	33,703	39,798
	119,545	140,741
Multi-source feedback		
Salaries and benefits	176,104	155,417
General program expenditures	3,408	19,779
MCC 360 survey implementation	55,655	102,552
MSF survey facilitation	227,802	157,173
	462,969	434,921
Infection Prevention and Control (IPAC)		
General program expenditures		
Consulting fees	9,184	581
Office expenses	6,657	5,517
Professional development	5,921	2,931
Salaries and benefits	252,661	272,110
Travel, meals and accommodations	985	226
	275,408	281,365
IPAC committee expenditures		
Per diem	17,268	11,534
Travel, meals and accommodations	3,856	3,598
Sundry	682	-
	21,806	15,132

College of Physicians & Surgeons of Alberta

Schedule of Physician Practice ... *continued*

For the year ended December 31, 2018

	2018 $	2017 $
Physician office assessments (internal)		
Travel, meals and accommodations	3,283	8,235
Sundry	-	499
	3,283	8,734
Physician fees office assessment (external)		
Consulting fees/per diem	58,993	53,202
Travel, meals and accommodations	20,830	14,373
	79,823	67,575
	380,320	372,806
Net expense for the year	3,229,291	2,766,854

College of Physicians & Surgeons of Alberta

Schedule K

Schedule of Prescribing Analytics

(Unaudited)

For the year ended December 31, 2018

	2018 $	2017 $
General program expenditures		
Conferences	7,267	11,324
Consulting fees	301,050	222,338
Legal	2,101	-
Office expenses	98,669	97,730
Professional development	10,819	14,054
Salaries and benefits	793,302	660,605
Travel, meals and accommodations	19,234	18,759
	1,232,442	1,024,810
PPP advisory committee expenses		
Per diem	11,477	11,779
Sundry	351	4
Travel, meals and accommodations	4,220	2,508
	16,048	14,291
General assessment committee		
Per diem	-	14,691
Sundry	-	29
Travel, meals and accommodations	-	1,664
	-	16,384
Harm reduction advisory committee	(1,445)	1,445
Total prescribing and analytics operating costs	1,247,045	1,056,930
Methadone exemption costs		
Office expenses	348	358
Professional development	-	63
Salaries and benefits	15,416	11,392
	15,764	11,813
Research and evaluation		
Consulting fees	5,061	400
Office expenses	7,415	440
Travel, meals and accommodations	38,356	15,286
Salaries and benefits	335,379	219,734
	386,211	235,860

College of Physicians & Surgeons of Alberta

Schedule of Prescribing Analytics ...*continued*

For the year ended December 31, 2018

	2018 $	2017 $
Physician Factors		
General expenditures		
Office expenses	235	148
Professional development	1,053	1,068
Salaries and benefits	89,215	83,321
Travel, meals and accommodations	-	78
	90,503	84,615
Physician risk identification project		
Consulting fees	18,900	10,096
Travel, meals and accommodations	-	4,581
Grant funding	(18,900)	(14,677)
	-	-
Subtotal physician factors	90,503	84,615
Net expense for the year	1,739,523	1,389,218

College of Physicians & Surgeons of Alberta

Schedule L

Schedule of Triplicate Prescription Program

(Unaudited)

For the year ended December 31, 2018

	2018 $	2017 $
Revenue		
Government grant	(627,341)	(573,787)
Investment income	-	(882)
Grant – other sources	(135,400)	(128,625)
Designated portion of annual fee	(155,640)	(150,719)
	(918,381)	(854,013)
General program expenditures		
Consulting fees	198,829	159,076
Occupancy costs	48,600	49,300
Office expenses	341,727	320,612
Operating costs	59,000	61,200
Travel, meals and accommodations	46	124
	648,202	590,312
Staff costs		
Professional development and dues	1,559	688
Salaries and benefits	268,529	263,013
	270,088	263,701
Committee expenditures	91	-
Total expenditures	918,381	854,013
Net expense for the year	-	-

College of Physicians & Surgeons of Alberta

Schedule M

Schedule of Physician Health Monitoring

(Unaudited)

For the year ended December 31, 2018

	2018 $	2017 $
Revenue		
Annual fees	(99,125)	(87,700)
Staffing costs		
Salaries and benefits	882,493	790,436
Professional development	9,646	1,939
	892,139	792,375
General program expenditures		
Conferences	5,737	7,692
Legal	803	1,677
Office expenses	14,431	11,581
Consulting fees	24,200	-
Travel, meals and accommodations	7,240	5,115
	52,411	26,065
Monitoring expenses		
Addictions	551,749	525,673
Blood borne illness	21,851	7,923
Boundary	20,316	20,464
Boundary workshop	13	-
	593,929	554,060
Physician health monitoring committee expenditures	10,667	13,733
Education and training		
Chaperone course revenue	-	(833)
Chaperone course	8,207	-
	8,207	(833)
Other		
Physician support	-	444
Net expense for the year	1,458,228	1,298,144

College of Physicians & Surgeons of Alberta

Schedule N

Schedule of Accreditation Programs

(Unaudited)

For the year ended December 31, 2018

	Schedule	2018 $	2017 $
Accreditation programs			
Imaging	O	(117,331)	(238,633)
Laboratory	P	55,296	(53,217)
Medical Facility Accreditation Committee (MFAC)	Q	(829)	(1,226)
Neurodiagnostics	R	48,371	51,026
Non-Hospital Surgical Facility (NHSF)	S	(61,472)	(153,943)
Pulmonary	T	8,727	(31,924)
Sleep Medicine Diagnostics	U	226,849	181,345
		159,611	(246,572)
Other			
ECG Program	V	11,104	(1,972)
Net expense (revenue) for the year		170,715	(248,544)

College of Physicians & Surgeons of Alberta

Schedule O

Schedule of Imaging

(Unaudited)

For the year ended December 31, 2018

	2018 $	2017 $
Revenue		
Annual and registration fees	(728,618)	(727,674)
Allocation of fees to MFAC	30,963	39,853
	(697,655)	(687,821)
Expenditures		
General program expenditures		
Computer programmer time	965	4,253
Consulting fees	5,854	55,942
Inspector training	-	94
External accreditation	427	400
Legal	181	224
Occupancy costs	18,200	14,400
Office expenses	12,968	8,634
Operating costs	34,300	29,300
Travel, meals and accommodations	2,765	11,502
	75,660	124,749
Staff costs		
Salaries and benefits	372,922	247,686
Dues and assessments	675	670
Professional development	7,326	9,663
Team building	81	121
	381,004	258,140
Committee expenditures		
Consulting fees/per diem	78,162	65,519
Travel, meals and accommodations	30,102	23,189
Sundry	230	-
	108,494	88,708
Facilities assessments		
Recovery of assessment costs	(112,296)	(224,859)
Consulting fees	27,184	143,667
Travel, meals and accommodations	100,159	58,783
Sundry	119	-
	15,166	(22,409)
Total expenditures	580,324	449,188
Net revenue for the year	(117,331)	(238,633)

College of Physicians & Surgeons of Alberta

Schedule P

Schedule of Laboratory

(Unaudited)

For the year ended December 31, 2018

	2018 $	2017 $
Revenue		
Annual and registration fees	(464,842)	(721,616)
Allocation of fees to MFAC	33,028	20,839
	(431,814)	(700,777)
Expenditures		
General program expenditures		
Computer programmer time	770	3,265
Consulting fees	2,966	39,099
External accreditation	4,957	4,564
Legal	181	671
Conferences	2,014	87
Occupancy costs	16,800	13,000
Office expenses	13,344	15,749
Operating costs	32,100	25,700
Travel, meals and accommodations	7,399	5,496
	80,531	107,631
Staff costs		
Salaries and benefits	306,061	262,882
Dues and assessments	1,496	2,326
Professional development	8,743	8,712
Team building	1,030	72
	317,330	273,992
Committee expenditures		
Consulting fees/per diem	35,878	40,533
Travel, meals and accommodations	5,481	7,667
Sundry	357	782
	41,716	48,982
Facilities assessments		
Recovery of assessment costs	(147,831)	(183,736)
Consulting fees/per diem	137,538	116,156
Travel, meals and accommodations	57,729	49,255
Sundry	97	76
	47,533	(18,249)

College of Physicians & Surgeons of Alberta

Schedule of Laboratory ...*continued*

For the year ended December 31, 2018

	2018 $	2017 $
ALQEP expenditures		
Administrative expenditures		
Consulting fees	-	47,650
Occupancy costs	-	10,300
Office expenses	-	3,796
Operating costs	-	20,100
Travel, meals and accommodations	-	634
	-	82,480
Staff costs ALQEP		
Salaries and benefits	-	151,357
Dues and assessments	-	-
Professional development	-	1,349
	-	152,706
Sample expenditures		
Mailing supplies	-	18
Total expenditures	487,110	647,560
Net (revenue) expense for the year	55,296	(53,217)

College of Physicians & Surgeons of Alberta

Schedule Q

Schedule of Medical Facility Accreditation Committee (MFAC)

(Unaudited)

For the year ended December 31, 2018

	2018 $	2017 $
Revenue		
Annual and registration fees	(33,750)	(36,550)
Allocation of fees to MFAC	(103,212)	(109,149)
	(136,962)	(145,699)
Expenditures		
General program expenditures		
Computer programmer time	81	270
Consulting fees	1,077	10,572
Occupancy costs	6,600	6,000
Office expenses	3,507	6,343
Operating costs	7,900	7,600
Travel, meals and accommodations	-	15
	19,165	30,800
Staff costs		
Salaries and benefits	97,023	82,679
Dues and assessments	739	1,141
Professional development	3,145	3,359
	100,907	87,179
Committee expenditures		
Consulting fees/per diem	12,156	16,901
Travel, meals and accommodations	(457)	2,156
Sundry	353	268
	12,052	19,325
Quality assessments expenses	5,492	6,315
Facilities assessments		
Recovery of assessment costs	(10,437)	(9,963)
Consulting fees	6,322	8,543
Travel, meals and accommodations	2,471	2,223
Sundry	161	51
	(1,483)	854
Total expenditures	136,133	144,473
Net revenue for the year	(829)	(1,226)

College of Physicians & Surgeons of Alberta

Schedule R

Schedule of Neurodiagnostics

(Unaudited)

For the year ended December 31, 2018

	2018 $	2017 $
Revenue		
Annual and registration fees	(94,723)	(96,578)
Allocation of fees to MFAC	4,128	5,239
	(90,595)	(91,339)
Expenditures		
General program expenditures		
Computer programmer time	228	878
Consulting fees	130	9,992
Occupancy costs	5,600	4,900
Office expenses	3,015	3,258
Operating costs	12,100	10,000
Travel, meals and accommodations	119	404
	21,192	29,432
Staff costs		
Salaries and benefits	107,591	102,908
Dues/conferences	214	-
Professional development	2,269	2,731
	110,074	105,639
Committee expenditures		
Consulting fees/per diem	5,101	6,240
Travel, meals and accommodations	18	-
Sundry	31	66
	5,150	6,306
Facilities assessments		
Recovery of assessment costs	(20,336)	(13,733)
Consulting fees	19,192	12,224
Travel, meals and accommodations	3,501	2,018
Sundry	193	479
	2,550	988
Total expenditures	138,966	142,365
Net expense for the year	48,371	51,026

College of Physicians & Surgeons of Alberta

Schedule S

Schedule of Non-Hospital Surgical Facilities (NHSF)

(Unaudited)

For the year ended December 31, 2018

	2018 $	2017 $
Revenue		
Annual and registration fees	(469,310)	(468,115)
Allocation of fees to MFAC	20,642	24,448
	(448,668)	(443,667)
Expenditures		
General program expenditures		
Consulting fees	79,785	33,473
External accreditation	427	400
Inspector training	1,219	-
Occupancy costs	13,700	12,300
Office expenses	10,831	8,949
Operating costs	21,300	17,400
Travel, meals and accommodations	24,192	6,528
	151,454	79,050
Staff costs		
Salaries and benefits	205,578	154,234
Dues and assessments	214	616
Professional development	3,041	3,723
	208,833	158,573
Committee expenditures		
Per diem	32,856	28,542
Travel, meals and accommodations	13,394	6,202
Sundry	528	512
	46,778	35,256
Reportable incident review committee	-	8,618
Facilities assessments		
Recovery of assessment costs	(70,773)	(66,456)
Per diem	32,029	60,984
Travel, meals and accommodations	18,204	12,874
Sundry	671	825
	(19,869)	8,227
Total expenditures	387,196	289,724
Net revenue for the year	(61,472)	(153,943)

College of Physicians & Surgeons of Alberta

Schedule T

Schedule of Pulmonary

(Unaudited)

For the year ended December 31, 2018

	2018 $	2017 $
Revenue		
Annual and registration fees	(274,990)	(287,133)
Allocation of fees to MFAC	13,417	14,807
	(261,573)	(272,326)
Expenditures		
General program expenditures		
Computer programmer time	413	1,688
Consulting fees	4,368	25,006
External accreditation	427	400
Legal	220	199
Occupancy costs	8,300	7,500
Office expenses	5,573	5,101
Operating costs	18,900	16,800
Travel, meals and accommodations	2,377	3,902
	40,578	60,596
Staff costs		
Salaries and benefits	176,356	129,008
Dues and assessments	708	-
Professional development	2,603	3,466
	179,667	132,474
Committee expenditures		
Consulting fees/per diem	34,683	35,843
Travel, meals and accommodations	7,773	5,902
Sundry	179	259
	42,635	42,004
Facilities assessments		
Recovery of assessment costs	(30,859)	(61,025)
Consulting fees	23,346	55,396
Travel, meals and accommodations	14,473	9,621
Sundry	460	1,336
	7,420	5,328
Total expenditures	270,300	240,402
Net expense (revenue) for the year	8,727	(31,924)

College of Physicians & Surgeons of Alberta

Schedule U

Schedule of Sleep Medicine Diagnostics

For the year ended December 31, 2018

	2018 $	2017 $
Revenue		
Annual and registration fees	(18,000)	(10,650)
Allocation of fees to MFAC	1,032	3,964
	(16,968)	(6,686)
General program expenditures		
Consulting fees	4,770	23,073
Conferences	-	6,439
Inspector training	88	-
Occupancy costs	8,700	5,000
Office expenses	2,942	2,935
Operating costs	17,400	12,800
Travel, meals an accommodations	3,401	2,442
	37,301	52,689
Staff costs		
Salaries and benefits	164,032	99,054
Dues and assessments	272	1,112
Professional development	2,502	2,555
	166,806	102,721
Committee expenditures		
Consulting fees/per diem	27,817	23,516
Travel, meals and accommodation	9,311	9,230
Sundry	140	35
	37,268	32,781
Facility assessments		
Recovery of assessment costs	-	(1,275)
Consulting fees	(3,536)	1,088
Travel, meals and accommodations	5,978	-
Sundry	-	27
	2,442	(160)
Total expenditures	243,817	188,031
Net expense for the year	226,849	181,345

College of Physicians & Surgeons of Alberta

Schedule of Electrocardiogram (ECG)

(Unaudited)

For the year ended December 31, 2018

Schedule V

	2018 $	2017 $
Revenue		
Exam fees	(10,000)	(20,000)
Expenditures		
General program expenditures		
Consulting fees/per diem	773	1,939
Occupancy costs	1,000	1,000
Office expenses	504	748
Operating costs	1,300	1,200
Travel, meals and accommodations	-	795
	3,577	5,682
Staff costs		
Salaries and benefits	16,819	11,730
Professional development	708	616
	17,527	12,346
Total general program expenditures	21,104	18,028
Net expense (revenue) for the year	11,104	(1,972)

College of Physicians & Surgeons of Alberta

Schedule W

Schedule of Radiation Equipment

(Unaudited)

For the year ended December 31, 2018

	2018 $	2017 $
Revenue		
Registration fees	(209,346)	(198,880)
Surplus revenue recognized	41,026	18,119
	(168,320)	(180,761)
Expenditures		
General program expenditures		
Audit	2,000	-
Administration cost	8,009	8,608
Occupancy costs	6,000	7,600
Office expenses	5,615	4,694
Operating costs	15,600	19,600
	37,224	40,502
Staff costs		
Salaries and benefits	129,096	137,843
Professional development	2,000	2,416
	131,096	140,259
Total expenditures	168,320	180,761
Net expense for the year	-	-

College of Physicians & Surgeons of Alberta

Schedule of Development Costs

(Unaudited)

For the year ended December 31, 2018

Schedule X

	2018 $	2017 $
Registration		
Summative assessments		
Consulting fees	4,896	-
Travel, meals and accommodation	1,478	-
	6,374	-
Prescribing and analytics		
Analytics portal		
Consulting fees	246,750	299,250
Case management application		
Consulting fees	-	252,000
Physician factors stratification project		
Consulting fees	90,562	99,750
Physician practice		
Factor-based IPR pilot		
Consulting fees	76,967	-
Travel, meals and accommodation	2,428	-
Sundry	5,113	-
	84,508	-
Group practice review pilot development team		
Per diem	47,411	12,900
Travel, meals and accommodation	10,838	3,178
Sundry	634	74
	58,883	16,152
Group practice review pilot development project		
Travel, meals and accommodation	1,260	4,492
Sundry	1,434	-
	2,694	4,492
Clinic pre-open assessment pilot		
Consulting fees	6,145	-
Travel, meals and accommodation	2,158	-
Sundry	619	-
	8,922	-
Information technology		
DOC development costs		
Staffing costs		
Salaries and benefits	185,423	70,788
Office expenses	46	-
	185,469	70,788
Total development costs	684,162	742,432

Pension Fund for Employees of College of Physicians & Surgeons of Alberta

Financial Statements
December 31, 2018

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Independent auditor's report

To the Sponsor of Pension Fund for Employees of College of Physicians & Surgeons of Alberta

Our opinion

In our opinion, the accompanying financial statements present fairly, in all material respects, the net assets available for benefits of Pension Fund for Employees of College of Physicians & Surgeons of Alberta (the Fund) as at December 31, 2018 and the changes in its net assets available for benefits for the year then ended in accordance with the basis of accounting described in note 2 to the financial statements.

What we have audited

The Fund's financial statements comprise:

- the statement of net assets available for benefits as at December 31, 2018;
- the statement of changes in net assets available for benefits for the year then ended; and
- the notes to the financial statements, which include a summary of significant accounting policies.

Basis for opinion

We conducted our audit in accordance with Canadian generally accepted auditing standards. Our responsibilities under those standards are further described in the *Auditor's responsibilities for the audit of the financial statements* section of our report.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Independence

We are independent of the Fund in accordance with the ethical requirements that are relevant to our audit of the financial statements in Canada. We have fulfilled our other ethical responsibilities in accordance with these requirements.

Emphasis of matter - basis of accounting and restriction on use

We draw attention to note 2 to the financial statements, which describes the basis of accounting. The financial statements are prepared to assist the Sponsor of the Fund to meet the filing requirements of the Alberta Superintendent of Pensions (the Pension Regulator). As a result, the financial statements may not be suitable for another purpose. Our report is intended solely for the Sponsor of the Fund and the Pension Regulator, in accordance with the terms of our engagement, and should not be used by parties other than the Sponsor of the Fund or the Pension Regulator. Our opinion is not modified in respect of this matter.

PricewaterhouseCoopers LLP
Stantec Tower, 10220 103 Avenue NW, Suite 2200, Edmonton, Alberta, Canada T5J 0K4
T: +1 780 441 6700, F: +1 780 441 6776

Responsibilities of management and those charged with governance for the financial statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with the basis of accounting described in note 2 to the financial statements, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Fund's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Fund's ability to continue as a going concern. If we

pwc

conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Fund to cease to continue as a going concern.

- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

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

PricewaterhouseCoopers LLP

Chartered Professional Accountants

Edmonton, Alberta
April 23, 2019

Pension Fund for Employees of College of Physicians & Surgeons of Alberta

Statement of Net Assets Available for Benefits

As at December 31, 2018

	2018 $	2017 $
Assets		
Investments (note 3)	34,549,858	33,762,740
Liabilities		
Accrued liabilities	54,127	17,325
Net Assets Available for Benefits	34,495,731	33,745,415
	34,549,858	33,762,740

Approved by the Finance and Audit Committee Chair

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

Pension Fund for Employees of College of Physicians & Surgeons of Alberta

Statement of Changes in Net Assets Available for Benefits

For the year ended December 31, 2018

	2018 $	2017 $
Increases in net assets available for benefits		
Contributions		
Employer	1,926,629	1,840,081
Employer special	-	605,052
Employee	692,808	618,588
	2,619,437	3,063,721
Investment income		
Dividend distributions	2,452,047	2,730,579
Net realized loss on disposal and settlement of investment assets and liabilities	(54,456)	(16,537)
Net change in unrealized loss on investment assets and liabilities	(3,284,582)	(183,295)
Net change in the fair values of investment assets and liabilities	(3,339,038)	(199,832)
	1,732,446	5,594,468
Decreases in net assets available for benefits		
Retirement benefit payments	(701,997)	(574,535)
Fees and expenses (note 6)	(198,300)	(178,074)
Termination payments	(81,833)	(116,154)
	(982,130)	(868,763)
Increase in net assets available for benefits during the year	750,316	4,725,705
Net assets available for benefits – Beginning of year	33,745,415	29,019,710
Net assets available for benefits – End of year	34,495,731	33,745,415

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

1 Description of the Fund

Pension Fund for Employees of College of Physicians & Surgeons of Alberta (the Fund) provides for retirement benefits for the employees of the College of Physicians & Surgeons of Alberta (the Employer or Sponsor). The Fund is a contributory, defined benefit plan registered with the Canada Revenue Agency (registration #546473) and the Alberta Superintendent of Pensions (registration #41726).

The Fund is directed by the Sponsor with actuarial services provided by Mercer (Canada) Ltd. (Mercer), where Sun Life of Canada (Sun Life) serves as the Trustee, Custodian, transfer agent, investment manager and record keeper of the Fund.

Actuarial valuation

The most recent actuarial valuation was performed by Mercer for the effective date of December 31, 2017, updated from the December 31, 2015 actuarial valuation. The Employment Pension Plans Act (EPPA) of the Province of Alberta (the Act) requires that such valuations be performed at no greater than three-year intervals, with the next valuation required by the effective date of December 31, 2020. Significant assumptions used in the existing valuation include the rate of inflation of 2.0% (2015 – 2.0%) and the discount rate of 4.7% (2015 – 4.7%).

Funding policy

The Employer contributes such amounts to the Fund as are required based on the advice of the Fund's actuary. The Employer's contributions may include special payments toward any unfunded liability and/or solvency deficiency. Under this pension financing arrangement, the Employer bears the investment risk. Eligible employees must become Members and contribute 5% of their monthly earnings to the Fund until they have completed 35 years of service with the Employer, at which point they stop making contributions.

Eligibility

Regular full-time employees become eligible to participate in the Fund on the first day of the month on or after the completion of three months of continuous service, or attaining age 21, if later. Participation in the Fund is mandatory for full-time employees. Part-time employees may voluntarily elect to join the Fund after two years of continuous service, provided they have earned at least 35% of the yearly maximum pensionable earnings in two consecutive calendar years.

Retirement benefits

The normal retirement date is the first day of the month immediately following the Member's 65th birthday. Members can elect early retirement between the ages of 55 and 65. Early retirement may result in a pension reduction.

On retirement, Members receive a monthly pension payment based on their number of years of service with the Employer and the average of their earnings over the best five calendar years in the last ten years of employment.

Termination benefits

A Member who terminates employment with the Employer will be entitled to a deferred pension benefit commencing on his or her normal retirement date. Deferred pension benefits are eligible for early commencement.

Death benefits

When a Member dies, his or her beneficiary will receive the balance of the commuted value of the pension benefits. If the beneficiary is a spouse, he or she may elect to receive the refund as a transfer to an RRSP or as a life annuity; otherwise, the pension benefits will be paid in a lump sum.

2 Summary of significant accounting policies

Basis of accounting

The Act, as clarified under EPPA Update 14-04 effective for year-ends on or after September 30, 2014, allows the preparation of financial statements in accordance with Canadian generally accepted accounting principles for pension plans, excluding recognition and disclosures of pension obligations. Accordingly, to comply with the Act, the Fund reports under Canadian accounting standards for pension plans, excluding recognition and disclosures relating to the Fund's pension obligations. These financial statements are prepared on a going concern basis and present the information of the Fund as a separate financial reporting entity independent of the Sponsor and Fund Members. The Fund applies Canadian accounting standards for private enterprises in Part II of the Chartered Professional Accountants of Canada (CPA Canada) Handbook – Accounting for its accounting policies not related to its investment portfolio.

These financial statements differ materially from financial statements prepared in accordance with Canadian accounting standards for pension plans and do not purport to show the adequacy of the Fund's assets to meet its pension obligations. They have been prepared to assist in meeting the requirements of the pension regulator.

Investment assets

Investments are stated at fair value in accordance with International Financial Reporting Standard 13, Fair Value Measurement. Purchases and sales of investments are recorded as of the trade date (the date on which the substantial risks and rewards have been transferred). Transactions that have not been settled are reflected in the statement of net assets available for benefits as amounts receivable or payable for unsettled trades.

The methods used to determine fair value for each category of investment assets and liabilities are explained in note 5.

Transaction costs

Transaction costs are not part of the fair value of investments and are expensed as incurred in the statement of changes in net assets available for benefits.

Income recognition

Dividend income is recognized based on the ex-dividend date. Net realized gain (loss) on investments sold during the year represents the difference between settlement proceeds and book value. Change in unrealized gain (loss) on investments represents the change in the difference between fair value and book value of investments as at the beginning and end of the year. All changes in realized and unrealized gains and losses on investments are recorded in the statement of changes in net assets available for benefits in the year in which they occur.

Investment manager fees

Investment managers of the CC&L Group Balanced Plus Segregated Fund charge management fees, which are netted against the net assets of the Fund, and are recorded in the statement of changes in net assets available for benefits in the fees and expenses of the Fund.

Administrative expenses

Administrative expenses incurred are paid directly by the Fund.

Income taxes

The Fund is a registered pension plan as defined under the Income Tax Act (Canada) and is not subject to income taxes.

Use of estimates

The preparation of financial statements requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of income and expenses during the reporting period. Actual results could differ from those estimates. The most significant estimates relate to the determination of fair value of financial instruments.

3 Investments

Assets for the Fund are invested in the CC&L Group Balanced Plus Segregated Fund by Sun Life as at December 31, 2018. The book value of the assets held as at December 31, 2018 was $39,765,276 (2017 – $35,693,576). The cumulative unrealized loss as at December 31, 2018 was $5,215,418 (2017 – loss of $1,930,836).

Investments as at December 31 are summarized based on percentage holding as follows:

	2018 %	2017 %
Pooled funds, mutual funds and segregated funds contracts		
Cash	1.8	2.2
Fixed income	32.6	26.7
Canadian equity	25.5	26.3
Global equity and other	40.1	44.8
	100.0	100.0

4 Financial risk management

The objective of the Fund is to achieve medium to long-term growth of its investment portfolio to provide the Fund with assets sufficient to meet Members' pension benefit payment obligations. The Fund's investment policy is set out in the Statement of Investment Policies and Procedures.

The Fund invests in pooled funds that are in turn invested in government and government guaranteed bonds, corporate bonds, debentures and equity securities. The investment managers of the funds must adhere to the investment policies governing these funds, which are monitored by the Sponsor. The Fund's investing activities expose it to a variety of direct and indirect financial risks: market risk, credit risk and liquidity risk.

The allocation of assets among the various types of investments and the performance of investments held by the Fund are monitored by the Fund's investment managers and are reviewed by the Sponsor as needed.

The Sponsor monitors compliance with the Fund's risk management policies and procedures and reviews the adequacy of the risk management framework in relation to the risks faced by the Fund.

Market risk

The Fund's investments are susceptible to market risk, which is defined as the risk the market value or future cash flows of a financial instrument will fluctuate because of changes in market prices. Market risk comprises three types of risk: currency risk, interest rate risk and other price risk.

Currency risk is the risk the fair value or future cash flows of a financial instrument will fluctuate because of changes in foreign exchange rates. Interest rate risk is the risk the fair value or future cash flows of a financial instrument will fluctuate because of changes in market interest rates. The Fund invests in the units of pooled funds, which in turn invest in a diversified portfolio of assets. While the underlying investments of the Fund are susceptible to both currency and interest rate risk, the risk to the Fund is indirect in nature. Given the Fund is not directly holding any investments denominated in a foreign currency or any interest sensitive securities, the Fund has no direct exposure to currency or interest rate risk.

Other price risk is the risk the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices (other than those arising from interest rate risk or currency risk), whether those changes are caused by factors specific to the individual financial instrument or its issuer, or factors affecting all similar financial instruments traded in the market. The investments of the Fund are directly exposed to other price risk. If the unit price of the pooled funds were to increase or decrease by 1%, with all other variables being held constant, the impact on the net assets available for benefits would be approximately $345,000 (2017 – $338,000).

As noted above, the Fund manages its market risk by investing in pooled funds and by monitoring the performance of the pooled funds and compliance of each investment manager with the set investment policies.

Credit risk

Credit risk is the risk one party to a financial instrument will cause a financial loss for the other party by failing to discharge an obligation. The Fund is indirectly susceptible to credit risk through its investments in pooled funds. The Fund views the risk in this area to be insignificant.

Liquidity risk

Liquidity risk is the risk the Fund may be unable to meet obligations in a timely manner. In addition to recurring expenses, the Fund is called on to meet regular pension benefit payments as well as lump sum transfers that may occur on retirement or termination of qualifying Members. The risk the Fund would be unable to meet such obligations is managed through the Fund's ongoing monitoring of the individual investment managers and in their ability to redeem units in the pooled funds in which the Fund has invested. All Fund liabilities, other than pension obligations, are due and payable within ninety days.

5 Fair value measurement

Pooled funds

Units of pooled funds are valued at the unit values supplied by the fund manager, which represent the underlying net assets at fair value, determined using closing market prices, divided by the number of units outstanding. This is the value at which units of the pooled funds can be redeemed or subscribed for by the Fund as at the reporting date. There have been no significant changes in the valuation methodology during the current year.

As set forth in the Appendix to CPA Canada Handbook – Accounting Section 4600, instruments that are measured at fair value use a hierarchy. The hierarchy prioritizes the inputs to fair value measurement, placing the highest priority on unadjusted quoted prices in active markets for identical assets or liabilities (Level 1) and the lowest priority to inputs not based on observable market data (Level 3).

The three levels of the fair value hierarchy are:

- Level 1 – unadjusted quoted prices in active markets for identical assets or liabilities;
- Level 2 – inputs that are observable for the assets or liabilities either directly or indirectly; and
- Level 3 – inputs for assets or liabilities that are not based on observable market data.

The pooled funds are classified as Level 2 in the hierarchy.

6 Fees and expenses

Fees and expenses are charged against the defined benefit component and consist of the following:

	2018 $	2017 $
Investment management fees	183,610	164,612
Administrative and servicing fees	14,690	13,462
	198,300	178,074

7 Management of capital

Management of the Fund defines capital as the net assets available for benefits. These financial statements, however, represent only the net assets available for benefits of the Fund; management of capital is done at the Fund level. As stated in note 2, these financial statements do not purport to provide information about the solvency of the Fund.

8 Related party transactions and balances

The Sponsor provides administration services to the Fund, which include the payment of the 2017 audit fees of $10,000 on behalf of the Fund. The fees for the 2018 audit of $10,000 will be paid by the Sponsor.

College of Physicians & Surgeons of Alberta

Governance Committee

Report to Council
College of Physicians & Surgeons of Alberta
30 May 2019

The Governance Committee met on 3 April 2019 and addressed the following issues:

1. Executive Elections

   The Committee discussed the information to include in the call for nominations of individuals for the Executive Committee positions. The nomination process and responsibilities of the Nominating Sub-Committee were also reviewed.

2. Council Evaluations

   The Committee discussed the next steps regarding implementing Council evaluations. It was determined that in order to develop an appropriate tool, Council would need to develop key performance indicators (KPIs) that would be used to measure Council's effectiveness. Consequently, some proposed KPIs will be developed and shared with the Committee in June for review by Council in September.

3. Review of Indemnification and Protection Policies

   The Committee reviewed the indemnification and protection policies and was satisfied that the College has appropriate coverage. In future, it was decided that the review of the indemnification and protection policies should be part of the Finance and Audit Committee's (FAC) mandate. As such, the Terms of Reference for the Governance Committee and FAC will be updated to reflect this change. The Committee also recommended that new members be provided an overview of the indemnification and protection policies as part of their orientation.

4. Confirm Committee Mandates

   Each year the Committee reviews written reports from all of Council's standing committees to confirm committees are fulfilling their mandates. To ensure Council is aware of the work being done in the Committees, the Standing Committee Reports have been shared with Council as part of the in-camera agenda. The Committee was advised that, while the Medical Informatics Committee has not met for several months, a decision on the future of that committee will be deferred until September when more information will be available regarding the College's Digital Health Strategy. The Legislation Committee is another committee that is underutilized. Based on discussions between Dr. Alakija and Dr. Campbell, the current chair of the Legislation Committee, responsibility for reviewing and updating the Bylaws will be transitioned to the Legislation Committee.

In discussing the committee mandates, the Committee asked administration to review Council member access to committee minutes in SharePoint. At this time, all Council members have access to the Finance and Audit Committee site, which would include minutes from the FAC meetings. Currently, the Competence Committee site and the Medical Facility Accreditation Committee have restricted access. Redacted minutes from the Competence Committee have been provided to Council previously, though none have been shared since August of 2018. Further investigation will need to be done regarding the minutes of the Medical Informatics Committee. The Governance Committee will discuss this matter further at the meeting in June.

5. Committee Member Appointments

   The Committee is recommending that Council approve appointments to the Medical Facility Accreditation Committee as well as two reappointments to the Complaint Review Committee/Hearing Tribunal list. See separate cover page.

6. Council Retreat – planning for 2020

   As past president, Ms. Kate Wood is charged with developing the yearly Council Retreat. She will be presenting information regarding potential retreat topics as part of Council's agenda.

7. Physician Member Elections

   The Committee discussed the upcoming physician member elections and requested that the topic be brought forward for further discussion/clarification at Council. This topic will be discussed in-camera.

8. Watson Report – Action Items

   The Committee noted that there has not been any significant follow up to the recommendations from the Watson Report on the culture of Council. As such, a recommendation will be discussed in-camera regarding a proposal that the Governance Committee be charged with implementing the recommendations.

College of Physicians & Surgeons of Alberta

Submission to:	**Council**

Meeting Date:	Submitted by:		
30 May 2019	Dr. Pauline Alakija		
Agenda Item Title:	Governance Committee Report		
Action Requested:	☒ The following items require approval by Council See below for details of the recommendation.	☐ The following item(s) are of particular interest to Choose an item. Feedback is sought on this matter.	☐ The attached is for information only. No action is required.
AGENDA ITEM DETAILS			
Recommendation (if applicable) :	***The Governance Committee is recommending that Council approve the following item as discussed at the 3 April 2019 Governance Committee Meeting:*** Policy to Measure Council Effectiveness and Self-Evaluation		
Background:	As a standing committee of Council, the Governance Committee has reviewed and discussed the matters above at its meeting. Based on this review, the Committee is bringing forward these items for approval by Council as part of Council's consent agenda. As such, it is expected that the matters are non-controversial and that sufficient information is provided to Council in the dossier materials to enable the approvals to be made without additional discussion. However, Council is welcome to ask questions or request additional discussion of these matters by contacting the Chair, Dr. John Bradley, prior to the Council meeting. A draft policy regarding Council evaluations was previously shared with Council. The policy has been revised so that there is clarification regarding the role of the Governance Committee and the Executive Committee with respect to the evaluation process.		
Next Steps:	The Governance Committee will develop the tools to be used for evaluation for implementation by the Executive Committee.		
List of Attachments:			
1. Policy to Measure Council Effectiveness and Self-Evaluation			

Council Policy

Policy to Measure Council Effectiveness and Self-Evaluation

1. Purpose

The purpose of evaluation is to ensure continuous improvement of the Council and its committees, and to provide formative feedback to individual Councillors to assist in their own development.

2. Scope

Each Councillor will participate in an evaluation of the performance of Council as a whole and of his/her own performance as a Council or committee member.

3. Background

For the Council of a regulatory College to fully achieve its legislative mandate to act in the public interest, it must govern itself with integrity, and also hold itself accountable for doing so. All Health Regulatory Colleges in Canada must meet legislative and regulatory obligations which place high expectations on Council members, both elected and appointed, to embrace and abide by good governance principles while also serving and protecting the public interest.

Regular processes to evaluate Council's effectiveness in meeting good governance principles, accompanied by a reporting of the assessment results, are identified 'best practices' across Canada.

Public reporting of activities undertaken to evaluate effectiveness and performance is further identified as a regulatory best practice.

4. Policy

Measuring Council and Council member effectiveness will be accomplished through three evaluations:

a) Council Meeting Evaluation – following each Council meeting, Councillors will be asked to respond to a short survey developed by the Executive Committee to evaluate the overall effectiveness of that meeting. The data gathered will be reviewed and acted upon by the Executive Committee.

b) Council Member Self Evaluation – on an annual basis, Council members will be asked to complete a self-evaluation based on a list of desired skills and behavioural competencies. The Governance Committee, will develop the evaluation tool for approval by Council. The Executive Committee will review the outcomes of the evaluation tool to determine how best to meet the learning needs of individual Council members while ensuring Council is able to fulfil its mandates based on the skills and competencies of its members. The data will also be used to address any areas impacting Council performance.

c) Evaluation of Council Effectiveness – on an annual basis, all Council members will be asked to complete a questionnaire to evaluate the functioning of Council as a whole. The questionnaire will be developed by the Governance Committee and approved by Council. This assessment will consider how well Council has fulfilled its roles and responsibilities as well as the effectiveness of the processes and structures of

Council. The Executive Committee will use this information to propose changes to improve Council's effectiveness.

5. Responsibility

Governance Committee is responsible to develop the process for evaluations and the Executive Committee will implement the evaluations and take action based on the data gathered through this process.

6. Monitoring, Evaluation, and Review

This policy will be reviewed every three years.

Approved Date:

College of Physicians & Surgeons of Alberta

Submission to:	**Council**

Meeting Date:	Submitted by:		
May 30, 2019	Dr. Susan Ulan, Assistant Registrar Registration		
Agenda Item Title:	Consent Agenda – Unique Identifier Information		
Action Requested:	☐ The following items require approval by Choose an item. See below for details of the recommendation.	☐ The following item(s) are of particular interest to Choose an item. Feedback is sought on this matter.	☒ The attached is for information only. No action is required.
AGENDA ITEM DETAILS			
Recommendation (if applicable) :	***It is recommended that the unique identifier published in the College's register include the member's name and registration number (Bylaws section 47 Publication 2(a)(i) approved by Council March 1, 2019).***		
Background:	• Bill 21: *An Act to Protect Patients* received Royal Assent on November 19, 2018. The Act requires each College to pass Bylaws respecting additional information to be published on each College's website as per S. 26 of the Bill. • Council passed a Motion (C-10-19) on March 1, 2019 amending the Bylaws S. 47 (http://www.cpsa.ca/wp-content/uploads/2017/12/CPSA-Bylaws.pdf?highlight=bylaws) Publication to include information on the College's register, including: The member's name and a unique identifier (2(a)(i)). • Council discussed the importance of correctly identifying the physician on the website, particularly when disciplinary matters are published. A discussion ensued if there was potential for risk of fraud if the unique identifier was the registration number and administration committed to reviewing if another unique identifier such as the MINC number could be used instead. • The MINC was created for a specific purpose and as a prime user, the CPSA has agreed to use the MINC for a limited purpose only. Most physicians are unaware of their MINC number and it could create confusion with their registration number which the majority of physicians are aware of. If the CPSA regulates physician assistants at some point in the future, they will not be able to be identified with a MINC. • 60% of the provincial MRAs publish the registration number on their website. Communication with colleagues from CPSO and CPSBC reported that they have not received any reports of inappropriate or fraudulent use of the published registration numbers.		

College of Physicians & Surgeons of Alberta

	• Creation of another unique identifier separate from the member's registration number has the potential to create confusion for members and external stakeholders such as pharmacists with their registration numbers.
Next Steps:	The CPSA will publish member registration numbers as the unique identifier and will monitor for any concerns regarding the inappropriate use of member registration numbers.

PRESIDENT'S REPORT

DATE: **MAY 30, 2019**
TO: **CPSA COUNCIL**
FROM: **DR. JOHN SJ BRADLEY**

Since our last Council meeting, I have had the opportunity of meeting with various stakeholders and receiving feedback. I would also like to comment on our priorities when it comes to developing future agendas.

1. ENGAGEMENT

MESSENGER ARTICLE- UNINTENDED CONSEQUENCES

I had the opportunity to post an article in a recent edition of the Messenger for which I received a great deal of feedback, both formal and informal. The purpose of the article was to acknowledge the reasoning/ necessity for investigating CPSA complaints and to offer support for physicians who are currently involved in the process. Most of the feedback from physicians was positive, albeit with calls to try and streamline/ expedite the process. However, I did receive a letter from a member of the public whose interpretation was the opposite, that the article reinforced the notion that physicians are never "punished" and that the process simply is designed to "protect our own". This serves as a reminder that with any communication from the CPSA, we must consider the potential interpretation of both the public and our membership.

WOMEN LEADERS IN MEDICINE

After a short presentation, I participated in an informative session with a group of female medical leaders in which I tried to simply listen to concerns and suggestions with the goal of increasing diversity on Council and committees.

I. Breastfeeding. Interestingly, the main topic of discussion had to do with barriers regarding breastfeeding mothers. This of course is a barrier restricted only to our female colleagues and one which we can quickly address. With this in mind, I am pleased to note the implementation of a draft policy to accommodate our female colleagues which will hopefully minimize at least one barrier for their participation.

II. Care of Children and the Elderly. Although we think of child care being a barrier to participation, it was also pointed out that the care of elderly relatives is also disproportionately shouldered by women in society. However, in this case, there was also debate in terms of how much the CPSA should be expected to accommodate. Some argued that there should be some extra financial/ logistical assistance, while others countered that there was already a stipend. Given that most meetings are scheduled at least 12 months in advance, there were also arguments that the general

membership should not be responsible. Lastly as circumstances vary individually, men would also qualify for these potential initiatives.

III. Candidates for Elections. As has been repeated before, it was noted that women need to be asked numerous times to run for Council and they need mentors (who can be either men or women). Following this evening, I was given the names of some excellent potential candidates. I was able to proactively contact each of them and all are interested in participating. However, uniformly, all said this year likely would not be feasible given other commitments. I would encourage all of us to continue actively recruiting colleagues of all demographics to consider running for Council.

PARA EXECUTIVE

I was able to discuss issues regarding Council elections with the PARA executive. As has previously been noted by Dr. C. Chan, there was definite concern regarding potential disenfranchisement if resident were restricted in their ability to vote and/ or run for Council. As per our previous Council discussions, I indicated the status quo would be maintained with respect to election eligibility.

CLINICAL ASSISTANTS

I was able to engage Dr. A.Labib, the Past-President/ RF Delegate for the AMA Section of Clinical Assistants. Many points of interest were raised which can be discussed in the future as more information is obtained.

2. OPTIMIZATION

AGENDA

It is becoming apparent that the pressure on our agenda for each Council meeting is becoming more intense. There are certain responsibilities which must be addressed and we are having more requests to discuss various interesting/ relevant topics. As a Council we will have to decide which topics will take priority and are there other means to more efficiently comply with our duties?

SUMMARY: FEDERATION OF STATE MEDICAL BOARDS (FSMB) 2019 ANNUAL MEETING

The FSMB held their annual meeting and it was interesting to note some of the similarities and differences faced by our American counterparts with respect to relevant issues facing the CPSA.

1. Competency

Discussions identified a desire to transform from simply "catching" bad behaviours to utilizing regulatory bodies to promote excellence and quality. Public safety is the most important consideration in all decisions, but transparency, accountability, consistency and fairness also need to be considered. These issues mirror many of the discussions we have had.

2. Sexual Boundary Violations

Given our recent legislative changes, we have moved past many of the issues and discussions which individual states are contemplating. However, it was interesting to note that >90% of physicians who commit these violations previously had exhibited more visible but "milder" forms of sexual impropriety.

3. Composition of Boards

Some states such as Michigan, seem to place much more value on the role of public members, while others have minimal input. Most of the discussions around board composition involves the relative proportion of medical doctors, osteopathic doctors, podiatrists and chiropractors.

4. Role of Medical Boards

It was emphasized time and time again that Boards are to provide guidance in terms of the desired outcomes of regulatory bodies and oversight. It is NOT their role to interfere with operations.

5. Sunset Clause

Interestingly, in most (? all) states each regulatory body operates under a sunset clause whereby on a regular basis (for example every 12 years) state medical boards must convince state governments that they have effectively carried out their legislated responsibilities and have laid out their future plans for innovation. Failure to successfully accomplish this may result in the state assuming control/ responsibility for their functions. There is also a movement in many states to further deregulation. An argument is being made that education alone is all that is required for the ability to provide services (ie. Practitioners would not necessarily have to be registered members).

6. Opioid prescribing

The Ohio experience was in particular an interesting case study. Guidelines surrounding the prescribing of opioids in the acute setting appeared to have the greatest impact with respect to changing behaviours. As well, the simple act of including an ICD (International Classification of Diseases) code with prescriptions allowed for some interesting data and trends to be identified.

7. Late Career Physicians

There are competing interests in terms of the degree of confidentiality and physician health vs. public safety. It would appear that our Physician Health Monitoring Program is more robust and established compared to some in the USA.

For those who are interested in specifics, a more detailed summary follows. As well, here is the link to the meeting which contains some of the presentations.

https://www.fsmb.org/education/2019-fsmb-annual-meeting-summary-highlights/

Please feel free to contact me if you have any questions or wish for clarification.

John SJ Bradley MD FRCPC

DETAILED SUMMARY

1. COMPETENCY

From a patient perspective, they are looking for the "AAAs"

- Accessibility
- Affability
- Acknowledgement

With respect to complaints:

1. Most patients recognize physicians will never be 100% correct
2. Complaints are rarely due to an "honest mistake"
3. Communication issues are most common basis of complaints

Regulators Must Consider:

- Safety of the public
- Transparency
- Accountability to multiple stakeholders
- Consistency
- Fairness – administrative law

Aspiration for medical regulators:

- **Transition from competency to excellence and quality**
- Competence assessment must support and reinforce good behaviours, not simply "catch" bad behaviours

2. SEXUAL BOUNDARY VIOLATIONS

- Lack of data
- Likely only 5-10% of cases are reported

In a study of 101 cases involving identified physicians

- 96% involved repeat offenders
- >90% were found to previously had exhibited more visible but "milder" behaviours (eg. Inappropriate comments, touching)

Difficult to prevent the first occurrence, but regulators must aspire to prevent further recurrences.

Regulators must clearly identify reporting mechanisms to the public

Training regarding sexual assault
- Board members
- Investigators
- Prosecutors

3. COMPOSITION OF BOARDS

Wide discrepancy in regards to the number and "influence" of public members
- Some boards still have none
- Michigan:
    - Public members must chair the investigation and Discipline committees
    - 2 public members together can veto any board decisions

At least in the USA, it would appear the greater debate is in regards to the proportion of Medical Doctors, Osteopathic Doctors, Chiropractors and Podiatrists

Many of the boards are entirely appointed by state governors/ legislators

4. ROLE OF MEDICAL BOARDS

Governance vs. Operations

Governance
- Boards are responsible for oversight
- Outcome focused
    - "What is it as an organization that we want to do?"

Operations
- The CEO's responsibility to achieve the outcomes set forth by the Board
- Boards should NOT function at this level

Function of the Board

1. Restrict activities to those outlined in legislation
2. Clearly identify desired OUTCOMES
3. Monitor progress without meddling
4. Challenge the CEO but avoid specifying specific operational aspects

Evaluations

- Self
- Post-meetings
    - Did we discuss relevant issues?
    - Was our time wisely spent?

5. SUNSET CLAUSE

Regulatory bodies are abolished unless their mandates are renewed by legislatures
Typically reviews occur every 12 years

- Regulatory bodies are "forced" to critically appraise both their past performance and future plans for innovation
- Common finding in reviews
    - Boards overstep their roles and become too involved in operations

Movement for DEREGULATION

- Suggestion that simply having academic qualifications is enough
- Allow other practitioners to provide similar services.

6. OPIOID PRESCRIBING

Experiences in Ohio and Tennessee were discussed, Ohio in particular had some relevant lessons which may be applicable to the CPSA

- Pain clinics must be owned and operated by physicians
- Chronic/ subacute guidelines
    - No change in prescribing
- Acute guidelines
    - Duration ≤ 7 days
    - Average prescription 30 OME
    - ICD Code MUST accompany every prescription
    - Allows for detailed analysis of prescriptions for each diagnosis
        - Data can be obtained for the average dose and duration of therapy for various indications
        - For instance, there is a 1 day difference in the duration of therapy of a fractured wrist depending if it is the right or left

7. LATE CAREER PHYSICIANS

Competing interest between the "Ill Physician" and the Licensing Body

From the ill physician's perspective

- Greatest concern is the affect on their ability to practice
- Programs requires
    - Confidentiality
    - Effective Rx

Licensing Body's Perspective

- Public safety trumps all other considerations
- Confidentiality cannot be unlimited
- Concerned about quality of the workforce in total

Physician Health Programs

To function optimally the following must be satisfied

1. Effective treatment for physicians
2. Confidentiality
3. Safeguards for public safety

Aging workforce and population

- Likely there will be a shortage of physicians
- Resultant decrease in patient access will disproportionately affect disadvantaged populations

MEMORANDUM

TO: CPSA COUNCIL
RE: RELEVANT TOPICS TO CPSA AT SPRING 2019 AMA RF

Registrar Presentation

1. PROactive Initiative
   - History
   - Components

2. Bill C-21
   - Clarified sanctions and impact on registration for members convicted of sexual assault and misconduct
   - Clarified guidelines around consensual sexual relationships after a regulated member-patient relationship ends
   - Noted mandatory education around relevant issues
     - Currently being developed by the UofC

CMA Presentation

- Indicated the CMA is advocating for a national license
- CPSA delegate noted:
  - From a legislative perspective, this was likely impossible
  - Reviewed potential for a portability license and streamlined application process for physicians regulated in other Canadian jurisdications.

Relevant Motion

- Proposal that nominees for AMA positions must attach to their nominations any publicly available CPSA practice restrictions/ disciplinary history
  - Referred to the Board of Directors
  - Must balance disclosure of relevant information vs. revealing potential health issues
  - AMA may choose to review individual profiles on cpsa.ca or conceivably contact the CPSA for more information (Certificates of Professional Conduct may not be appropriate as they may reveal private health issues)

College of Physicians & Surgeons of Alberta

To: College Council

From: Scott McLeod

Date: May 30, 2019

Subject: Registrar Report to Council

Introduction

The past few months have been a period of significant change for the CPSA and Alberta overall. With a new government the shift in provincial leadership will obviously have an impact on the CPSA. It's still too early to say what that impact will be on medical regulation; however, if our pre-election assessment is correct we can expect the UCP government to have very high expectations for medical regulation in Alberta. As the official opposition, the UCP was committed to providing the CPSA with the legislative authorities to protect patients and with that comes the expectation that those authorities will be used appropriately.

The past two months have also seen a change in the CPSA senior leadership team and this has allowed for a complete review of the organizational structure. This review has looked at ways to better align similar functions within the organization to allow more synergy of work. It has also given the College an opportunity to identify functions that may no longer be required. This provides the possibility of reallocating staff to other functions that need attention moving forward. We have also identified some areas that need more investment to properly address the work.

During these changes there has also been a great deal of focus on the most important part of the CPSA; the staff and the work they do each day. We have been putting a great deal of effort into developing the Human Resource Philosophy, the Total Compensation Philosophy, the Brand Strategy, the Digital Health Strategy and the five year Strategic Action Plan. All of this, along with the redesign of the organizational structure, will set the CPSA up to execute its mission to protect the public.

1. Key Performance Indicators.

As per my last report, I promised to keep you up to date on some work we are aiming to complete this year. The following is a brief update on that work. I have also attached a dashboard to report on some of the other targets I identified in February.

a. Professional Conduct

Our Professional Conduct department has been working very hard to get caught up on the backlog of cases and reviewing the processes and procedures that currently exist in the department. Both of these are intended to improve the short and long term functioning of the department. This work is moving along as expected and the backlog is already showing a reduction due to the hard work of the staff. As

predicted last year, there should be no expectation that the short term increase in staff will be able to reduce the backlog within one year; therefore there will be a requirement to continue this work into 2020.

We currently believe that we will meet the 2019 key performance indicator of reducing the backlog by 30% by Dec 31st 2019.

b. The Strategic Action Plan

I'm happy to report that we are well on our way to completing this work We are now translating this work into the business planning process to develop both a one year and a three year extended business plan.

c. The CPSA "Brand"

The Communications team have been working incredibly hard to move the Brand Strategy forward. As you will see there is an update on this project later in this meeting.

d. Standards of Practice

The Chief of Staff has already incorporated some significant changes to our SOP process as a result of the recommendations that came out of the external review. The "pre-consultation" process is one of those very specific details that is now rolling out. We are on track to meet the expectations for this year.

2. Bill 21

Bill 21 came into effect April 1st 2019 and the CPSA was able to meet all of its legislative requirements by that deadline. Our SOP, which was developed in very short order and approved by Council just prior to the Christmas break, was well received by government with very few recommended changes. We have been able to establish a mechanism for victims who come forward to the College to receive the psychologic support they require. Training programs have been developed for staff, Council, Committee members, Tribunals and Alberta doctors.

This truly was a herculean effort by many people. This meant that other priority work had to be put aside for the time being. That work is now moving forward.

3. Federation of Medical Regulatory Authorities of Canada (FMRAC) Update

As I'm sure many of you are aware, the Canadian Medical Association (CMA) has been advocating for a national medical license in Canada. I have attached a Background Paper from the Federation of Medical Regulatory Authorities of Canada (FMRAC) for Council's information. It outlines some of the challenges related to a national license.

Despite the fact that a national license may be a stretch goal, FMRAC believes it can meet the intent of the national license and address the concerns raised by the CMA. For that reason, FMRAC has established a working group on expedited licensure. I sit on this working group and I'm confident we will be able to solve at least some of the concerns. Three of the concerns are related to the following:

a. Expedited Licensure – One concern raised was the amount of time and money required to get a license from a Medical Regulatory Authority (MRA) in Canada when you already hold a license in good standing with another Canadian MRA. This is being address by developing an agreement between MRAs that allows for a much quicker process. Essentially, it would involve a short questionnaire, a Certificate of Professional Conduct from the home MRA and a reduced application fee. The physician would still pay for the full license to practice, but the process will be simplified.

   The intent was to have this agreement signed in June of this year but due to scheduling issues for FMRAC, we did not have it prepared in time for this Council to approve the new process. I suspect we will see this come to Council's fall meeting for discussion.

b. License Portability - The other concern was how difficult it was for physicians to do locums in support of underserviced populations in Canada. The CMA believed that it was both cumbersome and expensive for physicians to hold multiple licenses in different jurisdictions just so they could do locums.

   To address this concern, another agreement is being developed that would allow for a physician to be prescreened by their home MRA and other provincial and territorial MRAs would agree to grant them a temporary permit to practice under the portability agreement. The physician would need to meet certain criteria to hold such a portability license, but it would be faster and less cost prohibitive for physicians wanting to do locums in other jurisdictions. There are more complicated issues related to this concept and therefore it will be slower to develop, but we are hoping to have this in place by spring 2020.

c. Telemedicine is an expanding area of concern for medical regulation in Canada and abroad. As is the practice of medicine in the digital environment. We recognize that telemedicine is a reality today and into the future. It globalizes health care and creates some significant concerns for MRAs. There is also great variability in how each MRA addresses telemedicine. Some require full licensure, some require a partial license of some sort and some don't require a license from that jurisdiction.

   Dr Heidi Otter from the College of Physicians and Surgeons of BC (CPSBC) has drafted an MOU hoping that signatories to it would allow someone holding a license in good standing with an MRA in Canada to provide care via telemedicine into another province or territory. Although this is a good idea in concept there are several legal issues that must be taken into consideration including the fact that for most MRAs, it is illegal to provide care to a resident of that province

without a license to practice in that province or territory. An MOU is not sufficient to allow a practice that is fundamentally against the law.

A Task Force on Virtual Health Care, co-chaired by the Royal College of Physicians and Surgeons of Canada, The College of Family Physicians of Canada and the CMA, has also been established. They will look at the issue of telemedicine and other challenges related to providing care in the digital environment. There is FMRAC representation on this task force and I'm confident we will have sufficient input into the discussion and outcome of this task force.

4. Renovation

Since we're holding this Council meeting in the newly renovated Council Chambers, you know that our renovations are in the very final stages. It is with great pleasure that I report the renovations have come in on budget even though we were delayed by 3 weeks in our timeline. There is no way this task could have been completed in such a way if it wasn't for the incredible work of several people at the CPSA. The team organizing this work consisted of Tracy Simons, Jim Kiddo, Karla Schultz and Anna Cartasano.

There are many others who have put in many hours on this task and they need to be recognized as well. Please help me thank the following: Desiree Meronyk, Engels Aguirre, Evan Tickner, Glenda Awid, Jessica Trepanier, Jordan Tee, Kasia Bradford, Kendra Benson, Lareina Isabelle, Luis Barrantes, Marek Garbowski, Mark Patterson, Michelle Thiel, Monika Valentovic, Sam Ugbechie, Tara Court, Ted Gabara and Trent Farewell.

5. Letters of Commendation

As I have reported previously, we do get letters and emails from patients wanting to commend the work of their physicians. Since January we have had 6 patients commending 14 physicians. I have sent personal letters to each of those patients and all 14 physicians thanking them on behalf of the CPSA leadership and Council for being excellent representatives of the profession of medicine.

6. External engagement

One of the key roles for the Registrar is to maintain external collaborations with partner organizations and other stakeholders. The following is a brief list of some of the work I have been engaged in over the past 3 months. These do not include CPSA internal meetings and committees:

a. Deputy Minister of Health
    i. Monthly meetings
    ii. Health Information Executive Committee
    iii. Physician Resource Planning Advisory Committee
b. AHS
    i. Quarterly meetings with the CEO
    ii. Quarterly CPSA/ZMD meetings

c. FMRAC
    i. Board meeting
    ii. 3x Program Planning Committee – Committee member
    iii. Working Group on Streamlined Registration (formerly Pan-Canadian Registration)
    iv. Registration Working Group (Chair)
    v. Registration Working Group Subcommittee on Different Approaches to the Model Standards (Chair)
    vi. Working group on Artificial Intelligence (Chair)
    vii. Western Registrars meeting
    viii. Committee on the Accreditation of Canadian Medical Schools
    ix. CPSA/CPSBC peer evaluation of registration using FIRMS
d. U of A
    i. Faculty of Medicine and Dentistry Dean Selection Committee
    ii. Faculty Council
e. Health Quality Council of Alberta
    i. meeting with CEO
    ii. Perception Audit Interview
f. Alberta Medical Association (AMA)
    i. Rep Forum
    ii. Presidents and CEOs meeting
    iii. Joint staff executives and Council executives
g. Canadian Medical Association (CMA)
    i. Meeting with CEO
    ii. Gender Equity and Diversity in Canada's Medical Profession presentation.
h. Professional Association of Resident Physicians of Alberta
    i. Meeting with the Executive Director
    ii. Keynote speaker for leadership workshop
i. Well Doc Alberta
j. Grand Rounds Presentation Calgary Department of Psychiatry
k. Concordia University - Centre for Applied Artificial Intelligence
l. Canadian Medical Protective Association - discussion on areas of mutual interests
m. Choosing Wisely Alberta
n. Institute of Health Economics Physician's as Stewards of Resources meeting
o. Edmonton Zone Medical Staff Association
p. College and Association of Registered Nurses of Alberta (CARNA) collaboration meetings
q. Alberta College of Pharmacy (ACP) collaboration meetings
r. CEO Blue Cross – Discussions related to quality improvement initiatives within Alberta
s. Royal College Professional Practice Summit – Alignment of continuous quality improvement
t. Federation of State Medical Boards meeting
u. Saskatchewan Medical Association - Key Note speaker on Physician Leadership
v. Rural Health Professions Action Plan - meetings with CEO
w. Health Improvement Alliance Europe webinar

The list above is not intended to provide Council with any details related to each of these meetings, committees, conference, presentation etc. It is only intended to provide everyone with a general sense of the types of interactions the Registrar has outside of the CPSA. There were also several meetings with physicians and patients/complainants about concerns such as: our complaint process; the senior surgeon policies within AHS; access to medical services; and concerns around decisions made by the College to restrict or suspend physicians from practice. If anyone would like more details on any of these items, please feel free to ask.

Conclusion

There have been some significant changes both within the CPSA and the Alberta government, but I'm happy to report that the CPSA is still meeting its legislative mandate of protecting the public and continuing to strive for improvement. As a result of the extensive external interactions the CPSA is fortunate to participate in and the results of the Council retreat planning, I am pleased to say that the CPSA is not only in alignment within its own governance framework in the work that we're doing, but we are in line with, or leading, other advancements in regulation.

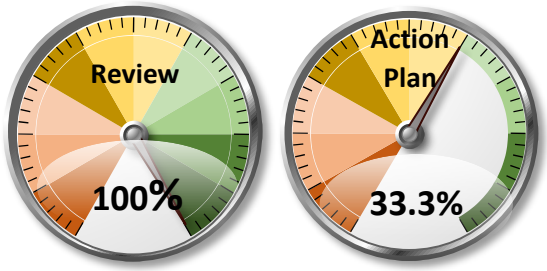
It should, however, be noted that as a result of the changes required to meet the provisions of Bill 21, it will likely be necessary to increase registration fees in 2020.

College of Physicians & Surgeons of Alberta

2019 Key Performance Indicators
Status at Q1 2019

Align all continuing competence programs & physician practice data among stakeholder jurisdictions
Risk type: OPERATIONAL/STRATEGIC
Risk likelihood: MEDIUM
Risk seriousness HIGH.
Key performance indicator:
Agreed upon minimum criteria for CQI programs
Target: Draft criteria established by CPSA multi-stakeholder WG Q4 2019

Review Professional Conduct processes, resources, workflow & decision making criteria to incorporate leading practices.
Risk type: REPUTATIONAL
Risk likelihood: HIGH
Risk seriousness: EXTREME
Key performance indicators:
Review complete **Target:** Q1 2019
Action plan developed **Target:** Q3 2019



Address backlog in complaint files
Risk type: REPUTATIONAL
Risk likelihood: HIGH
Risk seriousness: EXTREME
Key performance indicator:
Investigation file backlog eliminated
Target: 30% reduction in backlog by Q4 2019

Develop plans for: Marketing/Communications Engagement Media Relations
Risk type: OPERATIONAL/STRATEGIC
Risk likelihood: MEDIUM
Risk seriousness: HIGH
Key performance indicators:
Marketing/Communications plan complete **Target:** Q4 2019
Engagement plan complete **Target:** Q4 2019
Media strategy plan complete **Target:** Q4 2019

Develop Summative Assessment process
Risk type: OPERATIONAL/STRATEGIC
Risk likelihood: MEDIUM
Risk seriousness: HIGH
Key performance indicator:
Summative assessment process developed and tested
Target: Complete 5 pilot summative assessments by Q4 2019

College of Physicians & Surgeons of Alberta

Submission to:	**Council**

Meeting Date: May 30 – 31, 2019	Submitted by: Key Performance Measures Working Group		
Agenda Item Title:	Key Performance Indicators and Targets for 2020 to 2024 Strategic Action Plan		
Action Requested:	☒ The following items require approval by Council. See below for details of the recommendation.	☐ The following item(s) are of particular interest to Choose an item. Feedback is sought on this matter.	☐ The attached is for information only. No action is required.
AGENDA ITEM DETAILS			
Recommendation (if applicable) :	***It is recommended that*** Council approve in principle the strategic pillars, KPIs and five year targets as presented.		
Background:	The Performance Measures Working Group was established by Council to develop Key Performance Indicators (KPIs) for CPSA for the next five years (2020 to 2024). The working group, comprised of Dr. Francescutti, Dr. Jones and Ms. Wood met on March 29 and April 18, 2019. Building on Council's discussion at their February 2019 retreat, the working group provided input into the Strategic Action Plan for 2020 to 2024 drafted by CPSA leadership. Following approval of the plan in principle, the working group developed KPI's and targets for CPSA leadership to accomplish by 2024. The draft Strategic Action Plan consists of six strategic pillars, which if approved by Council, will shape the future of medical regulation in Alberta. The six strategies, along with the desired five year outcomes, recommended KPIs, measures and targets are described here.		
Next Steps:	The leadership team will finalize the five year Strategic Action Plan with annual targets for presentation and final approval by Council in September. At the same time a three-year detailed business plan and budget will be presented.		
List of Attachments:			
Memo to Council from Performance Measures Working Group			

College of Physicians & Surgeons of Alberta

MEMORANDUM

To: Council

From: Performance Measures Working Group

Date: April 18, 2019

Subject: Key Performance Indicators and Targets for 2020 to 2024 Strategic Action Plan

The Performance Measures Working Group was established by Council to develop Key Performance Indicators (KPIs) for CPSA for the next five years (2020 to 2024). The working group, comprised of Dr. Francescutti, Dr. Jones and Ms. Wood met on March 29 and April 18, 2019. Building on Council's discussion at their February 2019 retreat, the working group provided input into the Strategic Action Plan for 2020 to 2024 drafted by CPSA leadership. Following approval of the plan in principle, the working group developed KPI's and targets for CPSA leadership to accomplish by 2024. The draft Strategic Action Plan consists of six strategic pillars, which if approved by Council, will shape the future of medical regulation in Alberta. The six strategies, along with the desired five year outcomes, recommended KPIs, measures and targets are described below.

Quality Mandate Strategy

Definition: This strategy has two key elements:

- To ensure all physicians meet minimum standards expected of the profession.
- To foster and support the highest quality of medical/health care through collaboration and cooperation with key stakeholders.

CPSA Council Strategic Goals Supported: 1, 3, and 4.

Desired Outcomes:

1. CPSA has confirmation that all AB physicians are engaging in high quality and relevant CQI.
2. At risk physicians are assessed by CPSA and, when necessary, are elevated to minimum standards.
3. Practice enhancement/remediation is outsourced to faculties of medicine and other outside educational bodies.
4. All physicians prescribe antibiotics appropriately.
5. All physicians prescribe benzodiazepine and opioids appropriately.
6. All physician practices reprocess medical devices to medical device reprocessing (MDR) standards.

KPIs/2024 Targets:

- CPSA has engaged regulated members to encourage, support and confirm participation in QI
    - 100% by 2024
- High risk individual physicians are assessed
    - 200 annually from 2020 onwards (2% of membership)
- Practice enhancement/remediation is outsourced
    - 80% by 2024
- Variation from recommended best practice opioid indicator is reduced (indicator TBA)
    - 5% by 2024
- Variation from recommended best practice benzodiazepine indicator is reduced (indicator TBA)
    - 5% by 2024
- Variation from recommended best practice antibiotic indicators is reduced (indicators TBA)
    - TBA by 2024
- Deficiencies (not meeting minimum standards) in infection prevention and control (IPAC) are reduced
    - For new clinics - 0% by 2024 (currently 30%)
    - For existing clinics – 15% or less by 2024 (currently 30%)
- Critical deficiencies in IPAC (reportable breaches to Medical Officer of Health) are reduced
    - For new clinics – 0% by 2024 (currently 5%)
    - For existing clinics – 2.5% or less by 2024 (currently 5%)

Organization Presence & Influence Strategy

Definition - CPSA is a respected and credible organization that promotes high quality healthcare for all Albertans and is recognized as a key stakeholder in the Alberta and Canadian healthcare scene. As an innovative and forward thinking regulator, CPSA is and is sought out to participate in health related initiatives provincially, nationally and internationally.

CPSA Council Strategic Goals Supported: all

Desired outcomes:

1. Through PRO-Active, CPSA has collaborated with stakeholders to improve the healthcare workplace for physicians in all sectors.

> PRO-Active - A multi-stakeholder action plan to support the advancement of professional behaviour among physicians, learners and leaders in Alberta.

2. The CPSA through a brand strategy will be recognized as an organization that supports, guides and mentors physicians, empowering them to deliver quality health care. CPSA will be seen as an organization that promotes a collaborative approach to profession–led regulation that adapts to the complexities of front line care delivery.

3. CPSA is an organization recognized for establishing cultural awareness and understand the unmet health needs for vulnerable populations.

4. In collaboration with stakeholders, CPSA has advanced the vision of physician integration and quality described in the 2017 Office of the Auditor General (OAG) report – *Better Healthcare for Albertans.*

5. Council/CPSA effectively uses public input.

KPIs/2024 Targets:

- Physician engagement scores are increased in settings where PRO-Active has been implemented – demonstration projects (note: achieving target dependent on willingness of other organizations to participate)
    - target TBA – need to establish baseline
- Improved physician opinion of CPSA as shown by an improvement on bi-annual survey
    - from 20% to 60% by 2024
- Improved public impression of CPSA on surveys of public from 87% to 95% by 2024
    - Patient Family Advisory Council (PFAC) up and running by 2021
- Improve media sentiment score
    - To an average of 75% by 2024

<u>Digital Health Strategy</u>

Definition: Digital health refers to the use of information technology/electronic communication tools, services and processes to deliver health care services or to facilitate better health (definition from Canada Health Infoway).

CPSA Council Strategic Goals Supported: 1, 2, and 4.

Desired Outcomes:

1. Seamless licensure for cross jurisdictional patient care using digital means is enabled in Canada.
2. The public can trust that digital health technologies offered via medical practitioners are safe and effective.
3. Members understand CPSA expectations regarding digital health (Standard of Practice (SOP) in place).
4. Members have the competencies required to practice in the digital healthcare environment.

KPIs/2024 Targets:

- Patients have confidence that physicians providing cross jurisdictional digital health are regulated to a standard acceptable to CPSA
    - By 2024, a process is in place to ensure acceptable licensure for out of province physicians providing remote care to AB patients

- Physicians wishing to use digital means to practice medicine on Alberta patients will experience minimal regulatory barriers
    - By 2024 there will be a seamless process in place to register out of province physicians who wish to practice medicine in Alberta using digital means.

- There is an SOP in place outlining the requirements to practice digital health on AB patients
    - Target 2022

- Undergraduate training programs, post-graduate training programs and maintenance of competence programs have identified necessary competencies to practice in a digital environment and have standards in place to ensure those educational requirements are met.
    - CPSA and partners will influence the Medical Council of Canada to incorporate digital competence into Licensing exams by 2024
    - CPSA and partners will influence Undergraduate Medical Education, Postgraduate Medical Education and Continuing Professional Development to incorporate standards regarding teaching and assessing digital competencies by 2024

- Patients can have confidence that digital heath technologies used by physicians to support medical decision making will be safe and effective.
    - Through participation at national tables CPSA and partners will influence Health Canada to take on the role of regulating digital health and artificial intelligence (AI) technologies that may impact human health by 2022.

Business Intelligence Strategy

Definition: Clear understanding and governance around the confidentiality, integrity and availability of the data that are required to fulfill the College mandate in all areas. Development of analytics infrastructure to manipulate and report for all areas of the College that need data informed results/decisions (e.g. Continuing Competence, Research & Evaluation Unit (REVU), Organizational Risk, etc.). This will be a unified model for all areas of the College that not only looks at what we currently have and how to use it, but also future needs and scalability in the systems that will support it.

CPSA Council Strategic Goals Supported: 1, 2, 3 and 4

Desired Outcomes:
1. CPSA has developed the capacity to understand and evaluate where its physician members lie on a continuum of performance and quality.
2. CPSA uses data and analytics to inform all regulatory processes.

KPIs/2024 Targets:

- Physicians are assigned a validated risk score
    - 100% by 2022
- Physicians report using their validated risk score for self-improvement
    - TBA by 2024
- CPSA processes are informed by validated risk score (measure TBA)
    - 100% by 2024

Organizational Culture and Capacity Strategy

Definition – To develop a culture where our people are intrinsically invested in our work, our teams, and each other.
To develop a capacity and mix of staff to meet current and adaptable future needs to address a changing regulatory landscape.

CPSA Council Strategic Goals Supported: all

Desired Outcomes

1. All CPSA staff feel valued for their commitment and contribution to the organization

2. CPSA is a high-functioning organization – best-in-class not only as a regulator but a benchmark beyond its sector.

3. CPSA has a well-trained, capable and adaptive workforce.

KPIs/Targets:

- Exemplary Employee engagement as reported on the AON Best Employer survey
    - maintain our status of employer rating on the AON Best Employer survey in the small-medium employers in Canada
- Appropriate Turnover rate
    - 10% by 2024

Learning Organization Strategy

Definition: A learning organization is an innovative organization that anticipates future trends and takes pro-active steps to prepare. A learning organization takes calculated risks and uses learnings from past successes and failures to continually improve processes.

CPSA Council Strategic Goals Supported: all

Desired Outcome: All CPSA functional areas engage in high quality CQI

KPIs/Targets:

- Departments are engaged in CQI

    - 100% by 2024
- Each functional area will have identified stretch KPIs and show progress to established targets by 2024
    - 100% by 2024

Recommendation

- That Council approve in principle the strategic pillars, KPIs and five year targets as presented

Next steps: Leadership team will finalize the five year Strategic Action Plan with annual targets for presentation and final approval by Council in September. At the same time a three year detailed business plan and budget will be presented.

College of Physicians & Surgeons of Alberta

Submission to:	**Council**

Meeting Date:	Submitted by:		
May 30, 2019	Dr. Richard Martin, Chair, Competence Committee		
Agenda Item Title:	Competence Committee		
Action Requested:	☐ The following items require approval by Choose an item. See below for details of the recommendation.	☐ The following item(s) are of particular interest to Choose an item. Feedback is sought on this matter.	X The attached is for information only. No action is required.
AGENDA ITEM DETAILS			
Recommendation (if applicable) :	***n/a***		
Background:	The Competence Committee met on April 17, 2019. The following items discussed will be of interest to Council: 1. **PRO-Active**: In 2017, Council directed staff to work with stakeholders to develop a robust plan to address disruptive behavior in the workforce. This work, supported by a consultant Ms. Annamarie Fuchs, has been completed and was presented to Council in September 2018. Subsequently, at the request of the healthcare CEOs, a design team comprised of individuals from each participating organization completed a return on investment analysis, a detailed one year business plan and a budget to support that plan. This was delivered to the healthcare CEOs on target on January 31, 2019. The recent election has delayed a response from the CEOs however we anticipate that a meeting will be held in the near future. The plan includes project support, a community of practice to support leaders in dealing with disruptive behavior in the workplace, a wellness initiative, leadership development, a series of demonstration projects and a marketing and evaluation strategy. The Alberta Medical Association has committed to fund and implement the wellness part of the plan. Given that this was driven by CPSA Council, there is an expectation that CPSA will contribute financially to support this initiative going forward. To that end, staff are including funds in the budget for the next three years (2020 to 2022) to support the project. Details will be reviewed by the Finance and Audit committee and will be brought to Council in September for approval. 2. **Cannabis**: For several years, CPSA has been monitoring cannabis. For each authorization, physicians must submit detailed information to CPSA, which is manually entered into a database. Currently, CPSA employs two full time		

College of Physicians & Surgeons of Alberta

data entry clerks to perform this function because cannabis, not having a DIN, is not entered into PIN. To date there has been limited value for this expenditure, we have interacted with a small number of physicians as a result of this data. The egregious cannabis prescribing issues have also come directly to the complaint director's attention via a complaint. Health Canada collects prescribing data from licensed producers and informs the medical regulatory authorities periodically when physicians prescribe 25 grams/day. CPSA is the only MRA in Canada that has their own monitoring process. We have recently been informed that Health Canada will be enhancing their reporting to MRAs and we are proposing that cannabis monitoring by CPSA be eliminated if the information from Health Canada meets our needs. The Competence Committee felt it was important to ensure any monitoring process identify all cannabis prescribing to minors. We can request additional information from Health Canada, including all authorizations to patients under the age of 18.

3. **Continuing Competence Plan 2020 - 2024**: The Competence Committee reviewed and provided input into a draft 5 year plan for the continuing competence program. The plan includes five strategies:
    a. Members engage in quality improvement programs to support physician performance.
    Desired outcome:
        i. By 2024, 100% of Alberta physicians are engaged in quality improvement and CPSA has a mechanism in place to monitor member participation.
    b. Members at risk are meeting minimum standards.
    Desired outcomes:
        i. All at risk physicians are identified and assessed and when necessary performance is elevated to minimum standards
        ii. Stakeholders with expertise provide support to CPSA (assessment and remediation programs – ie APASS)
        iii. Members who fall below the minimum standard will bear 100% of cost for remedial and enhancement activities.
    c. CPSA has a mechanism to identify and review high risk community practices.
    Desired outcome:
        i. By 2024, the CPSA can confirm that all practices that may place patients at greater risk (Complementary and Alternative Medicine, Aesthetics, unproven treatments, medical device reprocessing) are safe for patients.
    d. Prescribing and Analytics Programs support program effectiveness and enhance research.
    Desired outcomes:

College of Physicians & Surgeons of Alberta

	i. All physicians are assigned a validated risk score ii. CPSA uses data and analytics to support all regulatory processes iii. Physicians view MD snapshot reports as useful tools to enhance practice iv. Inappropriate variation from best practice recommendations for benzodiazepine and opioid prescribing is virtually eliminated v. Inappropriate variation from best practice recommendations for antibiotic prescribing is reduced. e. <u>CPSA's research and evaluation outputs improve the quality of medical regulation at CPSA and advances evidence based medical regulation worldwide.</u> Desired outcome: i. REVU is recognized as an innovative, collaborative, approachable, valued, trusted leader in evidence based regulation both internally and externally (among the membership, public and research community).
Next Steps:	Competence committee's direction as per above will be incorporated into the three year business plan and budget (2020 to 2024) which will be presented to the Finance and Audit committee and subsequently to Council for approval in September 2019.
List of Attachments:	

College of Physicians & Surgeons of Alberta

Submission to:	**Council**

Meeting Date:	Submitted by:		
May 30, 2019	Dr. John Bradley		
Agenda Item Title:			
Action Requested:	☐ The following items require approval by Choose an item. See below for details of the recommendation.	☒ The following item(s) are of particular interest to Council Feedback is sought on this matter.	☐ The attached is for information only. No action is required.
AGENDA ITEM DETAILS			
Recommendation (if applicable) :	N/A		
Background:	Council participated in a retreat February 1 & 2, 2019 called The Future of Professional Regulation: Public Partnerships or Professional Privilege. - Council, with the assistance of expert presenters, explored four topics 1. Is Professionally Led Regulation in Danger? 2. Oversight: What is most effective Public or Profession? 3. What are Public/Patient Expectations of Regulators? 4. Regulatory Excellence: What are the Expectations of Council to be good Governors? - Four themes were identified out of the retreat for future exploration, they are: • Engagement • Do Good Work • Influence the Narrative • Patient and Family Advisory Council - To ensure Council acted on the themes from the retreat it was decided the 2019 Council Retreat Summary and Outcomes Report would be discussed at the May 2019 Council meeting.		
Next Steps:	Taking into consideration work that is ongoing under the four themes, additional actions items for each theme will be explored.		
List of Attachments:			
Council Retreat Summary 2019			

CPSA Council 2019 retreat

Summary of discussion and outcomes

Jan. 31 - Feb. 1, 2019

Royal Mayfair Club

College of Physicians & Surgeons of Alberta

CONTENTS

COUNCIL RETREAT AGENDA

Link to full agenda

Retreat objectives

Primary objectives:

1. **Understand** - Develop a deeper understanding of a regulatory college's role, by examining the current Canadian context (such as public expectations, best practices and current research).
2. **Identify** – Discover where challenges and opportunities are situated, by learning from experts and through facilitated group discussions.
3. **Act** - Create tangible actions, which can be integrated into the CPSA's strategic plans.

Secondary objectives:

4. Develop a more cohesive and supportive team by learning, interacting and developing goals together.
5. Cultivate a stronger collective vision of how to position the CPSA for the future.
6. Build on lessons from the 2018 Council retreat.

DAY 1: EXPERT PRESENTATIONS

Presenter bios

Each speaker had 60 minutes to present and facilitate a question and answer period. This set the stage for workshop discussions in the afternoon, which covered the same pre-selected topics. Each presenter brought their own emphasis, opinions and recommendations to each topic, based on their personal knowledge, experience and professional frame of reference.

The topics:

1. Is Profession Led Regulation in Danger?
2. Oversight: What is most effective Public or Profession?
3. What are Public/Patient Expectations of Regulators?
4. Regulatory Excellence: What are the Expectations of Council to be good Governors?

Highlights of Dr. Bell's presentation

Dr. Bell's presentation focused on four major areas identified as risks to fairness, transparency, governance and oversight of boards. He spoke about the challenge regulators have in balancing fairness to the profession and their obligation to protect the public, explaining that if regulators do not keep up with their obligation to the public, professional regulation is definitely at risk. Greater transparency to the public and government must be a top priority of any regulator, to ensure the organization gains and retains credibility. He further discussed that it's difficult for a regulatory Council's elected members to not, at least subconsciously, view matters from the interest of their profession. For that reason, he favours regulatory Councils with members appointed under a skill-based model. Although governments may not view skills-based appointments as a top priority regulators can be proactive in this area and lobby for appropriate Council appointments. Dr. Bell further explained that he also favours an even distribution of elected regulated members and public councillors, with a 50/50 mix. He ended his presentation by discussing the work of Harry Cayton and the Professional Standards Authority (United Kingdom), explaining some pros and cons of such an arrangement, where a non-government organization oversees the work of all professional regulators.

Highlights of Dr. Adams' presentation

The presentation was focused on the sociology of profession-led regulation and provided examples of the difference between regulatory environments in Canada and the U.S./U.K. While she explained how we could learn from other jurisdictions, Dr. Adams felt it best not to copy, but to borrow and adapt for Alberta's regulatory climate. Dr. Adams recommended continuing to review our regulatory system for improvements, so the CPSA can be the one driving change. She recommended our focus be on reviewing our organization for adjustments, verses wholesale change, while keeping in mind the forces which will influence change in profession-led regulation. Specifically she highlighted the following:

1. Populism: ordinary people who feel their concerns are disregarded by established elite groups.
2. Growing lack of respect/distrust of experts: “Everyone is an expert”.
3. Neo-liberalism: supports privatization and de-regulation.
4. Globalization: business and organizations develop international influence, with increased pressure towards standardization/harmonization across borders.
5. Changing attitudes towards change and risk: a push to change and take calculated risks, due to the belief that failure to change is failure in and of itself.
6. Diversity: institutions pressured to reflect diversity and strive to understand the diverse needs and concerns of patients.
7. Patient-centred care is paramount.
8. Collaborative health care, team-based practice is critical.
9. Demands for interprovincial coordination of services and practice standards will increase.
10. Tendency for organizations to adopt similar organizational forms.
11. Government concerns for cost and a push towards low-cost regulation.
12. The #MeToo movement and similar trends: a sense that people in authority have gotten away with wrongdoing for too long.

Dr. Adams mentioned the strength of the current governance model and indicated that change for the sake of change was the wrong approach. However she did not that there is a diminishing trust of the public, thus any review of our governance models must aim to address the public concerns while not discounting the strengths of the current model.

Highlights of Ms. Prowse’s presentation

Ms. Deborah Prowse, Q.C. spoke about her very personal experiences as a family member of someone in the health care system. She shared a heartfelt story of how a medical error was responsible for the death of her mother. Her discussion focused on the process of medical error and the role regulators can play in improving the patient experience, from both a quality and safety perspective. She explained that the regulatory bodies need to hear from patients and speak with their voices. She further explained that health regulatory colleges need to engage and truly hear from patients and the public. She feels the public and patients are different and when consulting them about their concerns and recommendations, they should be engaged as two different groups. She understands engaging the public and patients fully and authentically is not an easy task—it takes courage as there is going to be feedback that is not always positive and by consulting, you are at a minimum committing to listening and considering change. She recommended a formal commitment to engaging the public, patients and family through advisory groups and other formal means of engagement. In fact, she believes the CPSA should begin to filter and focus all of its work through these groups, to ensure our lens is crystal clear on standards, complaint processes and image. She recommended using our public members more in our engagement activities as they are more likely to easily form the trust relationships required to produce meaningful and actionable dialogue.

Post-presentation discussion highlights

After each presentation, there was active discussion and debate, which allowed everyone to dive further into the presenter's topics. The discussion allowed all Councillors to not only gain a more informed perspective, but to hear their fellow Councillors thoughts on specific topics. These are some of the highlights from the post-presentation discussions:

- Significant discussion took place on the merits of elected physician members vs. appointed physician members, with many differing opinions debated. The topic of regulatory outcomes and the idea of using other regulatory examples (such as the airline industry) were discussed. The discussion focused on whether these more operational examples can be translated into a governance model to create change. Significant discussion ensued regarding whether increasing the CPSA's effectiveness as a regulator would persuade government that direct intervention and new legislation is not required. There was a discussion on whether the initial unilateral introduction of Bill 21 could have been avoided, or whether this was a case of public opinion moving faster than the evolution of the regulatory process.
- There were many discussions on what good governance is and whether the lived experience of regulation was sufficient to guide regulators into the future. It was understood that collecting evidence of good governance is difficult, given diverse jurisdictions and populations, so regulators should focus on building sound governing principles that are focused on protecting the public. As well, by focusing on public protection in an openly transparent manner, the CPSA will not only be seen to be doing the right thing, much more importantly, we will be doing the right thing.
- Many of the post-presentation discussions focused on outcomes and it was suggested that medical errors or deaths might be the "tip of the iceberg" with respect to quality and safety issues. It was said that the CPSA has a significant opportunity (some said obligation) to be involved in these issues, with the focus of improving the health system as a whole.

Workshop discussions

Format: World Café—four rotating groups worked through one of the topics listed below. Groups rotated every 45 minutes, with each group attending two tables before the break and the remaining two tables after the break.

Facilitators: Ms. L. Louie, Dr. G. Campbell, Dr. K. Jones & Dr. R. Martin

Objectives: Each group will explore their table's topic to develop concepts and actions.

Topics:

- **Is Profession-Led Regulation in Danger?**
- **Oversight: What is Most Effective Public or Profession?**
- **What are Public/Patient Expectations of Regulators?**

- **Regulatory Excellence: What are the Expectations of Council to be Good Governors?**

Goal of table discussions:

To fully discuss the table topic, with the goal of generating ideas that Council will later explore for action during the priority exercise. The expert presenters moved from table to table, to further explore some of the ideas they presented.

END OF DAY ONE

DAY 2: WORKSHOP PRESENTATION REPORTS

Facilitated by Dr. Jim Stone

Format: Each Council member (table facilitator) presented their table's findings and recommendations based on the previous day's discussions. Each topic took approximately 25 minutes, with discussion during the presentation.

What was Heard at the Tables?

Is Profession-Led Regulation in Danger?

Some of the key items discussed at this table included the risk of losing relevance and effectiveness in the eye of the public. It was stated that public perception versus clinical and medical realities is often not accurate. However it does not matter as the CPSA needs to care about this perception as it is consider the reality, and respond in a manner that the public expects. To be relevant means to be effective in every piece of work, through the promotion of the good work that is done in a manner the public understands and is receptive to. Engagement with the public is key to reaffirming to the public and patients that the CPSA governs with their interests at the very top of our minds.

Doing good work is key to being good governors and sharing our work is important in developing public trust. The CPSA must be proactive in understanding the risks to patients and the public and must engage both the public and the media, to both learn and share our messages and information. It was discussed that an important part of being proactive is also having a strategy to engage the profession, as they are an important partner in protecting the public. Demonstrating change in an authentic, reflective and open manner will help our communication be more effective. The CPSA should be open to learning and sharing the important work we do as a tool to improve our engagement with the public, patients and profession.

Oversight: What is Most Effective Public or Profession?

Currently there is limited evidence to support changing our oversight model However, the CPSA needs to be aware of public perception, as there is a delicate balance between evidence and public opinion. The public's perception is often the reality the public draw on, so we should be proactive to ensure we tell our story. The CPSA needs to increase its engagement with the public, media and government, to tell the human story of how we bring value with the work we do. The concept of a patient and family advisory group should be considered, much like the Ontario Citizens Advisory Committee, to demonstrate our commitment to public, and patient engagement. It was suggested that a public member from Council be the chair of such a group.

It was mentioned that governance is likely more than art than and science. It was also suggested that the CPSA we also need to be aware of public and patient opinion, so when Council is making decisions, it is under the right assumptions and conditions. Council considered more public

participation on Council, which could mean a move towards 50 per cent public membership. The discussion reveled a limited appetite at this time to move there is was only due to the fact that there is no evidence to such a change will have better outcomes and that the current model is not working. In fact the discussion suggested that both the public members and physician members are equally focused on the public. The discussion also supported a more skills-based approach to Council positions—increasing governance training and possibly making it mandatory prior to running for Council was suggested.

What are Public/Patient Expectations of Regulators?

It was discussed that transparency is key to meeting the expectations of the public and patients, and should be a key principle in Council discussion, decisions and the CPSA operations. Awareness of the CPSA's role was discussed, as it is clear that much of the public does not know what the CPSA does. We must be proactive in creating awareness about how we manage high-risk physicians and identify physician credentials to the public in order to gain their trust.

Exactly how to earn and maintain that trust of the public was a key significant element of the discussion. It was suggested that the public wants to be informed and the best way to tell our stories is to engage the public in a proactive manner, to tell positive stories of the work the CPSA does. This engagement should use various methods such as town halls, marketing strategies, improvements to the website and social media. Increasing public representation was suggested as another way to gain the trust of the public, as well as potentially having more public members on appeals panels. The public needs to feel be reassured that the CPSA's focus is on what is best for the public.

Regulatory Excellence: What are the Expectations of Council to be Good Governors?

It was discussed that to be good governors, Council needs to understand its role, be open and listen to the public and when offside, take responsibility. Understanding public perception is important and for the CPSA to be patient-centred, the patient must feel connected to us in some manner. It was discussed that because it can be difficult to match meld the diversity of society with a combined appointed and elected Council, the CPSA must be diligent in hearing different perspectives from the public and patients. The discussion also focused on ensuring the CPSA is addressing the areas which appear to be more of interest to the public, such as the complaint process. The public needs to see that the CPSA is willing to make changes that affect the public, such as participating in a more streamlined process for dealing with complainants that involve other health professions.

It was also stated that it is important to spend more time and energy with an outward focus on public and patient engagement and less time continuing to look at the governance structure. While understanding that governance activities will always be important if we want to be a high-performing organization, it is equally important to ensure Council understands the perception of the people we

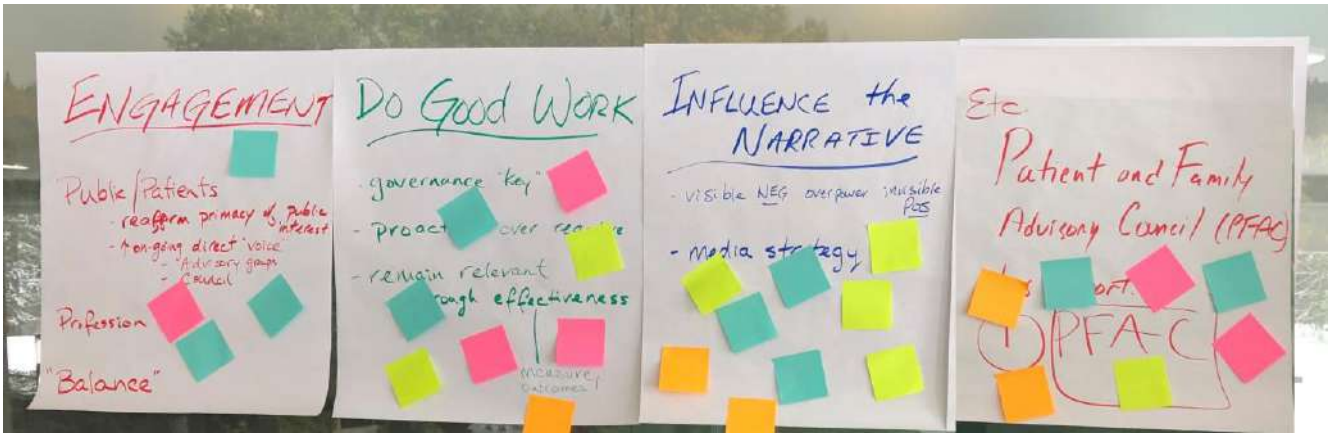
serve. It was also discussed that there is a perception that physician Council members and public Council members have different agendas and that this needs to change, as all members of Council should serve with the same goal: to regulate the Profession in a manner that best serves the needs of the Public. To truly meet achieve regulatory excellence, all Council members should understand their role and work as a collective team to achieve the same mission.

FINAL TABLE DISCUSSION

There were a significant number of topics brought up for discussion and placed on posters for consideration. The amount of ideas discussed was empowering, however there was concern that since there were so many ideas to consider, it would be difficult to do all of this good work. As a word of caution, one member of the retreat reminded the participants of the coconut story: if a person swallows a whole coconut, they better have a high level of confidence in their ability to exit the coconut. Meaning, to take on a large amount of work is okay, so long as you have a solid plan on how that work will get done and resource appropriately.

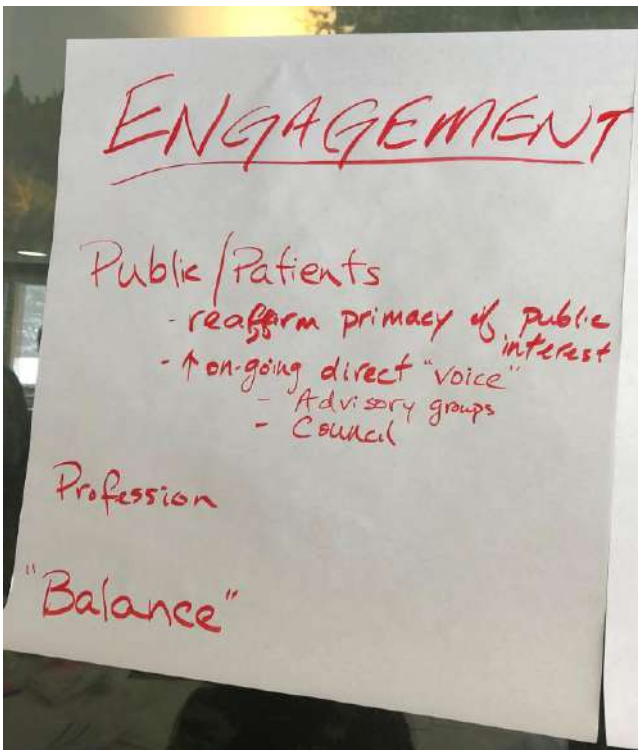
Priority exercise, to identify the top four ideas

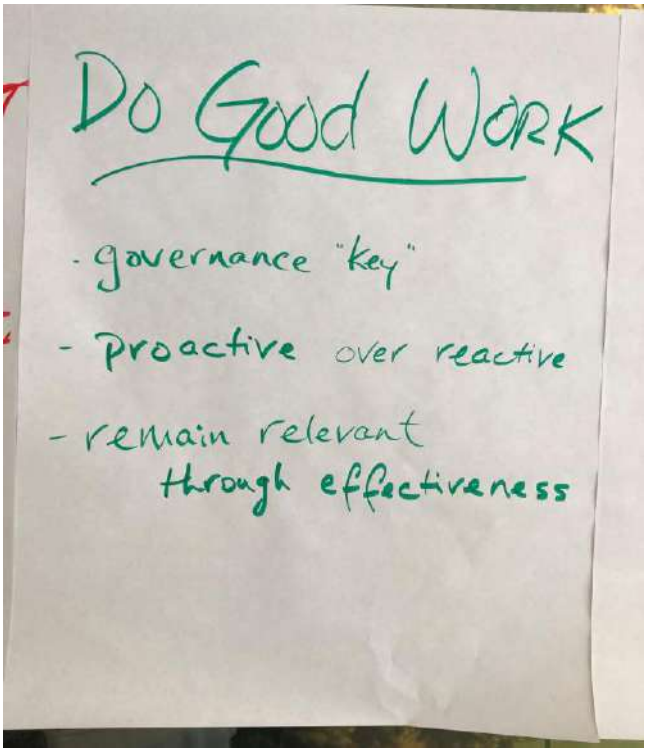
The table discussion generated sixteen posters, with ideas from the table reports.
After discussing the ideas represented on each poster, Council members were asked to leave a sticky note on the four ideas they most wanted to see move forward.
As a result of the voting exercise, the following four topics will be prioritized for action items:

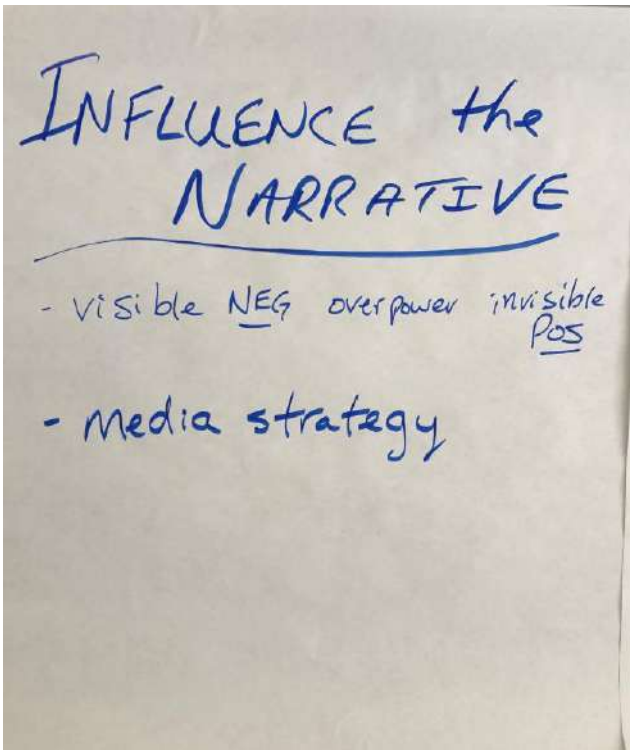


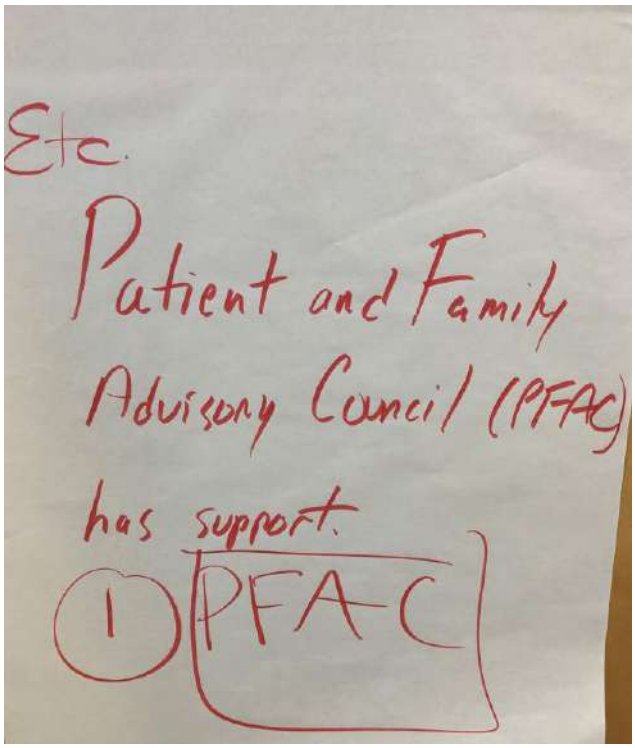
Top four priorities for further discussion

A common theme throughout the retreat was that Council members want to ensure the work that comes out of the retreat is not lost. Council members were motivated to ensure this would not be the case, thus they asked for the retreat summary to be on the May Council agenda for further discussion of the priorities. With this goal in mind, administration ensured that current the CPSA work and future planning was done through the lens of these four priorities. Although Council has yet to fully direct administration on these priorities, it was felt that if these four priorities are used as a guide, the work from the retreat would not be lost. The four priorities have already had significant influence in the strategic planning implementation work that Council will approve, thus demonstrating the retreat has had positive impact.









The following chart describes the alignment with our current work, future planning and opportunities for Council to provide further direction regarding the four priorities identified at the retreat:

Council Discussion to Direct Future Opportunities

Engagement	Do Good Work	Influence the Narrative	Patient and Family Advisory Council
Current activities			
- ProActive - Public engagement strategy - Brand focus groups for staff, physicians and the public - Bi-annual physician survey - Regional Tour	- ProActive - Standards of Practice (SoP) - Professional Conduct operations review implementation - IPR & GPR - MD Snapshot: Prescribing	- Media relations strategy - Media analytics - CPSA Annual Report: Report to Albertans - The Minister's Opioid Emergency Response Commission - CPSA brand strategy - Partner collaboration: SACE - Government Relations: MLA Dine & Dash	- AHS Patient and Family Advisory Group (PFAG)- Bill 21 SoP engagement
Current planning in the works			
- SoP profession engagement group - Pre-consultation on all SoPs	- TPP for antimicrobial - Quality mandate: ▪ Q1 framework ▪ All physicians engaged in Q1	- Crisis communication planning	- Further engagement with AHS PFAG for SoPs
Potential future opportunities			
- Quarterly public focus groups - Physician focus groups	– Physician performance - Health & wellness risk assessment – Digital Health	- Quarterly public focus groups - Physician focus groups	- AHS PFAG - Public engagement strategy - Quarterly public focus groups

Next Steps

Council to review, discuss and develop actions to explore future opportunities for the four priorities.

NOTES:

End of Document

College of Physicians & Surgeons of Alberta

Submission to:	**Council**

Meeting Date:	Submitted by:		
30 May 2019	Dr. Pauline Alakija		
Agenda Item Title:	Governance Committee Report – approval of committee appointments		
Action Requested:	☒ The following items require approval by Council See below for details of the recommendation.	☐ The following item(s) are of particular interest to Choose an item. Feedback is sought on this matter.	☐ The attached is for information only. No action is required.
AGENDA ITEM DETAILS			
Recommendation (if applicable) :	***The Governance Committee is recommending that Council approve the following items as discussed at the 3 April 2019 Governance Committee Meeting:*** 1. Appointment of Dr. Thomas Szabo as chair of the Medical Facility Accreditation Committee to replace Dr. Brian Muir who resigned to avoid a conflict of interest in regards to his new position with Alberta Health Services (see information in attachment 1). 2. Appointment of Dr. Peter Miles as a new member of the Medical Facility Accreditation Committee (MFAC), given Dr. Szabo's appointment as chair. (See additional information in attachment 1) 3. Re-appointment of Dr. Don Yee and Dr. John Pasternak to the Complaint Review Committee and Hearing Tribunal (CRA/HT) list of regulated members. (See attachment 2 for additional information).		
Background:	As a standing committee of Council, the Governance Committee has reviewed and discussed the matters above at its meeting.		
Next Steps:	Notifications will be given regarding the appointments to MFAC and the CRC/HT list.		
List of Attachments:			
1. MFAC Appointments 2. Complaint Review Committee/Hearing Tribunals List – Reappointments			

College of Physicians & Surgeons of Alberta

Memorandum

Date: **April 4, 2019**

To: **Council**

From: **Liz McBride, Director, Accreditation**

Subject: **Appointment of New Chair and New Committee Member to the Medical Facility Accreditation Committee (MFAC)**

New MFAC Chair:

On March 25, 2019, Dr. Brian Muir, Chair of the Medical Facility Accreditation Committee, resigned from MFAC due to his acceptance of a full-time positon with Alberta Health Services which pose a potential conflict of interest. Dr. Muir advised that his resignation is effectively immediately.

The CPSA Accreditation staff, in consultation with Dr. Muir, reviewed the list of current committee members and determined that Dr. Thomas Szabo would be an appropriate replacement. Dr. Szabo has been an exemplary member, has extensive knowledge of the Committee and its processes, and has demonstrated that he would have a strong presence as Chair of this Committee. An additional consideration was that Dr. Szabo's term on the Committee is effective until 2021, with possible extension opportunities.

The CPSA seeks to appoint Dr. Thomas Szabo (see attached CV for Council only), current member, to the role of Chair and is seeking approval of this appointment. Dr. Szabo is a family medicine physician from Calgary and has been a member of MFAC since January 2016.

New MFAC Member:

Subsequent to the resignation of Dr. Muir from the Committee, the CPSA seeks the approval of Dr. Peter Miles as a new member of MFAC. Dr. Miles was recruited as a new member on the suggestion of both Dr. Muir and Dr. Hindle (Senior Medical Advisor, Accreditation). With Dr. Muir's departure it was felt that representation from the North Zone would be advantageous on the Committee due to the area's unique needs and challenges. Dr. Miles' CV, along with the current Committee membership document, are provided for Council's review/reference.

Action: For Approval

College of Physicians & Surgeons of Alberta

Briefing Note

To: Council

From: Dr. Susan Ulan, Hearings Director

Date: 30 May2019

Subject: Re-nomination of two physician members to Complaint Review Committee (CRC) and Hearing Tribunal (HT) list

Issue: Will Council re-nominate two members whose first terms are ending December 2019 to the list for Complaints Review Committees and Hearing Tribunals for a second term?

Background: The *Health Professions Act* directs that the college must maintain a list of regulated members from which Complaint Review Committees and Hearing Tribunals (CRC/HT) are appointed. The Bylaws of the CPSA state that members are appointed to this list for a three year term, with an optional further appointment of an additional three year term for a total of six years.

Dr. Don Yee and Dr. John Pasternak have previously served one term on the CRC/HT list.

Both have provided excellent service to the College in this capacity. They have contributed; not only as members of panels, but most have chaired many of the panels to which they were named.

All of the above-mentioned physicians have each expressed an interest in serving a second term on the membership list for Complaint Review Committees and Hearing Tribunals.

Recommendation: That the Council reappoints the two above-mentioned physicians to the Complaints Review Committee and Hearing Tribunal list for a second term.

College of Physicians & Surgeons of Alberta

Submission to:	**Council**

Meeting Date:	Submitted by:		
May 30, 2019	Ms. Kate Wood, Past President		
Agenda Item Title:			
Action Requested:	☒ The following items require approval by Choose an item. See below for details of the recommendation.	☐ The following item(s) are of particular interest to Council Feedback is sought on this matter.	☐ The attached is for information only. No action is required.
AGENDA ITEM DETAILS			
Recommendation (if applicable) :	It is recommended that Council approves the general theme/topics for Council's retreat in 2020.		
Background:	At the April 3, 2019 Governance Committee meeting, the Committee discussed the purpose of Council retreats and some potential topics for the 2020 retreat taking place on January 31 and February 1. Feedback from Council on these suggested topics and potential speakers is needed to allow continued work on the development of the agenda for the retreat. The Committee is proposing the following theme: *How might the College's regulatory approach change in the future to increasingly protect the public interest as advocated from the public, patient and Alberta Health perspectives?* This theme echoes the outcome of the 2019 retreat regarding the establishment of a patient advisory committee. Potential speakers could include: • Justice Gouge • Harry Cayton • Dr. Zayna Khayat • Someone from the McMaster's Citizen Panel • Someone from Alberta Innovates to talk about Health Innovation • Someone from the Canadian Patient Safety Institute • Others who are advocating for potential changes to health care as driven by shifts in public expectations The Committee would like to encourage Council to "be bold" in the development of this retreat and ensure that discussions are evidence based.		

College of Physicians & Surgeons of Alberta

Next Steps:	With Council's approval of the general theme and topics for the retreat, the Past President and Governance Committee will put together a draft agenda which will be shared with Council in September. Information about speakers and facilitators will also be provided to Council in September.
List of Attachments:	

College of Physicians & Surgeons of Alberta

Submission to:	**Council**

Meeting Date:	Submitted by:		
May 30, 2019	Ms. Chantelle Dick, Standards of Practice Coordinator		
Agenda Item Title:			
Action Requested:	☒ The following items require approval by Council See below for details of the recommendation.	☐ The following item(s) are of particular interest to Choose an item. Feedback is sought on this matter.	☐ The attached is for information only. No action is required.
AGENDA ITEM DETAILS			
Recommendation (if applicable) :	***It is recommended that Council approve the adoption of the Canadian Medical Association's (CMA) 2018 Code of Ethics to replace the 2004 version currently in effect at CPSA.***		
Background:	After a 2-year consultation, the CMA published an updated *Code of Ethics* in 2018 (attachment 1). Per Section 133 of the *Health Professions Act*, CPSA was required to consult with our membership, the Minister of Health, and organizational partners before adopting a new code of ethics. Consultation ran March 11-May 10; 57 regulated members provided feedback (attachment 2). • 45% of respondents agreed with the proposed adoption of the updated *Code of Ethics* • 20% of respondents voiced dislike of the new edition • Despite clear messaging that changes to this document were not possible, 35% of respondents provided suggested edits; however, only 2 respondents explicitly suggested CPSA create its own code of ethics. • The majority of questions or requests for clarification are addressed in current CPSA standards • 8 respondents do not believe singling out Indigenous people is appropriate • 6 respondents found the document too long in comparison to the 2004 version • 2 respondents do not view the CMA as representative of Canadian physicians While the Department of Health understood the challenge in consulting on a national standard that is already published, it has requested invitations for feedback be sent while suggested edits are still possible.		

College of Physicians & Surgeons of Alberta

Next Steps:	Approve adoption of CMA's 2018 *Code of Ethics* to replace the 2004 version currently in use.

List of Attachments:

1. 2018 *Code of Ethics*
2. Collated feedback

ASSOCIATION MÉDICALE CANADIENNE | CANADIAN MEDICAL ASSOCIATION

CMA CODE OF ETHICS AND PROFESSIONALISM

The CMA Code of Ethics and Professionalism articulates the ethical and professional commitments and responsibilities of the medical profession. The Code provides standards of ethical practice to guide physicians in fulfilling their obligation to provide the highest standard of care and to foster patient and public trust in physicians and the profession. The Code is founded on and affirms the core values and commitments of the profession and outlines responsibilities related to contemporary medical practice.

In this Code, ethical practice is understood as a process of active inquiry, reflection, and decision-making concerning what a physician's actions should be and the reasons for these actions. The Code informs ethical decision-making, especially in situations where existing guidelines are insufficient or where values and principles are in tension. The Code is not exhaustive; it is intended to provide standards of ethical practice that can be interpreted and applied in particular situations. The Code and other CMA policies constitute guidelines that provide a common ethical framework for physicians in Canada.

In this Code, medical ethics concerns the virtues, values, and principles that should guide the medical profession, while professionalism is the embodiment or enactment of responsibilities arising from those norms through standards, competencies, and behaviours. Together, the virtues and commitments outlined in the Code are fundamental to the ethical practice of medicine.

Physicians should aspire to uphold the virtues and commitments in the Code, and they are expected to enact the professional responsibilities outlined in it.

Physicians should be aware of the legal and regulatory requirements that govern medical practice in their jurisdictions.

A. VIRTUES EXEMPLIFIED BY THE ETHICAL PHYSICIAN

Trust is the cornerstone of the patient–physician relationship and of medical professionalism. Trust is therefore central to providing the highest standard of care and to the ethical practice of medicine. Physicians enhance trustworthiness in the profession by striving to uphold the following interdependent virtues:

COMPASSION. A compassionate physician recognizes suffering and vulnerability, seeks to understand the unique circumstances of each patient and to alleviate the patient's suffering, and accompanies the suffering and vulnerable patient.
HONESTY. An honest physician is forthright, respects the truth, and does their best to seek, preserve, and communicate that truth sensitively and respectfully.
HUMILITY. A humble physician acknowledges and is cautious not to overstep the limits of their knowledge and skills or the limits of medicine, seeks advice and support from colleagues in challenging circumstances, and recognizes the patient's knowledge of their own circumstances.
INTEGRITY. A physician who acts with integrity demonstrates consistency in their intentions and actions and acts in a truthful manner in accordance with professional expectations, even in the face of adversity.
PRUDENCE. A prudent physician uses clinical and moral reasoning and judgement, considers all relevant knowledge and circumstances, and makes decisions carefully, in good conscience, and with due regard for principles of exemplary medical care.

B. FUNDAMENTAL COMMITMENTS OF THE MEDICAL PROFESSION

Commitment to the well-being of the patient

Consider first the well-being of the patient; always act to benefit the patient and promote the good of the patient.
Provide appropriate care and management across the care continuum.
Take all reasonable steps to prevent or minimize harm to the patient; disclose to the patient if there is a risk of harm or if harm has occurred.
Recognize the balance of potential benefits and harms associated with any medical act; act to bring about a positive balance of benefits over harms.

Commitment to respect for persons

Always treat the patient with dignity and respect the equal and intrinsic worth of all persons.
Always respect the autonomy of the patient.
Never exploit the patient for personal advantage.
Never participate in or support practices that violate basic human rights.

Commitment to justice

Promote the well-being of communities and populations by striving to improve health outcomes and access to care, reduce health inequities and disparities in care, and promote social accountability.

Commitment to professional integrity and competence

Practise medicine competently, safely, and with integrity; avoid any influence that could undermine your professional integrity.

Develop and advance your professional knowledge, skills, and competencies through lifelong learning.

Commitment to professional excellence

Contribute to the development and innovation in medicine through clinical practice, research, teaching, mentorship, leadership, quality improvement, administration, or advocacy on behalf of the profession or the public.

Participate in establishing and maintaining professional standards and engage in processes that support the institutions involved in the regulation of the profession.

Cultivate collaborative and respectful relationships with physicians and learners in all areas of medicine and with other colleagues and partners in health care.

Commitment to self-care and peer support

Value personal health and wellness and strive to model self-care; take steps to optimize meaningful co-existence of professional and personal life.

Value and promote a training and practice culture that supports and responds effectively to colleagues in need and empowers them to seek help to improve their physical, mental, and social well-being.

Recognize and act on the understanding that physician health and wellness needs to be addressed at individual and systemic levels, in a model of shared responsibility.

Commitment to inquiry and reflection

Value and foster individual and collective inquiry and reflection to further medical science and to facilitate ethical decision-making.

Foster curiosity and exploration to further your personal and professional development and insight; be open to new knowledge, technologies, ways of practising, and learning from others.

C. PROFESSIONAL RESPONSIBILITIES

PHYSICIANS AND PATIENTS

Patient–physician relationship

The patient–physician relationship is at the heart of the practice of medicine. It is a relationship of trust that recognizes the inherent vulnerability of the patient even as the patient is an active participant in their own care. The physician owes a duty of loyalty to protect and further the patient's best interests and goals of care by using the physician's expertise, knowledge, and prudent clinical judgment.

In the context of the patient–physician relationship:

1. Accept the patient without discrimination (such as on the basis of age, disability, gender identity or expression, genetic characteristics, language, marital and family status, medical condition, national or ethnic origin, political affiliation, race, religion, sex, sexual orientation, or socioeconomic status). This does not abrogate the right of the physician to refuse to accept a patient for legitimate reasons.
2. Having accepted professional responsibility for the patient, continue to provide services until these services are no longer required or wanted, or until another suitable physician has assumed responsibility for the patient, or until after the patient has been given reasonable notice that you intend to terminate the relationship.
3. Act according to your conscience and respect differences of conscience among your colleagues; however, meet your duty of non-abandonment to the patient by always acknowledging and responding to the patient's medical concerns and requests whatever your moral commitments may be.
4. Inform the patient when your moral commitments may influence your recommendation concerning provision of, or practice of any medical procedure or intervention as it pertains to the patient's needs or requests.
5. Communicate information accurately and honestly with the patient in a manner that the patient understands and can apply, and confirm the patient's understanding.
6. Recommend evidence-informed treatment options; recognize that inappropriate use or overuse of treatments or resources can lead to ineffective, and at times harmful, patient care and seek to avoid or mitigate this.
7. Limit treatment of yourself, your immediate family, or anyone with whom you have a similarly close relationship to minor or emergency interventions and only when another physician is not readily available; there should be no fee for such treatment.
8. Provide whatever appropriate assistance you can to any person who needs emergency medical care.
9. Ensure that any research to which you contribute is evaluated both scientifically and ethically and is approved by a research ethics board that adheres to current standards of practice. When involved in research, obtain the informed consent of the research participant and advise prospective participants that they have the right to decline to participate or withdraw from the study at any time, without negatively affecting their ongoing care.
10. Never participate in or condone the practice of torture or any form of cruel, inhuman, or degrading procedure.

Decision-making

Medical decision-making is ideally a deliberative process that engages the patient in shared decision-making and is informed by the patient's experience and values and the physician's clinical judgment. This deliberation involves discussion with the patient and, with consent, others central to the patient's care (families, caregivers, other health professionals) to support patient-centred care.

In the process of shared decision-making:

11. Empower the patient to make informed decisions regarding their health by communicating with and helping the patient (or, where appropriate, their substitute decision-maker) navigate reasonable therapeutic options to determine the best course of action consistent with their goals of care; communicate with and help the patient assess material risks and benefits before consenting to any treatment or intervention.
12. Respect the decisions of the competent patient to accept or reject any recommended assessment, treatment, or plan of care.
13. Recognize the need to balance the developing competency of minors and the role of families and caregivers in medical decision-making for minors, while respecting a mature minor's right to consent to treatment and manage their personal health information.
14. Accommodate a patient with cognitive impairments to participate, as much as possible, in decisions that affect them; in such cases, acknowledge and support the positive roles of families and caregivers in medical decision-making and collaborate with them, where authorized by the patient's substitute decision-maker, in discerning and making decisions about the patient's goals of care and best interests.
15. Respect the values and intentions of a patient deemed incompetent as they were expressed previously through advance care planning discussions when competent, or via a substitute decision-maker.
16. When the specific intentions of an incompetent patient are unknown and in the absence of a formal mechanism for making treatment decisions, act consistently with the patient's discernable values and goals of care or, if these are unknown, act in the patient's best interests.
17. Respect the patient's reasonable request for a second opinion from a recognized medical expert.

PHYSICIANS AND THE PRACTICE OF MEDICINE

Patient privacy and the duty of confidentiality

18. Fulfill your duty of confidentiality to the patient by keeping identifiable patient information confidential; collecting, using, and disclosing only as much health information as necessary to benefit the patient; and sharing information only to benefit the patient and within the patient's circle of care. Exceptions include situations where the informed consent of the patient has been obtained for disclosure or as provided for by law.
19. Provide the patient or a third party with a copy of their medical record upon the patient's request, unless there is a compelling reason to believe that information contained in the record will result in substantial harm to the patient or others.
20. Recognize and manage privacy requirements within training and practice environments and quality improvement initiatives, in the context of secondary uses of data for health system management, and when using new technologies in clinical settings.
21. Avoid health care discussions, including in personal, public, or virtual conversations, that could reasonably be seen as revealing confidential or identifying information or as being disrespectful to patients, their families, or caregivers.

Managing and minimizing conflicts of interest

22. Recognize that conflicts of interest may arise as a result of competing roles (such as financial, clinical, research, organizational, administrative, or leadership).
23. Enter into associations, contracts, and agreements that maintain your professional integrity, consistent with evidence-informed decision-making, and safeguard the interests of the patient or public.
24. Avoid, minimize, or manage and always disclose conflicts of interest that arise, or are perceived to arise, as a result of any professional relationships or transactions in practice, education, and research; avoid using your role as a physician to promote services (except your own) or products to the patient or public for commercial gain outside of your treatment role.
25. Take reasonable steps to ensure that the patient understands the nature and extent of your responsibility to a third party when acting on behalf of a third party.
26. Discuss professional fees for non-insured services with the patient and consider their ability to pay in determining fees.
27. When conducting research, inform potential research participants about anything that may give rise to a conflict of interest, especially the source of funding and any compensation or benefits.

PHYSICIANS AND SELF

28. Be aware of and promote health and wellness services, and other resources, available to you and colleagues in need.
29. Seek help from colleagues and appropriate medical care from qualified professionals for personal and professional problems that might adversely affect your health and your services to patients.
30. Cultivate training and practice environments that provide physical and psychological safety and encourage help-seeking behaviours.

PHYSICIANS AND COLLEAGUES

31. Treat your colleagues with dignity and as persons worthy of respect. Colleagues include all learners, health care partners, and members of the health care team.
32. Engage in respectful communications in all media.
33. Take responsibility for promoting civility, and confronting incivility, within and beyond the profession. Avoid impugning the reputation of colleagues for personal motives; however, report to the appropriate authority any unprofessional conduct by colleagues.
34. Assume responsibility for your personal actions and behaviours and espouse behaviours that contribute to a positive training and practice culture.
35. Promote and enable formal and informal mentorship and leadership opportunities across all levels of training, practice, and health system delivery.

36. Support interdisciplinary team-based practices; foster team collaboration and a shared accountability for patient care.

PHYSICIANS AND SOCIETY

37. Commit to ensuring the quality of medical services offered to patients and society through the establishment and maintenance of professional standards.
38. Recognize that social determinants of health, the environment, and other fundamental considerations that extend beyond medical practice and health systems are important factors that affect the health of the patient and of populations.
39. Support the profession's responsibility to act in matters relating to public and population health, health education, environmental determinants of health, legislation affecting public and population health, and judicial testimony.
40. Support the profession's responsibility to promote equitable access to health care resources and to promote resource stewardship.
41. Provide opinions consistent with the current and widely accepted views of the profession when interpreting scientific knowledge to the public; clearly indicate when you present an opinion that is contrary to the accepted views of the profession.
42. Contribute, where appropriate, to the development of a more cohesive and integrated health system through inter-professional collaboration and, when possible, collaborative models of care.
43. Commit to collaborative and respectful relationships with Indigenous patients and communities through efforts to understand and implement the recommendations relevant to health care made in the report of the Truth and Reconciliation Commission of Canada.
44. Contribute, individually and in collaboration with others, to improving health care services and delivery to address systemic issues that affect the health of the patient and of populations, with particular attention to disadvantaged, vulnerable, or underserved communities.

Approved by the CMA Board of Directors Dec 2018

College of Physicians & Surgeons of Alberta

Consultation 016
Code of Ethics: Regulated Members

RM01
3/11/2019
Shouldn't there be a requirement for us to refer patients to other physicians if we feel unable or unwilling to carry out a provided service such as providing birth control, pregnancy termination and assisted ending of life?

RM02
3/11/2019
I approve of the updated Code of Ehics

RM03
3/11/2019
The 2004 and the 2018 documents are very different codes in many respects. Personally I prefer the format of the 2004 document. The 2018 version does not provide much clarity in areas of tension. How does one respect the autonomy of a patient when their decisions are harmful to themselves? Surely I cannot enable that.

Why does the self-care portion of the document bother to mention physician physical, mental, and social well being, and not mention spiritual well being?

These are just two out of a number of statements that got my notice as being either unclear in practice, or unnecessarily directive, and not really providing an improvement over the 2004 document.

I know the CMA has been working on this for awhile, but without specifying their reasons for the overhaul, it is hard to say that the new document is better than the previous version.

RM04
3/11/2019
In general, the document is fairly well-written, although I would suggest it is a bit lengthy.

First, just a few nit-picky style points / definitional issues. On page 4, point 10., there is a description of "inhuman" procedures. I wonder if the authors instead mean "inhumane" ? Also, on page 2, section A. the definition of Integrity states that this is represented by consistency with professional expectations. I would argue that integrity generally refers to the consistency between one's actions and one's deeply held moral beliefs. I also note that "professional integrity" is referred to on the next page. I wonder if these two (arguably different) concepts might be confused or conflated as the current document is written?

Under section B. "Commitment to Justice" (alluding to social advocacy) is listed in parallel with other "Fundamental Commitments" of the Medical Profession, like being committed to the well-being of the patient, having professional integrity, and so forth. I believe that it is disingenuous to list virtues on an equal plane when they inevitably come into conflict with one another. Consider that some societies prioritize honesty over loyalty and others loyalty over honesty and how fundamentally differently they operate. I believe that "justice" as it pertains to physicians, mostly applies to the microlevel (i.e. treating your patients fairly and equally and not favouring some over others). There is no training in medical school that I am aware of that grooms physicians to take up their megaphones and make political comments to the general public. The gun control debate comes to mind. If called upon to provide a scientific opinion, then one can cautiously make statements within one's area of expertise. This is different than saying, "Therefore, handguns should be banned" or other such sweeping hubris.

Point #36 about "fostering team ... shared accountability" would be easier to swallow if nurses or social workers or physiotherapists were ever sued for malpractice. Except in extreme cases, the buck stops with the physician. Until that changes, it is probably appropriate that physicians act as quarterbacks.

Point #38 seems overstated to me. I prefer the phrase "social correlates of health," because to use more deterministic language erodes personal agency of my patients and becomes a form of bigotry / low expectation.

Point #43 seems vaguely out of place or even racist to me. I think we should treat patients with dignity and respect whether they are Indigenous, Caucasian, Black, Liberal, etc. I don't think Indigenous peoples should merit an extra bullet point. I doubt that similar documents in the United States have separate bullet points for African-Americans or make reference to Civil War era issues.

RM05

3/11/2019

I agree with the Code of Ethics. It does not adequately reflect some of the challenges we face with respect to technology etc. Hopefully, HIPPA will address all that.

RM06

3/11/2019

What should occur in the situation when patient and physician disagree on care, particularly in specialist consultation? My sense is to politely agreed to disagree and to send a respectful letter back to the referring physician, perhaps suggesting referral to another colleague.

Can you somehow address the issue of patients recording interactions on the phone or in person without informing the physician? This happens more often than is realized, and could sensibly be construed as a breach of trust. In this case I would politely inform the patient and send a letter to the referring physician terminating the relationship. Patients have responsibilities of respect and trust as

well. This would work both ways, of course, as sometimes patient interactions are recorded by the physician for teaching purposes. Full disclosure and the patient giving consent prior to starting the interaction would be proper and respected.

RM07

3/11/2019
Good to go.

RM08

3/11/2019
Seems quite acceptable and doable. If all physicians read and contemplated would make things better.

RM09

3/11/2019
The document is unwheldy. Better to be concise than too verbose such that interest wanes with reading it.

I worry about catch all phrases such as "goals of care" which refer to something very specific in Alberta.

Item 15 regarding the incompetent's pre-existing values seems like a slippery slope that would lead a prudent physician to run afoul of the law by ignoring the protections now given to that person in law.

Finally it is sad that the Aboriginal community is singled out from all the others. Are they not human beings as well covered by the previous admonitions avoiding prejudice? Separating them from the rest is degrading in my opinion.

RM10

3/11/2019
Approve

RM11

3/11/2019
This caught my eye: “Accept the patient without discrimination (such as on the basis of age, disability, gender identity or expression, genetic characteristics, language, marital and family status, medical condition, national or ethnic origin, political affiliation, race, religion, sex, sexual orientation, or

socioeconomic status). This does not abrogate the right of the physician to refuse to accept a patient for legitimate reasons.

2. Having accepted professional responsibility for the patient, continue to provide services until these services are no longer required or wanted, or until another suitable physician has assumed responsibility for the patient, or until after the patient has been given reasonable notice that you intend to terminate the relationship."

These questions come to mind:

What would be legitimate reasons to refuse a patient? What would be a reasonable notice for termination?

RM12

3/11/2019

I have reviewed the revised CMA code of ethics and commend the authors of the document which addresses some current technological and cultural aspects of medical practice. The only specific comment I have relates to an item under commitment to respect for persons: That is: always respect the autonomy of the person. As a psychiatrist, we at times must hold patients against their will when they pose a danger to themselves or to others and suffer from a mental illness. This is one of the few circumstances when safety demands overriding the patients autonomy. It would be helpful if there was clarification provided about such circumstances as outlined in the Provincial Mental Health Act.

RM13

3/11/2019

This is a good comprehensive document. It seems to have very reasonable guidelines consistent with what should be part of a medical practice. I do not see any items that seem pushed by special agenda groups or other third party interests.

RM14

3/11/2019

Review the Code of Ethics and found them acceptible

RM15

3/11/2019

I agree with the new code of ethics

RM16

3/11/2019

It’s interesting that it is not explicitly stated that physicians should not enter into relationships with patients.

RM17

3/11/2019

I felt that this was a very well thought out and comprehensive code of ethics and professionalism. Very well written and easy to understand.

RM18

3/11/2019

In regards to Section B, sub-section "Commitment to justice":

I strongly object to using the word "justice". This is a socially in vogue use of the term justice that should be discarded so as to avoid creating a political document.

Furthermore, "social accountability" is a superficially vague term that is also politically popular but means something different than it implies. The WHO definition from 1995 is “the obligation [of medical schools] to direct their education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they have a mandate to serve. The priority health concerns are to be identified jointly by governments, health care organizations, health professionals and the public.” If this is what physicians should promote or aspire to do, then let's be more specific in the code of ethics.

RM19

3/11/2019

Let's be clear- the CMA doesn't represent me or most other physicians. Only one province got to vote on who its president is. Same with the past and future presidents. That's three members of the board I don't get a vote for. As an Alberta physician, I get to vote for exactly one board member, and that member gets the same pull as the med student rep and the non-physician rep. I get literally no say. Its board regularly defies the will of its members, such as by secretly selling off MD Management and using the proceeds for a political slush fund.

So please, don't pretend the CMA has moral authority to tell me what is ethical and what isn't.

RM20

3/11/2019

I think the new code is fine although a bit more wordy than the previous version.

RM21

3/12/2019

1) Recognizing that medical students and residents are still colleagues (as defined in #31 under "Physicians and Colleagues", I would despite this suggest that under "Commitment to self-care and peer support", the second sentence be altered to read, "Value and promote a training and practice culture that supports and responds effectively to LEARNERS AND colleagues in need and empowers them to seek help to improve their physical, mental, and social well-being." Given that learners are mentioned in other areas of the document, I think that the addition of "learners" to this particular sentence is important given the vulnerable situation that students and residents may be in (with respect to power hierarchies) and the additional struggles that they may face with respect to wellness, given their lower levels of autonomy and relative inexperience balancing their medical work with the rest of their life. I hope that this would also serve as a reminder to attending physicians that they can be a huge resource and support for learners and impact them deeply through their influence and role-modeling.

2) Regarding point #13 under "Decision-making", could this possibly say "...a mature minor's right to consent to OR DECLINE treatment..."? It may be implicit, but I wonder if there is value in being clearer about this.

3) In #21 under "Patient privacy and the duty of confidentiality", I am confused as to why "health care discussions" are specified. Shouldn't this just be "discussions" (health care or not?). I understand that the only discussions being had about patients should be "health care" ones, but it seems to unnecessarily restrict the applicability in a way that isn't necessary.

RM22

3/12/2019

2. Having accepted professional responsibility for the patient, continue to provide services until these services are no longer required or wanted, or until another suitable physician has assumed responsibility for the patient, or until after the patient has been given reasonable notice that you intend to terminate the relationship.

This wording does not consider a situation when a patient becomes violent (e.g. declares intent to harm or kill the physician). There needs to be wording that explicitly indicates that the relationship is terminated when safety is a concern.

RM23

3/12/2019

In this statement of the Code of Ethics, under the section of "Commitment to Respect for Persons", the fourth line states "Never participate in or support practices that violate basic human rights". Article 3 of the UN Declaration of Human Rights states "Everyone has the right to life, freedom and security of person". If all of us have an inalienable right to life, then how is medical assistance in dying - in which a physician actively participates in the death of an individual, thus taking away that patient's life, acceptable according to this proposed Code of Ethics?

RM24

3/12/2019

In respect of new plans to go forward with connect care and information sharing with patients, I am concerned for sharing private dr-pt notes with patients. I have already been approached by patients whom are requesting these, whilst referring to new ability to information share with drs.

Some have even spoken of the need to use this information together with a hired third party eg private lawyer to then argue a denial of claim for disability or other.

I feel the owners note taking and record keeping are private and unique to a physician creating it; although belonging to a patient indeed. To liberally hand these out, I am concerned to do so.

Can there be a structure/guideline to oversee this part of the information sharing & still be respectful of both parties involved.

RM25

3/12/2019

Please review the Hippocratic oath. It is far removed from the amoral thinking that is current.

What is ethical? Where can a REAL doctor act with empathy and true care without being hounded by some medical or other rules? It is with relief that I will retire very soon.

RM26

3/12/2019

There is no definition of reasonable notice for termination of the physician patient relationship. This could lead to significant disputes between physicians and surgeons, some of whom might consider a month reasonable and other a year.

RM27

3/12/2019

I think this is an excellent modification to include attention to physician health and ability to reflect on the process of the relationship. This is very important to maintain a balanced approach towards the fiduciary relationship of Doctor patient.

RM28

3/12/2019

I am greatly concerned about the CPSA's shift towards over reach. We already operate in a system where any physician / College interaction starts off with "guilty before being proven innocent." Now the College aims to overstep its bounds from primarily acting in the best interest of patients and to specifically regulate physician behaviour outside of the patient-physician relationship.

Take for instance a physician who develops or pursues a romantic relationship with a colleague - be it a physician, nurse, RT, pharmacist, hospital allied staff, trainee physician etc . All of this is now regulated between the College and the Gov't recent legislation.

Physicians aren't allowed to be human anymore. Every aspect of physician life is now under the control and regulation and judgement of the CPSA.

The CPSA has lost its way. It seeks power wherever it can. THis is a dangerous slope and distracts the CPSA from its primary mission: the public interest.

RM29

3/12/2019

It would help to have access to a document that shows the differences between the 2004 and 2018 version of the code of ethics.

RM30

3/13/2019

38. Recognize that social determinants of health, the environment, and other fundamental considerations that extend beyond medical practice and health systems are important factors that affect the health of the patient and of populations.

I don't buy into this idea of the social determinants of health. It seems to me a lazy way to blame society for poor health, rather than recognizing that good health is significantly more the result of good personal choices than it is the availability of health care resources. The same characteristics that predict poor health are those that predict poverty.

10. Never participate in or condone the practice of torture or any form of cruel, inhuman, or degrading procedure.

Does this include ripping apart unborn children limb from limb? Does this include encouraging or facilitating genital mutilation (what some call sex-change) in kids under the age of 18? Puberty blockers despite overwhelming medical evidence that this is a bad idea? Last I checked, the CPSA doesn't take a firm stance against these terrible practices that have become common place for some physicians.

RM31

3/13/2019

These modifications look fine - I have no issues with the Code

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RM32

3/13/2019

No concerns.

RM33

3/13/2019

I question why Medical Doctors accepted Minister Sarah Hoffman return of 90 Million Dollars , if Physicians controlled Healthcare Costs and were diligent and prudent when requesting Medical Testing . Reading the old Physicians Code of Ethics , this should be a blatant breach and viewed as an outside influence upon accepting these funds . Is it reasonable to believe that with be the promise of funds returned to Physicians , it would not unduly influence their decision making Process . I am glad the Code of Ethics and ProffessionIsim is be reviewed . Patient care depends on it .

Thank you

RM34

3/14/2019

The items in point #43, while socially relevant, appear to reduce the understandings of our professional obligations of care to a specific historically marginalized group in this instance. My concern is our perception that this is necessary, as we are all tasked with the moral and ethical obligations of providing unbiased care to all persons regardless of race, religion, creed, or need. I feel that we could place ourselves in the unnecessary position of identifying many other groups in specific ways (ie. LGBTQ/Immigration/etc.), whereas the core tenets and moral imperatives directing the expectations of the care we provide remain unchanged. As such, I feel that this item need not be included - not because

it doesn't't reflect important considerations, but because they are not inherently specific to our medical considerations.

RM35

3/14/2019

Dear Colleagues

This is clearly an improvement. Over many years I have tried to apply the code to my practice and those who worked with me. What I found was that the wording is often highly philosophical and general I.e. not pragmatic. That is no surprise obviously because it would become a huge document otherwise. Therefore it is however subject to interpretation, and in the case of bad behavior subject to manipulative arguement. My main additional suggestion therefore is to identify where in the code one addresses the issue of the “disruptive physician”. It is not clearly spelled out in precise terms. Disruptive physician behavior is outlined by the HQCA document but only as a guideline to follow. This needs the authority of the college and the CMA Code so it may be enforced by small groups of physicians in their practices. In that way the college doesn’t end up dealing with corrosive but not flagrant bad behavior at a high level. Ie self governance by our groups at the most basic level of good conduct in the office. In many years of practice the broad issues described in the new code are much less of a problem then the softer issues of disruptive behavior, that sadly eventually lead to formal complaints to the college. But not without a lot of damage caused by the disruptive physician in the meantime. I would ask the registrar how we might add some teeth to the HCQA guidlelines in our community practices. Will this come with the CPSA move to start requiring all community practice groups to have proper and authorized Medical Director positions...across the province? I look forward to your response.

RM36

3/14/2019

It is about time that we, as a profession, move into the 21st Century. Re-writing the Code including the above changed accomplishes a large portion of the changes necessary to move us toward modernization.

RM37

3/16/2019

INCLUSION THAT FELLOW PHYSICIANS SHOULD ALWAYS SPEAK POSITIVE ABOUT OTHER PHYSICIANS ESPECIAL APPARENT MISTAKES WERE MADE. (TO PREVENT UNDUE COMPLAINTS)

RM38

3/17/2019

Two comments:

-Should the CMA include a position on the emerging role of AI in medicine, and its potential impact on patients and physicians? What are the ethics around this that need to be codified?

-The CMPA has advised you have a duty of care to advocate for patients when government/hospitals do not provide appropriate resources. Ie, simply accepting a detrimental delay in diagnosis or treatment because your jurisdiction appears to lack access or resources does not meet the duty of care to an individual patient / plaintiff. The document mentions a stewardship role, but must cut both ways - physicians should be conserving resources where appropriate, but they must also be enabled to communicate the need for additional ones where required and advocate appropriately.

RM39

3/17/2019

1. I applaud the inclusion/focus of social determinants of health, health inequity, responsible resource stewardship, mention of the TRC, and physician wellness/self-care and peer support.

2. The layout of the 2004 version (2 columns rather than full page text) is much easier to read and digest.

3. Section A and Section C are straightforward and offer valuable information in a succinct format. The information in Section B, 'FUNDAMENTAL COMMITMENTS OF THE MEDICAL PROFESSION', is not as 'tight', in format or in content. Information under 'Commitment to the well-being of the patient' and 'Commitment to respect for persons' could be combined under a single heading. Information under 'Commitment to professional integrity and competence', 'Commitment to professional excellence', and perhaps 'Commitment to inquiry and reflection' could all similarly be grouped under one single heading. Less headings would offer this information in a more streamlined format that would be easier to process/digest.

4. The title of section C, 'PROFESSIONAL RESPONSIBILITIES' is clear and readily understandable. In comparison, the titles of sections A and B, 'VIRTUES EXEMPLIFIED BY THE ETHICAL PHYSICIAN' and 'FUNDAMENTAL COMMITMENTS OF THE MEDICAL PROFESSION' are wordy and therefore less clear in the information they are trying to convey. Consistency between the titles would help tie the different sections of the document together and reinforce its entire message. For example:

A. Fundamental Values of the Medical Profession

B. Fundamental Commitments of the Medical Profession

C. Fundamental Responsibilities of the Medical Profession

Or simply:

A. Values

B. Commitments

C. Responsibilities

5. Re: #8 'Provide whatever appropriate assistance you can to any person who needs emergency medical care' should perhaps be expanded to be not quite so broad. This point should encompass questions such as:

-Are there medicolegal ramifications to providing care in certain situations (eg. on airplanes, in foreign countries)?

-Are you providing care within your scope of practice?

-Take the goals of care or context of the patient into consideration (ie. ensure you are not providing CPR to someone with end stage disease, should this background information be readily available at the scene of the emergency)

'appropriate assistance' of course encompasses these above points, and I am sure consideration of the above points already goes without saying for most physicians, but the current statement kind of reads as 'Always do everything that you can for a person in a medical emergency'.

6. 'Provide appropriate care and management across the care continuum' (under 'Commitment to the well-being of the patient') is a bit nebulous and confusing.

7. 'Always respect the autonomy of the patient' (under 'Commitment to respect for persons') should be qualified - patient autonomy should always be respected in areas where the patient has capacity and as long as respecting their autonomy is not going to cause harm to themself or others.

RM40

3/17/2019

I totally agree with the new Renewed Code of ethics

RM41

3/18/2019

I agree entirely.

RM42

3/18/2019

seems very acceptable

RM43

3/19/2019

I feel very strongly that every patient is equally entitled to evidence based high quality health care, free from social or political interference. By mandating advocacy for one or more special populations, we may inadvertently marginalize another group or neglect the fact that every patient has vulnerabilities whether or not they fit into a defined vulnerable population. In view of this I would ask the CPSA to refrain from including articles 43 and 44 and any other article which mandates advocacy for one particular group of patients.

RM44

3/22/2019

This is a great improvement!

I particularly like the emphasis on virtues.

RM45

3/24/2019

While I generally like this new Code (I like the inclusion of virtues) I would have liked to see a clear statement that the patient's interests are paramount, and trump the physician's interests. The new Code suggests this in a couple of places (e.g. around non-abandonment) but fails to make this principle explicit.

RM46

3/28/2019

The new format reads well but represents a “rules based” approach to ethical decision making. This works but takes away the sense of freedom encompassed in profeasionalism in that physician’s need to know more about making ethical decisions than simply expecting to find the “right rule” for the occasion. Few situations fit expectations embodied in rules. I’d suggest there be added a paragraph regarding the way to navigate “grey” situations and recognize the highest principles of medical practice such as “do no harm” and how to build that thought into our decisions. Too many rules and not enough thought.

RM47

4/5/2019

The College has turned a perfectly good code of ethics into a mean, petty, uninspiring document which is verbose and repetitive. It may not be exhaustive, but it is certainly exhausting. It needs an editor. The preamble needs to be stuffed into a footnote at the end. The code of ethics needs to be separated from the code of professionalism. If the college did that, it would be able to stuff as many petty little rules as it could think of into the code of professionalism and at least leave us with one brief inspiring document called a code of ethics.

What is the intended audience for this document? The public? The profession? Both? Who is going to actually read something so long-winded?

I suggest that the College contact a reputable Canadian publisher and seek advice from one of its senior editors. Failing that, it could contact several professors of English at an Alberta university for suggestions on a rewrite.

Winston Churchill was once asked how long his speech would be. “Rather long, I’m afraid,” he answered, “I didn’t have time to write a short one.”

RM47

4/5/2019

I have commented previously that this document is “wordy”. I here provide an example.

Section 1.

Four different terms are used regarding sexual matters. These are: “gender identity”; “gender expression”; “sex” and “sexual orientation”.

Am I such a dinosaur that I do not realize that these refer to four distinct things? Or is this an example of lazy use of language? Is it really necessary to use “gender expression” when you already have “gender identity”. After all, people who identify in a certain way express themselves accordingly. Is it necessary to use both terms “sex” and “sexual orientation”. Does the use of the word “sex“ really add anything? What does it mean here? Would it not be as meaningful merely to use the two terms, “gender identity“ and “sexual orientation“? It seems to me that these terms cover pretty much everything from straight to gay to bisexual to transgender. Aren’t we trying to cover as much as possible in as few words as possible? Good editing usually involves the removal of words, not their insertion.

In the course of a fairly long career I have been the first point of contact for three people who transitioned and I helped them on their way until their needs exceeded my psychiatric and surgical skill. Therefore, I do not consider myself a dinosaur, Nor do I consider that my understanding of this vocabulary is faulty. If I am wrong, I would appreciate being corrected.

RM47

4/5/2019

I dislike the mention of one particular ethnic/racial/cultural/native group not because I am opposed to that particular group - I am not and I have numerous patients who belong to that group and who are happy to come and see me - but I fear that specific mention of one group diminishes the group rather than enhances it. My argument is similar to that which has been used against the introduction of the "Islamophobia bill" by the Liberal government. Before this, there was never any specific protection for other minorities such as Jews (Does anybody remember anti-Semitism?) - anti-semitism used to be a word. You don't hear it anymore. Now you hear Islamophobia.

So let's stick to the general. Discrimination against people on the basis of race or religion is wrong. Period.

RM47

4/5/2019

I find this document overly political. It reminds me of an editorial by a former registrar regarding a current US president. I think the College should stay away from political statements as much as possible. Stick to basics. Stay away from politics. The registrar was retiring at that time so he could say anything he wanted to. I don't think that The Messenger should be used for such purposes. And I don't think political matters should find their way into the code of ethics. The code of ethics should be brief and inspirational. It should "inspire". This one does not.

By the way, though this so-called code of ethics and professionalism was instituted by the Canadian Medical Association; that is no seal of approval. The Canadian Medical Association has long since ceased to be a representative vehicle for many Canadian physicians. (But it has become very political. And its goals, and reasons for being, are entirely different from those of provincial regulatory bodies. We should not lose sight of that. I think the College HAS lost sight of that.)

Finally, let me say that it does not inspire me when the College states (as it has from time to time) that it has consulted with different groups such as Alberta Health Services. Alberta Health Services is not a sentient being. It is an enormous, anonymous organization. What I want to know is with whom did The College consult? With which human beings? With what credentials? Are these "consultants" willing to stand up and be counted? The College can say it "consulted" with any groups it wants but this does not lend credibility to the College. The College itself is not a sentient being. Any other organization could say "We consulted with the College of Physicians and Surgeons of Alberta." So what? With whom?

The College should quit trying to gain credibility by pretending that it has consulted with others. It does not matter whether you have consulted or not. What matters is the final document. This is the document that you are taking responsibility for. Consultation does not lend credibility. You have to take responsibility for the document yourselves. The College's consultants are not taking

responsibility for this document. It is entirely the responsibility of the College. That is the end of it.

RM47

4/5/2019

Why do you have to use such obtuse and academic language? Why do you have to say “articulates” instead of “says” , “states” or “lists”. No one in the general public “articulates” anything. They “say” what they have to say. They “state“ things.

I am presuming, of course, that you wish this document to be accessible to the general public and not just to the profession.

RM47

4/6/2019

Despite the fact that this new code is so disappointing, so uninspiring, and so terribly prescriptive, I think I will be forced to support it, with regret, because of its multiculturalism aspect. The “heavy hand” of multiculturalism obviously underlies this document. “Common sense” is something that is taken for granted in different cultural groups. But “common sense” is not “common” at all “between” cultural groups. The Canadian physician population is now a heavily multicultural group. It is distressing to me, but apparently entirely necessary, that there be a very detailed code of ethics and professional responsibilities to which all these different groups should adhere. I guess this code is merely a reflection of the times.

I am disturbed, though, by what I consider “mission creep”. This is the gradual, progressive extension of regulatory authority that the College grants itself. I wonder how long it will be before people are disciplined for working too long, being overweight, or smoking. The section on physician health is disturbing. It would be far better if the College did something to assist physicians who are in difficult work situations rather than creating a framework in which punitive measures could be taken.

RM47

4/12/2019

Hello there,

I wanted to pass along a few comments I had from some points seen in the document.

"4. Inform the patient when your moral commitments may influence your recommendation

concerning provision of, or practice of any medical procedure or intervention as it

pertains to the patient’s needs or requests."

I bring up this point specifically as there were a fair number of issues recently arising re: objection to MAID. I wonder if this is contentious in light of these discussions. While I personally support this as written I am uncertain on how this would be communicated from physicians to patients (such as stating that because their Catholic beliefs they are not able to provide a patient with administering MAID -- what level of self disclosure is appropriate in this circumstance).

"7. Limit treatment of yourself, your immediate family, or anyone with whom you have a

similarly close relationship to minor or emergency interventions and only when another

physician is not readily available; there should be no fee for such treatment."

I am under the impression the College stance on this is that there must be no charge, not that there should be no charge? I believe this has been explicitly stated in recent communications.

"8. Provide whatever appropriate assistance you can to any person who needs emergency

medical care."

Does this change the ethical obligation where a physician is not obligated when not on-duty to provide emergency services to then become involved in situations where there is a need for emergency care? I was under the impression that a physician has not been ethically obligated to stop and help at a motor vehicle accident scene. It appears this is a reversal of that and this stance makes me concerned re: this as I do not like how this is worded as it reflects on our obligations as a profession.

"23. Enter into associations, contracts, and agreements that maintain your professional integrity, consistent with evidence-informed decision-making, and safeguard the interests of the patient or public.

24. Avoid, minimize, or manage and always disclose conflicts of interest that arise, or are perceived to arise, as a result of any professional relationships or transactions in practice, education, and research; avoid using your role as a physician to promote services (except your own) or products to the patient or public for commercial gain outside of your treatment role."

I think that these two points need to be specifically thought about by the college. I am all for the removal of influence of the pharmaceutical influence on provision of patient care and I think that the College could do a better job of speaking to the profession on the evidence that those with relationships to industry provide care that is at significant risk of bias.

"43. Commit to collaborative and respectful relationships with Indigenous patients and communities through efforts to understand and implement the recommendations relevant to health care made in the report of the Truth and Reconciliation Commission of Canada"

I have concerns with the wording of this point and its adoption at the level of the College as the blanket stance under which all practitioners should follow, specifically with respect to the amount of nested information. If the CPSA is using an ethics document created by the CMA which is referencing a document (which document they are referencing is quite unclear, actually) done by the Truth and

Reconciliation Commission then I feel you are at risk of just having the ethics document be mere lipservice to actual change.

In the calls to action on health there are seven listed in the 535 page executive summary. There are many other documents beyond this. I do not think it is expected that a professional will read the report in its entirety (I have not) and as such, even the summary I've quoted below may not represent what is fully emphasized by the CMA document.

" Health

18) We call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties.

19) We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long-term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.

20) In order to address the jurisdictional disputes concerning Aboriginal people who do not reside on reserves, we call upon the federal government to recognize, respect, and address the distinct health needs of the Métis, Inuit, and off-reserve Aboriginal peoples.

21) We call upon the federal government to provide sustainable funding for existing and new Aboriginal healing centres to address the physical, mental, emotional, and spiritual harms caused by residential schools, and to ensure that the funding of healing centres in Nunavut and the Northwest Territories is a priority.

22) We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.

23) We call upon all levels of government to: i. Increase the number of Aboriginal professionals working in the health-care field. Calls to Action • 323 ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities. iii. Provide cultural competency training for all health-care professionals.

24) We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism."

From reading this, the majority of the calls speak to government bodies or medical/nursing schools. As a profession we are not these government bodies, nor are we the medical schools or nursing schools.

Point 22 seems appropriate to add to the ethics with respect to how indigenous patients are treated as part of a patient-centered approach that values patient values and autonomy. Whether these treatments need to be tempered by the other ethical principles of evidence-based care is relevant in the discussion of ethics, as well. I would like to see this specifically put in the CPSA document instead of having it be referenced information. I feel having it be specified directly in the source document without needing to cross reference another book it will be able to be taken more seriously and not simply as lipservice.

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Beyond the above, I feel that the 2004 CMA document is more concise and has less nebulous recommendations. I do not particularly see any strong case from the philosophy of ethics why the CMA would begin to overtly embrace virtue ethics in beginning of the new document. I do not think the medical profession is specifically well-served by adopting virtue ethics and I do not think that the CPSA should be promoting through its standard a particularly focused ethical school of thought it expects the profession to follow.

My ultimate preference would be to have a CPSA document that has been specifically drafted for our profession in Alberta that provides a useful guide to the profession on actual, tangible points that are well expressed and clear without stating a professional needs to follow a particular ideology. I do not feel this new guide adequately does this in its present form.

RM48

4/13/2019

It's a bit hard to compare the 2004 and 2018 versions. The new version seems remarkably "vague" overall, possibly because of so many terms like "guide", "aspire to", "strive to", etc. It will probably be harder to decide whether a specific decision or action by a Canadian physician meets the new CMA Code or not. Although it's the "highest" point of reference for medical ethics/professionalism in Canada, in many ways it's too vague to be useful. An aspirational document might inspire those (few) docs who actually read it, but the gray zones are where a Code of Ethics/Professionalism is most needed, and I would suggest the new version is perhaps worse than the previous one at helping navigate those gray zones.

Many of the terms used aren't defined, although I'd hate to see the Code lengthened further! As one of many examples, I struggle with the inconsistent self-referencing of various terms in the following:

"In this Code, medical ethics concerns the virtues, values, and principles that should guide the medical profession, while professionalism is the embodiment or enactment of responsibilities arising from those

norms through standards, competencies, and behaviours. Together, the virtues and commitments outlined in the Code are fundamental to the ethical practice of medicine." Maybe it's just me.

As far as specific comments go, here are a few:

Preamble

- for some reason, specifying that the Code outlines responsibilities related to "contemporary" medical practice seems jarring, and begs the question whether this Code needs yearly review to ensure that statement continues to apply?

Section A.

- "COMPASSION. A compassionate physician recognizes suffering and vulnerability, seeks to understand the unique circumstances of each patient and to alleviate the patient's suffering, and accompanies the suffering and vulnerable patient." An example of when aspirational language is simply confusing - what exactly is meant by "accompanies the suffering and vulnerable patient"? Accompany them home? Or to the bathroom? Accompany them in their "medical journey", somehow? It sounds fine on first reading, but seems to fall apart when one attempts to apply it.

Section B.

- "Provide appropriate care and management across the care continuum." Although (I think) I understand what this means, it seems to fall apart as soon as I try to think of practical examples. Does the "care continuum" refer to cradle-to-grave, or resuscitative/curative/palliative care, or care at home/in-hospital/in-clinic/other? Surely all physicians can't be expected to provide care across all, or even one, of these continuums?

Section C.

- Another example of vagueness to the point of impracticality: "Act according to your conscience and respect differences of conscience among your colleagues; however, meet your duty of non-abandonment to the patient by always acknowledging and responding to the patient's medical concerns and requests whatever your moral commitments may be." How does "acknowledging and responding" to the patient's concerns and requests equate to fulfilling a "duty of non-abandonment"? Clearly this is aimed at referrals for morally-sensitive things like abortion or MAID, but as written it means I fall foul of the Code if I don't "respond" (presumably by acquiescing) to my patients' requests - I can think of ten examples off the top of my head where doing so would be blatant malpractice.

- "Provide opinions consistent with the current and widely accepted views of the profession when interpreting scientific knowledge to the public; clearly indicate when you present an opinion that is contrary to the accepted views of the profession." It's surely overly-optimistic to state that there is a single "accepted view of the profession" on contentious issues, where this guidance is likely to be most relevant? Is the CMA the arbiter of this "accepted view"? Not being paranoid, but realistic.

In some ways, the revised Code is a classic example of a shift from a somewhat objective (or at least codified) set of ethical principles, to a somewhat subjective ethics that flirts with relativism - it becomes much harder to say "do this" or "don't do this", but instead we're left looking at "the medical profession" in a mirror, and defining ethics and professionalism by what we see, or hope to see, there. It's perhaps not the CMA's fault, as we're only following general society in this respect, but it's worth a passing thought to where this road leads, given some historical examples where the profession's "accepted view" was, in hindsight, entirely wrong. In many ways, the revised Code makes a laudable attempt to update the way in which we view our responsibilities to patients and society, and a lot of the new content is wonderful, but I do feel the result is a document that is less practically useful and much more "open to interpretation" than the previous one. Whether this actually matters or not remains to be seen. I wonder whether the CMA Code of Ethics and Professionalism will ever be relied on by physicians themselves, the Colleges, or the courts, in determining anything that matters? Or if it's simply aimed at the court of public opinion?

RM49

5/8/2019

CMA code of ethics Dec 2018 version is a comprehensive document which covers all the ethical aspects of physician practice.

This will help us to understand the ethical responsibilities of physicians. It will also help to achieve the higher standards of practice.

RM50

5/9/2019

It is very clear that we live in a different society compared to 15-20 years ago. Patients are demanding treatments, with the autonomy principle being overriding all the other rational and ethical values.

The code should have some protection against the demands for treatments that are not within the best interest of the patient or treatment for which the results would inevitable prolong the dying process. Without using the "futile" word (dangerous due to different interpretations), at least the "physiologic futility should be advocated as a parameter. A treatment that is known that will not be physiologically plausible.

We are moral agents – patients are not our properties, but also physicians are not “vending machines” who must act against what they think is medically advisable or which affronts their personal and idiosyncratic morality (except in emergencies). Treatments that will bring moral distress to the whole team as well.

(Eric Loewy, Theoretical Medicine & Bioethics 2005)

Physicians do not “hang their own moral beliefs together with their coats on a coat hanger, and provide whatever services a patient wishes as long as they are within the confines of the contract and the law.

(Engelhardt “The foundations of Bioethics”.)

RM51

5/10/2019

Thanks for the opportunity to have some input into this document; it seems very well thought out and thorough.

My input focuses on the conscience of the individual physician. We are all trying to do what is good and right for the patient, but inevitably there will be a diversity of opinion about this among doctors, among patients, and even within the membership of the governing bodies of our profession.

If there weren't diversity among the membership, that could be a sign of "group-think" or perhaps a reluctance to speak up for something different – not a good thing! Our ethical guidelines need to acknowledge that and do their level best not to force anyone to breach their own conscience.

Under the conscience consideration, I have two questions:

1. Do the guidelines give adequate consideration and protection to the ethnic and religious diversity among practicing physicians? I would include atheism in the word ‘religious’ for it is truly a religious viewpoint. For example, the paragraph on Prudence indicates a physician should make a decision “…in good conscience…”. The good conscience decision of one physician will be different from another based on, in many cases, diverse ethnic and religious viewpoints. Will one of those physicians be subject to discipline, and the other not, even if both made their decision absolutely based on good conscience, and good clinical and moral reasoning, etc. as the paragraph states? If so, then one physician’s conscience will have been protected, and the other's not. Will the result be that only the physicians whose conscience and therefore underlying worldview conform to the worldview of the governing body will be protected? Sometimes the minority is ‘right’, so we must allow them to stand on their conscience, even when the majority disagrees. Isn’t that how much of the progress on human rights and science has been achieved? Perhaps more explicit, stronger wording could be inserted to protect, if not encourage the independent expression and practice of diverse moral and religious consciences.

2. Do the guidelines offer adequate opportunity for expression of diversity and/or dissent by individual physicians vis-à-vis the public representations of their governing bodies? I’m thinking specifically of clause 41, which requires a physician to “Provide opinions consistent with the current and widely accepted views of the profession…” While allowance is made to “…clearly indicate when you present an opinion that is contrary to the accepted views of the profession” the previous wording seems to require a physician to ‘toe the party line’. If a physician is just sadly uninformed or stubbornly refuses to accept scientifically proven facts, this can be dealt with under competence requirements. Or does the proposed obligation to provide ‘opinions’ consistent with widely accepted ‘views’ refer to more than simply

providing competent medical care? Given the competence requirements already in place to ensure good care, would anything be lost if clause 41 were deleted?

Both of these concerns go back to the truth of history, that not infrequently it is the ones who voice the dissenting view who have sometimes changed the world and medicine for the better – Galileo, Copernicus, etc. Let's ensure they have a voice.

Thanks for your work.

College of Physicians & Surgeons of Alberta

Submission to:	**Council**

	Submitted by:		
May 30, 209	Dr. Karen Mazurek		
Agenda Item Title:	**Bill 21 Updates** • Patient Relations Fund		
Action Requested:	☐ The following items require approval by Choose an item. See below for details of the recommendation.	x The following item(s) are of particular interest to Council Feedback is sought on this matter.	☐ The attached is for information only. No action is required.
AGENDA ITEM DETAILS			
Recommendation (if applicable) :	***Feedback is sought from Council on the scope of the Patient Relations Fund. Should funding be strictly limited to minimum guidelines set by Alberta Health or would Council like to consider funding beyond those guidelines? Is this an opportunity for CPSA to act beyond minimum obligations in the interest of the public?***		
Background:	The recent amendments to the Health Professions Act require the health regulatory Colleges to establish a Patient Relations Fund to support counselling for complainants who have been the subject of sexual abuse and sexual misconduct by health professionals. The Patient Relations Fund must meet the guidelines established by Alberta Health. CPSA participated in an Alberta Federation of Regulated Health Professionals working group which: 1. Developed a framework for Colleges to use to establish the fund. 2. Negotiated a contract with Homewood Health to deliver the services as per the framework. The intent is that each health College wanting to use Homewood will use the contract template. CPSA has signed the contract with Homewood health. The framework provides for $22,500.00 worth of counselling for each complainant. The funding is made available as soon as the complaints director identifies the complaint as falling under the definition of sexual abuse or sexual misconduct. Complainants may use the funding for a period of five years. If the complaints director or a hearing tribunal dismisses the complaint, Alberta Health guidelines allow colleges to terminate the funding. The requirement for a patient relations fund has considerable financial implications for CPSA which will be incorporated into the budget that Council will be asked to approve in September 2019. Between 2015 and 2017, CPSA handled 48 complaints		

College of Physicians & Surgeons of Alberta

	that would likely have met the definitions for sexual abuse/misconduct under the new legislation (although not all may have met the definition of patient under CPSA's new SOP). If each complainant used the full funding, the cost to CPSA would be in the range of $360,000.00 per year. Given the increased awareness raised by recent events there is a good likelihood we will see more complainants coming forward. There are some philosophical questions Council should consider. The legislation and the subsequent standard of practice the Council adopted are black and white. A "patient" is strictly defined. As a result, whether or not a complainant is entitled to funding rests on the timing of the inappropriate behavior. If the behavior occurs within 365 days, the complainant receives funding. If it occurs on the 366th day or later, they do not. The legislation applies only to patients – we have had cases of inappropriate sexual behavior toward parents of minors and to learners; neither would be eligible for funding. Although they may not fall within the strict definitions of the sexual abuse/misconduct legislation, the behavior may be determined to be unprofessional and the complainants may experience the same degree of emotional trauma. Furthermore, Council should consider the implications of withdrawing funding when cases are dismissed by the complaints director or the hearing tribunal. It is extremely rare that these complaints are found to be trivial or vexatious. Most often, the cases are dismissed due to insufficient evidence. Often the only evidence available is the witness testimony of the two parties, the patient can be very vulnerable and traumatized which affects their ability to testify. Considering the grave consequences of a guilty finding under the new legislation, the hearing tribunals will need to ensure duty of fairness and will look to solid evidence before making a finding of sexual abuse or misconduct. Council is asked to provide feedback on the following questions: 1. Does Council support continued funding following dismissal of a complaint meeting the definition of sexual abuse or sexual misconduct unless the complaint is dismissed as trivial or vexatious or there is evidence to support unprofessional conduct did not occur (vs. insufficient evidence to proceed)? 2. Does Council support extending the funding to complainants who do not meet the definition of "patient" in our SOP – e.g. last physician/patient encounter more than one year ago, after termination of an episodic encounter, or parent of a minor? 3. Should CPSA provide funds for counselling for learners who complain of inappropriate sexual behavior by a preceptor or is this more appropriately the realm of the universities considering the faculties have an obligation to keep their learners are safe?
Next Steps:	CPSA staff will budget based on Council direction. Budget will be presented to the Finance and Audit committee and subsequently to Council for approval in September 2019.

Alberta Health

10025 Jasper Avenue NW
PO Box 1360 Stn Main
Edmonton, Alberta T5J 2N3
Canada
www.health.alberta.ca

March 18, 2019

Dear Colleges,

I am pleased to provide you with a copy of the proposed funding guidelines for treatment and counselling established under section 135.9 of Bill 21, *An Act to Protect Patients*.

The Ministry appreciates colleges' collaboration and support for the development of these funding guidelines, and for your commitment to the successful implementation of this legislation.

Colleges' commitment to voluntary adhere to these standards is heartening. Using these guidelines until a regulation is in place will allow Colleges and the Ministry to assess the feasibility of these proposals for Colleges. Adherence to the funding guidelines will ensure Albertan's receive effective and consistent treatment or counselling across regulated professions in our province.

Once you have had the opportunity to finalize your college's funding plans, please submit an overview of your funding program for informational purposes, to Andrew Douglas, Director, Health Professional Regulation Unit, at andrew.douglas@gov.ab.ca.

If you have any questions, please contact Andrew Douglas directly at 780-422-8860 or by e-mail.

We will work with you to monitor over the coming months the number of complaints that are eligible for funding. A template will be distributed in the upcoming weeks to allow for consistent data collection.

Thank you again for your support and commitment to the successful implementation of this legislation.

Sincerely,

Leann Wagner
Assistant Deputy Minister, Health Workforce Planning & Accountability
Alberta Health

Attachment

cc: Alberta Regulatory Colleges

ATTACHMENT

Funding Guidelines for Treatment and Counselling - Section 135.9 of the *Health Professions Act*
April 1, 2019

- A patient will have access for funding for up to five years or until the maximum amount of funding has been provided (whichever occurs first).
- Funding ceases if a complaint has been dismissed by the complaints director or the hearing tribunal.
    - After a dismissal, the regulatory college will provide the patient with a letter outlining:
        a) That the patient's eligibility to receive funding has ceased as a result of the dismissal of the complaint;
        b) The patient's right to appeal the dismissal of the complaint;
        c) That upon successful appeal, funding will resume and will remain in place until the complaint is resolved; and,
        d) Referral to relevant community resources (e.g. sexual assault centres).
- A patient will not be required to undergo any assessment prior to being eligible to receive funding.
- A patient will be eligible to choose any regulated health professional to provide treatment or counselling, subject to the following restrictions:
    - The regulated member must not treat the patient if there is a conflict of interest (e.g. family member); and,
    - The regulated member must be in good standing with the regulatory college they are registered with.
- Funding can only be used to cover cost of treatment or counselling.
- The maximum amount of funding that a college will be required to pay out would be equivalent to the cost of 100 hours of psychiatric counselling as per the rates listed in the Schedule of Medical Benefits.
- A regulatory college will be entitled to recover the costs associated with providing treatment or counselling from a regulated member found to have committed unprofessional conduct involving sexual abuse or sexual misconduct.
- A regulatory college will not be entitled to recover costs from a patient where a complaint is dismissed or deemed frivolous or vexatious.
- Colleges will provide the Minister with an annual report outlining the total amount of funds dispersed to patients as well as the total number of patients who have accessed the fund.

Version Date: 11 April 2019

Bill 21: Outline - Fund for Treatment and Counselling

Background – From Alberta Health: "In November 2019, Bill 21 *An Act to Protect Patients* amended the Health Professions Act (HPA) by adding Section 135.9 which states:

- A college must provide funding for the purposes of providing treatment or counselling for patients who meet the requirements set out in s. 135.9;
- Each college may establish its own fund or establish a fund with one or more colleges;
- A college may appoint one or more persons to assist with the administration of the fund;
- A patient is eligible for funding if (a) a complaint is made respecting a regulated member that relates to sexual abuse or sexual misconduct towards that patient by the regulated member; or, (b) the patient meets the requirements set out in the regulations;
- Funding under this section must be provided in accordance with the regulation."

Funding guidelines for Treatment and Counselling were released by Alberta Health on March 18, 2019 (see attached).

Treatment and Counselling Program– the following outlines a program model that could be used by one or more colleges to provide a fund for treatment and counselling services for Eligible Complainants[1]**.**

The key component is the use of a contracted Provider (e.g. Homewood Health) that would offer treatment and counselling services themselves (outpatient, virtual and inpatient), and/or pay a Professional[2] of the Eligible Complainant's choice for for treatment and counselling services.

Program Process –

1. A complainant contacts the relevant college with a complaint of sexual abuse or sexual misconduct. The college makes a determination using its standard of practice and internal processes as to whether the complaint falls within the definitions of sexual abuse or sexual misconduct under the HPA. If so, the complainant (Eligible Complainant) is provided with:

    a. information on available treatment and counselling services;
    b. information on how those services will be paid; and,
    c. a complaint reference number and the intake contact information for the Provider.

2. Eligible Complainants are informed of the maximum allowable amounts ($22,500) and the maximum time period payments from the Provider will be made (5 years from the date on which the eligibility is determined by the College).
3. The College notifies the Provider of the Eligible Complainant name, complaint reference number and eligible funding start date. The College provides a copy of the notification to the Eligible Complainant.

[1] A complainant deemed by a college using its standard of practice and decision-making process to be eligible for treatment and counselling funds under the sexual abuse and sexual misconduct provisions of the HPA

[2] An Alberta regulated health professional who is in good standing with the regulatory college they are registered with, or in circumstances where the eligible complainant resides outside of Alberta, an equivalent regulated health professional registered in another Canadian province.

4. It is **not** the college's role to determine what kind of treatment or counselling is appropriate for the Eligible Complainant nor shall it receive reports about the therapy being funded.

5. An Eligible Complainant contacts the Provider and completes the required forms[i] to fund the treatment and counselling services.

6. The Eligible Complainant begins treatment or counselling through the Provider, or may choose another Professional. In this case, that Professional is to submit invoices for service provided directly to the Provider for payment. The Provider will only pay the Professional and not the Eligible Complainant.

7. The funding can be shared between more than one Professional, up to the maximum allowable amount. Invoices are processed by the Provider as they are received.

8. The funding will terminate if a charge of unprofessional conduct is dismissed by the Complaints Director or a Hearing Tribunal. Upon termination of funding, the complainant will be advised of their right to appeal dismissal of the complaint and that upon successful appeal, the funding will resume and remain in place until the complaint is resolved.

9. A patient is ineligible to receive funding for past treatment or counselling costs.

Administrative Components –

1. Pricing – Services provided by a Professional of the Eligible Complainant's choice would be directly reimbursed by the Provider to the Professional at the rates set by that Professional. Services provided by the Provider would be charged out at their rates based on the treatment and counseling service required and their intensity, i.e. individual psychotherapy, couple/family therapy, multi-disciplinary day program and inpatient program. An administrative fee ($95/hour) with a maximum per Eligible Complainant ($500) will be charged by the Provider to cover program costs and to maximize funding going to Eligible Complainants for treatment and counselling services.

2. Cash Flow – Participating colleges would provide funds to the Provider to draw upon (a float) once there was an Eligible Complainant from that college. The Provider shall keep funds directed for the Treatment and Counselling Program in a separate Trust Account.

3. Record Keeping – It is proposed that the Provider provide:
    a. Quarterly reports, plus college year end reports, to participating colleges at a minimum outlining the funds transferred in, the funds disbursed by Eligible Complainant reference number and payment dates, and the declining balance from the maximum allowable amount ($22,500) for the reporting period. Participating colleges would use that information to manage their funding contribution.
    b. Annual report, based on the college year end, summarizing the total amount of funds disbursed for services provided to Eligible Complainants and the total number of Eligible Complainants who have accessed the fund.

4. Agreement – A template agreement between the Provider and each participating college would be used versus a single agreement covering all participating colleges.

[i] It is foreseen that one or more forms may be required to obtain information needed to process payments to a Professional.

A Professional must agree to only use the funds for treatment and counselling services, affirm that s/he has no family relationship to the recipient.

College of Physicians & Surgeons of Alberta

Submision to:	**Council**

Meeting Date:	Submitted by:		
May 30, 2019	Finance & Audit Committee		
Agenda Item Title:			
Action Requested:	☐ The following items require approval by Choose an item. See below for details of the recommendation.	☒ The following item(s) are of particular interest to Council Feedback is sought on this matter.	☐ The attached is for information only. No action is required.
AGENDA ITEM DETAILS			
Recommendation (if applicable) :	***b2ű l-ŁJŁJŧŧŎl-ōtŜ***		
Background:	The Finance & Audit Committee is seeking the following: 1) Council's endorsement of the list of honorarium principles. 2) Council's feedback if the CPSA should be paying committee members an honorarium for meeting preparation. **Background** The CPSA practice for paying honorariums for meeting attendance has included all committee members. This has included: • Physician members • Public members, or non-physician members • Dean of Medicine from the Alberta and Calgary universities • Medical Student representative • PARA (Professional Association of Resident Physicians of Alberta) representative The CPSA also pays travel time to members based on the number of kilometers from the committee member's place of residence to the College meeting. The CPSA's current Honoraria & Expense policy includes the following: **Honoraria** 1. Per diem/honorarium entitlement is based on an 8 hour work day.		

College of Physicians & Surgeons of Alberta

2. Honoraria are generally payable for formal meetings only. Time spent preparing for meetings, reviewing agendas or files, or preparing correspondence is not normally reimbursed. Preparation time for Council meetings may be paid, but this would be by exception, at the call of the President in advance of the meeting.

3. Observers who are invited to attend CPSA Committee meetings may be eligible for reimbursement of travel expenses but are generally not eligible to be paid an honorarium (both at the discretion of the Registrar).

4. Honoraria will be paid for travel time if a physician/committee member must travel to and from a College meeting, as follows:
   70 to 550 km (round trip), an additional 1/2 day
   551 to 950 km (round trip), an additional 1 day
   Over 950 km (round trip), an additional 1.5 day

5. No per diem is paid for attendance of Councilor or Committee members at College-related social functions, but expenses related to attendance may be claimed. Councilors attending their local Regional Tour are eligible for a ¼ day honorarium plus travel time, if outside their home community.

6. Councilors attending seminars or retreats for Council (i.e. the business of Council) will be paid according to the same arrangements as regular Council meetings.

7. Meetings held via teleconference or video conference may be claimed at the same rate as an in person meeting.

8. Honorarium payments will be issued in the committee member's name. Source deductions (CPP and income tax) will be withheld at source on honoraria paid to all Council and Committee members as required by Canada Revenue Agency. In February of the following year, T4s will be issued.

9. Councilors and committee members who attend a meeting that is less than 8 hours but greater than 5 hours, will receive an 8 hour honorarium payment. This applies regardless if they attended in-person or teleconference.

Issue:

1) A questions was raised if the CPSA should be paying an honorarium to a committee/council member if that person is receiving a salary from their employer?

College of Physicians & Surgeons of Alberta

The FAC discussed the issue of paying honorariums and prepared a list of principles for Council's consideration.

Honorarium Principles

- An honorarium is **an *ex gratia* payment** made to a person for their services in a volunteer capacity, or for services for which fees are not traditionally or legally required.
- An honorarium is a payment made to a person that **does not represent a full compensation for time and effort** expended.
- An honorarium is typically a payment made on a special or non-routine basis to an individual who is **not an employee** of the CPSA, to recognize or to acknowledge the contribution of gratuitous services to the CPSA.
- An honorarium is paid if the individual is **in attendance at the meeting** as shown on the minutes of the committee.
- **Honorarium rates** are set by the CPSA Council.
- An **honorarium is not based on an agreed amount between the individual providing services and the CPSA representative seeking services**. If payment is agreed upon, this constitutes a contractual agreement and will involve invoicing, taxes, and related factors.
- Any individual **receiving normal pay from their employer** to attend CPSA meetings, **should not accept** an honorarium. If an individual has to use their vacation time or needs to take time off without pay to attend meetings they may be eligible for an honorarium.
- Any **conflicts of interest must be disclosed** to the CPSA in advance of any services being rendered.

FAC is seeking feedback from Council to endorse the list of honoarium principles.

College of Physicians & Surgeons of Alberta

Issue:

2) Should the CPSA be paying committee/Council members an honorarium for meeting preparation?

Committee/ Council members are expected to be prepared for meetings, including reviewing dossier materials prior to meetings.

Some meeting dossier packages can be quite lengthly requiring additional time to review.

The current CPSA policy pays for formal meeting time only.

Honoraria are generally payable for formal meetings only. Time spent preparing for meetings, reviewing agendas or files, or preparing correspondence is not normally reimbursed. Preparation time for Council meetings may be paid, but this would be by exception, at the call of the President in advance of the meeting.

The 2019 honoaria rates:

Description	Reimbursement Rate
Council Members	$960.00
Committee Chairs	$960.00
Committee Members	$864.00

2018 Total expenses for honoariums

Per Diem/Honorarium	618,888.25
Per Diem/Honorarium Travel	182,228.00
CPP on Committee Expenses	17,394.00
	818,510.25

If meeting preparation time was paid, there would be additional costs incurred.

For example, if ¼ day honorarium was paid for each full day meeting, the annual cost to the CPSA could be $150,000. This represents $14 out of the physican annual fee.

FAC is seeking feedback, if the CPSA honoarium policy should change to include payment of honoraria for meeting preparation?

Next Steps:	If there are changes to the honoarium policy, the changes would be rolled out with the 2020 budget.

List of Attachments:

None

College of Physicians & Surgeons of Alberta

Submission to:	**Council**

Meeting Date:	Submitted by:		
May 31, 2019	Dina Ovics		
Agenda Item Title:			
Action Requested:	☒The following items require approval by Council. See below for details of the recommendation.	☐The following item(s) are of particular interest to Choose an item. Feedback is sought on this matter.	☐The attached is for information only. No action is required.
AGENDA ITEM DETAILS			
Recommendation (if applicable) :	***It is recommended that*** Council approve this report.		

Background:	• Under the *Health Professions Act (HPA)*, CPSA is required to deliver an annual report to the Minister of Health. The annual report becomes part of public record when the Minister tables it in the Legislative Assembly.
	• An annual report is also our opportunity to tell our story in an engaging way that connects with stakeholders.
	• In 2018, "Me Too/Times Up", issues faced by the LGBTQ2S+ community, legalized marijuana and other social and technological movements really shifted the public's agenda and their expectations from the organizations they interact with.
	• This year's report is centered on how the College reflected on and responded to social and technological change in 2018.
	  ○ We released a digital version of the annual report, called the "Report to Albertans" in May.
	  ○ The print and digital report contain the same content, but each use different media to enhance how stakeholders absorb the information.		

Next Steps:	With Council's approval, this print report will be submitted to government by June 30th, 2019. Roll out of the print and digital reports will continue throughout 2019.		
List of Attachments:			
CPSA_AnnualReport_v04_051719			

2018 Annual Report

Navigating Social Change

College of Physicians & Surgeons of Alberta

Contents

President's Message

Council President

Ms. Kate Wood, Q.C.

Council's responsibility is to be in touch with what is happening in both the community and the profession, to ensure the choices we're making are informed and in the best interest of the public. Every decision we make impacts patients and physicians across the province, so we need to make sure we get it right. This year, Council toughened its stance on sexual misconduct and worked to increase discipline transparency. We continued to research the emerging opportunities and challenges facing medical regulation in the digital age. We looked for ways to contribute to healing the opioid crisis, by supporting prevention strategies and drafting a new standard of practice, to make it easier for patients with opioid use disorders to get the care they need. We worked with leaders in the LGBTQ2S+ community to better understand the unique challenges this community can have in their healthcare interactions, so that we can make future recommendations and policy improvements for a more inclusive system.

2018 was a year of remarkable social change; it was also a year of significant change for the College. This report, approved by Council, tells that story.

Society will continue to evolve at a rapid pace and it's our job to continue to stay ahead of societal expectations and enable our regulated members to give Albertans the best care possible. We did it in 2018 and I have complete faith that we'll carry that into the years to come.

Our year in numbers

Practising physicians

569 new regulated members

11,437 physicians on an independent practice register

Setting the standard

2 new draft standards of practice

- *Sexual Abuse and Sexual Misconduct*
- *Safe Prescribing for Opioid Use Disorder*

2 amended standards of practice

- *Boundary Violations*
- *Responsibility for a Medical Practice*

Supporting Albertans

2 LGBTQ2S+ in healthcare workshops

2 MLA information-exchange sessions

Improving practice quality

100% of Alberta physicians are required to enrol in Continuing Professional Development

98.3% pass rate for Practice Readiness Assessments—92 new-to-Alberta physicians started Practice Readiness Assessments this year

46 members referred for an Individual Practice Review—only two cases were forwarded on to Professional Conduct

49 group practices participated in a Group Practice Review and are working on action plans to enhance their group practice, with 14 already submitted

166 physicians started MSF+ to collect constructive feedback on their quality of care

99 Infection Prevention and Control assessments were conducted

149 physicians managed their own health and the safety of their patients by enrolling in the Physician Health Monitoring Program

Following up on community concerns

854 new complaints received (+3.4%)

825 complaint files closed (+16.2%)

Keeping Alberta's health facilities safe

31 new facilities accredited

119 facilities renewed accreditation

The vast majority of Alberta doctors treat their patients with respect and professionalism. However, because of the heightened awareness around the power imbalance between health professionals and patients, we need to work together to ensure patients feel safe and secure.

Navigating social change

#MeToo and medicine: how a social movement went viral and changed everything

In Oct. 2017, actor Alyssa Milano first drew viral attention to sexual assault and harassment in Hollywood when she tweeted with the hashtag #MeToo.

The phrase "Me Too" as it relates to sexual assault and harassment was actually first coined in 2006, by social activist Tarana Burke. Before #MeToo, other hashtags, including #MyHarveyWeinstein, #YouOkSis, #WhatWereYouWearing and #SurvivorPrivilege, trended their way across social media.

There was something unique about the social landscape in late 2017 and throughout 2018 that opened the floodgates—first for dialogue, then for a revolution. In January 2018, the TIME'S UP™ movement was born as a response to the overwhelming push for meaningful change.

All too soon, it became clear there was a systemic problem—sexual assault and harassment don't just happen in show business. Areas like politics, the financial industry, religious institutions, education, the world of sports and,

most poignantly for physicians, medicine and health care are not immune to what's happening in the world.

The impact of #MeToo on health care

The vast majority of Alberta doctors treat their patients with respect and professionalism. However, because of the heightened awareness around the power imbalance between health professionals and patients, we need to work together to ensure patients feel safe and secure. Physician sexual assault of patients is rare, but when it does happen, the effects are *incredibly* damaging to patients involved, public trust and the profession as a whole.

In the past, we often heard patients assume there are checks and balances in place to ensure medical professionals were doing their jobs, but there wasn't an appetite to see the evidence of that until recently. Over 2018, it became increasingly obvious that society's expectation for patient safety called for stronger legislation. This caused the medical profession to revisit our own regulatory processes to ensure we could safeguard trust, a critical element in a patient-physician relationship.

Bill 21 helps the medical profession keep patients safe

Today, patients want to see proof that self-regulating professions are doing their jobs—they need transparency and stronger rules. In response, the government drafted Bill 21: *An Act to Protect Patients.* This amendment to the *Health Professions Act* was passed Nov. 8, 2018, with the support of the College.

In 2018, we enhanced our transparency in publishing disciplinary information and made changes to our website so it's easier for the public to find which physicians in Alberta are currently involved in the discipline process.

The new Bill allowed the College and other regulators to use new and effective tools to regulate sexual misconduct in the profession and ensure patients are protected. Before the end of 2018, with the help of our members, the Sexual Assault Centre of Edmonton (SACE), the Association of Alberta Sexual Assault Services (AASAS) and other stakeholders, we drafted a standard of practice on *Sexual Abuse and Sexual Misconduct*. We endorsed action to seek higher penalties in cases of serious sexual abuse and misconduct, including cancellation of a member's practice permit. The new standard took effect April 1, 2019.

These are great steps towards a more transparent system in which patients feel secure. However, there is still more to do. Throughout 2019, we will continue to strengthen our discipline process, using feedback from legal counsel. We'll improve transparency for members and the public by enhancing our website and internal processes. And we'll begin to work in partnership with other health professions to develop an inter-regulatory victim treatment and counselling fund, to support those who have been victimized by a medical professional. It's important work for Colleges to engage in, and we all have a long way to go.

Our message to doctors in the midst of the #MeToo era: patients should feel safe with their doctors. While sexual assault of patients is thankfully rare, it is our collective job to make sure these new standards enhance existing trust and restore trust lost.

Clearing the smoke on cannabis

When the clock struck midnight on Oct. 17, 2018, recreational cannabis stores opened their doors to lineups of people waiting to legally purchase recreational cannabis in Canada for the first time.

In that moment, Canada officially became the second country in the world to universally legalize cannabis—signalling the start of one of our nation's most significant social shifts of the year.

Amid the anticipation for legalized recreational cannabis, many cannabis for medical purposes users and authorizing physicians were left with uncertainty around what accessibility of cannabis for medical purposes and the associated processes would look like post-legalization. Would physicians still have a role in guiding medical users' access to cannabis?

Today, the answer is yes. While the College does not have a position on cannabis, since 2014 we have provided physicians with support should they find the need to choose cannabis as a treatment option for patients. Physicians play an integral role in a patient's choice to access cannabis for medical purposes. Through open and informed dialogue, physicians take a holistic approach and consider things like a patient's current medication use and addiction risk factors in order to identify whether or not cannabis for medical purposes is a safe and viable treatment option. Physician involvement in a patient's choice to access cannabis for medical purposes also helps

CANNA-STATS

- 15% of Canadians (~4.6 million people) aged 15 and older reported using cannabis in the past three months—relatively the same amount of people who reported using cannabis prior to legalization.
- 16% of Albertans aged 15 and older reported using cannabis.
- One in four cannabis users reported using cannabis for medical purposes only.
- Medical users with documentation tend to access their cannabis from legally authorized licensed producers (86%) as opposed to illegal sources (19%) or growing their own.
- Medical users are less likely to choose smoking as their method of consumption.
- 76% of users reported quality and safety as their top consideration when purchasing cannabis.

Source: Statistics Canada's National Cannabis Survey, fourth quarter 2018; data collection from mid-November 2018 through mid-December 2018.

ensure clear communication among practitioners in a patient's circle of care.

There are very few strong, evidence-based reasons to use cannabis, but patients want the option as part of their treatment. We recognize that and have provided guidance to physicians on how this can be done as safely as possible. The College has three documents in place to help guide physicians to ensure the safety of patients: the standard of practice on *Cannabis for Medical Purposes* (*CMP*), the advice to the profession for *CMP* and the *CMP* Patient Medical Document. In preparation for legalization, the College updated the *CMP* Patient Medical Document, which tracks physician authorization and patient use of cannabis for medical purposes. We also enhanced the *CMP* advice to the profession, which is used to provide support and resources to physicians to ensure safety and professionalism when authorizing cannabis for medical purposes. The College chose not to update the standard of practice on *CMP* because the landscape of authorizing cannabis for medical purposes has remained the same, even with legalization of recreational cannabis.

So, what does all of this mean? Despite the societal changes that have come with the legalization of recreational cannabis, we expect all of our members to use good judgment in implementing cannabis into a patient's treatment plan—just as they would with any other drug or treatment.

When it comes to physicians using any form of cannabis, our expectation for responsible use is already clearly outlined in our *Code of Conduct*: "*As a physician, I will avoid misuse of alcohol or drugs that could impair the ability to provide safe care to patients.*"

Cannabis legalization was one of Canada's most talked about social changes in 2018. We're still in early days, but it is critical for the College to keep ahead of changes in the world of cannabis so we can continue to offer the best guidance to our members.

OUR *CMP* PATIENT MEDICAL DOCUMENT TRACKS:

- registered member's name
- patient's full name and date of birth
- patient's health care number
- indication for cannabis for medical purposes authorization
- dosing instructions
- duration of authorization
- member's relationship to the patient (e.g., family doctor or consulting physician)

What are your preferred pronouns?

Him/he, her/she or they/them? What name do you prefer to be called? What gender were you assigned at birth? What is your gender identity?

For some, these questions may be surprising and perhaps unnecessary. But for others, they are a sign of compassion, respect and a desire to learn and understand.

It's a topic that has seen a lot of news coverage over the last few years. A ban on transgender people serving in the United States military. The first-ever transgender contestant competes for the Miss Universe title. Debates about which public bathroom a transgender person should be allowed to use.

As transgender people simply try to live their lives openly and honestly, conversations are happening more frequently as many try to understand the issues faced by this community. Medicine is no exception, as concerns about accessible, timely and compassionate health care for transgender individuals are voiced more and more.

Dr. Michael Marshall, a psychiatrist based in Edmonton, is considered a specialist in providing health care to transgender Albertans. He's been instrumental in helping the College understand how we can support our members in asking their LGBTQ2S+ patients the *right* questions.

"It is often said I am one of five psychiatrists who do this work," shares Dr. Marshall. "But that's not actually, wholly correct. Any psychiatrist can do this work. Any physician who has engaged in that training and education can do this work."

This type of education has been lacking until recently. In medical school, there hasn't always been a lot of time spent on social issues (including LGBTQ2S+ issues) and how they impact a physician's role. As a result, many physicians graduate without confidence in their abilities to treat the gender-diverse population. According to Dr. Marshall, what many practitioners don't realize is that transgender persons have the exact same health concerns and require the same kind of care as any other patient.

Without understanding, physicians might worry about causing offence and therefore, gender-diverse persons often find it difficult to find practitioners who are not afraid to misstep. Because of this, the experience for people who are sexual minorities or gender-diverse in Alberta has been inconsistent. "My work with the LGBTQ community has mostly come about because I'm not afraid to say I'm sorry, I don't know this, let me find out. Or, what would you like me to call you, what are your pronouns? Questions we sometimes don't ask in medicine," says Dr. Marshall.

Talking is the first step

Recognizing this gap in education, the College sought Dr. Marshall's expertise and clinical experience for a CPSA round-table discussion about gaps in the delivery of diagnostic and lab services to LGBTQ2S+ Albertans. The majority of all clinical decisions are made as a result of a diagnostic test. To actually make an impact on the medical care received in the LGBTQ2S+ community, we needed to initiate work in this important area.

More than 20 participants from the College, Alberta Health Services and a variety of community agencies and health professions participated and spoke about how to change existing processes to ensure gender diverse patients receive appropriate procedures and safe and respectful care in these facilities.

"These conversations are hugely important on a number of different levels," shares Dr. Marshall. "As the transgender population is smaller than the rest of the population, sometimes it's easy to forget the experiences of persons who walk the earth differently. Simple things like lab investigations that may be unaffirming, or reports back that may be difficult to reconcile in terms of sex marker versus experienced gender, these things are an important first step for physicians to spend some time on—just one of the many steps that should be happening in parallel."

> *"My work with the LGBTQ community has mostly come about because I'm not afraid to say I'm sorry, I don't know this, let me find out. Or, what would you like me to call you, what are your pronouns? Questions we sometimes don't ask in medicine." says Dr. Marshall.*

These developments and new opportunities for education are a good start, but there is more to do. The College continues to engage in and drive these conversations to better understand how we as the medical regulator can help. Ideally, the gender-diverse community in Alberta needs a dedicated service—a cohesive system of well-trained, educated providers who work together, so that practitioners who treat the gender diverse community are not doing good work in isolation. We're continuing to advocate for that.

"It is our responsibility to offer good care as physicians," says Dr. Marshall. "And in order to do that, we sometimes have to learn things that we didn't expect to have to learn about. There is knowledge available, to allow us to provide good care to the transgender population, that we should all avail ourselves to.

It will save a person's life."

Digital Medicine is not just about access—it's also about ***quality*** care

Early in 2011, Greg Price saw his doctor for a routine physical, where a small testicular mass was discovered. Fifty-nine weeks after that first appointment and a series of gaps in communication later, Greg died as a result of complications from surgery to remove a cancerous testicle. He was 31.

Could better access to his own health information have saved Greg's life?

There's no way to know for sure, but better access to his health information may have given Greg the tools to follow up on his own care sooner and faster, and changed his outcome. Digital Medicine, and all the complex technologies and tools associated with it, have the potential to help a lot of people, now and in the future. If used properly, it can democratize health care—giving people equal access to potentially life-saving information, resources, guidance and ultimately, quality care.

Understandably, patients have a big appetite for it. Technology has eased almost all of our daily interactions: we tap to pay for purchases, order coffee and buy stocks through apps, all on our smartphones. Why shouldn't we be able to access a physician consult or our own health information on our phones?

Digital Medicine has actually been around for more than 25 years. Today, the majority of physicians use digital charts and more traditional means of telehealth like phone or email. However, many are *actively* engaging in the next level of digital tools by contributing to healthcare forums like patient.info and offering virtual consults on apps such as Babylon or Maple.

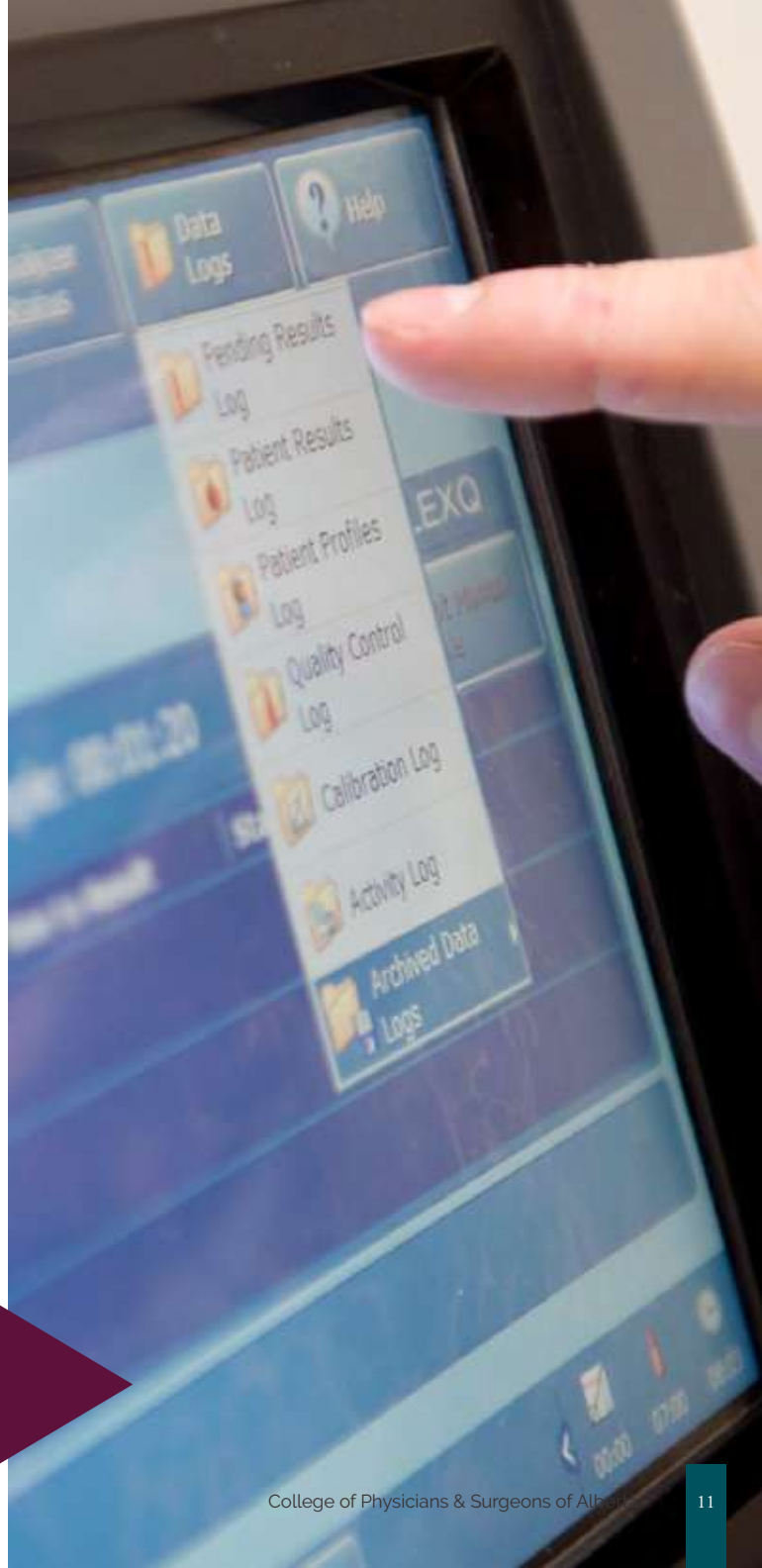
Over the next few years, the public will see significant changes in this field. For patients to get the most benefit out of these tools, regulators can't be a barrier to digital health. But we do have to keep patient safety at the forefront.

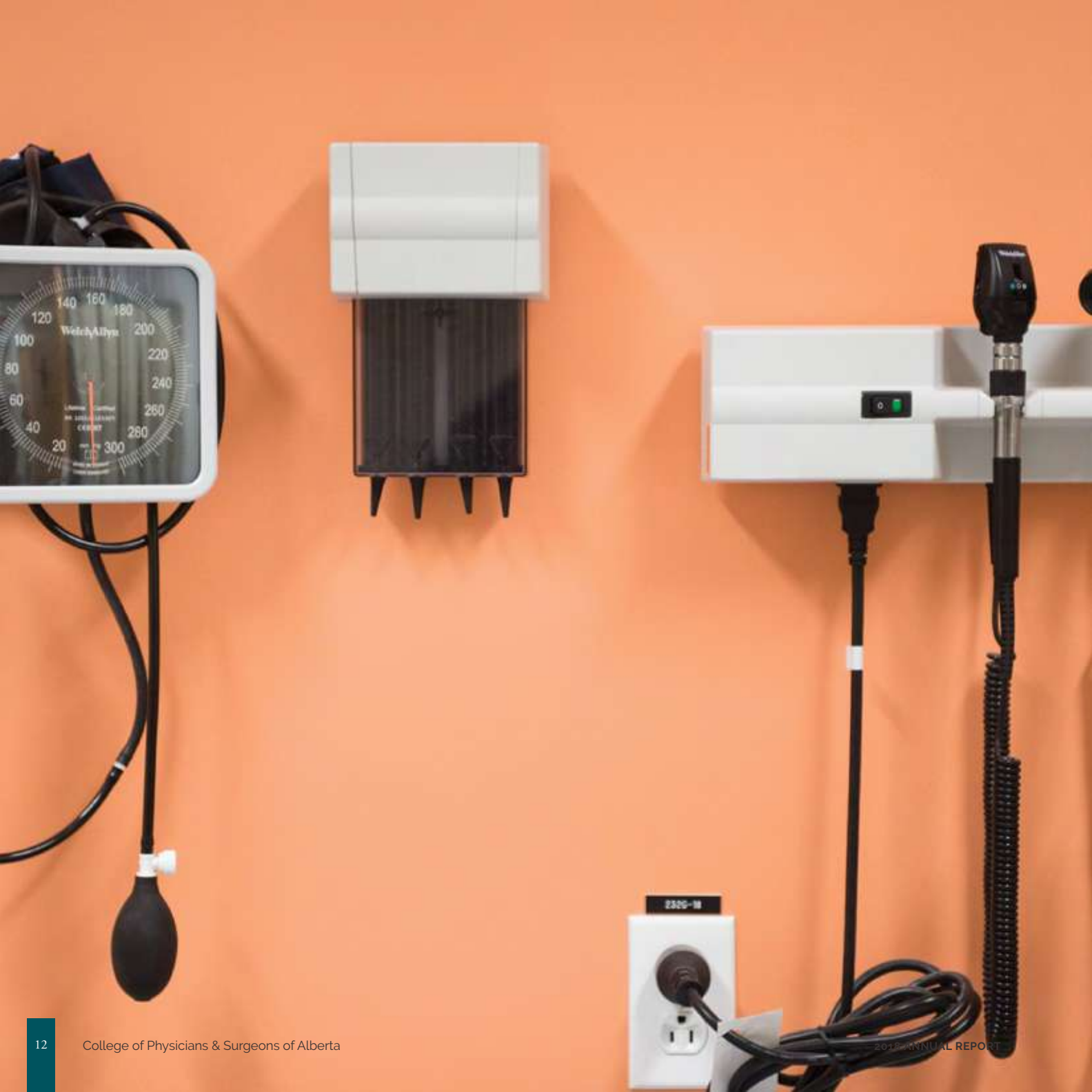
We need to ensure that even in the digital world, patients are getting safe, quality care from competent, ethical practitioners. While it is the government and private sectors' job to build out the tools that will allow for more digital health options, it's our job to push for well-designed systems and forward-thinking standards to improve patient care, as well as to advocate for enhanced training at a learner level, so new physicians know how to use this technology effectively. Digital health tools can enhance communication and the sharing of information, but it's critical that patients get the same quality care in the digital environment that they would sitting in front of their doctor.

It's a tough balance to achieve, but we've been working with our colleagues throughout Canada and looking at global research to find the right solution. In 2018, we initiated conversations with other Canadian regulators to streamline licensing and reduce regulatory barriers to accessing health care in the digital sphere. Some of the things we're considering are a pan-Canadian standard on telemedicine, so every physician across the country is held to the same standard, no matter where they work. In the

digital sphere, patients are consulting with physicians in other provinces and to uphold our standards, we need to reduce barriers for physicians to provide digital care. This year, we started exploring the possibility of creating portable licences that would allow doctors to perform a third of their work for patients in other provinces, or even expediting licence agreements for physicians in good standing. As the world goes more and more digital, medicine must follow suit if we want to continue providing the level of care our patients expect and deserve.

> *It's our job to push for well-designed systems and forward-thinking standards to improve patient care, as well as advocate for enhanced training at a learner level so new physicians know how to use this technology effectively.*

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Registrar's Message

Dr. Scott McLeod,
CPSA Registrar

Throughout 2018, change was a common theme. Not just here at the College, not just in Alberta, but everywhere. We saw many global and political situations influence the way we look at social issues, leading to a shift where people want more accountability and transparency from those in power.

The College's mandate is to protect the public—that's what we have always been here to do. As society's expectations change, so must the way we meet our mandate. We are accountable to Albertans, and the feedback we've heard over the past year tells us that you want to know more about how we operate.

With that in mind, one of the more significant changes we've made at the College in 2018, was to how we communicate about our disciplinary process. Early last year, it became clear that the public did not feel we were forthcoming enough with physician disciplinary decisions. We listened and adjusted our process accordingly, ensuring that we publish those decisions quickly and make them easily accessible to the public on our website.

I truly believe that Alberta's doctors are some of the very best, providing excellent care to their patients. But no human is infallible and everyone makes mistakes. For us, the complaint process is not about punishing doctors—it's about learning and trust. The more open and honest we are with each other as medical professionals, the better we can learn from mistakes so they don't happen again. And the more open and transparent we are with the public about what guides our decisions, the more trust we will build.

We can't do our business behind closed doors and expect anyone to have confidence in the decisions we make. Good regulation can't happen if we don't have the trust of the people we're here to protect. We will continue to listen, learn and grow, as a College and as a profession, so we can effectively support physicians in providing Albertans with high-quality health care.

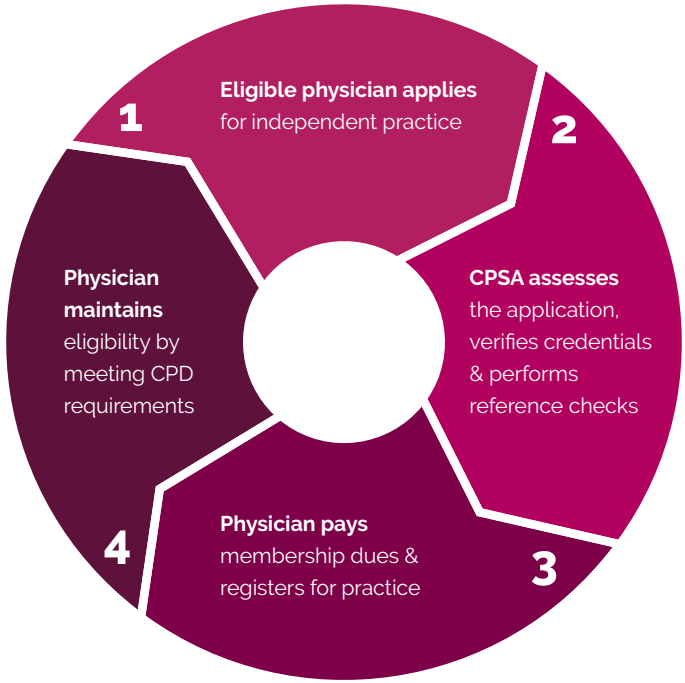
Day-to-day operations

Registration

The College is responsible for ensuring every physician who enters any form of medical practice in Alberta has the right credentials and qualifications to give Albertans the safe, effective care they deserve. There are approximately 11,000 physicians registered to practise in Alberta today, with 569 new registrants in 2018. **How do we ensure all physicians who register for practice in Alberta are competent professionals?**

All physicians who apply for practice in Alberta must have a medical degree, be in an independent practice or a continuous formal postgraduate training program within three years before applying, and meet postgraduate training requirements. In 2018, we also made it **mandatory** for applicants to submit a criminal record check or police certificate from every jurisdiction where they have ever held medical registration, licence or a practice permit.

Internationally-trained physicians must also take a series of nationally-established exams to prove fluency in English, and critical medical knowledge and decision-making abilities that are at the level expected of a Canadian graduate.



*In 2018, we made it **mandatory** for applicants to submit a criminal record check or police certificate from every jurisdiction where they have ever held medical registration, licence or a practice permit.*

The CPSA General Register eligibility requirements are rigorous, but they're a part of our process to ensure our profession is equipped to give the best possible care to Albertans.

Continuing Professional Development (CPD) is also a requirement to maintain an Alberta medical practice permit. During annual registration renewal, we follow up with our entire membership roster to ensure they're meeting credit requirements in one of two approved national CPD programs: Mainpro+ (College of Family Physicians of Canada) or Maintenance of Certification (Royal College of Physicians and Surgeons of Canada).

Registration and Membership

	2018	2017	Variance	2016*
Applications issued**	706	899	-21.5%	957
Physician registrations***				
Graduates from Alberta universities	215	238	-9.7%	236
Graduates from other Canadian universities	188	184	+2.2%	189
USA and other	166	189	-12.2%	219
Total new registrations	569	611	-6.8%	644
Reactivated registrations	70	75	-6.7%	64
TOTAL	**639**	**686**	**-6.9%**	**708**

*2016 data included for information only; variance is between 2017 and 2018

**Applications for independent practice registration, issued by the College to qualified candidates via physiciansapply.ca.

***Includes registrations from applications issued in prior years.

Members on an independent practice register**	2018	2017	Variance	2016*
General Register	10,531	10,048	+4.8%	9,680
Provisional Register Conditional Practice	906	1,071	-15.4%	1,056
TOTAL	**11,437**	**11,119**	**+2.9%**	**10,736**

* 2016 data included for information only; variance is between 2017 and 2018

**Unique individuals, active at any time during the year.

General Register, by category*	2018	2017	2016
Family Physician**	3,619	3,443	3,258
General Practitioner	1,301	1,250	1,266
Non-Specialist, Defined Practice	53	42	46
Specialist	5,558	5,313	5,110
TOTAL	**10,531**	**10,048**	**9,680**

*Unique individuals, active at any time during the year.

**Certification by the College of Family Physicians of Canada.

Provisional Register Conditional Practice, by category*	2018	2017	2016
Family Physician**	127	134	132
General Practitioner	508	598	583
Non-Specialist, Defined Practice	35	46	44
Specialist	236	293	297
TOTAL	**906**	**1,071**	**1,056**

*Unique individuals, active at any time during the year.

**Certification by the College of Family Physicians of Canada.

Permit denials, restrictions and courtesy register

Practice permits denied, restricted or not renewed	2018	2017	2016
Denied	8	13	9
Restricted (see breakdown)	176	162	153
Not renewed (see breakdown)	400	379	352
TOTAL	**584**	**554**	**514**

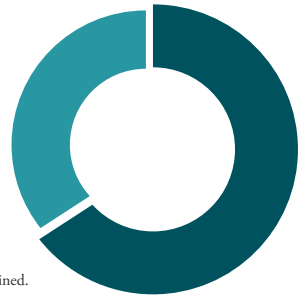
Practice permits restricted* by category	2018	2017	2016
General Register			
Family Physician	46	37	30
General Practitioner	47	45	44
Non-Specialist, Defined Practice	8	6	6
Specialist	41	42	36
Provisional Register			
Family Physician	2	2	2
General Practitioner	15	12	14
Non-Specialist, Defined Practice	8	7	7
Specialist	9	11	14
TOTAL	**176**	**162**	**153**

*Any condition on practice other than the standard restrictions on provisional practice.

Physician workforce breakdown

Medical graduates on an Independent Practice Register*

34.1%
International Medical Graduates



65.9%
Domestic Medical Graduates

*General Register and Provisional Register Conditional Practice combined.

International Medical Graduates by Nature of Practice

2.1%
Non-specialist, defined practice

36%
Non-specialist

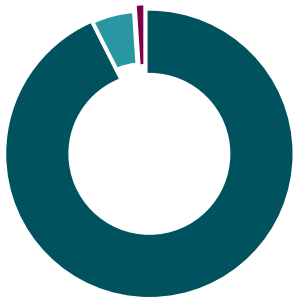
61.8%
Specialist*

*Includes Family Medicine specialists.

Domestic Medical Graduates by Nature of Practice

0.19%
Non-specialist, defined practice

7.2%
Non-specialist



92.6%
Specialist*

*Includes Family Medicine specialists.

Practice permits not renewed, by category	2018		2017		2016	
	Retired	Inactivated*	Retired	Inactivated*	Retired	Inactivated*
General Register						
Family Physician	25	76	22	85	22	76
General Practitioner	42	18	39	18	32	18
Non-Specialist, Defined Practice	0	2	0	0	4	1
Specialist	79	133	64	130	51	125
Provisional Register						
Family Physician	0	2	0	4	0	2
General Practitioner	0	9	0	9	1	9
Non-Specialist, Defined Practice	0	3	0	1	0	1
Specialist	0	12	0	9	1	11
TOTAL	**146**	**255**	**125**	**256**	**111**	**243**

*Inactivated for any reason other than retirement (e.g., withdrew from practice, moved out of province, etc.).

Courtesy Register	2018		2017		2016	
	Registrants	Avg. Days*	Registrants	Avg. Days*	Registrants	Avg. Days*
Clinicians	7	4	18	4	38	3
Instructors	5	3	4	8	5	5
Learners	25	54	30	43	20	26
TOTAL	**37**	**36**	**52**	**26**	**63**	**N/A**

*Based on total days, which may include multiple registrations for one individual.

Registration assessments

Practice Readiness Assessment (PRA-AB)	2018	2017	2016
Initiated	92	121	182
Supervised practice assessment only	32	41	58
Preliminary clinical assessment plus supervised practice assessment	60	80	124
Completed*			
Passed	81	87	165
Failed	1	4	8
Withdrawn	2	3	2
On hold**	2	0	N/A[1]
In progress at Dec. 31	30	31	7
Pass rate	98.28 %	95.4%	95%

*Completed assessments may have been initiated in a prior year.
**On hold assessments
1. Category not reported in 2016

Return to Practice	2018	2017	2016
Initiated	2	1	1
Completed*	3[1]	0	2[1]
In progress at Dec. 31	0	1	1[2]

*Completed assessments may have been initiated in a prior year.
1. Approved for full return.
2. Closed with no return to practice assessment.

Change in Scope	2018	2017	2016
Initiated	5	2	1
Completed*	3[1]	3[1]	1[1]
In progress at Dec. 31	2	0	1

*Completed assessments may have been initiated in a prior year.
1. Approved for full change.

Continuing Competence

The College takes a holistic approach to regulating the medical profession. Giving physicians the resources they need to support their performance throughout their careers is a major priority for us and will continue to be part of our long-term strategy. We use our access to prescribing data from TPP Alberta and the Pharmaceutical Information Network (PIN), as well as details shared with us during the registration and renewal process, to help every physician in Alberta identify their unique growth opportunities.

Here are the programs we deliver to physicians to help them maintain and optimize the care they give their patients:

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MD Snapshot

We know that access to information helps our members make better choices about their medical practice. We provide individual physicians with custom reports of practice-specific data to help them make the best possible choices for self-directed quality improvement.

MD Snapshot – Practice Checkup is sent to every active Alberta physician annually. Customized to the physician, it outlines factors that can potentially impact physician performance as well as opportunities for self-reflection, to help physicians reduce possible risks and improve the quality of their practice.

MD Snapshot – Prescribing gives physicians accurate and timely data about their prescribing practice. This custom report of patient-level prescribing data includes specialty peer comparisons and best practice clinical guidelines, so prescribing physicians can enhance their patient care and improve their approach to prescribing.

Group Practice Review

Group Practice Review (GPR) pairs clinics with a facilitator to identify how they can improve their group practice quality, share best practices among other groups and build processes to ensure the group meets *CPSA Standards of Practice*.

Individual Practice Review

Individual Practice Review (IPR) pairs individual physicians with an experienced clinical team to help them improve their practice. IPR is confidential and offers targeted support for physicians referred to the program.

MSF+

Multi-Source Feedback+ combines feedback from physicians' allied health co-workers, physician colleagues and patients with custom prescribing and registration data to help selected members self-reflect on their performance and discuss practice improvement opportunities with a facilitator.

Infection Prevention & Control

Infection Prevention & Control (IPAC) creates safeguards to help physicians protect patients and healthcare workers from infections. IPAC develops and promotes standards based on industry best practice and gives members guidelines, courses and resources to help them sustain a sterile clinical environment.

Physician Prescribing Practices

Physician Prescribing Practices provides members with educational materials, peer support, practice tools to enhance patient safety and strategies to reduce the potential for misuse and abuse of prescription drugs.

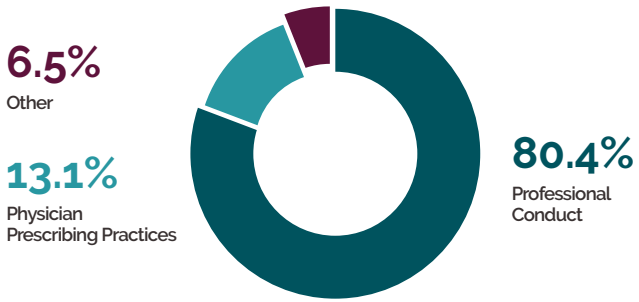
Continuing Competence statistics

Individual Practice Review (IPR)	2018	2017	2016
Physician referrals received	46	43	83
Files closed[1],[2]	51	45	111
Referred to Professional Conduct[3]	2	3	2
In progress at Dec. 31	48	55*	13

1. May have been opened in a prior year.
2. Closed after competence concerns resolved through appropriate support(s) or other (e.g., physician retired, health concern, etc.).
3. In a small number of cases where IPR is unsuccessful at helping a physician meet a minimum standard, the file is referred to Professional Conduct.

* This number was reported as 32 in the 2017 Annual Report in error.

IPR Source of Referral



MSF+	2018	2017[1]
Initiated	166	500
Files closed	301	0
In progress at Dec. 31[2]	365	500

1. Inaugural year for MSF+. Participants received facilitated review of their results in 2018.
2. May have been initiated in a prior year.

Group Practice Review (GPR)	2018	2017	2016[2]
Clinic reviews initiated	49	50	8
Completed[1]	14	49	8
In progress at Dec. 31	36	1	0

1 Facilitation report sent and action plan submitted.
2. Inaugural year for Group Practice Review.

Fitness to Practice assessments	2018	2017	2016
Initiated	5	0	0
Completed	3	0	0
In progress at Dec. 31	0	1	1

Members assessed under Section 118, Health Professions Act (incapacity)	2018	2017	2016
Files opened	0	0	0
Assessments completed	0	0	0

Physician Prescribing Practices program

	High Risk Patient Identification project[1]			3-plus Benzodiazepines 3-plus Opioids[2]			4- Plus Benzodiazepines[3]		
Prescribing notification letters	**2018**	**2017**	**2016**	**2018**	**2017**	**2016**	**2018**	**2017**	**2016**
Physicians notified of at least one patient who met criteria	54	98	266	48	215	361	140	135	366

1. Physician alerted when a patient on a high oral morphine equivalent (OME) dose has attended three or more physicians and three or more pharmacies within a three-month period. As a result of a reduced number of cases, the dose threshold has been reduced from 500 OME/day to 300 OME/day.
2. Physician alerted when a patient is receiving three or more benzodiazepine and three or more opioid prescriptions within a three-month period.
3. Physician alerted when a patient received four or more benzodiazepine prescriptions within a three-month period. We reduced the 2017 threshold of five or more benzodiazepine ingredients to four or more benzodiazepine ingredients in 2018.

Daily Oral Morphine Equivalent (DOME) project[1]	**2018**	**2017**	**2016**
Opened	4	3	5
Closed	4	4	4
In progress at Dec. 31	14	14	12

1. Physicians with patients receiving the highest Oral Morphine Equivalent (OME)/day over a 3-month period are paired with a chronic pain specialist mentor to help them improve their prescribing and safely reduce dose levels for these patients. The 2017 threshold of ≥3000 OME/day was reduced to ≥2000 mg OME/day in 2018.

Methadone Prescribing Approvals[1]	**2018**	**2017[3]**
For dependence treatment		
General	140	124
Patient-specific	17	19
For analgesia		
General	218	260
Patient-specific	269	273
Suboxone® prescribers[2]	1023	535

1. Previously known as "Methadone Exemptions". In May 19, 2018, Methadone Exemption under section 56 of the Controlled Drugs and Substances Act was removed and oversight of methadone prescribing was deferred to the provincial regulatory colleges.
2. Physicians do not need to secure approval or meet additional educational or experiential requirements to prescribe Suboxone® (buprenorphine/naloxone).
3. First year methadone prescribing approvals were reported.

Infection Prevention and Control

Medical Office Assessments	**2018**	**2017**	**2016**
Medical Device Reprocessing (MDR)	54	99	61
Follow-Up Assessments	28	25	21
Public Concerns	12	31	22
By Request	0	3	4
Hair Transplantation	1	0	1
New Clinic Review Pilot*	7	0	0
TOTAL	**102**	**158**	**109**
Reportable Breaches**	6	6	3

*New category in 2018.

** Redefined from "Reports to the Medical Officer of Health", "Reportable Breaches" now encompasses all breaches regardless of source of identification. The new definition increases the 2017 numbers from 3 to 6.

Physician Health Monitoring Program (PHMP)

PHMP helps physicians monitor and manage personal health issues that have the potential to affect patient care. Although it's a College program, PHMP is closely aligned with the Alberta Medical Association's Physician and Family Support Program and is administered separately from the CPSA discipline process. Enrolment in this program is confidential.

For PHMP, there's no one-size-fits-all approach. Physicians can also be patients with their own unique health and work circumstances. We consider their medical condition, type of practice and work environment. We also often work with their healthcare provider to ensure the physician has the support they need to balance their clinical responsibilities to their patients while managing their own health. Physicians in this program are either referred or self-report their health conditions. More than 80 per cent of physicians enrolled in PHMP are safely able to continue their practice.

Practice Conditions Monitoring

	2018		2017	
Monitored	**Physicians**	**Conditions***	**Physicians**	**Conditions***
Opened	53	76[1]	47	75[1]
Closed	17	23	21	28

*Physicians may have conditions placed on their practice permits to ensure safe patient care (e.g., use of a chaperone, restrictions on performing certain procedures, patient age limits, prescribing restrictions, etc.)

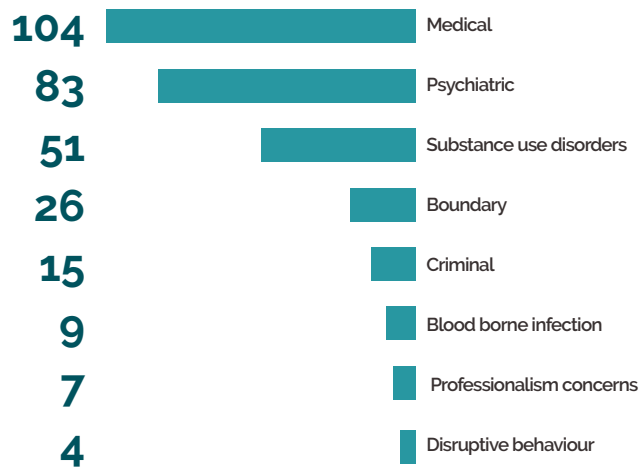
1. Of total conditions monitored, 29 are active prescribing conditions.

>80% of physicians enrolled in PHMP are safely able to continue their practice

Physician Health Monitoring Program

Physician files	2018	2017	2016
Opened	149	147	113
Closed	174	99	125
In progress at Dec. 31	288	295	234

Categories of issues monitored* 2018



*A single physician may be monitored in more than one category.

Professional Conduct

Ensuring physicians are practising ethically and professionally is one of the most important functions of the College. Feedback, both positive and negative, about our members is critical to our ability to perform this function.

Many complaints can be resolved informally. Often it just comes down to better communication. We help mediate a solution between the physician and complainant, sometimes recommending professional development opportunities or practice changes the physician involved can make.

When informal resolution fails or a complaint involves a serious allegation of professional misconduct, we launch a formal investigation. Some investigations end up in a hearing, where a tribunal determines if a physician is guilty of misconduct and what kind of penalty is appropriate. Most hearings are public and in the interest of transparency, all hearing information and results are published on cpsa.ca as soon as they become available.

When a complaint doesn't have enough evidence to support further action or is unrelated to good medical care, it is dismissed. If a person would like the decision to dismiss reviewed, our patient advocates offer support and resources.

Complaints Investigation & Resolution Statistics

Complaints received	2018	2017	Variance	2016*
New complaints	854	826	+3.4%	831
Complaint files closed	824	709	+16.2%	736
Complaint files in progress at Dec. 31	553	523	+5.7%	406
Total physicians receiving a complaint	**713**	**712**	**+0.1%**	**702**

*2016 data included for information only; variance is between 2017 and 2018

Disposition of complaints on intake*	2018	2017	2016
Directed to Informal Resolution	113	104	133
Directed to Investigation	380	434	437
Dismissed[1]	361	288	261

*How the College dealt with the complaint when first received. Disposition may change as more information becomes available.

1. Dismissed due to no or insufficient evidence of unprofessional conduct.

Natures of complaints received*(%)	2018	2017	2016
Quality of care	48.0	44.0	42.3
Practice management	25.0	22.9	25.4
Medical reporting	11.6	13.9	10.6
Ethics	9.4	11.6	12.3
Unclassified	4.7	5.9	6.8
Third party	0.8	1.2	1.7
Systemic	0.4	0.5	0.9

*A single complaint may include multiple natures:

1. Quality of care - Diagnosis (incorrect or delayed), treatment (prescribing, procedural and counselling, referral/consultations, follow-up)
2. Practice management - Physician availability, office management including finance and communication
3. Medical reporting - Release of records, report completion and accuracy
4. Ethics - Confidentiality, informed consent, advertising/self-promotion, research-related and boundary violations (including sexual, financial and others)
5. Third party - Independent Medical Examination (Workers' Compensation Board and non-Workers'
   Compensation Board, all others)
6. Systemic - Access to human resources and technology, continuity of care and interdisciplinary issues
7. Unclassified - All others

Sources of complaints received (%)	2018	2017	2016
Patient[1]	60.2	56.8	57.6
Family member of patient	20.7	19.5	17.7
Complaints Director[2]	6.6	6.9	9.2
Third party[3]	4.4	6.3	2.6
Lawyer	2.1	1.4	0.6
Other physician	6.0	9.1	12.3

1. Patient may refer to guardian.
2. Complaints Director may open a complaint file if there are reasonable grounds to believe a member
   has acted unprofessionally even if no written complaint has been received.
3. Third party may refer to government agency, Workers' Compensation Board, other health care provider, pharmacist, employer, friend, etc.

Average days to close by resolution process*	2018	2017	2016
Dismissed outright	8	12	11
Informal resolution			
Direct resolution[1]	90	40	28
Resolved with Consent[2]	163	249	119
Investigation[3]			
Dismissed after investigation	298	225	180
Resolved with investigation	464	374	335

*Complaints directed to hearing are not included as the days to close vary widely based on complexity and whether the decision is appealed, and the number of hearings is too small to determine a meaningful average.

1. Single-issue complaint resolved directly between physician and complainant.
2. Straightforward complaint where the College works directly with the physician to resolve the issue with the consent of both parties. Education or training is often part of this process.
3. Multi-issue complaint or serious allegation of professional misconduct. Evidence is gathered and witnesses may be interviewed.

Disciplinary Hearings Statistics

	2018	2017	2016
Hearing Tribunals convened	8	3	7
Hearing outcomes*	11[1]	4[1]	7[1]
Decision pending*	1	4	3
Ongoing (continuation of proceedings)	3	9	0

*May relate to hearings conducted in a prior year.

1. Allegations proven, penalties imposed (e.g., cost recovery, period of suspension, remedial training, conditions on practice permit, revocation of practice permit and/or other actions deemed appropriate by the Hearing Tribunal).

Appeals Statistics

Registration Appeals	2018	2017	2016
Registration denied due to character/reputation	1[1]	1[1]	0
Registration denied due to failed assessment	2[1]	1[1]	3[1]
Practice conditions imposed	0	0	1[2], 1[3]
Suspended due to complaint – reversed by Council appeal panel	1[1]		
TOTAL	4	2	5

1. Decision upheld.
2. Decision overturned.
3. Review overturned.

Professional Conduct Appeals	2018	2017	2016
Dismissed complaints			
By complainant	73	67	64
To Complaint Review Committee (CRC)*	50[1], 18[2], 0[3], 2[4], 0[5], 2[6]	65[1], 7[2], 2[3], 1[4]	34[1] 4[2]2[3]
To Alberta Ombudsman*	0	1[2], 1[5]	13[5]
Hearing decisions			
By Complaints Director, to Council	1	0	1[1]
By physician	1		
To Council	1[2]	0	0
To Courts*	1[6]	1	1

*May relate to appeals initiated in a prior year.

1. Decision upheld.
2. Investigation ongoing.
3. Withdrawn by complainant.
4. CRC referred to a hearing.
5. Determined to be administratively fair or recommendations met.
6. Decision pending.

Standards of practice

The *Code of Ethics*, *Code of Conduct* and *CPSA Standards of Practice* are the foundational documents that make up the framework for medical practice in Alberta. Either directly or indirectly, they ensure safe and effective patient care. When a physician's behaviour or actions are called into question, we measure the complaint against these core documents.

Because we use the standards of practice as a measure of professional conduct, the College is responsible for ensuring they are up-to-date so physicians can gauge their performance (and be measured) against the best available data. Every year, we weigh our standards against best practice and consult with our members, government, the public and other stakeholders on any potential Standard of Practice updates.

In 2018, the College consulted on two new draft standards and amended two existing ones.

- Two new draft standards of practice
    - *Sexual Abuse and Sexual Misconduct*
    - *Safe Prescribing for Opioid Use Disorder*
- Two amended standards of practice
    - *Boundary Violations*
    - *Responsibility for a Medical Practice*

Accreditation

If you've ever gone to a community facility for blood work, an x-ray or any other diagnostic or medical-surgical service, you were likely in a CPSA-accredited facility. The College is responsible for helping ensure these facilities, as well as a number of hospital-based facilities, provide safe care.

We write the safety, quality and technical standards for each of the following facilities and send CPSA-trained field experts to evaluate them upon opening, re-evaluating them every four years and for complaint investigations.

- Cardiac Exercise Stress Testing
- Diagnostic Imaging
- Diagnostic Laboratory Medicine
- Neurophysiological Testing
- Non-Hospital Surgical Facilities (NHSF)
- Pulmonary Function Diagnostics
- Sleep Medicine Diagnostics

2018 was a busy year for CPSA Accreditation. We rolled out new diagnostic imaging standards, with an enhanced focus on imaging quality and patient safety. We ensured more consistent and safer reporting of pulmonary function tests by standardizing the reporting metrics respiratory physicians use to interpret these tests.

The College also rolled out new standards to help regulate home sleep apnea testing in Alberta and ensure this diagnostic tool is used safely and effectively. We initiated assessments of 18 sleep medicine facilities under the new

standards and expect to grant CPSA-accreditation to each of them in 2019. As the list of CPSA-accredited sleep medicine facilities continues to grow, we look forward to working with third-party payers to make CPSA accreditation a condition of reimbursement for testing and treatment.

Staying abreast of technological advances in medicine is critical to ensuring Albertans get safe and quality care. The CPSA is the first Canadian healthcare regulator to establish NHSF standards for stem cell regenerative therapy with patient safety in mind.

Accreditation Statistics

	Accreditation Renewed[1]			Accredited (new)			Physicians approved to provide services		
Facility Type	**2018**	**2017**	**2016**	**2018**	**2017**	**2016**	**2018**	**2017**	**2016**
Diagnostic Imaging	17	47	71	27[2]	26[2]	31[2]	85	32	77
Diagnostic Laboratory	31	16	28	1	2	2	N/A	N/A	N/A
Non-Hospital Surgical	23	19	23	0	8[2]	6	80	49	70
Pulmonary Function Diagnostic	31	14	24	3	12	5	7	7	22
Neurophysiology	14	11	11	0	3	3	7	4	9
Cardiac Exercise Stress Testing	3	8	6	0	2	1	1	7	5
Sleep Medicine	0	0	0	0	0	0	7	0	0
TOTAL	**119**	**115**	**163**	**31**	**53**	**48**	**187**	**99**	**183**

1. Accreditations are renewed on a four-year cycle. As the number of facilities varies zone-to-zone, the number of accreditations renewed annually may also vary significantly.
2. Includes previously accredited facilities that added new modalities or procedure categories.

Governance

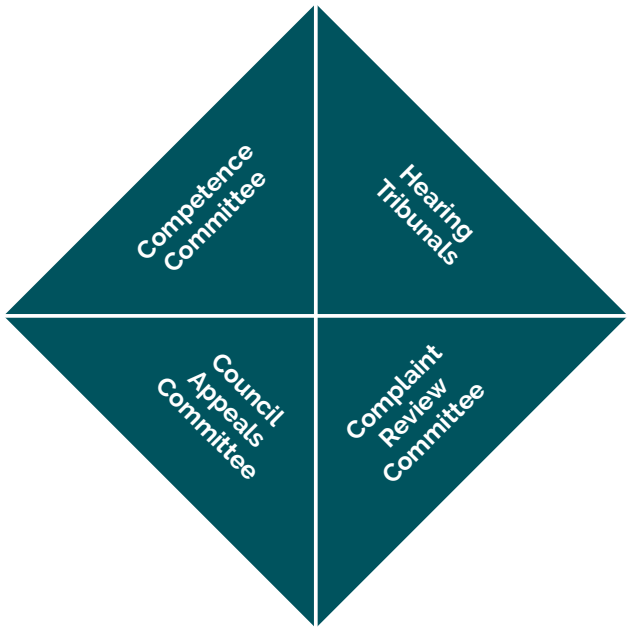
Medicine is one of the professions in Alberta in which the members of the profession are responsible for governing themselves through a regulatory body. This privilege of profession-led regulation is granted to the College of Physicians & Surgeons of Alberta (CPSA) by the *Health Professions Act* and is dependent on the trust Albertans have in physicians' ability to hold ourselves to the highest standards of competence, professionalism and ethics in our service to the public.

CPSA Council ensures the practice of medicine continues to be up-to-date with Albertans' needs and expectations. Council steers the direction for CPSA operations, discusses and votes on policy decisions and sets standards of practice for the profession.

Council is made up of 11 physicians who are elected by their peers and four members of the general public, appointed by Alberta's Lieutenant-Governor. Alberta's two medical school deans, a medical student observer, resident physician observer and the Past President of Council also attend meetings and help bring new perspectives to shape Council decisions.

College staff attend meetings to give Council background information on day-to-day College operations, answer Council's questions and report on how previous decisions are being carried out. CPSA Council meets four times a year. Anyone interested in what the College does is welcome to observe the meetings.

In addition to meeting four times a year, select Councillors also serve on CPSA Committees. The following are required by regulation:



2018 Council

Physician Members

Dr. Pauline Alakija

Dr. John Bradley

Dr. Graham Campbell

Dr. Louis Hugo Francescutti

Dr. Kirsten Jones

Dr. Carrie Kollias (Jan. to May)

Dr. Richard Martin

Dr. Tarek Motan (May to Dec.)

Dr. John O'Connor

Dr. Luke Savage

Dr. Patrick (PJ) White

Dr. Norman Yee

Medical Faculty Deans

*Dr. Richard Fedorak, University of Alberta

Dr. Dennis Kunimoto, University of Alberta

Dr. John Meddings, University of Calgary

President

Ms. Kate Wood, Q.C.

Past President

Dr. James Stone

Public Members

Ms. Levonne Louie

Ms. Cathy MacDonald (Jan. to June)

Ms. Margaret Munsch

Ms. Laurie Steinbach (July to Dec.)

Ms. Kate Wood, Q.C. (President)

Observers

Dr. Michele Foster (Jan. to May), medical resident

Dr. Casey Chan (June to Dec.), medical resident

Ms. Rachel Bethune, medical student

***Dr. Richard Fedorak passed away on Nov. 8, 2018. Dr. Fedorak is remembered by the College for the exceptional contributions he made to enhance the medical profession as a University of Alberta dean on CPSA Council.**

Public Members' Message

The world we live in is rapidly changing. Emerging technologies and social movements leave people, businesses, governments and agencies with two options: adapt or become stagnant. Part of Council's role is to help the medical profession adapt to social and technological change in a safe, sustainable and measured way.

As public members, we are an integral part of that. While physician Councillors represent best medical practice and ethics, we represent the patient perspective and work with our physician co-councillors to guide the direction of the College through social and technological change.

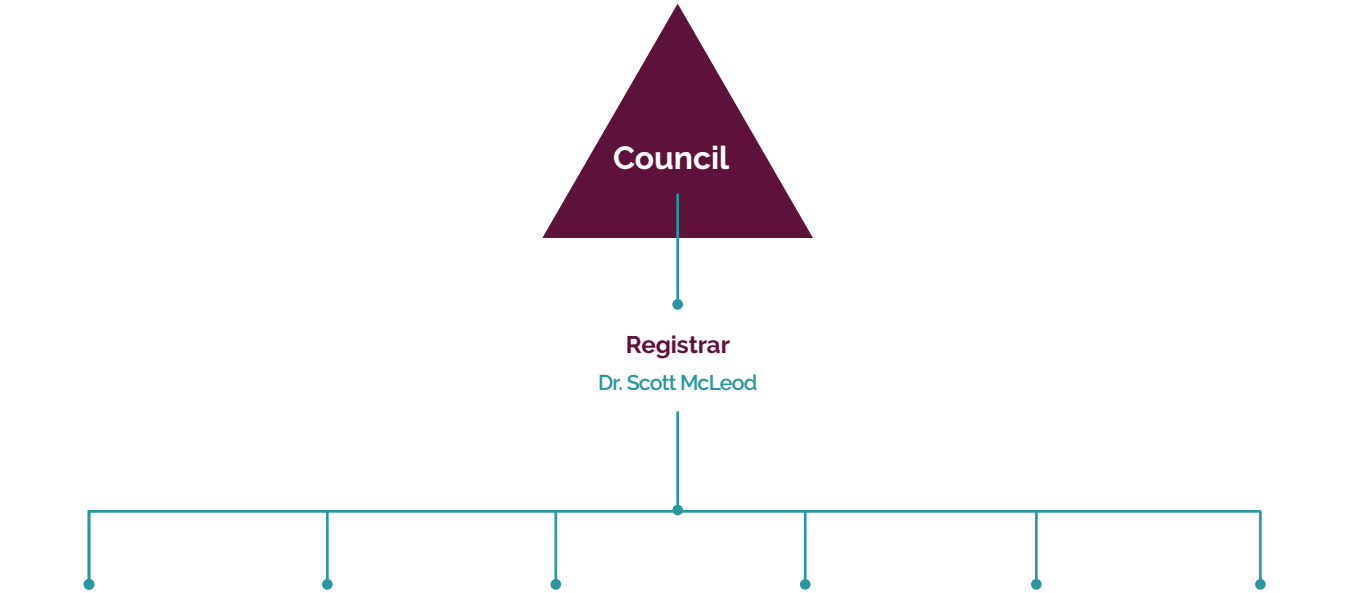
This collaborative approach ensures that public best interest is front-and-centre in every decision made by Council. In addition to the patient perspective we bring to the table, our professional experience in the legal, education and oil and gas industries helps bring unique problem-solving skills to Council and its Committees.

Serving Albertans by helping the medical profession navigate social and technological change is a serious responsibility and an honour we are grateful to fulfill.

L-R: Ms. Cathy MacDonald (Jan-June), Ms. Levonne Louie, Ms. Margaret Munsch, Ms. Kate Wood, Q.C. (Council President) |Missing: Ms. Laurie Steinbach (July to Dec.)

Our Leadership Team

L-R: Dr. Susan Ulan, Mr. Shawn Knight, Dr. Scott McLeod (Registrar), Dr. Michael Caffaro, Dr. Karen Mazurek (Deputy Registrar), Dr. Jeremy Beach
Missing: Mr. David Kay


Council
Registrar
Dr. Scott McLeod
Registration
Dr. Susan Ulan
• Practice Permits
• Continuing Professional Development
• Registration Assessments
Continuing Competence
Dr. Karen Mazurek
• Competence Assessments
• MD Snapshot
• Infection Prevention & Control
• Physician Prescribing Practices
• Triplicate Prescription Program
Chief Operating Officer
Mr. David Kay
• Operations
• Human Resources
• Information Technology
• Accreditation
• Hearings Director
Chief of Staff
Mr. Shawn Knight
• Standards of practice
• Communications
• Government Relations
• Public Policy & Research
Professional Conduct
Dr. Michael Caffaro
• Complaints Investigation & Resolution
• Complaints Director
Physician Health Monitoring
Dr. Jeremy Beach
• Physician Health Monitoring Program
• Practice Conditions Monitoring

Financials

Report of the independent auditor on the summary financial statements

To the Members of College of Physicians & Surgeons of Alberta

April 23, 2019

Our opinion

In our opinion, the accompanying summary financial statements of College of Physicians & Surgeons of

Alberta (the College) are a fair summary of the audited financial statements, on the basis described in note 1 to the summary financial statements.

The summary financial statements

The College's summary financial statements derived from the audited financial statements for the year ended December 31, 2018 comprise:

- the summary statement of financial position as at December 31, 2018;
- the summary statement of revenues and expenditures for the year then ended; and
- the related notes to the summary financial statements.

The summary financial statements do not contain all the disclosures required by Canadian accounting standards for not-for-profit organizations. Reading the summary financial statements and the auditor's report thereon, therefore, is not a substitute for reading the audited financial statements and the auditor's report thereon.

The audited financial statements and our report thereon

We expressed an unmodified audit opinion on the audited financial statements in our report dated April 23, 2019.

Management's responsibility for the summary financial statements

Management is responsible for the preparation of the summary financial statements on the basis described in note 1.

Auditor's responsibility for the summary financial statements

Our responsibility is to express an opinion on whether the summary financial statements are a fair summary of the audited financial statements based on our procedures, which were conducted in accordance with Canadian Auditing Standard (CAS) 810, Engagements to Report on Summary Financial Statements.

Chartered Professional Accountants

Summary Statement

As at December 31, 2018

Assets

Current assets	2018	2017
Cash and cash equivalents	30,328,433	30,652,199
Accounts receivable	5,351,231	2,251,260
Accrued interest receivable	13,957	15,259
Prepaid expenses and other assets	808,815	589,537
Total current assets	**36,502,436**	**33,508,255**
Investments	22,775,953	22,774,152
Equipment and leasehold improvements	3,913,412	691,429
Total assets	**63,191,801**	**56,973,836**

Liabilities

Current liabilities	2018	2017
Accounts payable and accrued liabilities	3,884,182	2,546,084
Deferred fee revenue	21,951,681	20,246,850
Deferred contributions	128,001	193,829
Deferred leasehold inducements	358,462	130,747
Total current assets	**26,322,326**	**23,117,510**
Deferred leasehold inducements	3,030,443	21,472
Employee future benefits	6,216,615	3,589,218
Asset retirement obligation	-	289,703
Total liabilities	**35,569,384**	**27,017,903**

Net assets	2018	2017
Invested in equipment and leasehold improvements	3,913,413	675,864
Internally restricted	7,850,583	7,759,473
Unrestricted	15,858,421	21,520,596
Total net assets	**27,622,417**	**29,955,933**
Total net assets and liabilities	**63,191,801**	**56,973,836**

Summary Statement

As at December 31, 2018

Revenues & expenditures

Revenues	2018	2017
Physician annual fees	22,810,798	22,145,901
Practice readiness fees	2,277,815	2,439,957
Professional corporation fees	1,405,350	1,405,550
Grant funding	832,328	789,089
Physician registration fees	783,260	889,590
Investment income	781,374	640,070
Miscellaneous	610,122	572,162
Recovery of investigation and hearing expenditures	539,679	236,059
Physician practice	238,539	120,315
Physician health monitoring fees	99,125	89,200
Rental income	92,129	100,337
Total revenues	**30,470,519**	**29,428,230**

Expenditures	2018	2017
Administration	5,171,251	4,654,235
Information technology	2,218,218	2,338,989
Governance	1,571,855	1,294,926
Office of the registrar	1,329,250	1,240,380
Communication	1,202,248	1,311,368
Amortization	583,499	586,385
College activities		
Professional conduct	4,231,043	3,642,928
Physician practice	3,469,429	2,975,554
Physician prescribing and analytics	2,725,890	2,241,523
Practice readiness	2,409,755	2,816,356
Registration	2,236,411	1,878,214
Physician health monitoring and practice conditions monitoring	1,741,274	1,559,624
Total expenditures	**28,890,123**	**26,540,482**
Excess of revenues over expenditures before other items	1,580,396	2,887,748
Developmental costs	684,162	742,432
Accredit Health Facilities		
Revenues	2,655,085	3,110,122
Expenses	(2,825,800)	(2,861,578)
(Deficiency) excess of revenues over expenditures for facilities	(170,715)	248,544
Other income (losses)	(170,715)	248,544
Fair value changes in investments	(687,937	536,772
Investment income building	91,110	74,345
	(596,827)	611,117
Excess of revenues over expenditures for the year	**128,692**	**3,004,977**

Notes to Summary Financial Statements

As at December 31, 2018

1. Basis of presentation

The summary financial statements are derived from the audited financial statements, prepared in accordance with Canadian accounting standards for not-for-profit organizations as at December 31, 2018 and for the year then ended.

The preparation of these summary financial statements requires management to determine the information that needs to be reflected in them so that they are consistent in all material respects with, or represent a fair summary of, the audited financial statements.

Management prepared these summary financial statements using the following criteria:

- the summary financial statements include all statements included in the audited financial statements with the exception of the statement of changes in net assets and the statement of cash flows, as these statements are readily available on request;
- information in the summary financial statements agrees with the related information in the audited financial statements;
- major subtotals, totals and comparative information from the audited financial statements are included; and
- the summary financial statements contain the information from the audited financial statements dealing with matters having a pervasive or otherwise significant effect on the summary financial statements, such as described in note 2.

The audited financial statements of College of Physicians & Surgeons of Alberta (the College) are available on request by contacting the College.

2. Summary of select significant accounting policies

Investments

Investments are recorded at fair value on the latest closing bid price, with the exception of the long-term deposit for the building fund (2018 – $7,850,566; 2017 – $7,542,066), which is measured at cost.

Revenue recognition

- Annual physician, professional corporation and facility fees – fees are set annually by Council and are recognized as revenue in the fiscal year to which they relate. Fees are recognized when collectibility is reasonably assured. Fees received in advance are recognized as deferred revenue.
- Grant funding – revenue is recognized in accordance with the terms of the grant agreement and when collectibility is reasonably assured.

College of Physicians & Surgeons of Alberta

- Investment income – includes interest and dividends and is recognized when earned.
- General and miscellaneous revenue – other revenue is recognized when the related services are provided or goods are shipped and collectibility is reasonably assured.

Employee future benefits

The College has a defined benefit pension plan for all permanent employees.

In the year-end summary statement of financial position, the College recognizes the defined benefit obligation, less the fair value of the plan assets.

	2018	2017
Fair value of plan assets	34,549,858	33,762,740
Accrued benefit obligation	40,766,473	37,351,958
Plan deficit	(6,216,615)	(3,589,218)

Our Mission, Vision and Values

Our Vision

The highest quality medical care for Albertans through regulatory excellence.

Our Mission

To protect the public and ensure trust by guiding the medical profession.

Our Values

The College values the privilege of self-regulation granted to us by the people of Alberta and is committed to continually earning their trust. In our work, we are guided by these values:

We do the right thing. We act responsibly, respectfully and with integrity, aspiring to be fair and reasonable. We acknowledge our mistakes as well as our successes, and strive to do what's right in service to the public.

We make informed decisions. Our decisions are based on evidence, knowledge, experience and best practice. We plan, measure outcomes and apply what we learn.

We empower people. We believe people perform best when they see the Vision, set their own goals, have the resources they need and aspire to excellence and personal growth.

We collaborate. We invite others to contribute to achieving our goals and value their time and expertise. We share what we know generously within our legislated limits, and seek opportunities to collaborate externally in areas of mutual interest.

We are innovators. We think ahead to create opportunity. We set the bar high and value creativity in exploring new and better ways of doing our work.

We enjoy and find meaning in our work. We care about what we do and give our best. While our work is serious, we enjoy camaraderie with our coworkers and take time to celebrate each other's milestones and achievements.

Idea Exchange

We consult with the following organizations and contribute to a number of healthcare workshops and panels in the interest of enhancing health care in Alberta.

Organizations:

Alberta Access Improvement Measures
Alberta College of Medical Diagnostic and Therapeutic Technologists
Alberta College of Combined Laboratory and X-Ray
Advisory Council of IMG Assessment Programs
Alberta Diagnostic Sonographers Association
Alberta Federation of Regulated Health Professionals
Alberta Health
Alberta Health Services
Alberta Innovates – Health Solutions
Alberta International Medical Graduate Program
Alberta Labour
Alberta Medical Association
Alberta Rural Physician Action Plan
Alberta Society of Radiologists
Assessment Continuum of Canada
Association of Alberta Sexual Assault Services
Association of Faculties of Medicine of Canada
Canada Health Infoway (Prescribe IT)
Canadian Association of Pathologists – Patient Safety and Quality Assurance Section
Canadian Centre for Substance Abuse
Canadian Life and Health Insurance Association
Canadian Medical Protective Association (CMPA
Canadian Post-MD Education Registry (CAPER)
Canadian Standards Association (CSA)
Coalition for Physician Enhancement (CPE)
College and Association of Respiratory Therapists of Alberta
College of Family Physicians of Canada
Council on Licensure, Enforcement and Regulation (CLEAR)
Covenant Health
Department of Health and Social Services, Government of Yukon
eHealth Collaborative (Alberta/BC/Ontario)
Federation of Medical Regulatory Authorities of Canada
Future of Medical Education in Canada – CPD
Health Canada
Health Quality Council of Alberta (HQCA)
International Organization of Standardization (ISO)
Technical Committee TC212
Lung Association of Ontario
MEDEC (Canada's Medical Technology Companies)
Medical Council of Canada
Medical Identification Number for Canada
Northern and Southern Alberta Institutes of Technology
National Assessment Collaboration
Office of the Information and Privacy Commissioner of Alberta
Pan Canadian Collaborative on Opioid Prescribing
Pan Canadian Physician Factors Project
Primary Care Networks
Provincial-Territorial Expert Advisory Group on Physician-Assisted Death
Public Health Agency of Canada
Respiratory Health Strategic Clinical Network (Alberta Health Services)
Royal College of Physicians and Surgeons of Canada
Sexual Assault Centre of Edmonton
Standards Council of Canada
University of Alberta, Faculty of Medicine & Dentistry and School of Public Health
University of Calgary, Faculty of Medicine
Western Canada Diagnostic Accreditation Alliance

Presentations, workshops, panels:

- Alberta Health and CPSA LBGTQ2S+ Roundtable (Edmonton)
- Institute of Health Economics Forum (Edmonton)
- Alberta College of Family Physicians' Annual Scientific Assembly (Banff)
- Interdisciplinary Health Education Partnership (IHEP) event (Edmonton)
- Alberta College and Association of Opticians Annual General Meeting (Edmonton)
- "Falling Through the Cracks" film screening panel (Calgary)
- Annual Medical Students' Conference and Retreat (Banff)
- Coalition for Physician Enhancement (Toronto and Washington)
- International Association of Medical Regulatory Authorities (Dubai)
- University of Alberta, Interprofessional Pathways Launch (Edmonton)
- University of Alberta, Faculty of Medicine & Dentistry Grad Week (Edmonton)
- University of Alberta Obstetrics and Gynecology retreat: Boundary violations (Edmonton)
- University of Alberta, Faculty of Medicine and Dentistry: CPSA disciplinary process and professionalism (Edmonton)
- University of Alberta Nephrology Fellows: Ethics and the Pharmaceutical Industry (Edmonton)
- University of Alberta Public Health Panel (Edmonton)
- University of Calgary, Undergraduate Medical Education Orientation Week (Calgary)
- "To Err is Human" Advanced Screening and Discussion (Edmonton)
- College and Association of Respiratory Therapists of Alberta: Annual General Meeting and educational day (Calgary)
- Canadian Association of Cardio-Pulmonary Technologists: Pulmonary Symposium (Calgary)
- University of Calgary, Department of Medicine, Sleep and Respiration Rounds (Calgary)

College of Physicians & Surgeons of Alberta

CPSA.CA

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TWITTER.COM/CPSA_CA

College of Physicians & Surgeons of Alberta

Submission to:	**Council**

Meeting Date:	Submitted by:		
May 31, 2019	Jessica McPhee and Morgan Hrynyk		
Agenda Item Title:	CPSA Brand Strategy		
Action Requested:	☐ The following items require approval by Choose an item. See below for details of the recommendation.	☐ The following item(s) are of particular interest to Council. Feedback is sought on this matter.	☒ The attached is for information only. No action is required.
AGENDA ITEM DETAILS			
Recommendation (if applicable) :	***It is recommended that Council review the CPSA Brand Strategy for information.***		
Background:	With the introduction of new programs and a well-defined strategic direction, over the last couple of years, the College has shifted its focus from being an "enforcer" to play more supportive role with physicians. This significant shift in approach is the perfect opportunity for CPSA to rebrand and signal a new era. The CPSA Brand Strategy will shape all facets of our business and provide a consistent lens for decision-making. Our brand connects our team and brings meaning to our work. It is more than a logo and colours—CPSA's brand defines our identity as an organization and touches every piece of what we do. Every single interaction with Albertans, physicians, partners and our team influences their perception of CPSA. The CPSA Brand Strategy will define how we want to be perceived. The Brand Strategy is a long-term approach and these changes won't happen overnight. Ultimately, we hope to see a profound, positive shift in our relationships with Albertans, physicians, partners and within our team. The project began in January with a comprehensive research phase which informed several revisions of the CPSA Brand Strategy. In May 2019, CPSA Registrar, Scott McLeod approved the CPSA Brand Strategy.		
Next Steps:	• Develop a new visual identity for CPSA with support from Lift Interactive, our agency partner for this project. Visual Identity will be delivered late-Summer 2019. • CPSA Brand Strategy roll-out will begin in Fall 2019 with our internal teams. An external roll-out will follow.		

College of Physicians & Surgeons of Alberta

	• CPSA website redevelopment will begin in Summer 2019 to align our main external communications channel with our new Brand Strategy. New website is expected to launch Spring 2020. • Implementation for the Brand Strategy will be ongoing.
List of Attachments:	
CPSA Brand Strategy – CONFIDENTIAL for Council members only	

College of Physicians & Surgeons of Alberta

Submission to:	**Council**

Meeting Date:	Submitted by:		
May 31, 2018	Rob Key, PARA CEO		
Agenda Item Title:	Presentation by the Professional Association of Resident Physicians of Alberta (PARA)		
Action Requested:	☐ The following items require approval by Choose an item. See below for details of the recommendation.	☐ The following item(s) are of particular interest to Choose an item. Feedback is sought on this matter.	☒ The attached is for information only. No action is required.
AGENDA ITEM DETAILS			
Recommendation (if applicable) :	***N/A***		
Background:	*Resident physicians, as both learners and care providers, have a distinct perspective that is important to health care conversations. PARA is very appreciative of this opportunity to come before the CPSA Council and share the learner perspective on some key issues facing the medical profession, including: duty to report, national licensure, physician resource planning, healthy work environments and health technology.*		
Next Steps:			
List of Attachments:			