College of Physicians & Surgeons of Alberta

AGENDA
Council Meeting

28 February and 1 March 2019 **Union Bank Inn – Devonshire Room 10053 Jasper Avenue** **Teleconference** **Local: 780 421 1483, code 87114#** **Calgary: 403 232 0994, code 87114#** **Toll-free: 1 877 385 4099, code 87114#**		
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. Meddings 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: Staff from Physician Health Monitoring Marian Stuffco, Government Relations & Strategic Engagement Advisor Bruce Leisen, Director, Registration		
Regrets: Mr. D. Kay, Assistant Registrar, COO & Hearings Director		

Thursday, 28 February 2019
0730 – Breakfast

Time Allotted		
0800-0830		**PHOTO SHOOT**
0830 – 0900	**1.0**	**In-Camera Session (Council and Executive Team)** • Check in • Approval of minutes, In-camera, 28 & 29 November 2018, 07 December 2018 and 21 December 2018 **ACTION:** For Approval/Discussion
0900	**2.0**	**Call to Order for Public Session** (**President, Dr. John Bradley**) • Introduction of guests

		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) **ACTION:** For Approval/Receive as Information (**MOTION**)
		2.2	Conflict of Interest Declarations (Real, Potential or Perceived)
	3.0	**Reports**	
0910-0920		3.1	President's Report (**President Dr. John Bradley)** • Councillor's Oath • Annual Conflict of Interest Declaration • Confidentiality and Non-disclosure Agreement **ACTION**: Sign documents: Councillor's Oath, Annual Disclosure and Confidentiality Agreement
0920 - 0950		3.2	Registrar's Report (**Dr. Scott McLeod**) • Update: Key Performance Indicators **ACTION:** Receive as Information
	4.0	**Approval Items**	
0950-1005		4.1	Appointment of inspectors under Part 3.1 of the HPA (**Dr. Karen Mazurek**) **ACTION**: For Approval (**MOTION**)
1005 – 1020	**COMFORT BREAK**		
1020 - 1050		4.2	Standard of Practice: Prescribing for Opioid Use Disorder (**Dr. Monica Wickland-Weller**) **ACTION**: Approval Post Consultation (**MOTION**)
1050 – 1105		4.3	Standard of Practice: CMA Code of Ethics and Professionalism (**Mr. Shawn Knight**) **ACTION:** Approval for Consultation (**MOTION**)
1105 - 1120		4.4	Standard of Practice: Boundary Violation (**Mr. Shawn Knight**)

			ACTION: Approval of Revisions (**MOTION**)
1120 - noon		4.5	Update re: Bill 21 Implementation (**Dr. Scott McLeod)** • Final approval of Bill 21 SOP (**MOTION**) • Progress on Bill 21 Implementation Work Plan (for information) **ACTION:** For information/discussion and approval
1200 – 1300	**LUNCH BREAK**		
1300-1330		4.5	Update re: Bill 21 Implementation (cont.) (**Dr. Susan Ulan**) • Request for feedback from Council regarding Criminal Record Checks **ACTION:** For information/discussion
1330 - 1430	**5.0**	**In-Camera (Council and Executive Team and Ms. Marian Stuffco)** • Government Relations – 2019 Provincial Election **ACTION:** Receive as Information	
1430-1530	**6.0**	**Role of Council Members (Dr. John Bradley)** **ACTION:** For discussion	
1530-1600	**7.0**	**In-Camera Meeting (Council and Registrar, by invitation)**	

Friday, 01 March 2019
0730– Breakfast

0800 0830	**8.0**	**In-Camera (Council and Executive Team)**
0830-0835	**9.0**	**Call to Order of Public Session (President, Dr. John Bradley)**
0835-0935	**10.0**	**Approval Item -** Physician Member Elections (**Dr. Pauline Alakija**) **ACTION:** For discussion and approval (**MOTION**)
0935 - 1000	**11.0**	**Proposed Bylaw Amendments (Dr. Pauline Alakija, Mr. Shawn Knight)** • Past President (**MOTION**) • Bill 21 Compliance (Sec 47. Publication, PART 4 – COMMUNICATION WITH THE PUBLIC, Section A – General) (**MOTION**) **ACTION:** For approval
1000 – 1015	**COMFORT BREAK**	
1015-1030	**12.0**	**Annual Report Preview (Mr. Shawn Knight)** **ACTION:** For Information

1030 - 1115	**13.0**	**Physician Impairment (Dr. Jeremy Beach)** **ACTION:** For discussion
1130 - noon	**14.0**	**Department Presentations – Physician Health Monitoring (Dr. Jeremy Beach)** **ACTION:** For information
Noon – 1300	**LUNCH BREAK**	
1300- 1430	**15.0**	**Council Education – CLEAR Introduction to Regulatory Governance: Module One (Mr. Shawn Knight and Mr. Dale Cooney)** **ACTION:** For information and learning
1430 – 1500	**16.0**	**In-Camera (Council and Registrar, by invitation)**

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 Council Chambers at 2700 Telus House, 10020 100 Street NW, Edmonton, Alberta on 29 and 30 November 2018.

Council Members:		**Additional Attendees:**
Ms. K. Wood, President Dr. L. H. Francescutti, Vice President Dr. J. Bradley, Executive Committee Member-at-Large Dr. P. Alakija Ms. R. Bethune, Student Observer Dr. G. Campbell Dr. C. Chan, PARA Observer Dr. K. Jones Dr. D. Kunimoto – absent Thursday morning Ms. L. Louie	Dr. R. Martin Dr. T. Motan Dr. J. Meddings Ms. M. Munsch Dr. J. O'Connor – absent Thursday and Friday morning Dr. J. Stone (Past President, non-voting) absent Friday afternoon Dr. L. Savage Ms. L. Steinbach Dr. N. Yee Dr. PJ White – absent Thursday	Dr. S. McLeod, Registrar Dr. K. Mazurek, Deputy Registrar Dr. J. Beach, Assistant Registrar Dr. M. Caffaro, Assistant Registrar Mr. D. Kay, Assistant Registrar, COO & Hearings Director Mr. S. Knight, Chief of Staff Dr. S. Ulan, Assistant Registrar Mrs. G. Jones, Senior Executive Assistant (Recording Secretary)

Guests:
Ms. Linda McFarlane, incoming Public Member
Mr. Matt Solberg, Consultant, New West Public Affairs (present on Friday, 30 November 2018)
Ms. Katrina Haymond, Field Law LLP (present on Friday, 30 November 2018)
Note: Dr. Jaelene Mannerfeldt, incoming Physician Member, Ms. Stacey Strilchuk, incoming Public Member and Mr. Ryan Chee, incoming Student Observer were unable to attend and send their regrets.

Thursday, 29 November 2018

1.0	**Call to Order for Public Session** Ms. Wood called the meeting to order at 8:43 a.m.	
	1.1	Approval of Agenda for 29 and 30 November 2018 and Approval of Consent Agenda items: • Minutes, 06 and 07 September 2018, Electronic Vote, 05 November 2018 • Finance and Audit Committee Report • Education Plan) • Moving Physicians from Provisional Register to General Register: Process Update • Medical Facilities Accreditation Committee (MFAC) Report **MOTION (C-41-18):** Moved by Dr. Martin and seconded by Ms. Munch to approve the agenda, with the addition of item 8.2 Delegation of Authority for Stays and Pending Appeals for the agenda on Friday. Carried. Regarding the items on the consent agenda, it was noted that items that do not require discussion or specific motions are included on the consent agenda. If additional clarification is required regarding an item on the consent agenda, Council members can ask for the item to be removed from the consent agenda. In this case, the Finance and Audit Committee report was removed and will be discussed on Friday as item 8.3.

		MOTION (C-42-18): Moved by Dr. Francescutti and seconded by Dr. Bradley that the items on the consent agenda be accepted, with the following revisions to the minutes for 06 and 07 September 2018: • 06 September 2018, Item 3.1 Moral Distress/Physician burnout, change the word "blame" to "responsible" • 07 September 2018, Item 2.1 Report on Complaint, revise the minutes to indicate that "the Professional Conduct area is experiencing difficulty in meeting internal process timelines." • 07 September 2018, Item 2.2 Finance and Audit Committee Report, remove the action item. A response to the question of the stocks in the portfolio was provided during the meeting, noting that there is a policy to guide investments decisions. • 07 September 2018, Item 2.2.2, Motion C36-18, correction to the spelling of Ms. Louie's name. Carried. Ms. Wood asked that Council bring forward corrections to the minutes to the recording secretary in advance of the meeting so they can be adjusted prior to circulation. Regarding minutes from Finance and Audit Committee and Medical Facilities Accreditation Committee meetings, it was noted that Council is not responsible for the approval of those minutes. If, however, a member of Council wishes to view those minutes, they can request access. Council discussed whether or not the College is doing any work to predict any correlations between members on the provisional register and the need for intervention or support later in their career. Dr. Ulan and Dr. Mazurek indicated that work to gather such data will begin in January.
	1.2	Conflict of Interest Declarations No conflicts were declared.	
2.0	**Reports**		
	2.1	President's Report Ms. Wood highlighted an article in the Messenger which indicated that Dr. Scott McLeod had recently received the Calvin Gutkin Award for his dynamic leadership, communication skills and collaborative efforts. Council observed a moment of silence in recognition of Dr. Richard Fedorak. Ms. Wood recognized Dr. Fedorak's outstanding contributions to Council and elsewhere and indicated that a donation will be made in his memory to the University of Alberta's scholarship program. **ACTION:** Administration will make a donation on behalf of Council to the University of Alberta in memory of Dr. Fedorak.	
		2.1.1	Registrar's Performance Evaluation – Process for 2019 Dr. Bradley presented the proposal to evaluate the Registrar's Performance in 2019 and subsequent years. The proposal includes an opportunity to gather feedback from relevant external stakeholders. The dossier includes proposed objectives, but Council will be given an opportunity to provide additional feedback for the objectives to be assessed. He suggested a separate sub-committee may be established to have an ongoing process to establish key performance indicators. Council noted that the CEO's contract is not negotiated annually, and asked that such references be removed from the process documents. Adjustments to the timeline may be required to ensure the

			timing of this process coincides with the timing for the Registrar's entitlement to an annual increment. Additionally, it was recommended that the process be reassessed after the first year. **MOTION (C43-18):** Moved by Dr. Martin and seconded by Ms. Louie that Council adopt the Governance Committee's recommended Registrar performance review process for 2019 and annually thereafter. Carried.
	2.2	Registrar's Report Dr. McLeod highlighted the following items from his report: • Quality Improvement – this is not solely the responsibility of the College and he hopes to work with others to identify areas in which the College can have the greatest influence. • The Role of Artificial Intelligence in Medicine – the College will need to consider its role and responsibility regarding the use of Artificial Intelligence. He noted that he has met with AMII (Alberta Machine Intelligence Institute) and will work with them to gain an understanding of the issues of regulation related to Artificial Intelligence • National Licensure – issues related to digital health has ignited conversations about national licensure which will be discussed further as part of the 30 November Council meeting. • Self-regulation – this is a topic for discussion at the upcoming Council retreat, but should also be considered in light of the Health Professions Act and Bill 21. Self-regulation is a core component that defines the medical profession, but trust in the profession is waning and this will impact how the profession is regulated and how the public will hold the College accountable. Dr. McLeod noted that one of the main projects in the next year is the work of Communications to develop the brand strategy for the College. • Physician Health and Wellness – again, the College needs to recognize its role in Physician Health and Wellness and where it can influence actions. Included in this discussion is a look at impairment, whether by drugs, fatigue or other causes. Dr. McLeod suggested there needs to be a balance between instituting too many rules and providing direction. • Renovations – work to renovate Council Chambers is scheduled to begin on January 14. At this point in time, work is expected to finish on time. Dr. Bradley shared with Council that at the recent IAMRA conference, Dr. Karen Mazurek gave a keynote speech regarding opioid use. It was very well received. He indicated the College should be very proud of this work, particularly since others recognize the CPSA as a leader in this area.
	2.3	Governance Committee Report Dr. Alakija provided some background information regarding the Governance Committee noting that the Committee was established approximately 3 years ago and many of the processes and procedures are being updated as the Committee gains knowledge and experience. Minutes from the Governance Committee are available for all Council members on SharePoint. Dr. Alakija directed Council to her written report for further details on the following items: • Council Retreat • Governance Manual • College Bylaws **Council Evaluations:** To develop a process for Council Evaluations, Deanna Williams brought information forward to the Committee regarding best practices across Canada and prepared a recommendation which is included in the dossier materials. Based on this information, a Council policy will be developed. Responding to a

		question about peer evaluations, Dr. Alakija noted that there is conflicting data on the value of peer assessments and therefore, the Committee, as recommended by the consultant, is not recommending peer evaluations at this time. Regarding the evaluation of Council as a whole, all voting members will be asked to complete a self-evaluation as well as an evaluation of the functioning of Council as a whole. Responding to a question about the data analysis, Dr. Alakija indicated that trends over time could be included in the analysis. Council suggested that it may be valuable to gather feedback from senior leadership through the Registrar. Once the evaluation process is developed, Council will need to determine what to do with the data gathered through this process. It will be necessary to create a feedback loop and act upon the information that is gathered. Given their unique roles, it may not be relevant for the PARA Observer and Student Observer to respond and evaluate Council in the same way the voting members of Council do. Dr. Alakija will discuss this further with the Governance Committee. It was noted that the proposed process may not accurately determine how effective Council is, particularly since it does not have any external feedback. Dr. Alakija indicated that this is a starting point for evaluation and once Council is ready to request external feedback that could be incorporated. **MOTION (C44-18):** Moved by Ms. Munsch and seconded by Ms. Louie that Council approves in principal the proposed process for Council Evaluations. Carried. (Two opposed). Those opposed indicated that having an external evaluation of Council would be more valuable and that the evaluation as proposed is not a valuable use of everyone's time because it won't encourage collegiality or provide better outcomes. Based on this discussion, Dr. Alakija suggested that Council re-evaluate the evaluation tool after a year to see if there is value in continuing the process. Dr. McLeod added that the way the information is used and presented will determine its value. A member of Council noted that the Primary Care Networks must do a self-evaluation and that their funding is tied to those evaluations. Given the risks to self-regulation, self-evaluations may become a requirement of government. Further discussion of the Governance Committee decision items was deferred until after lunch.
3.0	**Department Profiles**	
	3.1	Registration Department Dr. McLeod indicated that he would like to have various departments present to Council at each Council meeting so members have a better understanding of the work that is carried out by the College. He also hopes this will be an opportunity for Council members to meet and interact with staff. Mr. Bruce Leisen thanked Council for the invitation to present. He gave an overview to Council about the changes that have been made in the last 10 years to help manage stress and create efficient workflows. In implementing changes, his goals are to build bridges, be transparent and have policies and procedures that

		are defendable. Plans for the future include developing new key performance indicators to ensure the College is registering the right people. This will require the use of data analytics. As a result of Bill 21, his team is looking into developing processes to include criminal record checks for all new registrants. His team is working with the College of Physicians and Surgeons of Ontario to learn from their experiences in this area. Council discussed the requirements around currency of practice and a perceived inequity as a result of being out of practice for more than three years and the resultant barriers to registration. Mr. Leisen committed to ensuring the information on the website is clear regarding the need to maintain currency of practice. Regarding the ability of foreign trained physicians to challenge the Royal College exam, Council was advised that the Royal College will be phasing out the exam process and instead will evaluate the post-graduate training of foreign trained physicians to ensure it meets Canadian standards.
4.0	**Reports (Continued)**	
	4.1	Competence Committee Report Dr. Martin presented the Competence Committee Report, noting that the end goal of the quality improvement work being promoted by the Committee is to create an internal drive for physicians and physician leaders to take shared responsibility for quality improvement. He noted that there needs to be a shift in the focus of CPD because the time spent sitting in educational lectures is not effective. Some standards to encourage participation in Quality Improvement initiatives may be required. Dr. Mazurek added that the work on the current competence model began in 2014 and was based on the Cambridge model of physician performance. In addition to individual attributes, other issues such as health, age and how a practice is set up will impact performance. As the program develops, it is apparent that a deeper assessment is required to determine which physicians may be at risk. Further, there needs to be a way to assess the group as well. Providing regular feedback through the practice checkup report and the prescribing reports is useful, but may not be relevant to all physicians. Dr. Mazurek commented that she believes that in the next 5 or 10 years, physicians will participate in work to ensure quality improvement that is developed and delivered outside the College and will simply need to provide confirmation of their participation. Feedback on current processes has been very positive and 84% of participants in the program indicated that the data from the multii-source feedback has promoted practice improvements. Dr. Mazurek also shared some of the challenges and opportunities for the program, but overall sees more opportunities to develop quality improvement assessments. Dr. Martin added that the Competence Committee reviewed the program in detail at its meeting in October. The committee is comfortable with the approach and would like to stay on track with the current plans. They have endorsed the continued use of MCC 360 as a multi-source feedback tool and have asked that the scientific value of the tool be demonstrated. Dr. Mazurek indicated that as the program evolves, she hopes to be able to tap into additional data that reflects additional areas of competency. The system has been designed to be flexible and iterative as additional data is available. Dr. McLeod added that part of this work is tied to the changing philosophy of the College in promoting

		behaviors of self-improvement and quality improvement instead of chasing down bad behaviors. Dr. Martin responded to a question about the consequence if the College does not pursue this work indicating it is another threat to self-regulation. Dr. McLeod added that the College also has a mandate within the Health Professions Act to do this work. Dr. Martin closed by asking Council to support this work and provide feedback to the Committee so they are assured that they are moving in a direction which is supported by Council. Ms. Wood asked Council to indicate its support of this work and the direction going forward as highlighted through this report which was provided unanimously.
	4.2	Telemedicine Dr. McLeod brought forward two questions for consideration by Council: 1. Would Council be open to allowing physicians licensed in other provinces in Canada to provide telemedicine support to patients in Alberta without an Alberta license? 2. Would Council be interested in supporting an accelerated approach to registration for people registered in other Canadian Provinces or Territories? Councils opinions on these questions will assist Dr. McLeod in his work on a national committee through FMRAC to consider national licensure, national registration and/or national and bilateral agreements. At this time, Dr. McLeod suggested that the definition of telemedicine for purposes of this discussion refers to any kind of remote care which is provided to an Alberta patient. Regarding bilateral agreements, Dr. McLeod noted that he would only recommend a bilateral agreement with those provinces whose registration processes are trusted to be adequate and comparable to Alberta's standards for registration. Also to consider is an accelerated registration process. Dr. McLeod suggested that if an individual is doing a locum within Alberta, perhaps it should be sufficient that they provide a certificate of professional conduct. Consideration could be given to make the process quicker. It was also noted that no matter what Council decides, Albertans will seek care at a place convenient for them. However, Dr. McLeod added that a physician should not provide such care without authorization of the regulator. Given that patients will seek care that is most convenient to them, Council suggested that the Colleges should affiliate with patient groups and help the public be better patients. Provide them with some "buyer beware" messages. Council members recognized the need to develop a plan. Dr. McLeod committed to follow up with information to the public on the matter and will look further into developing agreements with other provinces. Ms. Wood suggested that if similar feedback is required in the future, it should be gathered through an electronic survey.

	4.3	Governance Committee Report – continued **Role of Past President** Dr. Alakija reminded Council that this discussion is not to evaluate Dr. Stone's capacity as past president, but to review whether or not the role of past president should continue. At present, the role is non-voting at Council, but is a voting member of the Governance Committee. The Governance Committee is recommending that the Past President should not be chair of the nominating committee as this would be a conflict of interest. The position should, however, run the Executive Elections. Additionally, it is recommended that the "Whistle-Blower" role be removed since the past president cannot act on any information brought forward. **MOTION (C45-18):** Moved by Dr. Martin and seconded by Ms. Louie that Council retain the past president role and that the duties of this role may include running the executive elections, new councillor orientation and retreat planning. Carried. The Governance Committee will revisit the Terms of Reference for the Past President and consider further the voting capacity of the past president at Council and Governance Committee. Council discussed the expectations regarding a nominating committee and the process to follow regarding nominations to the executive committee. The Governance Committee will take the feedback from Council to develop the role for a more active nominating committee and expectations around nominations to the Executive Committee. Dr. Alakija also asked Council to provide some direction to the Governance Committee about the physician member elections, and in particular, whether or not Residents should be able to run and/or vote in the election. In follow up to this question, she would also like Council to make any suggestions to increase diversity on Council. If Council determines that Residents should not be allowed to vote and/or run, Council bylaws may need to be amended. As part of the considerations regarding this question, Dr. McLeod advised Council members that 2430 registered members voted in the most recent election. Of those voters, 369 members were from the provisional register and 135 of those on the provisional register were Residents. Dr. Chan noted that it would be difficult for Residents to control their schedule and be available to attend Council for the 3 year term. However, if they chose to run, it would mean that they would have thought about this, planned for this, and their efforts in trying to become a Council Member should be commended. Further, he indicated that inherent in their training, residents are self-reflective. He felt residents likely know they do not have sufficient experience to fully dominate the Council, and hence, he did not feel they would vote as a cohort to push their resident colleagues to be elected to every single available position on Council. However, he added that it would send the wrong message if they are excluded from running or voting for Council. To the question about the role of the PARA member, should a Resident be elected to Council, Dr. Chan indicated that the PARA Representative would have a different mandate than an elected member of Council, even if that elected member was a Resident. It was also noted that if the decision is that no one on the provisional register be allowed to vote or run for a position, members on the provisional register would have an additional incentive to move to the general register. It was also pointed out that since Council members form the appeals committee, there could be a conflict of interest if any Council members are on the provisional register and overseeing a registration appeal. Other feedback noted that if you are licensed to provide medical services in Alberta, you should be able to vote for those who oversee your practice. Dr. McLeod added that whether a physician is on the provisional or general register, they are regulated by the same Standards to Practice.

Mr. Kay suggested that Council members consider the question further and put their feedback in writing and share it with Dr. Alakija who will review the feedback and develop a proposal.

Council wondered if the incumbents should be listed first on the ballot. While there seemed to be consensus that incumbents be identified, listing them first on the ballot was not deemed necessary.

Committee Member Appointments

MOTION (C46-18): Moved by Dr. Francescutti and seconded by Dr. Martin that Council approve the following Committee member appointments:

To Competence Committee:
Dr. Kirsten Jones - a three year appointment to end of 2021
Ms. Linda McFarlane - a three year appointment to end of 2021

To Finance and Audit Committee:
Ms. Levonne Louie –a three year appointment to end of 2021
Dr. Tarek Motan –a three year appointment to end of 2021
Mr. Jim McKillop –a three year appointment to end of 2021

Note: Subsequent to the meeting, it was noted that Dr. Louis Francescutti was omitted in the listing of members to be appointed to the Finance and Audit Committee. This was corrected by Motion C48-18 on 7 December 2018.

To Governance Committee:
Dr. Jaelene Mannerfeldt –a three year appointment to end of 2021
Ms. Stacey Strilchuk –a three year appointment to end of 2021

To Legislation Committee:
Ms. Laurie Steinbach –a three year appointment to end of 2021

To Medical Facility Accreditation Committee(MFAC):
Dr. James (Jim) Stone –a three year appointment to end of 2021
Dr. Todd Remington –a three year appointment to end of 2021
Dr. Brian Muir -as chair of MFAC effective 2019 and to end his term
Dr. Gary Gelfand –an extension of his term for one yearto end of 2019

Carried.

Dr. Alakija noted that the Terms of Reference for all committees should be updated in January or February. The meeting dates for the Governance Committee for 2019 have been confirmed.

Appointments to Complaint Review Committee and Hearing Tribunals

Discussion of the appointments for Complaint Review Committee and Hearing Tribunals was held in-camera. Council endorsed the reappointment of the following individuals for a second 3-year term as part of the in-camera session on 29 November 2018:

Dr. Brinda Balachandra
Dr. Vonda Bobart
Dr. Mark Chapelski
Dr. William Craig
Dr. Erica Dance

		Dr. Douglas Faulder Dr. Paul Greenwood Dr. Colm Mac Carthy Dr. Ingrid Vicas The new appointments to the end of 2021 for the Complaint Review Committee and Hearing Tribunals registered member list were ratified as follows when Council met on 7 December 2018 (see **MOTION C48-18**): Dr. Eric Wasylenko Dr. Kim Loeffler Dr. Sita Gouishankar Dr. Goldees Liaghati-Nasseri Dr. Oluseyi Oladele Dr. Harish Amin Dr. Neelan Pillay
5.0	**Adjournment of Public Session (Executive Team excused)** The public session of the Council meeting was suspended at 3:00 p.m.	

Friday, 30 November 2018

6.0	**Call to Order of Public Session** Ms. Wood called the public session to order at 9:28 a.m.
7.0	**Update: Bill 21 An Act to Protect Patients** Mr. Kay referred Council members to the information provided in the dossier. The ongoing implementation of processes required as a result of Bill 21 will be a top priority for the College for the next few months as the legislation will come into force in April. Workplans for each functional area have been developed and will include audits to ensure the College is prepared to comply with the spirit and the letter of the law. Training will be provided for registrants, staff and adjudicators. Funding has been provided to the University of Calgary to develop online training tools. Mr. Kay is involved in high level discussions with other regulators in the Alberta Federation of Regulated Health Professions and plans are in place to share educational tools across Colleges. It is hoped the Federation will be able to share other resources and are collaborating on the establishment of a victim fund that will be managed by an intermediary. He added that his colleagues at the College of Physicians and Surgeons of Ontario have been very helpful and willing to share their materials related to the implementation of their patient relations fund. He expects to bring forward a bylaw change early in the new year to codify the requirements of Council related to Bill 21. A robust communication plan has been developed and discussions with the Zone Medical Directors have begun. There will be meetings with Alberta Health Services as well as CMPA Counsel to engage them in the College's work as well. Council noted that the legislation does not include learners and colleagues who could potentially be a victim of sexual abuse and inquired if the Standard of Practice might be able to include provisions for this vulnerable group as well. Mr. Kay explained that these matters are currently included in the Boundary Violations Standard of Practice which will be updated to reflect the provisions of the new Bill regarding patients. Mr. Knight added that in reviewing the other Standards, staff will ensure there is agreement and coherence between them and the legislation.

	Council discussed the messaging around support for the legislation and reached consensus that having the ability to deal with the most serious offenders is the basis for the College's support of the legislation. Concerns about wrongful convictions will be mitigated by ensuring appropriate training is in place for hearing panels.	
8.0	**Council Discussions**	
	8.1	Council's dual role in impartially adjudicating appeals while also acting as the law making group This discussion began in the public session, but was moved in-camera upon the advice of legal counsel.
	8.2	Delegation of Authority for Stays and Pending Appeals Dr. McLeod indicated that a regulated member can request a stay of a hearing tribunal decision until an appeal of that decision is brought forward. Under the Health Professions Act, Council has the authority to make that decision. However, at this time, administration is requesting that Council delegate that authority to the Registrar to increase efficiency. Responding to a question about the risks involved in this delegation, Dr. McLeod indicated that while Council can delegate the authority to grant a stay, they can't delegate accountability and therefore needs to trust that Dr. McLeod would be acting in the best interest of Council and the protection of the public when exercising this authority. The following points were made during the discussion of this matter: • This motion formalizes a process that has been occurring without proper documentation of the delegation of authority to the Registrar. • If Council is requested to grant a stay, there could be a perceived conflict as Council would be involved in the appeal • If the motion is passed, the process could be reviewed and assessed in a few months to determine whether or not the delegation should continue. **MOTION (C47-18):** Moved by Ms. Louie and seconded by Dr. Bradley that pursuant to section 86 of the Health Professions Act, Council designates the Registrar or another person designated by the Registrar in writing to render a decision for a stay of the decision of a Hearing Tribunal pending an appeal to Council of the decision of the Hearing Tribunal. Carried.
	8.3	Finance and Audit Committee Report Council requested additional information regarding the reported variance. Dr. Campbell indicated that a number of expenses will be incurred in the fourth quarter and it is expected that by year end the variance will be approximately $600,000. Dr. Campbell noted he previously reported that a recommendation regarding the pension would be received in November. However, the timeline has been revised and a recommendation is expected in June 2019 to ensure consideration is given to the total rewards package for College staff.
9.0	**Council Education Items**	
	9.1	Emerging Healthcare Policy Issues: Safe Supply of Opioids Dr. Mazurek prefaced her presentation by noting that she does not require a decision from Council at this time. The purpose of this discussion is to share information about a safe supply of

		opioids and to understand what direction Council would support, should the College be asked to indicate Council's position on this topic. She highlighted some of the successes and challenges that have occurred since the Opioid Summit in November 2016. She noted that while much has been done, problems continue and some are proposing that if there was a safe supply of opioids, there would be fewer deaths of high risk opioid users. The British Columbia government is considering implementing a pilot project and Alberta Health is currently analyzing whether or not a similar project could be launched in Alberta. The most likely option would be to have a physician prescriber who would prescribe opioids on mass for distribution to high risk patients. Discussion by Council included the following: • Would need to have some evidence that this would be successful. • Research Protocols would need to be adhered to. • May only support on a time-limited basis, subject to an evaluation of the program's success • Have other solutions been considered? Reference made to Portugal's decriminalization of drugs • Should there be further education to ensure a judicious use of medication • May need to look a safe supply of other drugs as well • Ensure there is a strategy to contain unintentional consequences • Do high risk users want a safe supply? • This is a public health issue which is beyond the ability of the CPSA to solve. • Need to identify the problem, consider potential solutions and advocate collectively. • Are physicians protecting patients if they are getting their drugs from elsewhere? Dr. McLeod summarized the discussion, noting some discomfort in the concept, particularly the possibility of unintended consequences. There seems to be support for another opioid forum which focuses on a broader social approach and looks at some of the successes of other countries. While Council did not reject the idea outright, their concerns should be addressed and mitigated.
10.0	**Adjournment of Public Session** Prior to adjourning, Dr. Norm Yee and Ms. Levonne Louie were recognized for their service to the Governance Committee. Dr. PJ White was recognized for his service to Council. The public session adjourned at noon.	

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: 29 and 30 November 2018

Council met in-camera at various times during the 29 and 30 November 2018 Council meeting to discuss sensitive issues and in consultation with legal counsel, Ms. Katrina Haymond.

The following motion was made:

MOTION: (C-40-18) Moved by Dr. Martin and seconded by Ms. Munsch that the minutes from the in-camera sessions on 24 May 2018 and 06 September 2018 be approved as circulated. Carried.

In-Camera Meeting: 7 December 2018

This was a special meeting held via conference call to approve for consultation a draft Standard of Practice related to the requirements of Bill 21. The meeting was held in-camera as Council was receiving legal advice from Mr. James Casey, QC.

The following motions were made:

MOTION (C48-18) Moved and seconded that the agenda and items on the consent agenda (ratification of vote for Complaint Review Committee and Hearing Tribunals) be accepted as circulated. Carried.

MOTION (C49-18): Moved by Dr. O'Connor and seconded by Ms. Louie that the draft Standard of Practice, to meet the Bill 21 requirements, currently being called *Boundaries, Sexual: Protecting Patients,* be approved for consultation. Carried.

In-Camera Meeting: 21 December 2018

Following the conclusion of the consultation process on the draft Standard of Practice related to the requirements of Bill 21, Council again met via conference call to approve the revisions as recommended through the consultation process. As above, Mr. James Casey, QC was in attendance to provide legal advice on the matter.

The following motions were made:

MOTION (C50-18): Moved by Dr. O'Connor and seconded by Dr. Alakija that the agenda and item on the consent agenda (approval of the Therapeutic Decision Making Exam Score Recheck fee and the Summative Assessment Administrative Fee for January 1, 2019) be approved as circulated. Carried.

MOTION (C51-18): Moved by Dr. Martin and seconded by Ms. Louie that, subject to a clarification regarding 'Who is considered to be a "patient"?' on page 3 of the Standard, the draft Standard of Practice (labelled December 20), developed to meet the Bill 21 requirements, be approved for submission to the Minister of Health. Carried.

College of Physicians & Surgeons of Alberta

Submision to:	**Council**

Meeting Date:	Submitted by:		
28 February 2019	Finance & Audit Committee		
Agenda Item Title:	Finance & Audit 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) :	***It is recommended that Council approve the revised Individual Practice Review fees for 2019.*** Standard review = $3,500 + GST Complex review = $7,000 + GST		
Background:	Report to Council on the FAC meeting held on 8 February 2019.		
Next Steps:	n/a		
List of Attachments:			
1. FAC report to Council			

College of Physicians & Surgeons of Alberta

FINANCE AND AUDIT COMMITTEE

Report to Council
College of Physicians & Surgeons of Alberta
28 February 2019

The Finance and Audit Committee (FAC) met on 8 February and addressed the following issues:

1. **Investment Performance Review**
   The College has two investment advisors, each of whom manages one-half of the College's general operating surplus. Mr. Steven Thornitt of TD Waterhouse and Mr. Robert Cole of CIBC and attended the FAC meeting to provide overviews of how their portfolio had done in 2018, confirm the asset mix of the portfolios, and share their thoughts for adjustments contemplated for 2019, given expectations for investment opportunities.

   Total investments at December 31, 2018:

Investment Advisor	Dollars	% return net of fees	Benchmark Weighted portfolio index return
TD Waterhouse	$7,607,072	<1.31%>	<0.40%> (gross of fees)
CIBC Wood Gundy	$7,324,851	<2.93%>	<4.84%> (gross of fees)

   The building fund investments total $7.8 million at 31 December 2018. The funds were divided between the two investment managers in January 2019.

   FAC was satisfied that both investment managers were following the College's investment policies. Performance reviews of investment advisors emphasize three year results. The FAC is satisfied with the returns over the past three year period.

2. **Pension Investment Performance Review**
   FAC invited Ms Cheryl Shea, from Mercer to present her report on the review of the pension investment returns for 2018. Mercer is the College's actuary who provides independent oversight advice on the pension fund. Total plan assets at 31 December 2018 are $34,549,858.

   For 2018, the gross return on the pension investments was <2.5%>. Over a four year period, the investment achieved a 4.4% return, net of fees and has not met the return objectives stated in the pension Statement of Investment Policies and Procedures (SIPP) due to the poor returns experienced in 2018.

The FAC began initial discussions about the asset mix and the expected investment returns in the pension SIPP. The Committee decided on the following course of action:

1) Complete the pension review in 2019.
2) Review the asset mix strategy in the pension SIPP.
3) Review the manager selection for the pension investments.

The pension Statement of Investment Policies & Procedures (SIPP) was reviewed for some administrative changes to align with the College's Governance Manual and the College's pension governance policy. The final changes will be brought forward for further discussion at the April FAC meeting.

3. COO report

a) College Risk Register – An initial draft of the College Risk Register was shared with the FAC. The report outlines management's initial views of the organization's risk broken down into four categories: Financial, Operational/Strategic, Organizational/Strategic, and Reputational. Management will be working on the next iteration of the Risk Register to include heat maps or dashboards summarizing the information to be presented to FAC.

b) Accreditation - A multi-year accreditation contract was not completed as hoped for by 31 December 2018. AHS (Alberta Health Services) requested a 3-month extension of the current one-year extension agreement to 31 March 2019 to complete negotiations. One of three planned negotiation meetings was held on 25 January with the second to occur on 13 February 2019.

b) Bill 21 update - Bill 21 – *An Act to Protect Alberta Patients*
The FAC received a proposed outline for a treatment and counselling program that will be required for the College to establish under the *Health Professions Act* (HPA).

The committee reviewed experiences from CPSBC and CPSO and provided input into the assumptions to be used in the College's budget to set up the treatment and counselling program expense.

4. Individual Practice Review Fees

The FAC reviewed the revised fee structure proposed by management and the Continuing Competence Committee for the Individual Practice Review (IPR) program for 2019.

The original program structure included an administration fee + an invoice for the cost of the assessment. The assessor travel time can very between assessment, particularly between urban and rural communities. The original IPR administration fees included in the 2019 budget were

Standard review = $1,500 + GST
Complex review = $3,000 + GST

The **new 2019 fee proposed** for the IPR would be one fee charged to all physicians involved in the program.

Standard review = $3,500 + GST
Complex review = $7,000 + GST

There would no longer be a separate invoice for the recovery of costs.

The FAC is seeking Council's approval of the revised IPR fees for 2019.

5. Pension Sub-Committee Update

The FAC received a report on the pension project.

It is important to consider the "Total Rewards" that the College offers its employees in its compensation package. Total rewards considers salary, benefits and pension. The College's current Human Resources (HR) compensation strategy focuses on salary benchmarking in the Edmonton market along with offering competitive pension and benefits. The current HR compensation strategy is not detailed enough to provide input to the Pension Sub-Committee to analyze pension options and the impact on the College's ability to attract and retain its employees.

Total Reward Philosophy

The College, with the assistance of an external consultant in compensation governance, Hugessen Consulting, is developing a written "total reward philosophy". The Pension Sub-Committee reviewed the engagement proposal from Hugessen and approved the work plan.

Hugessen's work plan included gathering feedback from the pension sub-committee representatives, FAC Chair, the out-going Council President and the in-coming Council President, Registrar and select members of the staff executive, HR team, and four staff focus groups. The feedback was gathered in November and December 2018.

Hugessen (Scott Munn and Reanna Dorsher) presented their report on the Total Rewards Philosophy to the Pension Sub-Committee on 13 December 2018.

Management is working with Hugessen to develop a Total Reward Philosophy by the end of March 2019. The philosophy will be shared with FAC at their April meeting.

Salary, Benefit & Pension Survey

The College, with JUNA Consulting, conducted a salary, benefit and pension survey of peer organizations to benchmark its current "total reward" package. The survey was conducted in November & December 2018. Fifteen organizations responded to the survey covering 31 positions across nine College job bands.

JUNA's report was presented to the Pension Sub-Committee on 24 January 2019.

The benchmarking survey will be used by Management in developing the Total Reward Philosophy and the actions required to align current compensation to the targeted position.

The Pension Sub-Committee will be in a position to present options and a recommendation for an employee pension plan at the June 2019 FAC meeting.

6. University of Calgary Contract

The FAC reviewed interim Report #3 for a contract for services from the University of Calgary, Office of Continuing Medical Education and Professional Development for the following:

- IMG Orientation program
- Medical Record Keeping course
- Professionalism and Medical Ethics
- Focused Learning Plans

Report #3 covered the third year in a three-year agreement. FAC approved the final $40,000 disbursement be released upon confirmation from the University of Calgary that the Professionalism and Medical Ethics online course is open for registration.

7. Criteria for Honorariums

The FAC began discussions on the criteria for paying honorariums for College meetings.

Further discussion will continue at the April FAC meeting.

8. FAC Terms of Reference

The FAC reviewed its current terms of reference and made changes to align the terms with College bylaws.

The updated Terms of Reference will be forwarded to the Governance Committee.

College of Physicians & Surgeons of Alberta

Medical Facility Accreditation Committee

Report to Council
College of Physicians & Surgeons of Alberta
28 February 2019

The Medical Facility Accreditation Committee (MFAC) met on 6 February 2019 and addressed the following issues:

1. **Facility Accreditation/Physician Approvals**
   The MFAC:
   - Completed a 4-year review of 17 Laboratory facilities
   - Completed a 4-year review of 2 Imaging facilities
   - Completed a 4-year review of 3 Pulmonary facilities
   - Completed a 4-year review of 6 Non-Hospital Surgical Facility (NHSF) facilities
   - Completed a 4-year review of 9 Neurophysiology facilities
   - Accredited – New Facilities/New Modalities:
     - 2 Imaging Facilities
     - 1 Pulmonary Facilities
   - Approved/Confirmed:
     - 17 Physician Surgical Privileges
     - 23 Physician Anesthesia Privileges
     - 7 Physician Imaging Approvals
     - 9 Physician Neurophysiology Approvals
     - 5 Physician Pulmonary Approvals
     - 31 Physician Sleep Medicine Approvals

2. **New Advisory Committee Member**
   - A new Advisory Committee member was approved to replace a departing member on the Advisory Committee for Laboratory Medicine
3. **Committee Terms of Reference**
   - MFAC Terms of Reference were reviewed by the Committee and revised
4. **Standards Revisions**
   - 2019 Laboratory Standard revisions were approved for the following scopes:
     - Anatomic Pathology
     - General
     - Hematology
     - Microbiology
     - **Transfusion Medicine**
   - Revisions to the Sleep Medicine Standards - Appendix A.1.1 Medical Director Requirements were approved

5. **Advisory Committee Audits**
    - MFAC member audits of the 6 December 2018 Pulmonary Committee and 16 January 2019 Laboratory meetings were reviewed and discussed.

College of Physicians & Surgeons of Alberta

Governance Committee

Report to Council
College of Physicians & Surgeons of Alberta
28 February 2019

The Governance Committee met on 7 February 2019 and addressed the following issues:

1. Consideration of Bylaw Amendments
   Potential bylaw amendments regarding Physician Member Elections and inclusion of information regarding the Past President were discussed. Refer to agenda topics: Physician Member Elections and Proposed Bylaw Amendments.

2. Council Evaluations – Implementation
   As directed by Council, the Committee is working on the implementation plan for self-evaluations and Council Evaluations. Further information will be shared at the May Council meeting.

3. Executive Elections
   Elections of members to the Executive Committee for 2020 will take place during the May Council meeting. Before that meeting, the Governance Committee will establish a Nominating Committee to encourage participation in this election and ensure a full slate of interested candidates will be considered for these positions.

4. New member Orientation – debrief
   The Committee received feedback on the Orientation session that was held on January 31. As not all new members were able to attend, Dr. Alakija will meet individually to share important information with individuals as needed. Consideration is being given to providing information to potential Council members regarding time commitments prior to their submission of a nomination to Council.

5. Council Retreat – debrief and next steps
   The Committee was advised that a full report regarding the outcomes of the retreat will be brought to Council in May. Council will be asked to provide further input into the priorities and the development of next steps.

   Using feedback from this year's retreat, the Past President will begin generating ideas for the 2020 Retreat.

6. Discussion regarding Diversity on Council
   The discussion looked at ways that Council could increase diversity to better reflect membership across the province. One suggestion that will be explored further is the development of a "recruitment roadshow". Further investigation is being done to develop plans based on data

and research into ways to improve diversity, including the possibility of surveying the membership to better understand their expectations of diversity for Council.

7. Terms of Reference Review
   In reviewing its Terms of Reference, the Committee recognized the need to better align its terms of reference with those of the Executive Committee. It was also decided that details about the role of the past president will be included in the Governance Committee's Terms of Reference. These will come forward to Council for approval in May.

8. Hearing Tribunal and CRC Appointment Process – debrief
   Further refinements to the process of appointing physician members to the roster for Hearing Tribunals and Complaint Review Committee were proposed and will be implemented for the next round of appointments.

9. Planning Calendar
   In order to better track the agenda items coming forward for consideration by the Governance Committee, a planning calendar has been created for 2019. The calendar will be kept in SharePoint and regularly updated as topics for discussion/decision are proposed for upcoming meetings.

PRESIDENT'S REPORT

DATE: **FEBRUARY 28, 2019**
TO: **CPSA COUNCIL**
FROM: **DR. JOHN SJ BRADLEY**

As we move into March 2019, as a Council I would like to highlight 2 key areas of importance- ENGAGEMENT and OPTIMIZATION of our performance.

1. ENGAGEMENT

COUNCIL

We must commit to actively engaging ourselves and each other during Council activities. During debates, everyone should feel free to speak up, whether it be to ask for clarification, advocate for their beliefs or to challenge emerging group consensus. We should welcome and encourage diverse opinions and perspectives. Be passionate, be courageous and be respectful, let our behaviour mirror the professionalism we expect from our membership.

MEMBERS/ PUBLIC

As we await the CPSA's updated communications strategy, we as a Council need to do more to actively engage both our membership and the public. I had the opportunity of attending meetings with both physicians and health care stakeholders in Red Deer and co-representing the CPSA at the Edmonton Zone Medical Staff Association February meeting. The insights and questions which were raised reinforce that many of our colleagues and public partners are actively trying to deliver high quality health care, consider new and innovative ways of care delivery and being more efficient with the use of resources. However, it is also clear that many of our members fear the CPSA and many of the public likely do not know we exist or what is our primary role. To this end, I will continue to actively seek out opportunities of meeting with front line clinicians and public stakeholders, but as individual Councillors, as some of you have already done, I would ask we all go back to our communities to raise the profile and celebrate the work which the CPSA does. Certainly, we must recognize we can do better, but putting a human face on the CPSA will help develop good will and hopefully trust with physicians and Albertans in general.

2. OPTIMIZATION

RETREAT

In January we participated in an excellent retreat focusing on the future of professional self-regulation. Although there are potential threats to self-regulation, there are also opportunities for innovation. We will await a report and proposed action items developed from the retreat which we will then take back to Council for discussion. Not surprisingly, there is not necessarily

consensus or evidence to determine how we can evolve. However, this is an opportunity to not simply reflect on our current and past performance, but look forward to shape the CPSA over the next 5 to 10 years.

CPSA KEY PERFORMANCE INDICATORS

Relevant to shaping the future is the development of Key Performance Indicators for the CPSA. David Kay, Karen Mazurek and Louis Francescutti are actively seeking volunteers to assist in developing KPIs in the following realms:

I. Digital Health- What do we want the CPSA to achieve in the next 3-5 years?

II. Quality Improvement- Developing criteria and strategies which individual physician Sections can satisfy without CPSA scrutiny

III. Organizational Capacity- What are realistic targets for both the Registration and Complaints Departments?

IV. Business Intelligence/ Learning Organization- Define what this means and what metrics can be measured to assess success?

COMMITTEES

Although it is easy to think about the role of Councillors in the context of 8 days of deliberations per year, I would argue at least as important are the days and hours devoted to Committee assignments which is where much of the actual tangible work occurs. Although Council should not be simply present to rubber stamp committee reports, I would ask we validate and give significant weight to the recommendations they present.

If you have any concerns or questions regarding the above, please feel free to contact me at your convenience.

College of Physicians & Surgeons of Alberta

COUNCILLOR'S OATH

On an annual basis, during the first Council meeting of the year, Council members will sign the following Councillor's Oath:

I do solemnly affirm that:

- I will abide by the *Health Professions Act* and I will faithfully discharge the duties of the position of councillor, to the best of my ability;
- I will act in accordance with the law and the public trust placed in me;
- I will act in the interests of the College as a whole;
- I will act in a professional and respectful manner;
- I will uphold the objects of the College and ensure that I am guided by the public interest in the performance of my duties;
- I have a duty to act honestly;
- I will declare any private interests relating to my public duties and take steps to resolve any conflicts arising in a way that protects the public interest;
- I will ensure that other memberships, directorships, voluntary or paid positions or affiliations remain distinct from work undertaken in the course of performing my duty as a councillor.

_____ _____

Signature Date

_____

Printed Name

College of Physicians & Surgeons of Alberta

ANNUAL CONFLICT OF INTEREST DECLARATION

I have reviewed my current activities and those of recent years, particularly as they relate to the attached checklist. I have also considered the activities of my spouse and immediate family members insofar as they could be viewed to affect my impartiality. I would like to bring the following to the attention of the Council of the CPSA:

I undertake to inform the Council of circumstance(s) or situation(s) that may place me in a position of real, potential or apparent conflict of interest.

I undertake not to disclose or misuse in any way confidential or privileged information to which I may be made a party.

_____
Print Name

_____ _____
Signature Date

Return to gail.jones@cpsa.ab.ca

CONFLICT OF INTEREST CHECKLIST

In reviewing your activities (and those of your spouse and immediate family members) to determine whether they create a real, potential or apparent conflict of interest, among other things, consider the following with respect to your role as a councillor and to matters that may come before Council:

- Investments in a business enterprise (other than mutual funds or Registered Retirement Savings Plans that are not self-directed);
- Previous, present and potential contracts, grants and/or contributions;
- Pending negotiations regarding potential contracts;
- Honoraria and other sources of personal income;
- Advice to or close association with manufacturers;
- Gifts and hospitality of significant value;
- Travel sponsorship;
- Research support/funding;
- Participation as investigator in clinical trials of relevance to the Council’s mandate;
- Promotion of a product(s) of relevance to the Council's mandate;
- Publications;
- Public statements;
- Lobbying activities;
- Membership in special interest groups;
- Expert testimonies in Court;
- Access to confidential information;
- Any interest or activity that may create a reasonable apprehension of conflict of interest.

College of Physicians & Surgeons of Alberta

Confidentiality and Non-disclosure Agreement

Between

_____

and the

College of Physicians & Surgeons of Alberta ("the CPSA")

I acknowledge that I will respect the confidentiality of any and all information that I became aware of in the course of providing services to the CPSA, that confidentiality extends internally and externally and continues after the expiration of the contract period.

Accordingly, I undertake to:

1. abide by the attached CPSA Privacy and Confidential Information Policy.
2. hold the information in strict confidence and disclose it only with the express written consent of the CPSA.
3. implement procedures to safeguard against the accidental or unauthorized disclosure of the information.
4. access and use the information only in the performance of my assigned duties.
5. comply with all requirements imposed by the CPSA with respect to the handling of information.
6. transmit the information over the Internet in a secure manner.
7. immediately destroy the information, including any copies or reproductions, within seven (7) days maximum after its use or upon fulfillment or termination of the intended purpose.
8. dispose of the information in a manner acceptable to the CPSA.
9. ensure that no information obtained as a result of working for the CPSA is used by any individual for the purpose of furthering any private interest or as a means of making personal gain.
10. report any privacy incident involving the information, including its use or disclosure, not authorized by this agreement or in writing by the CPSA within one (1) business day after such an incident becomes known to me.

Any breach of this agreement may result in termination of this or any other relationship with the CPSA, as well as subsequent legal action by the CPSA.

_____ _____

Signature Date

date, print, sign, return

College of Physicians & Surgeons of Alberta

Our policy on

Privacy & Confidential Information

Contents

1. Purpose

The College of Physicians & Surgeons of Alberta (CPSA) is responsible for maintaining and protecting the confidential information under its control. This policy:

a. Documents practices as related to confidential information
b. Provides guidance to staff as they address challenges associated with handling confidential information
c. Aims to achieve statutory and regulatory compliance

2. Definitions

Business contact information: An individual's name, position name or title, business telephone number, business address, business e-mail, business fax number and other similar business information used to contact an individual in his or her capacity as an employee of an organization.

CPSA or the College: The College of Physicians & Surgeons of Alberta as established in section 1 of Schedule 21 of the *Health Professions Act*.

Confidential information: Not limited to, but includes:

i. all personal information as defined by the *Personal Information Protection Act;*
ii. all health information as defined by Alberta's *Health Information Act* to which the CPSA may have access;
iii. all protected employee information; and
iv. all business information deemed to be confidential.

Employee: An individual employed by the CPSA including a volunteer, council member, committee member, contractor and an agency placement who from time to time performs a service on behalf of the CPSA.

HIA: *Health Information Act,* H-5, RSA 2000 and applicable regulations.

HPA: *Health Professions Act,* H-7, RSA 2000 and applicable regulations.

OIPC: Alberta's Office of the Information and Privacy Commissioner.

Personal information: Information about an identifiable individual excluding business contact information.

PIPA: *Personal Information Protection Act*, S.A. 2003 c. P 6.5 and applicable regulations.

Policy/policies: Privacy and information-related policy instruments of the CPSA include this policy and all directives or procedures falling under it.

Potential employee: An individual who has an open application for employment with the CPSA.

Vendor: An individual or organization that performs a service on behalf of the CPSA, pursuant to an agreement with the CPSA; of particular relevance are vendors providing services that involve access to the CPSA information or that are otherwise information-related.

3. Policy Statement

As a professional regulatory body under the HPA, the CPSA has a responsibility to take all reasonable measures to safeguard confidential information in its custody and control or to which it has access.

Technical environments and best practices related to information handling change quickly and often. In response to this reality, the CPSA has delegated responsibility for confidential information to its privacy officer and senior technical staff.

4. Classification of Information

CPSA staff must treat, minimally handle and protect all information deemed confidential as described in this policy. This policy and all directives falling under it are the minimum standards the CPSA must use.

Confidential information of a particularly sensitive nature may be so classified. Management may impose further limitations upon the collection, use, storage, retention and/or disclosure of such information.

5. Accountability

The College is responsible for maintaining and protecting the confidential information under its control.

a. Accountability for ensuring privacy compliance rests with the management team of the CPSA. The Registrar will designate one employee as privacy officer responsible for the CPSA's compliance with privacy legislation. The Privacy Officer may delegate other individuals within the College to act on his or her behalf or take responsibility for routine handling of confidential information.

b. The CPSA shall implement policies and procedures to:
   - protect confidential information,
   - oversee compliance with privacy legislation,
   - receive and respond to privacy inquiries and complaints, and
   - inform employees and vendors about these policies and procedures.

c. The CPSA must provide all new employees with a policy orientation detailing organizational policies and obligations when accessing and/or handling confidential information.

d. The College is responsible for confidential information in its possession or control and ensuring that employees and vendors comply with the CPSA’s policies and procedures pursuant to relevant legislation and/or agreements.

e. The CPSA will share its privacy policies and procedures to individuals upon request.

f. The CPSA will comply with the provisions of any agreements governing access to and handling of information (including health information) and will comply with the HIA as required.

6. Notice (Identifying Purposes)

The CPSA will identify the purpose for which it is collecting personal information either before or at the time of collection.

a. The CPSA will communicate verbally, electronically or in writing that the primary purpose of collecting, using and/or disclosing confidential information is to conduct business that is authorized under legislation. Upon request, persons collecting confidential information will explain these identified purposes or refer the individual to the privacy officer for further explanation.

b. Unless required by law, the CPSA will not use or disclose confidential information that was previously collected for any new purpose without first obtaining the consent of the individual and documenting the new purpose.

7. Consent

The knowledge and consent of an individual is required for the collection, use and/or disclosure of confidential information except when authorized, required or permitted by legislation.

a. As a regulatory authority, provisions 14(b), 17(b) and 20(b) of PIPA allow the CPSA to collect, use and disclose personal information without consent if it is authorized or required to do so under legislation.

    i. For example, with respect to applicants to and registered members of the CPSA, personal information is collected, used and disclosed to consider and approve registration, and maintain an annual certificate of registration as set out in the *Health Professions Act,* Part 2, section 28. As such, consent is not required for this purpose.

b. If the collection, use and/or disclosure of confidential information is not authorized or required under the law, then at the time of collection, and in a manner that is easily understood, the CPSA will use reasonable efforts to ensure that an individual is advised of the identified purposes for which confidential information will be collected, used and/or disclosed.

c. Generally speaking, if consent is required, the CPSA will seek consent to collect, use and disclose confidential information at the time of collection. However, the CPSA may seek consent to use and disclose confidential information after it has been collected but before it is used or disclosed for a new purpose. Consent may be expressed or implied.

d. At any time, an individual may revoke consent to collect, use and/or disclose their confidential information if the purpose for collection/use/disclosure is not a requirement under legislation, and if doing so does not change or frustrate a legal obligation. If an individual revokes consent, the CPSA will cease to use and disclose the confidential information, except as permitted or required under PIPA, the HPA or other relevant legislation. Revoked consent may limit the CPSA's ability to serve that individual.

8. Collection of Confidential Information

The CPSA will collect confidential information by fair and lawful means and will limit its collection of confidential information to that which is reasonable for the purposes identified.

a. The CPSA collects confidential information routinely from members, applicants, employees, potential employees, and periodically from experts and the general public.

b. From time to time the CPSA may receive confidential information from other sources. These parties must represent that they have the authority to disclose the information before the CPSA will obtain it.

c. The CPSA will adhere to the provisions of all information sharing agreements made with those who may provide confidential information to the College. The CPSA will also adhere to any privacy legislation relevant to such information.

9. Use of Confidential Information

The CPSA can use confidential information only for the purpose identified at the time of collection.

a. Only authorized employees and/or vendors may access confidential information.

b. The CPSA cannot use information collected for one purpose for other purposes without clear legislative authority or individual consent.

c. CPSA staff can only access files containing confidential information in accordance with the CPSA's *Directive on Protecting Confidential Information*.

d. All employees using confidential information should be able to explain why the CPSA needs it, how it will use it, how it will protect it, and if/how it might share it.

10. Storage of Confidential Information

The CPSA will store all files containing confidential information in accordance with the CPSA's *Directive on Protecting Confidential Information*.

11. Disclosure of Confidential Information

The CPSA will not disclose confidential information for purposes other than those for which it was collected unless it has an individual's consent or is authorized or required by legislation.

a. Confidential information **will** generally be disclosed:
- to the individual about whom the information relates, or
- with the consent of the subject individual, or
- when clearly identified as information the CPSA will disclose at the time of collection, or
- when deemed publically available information, or
- as authorized or required by law.

b. Confidential information **will not** be disclosed:
- when prohibited by law, or
- when such disclosure would contravene the terms of an information sharing or other such agreement.

12. Accuracy of Confidential Information

The CPSA will ensure confidential information is as accurate, complete, and as current as possible.

a. Confidential information used by the CPSA will be as accurate and complete as is reasonably possible.
b. The CPSA will update confidential information about an individual upon notification from the individual.
c. The CPSA will, whenever authorized and reasonable, allow individuals to update their own confidential information.

13. Retention of Confidential Information

In accordance with PIPA section 35, the CPSA will retain personal information only for as long as reasonably needed for business or legal reasons.

a. The CPSA will maintain records of investigations and hearings, copies of ratified settlements and admissions of unprofessional conduct, and records of complete registration applications and reviews for a minimum of ten years.
b. The CPSA will maintain financial records for a minimum of six years following the year in which the record was made (e.g. all records pertaining to fiscal year 2012 must be maintained until fiscal year 2019).
c. CPSA management will determine the retention schedules for other records containing confidential information.

14. Protection of Confidential Information

The CPSA will take all reasonable measures to prevent unauthorized collection, use, disclosure, modification, or access to confidential information.

a. All employees and vendors will protect all confidential information held by the CPSA and respect the privacy of the individuals who are the subjects of that information.
b. All employees and vendors are required sign a confidentiality and non-disclosure agreement, and to uphold all policies and procedures respecting privacy and security of confidential information. The agreement remains in effect even after termination of any business, contractual or employment relationship with the CPSA.
c. The CPSA will safeguard all confidential information in accordance with the CPSA's '*Directive on Protecting Confidential Information*'.

15. Individuals' Access to Personal Information

Upon request, the CPSA will inform an individual of the existence, use and disclosure of their personal information and will give them access to that information. An individual may challenge the accuracy and completeness of the information and have it amended as appropriate.

a. The CPSA will handle all access requests in accordance with the CPSA's *Directive on Access to Personal Information* and the Privacy Department Procedure Manual: *Responding to Access Requests*.
b. Individuals and employees can seek access to their confidential information by contacting the privacy officer at the College.

16. Contracting for Services

The CPSA may contract a third party vendor to provide services involving access to confidential information. The vendor may only collect, use and/or disclose confidential information in accordance with College policy and in accordance with any contract and/or agreement established between the vendor and the College.

a. All vendor contracts or subsequent agreements must include provisions to protect confidential information in the custody and control of the CPSA.
b. All contracts and/or vendor agreements must comply with the CPSA's *Directive on Protecting Information when Contracting for Services*.

17. Incident Response

The CPSA will respond to any incident, real or potential, involving confidential information under its control which could significantly impact College operations.

a. Employees will report all security breaches or privacy compliance issues to the CPSA's privacy officer.
b. The privacy officer will investigate the breach and evaluate the severity based on the degree of harm to the individuals involved, the sensitivity of the information, and the degree of malicious intent. Additional staff will be involved in the investigation as necessary to determine the cause of the breach and to implement any corrective or disciplinary actions required.
c. Depending on the nature and severity of the breach, the privacy officer will notify the OIPC or other investigative bodies that a breach has occurred.
d. The CPSA will share the results of the investigation to appropriate staff and take any corrective action.
e. The appropriate supervisory/managerial staff will apply any applicable disciplinary action.

18. Policy Review

The CPSA will review all privacy related policies periodically, minimally every three years, to ensure they reflect current practice, legislation and/or technology.

a. Periodically, at the discretion of the privacy officer and when the CPSA is contemplating significant changes to programs and/or practices, the CPSA will conduct a thorough risk assessment to determine the effectiveness of current policy and procedures, and to identify gaps.
b. The privacy officer will also conduct ongoing ad hoc assessments of privacy risk and revise or update the CPSA's policies as needed.

19. Compliance

Employee or vendor failure to comply with this policy is cause for disciplinary action up to and including termination of employment or business relationship, and where applicable, legal or other action.

Employees can direct any questions or concerns about the CPSA's handling of confidential information to the CPSA's privacy officer.

20. References

This policy is the umbrella under which other policies, directives and guidance documents fall.

College of Physicians & Surgeons of Alberta

To: College Council

From: Scott McLeod

Date: 28 February 2019

Subject: Registrar's Report to Council

Introduction

It's a new year for Council and staff. Therefore, this report will focus on what we have ahead of us over the next year. I see this year as an important time for setting the stage for building an even stronger College over the next five years.

1. The Strategic Action Plan

A great deal of work has already been done on the Strategic Action Plan for the CPSA. By the end of this year Council will have a well-articulated action plan for the next five years that puts the CPSA strategic plan into some tangible and measurable actions that strive to meet the long term goals of Council. This will be built on the work done last year by the leadership team who identified the core components of what excellence in regulation means. This is captured on the attached infographic that will be described during my briefing to Council.

This planning is also being done in conjunction with a great deal of other planning at the CPSA. This is best depicted in the attached timeline.

2. The CPSA "Brand"

As Dr. Bradley pointed out in his first Messenger Article this year, the CPSA is in need of a change in how it's perceived by both the public and the profession. I believe there is a perception out there by some of the public that we are not effective in protecting the public from dangerous doctors. The introduction of Bill 21 is an example of that. On the other side of the coin, some physicians feel we're unfair and overly bureaucratic in the work we do. There is a perception that we have lost touch with front line health care in Alberta and we should not be telling them how they should do their business.

It is our goal to change that. But, I want to make it clear that we're not just talking about tag lines and stationary changes when we talk about changing our brand. We are talking about fundamentally changing how we do our jobs and how we communicate with the profession and the public.

I certainly don't have any expectations that we will see a dramatic change in the next year, but I do expect there to be a clear plan on how we will accomplish that goal over the next five years. To start with, our Communications team is developing a better understanding of how we are perceived and what physicians and the public feel we should be doing. The results of this work will all be incorporated into the Strategic Action Plan.

In addition, we will be creating a new website for the College that will have easier access to the information people need. It will enhance transparency for the College and it will be more accessible to the public.

By the end of this year we should see the core architecture of a new website developed and ready for implementation in early 2020.

3. Standards of Practice

In Sept 2017, I introduce a concern I had around our existing Standards of Practice (SOP). I believed they were a vulnerability to the CPSA and committed to doing something about it. In the spring of 2018, Field Law was contracted to do a review of our SOPs and a review of best practices from around Canada. This was difficult work that took several months to complete. We received the report in September of 2018 and the CPSA leadership team has now reviewed it. Our Chief of Staff is currently in the process of developing a work plan to transform our SOPs into tools of regulatory excellence.

With the introduction of Bill 21 and the requirement to rapidly develop a Standard of Practice, it was an ideal time to test some of the theories about how we can improve our SOPs and the process of developing them. We are taking those lessons learned, along with the report from Field Law, to improve all SOPs. In addition to this work, the following three SOPs will be reviewed this year.

a. *Duty to Report a Colleague*
b. *Duty to Report a Physician Patient*
c. *Self-Reporting to the College*

The process of developing and enforcing SOPs will be clear to the public and the profession. All consultation will be considered in the development of the standards. We will combine some SOPs where possible and we will develop new ones as required. Last year was the first time we offered "Advice to the Public" documents related to our SOPs and our intent is to expand that as we refresh the existing SOPs.

By the end of this year there will be a clear plan to revise all of our Standards of Practice over the next 5 years.

4. Professional Conduct

As Council already knows, our Professional Conduct department has been struggling to keep up with the numbers of complaints that are coming in. Although there is no indication that the numbers of complaints are growing significantly, the complexity of the complaints are growing. We had a record number of hearings last year and we see that trend continuing. Thanks to Council supporting an investment in the department over this next year, we have developed a plan to approach this from three key ways.

a. First was to increase the staff required on a short term basis to deal with the back log of cases. It is out intent to cut that backlog down by 30 % over the next year.
b. Second, we have hired an external consultant to look at the department overall and provide recommendations on how to improve the work done in the department. That report has been received and the planning is underway to implement the recommendations.
c. Last, we are exploring how we can address some of the complaints from a quality perspective instead of a disciplinary perspective.

Therefore we are cutting back the backlog, improving how we process complaints and trying to redirect concerns to a more appropriate regulatory process to get the best outcomes for Albertans.

By the end of this year the Professional Conduct department will be well on its way to dealing with both the short and long term requirements of the department.

5. Registration Department update and plans for 2019

- The CPSA receives information regularly from the RCPSC (Royal College of Physicians and Surgeons of Canada) and the CFPC (College of Family Physicians Canada) regarding physicians who are non-compliant with the CPD (Continuing Professional Development) requirements. We will establish a process to follow up with the physicians who have been identified as non-compliant or who report on the RIF (Renewal Information Form) that they don't participate in CPD.
- The MCC (Medical Council of Canada) Therapeutics Decision Making exam is now required for all physicians to be eligible to apply for registration on the Provisional Register in family medicine. It is offered twice yearly in January and June on the same date in different jurisdictions with the MCC marking the exams centrally. This will move to an online format by 2020.
- The new English Language Proficiency (ELP) rules come into effect July 01, 2019 which align the CPSA with current FMRAC (Federation of Medical Regulatory Authorities of Canada) model standards and allow the postgraduate training programs to have their own process to determine ELP. We are working with the PGME (Post Graduate Medical Education) offices to establish a process whereby their office will report completion of ELP assessment to the CPSA.
- PPAP (Provincial Physician Assessment Program) is working with the University of Calgary to finalize the orientation program that will be required for all International Medical Graduates (IMGs) coming to Alberta. The online modules are completed and the face to face component will be done by the end of 2019.
- The process to transition from the Provisional Register to the General Register continues to be refined:
    - The Summative Assessment (SUMA) process is under development and family medicine assessor training has started. The SUMA will be piloted with experienced family physician assessors in 2019 and the process will be finalized by the end of 2019.
    - Members of the Summative Assessment Review Committee have been identified and TORs and a process will be established for reviewing the SUMA documentation and making a recommendation on the outcome to the Assistant Registrar of Registration

- Process being developed to monitor physicians on the provisional register who are required to undergo a SUMA if they don't obtain their Canadian credentials by the end of five years. Physicians will be encouraged to get their Canadian credentials as the preferred route.

- Change in scope of practice has been identified as an issue to address and this year we will gather information on the scope of the issue and to review how other MRAs approach this issue to inform our own process development.

6. Becoming a Learning Organization

One thing the CPSA expects out of physicians is to continuously strive for improvement. We must therefore also expect that from ourselves. We must continuously look at feedback and data to learn as we go. We must continuously question whether we are doing things in the best way and we must strive for improvement in everything we do. We're fortunate to have a great deal of data at the College and we routinely receive feedback from others. There are also many metrics that can help inform us of where and how we can improve. In addition to this we have the right leadership team to make this a reality. Therefore the foundational information exists to become a learning organization.

Developing and reporting on key performance indicators (KPI) for the College is one way that we plan on becoming a learning organization. This important work will be done in partnership with Council and CPSA Staff. Dr Karen Mazurek and Mr. David Kay are working with Dr. Louis Francescutti to stand up a working group who will develop those important indicators over the next year. By the end of this year we will have a valuable set of KPIs that will be used to monitor and inform the CPSA of its performance and help facilitate its own learning as an organization.

7. CIHI (Canadian Institute for Health Information) report on Physician Supply

Attached is a 2 page summary that Steve Buick put together for us on physician supply in Alberta. I think it highlights some important points about physician supply in Alberta that all Councillors should be aware of.

8. FMRAC Update

I attended the FMRAC Board meeting on Feb 6th, where we addressed some very important subjects that Council needs to be aware of and which I would like some guidance on.

a. FMRAC Fast Track License Agreement– It is the opinion of the FMRAC Board that we can develop a shortened process for physicians to apply for a license in another province if they currently hold a license in good standing with another MRA in Canada. Attached is a draft of the criteria that would be considered for an expedited license. In principle, would the CPSA be ok entering into such an agreement?
b. FMRAC License Portability Agreement – This agreement would allow for someone to practice for up to 1/3 of their time in provinces other than their "home" province. This would allow for

enhanced portability for those who wish to do locums in other provinces. The draft criteria are attached for your reference. In principle, would the CPSA be interested in entering into an agreement such as this?

c. Common standard for Telemedicine – It was proposed that a "Pan-Canadian" Standard be developed that would be adopted by all provinces on Telemedicine. This would mean that our Telemedicine SOP would be identical to other MRAs and this would allow for easier use of Telemedicine services. In principle, would the CPSA be interested in adopting a Pan Canadian common standard on telemedicine?

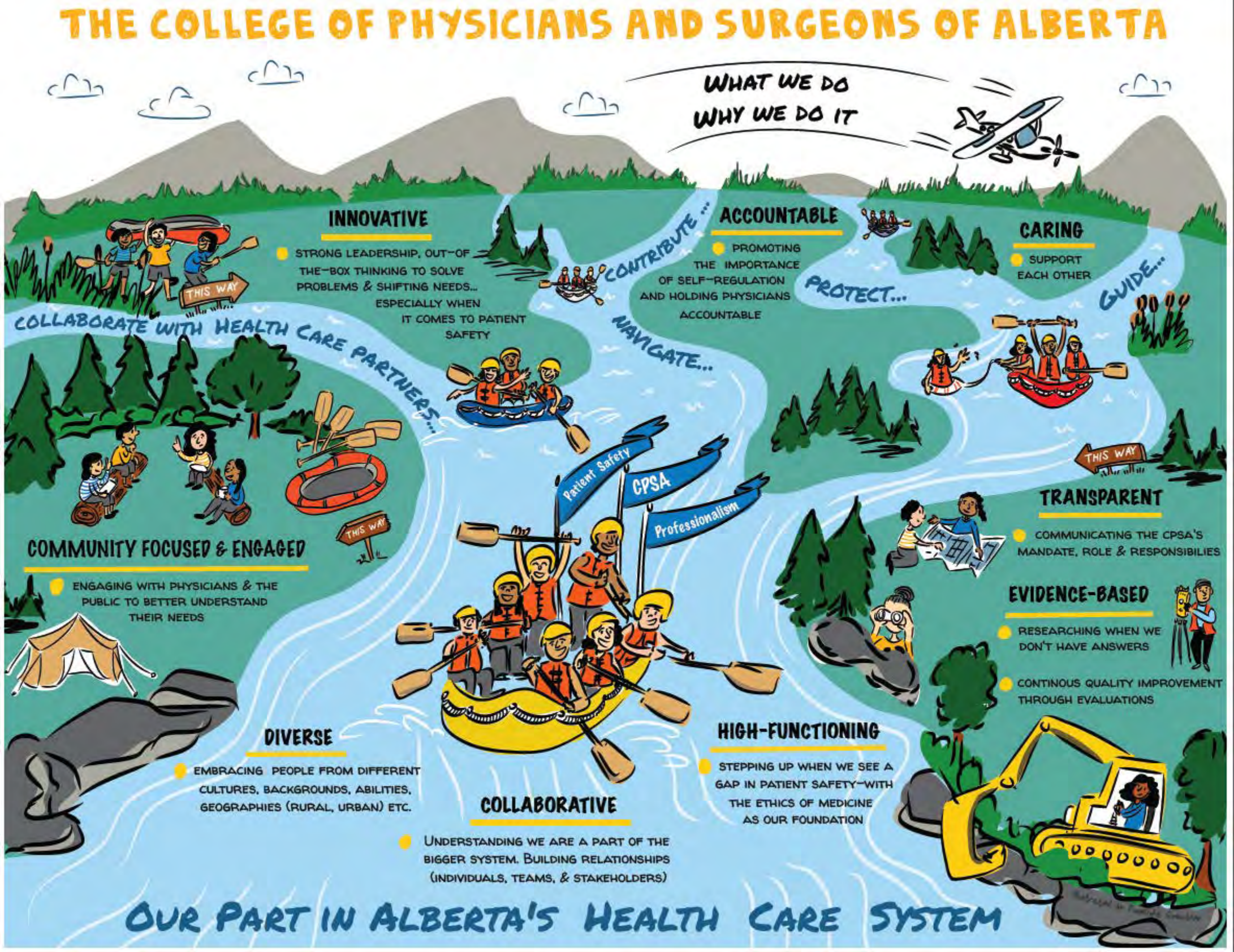
Conclusion

The above items are only a small part of what we have in front of us over the next year. There will continue to be a great deal of work in all departments, such as establishing a long term contract for accreditation with AHS, establishing an improved process around our provisional register, analyzing and providing feedback to physicians around their prescribing of antimicrobials and developing a better understanding of how the College can help protect Albertans by addressing physician impairment as a result of illness, fatigue, medication, drugs and alcohol. We will also continue to work at the national level to improve physician portability within Canada and look at regulation of medical practice in the rapidly advancing world of digital health.

As we move forward with this work over the next year we will continue to look to Council for guidance and support.

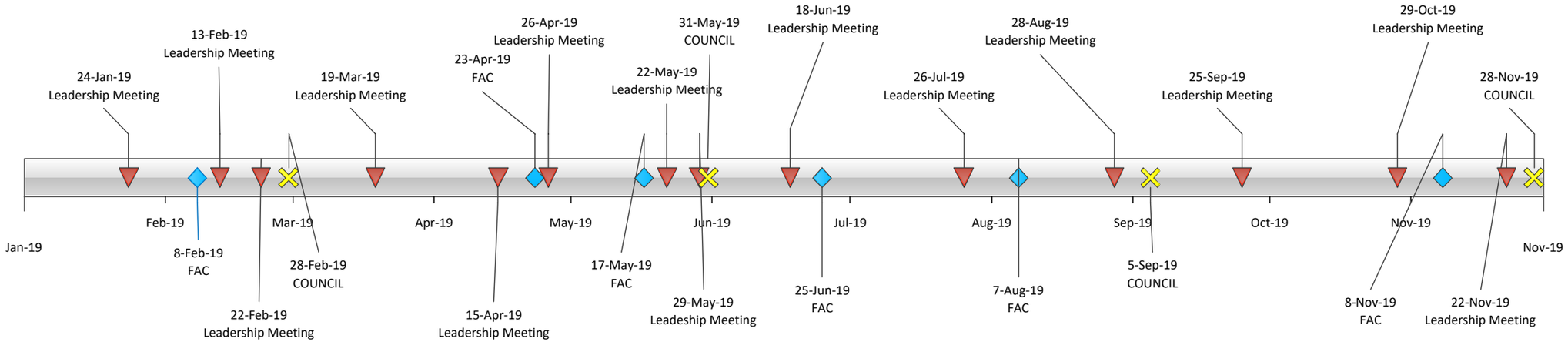
Attachments:
Best Regulator Infographic
2019 Timeline
Summary of CIHI Physician Workforce Report
FMRAC Streamlined Registration Information (FMRAC License Portability and FMRAC Fast Track License Agreement)

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ALBERTA



OUR PART IN ALBERTA'S HEALTH CARE SYSTEM

2019 Business Timeline



Jan-19 - Apr-19
Total Rewards Philosophy

Jan-19 - Apr-19
Management KPI for 2019Business Plan

Jan-19 - May-19
Council Strategic Priorities from Retreat

Jan-19 - Jun-19
Strategic Action Plan

Jan-19 - Jun-19
2020 Budget & Business Plan & related KPI

Jan-19 - Jun-19
Pension Review

Jan-19 - Nov-19
Governance KPI

College of Physicians & Surgeons of Alberta

Briefing Note
Council

From: Registrar

Date: February 15, 2019

Subject: Physician workforce trends

Issue **CIHI annual report – general information, no action required by CPSA**

Background

CIHI released a report, "Physicians in Canada, 2017" on Feb. 7, 2019. The report gives workforce/supply data as of Dec. 31, 2017, data on activity and payment for the fiscal year 2016-17, and change since 2013/2012-13.

Key trends:

- Alberta's physician supply (per capita) increased 11% from 2013 to 2017 vs national average 6.6%
- Alberta's physician supply is slightly higher than national average
- Alberta had the fastest growth in international medical graduates as a % of total physician workforce
- Alberta has the highest gross payment per physician, and by far the greatest reliance on ffs payment
- Alberta's gross payment per physician increased 11% from 2013 to 2017 vs national average 4%
- Distribution among the five Alberta Zones is uneven

Highlights – workforce/supply

- Canada's physician supply @ Dec. 31, 2017 was 234 per 100,000 population, the highest level ever.
- Supply has increased steadily since 2005. (It was flat from about 1988 to 2005 after dropping slightly in the mid-1990s.)
- Supply in Alberta increased 11% in the past 4 years, 2013-17, the largest increase among the provinces and nearly twice the national average increase, 6.6%.
- Alberta's physician supply is 243, slightly higher than the Canadian average (243); about the same as BC (247); higher than Ontario (224).
- Women are now 41% of Canadian physicians, up from 38% in 2013. The % is increasing in all provinces. In Alberta, 38% of physicians are women.
- Women are a higher % of family doctors (46%) than specialists (36%) but the % of women is increasing at about the same rate in both groups.
- Alberta physicians are the youngest in the country, average 48.3 years compared to national average 50.2.
- Alberta has more physicians with international MD degrees than national average, 35% of our total compared to national average 27%. (BC 31%, ON 30%).
- Alberta has had by far the largest increase in physicians with international MD degrees among the provinces: 35.1% of our total in 2017, up from 32.4% in 2013, an increase of 2.7%. Canada overall increased by 1.2%.

Highlights – payment

- Alberta's average gross clinical payment per physician in 2016-17 was $386,000, highest of all provinces.
- Alberta's average gross clinical payment per physician increased 11% from 2012-13 to 2016-17, nearly 3 times the national average 4%. (Ontario's average payment dropped 6% over the same 4 years.)

- For surgeons, average gross clinical payment per FTE is highest in Alberta, 28% higher than national average. For medical specialists, Alberta is tied for #1 with SK, 11% above average. For family physicians, Alberta is highest, 22% above national average. (CIHI now includes alternate payments as well as ffs in calculating FTE, except AB and SK – ffs only.)
- Alberta has by far the highest % of total payment by ffs: 83% of Alberta physicians were paid only by ffs in 2016-17, compared to national average 32%.
- Nationally, the move to alternate payment has been stalled for a decade. Alternate payments rose through the 2000s to nearly 30% of total payments around 2008, but the % has been flat since then and has declined slightly in the past few years, to about 27% in 2016-17.

Highlights – workforce/supply by Zone

- CIHI reports a wide range of other data on their website, including some basic statistics by region/Zone.
- The data below shows large differences among the Zones. Supply of both family physicians and specialists is much higher in South Zone than in Central or North. The specialist workforce has grown by similar percentages in recent years in the 3 Zones but the family physician workforce has grown faster in South, adding to the disparity in supply.
- Calgary has seen larger increases in both family physicians and specialists than Edmonton, resulting in a combined supply that is exactly the same in the 2 metro Zones. But note these crude supply per capita figures do not take into account population health needs or out-of-Zone utilization, both of which vary widely among the Zones. Also, effective supply at a point in time is influenced by factors in the local market, eg, average FTE worked. Workload per physician can vary widely as measured by, eg, panel size.

Family physicians

Health region							
Name	Total number, 2013	Total number, 2017	Percentage change, 2013 to 2017	Physicians per 100,000 population,* 2017	Average age,† 2017	Percentage female,‡ 2017	Percentage Canadian trained,§ 2017
Canada	**39,392**	**44,192**	**12.2%**	**120**	**50.0**	**45.5%**	**69.8%**
Alberta	**4,630**	**5,524**	**19.3%**	**128**	**48.0**	**42.2%**	**56.1%**
South Zone	304	376	23.7%	124	48.4	33.2%	58.2%
Calgary Zone	1,908	2,356	23.5%	143	47.7	49.9%	60.9%
Central Zone	435	492	13.1%	102	49.7	29.1%	37.8%
Edmonton Zone	1,596	1,832	14.8%	131	48.4	40.1%	60.6%
North Zone	380	432	13.7%	95	46.8	32.2%	31.3%

Specialists

Health region	Specialists						
Name	Total number, 2013	Total number, 2017	Percentage change, 2013 to 2017	Physicians per 100,000 population,* 2017	Average age,† 2017	Percentage female,‡ 2017	Percentage Canadian trained,§ 2017
Canada	**38,282**	**42,452**	**10.9%**	**115**	**50.4**	**36.2%**	**77.5%**
Alberta	**4,394**	**5,156**	**17.3%**	**119**	**48.5**	**34.2%**	**74.3%**
South Zone	183	225	23.0%	74	49.9	20.4%	62.2%
Calgary Zone	1,999	2,390	19.6%	145	48.1	37.4%	79.6%
Central Zone	172	209	21.5%	43	49.5	24.9%	64.1%
Edmonton Zone	1,937	2,194	13.3%	157	48.7	33.5%	72.2%
North Zone	102	126	23.5%	28	49.1	22.2%	48.4%

4.4 – Streamlined Registration – Attachment 1

		STREAMLINED REGISTRATION	
	Issue	***FMRAC License Portability Agreement***	***FMRAC Fast Track License Agreement***
1	Target audience	physicians seeking to practise for a short-term (locum) in another jurisdiction on a regular basis	physicians seeking to hold a regular license in another province or territory, whether or not they eventually set up practice there
2	Purpose	to provide these physicians ***<u>with a single license</u>*** that they can use across the participating jurisdictions	to provide a faster, simpler and less expensive application process
3	The physician must	a) hold a full, unrestricted license for independent practice in a Canadian jurisdiction (the Canadian Standard) b) not have any disciplinary actions, pending or concluded c) practise in the home jurisdiction for two thirds of each year d) show proof of CMPA or equivalent coverage e) complete and submit the application f) fulfill any and all other requirements that are not within the control of the MRA (e.g., criminal record checks), understand that some aspects of practice are beyond the responsibility of MRAs, such as institutional privileging and billing g) for the home jurisdiction: check out with the MRA upon departure to another jurisdiction and check in upon returning h) for the receiving jurisdiction: check in with the MRA upon arrival and check out upon departure	a) hold a full, unrestricted license for independent practice in a Canadian jurisdiction (the Canadian Standard) b) have practised in the home jurisdiction for the past three years c) have a CPC from ***<u>the home jurisdiction MRA only</u>*** that is satisfactory to the receiving jurisdiction MRA d) not have any disciplinary actions, pending or concluded e) complete and submit the application f) fulfill any and all other requirements that are not within the control of the MRA (e.g., criminal record checks), understand that some aspects of practice are beyond the responsibility of MRAs, such as institutional privileging and billing
4	The receiving jurisdiction MRA must	provide a report to the home jurisdiction MRA upon the physician's departure	
5	Cost	This "portable" license is ***<u>in addition to</u>*** the physician's regular license. The cost may be more than the regular license.	- the application will be ~50% of the regular application - the licensing fee remains the same
6	FMRAC Working Group needs to	- determine the maximum time allowed for each locum - draft a common application form - draft the Agreement to be signed by participating MRAs - draft the reporting requirements for the receiving jurisdiction MRA to send to the home MRA	- draft the Agreement to be signed by participating MRAs - draft a common application form
7	MRAs need to	- determine if a new class of registration is required in their jurisdiction	- determine the feasibility
8	Definition of home jurisdiction	- where the physician pays taxes <u>and</u> - where the physician provides care for two thirds of any given year (this can be in the form of locums)	- where the physician pays taxes <u>and</u> - where the physician has practised for the past three years
9	Time line	- draft Agreement for June 2020 FMRAC Annual Meeting	- draft Agreement for June 2019 FMRAC Annual Meeting
10	Other	- through the Application for Medical Registration in Canada	- through the Application for Medical Registration in Canada

College of Physicians & Surgeons of Alberta

Submission to:	**Council**

Meeting Date:	Submitted by:		
February 28, 2019	Dr. Karen Mazurek, Deputy Registrar		
Agenda Item Title:	2019 Key Performance Indicators		
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) :			
Background:	Council approved CPSA's business plan for 2019 at the September 2018 meeting. For each tactic on the business plan, a risk assessment was completed. There are five tactics on the plan that are categorized as high risk and are therefore high priority. Council level key performance indicators and targets have been identified for these high-risk/high priority items. **1. 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 **2. 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		

	3. Address backlog in complaint files Risk type: REPUTATIONAL Risk likelihood: HIGH Risk seriousness: EXTREME <u>Key performance indicator</u>: Investigation file backlog eliminated Target: 40% reduction in backlog by Q4 2019 **4. Develop plans for:** **Marketing/Communications** **Engagement** **Media Relations** Risk type: OPERATIONAL/STRATEGIC Risk likelihood: MEDIUM Risk seriousness: HIGH <u>Key performance indicators:</u> Marketing/Communications plan complete Target: Q4 2019 Engagement plan complete Target: Q4 2019 Media strategy plan complete Target: Q4 2019 **5. Develop Summative Assessment process** Risk type: OPERATIONAL/STRATEGIC Risk likelihood: MEDIUM Risk seriousness: HIGH <u>Key performance indicator:</u> Summative assessment process developed and tested Target: complete 5 pilot summative assessments by Q4 2019
Next Steps:	Progress will be reported to FAC and Council following each quarter beginning at the May meeting with Q1 results. The 2020 to 2024 Strategic Action Plan is currently under development. KPIs for the 5 year plan will be developed in collaboration with a working group of Council and will be presented at a future Council meeting.
List of Attachments:	

College of Physicians & Surgeons of Alberta

CPSA Business Plan 2019 & Risk Assessment for 2019 Budget

Updated: 31 July 2018

College of Physicians & Surgeons of Alberta

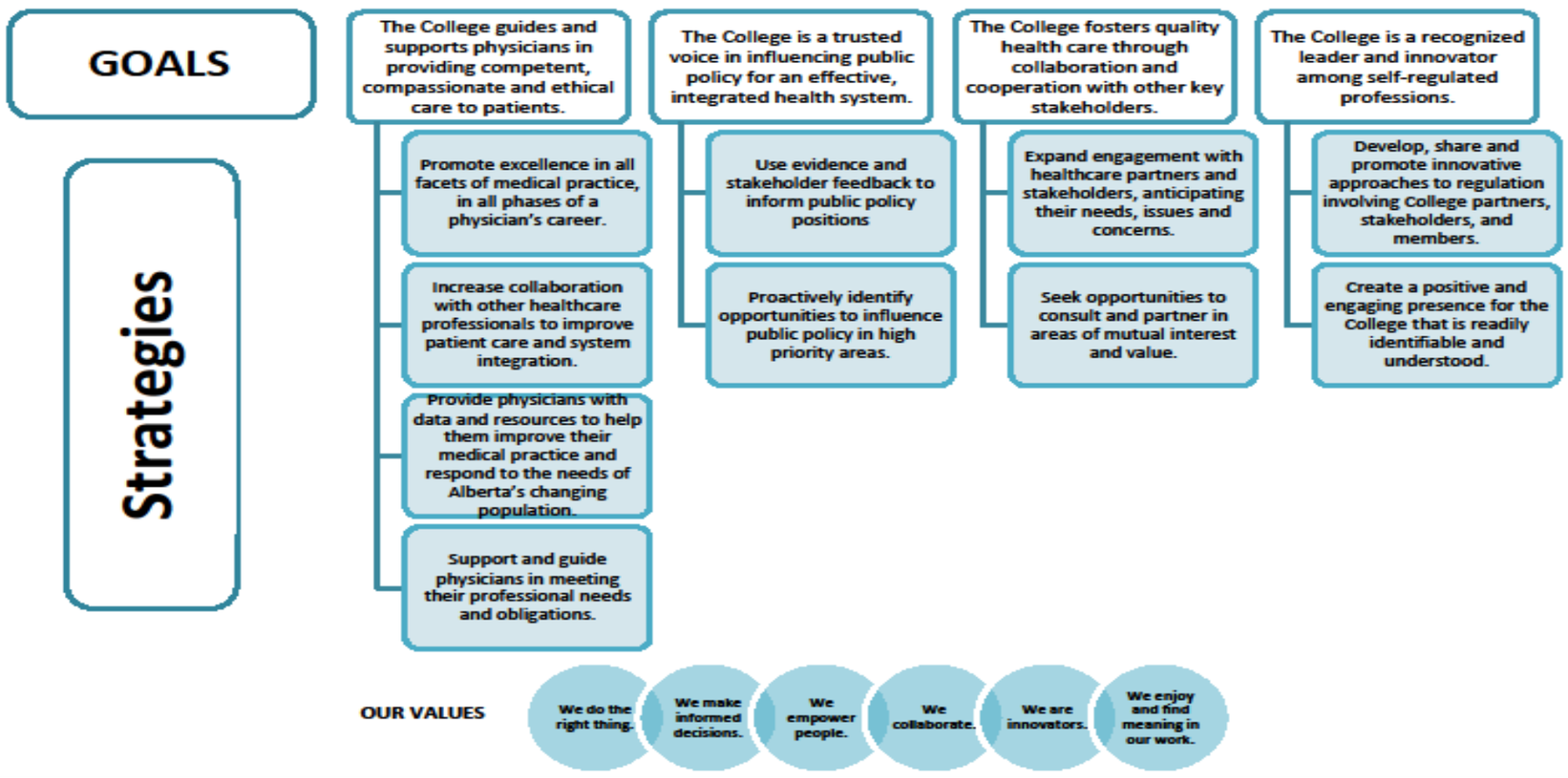
CPSA STRATEGIC PLAN

Our Vision

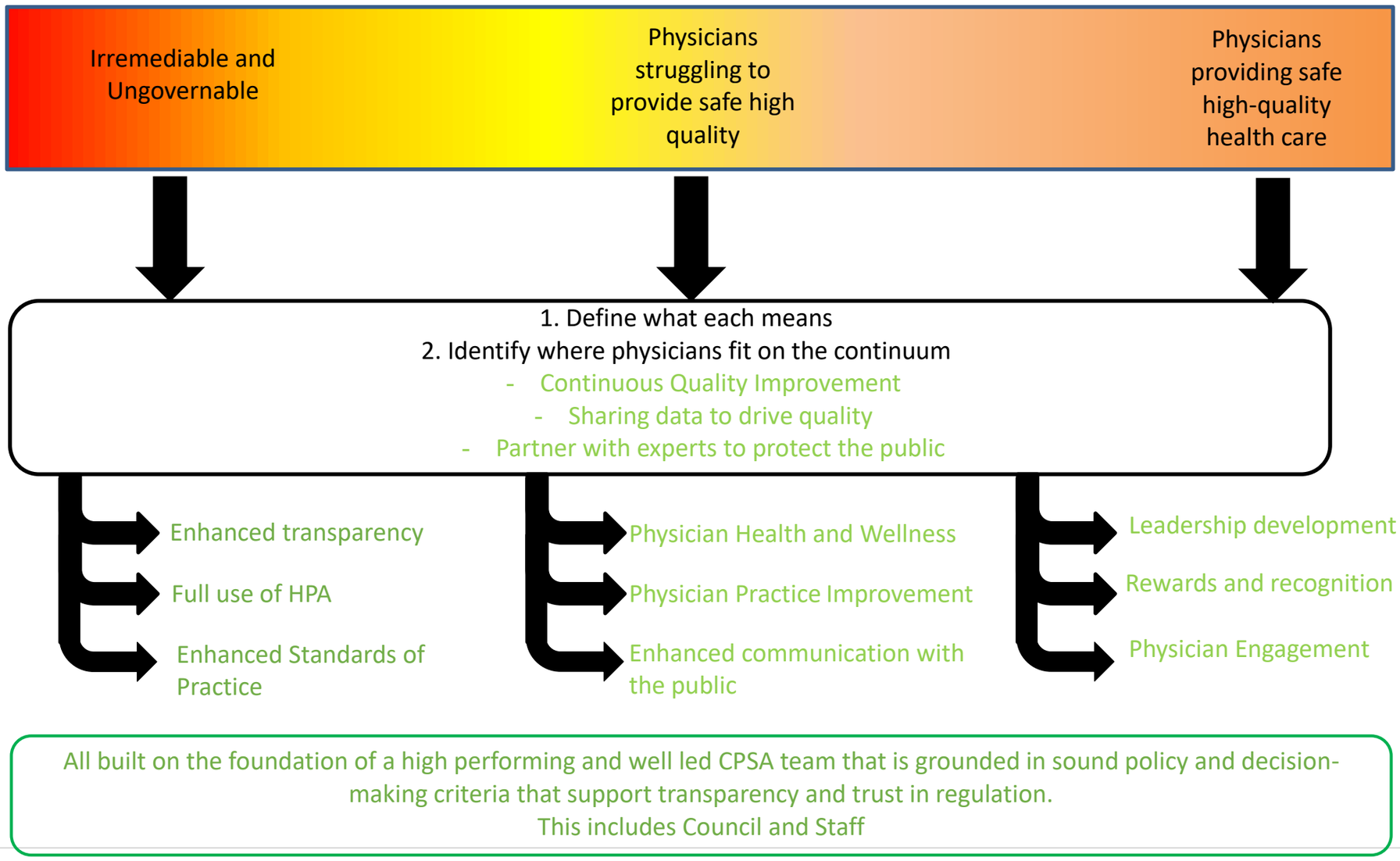
The highest quality medical care for Albertans through regulatory excellence

Our Mission

To protect the public and ensure trust by guiding the medical profession



College of Physicians & Surgeons of Alberta



All built on the foundation of a high performing and well led CPSA team that is grounded in sound policy and decision-making criteria that support transparency and trust in regulation.
This includes Council and Staff

College of Physicians & Surgeons of Alberta

Rank Each Proposed Activity as Follows:

1. Categorization of Risk if Deferred/Cancelled

Categorization of most prominent risk if proposed Activity was deferred/cancelled in 2019			
L	Legal	O	Operational/strategic
F	Finanical	R	Reputational

2. Likelihood and Seriousness of that risk occurring

Rating for Likelihood and Seriousness for each risk			
L	**Rated as Low**	**E**	**Rated as Extreme (Used for Seriousness only)**
M	**Rated as Medium**	**NA**	**Not Assessed**
H	**Rated as High**		

3. Combined grade of a risk occurrnig

Grade: Combined effect of Likelihood/Seriousness					
	Seriousness				
Likelihood		**Low**	**Medium**	**High**	**EXTREME**
	Low	**N**	**D**	**C**	**A**
	Medium	**D**	**C**	**B**	**A**
	High	**C**	**B**	**A**	**A**

College of Physicians & Surgeons of Alberta

College Goal #1: The College guides and supports physicians in providing competent, compassionate and ethical care to patients.

2019 Tactics	Activity				Risk Assessment			
	Dept	Year 2019	Priority Level: 1) Critical 2) Important 3) Table 4) Terminate (Based on Patient Safety, Reputational Risk, Resource Availability)	Implications: 1) Budget 2) Outcome to be achieved 3) Possible KPI 4) Workflow to be used, changed	Categorization	Likelihood	Seriousness	Grade
Strategy 1.1: Promote excellence in all facets of medical practice, in all phases of a physician's career.								
Improve identification & management of high-risk physicians	Physician Health Monitoring	▪ Literature review to identify tools for quantifying various high-risk categories. ▪ Collaborate with Continuing Competency and other departments for disruptive physicians' identification ▪ Assess recommended actions arising from Disruptive Behaviour review.	2	1) $65,000 budget effective 1 April 2019 New research assistant in College REVU (research & evaluation unit) to support high priority regulatory research activities including identifying risk factors for physician health monitoring. 2) Improved interactions and intervention strategies for disruptive members 3) To be developed 4) Builds on the 2018 PFSP-Physician Health Monitoring external evaluation	Operational/Strategic	Medium	Medium	C

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2019 Tactics	Activity				Risk Assessment			
	Dept	Year 2019	Priority Level: 1) Critical 2) Important 3) Table 4) Terminate (Based on Patient Safety, Reputational Risk, Resource Availability)	Implications: 1) Budget 2) Outcome to be achieved 3) Possible KPI 4) Workflow to be used, changed	Categorization	Likelihood	Seriousness	Grade
Accreditation "A" developed & implemented	Accreditation	▪ Begin higher risk clinic assessment program (Accreditation "A") development (2018/2019) ▪ Pilot Accreditation 'A" program & assess outcomes (2019/2020)	2 2	1) With existing staff in 2019 to design the new higher risk clinic assessment program (Accreditation "A") 2) Engage approximately 50 clinics in the pilot program 3) Approximately 50 clinics participate in Accreditation "A" clinic assessment in 2019/2020. 4) New workflow changes with IPAC and Accreditation	Operational/	Low	Medium	D

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2019 Tactics	Activity				Risk Assessment			
	Dept	Year 2019	Priority Level: 1) Critical 2) Important 3) Table 4) Terminate	Implications: 1) Budget 2) Outcome to be achieved 3) Possible KPI 4) Workflow to be used, changed	Categorization	Likelihood	Seriousness	Grade
Strategy 1.2: Increase collaboration with other healthcare professionals to improve patient care and system integration.								
Implementation of recommendations from 2018 Standards of Practice (SOP) process review & refresh	COO/COS	Implement recommendations from external review over 2018-2020	2	1) With existing staff in 2019. May require legal staffing in 2020 2) Reformed SOPs/SOP process to be evidence-based, effective & relevant 3) To be developed. 4) Will require changes in workflow & possibly never staffing.	Reputational	Medium	Medium	C
Develop new joint Accreditation reviews/guidance documents with other health regulators including Point of Care Testing (POCT)	Accreditation	Work with interested health regulators to develop joint accreditation reviews, FAQs, guidance documents & standards	2	1) Within existing staff & budget. 2) Models interprofessional health care delivery 3) To be developed. 4) Within exiting workflow.	Operational/Strategic	Low	Low	N

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2019 Tactics	Activity				Risk Assessment			
	Dept	Year 2019	Priority Level: 1) Critical 2) Important 3) Table 4) Terminate	Implications: 1) Budget 2) Outcome to be achieved 3) Possible KPI 4) Workflow to be used, changed	Categorization	Likelihood	Seriousness	Grade
Strategy 1.3: Provide physicians with data and resources to help them improve their medical practice and respond to the needs of Alberta's changing population.								
Design / implement *regulatory framework* to support the CPSA Health Informatics strategy.	Health Informatics Continuing Competence	▪ Draft CPSA *Health Informatics Strategy* - as framed by the *CPSA Strategic Plan* and industry best practices. ▪ Implement College Roadmap to integrated electronic patient records (IEPR) (COO) ▪ Implement College data infrastructure, data index, analytics & data governance framework (Digital Architecture) (COO) ▪ Improve access to provincial databases Secondary Use of Data Access (SUDA) o Agreement in place with Alberta Health for broader data sharing: o Antibiotics dispense data added to Prescribing reports. o Create sharing information agreements for access to data ▪ Provide leadership and coordination for CPSA representation on external Health Informatics initiatives.	2	1) Budgeted $25,000 for SMA travel/convention, contracted research, stakeholder engagement. New SMA hired May 2018 for 3 year contract period. 2) Relevant health informatics strategy to guide CPSA & Physician registrants 3) To be developed. 4) New Digital Architecture will support the framework & Secondary Use of Data Access (SUDA) external to CPSA	Operational/Strategic	Medium	Medium	C

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2019 Tactics	Activity				Risk Assessment			
	Dept	Year 2019	Priority Level: 1) Critical 2) Important 3) Table 4) Terminate	Implications: 1) Budget 2) Outcome to be achieved 3) Possible KPI 4) Workflow to be used, changed	Categorization	Likelihood	Seriousness	Grade
Physician practice data and patient records to be fully electronic and assessable	Continuing Competence	▪ Remote electronic chart audits to triage IPR referrals. We can adapt this to review up to 500 individual practices and triage them for IPR. ▪ Will continue into 2020.	2	1) Increase in consultant expenses $ included in strategy 1.1 required to review and triage up to 300 IPR's in 2019. This new IPR triage process will not be cost recovered. 2) Complete proof of concept for auditing charts remotely in preparation to increase IPR engagement to 500 annually in the next 3 years. 3) Remote chart audit for up to 300 IPR physicians in 2019. 4) Additional step in IPR. Up to 300 physicians will be triage to determine degree of competence enhancement or remediation required.	Operational/Strategic	Medium	Medium	C

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2019 Tactics	Activity				Risk Assessment			
	Dept	Year 2019	Priority Level: 1) Critical 2) Important 3) Table 4) Terminate	Implications: 1) Budget 2) Outcome to be achieved 3) Possible KPI 4) Workflow to be used, changed	Categorization	Likelihood	Seriousness	Grade
Physician portal utilization	Continuing Competence	Refinement of Prescribing report views/measures. Test the effectiveness and reach. MD snapshots delivered strictly through portal. Develop on-line support tools and feedback.	1	1) $240,000 consulting fees. Savings of $50,000 in mailing/ postage & supplies costs in 2019. Net $190,000 Additional savings in staff time not assembling paperwork and mail out. In addition, savings in future for other departments sending out material to physicians. Ongoing costs for license fee for software; Portion of costs for 2019 include one-time development costs. 2) Delivery of all MD Snapshot Reports through portal 3) # physicians reviewing/time period, time spent per report, collect feedback in real time, research into effectiveness of online audit and feedback No/limited staff time for mailouts required/paper and postage savings	Operational/Strategic	Medium	Medium	C

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2019 Tactics	Activity				Risk Assessment			
	Dept	Year 2019	Priority Level: 1) Critical 2) Important 3) Table 4) Terminate	Implications: 1) Budget 2) Outcome to be achieved 3) Possible KPI 4) Workflow to be used, changed	Categorization	Likelihood	Seriousness	Grade
Strategy 1.4: Support and guide physicians in meeting their professional needs and obligations.								
Recognition program	COS	Recognition initiatives for the Public to recognize registrants and for the College to recognize registrants	2	1) Within existing budget. 2) Registrant & Public engagement activities 3) To be developed. Will require new workflow	Reputational	Low	Low	N

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College Goal #2: The College is a trusted voice in influencing public policy for an effective, integrated health system.								
2019 Tactics	**Activity**				**Risk Assessment**			
	Dept	**Year 2019**	**Priority Level: 1) Critical 2) Important 3) Table 4) Terminate**	**Implications: 1) Budget 2) Outcome to be achieved 3) Possible KPI 4) Workflow to be used, changed**	**Categorization**	**Likelihood**	**Seriousness**	**Grade**
Strategy 2.1: Use evidence and stakeholder feedback to inform public policy positions.								
Strategy 2.2: Proactively identify opportunities to influence public policy in high priority areas.								
Know the issues Support public voice with actions	Government Relations	Find out Government of Alberta and Public priorities	2	1) Existing budget 2) Awareness of public concerns & alignment of regulatory tools with public expectation 3) TBD 4) No change to workflow	Reputational	Medium	Medium	C
Find and work with trusted voices	Government Relations	Build a coalition and meet regularly to shape views	2	1) Existing budget 2) Awareness of public concerns & alignment of regulatory tools with public expectation 3) TBD 4) No change to workflow	Reputational	Medium	Medium	C

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College Goal #3: The College fosters quality health care through collaboration and cooperation with other key stakeholders.								
2019 Tactics	**Activity**				**Risk Assessment**			
	Dept	**Year 2019**	**Priority Level: 1) Critical 2) Important 3) Table 4) Terminate**	**Implications: 1) Budget 2) Outcome to be achieved 3) Possible KPI 4) Workflow to be used, changed**	**Categorization**	**Likelihood**	**Seriousness**	**Grade**
Strategy 3.1: Expand engagement with healthcare partners and stakeholders, anticipating their needs, issues and concerns.								
Province Wide leadership strategy	(OOR-TBD)	Collaboration with other health partners to develop, implement & assess a province-wide physician leadership strategy	2	1) Existing staff time 2) Province-wide physician leadership activities in place 3) To be determined 4) No change to workflow	Reputational	Medium	Medium	C
Align all continuing competence programs & physician practice data among stakeholder jurisdictions	Continuing Competence	▪ Effective collaboration with Primary Care Networks (PCN's), Alberta Health (AH), Alberta Health Services (AHS) and Health Quality Council of Alberta (HQCA). Formulate a physician competence group involving stakeholders to begin amalgamation of data and assessments, reduce duplications. Complete list of membership by the end of 2019.	1	1) Travel costs for meetings with stakeholders and perhaps some consultations. $10,000 2) Establish a provincial Continuing Competence committee with the intent to avoid duplication of work and resources. 3) To be determined 4) Within existing workflow	Operational/Strategic	Medium	High	B

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College Goal #4: The College is a recognized leader and innovator among self-regulated professions.								
2019 Tactics	**Activity**				**Risk Assessment**			
	Dept	**Year 2019**	**Priority Level: 1) Critical 2) Important 3) Table 4) Terminate**	**Implications: 1) Budget 2) Outcome to be achieved 3) Possible KPI 4) Workflow to be used, changed**	**Categorization**	**Likelihood**	**Seriousness**	**Grade**
Strategy 4.1: Develop, share and promote innovative approaches to regulation involving College partners, stakeholders, and members.								
Review Professional Conduct processes, resources, workflow & decision-making criteria to incorporate leading practices	Professional Conduct	Implement recommendations from 2018 Professional Conduct Enhancement Review to incorporate leading complaint practices and improve: the front-end triaging of patient concerns to the appropriate remedy (e.g. informal resolution pre-complaint/pathfinding to other entities, diversion to Continuing Competence, etc.,), the control points for discretion/decision-making, the overall timeframe for case disposition, support to complainants, overall workflow/processes, required resources, implement meaningful KPI, and implement pattern recognition of harms for more effective (upstream) intervention & department process refinements	1	1) $65,000 for consultant fees 2) Outcome will support process changes, efficiencies and newly stated principles. 3) To be determined 4) New processes	Reputational	High	Extreme	A

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2019 Tactics	Activity				Risk Assessment			
	Dept	Year 2019	Priority Level: 1) Critical 2) Important 3) Table 4) Terminate	Implications: 1) Budget 2) Outcome to be achieved 3) Possible KPI 4) Workflow to be used, changed	Categorization	Likelihood	Seriousness	Grade
Address the Backlog in complaint files	Professional Conduct	Brainstorm interim solutions to address the immediate backlog of complaint files	1	1) Additional staff hired to address backlog New Staff: 2 contract SMA's & contract admin support. New staff position may be required pending result of enhancement review. Budget includes one new Patient Advocate. $761,000 New contract staff to be evaluated for potential succession planning for current staff coming up for retirement. 2) Back log eliminated 3) To be determined	Reputational	High	Extreme	A

2019 Tactics	Activity				Risk Assessment			
	Dept	Year 2019	Priority Level: 1) Critical 2) Important 3) Table 4) Terminate	Implications: 1) Budget 2) Outcome to be achieved 3) Possible KPI 4) Workflow to be used, changed	Categorization	Likelihood	Seriousness	Grade
Improve Public/Member Education	Registration	Process change to adopt FMRAC model standards of Registration	2	1) Within existing budget. Communications dept support required 2) Enhanced clarity and transparency for applicants. 3) To be determined 4) Within existing workflow processes	Operational/Strategic	Low	Medium	D

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2019 Tactics	Activity				Risk Assessment			
	Dept	Year 2019	Priority Level: 1) Critical 2) Important 3) Table 4) Terminate	Implications: 1) Budget 2) Outcome to be achieved 3) Possible KPI 4) Workflow to be used, changed	Categorization	Likelihood	Seriousness	Grade
Strategy 4.2: Create a positive and engaging presence for the College that is readily identifiable and understood.								
Develop plans for: - Marketing/ Communications - Engagement plan Media relations plan	Comms	New Director of Communication hired in 2018. Communications plans to be completed and rolled out in 2019.	1	1) Within existing budget 2) Communications outcomes in support of CPSA/department needs identified and associated tactics, resources, deliverables, targets, accountabilities 3) To be determined 4) New workflow may be required	Operational/Strategic	Medium	High	B
Rebrand CPSA	Comms	Continue work started in 2018 subject to new comms plans above: • Develop brand strategy with external vendor & CPSA leadership • Align physician engagement strategy with brand strategy • Implement new visual identity • Define CPSA voice & tone • Develop tools to support staff in maintaining brand consistency • With HR, incorporate into new staff onboarding	1	1) $50,000 2) position the organization as progressive & engaging to support business goals; 3) benchmarking based on research 4) some workflow implications for all staff, TBD	Reputational	Medium	Medium	C

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2019 Tactics	Activity				Risk Assessment			
	Dept	Year 2019	Priority Level: 1) Critical 2) Important 3) Table 4) Terminate	Implications: 1) Budget 2) Outcome to be achieved 3) Possible KPI 4) Workflow to be used, changed	Categorization	Likelihood	Seriousness	Grade
Evolve Registration	Registration	▪ Continuous Professional Development (CPD) Rule Change and Rollout – include reporting from national colleges (2018) ▪ English Language Proficiency (ELP) policy development and implementation ▪ Provisional Register Evolution – Therapeutic Decision Making (TDM), Provisional Register (PR) monitoring annually with members, ▪ FMRAC model standard alignment – Post-graduate Trainee (PGT) and Specialty recognition	1	1) Within existing budget. Communications and IT staff time required. 2) Implementation of process enhancements 3) To be determined 4) Some workflow changes required	Operational/Strategic	Medium	Medium	C

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2019 Tactics	Activity				Risk Assessment			
	Dept	Year 2019	Priority Level: 1) Critical 2) Important 3) Table 4) Terminate	Implications: 1) Budget 2) Outcome to be achieved 3) Possible KPI 4) Workflow to be used, changed	Categorization	Likelihood	Seriousness	Grade
Develop Summative Assessment process	Registration	▪ Work Plan – high level project map 2018 ▪ Communication – roll out 2018 targeted and general ▪ Process Development – development of summative assessment tools, pilot Q1 2019, assessor training, develop process and implement.	1	1) $ 47,900 for pilot (Development costs). IT and Communications support required. 2) More effective summative assessment process to support movement from PR, CP to General Register 3) To be developed 4) New workflow required	Operational/Strategic	Medium	High	B
HR Enhancement Strategy implementation plan rollout	COO/Human Resources	Implementation of proposed HR philosophy framework, areas of enhancement and supports for associated behaviours of employees; development of recommendations closing gaps in HR policy and process.	1	1) Budget: • HR Review Action Plan $61,530 • HR Staffing Assistance $56,700 2) An HR philosophy that builds on the pieces of an HR philosophy that are already in place and focuses on a commitment-based HR configuration, in which the organization enhances employee capabilities 3) To be developed as part of the implementation process 4) Staff enabled to support the Mission, Vision of the CPSA	Operational/Strategic	Medium	Medium	C

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2019 Tactics	Activity				Risk Assessment			
	Dept	Year 2019	Priority Level: 1) Critical 2) Important 3) Table 4) Terminate	Implications: 1) Budget 2) Outcome to be achieved 3) Possible KPI 4) Workflow to be used, changed	Categorization	Likelihood	Seriousness	Grade
Develop tool for document submission	Operations	Develop CPSA web site page for external parties to submit documents.	2	1) IT & Communications staff time required. 2) Streamlined approach for customers submitting documents. Reduced Admin staff time in uploading documents to QUEST. Reduced # of duplicate documents submitted requiring staff to review and submit document delete requests. 3) KPI = track # of documents submitted; # of deleted documents. Reduces time for the Admin team to work with documents to convert them to the acceptable format to be able to upload to QUEST.	Operational/Strategic	Medium	Low	D
Executive Coaching	OOR	Engagement of an external leadership coach to assess & coach towards required interventions for a more effective leadership team (Secretariat, directors, Secretariat-Directors)	1	1) $15,000 2) Enhanced leadership performance in support of the College Vision, Mission 3) To be developed New workflows for existing staff	Operational/Strategic	Medium	Medium	C

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Summary of activity tabled:

2019 Tactics	Activity				Risk Assessment			
	Dept	Year 2019	Priority Level: 1) Critical 2) Important 3) Table 4) Terminate	Implications: 1) Budget 2) Outcome to be achieved 3) Possible KPI 4) Workflow to be used, changed	Categorization	Likelihood	Seriousness	Grade
Redevelop the CPSA website	Communications	Continue work started in 2018 subject to new comms plans above: • Research best practice • Collaborate with all departments • Work with internal & external resources to transition the site Test extensively & make necessary improvements	3	1) $65,000; 2) meet best practice & improved performance; 3) less maintenance required; improved user experience; new College-wide governance model	Operational/Strategic	Low	Low	N
Triplicate Prescription Program (TPP) educational initiative & program evolution	Continuing Competence	Begin the development of educational and support package for new TPP applicants.	3	1) $25,000 2) On-line support materials package/testing tool for new TPP Applicants. 3) Increase Opioid Risk awareness Within existing workflow	Operational/Strategic	Low	Medium	D
Review and update of Methadone standards and guidelines	Continuing Competence	▪ Develop project plan to update and expand existing guidelines to incorporate Suboxone and other products used in ODT programs.	3	1) $20,000 2) Refresh to align with FMRAC National working recommendations 3) # of Primary Care physicians prescribing OAT	Operational/Strategic	Low	Low	N

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2019 Tactics	Activity				Risk Assessment			
	Dept	Year 2019	Priority Level: 1) Critical 2) Important 3) Table 4) Terminate	Implications: 1) Budget 2) Outcome to be achieved 3) Possible KPI 4) Workflow to be used, changed	Categorization	Likelihood	Seriousness	Grade
Peer Support – Members	Professional Conduct	▪ Evaluate and determine feasibility, identify lead	3	4) Time and effort to address will be considerable for executive and staff/portfolio	Operational/Strategic	Low	Low	N
Develop Employee Mentoring Program	HR /Operations	▪ Research and develop employee mentoring program	3	1) Staff time 2) Engaged staff; staff with enhanced skill sets 3) # of staff signing up for the program; # of staff wanting to be mentors	Operational/Strategic	Low	Low	N
Manage volume of work with PHM program.	Physician Health Monitoring	▪ To support the Assistant Registrar in his role in the Physician Health Monitoring (PHM) program. As the volume of activity grows in this program additional internal support is required for staff to maintain quality of work. ▪ Number of physicians in the program has grown significantly over the last three years. To have a meaningful impact on the AR's workload, this position must be	3	1) New 0.6 FTE SMA (senior medical advisor). Staff costs $177,000 2) Manage volume of work. 3) TBD	Operational/Strategic	Medium	Medium	C

2019 Tactics	Activity				Risk Assessment			
	Dept	Year 2019	Priority Level: 1) Critical 2) Important 3) Table 4) Terminate	Implications: 1) Budget 2) Outcome to be achieved 3) Possible KPI 4) Workflow to be used, changed	Categorization	Likelihood	Seriousness	Grade
		filled by another physician.						
Manage volume of work with PHM program.	Physician Health Monitoring	▪ Increasing the admin support by 0.4 FTE within the Physician Health Monitoring (PHM) program. As the volume of activity grows in this program additional internal support is required for staff to maintain quality of work.	3	4) Increase admin support by 0.4 FTE Staff costs $29,000 (increasing FTE within existing part-time roles). 5) Manage volume of work. 6) TBD	Operational/Strategic	Medium	Medium	C

College of Physicians & Surgeons of Alberta

Submission to:	**Council**

Meeting Date:	Submitted by:		
FEB 28 – MAR 01, 2019	Dr. Karen Mazurek, Deputy Registrar		
Agenda Item Title:	Delegation of Authority, HPA Part 3.1 Section 53.1		
Action Requested:	**X** 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 delegate authority to appoint inspectors under the Health Professions Act Part 3.1 [Inspections], Section 53.1 [Inspectors] to the Registrar, effective immediately.***		
Background:	Following major breaches in medical device reprocessing a number of years ago, two physicians practicing out of one clinic had conditions imposed on their practice permits. These conditions have restricted them from performing invasive procedures in community settings. Following a recent request to have these restrictions reviewed and potentially lifted, the CPSA IPAC program conducted assessments of infection prevention & control and medical device reprocessing (proposed setup and processes). The clinic was able to meet program standards. On the condition the clinic is subject to a monitoring program that (at least initially) includes unannounced inspection, the program believes invasive procedures can be performed by both physicians with minimal threat to patient safety. In addition, as a result of increasing expectations for public protection, the CPSA would like the ability to use unannounced inspection as a tool to ensure compliance to practice conditions in high risk situations. Practice conditions are imposed only when there is concern about public safety and the CPSA must ensure that they are followed. One example of a high risk situation is when chaperones have been imposed as a result of sexual boundary violations. Going forward, the reliance on chaperones will be less considering the penalties imposed by Bill 21 however we have several physicians with this condition in place as a result of past discipline. At this time proxy measures are used to assess compliance such as reports from the chaperone. It is believed that unannounced inspection to ensure conditions are being followed will allow the CPSA to carry out legislated duties more effectively in high risk cases.		

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	It is proposed that monitoring through unannounced inspections be carried out under the authority of the HPA Part 3.1 [Inspections], Section 53.1 [Inspectors]. This section stipulates "*A council may appoint inspectors for the purpose of determining whether regulated members are complying with this Act and the bylaws, standards of practice and code of ethics of the regulated profession*." It is impractical to have Council, on a quarterly basis, deal with appointment of inspectors and far more timely and responsive to the need to protect the public interest to have that authority delegated to the Registrar.
Next Steps:	If approved, the Registrar will appoint inspectors as required under the authority of the HPA for the purpose of: 1. monitoring physicians with practice conditions and 2. assessing if physicians who have recently had IPAC practice conditions lifted are following IPAC standards of practice .
List of Attachments:	
1. *Health Professions Act* Part 3.1, Section 53.1	

possible to relate the information to any particular identifiable person or facility,

(b) used by the competence committee to give to the complaints director the name of a regulated member and the grounds for a referral under section 51.1, and

(c) released or disclosed to the counsel of the regulated member in connection with proceedings under this Part, Part 2 or Part 4.

(3) If any person publishes, releases or discloses information in contravention of this section, that information may not be used in proceedings under any other Part of this Act, in any arbitration, inquiry, action or matter, or in any proceedings before a court.

RSA 2000 cH-7 s52;2001 c21 s12

Offence

53 A person who knowingly publishes, releases or discloses information in contravention of section 52 is guilty of an offence and liable to a fine of not more than $10 000.

1999 cH-5.5 s12

Part 3.1
Inspections

Inspectors

53.1 A council may appoint inspectors for the purpose of determining whether regulated members are complying with this Act and the bylaws, standards of practice and code of ethics of the regulated profession.

2008 c34 s9

Inspection powers

53.2(1) Subject to the regulations, an inspector

(a) may, at any reasonable time,

(i) require any person to answer any questions that are relevant to the inspection and direct the person to answer the questions under oath, and

(ii) require any person to give to the inspector any document, substance or thing relevant to the inspection that the person possesses or that is under the control of the person,

(b) may require any person to give up possession of any document described in clause (a) to allow the inspector to take it away to copy it, in which case the inspector must return it within a reasonable time of being given it,

(c) may require any person to give up possession of any substance and thing described in clause (a) to allow the inspector to take it away to examine it and perform tests on it, in which case the inspector must return it, if appropriate and possible, within a reasonable time of being given it, and

(d) subject to subsection (6), may at any reasonable time enter and inspect any place

(i) where a regulated member provides professional services,

(ii) related to the provision of professional services, or

(iii) where documents associated with the provision of professional services are maintained.

(2) An inspector may copy and keep copies of anything given to the inspector under subsection (1).

(3) A person may comply with a request to give documents under subsection (1)(a)(ii) or an order to produce documents under section 53.3(1)(a)(i) by giving copies of the documents to the inspector.

(4) If a person gives copies under subsection (3), the person must, on the request of the inspector, allow the inspector to compare the copies with the original documents at the person's place of business during regular business hours.

(5) An inspector who makes a comparison under subsection (4) may take away the original documents to perform tests on them and must return them within a reasonable time of taking them.

(6) No inspector may enter

(a) a private dwelling place or any part of a place that is designed to be used and is being used as a permanent or temporary private dwelling place except

(i) with the consent of the occupant of the dwelling place, or

(ii) pursuant to an order of the Court of Queen's Bench;

(b) a publicly funded facility as defined in section 51(1), except

(i) with the consent and agreement of the person who controls or operates the publicly funded facility to the

carrying out of one or more of the powers and duties under subsection (1), or

(ii) pursuant to an order of the Court of Queen's Bench.

2008 c34 s9

Application to Court

53.3(1) The registrar, on the request of an inspector, may apply to the Court of Queen's Bench for

(a) an order directing any person

(i) to produce to the inspector any documents, substances or things relevant to the inspection in the person's possession or under the person's control,

(ii) to give up possession of any document described in subclause (i) to allow the inspector to take it away to copy it, in which case the inspector must return it within a reasonable time after receiving it,

(iii) to give up possession of any substance or thing described in subclause (i) to allow the inspector to take it away, examine it and perform tests on it, in which case the inspector must return it, if possible, within a reasonable time of being given it, or

(iv) to allow an inspector to enter any place for the purpose of conducting an inspection,

(b) an order directing any person to attend before the inspector to answer any relevant questions the inspector may have relating to the inspection, or

(c) an order authorizing an inspector to conduct an inspection in a private dwelling place or in a publicly funded facility as defined in section 51(1).

(2) An application for an order under subsection (1) may be made without notice if the Court is satisfied that it is proper to make the order in the circumstances.

2008 c34 s9

Report of inspection to registrar

53.4(1) Within 90 days after completing an inspection the inspector who conducted the inspection must give a report setting out the findings of the inspection to the regulated member and the registrar.

(2) The registrar must make a referral to the complaints director if, on the basis of information contained in the inspection report, the registrar is of the opinion that

(a) a regulated member has failed or refused to co-operate with an inspector conducting an inspection under this Part,

(b) a regulated member has provided false or misleading information under this Part,

(c) a regulated member has failed or refused to comply with a direction made by the registrar under subsection (3),

(d) a regulated member may be incapacitated, or

(e) a regulated member's conduct constitutes other unprofessional conduct.

(3) Despite subsection (2)(e), if the registrar is of the opinion that the conduct of the regulated member constitutes unprofessional conduct that was minor in nature, the registrar may direct the regulated member to take specified actions instead of making a referral under subsection (2)(e).

(4) Information respecting a regulated member that is obtained under this Part may be provided to the complaints director if the registrar makes a referral to the complaints director in respect of that regulated member under this section.

2008 c34 s9

Inspection committee

53.5(1) A council may establish an inspection committee to carry out the powers and duties of the registrar under this Part except those described in section 53.3.

(2) An inspection committee must consist of one or more members appointed by the council.

(3) If a council establishes an inspection committee under subsection (1), the powers and duties of the registrar under this Part, except those described in section 53.3, are vested in and may be exercised by the inspection committee, and any reference to the registrar in this Part, except in section 53.3, is deemed to be a reference to the inspection committee.

2008 c34 s9

College of Physicians & Surgeons of Alberta

Submission to:	**Council**

Meeting Date:	Submitted by:		
February 28, 2019	Dr. Monica Wickland-Weller, Senior Medical Advisor		
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 new *Safe Prescribing for Opioid Use Disorder* as presented for implementation.		
Issues/Rationale:	Council approved the draft *Opioid Agonist Treatment* standard for consultation at its September 2018 meeting (attachment 1). A survey was disturbed to all members of the profession with 41 responses (attachment 2). Specific feedback was also received from the following stakeholders: • Alberta Health Services • Alberta College of Family Physicians • MOERC • Alberta Health • Office of the Chief Medical Officer of Health The feedback provided includes the following : • The title of the Standard of Practice was confusing and generated concern that Buprenorphine/Naloxone was included in the requirements provided in the SOP • Access to education and training to ensure availability • Concerns regarding best practice and evidenced informed guidelines and recommendations • Lack of prescriptive guidelines for prescribing of the medications for OUD • List of medications used for OUD should be included in the SOP • Role of primary care in providing maintenance for their patients • Availability of education, training for rural and remote locations • Continuity of care • Transition of care		

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	• Physicians with existing approvals • Setting for iOAT and associated requirements and/or approval from CPSA need to be defined • On site vs remote access to laboratory services, pharmacy services, multidisciplinary resources • Addressing stigma • Addressing harm reduction strategies • Define OUD and OAT • Address abrupt discontinuation of opioids in patients identified as potentially having an OUD • Methadone for Analgesia was not relevant to this SOP The information provided by the consultation was reviewed and the proposed standard of practice (attachment 3) – *Safe Prescribing for Opioid Use Disorder* – as well as an Advice to the Profession document (attachment 4) were developed to address the concerns identified from the feedback.
Proposed Revisions/Key Changes:	1. **Standard of Practice – *Safe Prescribing for Opioid Use Disorder*** • The name change will reduce confusion about the scope of the Standard and focus on the prescribing for opioid use disorder 2. **The use of Buprenorphine/Naloxone is the recommended preferred first line treatment for OUD** • Ensure that it is clear that the standard does not apply to Buprenorphine/Naloxone in terms of educational or training requirements or the need for an approval 3. **Removal of Methadone for Analgesia from the SOP** • This topic is not relevant to the SOP 4. **Advice to the Profession document** • Provide an advice document to accompany the SOP that outlines the following: o definition of "OUD" o list of applicable medications o expectations regarding abrupt discontinuation of opioids o expectations for the use of buprenorphine/naloxone as first line treatment o addresses stigma and harm reduction strategies o educational/experiential requirements for an OAT approval (initiate and maintain) o streamlined process for receiving an approval o clarification of appropriate setting and multidisciplinary resources o addresses continuity of care and the need for a team based medical approach to improve long term outcomes o provides structure for the use of iOAT in the community

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List of Attachments:
1. Original draft for consultation 2. Consultation feedback 3. Final draft for approval 4. Advice to the Profession document For those interested, additional resources that will be available upon implementation can be found on Share Point.

Opioid Agonist Treatment

The ***Standards of Practice*** of the College of Physicians & Surgeons of Alberta ("the College") are the **minimum** standards of professional behavior and ethical conduct expected of all regulated members registered in Alberta. Standards of Practice are enforceable under the *Health Professions Act* and will be referenced in the management of complaints and in discipline hearings. The College of Physicians & Surgeons of Alberta also provides **Advice to the Profession** to support the implementation of the Standards of Practice.

For the purpose of this standard, Opioid Agonist Treatment (OAT) refers to full opioid agonist therapies only and ***excludes*** the partial agonist/antagonist buprenorphine/naloxone.

(1) A regulated member who prescribes OAT **must** do so in accordance with recognized evidence-based guidelines and best practices for Opioid Use Disorder (OUD) treatment.

(2) A regulated member who INITIATES OAT **must**:

(a) have successfully completed an OUD workshop/course recognized by the CPSA;

(b) provide evidence of experiential training, supervision, mentorship and/or completion of an approved preceptorship-based course;

(b) hold an active CPSA approval to initiate OAT;

(c) as a condition of CPSA approval, maintain competence in OAT through ongoing, relevant education as part of their mandatory Continuous Professional Development cycle and provide evidence upon request;

(d) initiate OAT for a patient only in an appropriate setting with:

(i) access to medical laboratory services and pharmacy;

(ii) access to at least one other prescriber trained and approved to provide OAT to ensure continuity of care if the initiating prescriber is absent or suspends their practice;

(iii) access to Alberta prescription databases (e.g., Alberta Netcare, Pharmaceutical Information Network);

(iv) direct or remote access to appropriate multidisciplinary team support (e.g., social worker, addictions counselling); and

(v) other resources and services appropriate to the specific OAT provided; and

(e) if transferring OAT maintenance to another prescriber trained and approved to provide OAT:

(i) provide the maintaining prescriber with a letter of support for maintaining OAT for the patient and an information checklist, with a copy of the letter to the CPSA; and

(ii) collaborate with the maintaining prescriber, other regulated health professionals and multidisciplinary team members involved in the patient's care.

(3) A regulated member who MAINTAINS OAT **must**:

(a) have an understanding of OAT pharmacology before accepting OAT maintenance for a patient;

(b) have a letter of support and information checklist from the initiating prescriber;

(c) hold an active CPSA approval to maintain OAT;

(d) within six months of acquiring CPSA approval, complete an OAT educational course relevant to addiction medicine recognized by the CPSA;

(e) ensure another prescriber trained and approved to provide OAT is available to ensure continuity of care if the maintaining prescriber is absent or suspends their practice; and

(f) collaborate with the initiating prescriber, other regulated health professionals and multidisciplinary team members involved in the patient's care.

(4) A regulated member who TEMPORARILY prescribes OAT for a patient in an inpatient or correctional facility **must**:

(a) prescribe only for the duration of the patient's stay or incarceration, and may prescribe up to the first 72 hours after discharge/release after notifying the patient's community prescriber;

(b) restrict OAT prescribing to daily witnessed doses and not provide take-home doses for unwitnessed use;

(c) consult with the patient's current prescriber before making any changes to the OAT prescription or introducing any new medications with the potential to interact with OAT; and

(d) collaborate with the community prescriber, other regulated health professionals and multidisciplinary team members involved in the patient's care at transitions between treatment settings.

(5) A regulated member who prescribes INJECTABLE OAT (iOAT) **must**:

(a) hold an active CPSA approval to initiate or maintain OAT; and

(b) supervise or provide iOAT only within a facility operated by government or a provincial health authority, or a community setting approved by CPSA.

(6) A regulated member who prescribes METHADONE FOR ANALGESIA **must**:

(a) hold an active CPSA approval to initiate or maintain a patient on methadone for analgesia;

(b) if initiating methadone for analgesia for a patient:

(i) have related post-graduate training that is recognized by the CPSA; and

(ii) experience in palliative care or in a multidisciplinary chronic pain setting, as applicable; and

(c) if maintaining methadone for analgesia for a patient, provide the CPSA with a letter of support from a palliative care or chronic pain specialist, as applicable.

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Consultation 014
Safe Prescribing for Opioid Use Disorder: Regulated Members

RM01

10/1/2018

This is a clear standard and allows for changes in Clinical practice guidelines as they develop to address the " opioid crisis". I wonder if it needs to be clear what exactly is replacement therapy: includes methadone but does this also include use of other prescription narcotics as replacement? I am assuming that it does but this is not clear.

RM02

10/1/2018

I like it. I think it is very clear as to what is expected of us as physicians especially with regards to inpatient prescribing.

RM03

10/1/2018

liga

RM04

10/1/2018

I support the proposed document as it is, except, the potential area of gap that may require attention. This has been increasingly recognized the past several years that the patients with advanced cancer are increasingly living longer, with longer duration of symptom of pain and suffering. Some of them, may have unfortunately exposed to very high dose opioid therapy when diagnosed with cancer esp. AYA population, who went through extensive surgeries, bone marrow transplants, etc. or those who have underlined borderline personality disorder/bipolar disorder (or even with severe PTSD) who learned to cope with opioid analgesia for their psychological distress while also experiencing cancer associated phsyical pain syndrome or sometimes already on Methadone maintenance therapy (MMT) already.

Also the definition of palliative care has been changing and increasingly palliative care practitioners are seeing patients who are no yet facing life threatening illness though they do have potential life limiting illness, while experiencing severe symptoms for longer duration that we typically encountered previously (often less than three months of life expectancy).

I practice as a palliative care consultant, and have experienced occasions where patients with MMT was discharged from MMT clinic despite patients have many months or beyond years of prognosis, or patients with problematic behaviours related opioid taking and use unstable dose of very high dose of non-methadone full opioid agonists. As a palliative care physician, I do provide methadone for analgesics, however, some patients do require MMT than analgesics. Although I have taken the MMT course number of years ago in U of C, and taken the online buprenorphine assisted treatment course

already, I would not be able to maintain the number of experience in full license for MMT/buprenorphine assisted treatment due to the nature of practice.

For very difficult cases, I have consulted [College staff] and found very helpful, however, wish to see some comment on patients/population who may require co-management between MMT and analgesics until such time when a new practice guideline for those population available. JAMA September 4, 2018 Volume 320, Number 9 871-872 well-summarizes the same concern that I have been experiencing.

RM05

10/1/2018

The standard appears reasonable for the most part.

One part is a bit fuzzy: (2) (c) maintain competence in OAT ... what does this entail? How many hours over 5 years? Can it be self-study? To the extent that this requirement becomes onerous, this would then be a "cost of doing business" as an initiator and would have to be factored into each person's cost:benefit equation to see whether this is worthwhile to them. To those specializing in the area, this might not matter much. For those who are "trying to pitch in" and take on OAT duties as a peripheral area of interest, this might constitute a barrier.

Also, for those of us who deal with OAT in a "high turnover" patient population (e.g. corrections), we usually have institutional support (e.g. nursing and pharmacy) to help bridge the patients to a community clinic (e.g. Boyle McCauley or MetroCity). Having to provide a "letter of support" and associated paperwork as per (2) (e) would seem to be less applicable and administratively burdensome.

Another difficulty is the codified 72 hour Rx length noted in (4) (a) ... when these patients are discharged to remote locations (hard to find prescribers) or during holiday periods, 72 hours can be a tight timeline. In the past, I have had pregnant patients on methadone or suboxone discharged from jail for whom I needed to provide bridge Rx (no carries, DOT only) for up to 2 weeks. I would no longer be able to do this if the directive as written is implemented.

Thanks for your consideration.

RM06

10/1/2018

NA

RM07

10/1/2018

An example on another further encroachment into the practise of medicine. The CDC data which created their guidelines is increasingly being shown to be incorrect. Current opioid deaths are not occurring in regularly followed chronic pain patients in any significantly. Patient advocacy groups have presented evidence of patient harm directly caused by CPSA policy interpretation by doctors. This document contains a requirement for all physicians, including RCPS CERTIFIED Doctors such as myself to retrain. I oppose this proposed CPSA action. If instituted it will require a legal challenge to determine if

the value of this action is of sufficient need to justify tha harm to pain patients as reported by pain patient advocacy groups. What is required is a dramatic increase in services available to pain patients not another police action by CPSA.

RM08

10/1/2018

This standard should be fine and safe, as long as the associated courses and certifications are easily accessible in terms of time, fees and availability for physicians who are likely to need the use of the skills, as OUD appears to be a major and ubiquitous problem..

RM09

10/1/2018

I currently have approval to continue certain patients on methadone. 2 to be exact.

I never took any courses on using methadone, and as I recall, I would have to talk to the original prescriber prior to making any changes.

This has worked very well for me and my patients.

So, why, in this new scenario, would I have to take a course for continuation of therapy with the opiod antagonists ?

RM10

10/1/2018

I agree with the draft

RM11

10/1/2018

I work rurally and we are blessed to have one physician comfortable with prescribing OAT. Unfortunately the other physicians are not comfortable with prescribing these medications. Our Physician would have to discontinue OAT prescribing with these standards as there is no back up doctor when he is away. The other physicians are not willing to do all the courses to become prescribers as don't want to take on this role. I just wanted you to be aware of the potential impact for our rural community and rural patients who cannot afford to travel to Edmonton for OAT. Thank you for considering this.

RM12

10/1/2018

Is the wording of the initial setup TOO vague? Aren't nearly all opioids opioid agonists except Suboxone and Nubain? The title should therefore read "OAT for OUD". Otherwise this will affect ALL opioid prescribing, which doesn't appear to be the intent.

RM13

10/1/2018

6 (c) recommends that "if maintaining methadone for analgesia for a patient, (physicians must) provide the CPSA with a letter of support from a palliative care or chronic pain specialist, as applicable." I think that if a patient is started on Methadone by a specialist and is then referred back to his general practitioner, this should be enough for the generalist to continue prescribing the Methadone without obtaining or sending further documentation to the CPSA.

I was encouraged to note that these fairly restrictive guidelines do not include the prescribing of partial agonists such as Suboxone. The prescribing and de prescribing of opioids (and OAT) is not the favourite part of most family practitioners and some tend to refuse to see patients with chronic pain or opioid use or abuse disorders. These patients often float around and have trouble finding a family doctor willing to take them on. I hope to see more support for and encouragement of family doctors willing to engage with these challenging patients.

RM14

10/1/2018

It would be useful to have the standards for Suboxone also available in order to compare and contrast the different requirements;

It would also be helpful to provide a list of recognized workshops/courses/preceptorships in order to give providers a resource to seek these opportunities out;

How will the process of obtaining approval from the CPSA work?;

There are no outlines listed for requirements to prescribe take-home or "carry" prescriptions;

There is no mention of approved OAT medications (methadone, Kadian);

Will the college be providing templates for the "letters of support" and "information checklists" mentioned in the draft?

Thanks!

RM15

10/1/2018

It seems to be a great step .

RM16

10/1/2018

I had already completed the survey but forgot one more point. I think IOAT should be restricted to initiator's only and not maintainers (point a) and agree with point b

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RM17

10/2/2018

Not all patients dependent on opioids meet DSM-V criteria for opioid use disorder. A patient who is dependent on opioids, experiences withdrawal when dose is reduced or when abstinent is also in need of opioid agonist therapy, partial agonist therapy, or medically supervised gradual weaning.

RM18

10/2/2018

I believe that the OAT guidelines are made in a very easy way to use . I found very interesting and helpful all the info provided

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RM19

10/2/2018

Seems reasonable to me

However there should be much effort to get patients off narcotics unless absolutely indicated

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RM20

10/2/2018

Is this policy for just Methadone? Or does it include Suboxone?

It would seem to me that individuals that want to start Suboxone to get off opioids should have easy access from physicians. In the ER we have been trying to encourage patients to make this transition and provide them with initial doses and close followup at an approved clinic for further treatment. If this policy restricts that practice I fear many opioid abusers/ addicts will miss an opportunity to recover. The ER is a very common ground for presentation of this type of problem.

RM21

10/2/2018

The draft looks good. However will there be online courses for rural physicians? More information is needed even to understand the language in the draft ie what is truly opioid misuse disorder. What is an OAT? What do we do with people currently on butrans? I have a patient on methadone x 10 years, It was originally prescribed by a pain specialist and I obtained a limited license for this one patient. What now do I need to do?

I have had people come to the ER withdrawing from narcotics wanting OAT ? What is the process now? Who can we send this people to?

Lots more education needed.

I feel like this is just one more area where it is hard to keep up but have patients on meds and how do I now meet standards of care?

RM22

10/2/2018

I am going to make my comments simple - this is an incredibly restrictive standard that will actually see a decrease in OAT prescribers during a time of crisis. AH, PCN's and everyone else is pushing for opening up Suboxone prescribing and increasing prescribers to aid in the issue of increasing opioid deaths, with this standard in place that job will become almost impossible. This is going to decrease access to OAT and increase opioid deaths.

RM23

10/2/2018

I totally agree. I would also include in the draft OAT standard of practice warning re: pot.

This is psychoactive drug.

RM24

10/2/2018

I agree with above draft OAT standard of practise

RM25

10/3/2018

Consider removing requirement for letter from palliative or chronic pain doctor to maintain a palliative patient on methadone.

RM26

10/3/2018

I agree but due to practice restrictions not involved.

RM27

10/3/2018

I am curious to know how the College came to the rationale of having a separate policies for opiod agonists/methadone,... versus one comprehensive policy position about the prescribing of opiods in general, the cautions, thought process/test that be applied in a review of opiod prescribing, position of managing opiod dependence, roles of methadone, partial agonists... certification of prescribing, etc.

I personally would find it more user friendly to have one comprehensive policy that one can go to as a reference for any aspect encountered than having to determine and seek out the pertaining policy fragments. It is possible that a member could seek guidance with the best of intentions from the College's policy positions but not apply a particular aspect because the member did not think of the aspect in order to seek out and review that separate policy fragment, even though the member would have been more than willing to consider and reflect on that aspect if the member were given the opportunity to encounter that aspect as the member reviewed an available comprehensive policy document.

RM28

10/4/2018

The policy is ggod as far as I am concerned

RM29

10/4/2018

Please see my thoughts/questions outlined below regarding the draft guidelines.

1. The standard should include Buprenorphine/Naloxone as this is one of the key medications to treat addiction. If it is used appropriately it is a great medication to treat addiction and pain. However, should it be used inappropriately it will be ineffective in treating the addiction and consequently the patients will become sicker. No matter what, I believe that if one treats patients with addiction, at minimum there must be an understanding of how to approach these patients.

My current observations are that physicians prescribe one month of Suboxone with no clear instructions to patients with active addiction, or prescribe it for 2 days and then say it is a failure. Whereas other physicians will prescribe Suboxone with full opioid agonist such as Dilaudid and Percocet.

2. What is OAT? Should this be explained? Does OAT mean methadone, buprenorphine sublingual, buprenorphine rods/depot, heroin, morphine long acting/short acting/ injectable, hydromophone oral/injectable? I see that physicians are using Hydromorphone short acting as OAT.

3. There needs to be a documented purpose of an Opioid Agonist Treatment, that is, why are we using OAT? My recommendation would be to include information on the goals of OAT which are:

a. Prevention or reduction of withdrawal symptoms;

b. Prevention or reduction of opioid craving;

c. Prevention of relapse to use of addictive opioids; and

d. Restoration to or toward normalcy of any physiological and social function disrupted by opioid use.

Therefore, one should titrate the medication to reach the goals listed above as there is no standard dosage. For example, I am currently seeing patients who are prescribed Methadone 90mg per day. They are using Fentanyl and say they are craving the Fentanyl. Their family physician says that 90mg is the maximum. Since they are still taking the Fentanyl, they are still considered an addict and they stop the methadone. In a good addiction program, the physician should increase the Methadone to stop the cravings.

4. What does direct or remote access to appropriate multidisciplinary team mean? Does it mean that the physicians can refer a patient to the ODP? Does it mean the physician can phone an ODP or Lifemark? Does it mean that they can go on a waitlist at Lifemark and sit there for 14 months? I believe clarity is required here because a physician will refer a patient to LifeMark, the patient will wait for 14 months to see us and his addiction will get worse or he could die on the waitlist.

5. Does a multidisciplinary team have to have a social work worker and addictions counsellor on staff? At [redacted] we assess a lot of patients with addiction issues and start them on Methadone. Unfortunately we do not have either of these disciplines at our clinic. If we need these 2 disciplines we will not be able to see any patient with addiction.

6. We transfer a lot of our stable Methadone patients who have addiction to their family physician. A lot of these physicians will refuse to take a Methadone course, therefore our ability to use Methadone will be greatly limited. Hence by making physicians take a Methadone course to continue to prescribe methadone is stable patients will increase barriers to treatment. Currently, no course is needed to transfer stable patients on methadone to another patient.

7. There should a timeline for follow up appointments. For example, if a patient has a change in their dosage they should be seen at minimum within 30 days of that change.

8. Since Buprenorphine is not included in this standard, can anyone prescribe Buprenorphine depots and rods?

9. Should there be mention of doing baseline urine drug tests or ongoing drug tests? Should there be documentation of their functioning to see if they are improving? Should there be goals of care documented per patient?

10. Should Methadone for Analgesia be put on the Chronic Pain Standard since it is a different license than for OAT? This is the only place in OAT that discusses a specific medication.

11. What does “related post graduate training” for Methadone Analgesia mean? There is no good/effective post graduate training for Methadone for Analgesia that I am aware of.

12. In reference to 6b, do both points need to be achieved or just one point? What would be “post-graduate training that is recognized by the CPSA” for methadone for analgesia?

I hope you find the above information valuable as you move forward. If you have any questions or concerns, please do not hesitate to contact me.

RM30

10/4/2018

I think at this time, we should be doing as much as possible to remove barriers that prevent physicians from being involved in OAT and I don't really see much that removes these barriers. This will make it difficult especially in rural areas.

RM31

10/5/2018

I do not treat OUD in my practice

RM32

10/8/2018

I believe that, ideally, we in the prescribing side of the equation should be on the alert at all time to prevent the overuse of opiates and resulting addiction adverse effects.

I have taking the liberty to attach the opiates document above, which you are sure re very familiar with.

Thank you again and my whole support behind any measure to minimize opiates overuse and addiction without affecting those who really need the benefits of that group of medications.

RM33

10/9/2018

I agree with the decision to make buprenorphine/naloxone not part of the OAT, as it will encourage more use of it. However, it's more important to also provide training for people who want to prescribe buprenorphine/naloxone - creating similar education material will be of help.

RM34

10/10/2018

Please Section 2 subsection d (I) and d (II)

initiate OAT for a patient only in an appropriate setting with:

(i) access to medical laboratory services and pharmacy;

(ii) access to at least one other prescriber trained and approved to provide OAT to

ensure continuity of care if the initiating prescriber is absent or suspends their

practice;

Questions - what does access to laboratory service mean- (ability to do urine screen on site or is the ability to collect urine sample and ship to provincial lab sufficient?)

2. Access to at least one subscriber- does the location of another prescriber matter - what if the one other presciber is in a remote/different location?

RM35

10/12/2018

I must say, I find this draft most confusing from the perspective of who it is addressing. Some places it sounds like any physician who is going to prescribe any opioid, even Tylenol #3, will need a course in OUDs. In other places it sounds like it is addressing only physicians engaged in addiction services using opioids to manage the addiction. And then, at the end, it addresses the use of just one opioid (methadone) for use in analgesia. Which of these three groups of physician prescribers is the draft addressing, or is it addressing all three areas.

If it is addressing any physician prescribing any opioid, then there will be massive re-percussions in the palliative world as we are asking family physicians to follow their terminal patients and prescribe analgesics for them. If these family physicians cannot do this without a course, then my job will be filling one refill after another all day long.

If it is addressing only those who are dealing with addiction issues as in the old methadone maintenance program, then, I can follow the flow of the standard except for the addendum of METHADONE FOR ANALGESIA. Why do we add this to the standard when we are creating a standard addressing ALL opioid agonist therapies? The place of methadone for analgesia should be dealt with separately as the simplicity of the one half page point (6) is not clear enough. Also, if the standard is addressing just this group of prescribers, then it should be stated clearly in the first (1) & (2) points. I had to read down to the middle of the standard before it was clear that the group was being addressed.

If it is addressing the special status of methadone historically, then that requires a whole different approach, in my mind. The sigma of using methadone has come about because of it's "special authorization status". If methadone, and not the other opioid agonists, needs special prescription status, then, that should be a medical competency point, not so much a "standard of practice" point for one drug. Does methadone need a special licensing authorization to be prescribed as an analgesic? This is a question that would be answered depending upon whether ALL opioid agonist prescribers need to take a course, or whether this standard applies only to those in addiction services as I have attempted to outline above. If this course is for ALL opioid agonist prescribers, then include methadone for analgesia in the training. If this standard is for those prescribing for addictions, then there is no need to solely address methadone as it would be included under opioid agonist therapy.

Thanks for letting me share my perspectives on this.

RM36

10/24/2018

I understand that the Addiction Medicine Section of the AMA plans to respond to the Draft Opiate Agonist Treatment document which has been circulated for comment. I will send this to you directly, but expect there to be some similar concerns arising from the Section.

While is understand that the initial statement Excludes buprenorphine (and other partial agonists), it would be useful to be explicit as to what drugs are included, even as examples (methadone, SROM, diacetylmorphine, etc) to make this more clear. In addition, it would be best to state explicitly that this is for the provision of Opiate Agonist Therapy for Opiate Use Disorder.

Section 2b states that an approved experiential course must be included, and lists possible options. I had understood that the College was considering the new Alberta Opiate Dependency Training course to be adequate, possibly with the addition of some ongoing mentorship. As it is currently articulated, this does not make it easy for new learners to know the path to full initiation credentials. And at this point, it is this practical experience / mentorship which is most challenging. I strongly suggest that while specific suggestions of a path to competence is not appropriate for inclusion in the Standard, there needs to be articulation of a "common path" to competence. I would suggest this be through the Alberta Training (online) and mentorship through the ACFP Mentorship program which is just getting off the ground – for a specified period such as 6 months with x number of discussions as a minimum in that time period. As it stands, I understand that it provides the College with some flexibility, but it ends up looking very ambiguous to a practitioner from the "outside".

How was the College thinking of supporting the requirement for a fallback prescriber – 2-d-ii?

Section 2-d-iv which requires access to psychosocial services again may be seen as a hurdle. While such a provision can possibly protect against so-called "pill mills", the concern is that this may mitigate against primary care involvement, especially in smaller centres. Would simple referral to AHS Addiction Services fulfil this provision – if so all docs could do this and it becomes meaningless. Again, it reminds me of the difference between an Act and Regulations; it seems that some annotation is required to help the potential prescriber know what is expected in the real world in a way that it does not frighten well-intentioned practitioners while not protecting from the development of "pill mills".

Section 3-d looks like it will require a Maintaining physician to take the Course… which may make it less likely for the Initiating Prescriber to find GPs who would be willing to Maintain. Tricky…

Overall, it does not seem that the College is really wanting to make OAT other than buprenorphine any more accessible, at least that is what I take from the draft as it currently stands. Overall, between the CPSA regulations and the lack of specific billing for addiction assessment / treatment, it seems that there is more dis-incentive than incentive to get into this work. Perhaps this is not just the responsibility of the CPSA, but we need to consider this larger picture, at least in my view.

RM37

11/6/2018

Thanks for sharing the draft guideline

One comment -

For those who are not totally familiar with this area -

I would suggest that the guideline begin with a definition of what OAT actually is and what patient group this applies to….

I am really confused - does this apply to all physicians who prescribe narcotic analgesic using the triplicate prescription pad…

or to those who use methadone or other opioid withdrawal techniques…??

Do all physicians use prescribe the occasional temporary narcotic analgesic for various aches and pains need to attend a training course?

RM38

11/6/2018

It would be of great help to provide a list of preceptors, mentors and programs to assist geographically isolated physicians with resources to aid in prescribing OAT. 24/7 on call addiction counselor guiding to available resources and available for physicians and patients who needs access to those resources, for example, via RAAPID NORTH, would also be beneficial.

RM39

11/6/2018

I echo [redacted]'s view of this.

I am uncertain how this will affect me as I don't do addiction medicine but do use opioids and methadone for analgesia.

RM40

11/6/2018

What about Targin?

RM41

11/6/2018

I have no concerns or comments about the standards.

RM42

11/6/2018

Excellent ideas and standard of practice. One of my concerns is are you going to get enough Family Doctors prepared to take on this extra responsibility this may be problematic in a busy rural practice. A real problem I have encountered in dealing with WCB patients with acute physical injuries is how ready the junior staff in A&E prescribe Tylenol 3 when all the research has shown it is ineffective and this then leaves the family physician having to deal with patients requesting more Tylenol 3 or stronger opioids. I know the College is aware but the college should continue to emphasize alternative modes of treatment to reduce dependence on opioids.

RM43

11/6/2018

Agree with the draft oat standards. Looks good to me.

RM44

11/6/2018

Upon reviewing this standard of practice for opioid agonist treatment, I am confused as to the definition for opioid agonist treatment. Are we talking primarily about methadone or are we dealing with all opioid agonists prescribed such as oxycodone, hydromorphone, morphine and fentanyl? Because if we are talking all opioids, this will be another significant restriction to physicians' practices in prescribing opioids for pain management.

I am currently dealing with the repercussions of the opioid standard of care and guidelines for chronic noncancer pain. The result of this standard of care is that a number of physicians are refusing to prescribe opioids for chronic non-cancer pain. In addition, patients that we have initiated opioids are no longer being followed by their family physicians and we are now responsible for their follow-up every 3 months as per the standard of care. In my practice, this has consumed the majority of my time resulting in longer wait-lists and my interventional practice becoming restricted.

I would hope that there will be some clarification regarding the definition of opioid agonist treatment and the population this particular standard is addressing. I do appreciate the fact that opioid use disorder is the purpose of the standard but a clear definition of opioid use disorder needs to be made in the standard.

I would agree with other comments that a focus on further education regarding pain management with opioids should be a mission of the College. The limited education received in medical school and residency training on the use of opioids is a major problem for future care. I think what a lot of people in particular physicians fail to appreciate is that the only pain relievers we have are opioid agonists. NSAIDs are great in an acute injury and reducing swelling and inflammation but do not help much with chronic ongoing osteoarthritic (non-cancer) pain. Another important thing to understand is that a pain clinic like HealthPointe struggles trying to manage large volumes of pain patients on opioids requiring increasing resources with no public funding. Majority of new establishing pain clinics are focusing primarily on interventions and less on medication management. So unless more physicians are willing to take on an opioid agonist role, more patients will be going to the street for their pain relievers and

unfortunately obtaining pills containing fentanyl/carfentanil versus oxycodone. And we all know this unfortunate outcome.

RM45

11/6/2018

They seem very appropriate to me. Though I neither prescribe Opiates nor treat Opioid abuse.

RM46

11/6/2018

It would be helpful to have Suboxone kits ready to give out at Urgent Cares/ED's like we do for HIV PEP, rather than having to write a triplicate prescription to carry them over until they can be seen at the opioid clinics.

RM47

11/7/2018

OAT and in particular, methadone have become businesses. Patients are kept on them for too long. There needs to be an expectation that patients will be weaned, the longer they're on these, the higher the chance of overdose death. In particular, those who are prescribing in a correctional facility have the opportunity to wean over most periods of incarceration. On top of that, there must be a duty to ensure that the inmates have their medications transferred. There has to be a plan. These patients often end up being discharged without refills and wind up in withdrawal in the Emergency Department or expecting refills of meds that can't be refilled from an ED. There is lots of time to have this planned, it shouldn't become an emergency and there has to be an attempt to get these patients off narcotics. Though it may be an inconvenience for the business people who are profiting from it and not great for their business plan.

RM48

11/7/2018

This is a realm of medicine in which I do not practice so it will have little effect on my practice. However, in section 4 C and D, there is no provision for emergent care of an overdose. If the patient who is on OAT presented to a hospital in an overdose condition from taking either too much methadone or a different narcotic, as these rules are currently written, the treating emergency physician would be not allowed to stop the next scheduled dose of methadone, even if it was going to make the patient worse, without first consulting with the patient's prescribing physician.

RM49

11/7/2018

I agree with the Draft OAT Standard of Practice Document - Do I require any further Educational requirements regarding OAT with this revised Document being Implemented?

RM50

11/9/2018

I have inherited some patients who have been on Opiates and some on Benzodiazepines.

I strive to pursue dose reductions with difficulty. Referral is not easy and some patients resist.

Thankfully I only have a few of these patients. I find them difficult to manage.

RM51

11/10/2018

The practicing physician , has to have a effective alternative available for pain control other than marihuana, before patients using opioids are going to change present usage. All prescriptions for opioids has to be filled once a week only to reduce the amount of these drugs lying around. It however will put a further burden on for the dispenser but on the other hand will result in the user be more aware of the necessary control over these drugs and its availability.

RM52

11/11/2018

The Drafts seems to be okay

RM53

11/12/2018

Others have identified the overarching flaw - there is no clarity with respect to the scope of this Standard of Practice. Codeine, morphine, oxycodone, hydromorphone, fentanyl, and others are opioid agonists. The scope must be clarified otherwise the Standard could be interpreted to encompass any of these medications, which would not appear to be the intent. All mothership statements exist outside of the Standard as written.

RM54

11/27/2018

Consideration needs to be given to solo/isolated physicians who may have limited access to another prescribing physician in case of practice closure. There are currently prescribing physicians who are

already in this position. Does the current wording of the proposed standards mean that their practice is now below standard?

CPSA should set minimum criteria as to what constitutes the transfer of care letter (which must now be copied to the College). Perhaps a template provided as an appendix.

RM55

11/30/2018

After reviewing the draft and reading about the topic, I have noticed it is safe for effective care and having less side effects as compare to Opoids. Based on its properties , it is becoming the drug of choice for suppression of withdrawal symptoms. That will help in rehab and chronic pain syndrome. Even helpful in post op.

analgesia.

Having receptors similar to Morphine, effective in MSK conditions.

Clearance from liver is slow, in pts taking, chemotherapeutic agents or anticonvulsant.

However before reaching to rehab, indications

of treatment with narcotics should be clear for the initial start, it need understanding of disease, pt doctor relationship, comorbidities , follow ups, and bold decisions.

I am very behind trying to learn, but all these program for example ARCH is very effective and I have seen the impact on hospital admissions, and congrulate all those helping the community.

College of Physicians & Surgeons of Alberta

Consultation 014
Safe Prescribing for Opioid Use Disorder: Stakeholder Organizations

ST01 Alberta Medical Association

10/8/2018
Dr. Darryl LaBuick, Section of General Practice

I cannot see any major concerns regarding the draft for full Opioid Agonist Therapy

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ST02 Minister's Opioid Emergency Response Commission

10/30/2018
Commission Secretariat, Minister's Commission

General comments on the standard

• What are the practical implications of the standard? Could it push more prescribers to use Suboxone and stop prescribing OAT?

• Would it be better to re-frame the standard around treatment for opioid use disorder and exclude prescribing for analgesia?

• What happens if a practitioner is treating a patient for pain and they start developing OUD? Would they have to transfer the patient if they didn't have OAT training? Might want to add another bullet at the top to exclude opioid treatment for chronic pain.

• Could you put buprenorphine/naloxone in its own clause instead of a note? New drugs are coming in from other countries that might need their own standard(s) to limit access to a small subset of prescribers. One of these is technically a partial that would be excluded by this standard but has a significant risk of death. Treatments are ever-evolving; is this standard enough?

• Primary care has an important role, so hope there is a lot of consultation with that group. Some may decide not to prescribe Suboxone if they misunderstand the standard.

• There is an opportunity to bring the draft to the provincial PCN committee for input.

• Can the standard be given a new name/acronym that isn't confusing?

• CPSA is moving in an appropriate direction with this standard.

Clause 2d

• Need to ensure requirements don't create barriers to access in remote locations.

• Will have to define "access": can it be anywhere in the world? (i.e., digital)

• Language is consistent with that being used in PCNs and primary care. Open to expanding to include other government supports and services

• Access might not be the right term – might want to emphasize relationships are helpful, but not necessary to good care

• Training materials should support importance of relationships and mentorship.

• Access is a pretty low bar, so need to be clear what that means. If a clinic/practitioner is unable to meet access requirements, would the CPSA shut them down? Need to be aware that could be a point of tension.

• Specialists have more access to resources; it's harder in primary care.

• Medical care should not be contingent of availability of public resources.

• What we want for clients & families is reasonably good care; not quick access to poor care. Simply being aware of available resources to direct patients to is a low bar.

Clause 2e

• Could be a large number of letters. Is the CPSA prepared?

Clause 3

• How does the Alberta course compare with the BCCSU course?

• What is the rationale for the 6-month timeline for maintainers to complete the course? If the course is needed for safety, it should be required right away. Is education really necessary when the patient is stable? Could it be a guidance document?

• The letter (from the initiating physician) should be enough at the start. Might be better to require consultation with a specialist in certain situations.

• Would CPSA come after a physician who didn't complete the training?

Clause 3e

• Change wording to "ensure another prescriber trained and approved to provide maintain OAT…

• Physician should making the request should provide information. Don't want physicians to be constantly having to write letters

• Will having to ensure backup be a barrier?

• Should be clear backup has to be arranged in advance.

• Need to create capacity in the community/zone, e.g., RODP as an option (AHS Rural Opioid Dependency Program)

• PCNs could have a role in providing backup

Clause 4a

• Can the 72-hour timeframe be extended/apply to business hours, to avoid possible disruptions on long weekends?

• Maybe all physicians working in a correctional facility should be required to take OAT training.

Clause 5

• What is a CPSA-approved setting? Are there standards in place? Dr. Mazurek: AHS is doing a pilot. Facility standards will be developed in collaboration with AH and AHS and will involve consultation.

Francois Belanger, MD, FRCPC
Vice President, Quality and
Chief Medical Officer
Alberta Health Services
10301 Southport Lane S.W.
Calgary, AB T2W 1S7
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Francois.belanger@albertahealthservices.ca

Chantelle Dick
Standards of Practice Coordinator
College of Physicians & Surgeons of Alberta
2700 – 10020 100 Street NW
Edmonton AB T5J 0N3

Dear Ms. Dick

Thank you for the opportunity to participate in your consultation regarding the Standards of Practice: Opioid Agonist Treatment (OAT). Alberta Health Services has sought feedback form its medical leader leaders to provide your office with the feedback included as an attachment to this letter.

If you have any questions or concerns regarding this feedback, please don't hesitate to contact our office. Thank you once again for the opportunity to participate in the Standard of Practice Consultation.

Sincerely

Dr. Francois Belanger
Vice President, Quality and Chief Medical Officer
Alberta Health Services

cc Donna Carlson, Health Professions Policy and Partnerships, Alberta Health

Section	Feedback
Overall Document	• This is a really excellent draft document. Perhaps the new standards of practice should include something along the lines of the OAT prescriber should be responsible for educating the patient with important information such as mechanisms of action and possible side effects. • It would also be great to see something in the policy that states the OAT prescriber is responsible for checking on the patient within a certain time period (after initiating the new medication) to ensure the patient is complying and that no negative consequences have occurred. I am thinking of inpatient units. • There is no discussion/comment regarding when to discontinue OAT. • There is no discussion regarding follow-up responsibility of the prescriber or physician who is maintaining OAT. • There is no discussion regarding managing patient who leave AMA and are on OAT. What is the physician's responsibility here? • Clinical toxicology testing plays a major role in OAT and hence some direction to physicians would be in order. Any recommendations must be made in consultation with AHS clinical toxicology experts. • The MMT document gives more specific direction regarding toxicology testing but unfortunately was developed by CPSA without clinical toxicologist input.
2(b)	• Please provide length of time expectations for the experiential training, supervision and mentorship. A learning plan or learning objectives would be valuable as well to ensure that the physician is meeting outcomes and acquiring the skills, knowledge and abilities. • This provides the CPSA with the ability to ensure preceptors and mentors are qualified and that training, reflection and evaluation takes place over an appropriate length of time. It is important to ensure that practitioners are able to initiate OAT in a manner that reduces the risk of adverse events and a failed initiation.
2(d)(i)	• Medical laboratory services is a service but pharmacy is a building. This statement should say "medical laboratory services and pharmacy services" which includes medications and care. • This statement is very non-specific. Was this intentional? If so, why? What is implied here? • Services to positively identify patient? Documentation capabilities?
2 (d)(ii)	• What is the follow-up timeline for physicians once the prescription and the treatment has been initiated? ○ 2.d.ii refers to continuity of care
2(d)(iv)	• Would change to "collaboration with other regulated health professionals and multidisciplinary team members by direct or remote access (e.g. social worker, addictions counselling)" as in 2(e)(ii). • As with evidence informed practice, medication is only one part of recovery for addiction and, therefore, having access to a multidisciplinary team and collaborating with said team is essential for success. If the CPSA considers these standards as **musts** then ensuring patients receive the best care possible should be supported by them. Collaboration

	needs to occur at all stages of patient care not just during transfer to another prescriber. Interestingly, collaboration is mentioned in the other standards.
2(e)(ii)	• What is the follow-up timeline for physicians once the prescription and the treatment has been initiated? ○ refers to collaborating with maintain prescribers
3	• Perhaps covered under another practice document but there is no mention of documentation practices.
3(a)	• "have an understanding of ..." is not a measurable statement and open to many interpretations. • In order for a member to maintain OAT, define what is required of their pharmacology knowledge. Is it just knowledge? Is it the application? Comprehension? I suggest looking at Blooms' Taxonomy for other wording. • Can a physician refuse/not accept OAT maintenance? I can see our physician group refusing to take on responsibility of OAT maintenance. What is the process if a physician refuses to accept OAT maintenance, who then is the responsible provider?
4	• I have concerns around the implementation – physician and surgeon knowledge regarding the rules and regulations for continuing OAT therapy for inpatients may be lacking. A concerted effort needs to be made to implement and communicate this piece. • I am concerned that there will be issues at transitions of care (both admission and discharge) because prescribers will not be aware of the regulations and processes outlined in section (4). • Please clarify what exactly "inpatient" means. Does this include inpatient emergency? Is it when the patient is admitted or physically in the facility? Some facilities have an "inpatient emergency" ward. • Why are they limiting this to inpatients or correctional facility? I am wondering if there would be times during an outpatient visit or a community visit that this might apply.
4(c)	• What is the process if the patient's current prescriber cannot be contacted? I have concerns that if the patient's status changes and the OAT needs to change that it may delay treatment for the patient.

6(c)	• I would like to see what this means in actual practice. I think it's a good idea but how will it be operationalized?
	  ○ eg. Will CPSA deny or actively contact FPs who are prescribing methadone, but have no letter of support from palliative care? Will FPs get into trouble for doing this without sending in a letter?
	  ○ How will they distinguish between FPs with palliative care experience with FPs without palliative care experience?
	  ○ Should the palliative programs/specialists, routinely, now send out letters of support to FPs who have agreed to continue prescription? If yes, can CPSA give us a letter template on what it should say?

November 30, 2018

Via email: consultation@cpsa.ab.ca

Chantelle Dick
Standards of Practice Coordinator
College of Physicians & Surgeons of Alberta
2700-10020 100 Street NW
Edmonton, AB T5J ON3

Re: Consultation 014 – CPSA standard for Opioid Agonist Therapy.

Dear Chantelle,

We would like to thank The College of Physicians and Surgeons of Alberta for the opportunity to provide feedback on the new Opioid Agonist Therapy standard which is intended to replace the Methadone Maintenance Treatment standard.

The draft standard is inclusive of full opioid agonist therapies, which provides flexibility as treatments for opioid use disorder advance in the future. There is similarity between this standard and the CARNA *Prescribing Standards for Nurse Practitioners* (Standard 4 – Management of Opioid Use Disorder) that provides consistency and minimizes confusion in prescribing practices among health-care professionals with prescribing authority.

We suggest a separate standard for prescribing methadone for analgesia. This is currently placed at the end of the draft standard for Opioid Agonist Therapy and may lead to confusion or may be perceived that CPSA does not have a standard for prescribing methadone for analgesia.

If you have any questions about the above, please do not hesitate to contact us.

Sincerely,

Sincerely,

Joy Peacock, BSN, MSc, RN
Chief Executive Officer and Registrar

ST05 Alberta College of Pharmacy

12/12/2018
Mr. Monty Stanowich, Compliance Officer

Thank you again for the opportunity to provide feedback to this draft standard. Please find our comments below and

attached to the pdf document.

1. Std 2 - Lack of patient centeredness - what about a standard requiring members to inform patients of the

inherent dangers of OAT (overdose, drug interactions, dangers of stopping and restarting)

2. std 2(b)(i) - perhaps more a point of guidance - we have heard concerns about patients being directed to

specific pharmacies by prescribers and being required to use their services. Will there be any discussion or

guidance on weighing and respecting patient autonomy vs. physician's determination that a patient shows a

clinical need to be restricted to a specific pharmacy?

3. std 3 - nothing on transitioning from witnessed to take-home doses. Are there "must" statements to be

developed here (as opposed to guidance) respecting when take-home doses can be started and when they

need to be withdrawn. e.g "must" demonstrate clinical suitability or clinical stability?

4. It's not clear what 5(b) means. There are community pharmacy settings providing iOAT and this is likely to

expand in the future. This standard would imply these facilities require CPSA approval.

If you have questions or wish to discuss any of these points, please let me know.

Alberta Health

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

AR 158005

Ms. Chantelle Brigden
Standards of Practice Coordinator
College of Physicians & Surgeons of Alberta
2700 – 10020 100 Street NW
Edmonton, AB T5J 0N3

Dear Ms. Brigden:

On behalf of Honourable Sarah Hoffman, Deputy Premier and Minister of Health, I appreciate the opportunity to provide comments on the College of Physicians & Surgeons of Alberta's (CPSA) proposed standard of practice: Opioid Agonist Therapy.

In reviewing the standards, the Ministry circulated copies of the current and revised standards to the department and external stakeholders. These included all health professional regulatory colleges, selected government departments and agencies, professional associations, Alberta Health Services (AHS), unions and insurance providers.

Two reviewers provided extensive comments: AHS and the Office of the Chief Medical Officer of Health (OCMOH). I understand that AHS has already provided a copy of its feedback directly to the CPSA; however, copies of [redacted] and OCMOH feedback are attached for the CPSA's consideration.

One of the concerns identified by OCMOH was that the proposed standard addresses the use of Opioid Agonist Treatment for the management of pain and this conflicts with the stated intent of the standard. Other stakeholders noted a similar concern with methadone and suggest that this be addressed in a separate standard.

If you have any questions regarding this feedback, please contact Andrew Douglas, Director, Health Professions Policy and Partnerships Unit, Alberta Health, at Andrew.douglas@gov.ab.ca or by phone at 780 422-8860.

Sincerely,

Leann Wagner
ADM, Health Workforce Planning and Accountability
Alberta Health

Attachments:

[redacted]

2. Feedback from the Office of the Chief Medical Officer of Health

cc: Honourable Sarah Hoffman, Deputy Premier and Minister of Health
Andrew Douglas, Director, Health Professions Policy and Partnerships Unit

Appendix 2: Feedback provided by the Chief Medical Officer of Health

- Scope of the standard is not clear. For example:
  - Not all full opioid agonists are included in the proposed standard; where do other OAT drugs fit in (e.g., buprenorphine/naloxone, Sublocade, naltrexone, etc)
  - OAT used for pain is included, which conflicts with what the purpose appears to be
  - Concerns with including iOAT, especially hydromorphone and diacetylmorphine; suggest this is put in its own standard
- There are concerns with the 6 month period between CPSA approval and completing an educational course
  - Suggest the educational component is completed prior to approval, the time period is shortened, or education is a recommendation.
  - Will there be a mechanism to grandfather in members who have been previously approved by CPSA.
- Requirements for access to other services and collaboration may have unintended consequences (e.g., push prescribers to buprenorphine/naloxone rather than methadone or SROM, etc).
- Some of the requirements seem stigmatizing. For example:
  - Having another physician to take over prescribing if the original physician is away would be expected in other scenarios, so why is it specifically mentioned here?
- Correctional facility (clause 4):
  - May want to rename to "institutional setting" to include other such settings
  - Consider extending 72 hours to 3 business days to account for long weekends.

College of Physicians & Surgeons of Alberta

Consultation 014
Safe Prescribing for Opioid Use Disorder: Other Healthcare Professionals

OTH01

10/23/2018

I am pleased with this clear and concise directive. I hope it encourages more physicians to initiate on OAT.

OTH02

10/24/2018

I find it interesting to know that they must be attached to a Pharmacy system like PIN or netcare to prescribe, as this was not the way we have been practicing. But its very important.

As well, we would need to know to know if it goes through as it affects us, in that we must send a letter to the CPSA if a client transfers. Right now we just do it if they discontinue.

It is good that the prescriber in hospital/corrections would have to contact our Doctor/us if they prescribe to one of our clients while they are in their care. As of now we have to find out through the Pharmacy or family members.

I think that Doctors that are prescribing in hospital or in correction facilities should have more than 72 hours to bridge a prescription as it is safer for the client to be properly bridged to a program and that may not happen in 72 hours.

OTH03

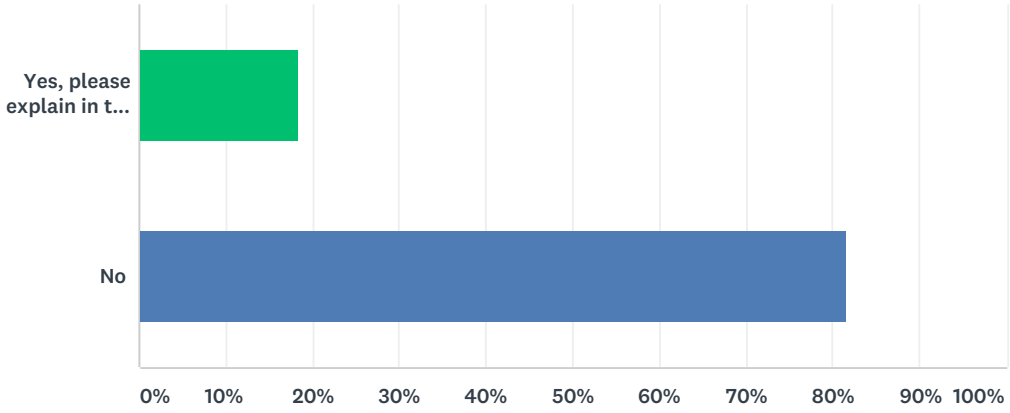
11/4/2018

The document is helpful to clarify roles, responsibilities and expectations. Not sure why you chose to exclude partial agonist/antagonist buprenorphine/naloxone as physicians/prescribers will need your direction for this prescribing practice as well.

You briefly referenced the iOAT prescribing. Is there a plan to develop a standard on iOAT? I am co-lead on the iOAT clinic work in AHS and currently we have medical protocols to guide the work and prescribing practices. A CPSA standard on the topic would be helpful. There is work underway to develop national guidelines as well.

Q1 Do you have any comments or concerns about replacing clinical guidelines for methadone maintenance treatment with a more flexible requirement to use evidence-based guidelines and best practices for treating OUD? (clause 1)

Answered: 38 Skipped: 3



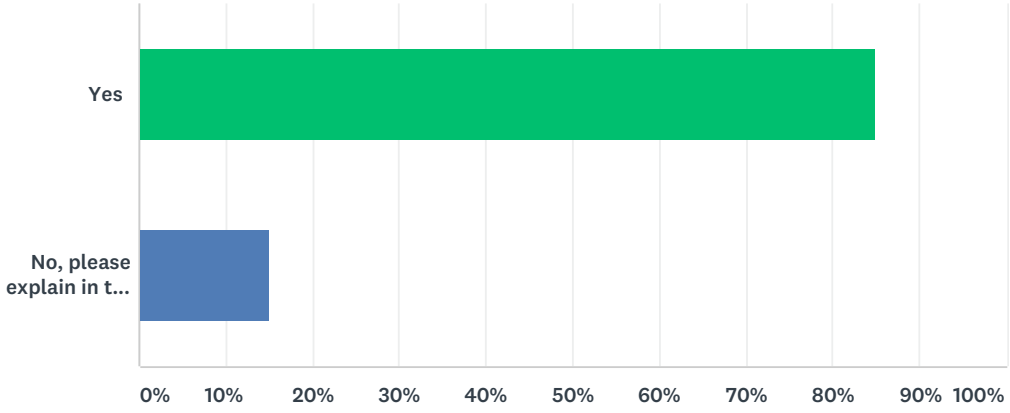
ANSWER CHOICES	RESPONSES	
Yes, please explain in the text box below.	18.42%	7
No	81.58%	31
TOTAL		38

#	MY COMMENTS OR CONCERNS:	DATE
1	You are correct in your observation populations of patients are changing (Eg LTC). We need usable directives to ensure we and our covering colleagues have the skills and permission to continue care for patients we encounter already having a prescriber.	11/29/2018 8:04 PM
2	I'm very happy that along with the progression in evidence that demonstrates the benefit of various OAT therapies, the standards in Alberta will follow.	11/22/2018 8:13 PM
3	I think flexibility is necessary as this area of medicine is evolving rapidly. However, it may be helpful to specify some examples of guidelines, possibly even a formal endorsement of these examples.	11/20/2018 10:43 PM
4	I support evidence-based prescribing.	11/7/2018 9:12 AM
5	Please clarify the provision of logistics of physicians to “provide evidence of experiential training, supervision, mentorship and/or completion of an approved apprenticeship” This idea is good but will the CPSA facilitate this? How if not done during postgraduate training is this to be completed? L	11/1/2018 4:09 PM
6	I think leaving this up to individual practitioners without first organising this through a Psychosocial intervention program is very unwise as there will be no clear end-point and no change will be effected	10/30/2018 9:11 PM
7	In my opinion all requirements are described in great detail for all OAT prescribers (for starting methadone, maintaining, temporary prescribing, injectable form and also for using methadone as an analgesic)	10/16/2018 9:31 PM
8	No I think this document allows prescriber's to utilize evidence and allows for a harm reduction approach to OAT	10/16/2018 2:58 PM

9	I think patients should be encouraged to wean off methadone over time. Too many are being kept on forever, even when they have strong motivation to wean down and/or off. The fewer prescribers , the better and the fewer patients in opioids or methadone, the better.	10/1/2018 7:54 PM
10	I think that the CPSA risks falling down the rabbit hole of political-correctness by over-medicalizing the issue. There is no such thing as a disease of "opiate use disorder". I have been treating opiate abuse for many years with great success and have found that being overly polite by calling it a "disorder", tends to preliminarily absolve patients of all responsibility regarding their actions. This unearned absolution actually impairs the successful assessment and treatment of the condition, and in my opinion, the CPSA should reconsider this approach to over acronymizing the condition with an overly politically correct definition of the condition. This sets a dangerous precedent and falls, in my opinion, beneath the CPSA's mandate to protect the public from abuse by the Profession. In this case, the CPSA needs to protect the public from the CPSA that is "getting in the way" of treatment through the (in my opinion) inappropriate use over overly polite acronyms that preliminarily absolve patients of any responsibility towards the condition of opiate abuse.	10/1/2018 7:53 PM
11	does that mean that the 2014 Standards and Guidelines for methadone is being replaced and no longer valid? I do have some concerns about removing this completely and it is still beneficial to have a document like that to act as a guidefor new practitioners.	10/1/2018 7:49 PM

Q2 Are the requirements for INITIATING OAT appropriate? (clause 2)

Answered: 40 Skipped: 1



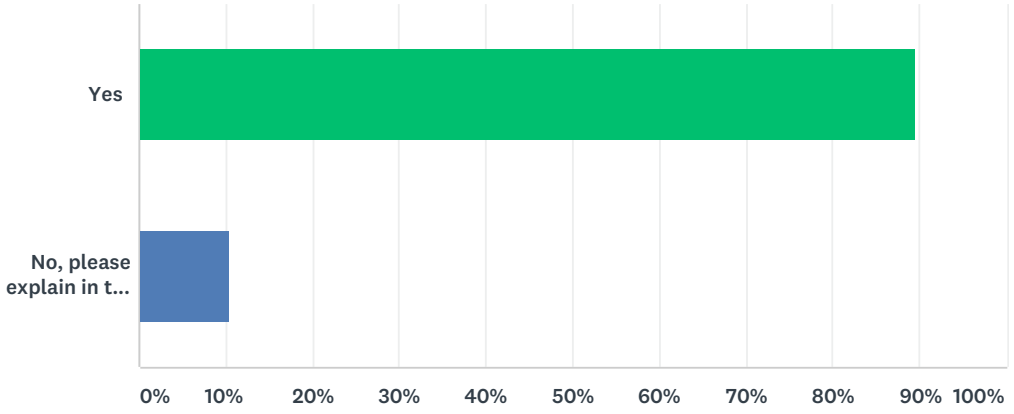
ANSWER CHOICES	RESPONSES	
Yes	85.00%	34
No, please explain in the text box below.	15.00%	6
TOTAL		40

#	MY COMMENTS OR CONCERNS:	DATE
1	The awareness of the “Virtual Hospice” learning opportunity makes it an obtainable level of competence. The assistance of De Weller has also been essential.	11/29/2018 8:04 PM
2	2.d.iv I think that must requiring access to a multidisciplinary team, this may act as a barrier to rural/remote physician. From an equity point of view, with Indigenous communities being so heavily impacted, I'm afraid this clause would further the inequities. I think the language could be softer. SUch as "it is strongly recommended. 2.d.ii May have similar concerns.	11/22/2018 8:13 PM
3	If the purpose of the change is to improve access for patients the limitations are: 1. little capacity to get experience and teachers/physicians are not compensated to teach 2. access to multidisciplinary team - the onus should be on AHS to provide the services that are deemed necessary - eg. social work, addiction counselling (not the prescriber's clinic) 3. letter from initiator to decide if someone else is competent would generally be outside a physician's scope of practice 4. completing a course within 6 months, without covering the cost of the course, is likely going to have low uptake	11/7/2018 9:12 AM
4	As above. There seems to be no co-ordination at all and it all seems very random as to who will get it and	10/30/2018 9:11 PM
5	2 d iv should reference nursing support given most of the current clinics are coordinated by nursing staff.	10/16/2018 2:58 PM
6	Not in the 3 pages I reviewed.	10/4/2018 10:05 AM
7	As far as I can tell. I do not initiate OAT in my practice so am unable to comment further.	10/2/2018 8:02 AM
8	I do not perform this type of medicine. I think I will have to leave it up to those who do to comment.	10/2/2018 4:55 AM

9	The CPSA is appears to be getting in the way of patient treatment by making it at once intimidating, inconvenient and overly troublesome for Physicians to participate in OAT. The CPSA is also appears to be unaware of or insensitive to the significant time and financial burden incurred by the requirements of Physicians in clause 2 to participate in OAT. This will lead ultimately to patient harm, because very few Physicians will bother to participate in OAT. The CPSA does not seem to have considered that there is really no financial offset for Physicians to undertake the significant costs associated with the requirements in clause 2. The requirements should be less stringent and inclusive of various other sources of training or maintenance of competence such as online resources, peer mentorship, etc.	10/1/2018 7:53 PM
10	Point 2 b still requires a face to face mentorship,preceptorship or supervision? there remains a limited number of preceptors to provide the supervision and experience. how will the CPSA evaluate 'experience'	10/1/2018 7:49 PM

Q3 Are the requirements for TEMPORARILY prescribing OAT appropriate? (clause 4)

Answered: 38 Skipped: 3

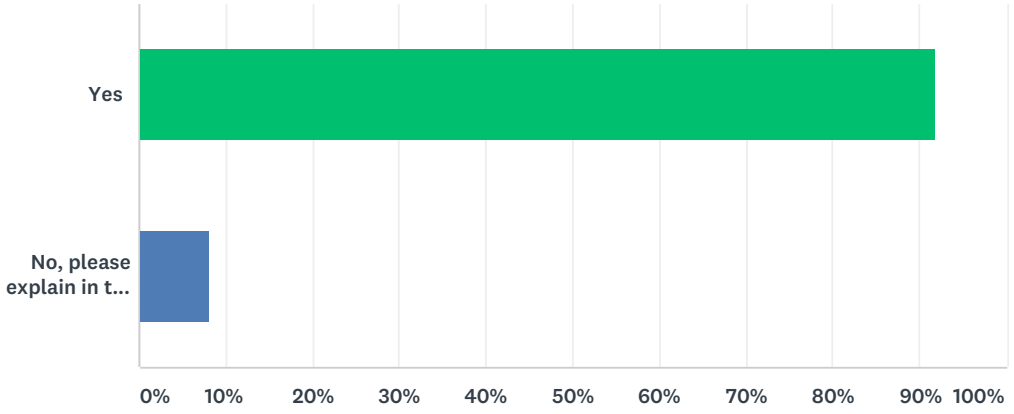


ANSWER CHOICES	RESPONSES	
Yes	89.47%	34
No, please explain in the text box below.	10.53%	4
TOTAL		38

#	MY COMMENTS OR CONCERNS:	DATE
1	The requirements are generally appropriate; however there needs to be some sort of caveat for circumstances under which the current prescriber cannot be contacted despite efforts to do so and a change must be made urgently or emergently - perhaps a requirement to consult with a qualified alternate physician and that the current prescriber must still be contacted as soon as possible?	11/30/2018 10:36 AM
2	What happens when someone is discharged and doesn't have a doctor to prescribe ??	10/30/2018 9:11 PM
3	this will be difficult as individuals being discharged from Correctional facilities can be released without any notice Although there if reference to transitioning to community having no carries will increases risk not sure if the language needs to be stronger for transitions. Also some of the clinics only operate Mon to Friday and do not have on call physicians. What is the process then is there a role for pharmacy and should there be direction in the document regarding this dilemma	10/16/2018 2:58 PM
4	Please see my comments above. No Physicians will bother with this because of the CPSA's requirements - and this will ultimately lead to significant patient harm.	10/1/2018 7:53 PM
5	I'm concerned about whether 4c) is practical for patients admitted to acute care. It may not always be possible to consult with the current prescriber BEFORE making changes. Perhaps something like: - consult with the patient’s current prescriber as soon as possible regarding any changes to the OAT prescription or introducing any new medications with the potential to interact with OAT (ideally before changes are made).	10/1/2018 3:24 PM

Q4 Are the requirements for prescribing INJECTABLE OAT appropriate? (clause 5)

Answered: 37 Skipped: 4

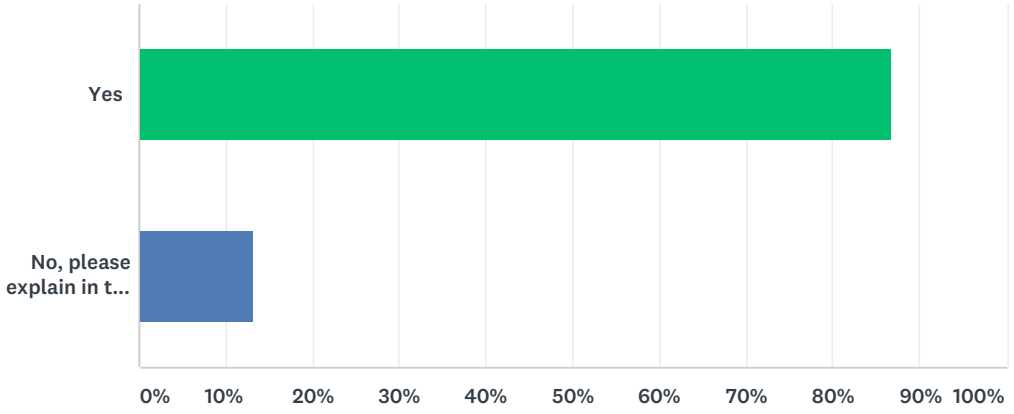


ANSWER CHOICES	RESPONSES	
Yes	91.89%	34
No, please explain in the text box below.	8.11%	3
TOTAL		37

#	MY COMMENTS OR CONCERNS:	DATE
1	Not an expert on this subject.	11/7/2018 9:12 AM
2	Injectables should not be allowed at all	10/30/2018 9:11 PM
3	Unknown. Again, this is not part of my practice. I would, at most, be temporarily prescribing if a patient happens to be admitted to me, I would maintain their current doses.	10/2/2018 8:02 AM
4	Please see my comments above. No Physicians will bother with this because of the CPSA's requirements - and this will ultimately lead to significant patient harm.	10/1/2018 7:53 PM

Q5 Are the requirements for prescribing METHADONE FOR ANALGESIA appropriate? (clause 6)

Answered: 38 Skipped: 3

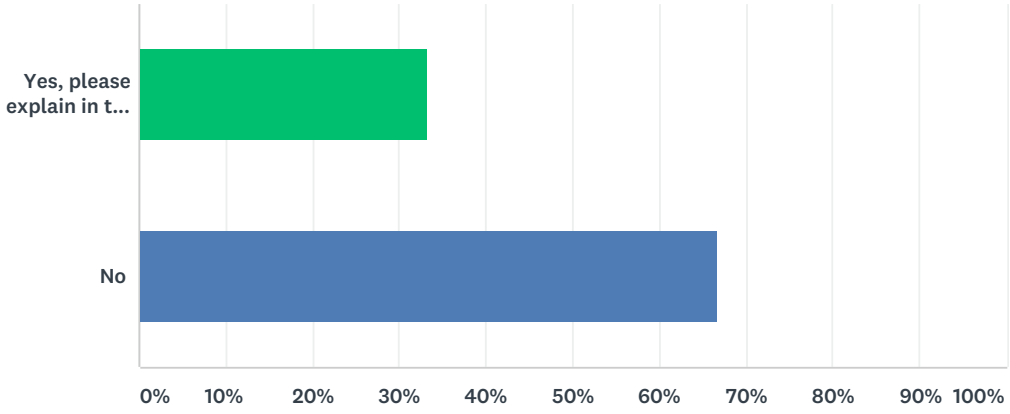


ANSWER CHOICES	RESPONSES	
Yes	86.84%	33
No, please explain in the text box below.	13.16%	5
TOTAL		38

#	MY COMMENTS OR CONCERNS:	DATE
1	This will no doubt be a frequently encountered situation compared to OAT patients.	11/29/2018 8:04 PM
2	I do not think any analgesia indications should be addressed in this standard. I believe it is one of the reasons for commenter confusion. I would suggest one prescribing standard for OUD and another (which already exists, could add specific section on methadone to this) for analgesic indications.	11/20/2018 10:43 PM
3	Not an expert on this subject.	11/7/2018 9:12 AM
4	In palliative care circumstances only	10/30/2018 9:11 PM
5	My concern would be the ease or difficulty to consult with a palliative care or chronic pain specialist if I accept and continue care of a patient receiving methadone for analgesia.	10/9/2018 9:17 PM
6	what about physicians who have been doing this for years before	10/2/2018 9:26 AM
7	please clarify/elaborate on maintenance	10/1/2018 7:58 PM
8	Please see my comments above. No Physicians will bother with this because of the CPSA's requirements - and this will ultimately lead to significant patient harm.	10/1/2018 7:53 PM

Q6 Has anything been missed that should be included in this standard of practice?

Answered: 39 Skipped: 2



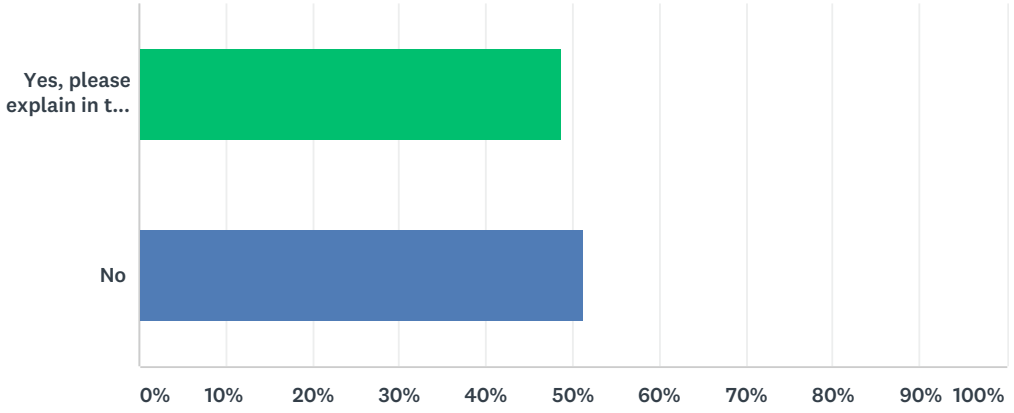
ANSWER CHOICES	RESPONSES	
Yes, please explain in the text box below.	33.33%	13
No	66.67%	26
TOTAL		39

#	THE STANDARD SHOULD ALSO INCLUDE:	DATE
1	There will be issues of on-call well beyond your statement requiring a single supporting colleague. Do we need sun-groups in call? This is a complex scenario and I don't believe you have a grasp	11/29/2018 8:04 PM
2	A clear requirement to have an understanding of AHS programs and services in Addiction and Mental Health and in community to support clients in active treatment. If physicians are not connecting clients to community resources our clients will not be set up for success in treatment in the long run.	11/21/2018 10:23 AM
3	Need opening statement to be even more explicit, as clearly many commenters have missed that this document is NOT intended to address Suboxone, and does NOT address prescribing for pain or palliation. For example, in larger bolder highlighted font: "Full opioid agonist therapies, specifically methadone / SROM / injectable HM, for OUD indication only. The standard does NOT apply to buprenorphine, nor to analgesic indications."	11/20/2018 10:43 PM
4	Since buprenorphine/naloxone is the gold standard of OAT treatment, I am unsure why it is not included. If this goes forward, I would rename this standard and specifically use METHADONE in the title. I think having a standard titled OAT and then not including Suboxone would cause confusion for primary care practitioners considering prescription of OAT.	11/7/2018 9:12 AM
5	Please explain how First Nations people, rural and remote clients will be able to access treatment with this standard. Will tele-Health Be an acceptable to the CPSA or has consultation with Indigenous communities been completed.	11/1/2018 4:09 PM
6	There should be clear teamwork and prescribing should only occur when it is linked to a recognized psychosocial intervention program	10/30/2018 9:11 PM
7	Will there be a separate document regarding the prescribing of Suboxone?	10/16/2018 2:58 PM

8	While it may be implied, the standard should include a requirement that prescribers discuss expectations/behaviours and goals/intentions of OAT treatment with their patients so that everyone is on the same page. Patients may be more willing to engage and stay on treatment if these discussions are had. Prescribers should have clinic procedures in place and regular contact with community supports (i.e. pharmacies) so that regular follow-up with patients can be coordinated. Patients may not always be 'on the ball' when it comes to booking appointments in advance, so if their Rx runs out, there should be better methods in place to help facilitate continuation of treatment and prevent patients from 'falling off the wagon'.	10/15/2018 1:04 PM
9	The assumptions and principles on which these revisions are based.	10/4/2018 10:05 AM
10	1. why no request to comment about clause 3? 2. what about long term care facilities? 3. isn't access to prescription database as important for maintenance and analgesia?	10/1/2018 7:58 PM
11	Details regarding acquisition and maintenance of competence other than costly professional courses. The CPSA should make online courses and resources available to Physicians at no cost, and ensure that Physicians are actually paid to access and maintain such competence. Expecting Physicians to personally undertake these significant costs with no financial offset, puts a potentially dangerous barrier between patients in need of treatment and Physicians that are able to deliver it. There is simply, in my opinion, a naively inadequate balance of all the pertinent issues around this problem.	10/1/2018 7:53 PM
12	I may have missed the explanation, but the guideline seems specifically to exclude suboxone, yet doesn't identifies what OAT comprises - are we talking about methadone only? Please may it clear what OAT refers to.	10/1/2018 4:47 PM

Q7 Do you see any challenges in implementing this standard of practice?

Answered: 37 Skipped: 4



ANSWER CHOICES	RESPONSES	
Yes, please explain in the text box below.	48.65%	18
No	51.35%	19
TOTAL		37

#	CHALLENGES MIGHT INCLUDE:	DATE
1	(3)(e) - In a community with two physicians capable of maintaining OAT, and therefore are each other's "another prescriber", if one were to become unavailable (e.g., "suspends their practice"), according to the standard of care the second prescriber could not actually provide continuity of care as he or she would no longer be able to provide maintenance OAT due to not having "another prescriber" available anymore. This would have the biggest impact on smaller, rural/remote communities. I do not have recommendations on how the standard of care could be adjusted to account for this, however.	11/30/2018 10:36 AM
2	This a a huge change in practice and I believe most practitioners are afraid and keen to avoid the entire issue Way more PR is required	11/29/2018 8:04 PM
3	Tthe limitations for rural practitioners	11/22/2018 8:13 PM
4	What supports or considerations should be factored in to support north zone physicians?	11/21/2018 10:23 AM
5	Messaging will be critical, see #6 above. We cannot afford to discourage physicians from supporting patients with OUD. When rolling out standard, remind physicians of available resources for buprenorphine prescribing and opioid analgesia prescribing.	11/20/2018 10:43 PM
6	Recall: this is just one of hundreds of policies and regulations coming from CPSA, AHS, AMA, etc. In isolation, these OAT standards are good. When considered in the broader context of all the demands placed on clinicians, I believe that many clinicians are simply overwhelmed.	11/9/2018 9:07 AM
7	As indicated above. Provincially, I do not feel the system structures are in place to support increased prescription capacity by primary care practitioners. Having rules will not solve the lack of support structures that are needed to successfully treat patients with Opioid Use Disorder.	11/7/2018 9:12 AM
8	This is not first line for OUD so the implementation may be ignored.	11/1/2018 4:09 PM
9	It seems to be very open to manipulation of the doctor who is prescribing. There should be clear guidance on when to prescribe and when not to prescribe ie when not to give a prescription.	10/30/2018 9:11 PM
10	Other than Corrections Piece	10/16/2018 2:58 PM
11	I anticipate that uptake will be slow due to the need to complete courses. However, I have no suggestions as to how this can be done better.	10/9/2018 1:27 AM

12	Availability of the required training	10/4/2018 10:05 AM
13	Ability to find mentorship to complete requirements. Availability of CME to maintain qualifications.	10/2/2018 7:54 PM
14	ensure that the prescriber is part of a team familiar with these medications, and that he does not work in isolation.	10/2/2018 6:41 PM
15	lack of ahs support in rural practice	10/2/2018 9:26 AM
16	It does put a further pressure and deterrent upon the primary care comprehensive generalist.	10/2/2018 1:47 AM
17	For maintenance as analgesic or addiction, in long term care settings.	10/1/2018 7:58 PM
18	Too much cost, time and trouble for Physicians to bother with satisfying this standard of practice. No possible financial compensation for Physicians to constantly meet this SOP. Therefore no Physicians will bother with this, and the CPSA will have indirectly and unintentionally led the way to significant patient harm in direct contravening of the CPSA's mandate.	10/1/2018 7:53 PM
19	the requirement of 2b I thought that the Alberta ODT course would remove the need for a face to face preceptorship. if the intent is that 'evidence of experience' in initiating is sufficient, would completion of the course alone be enough and should be clarified	10/1/2018 7:49 PM
20	Narcotic prescription phobia based on our quarterly RX report cards	10/1/2018 3:26 PM

Q8 Do you have any other comments or concerns about the draft OAT standard of practice?

Answered: 16 Skipped: 25

#	RESPONSES	DATE
1	Overall it reads well and matches our experience this fall in gearing to deal with this reality	11/29/2018 8:04 PM
2	No other comments or concerns about draft OAT standard of practice	11/21/2018 7:49 PM
3	Thank you for this much needed update.	11/20/2018 10:43 PM
4	No	11/9/2018 9:07 AM
5	As above.	11/7/2018 9:12 AM
6	I suffer from OUD and OAT fatigue. If I never have to read anything related to this topic again it may still be too soon	11/6/2018 5:17 PM
7	Everything really	10/30/2018 9:11 PM
8	No, everything was explained in great detail	10/16/2018 9:31 PM
9	No	10/15/2018 1:04 PM
10	Just make it easier to prescribe opioid agonist.	10/11/2018 4:12 PM
11	I feel that prescription of ANY opiate for non-cancer pain should be regulated in a similar manner.	10/9/2018 1:27 AM
12	These standards don't seem to be patient focused	10/4/2018 10:05 AM
13	NO	10/2/2018 2:43 PM
14	Anything to restrict the number of opioid prescribers is a great step forward. Ensure that those who want to prescribe are readily available for the few patients who actually need opioids and really work on getting rid of the hundreds of prn prescriptions out there.	10/1/2018 7:54 PM
15	Too much time and trouble to be worthwhile for the Physician.	10/1/2018 7:53 PM
16	See above	10/1/2018 3:26 PM

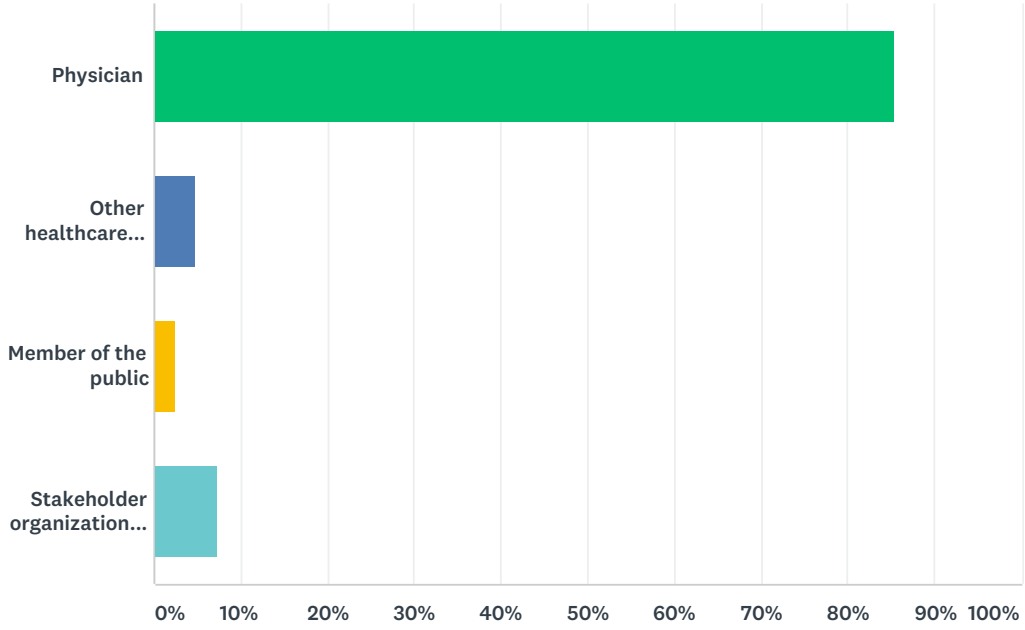
Q9 Do you have any suggestions to improve the consultation process?

Answered: 13 Skipped: 28

#	RESPONSES	DATE
1	I have found it superb to date	11/29/2018 8:04 PM
2	This survey is handy!	11/22/2018 8:13 PM
3	No	11/9/2018 9:07 AM
4	Consultation with family physicians and primary care providers of their needs.	11/7/2018 9:12 AM
5	Indigenous community	11/1/2018 4:09 PM
6	Initiation should be restricted centres where prescribing and psychosocial intervention is thoroughly assessed, started, stablised then farmed out to a shared care model once the client is stable and has a clear treatment plan and a contract with the prescriber. I have worked in the UK where there are clear guidelines and models exist and these have worked well. What research has been done on how other places do it successfully? https://humankindcharity.org.uk/ is an example of prescribers and therapists working in tandem to very good results	10/30/2018 9:11 PM
7	No	10/16/2018 9:31 PM
8	Continue to include feedback from a variety of health professionals, including those at the forefront of OAT dispensing/administration.	10/15/2018 1:04 PM
9	More background information would be helpful.	10/4/2018 10:05 AM
10	NO	10/2/2018 2:43 PM
11	No	10/1/2018 7:54 PM
12	Publish a summary of the most supportive comments, along with a summary of the most critical comments - then propose a middle column that lists the best compromise/resolution to the diametrically opposed opinions.	10/1/2018 7:53 PM
13	Focus group?	10/1/2018 3:26 PM

Q10 I am responding as a:

Answered: 41 Skipped: 0



ANSWER CHOICES	RESPONSES	
Physician	85.37%	35
Other healthcare provider	4.88%	2
Member of the public	2.44%	1
Stakeholder organization, please identify below	7.32%	3
TOTAL		41

#	NAME OF STAKEHOLDER ORGANIZATION:	DATE
1	[redacted]	11/21/2018 7:49 PM
2	AHS operations in Addiction and Mental Health	11/21/2018 10:23 AM
3	n/a	11/16/2018 9:27 AM
4	Alberta College and Association of Chiropractors	11/6/2018 7:46 PM
5	Moms Stop the Harm	10/4/2018 10:05 AM
6	[redacted]	10/2/2018 2:43 PM
7	[redacted]	10/2/2018 9:26 AM
8	University of Alberta	10/2/2018 1:47 AM
9	Consort Hospital And Clinic	10/1/2018 4:50 PM

College of Physicians & Surgeons of Alberta

Standard of Practice

Safe Prescribing for Opioid Use Disorder

DRAFT for consultation

Commented [CB1]: Title changed to clarify purpose.

Safe Prescribing for Opioid Use Disorder

The ***Standards of Practice*** of the College of Physicians & Surgeons of Alberta ("the College") are the **minimum** standards of professional behavior and ethical conduct expected of all regulated members registered in Alberta. Standards of Practice are enforceable under the *Health Professions Act* and will be referenced in the management of complaints and in discipline hearings. The College of Physicians & Surgeons of Alberta also provides **Advice to the Profession** to support the implementation of the Standards of Practice.

(1) For the purpose of this standard, Opioid Agonist Treatment (OAT) refers to full opioid agonist therapies for opioid use disorder treatment.

(2) This standard **does not** apply to the partial agonist/antagonist buprenorphine/naloxone (Suboxone®).

Commented [CB2]: New clause to clearly identify the exclusion of Suboxone.

(3) A regulated member who prescribes OAT **must** do so in accordance with recognized, evidence-based guidelines and best practices for Opioid Use Disorder (OUD) treatment.

(4) A regulated member who INITIATES OAT **must**:

(a) have successfully completed an OUD workshop/course recognized by the CPSA;

(b) provide evidence of experiential training, supervision, mentorship and/or completion of an approved preceptorship-based course;

(c) hold an active CPSA approval to initiate OAT;

(d) as a condition of CPSA approval, maintain competence in OAT through ongoing, relevant education as part of their mandatory Continuous Professional Development (CPD) cycle, and provide evidence upon request;

(e) only initiate OAT for a patient in an appropriate setting with:

(i) access to medical laboratory services and pharmacy services;

Commented [CB3]: "Services" added to "pharmacy" to clarify that this does not refer to a specific pharmacy, nor that lab and pharmacy services need to be available at the same location.

(ii) access to at least one other prescriber who is trained and approved to provide OAT, to ensure continuity of care if the initiating prescriber is absent or suspends their practice;

(iii) access to Alberta prescription databases (e.g., Alberta Netcare, Pharmaceutical Information Network);

(iv) the ability to refer patients to appropriate, multidisciplinary team support (e.g., social worker, addictions counselling); and

Commented [CB4]: "Ability to refer" to clarify that multidisciplinary team support does not have to be on premises, nor that a physician must have a direct, established relationship with these team members.

(v) other resources and services appropriate to the specific OAT provided;

Terms used in the Standards of Practice:

- *"Regulated member"* means any person who is registered or who is required to be registered as a member of this College. The College regulates physicians, surgeons and osteopaths.
- *"Must"* refers to a mandatory requirement.
- *"May"* means that the physician may exercise reasonable discretion.
- *"Patient"* includes, where applicable, the patient's legal guardian or substitute decision maker.

(f) if transferring OAT maintenance to another prescriber trained and approved to provide OAT:

(i) provide the maintaining prescriber with an information checklist and a letter of support for maintaining OAT for the patient, with a copy of the letter to the CPSA; and

(ii) collaborate with the maintaining prescriber, other regulated health professionals and multidisciplinary team members involved in the patient's care.

(5) A regulated member who MAINTAINS OAT **must**:

(a) have knowledge of OAT pharmacology before accepting OAT maintenance for a patient;

(b) have a letter of support and information checklist from the initiating prescriber;

(c) hold an active CPSA approval to maintain OAT;

(d) at minimum, complete an OAT educational module or course recognized by the CPSA within six months of acquiring CPSA approval;

(e) ensure another prescriber approved to maintain OAT is available for continuity of care if the maintaining prescriber is absent or suspends their practice; and

(f) collaborate with the initiating prescriber or appropriate delegate, other regulated health professionals and multidisciplinary team members involved in the patient's care.

(6) A regulated member who TEMPORARILY prescribes OAT for a patient in an inpatient or correctional facility **must**:

(a) prescribe only for the duration of the patient's stay or incarceration, and may prescribe up to the first 120 hours after discharge/release after notifying the patient's community prescriber;

(b) restrict OAT prescribing to daily, witnessed doses and not provide take-home doses for unwitnessed use;

(c) consult with the patient's current prescriber or appropriate delegate before making any changes to the OAT prescription, or introducing any new medications with the potential to interact with OAT; and

(d) collaborate with the community prescriber, other regulated health professionals and multidisciplinary team members involved in the patient's care at transitions between treatment settings.

(7) Notwithstanding clause 6 subclause (c), regulated members **may** proceed without consulting the current prescriber if patients require urgent or emergent care.

(8) A regulated member who prescribes INJECTABLE OAT (iOAT) **must**:

(a) hold an active CPSA approval to initiate or maintain OAT; and

(b) supervise or provide iOAT only within a facility operated by government or a provincial health authority, or a community setting approved by CPSA.

Commented [CB5]: Under development.

Commented [CB6]: Under development.

Commented [CB7]: Modified to clarify educational modules are acceptable: does not have to be an entire course.

Commented [CB8]: Time frame extended to allow for weekends, statutory holidays, etc.

Commented [CB9]: Per feedback that the section was irrelevant to this standard, the clause regarding methadone for analgesia was removed.

Terms used in the Standards of Practice:

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- *"Must"* refers to a mandatory requirement.
- *"May"* means that the physician may exercise reasonable discretion.
- *"Patient"* includes, where applicable, the patient's legal guardian or substitute decision maker.

College of Physicians & Surgeons of Alberta

ADVICE TO THE PROFESSION

Safe Prescribing for Opioid Use Disorder

Related Standards of Practice: *Continuity of Care, Safe Prescribing for Opioid Use Disorder, Transfer of Care*

The College of Physicians & Surgeons of Alberta (CPSA) provides advice to the profession to support physicians in implementing the *CPSA Standards of Practice*. This advice does not define a standard of practice, nor should it be interpreted as legal advice.

Table of Contents

Scope

Opioid Use Disorder (OUD) is one of the most challenging forms of addiction and a major contributing factor to the recent rise in opioid-related morbidity and mortality. In recent years, the non-medical use of pharmaceutical opioids and the emergence of highly potent, illegally manufactured opioids have increasingly impacted the evolving landscape of opioid use.

OUD is best conceptualized as a chronic, relapsing illness which has the potential to be in sustained, long-term remission with appropriate treatment. OUD can involve misuse of prescribed opioid medications, use of diverted opioid medications or use of illicitly manufactured heroin, fentanyl or fentanyl analogues. For more information, refer to the DSM on Diagnostic Criteria for OUD.[1]

The intention of the *Safe Prescribing for Opioid Use Disorder* standard of practice is to provide physicians with clear requirements that allow for safe and responsible management of OUD with evidence-supported, full opioid agonist treatments. The standard is deliberately nonprescriptive in requiring use of specific treatment guidelines, as the treatment modalities for OUD are changing rapidly. It is our expectation that physicians provide care based on the most current guidelines and recommendations available, as well as evidence-based best practices (see Appendix 1). Opioid Agonist Treatments (OAT) are described in the medication list provided (see Appendix 2).

The current guidelines strongly recommend buprenorphine/naloxone and methadone as the first-line treatments for OUD. The advantages provided by buprenorphine/naloxone are well-recognized and include a superior safety profile, greater flexibility and patient autonomy (which allows for earlier take-home dosing), and unobserved home inductions where appropriate. The use of buprenorphine/naloxone can be safely provided with access to laboratory services and a collaborative relationship with a community pharmacist.

There are **no** requirements for an approval from the CPSA to prescribe buprenorphine/naloxone, or proof of certain educational or training certification. The expectation is that physicians will acquire the required knowledge and skills to diagnose OUD and provide front-line treatment and medication in accordance with the current guidelines and best practice information, as they would for any other chronic medical condition and medication. For the purpose of this standard, buprenorphine/naloxone is excluded.

Providing Safe and Compassionate Care

Evidence-informed, comprehensive treatment is known to improve the lives of patients who are in pain and living with OUD. These patients need patient-centered, holistic care, delivered with compassion and support.

[1] DSM-5 Clinical Diagnostic Criteria for Opioid Use Disorder

It is **never** acceptable to abruptly discontinue a patient's prescription opioids because an opioid use disorder is suspected or diagnosed. Patients with OUD, as those living with any other chronic/relapsing illness, benefit most when engaged as partners in their care along with their physician. Actions that undermine such a relationship are not only problematic for obvious reasons, but can also put a patient at serious risks in the context of a contaminated drug supply. For complex patients or where the diagnosis of an OUD is challenging, a consultation with an experienced OAT provider is strongly recommended. (see Appendix 3).

It is **never** acceptable to abruptly discontinue a patient's prescription opioids because an opioid use disorder is suspected or diagnosed.

Patients with OUD may benefit from harm-reduction interventions, including education about:

- Sterile syringe use and safer injection practices, to reduce the risk of blood-borne (HIV, hepatitis C) and soft tissue infections.
- Access to take-home naloxone.
- Syringe distribution programs and supervised consumption services, to reduce the risk of blood-borne infection and fatal overdose (particularly amongst high-risk patients or patients with ongoing opioid use).

Stigma is a major barrier to seeking treatment and maintaining recovery, and respectfully treating people who use substances improves health outcomes and helps save lives. All efforts should be taken to reduce stigma, which contributes to isolation and means patients are less likely to access services. We must all work to change the conversation about OUD. Language matters and we support and encourage the use of language that puts people first, reflects the medical nature of OUD and promotes recovery.

"We must all confront the intangible and often devastating effects of stigma. The key to recovery is support and compassion. Patients in pain and patients with a substance use disorder need comprehensive treatment, not judgment." - Patrice A. Harris, MD, MA, chair AMA Opioid Task Force"

Education and Experience

Knowledgeable and experienced physicians are an integral part of providing patient-centered care in the treatment of OUD. The ability to choose the most appropriate treatment in complex situations, in the context of rapidly evolving treatment options, requires that physicians have current knowledge, relevant experiential training and can maintain their knowledge and skills through Continuing Professional Development (CPD).

Physicians who do not have an OAT approval[2] must complete a CPSA-recognized Opioid Dependence Training Program and provide evidence of experiential training, supervision, mentorship and/or completion of an approved preceptor-based course or residency.

To provide readily-accessible education and experiential training options for physicians, the Alberta Opioid Dependency Virtual Training Program was developed by Alberta Health Services (AHS), in collaboration with the CME Office at Calgary's Cumming School of Medicine. The focus of this program is to give healthcare providers the knowledge, skills and attitudes necessary to provide care to patients with OUD by teaching the complex integration of technical and behavioral competencies required for addiction and mental health in day-to-day clinical practice. AHS also has the Alberta ODT Virtual Training Program available through Provincial Addiction Curricula & Experiential Skills Training (PACES), which can be accessed at any time through their website.

Successful completion of this program will meet the educational and experiential training required for an approval to initiate OAT for OUD. Upon completion of this course, a certification of completion is provided directly to the CPSA, and an approval is granted without the need for physicians to submit an application or any other evidence.

The program takes a proactive approach—it streamlines the approval process and provides Alberta physicians with access to education and training necessary to ensure competency in OAT, regardless of their location. Physicians who complete other recognized courses (e.g., BC Center on Substance Use (BCCSU) or Center for Addiction and Mental Health (CAMH)) need to submit the following to obtain an approval to initiate OAT for OUD:

- an application for approval;
- evidence of course completion; and
- evidence to support experiential training.

Physicians who presently have an OAT approval (formerly known as a Methadone Exemption/Methadone Approval) for initiating or maintaining treatment for patients with OUD will not be required to have any further training to maintain their approval. It is expected that these physicians maintain their competence in OAT through ongoing education (as part of their mandatory CPD) and provide evidence of the relevant Continuing Medical Education (CME) upon request.

Renewal requirements for prescribing approvals for OAT have been relaxed from those under the previous Health Canada Methadone Program. Physicians with a CPSA approval to initiate OAT (or a pre-existing Methadone Exemption/Approval for initiation) will now only need to renew their prescribing approval once every five years. Physicians with a prescribing approval to maintain OAT are exempt from the renewal requirement. The physician will receive notification of renewal from the CPSA and renew by return email.

[2] Per clause 1 of the *Safe Prescribing for Opioid use Disorder* standard of practice, OAT approval refers to full opioid agonist therapies for opioid use disorder treatment.

Appropriate Settings, Continuity and Transfer of Care

Appropriate Settings

OAT for OUD must be initiated where there is access to Alberta Netcare/PIN data, medical laboratory services and pharmacy services. Physicians are expected to be able to refer patients to appropriate multidisciplinary support and other resources and services, as indicated by patient preference and suitability to the patient's care. These services do not necessarily need to be located at the same site as the clinic providing OAT for OUD, but should be easily accessible for collaboration and continuity of care. Evidence shows that pharmacotherapy should not be offered in isolation, but rather should include ongoing assessment, monitoring and support for all aspects of physical, emotional, mental and spiritual health. These are equally important components of treating OUD—addressing these needs should be considered the standard of care. Evidence-based psychosocial supports focused on individual circumstances (e.g., housing, employment, etc.) and other survival needs (e.g., social assistance) may also be helpful in supporting recovery from OUD.

Continuity of Care

Continuity of care is also an important aspect of medical management in all settings. In the absence of the initiating provider, physicians must have access to other prescribers with the ability to prescribe OAT. It is expected that physicians working within groups have a process to manage continuity of care and provide coverage for each other. This may be challenging for those who work in rural or remote locations, but physicians need to be aware of the resources available to help manage this aspect of their practice. Alberta's Virtual Opioid Dependence Program supports physicians in rural/remote locations in maintaining continuity of care for their patients. The AHS Opioid Use Disorder Telephone Consultation service, a province-wide, e-consult service, is another resource for prescribers.

Continuity of care remains a vital part of patient safety and maintaining prescribers must have arrangements in place to provide patient care in their absence. Collaboration with colleagues, mentoring networks and educational resources will ensure that patient safety is not compromised.

Patients who are hospitalized, treated in emergency room settings or who are incarcerated are particularly vulnerable to loss of continuity of care. Physicians who temporarily provide OAT in these circumstances must ensure the patient has a sufficient amount of medication on discharge to allow them to contact their community physician. The community physician must also be notified of their patient's discharge. Direct contact with the community physician is preferred, to allow timely communication about the patient's treatment while under the temporary prescriber. Written communication should also be provided to the community physician.

If a change in medication becomes necessary during the course of the patient's hospitalization, emergency room stay or incarceration, the temporary prescriber must consult with the initiating prescriber or a qualified colleague to ensure any changes are made appropriately and safely. It is expected that all initiating prescribers have a process in

place which allows for prompt accessibility of themselves or a delegate prescriber. In the event of urgent or emergent situations, it is expected that the temporary prescriber use best practices to inform their clinical decision.

Collaboration between prescribers during transitions of care is essential to providing continuity and safe patient care.

Transfer of Care

Stable patients can be maintained in a community setting by their primary care provider. Transfer of care to a community physician requires the initiating prescriber to provide the maintaining physician with a letter of support and an information checklist. The letter of support should indicate that the initiating prescriber (or appropriate delegate) will be available to provide support, accessibility and advice to the maintaining physician. The information checklist should provide the maintaining prescriber with information about any potential risks from the OAT, possible adverse effects and red flags that may indicate a loss of stability requiring further consultation with the initiating prescriber (or their delegate).

The success of transferring the care of stable patients to community physicians is dependent on the ability of the initiating prescriber to provide accessible support for the maintaining physician, so patient care is provided safely. Establishing and maintaining a collaborative environment between both physicians is an integral part of this success.

It is expected that community physicians will accept transfer of care to maintain prescribing of OAT for stable patients and provide patient-centered, holistic care to patients with OUD. Evidence demonstrates that patients receiving team-based health care have improved outcomes, more patient satisfaction and reduced use of hospital, emergency room and specialty clinic services. This treatment also has the advantage of integrating addiction, medical and psychiatric services into mainstream services, reducing the stigma of addiction and the professional isolation of medical staff. Patients may prefer to receive treatment for their OUD in specialty clinics, so it is necessary to support patients as they integrate into a team-based health care setting.

An approval for maintaining a patient on OAT for OUD is provided to the maintaining physician upon receipt of a support letter from the initiating prescriber. After accepting a patient transfer from the initiating physician, the maintaining prescriber must complete an approved educational course within six months. Module 5 of the Alberta Opioid Dependence Virtual Training Program meets this educational requirement. This online program is free and can be used for CME credits. The program also streamlines the approval process by providing the CPSA with confirmation of completion.

Physicians who already hold an approval for OAT for OUD–Patient Specific are **not** required to complete further educational training to maintain treatment for present or future patients. It is expected that physicians ensure their competency through relevant CME.

When a physician with an approval to maintain OAT for OUD accepts the responsibility of maintaining OAT for OUD for additional patients, a letter of support from the initiating prescriber is required for each additional patient.

Injectable Opioid Agonist Treatment

Injectable OAT (iOAT) is an evidence-based, high-intensity treatment option for patients with OUD who have not benefited from other treatments. It is important to note that the use of iOAT should be considered an integral component of the continuum of care for OUD, rather than a response to the opioid overdose emergency. The expansion of OUD treatment programs to include iOAT must be implemented in a way that supports long-term sustainability.

Optimizing patient safety is an important factor in the designation of iOAT as a alternative intervention, when oral OAT has not been successful. It is important to remember that any frequently-administered injectable treatment comes with higher risks of cutaneous and infectious complications. It should be considered that intravenous or intramuscular injections such as iOAT have a more rapid onset of action, and peak effects (including respiratory depression) are reached faster than with oral ingestion of high-dose, full agonist opioid medications.

To provide iOAT, physicians **must** have an active CPSA approval to initiate or maintain OAT for OUD. Doses must be administered in a facility operated by AHS, or in a community setting approved by the CPSA, with sterile supplies, safe conditions and qualified staff trained to intervene in the event of an emergency.

Community settings that wish to provide this treatment option must submit a letter of intent to Methadone.Info@cpsa.ab.ca, outlining the policies and procedures under which their setting will operate. It is expected the policies and procedures provided will adhere to other recognized models of care for this type of practice, such as those in use by AHS or the BCCSU guideline documents. The physician competency requirements are outlined in Appendix 4, and additional training for all physicians providing this option in the community is strongly recommended.

The guidance document from BCCSU (Injectable Opioid Agonist Treatment for Opioid Use Disorder) outlines the current best practices available. Physicians using this treatment option are expected to be familiar with these guidelines (or other recognized iOAT guidelines/best practices) and practice within them.

Conclusion

A stepped and integrated-care approach, where choice and intensity of treatment is continually adjusted to accommodate both the circumstances and preferences of patients, while recognizing that many individuals may benefit from the ability to move between evidence-based treatments, is an integral part of the safe, effective and sustainability of treatment for OUD.

Educational and Training Resources

CPSA Physician Prescribing Practices: Prescribing Resources and Tools

Provincial Addiction Curricula & Experiential Skills Training (PACES)

ODT Virtual Health Training Sessions: 2018-2019

Alberta Opioid Dependence Virtual Training Program

CAMH – Opioid Dependence Treatment Core Course

British Columbia Center for Substance Use

Reducing Stigma Resources

Naloxone Kits – where to access

Supervised Consumption Services

Safe Needle Disposal/Needle Exchange Programs – Streetworks, Turning Point Society, Safeworks

Appendix 1: Current Guidelines for the Management of OUD

Best Practices for the Treatment of Opioid Use Disorder

British Columbia Center for Substance Use – OUD Guidelines

CRISM National Guidelines for the Clinical Management of OUD

American Society of Addiction Medicine – National Guidelines for the use of Medication in the treatment of addiction involving opioid use

Appendix 2: Medications Including in the Treatment of OUD

- Methadone
- Slow-release oral morphine
- Injectable OAT (hydromorphone)
- Medical-grade heroin (diacetylmorphine)

Appendix 3: Specialty Clinics and Consult Resources

Virtual Opioid Dependency Program (AHS)
Opioid Agonist Therapy, Emergency Medication Treatment & Transition Support
Phone: 1-844-383-7688
Fax: 403-783-7610

Opioid Use Disorder – AHS Telephone Consult
This telephone consult service is for primary care physicians and prescribers seeking advice regarding:

- Initiating and managing opioid agonist therapy
- Prescribing drugs like buprenorphine/naloxone, methadone or naloxone
- Treating patients with existing opioid use disorder
- Managing opioid withdrawal and consideration of opioid agonist therapy

This service will not provide advice on pain management using opioids or alternatives. Primary care providers who want to consult a pain management specialist may benefit from resources listed by the Calgary Pain Management Centre.

For patients **north** of Red Deer, access the service by calling RAAPID North at 1-800-282-9911 or 1-780-735-0811.

For patients **south** of Red Deer, call RAAPID South at 1-800-661-1700 or 403-944-4488.

Addiction and Mental Health – Opioid Dependency Program

Alberta Health Services' Opioid Dependency Program (ODP) clinics are available in Edmonton, Calgary, Fort McMurray, Cardston, Grande Prairie, High Prairie and through the Rural ODP clinic, which serves patients from 60 central Alberta communities.

What is an eReferral advice request?

An eReferral advice request is a secure and efficient process within Alberta Netcare, for physician-to-physician advice. *Addiction, Medicine & Mental Health – Opioid Agonist Therapy* joined eReferral in February 2018.

If you have a non-urgent question, are seeking guidance with the management of a patient's opioid use disorder, or are wondering if a referral is appropriate, send an advice request. The response target is five calendar days.

Appendix 4

Injectable Opioid Agonist Treatment for Opioid Use Disorder (BCCSU)

Example Framework for Prescriber Competencies (excerpted from AHS IOAT Medical Protocols)

Due to the intensity of this model of care and highly supervised nature of this medical intervention, it is important that prescribers have experience with OAT prescription and an up-to-date understanding of the evidence and best practices with regard to iOAT provision.

As such, prescribers who wish to administer iOAT must meet the following criteria:

- Licensed to practice medicine in Alberta by CPSA or Nurse Practitioner by CARNA.
- Hold a methadone exemption/OAT approval.

Prescribers should obtain knowledge and competency in addiction medicine, OAT and iOAT through the following resources:

- AAAP – American Academy of Addiction Psychiatry
- Certification in Addiction Medicine and/or Addiction Psychiatry via CSAM (Canadian Society of Addiction Medicine), ISAM(International Certification in Addiction Medicine), ABAM(American Board of Addiction Medicine)
- College of Family Physicians of Canada Certificate of Added Competence (CAC) in Addiction Medicine
- Fellowship and/or Residency training in Addiction Medicine
- At least two years of clinical experience in Addiction Medicine/Psychiatry
- At least two years of clinical experience in OAT
- Extra training completed in iOAT (i.e. the iOAT module of the Provincial Opioid Addiction Treatment Support Program offered through the BCCSU, or equivalent)

College of Physicians & Surgeons of Alberta

Submission to:	**Council**

Meeting Date:	Submitted by:		
February 28, 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	***It is recommended that*** Council approve CMA's 2018 *Code of Ethics* for consultation.		
Issues/Rationale:	The Canadian Medical Association began a major renewal of its *Code of Ethics* in 2017 to address medical innovation, technological advances and how new patient expectations have led to considerable transformations in health care and how medicine is practised. The updated Code is the result of extensive research and consultation with physicians and stakeholders. CMA received over 6,000 comments that helped inform the revision. After an extensive two-year consultation process, the CMA Board of Directors approved its new *Code of Ethics and Professionalism* in December 2018. Under Section 133 of the *Health Professions Act*, CPSA must consult with our members and stakeholders before adopting a new code of ethics. In accordance with Section 9 of the CPSA Bylaws, we must consult for at least 60 days prior to bringing the *Code* back to Council for adoption. We will continue to use the 2004 version (attachment 1) until consultation is complete and Council adopts the 2018 version of the *Code* (attachment 2).		
Highlights of New Code:	1. Inclusion of "professionalism" in the title to highlight the growing emphasis on medical professionalism and to make a distinction between the core values of the profession and its evolving responsibilities. 2. Reintroducing and emphasizing virtues to reaffirm what has long been considered to define what it means to be an ethical physician, while also complementing the fundamental principles of the Code. 3. Articulating fundamental commitments to illustrate the distinction between professional responsibilities and fundamental commitments.		

College of Physicians & Surgeons of Alberta

	4. Emphasizing the new physician-patient relationship to reinforce its importance by addressing the changing nature of both this relationship and medical decision-making. 5. Emphasizing new commitments to oneself in response to growing evidence linking poor physician health and the impact on patient care.
List of Attachments:	
1. 2004 *Code of Ethics* 2. 2018 *Code of Ethics and Professionalism*	

ASSOCIATION MÉDICALE CANADIENNE / CANADIAN MEDICAL ASSOCIATION

CMA POLICY

CMA Code of Ethics
(Update 2004)

Last reviewed March 2018: Still relevant

This Code has been prepared by the Canadian Medical Association as an ethical guide for Canadian physicians, including residents, and medical students. Its focus is the core activities of medicine – such as health promotion, advocacy, disease prevention, diagnosis, treatment, rehabilitation, palliation, education and research. It is based on the fundamental principles and values of medical ethics, especially compassion, beneficence, non-maleficence, respect for persons, justice and accountability. The Code, together with CMA policies on specific topics, constitutes a compilation of guidelines that can provide a common ethical framework for Canadian physicians.

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

Physicians may experience tension between different ethical principles, between ethical and legal or regulatory requirements, or between their own ethical convictions and the demands of other parties. Training in ethical analysis and decision-making during undergraduate, postgraduate and continuing medical education is recommended for physicians to develop their knowledge, skills and attitudes needed to deal with these conflicts. Consultation with colleagues, regulatory authorities, ethicists, ethics committees or others who have relevant expertise is also recommended.

Fundamental Responsibilities

1. Consider first the well-being of the patient.

2. Practise the profession of medicine in a manner that treats the patient with dignity and as a person worthy of respect.

3. Provide for appropriate care for your patient, even when cure is no longer possible, including physical comfort and spiritual and psychosocial support.

4. Consider the well-being of society in matters affecting health.

5. Practise the art and science of medicine competently, with integrity and without impairment.

6. Engage in lifelong learning to maintain and

Correspondence and requests for additional copies should be addressed to the Member Service Centre, Canadian Medical Association, 1867 Alta Vista Drive, Ottawa, ON K1G 5W8; tel 888 855-2555 or 613 731-8610 x2307; fax 613 236-8864.

All policies of the CMA are available electronically through CMA Online (www.cma.ca).

improve your professional knowledge, skills and attitudes.

7. Resist any influence or interference that could undermine your professional integrity.

8. Contribute to the development of the medical profession, whether through clinical practice, research, teaching, administration or advocating on behalf of the profession or the public.

9. Refuse to participate in or support practices that violate basic human rights.

10. Promote and maintain your own health and well-being.

Responsibilities to the Patient

General Responsibilities

11. Recognize and disclose conflicts of interest that arise in the course of your professional duties and activities, and resolve them in the best interest of patients.

12. Inform your patient when your personal values would influence the recommendation or practice of any medical procedure that the patient needs or wants.

13. Do not exploit patients for personal advantage.

14. Take all reasonable steps to prevent harm to patients; should harm occur, disclose it to the patient.

15. Recognize your limitations and, when indicated, recommend or seek additional opinions and services.

16. In determining professional fees to patients for non-insured services, consider both the nature of the service provided and the ability of the patient to pay, and be prepared to discuss the fee with the patient.

Initiating and Dissolving a Patient-Physician Relationship

17. In providing medical service, do not discriminate against any patient on such grounds as age, gender, marital status, medical condition, national or ethnic origin, physical or mental disability, political affiliation, race, religion, sexual orientation, or socioeconomic status. This does not abrogate the physician's right to refuse to accept a patient for legitimate reasons.

18. Provide whatever appropriate assistance you can to any person with an urgent need for medical care.

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

20. Limit treatment of yourself or members of your immediate family to minor or emergency services and only when another physician is not readily available; there should be no fee for such treatment.

Communication, Decision Making and Consent

21. Provide your patients with the information they need to make informed decisions about their medical care, and answer their questions to the best of your ability.

22. Make every reasonable effort to communicate with your patients in such a way that information exchanged is understood.

23. Recommend only those diagnostic and therapeutic services that you consider to be beneficial to your patient or to others. If a service is recommended for the benefit of others, as for example in matters of public health, inform your patient of this fact and proceed only with explicit informed consent or where required by law.

24. Respect the right of a competent patient to accept or reject any medical care recommended.

25. Recognize the need to balance the developing competency of minors and the role of families in medical decision-making. Respect the autonomy of those minors who are authorized to consent to treatment.

26. Respect your patient's reasonable request for a second opinion from a physician of the patient's choice.

27. Ascertain wherever possible and recognize your patient's wishes about the initiation, continuation or cessation of life-sustaining treatment.

28. Respect the intentions of an incompetent patient as they were expressed (e.g., through a valid advance directive or proxy designation) before the patient became incompetent.

29. When the intentions of an incompetent patient are unknown and when no formal mechanism for making treatment decisions is in place, render such treatment as you believe to be in accordance with the patient's values or, if these are unknown, the patient's best interests.

30. Be considerate of the patient's family and significant others and cooperate with them in the patient's interest.

Privacy and Confidentiality

31. Protect the personal health information of your patients.

32. Provide information reasonable in the circumstances to patients about the reasons for the collection, use and disclosure of their personal health information.

33. Be aware of your patient's rights with respect to the collection, use, disclosure and access to their personal health information; ensure that such information is recorded accurately.

34. Avoid public discussions or comments about patients that could reasonably be seen as revealing confidential or identifying information.

35. Disclose your patients' personal health information to third parties only with their consent, or as provided for by law, such as when the maintenance of confidentiality would result in a significant risk of substantial harm to others or, in the case of incompetent patients, to the patients themselves. In such cases take all reasonable steps to inform the patients that the usual requirements for confidentiality will be breached.

36. When acting on behalf of a third party, take reasonable steps to ensure that the patient understands the nature and extent of your responsibility to the third party.

37. Upon a patient's request, provide the patient or a third party with a copy of his or her medical record, unless there is a compelling reason to believe that information contained in the record will result in substantial harm to the patient or others.

Research

38. Ensure that any research in which you participate is evaluated both scientifically and ethically and is approved by a research ethics board that meets current standards of practice.

39. Inform the potential research subject, or proxy, about the purpose of the study, its source of funding, the nature and relative probability of harms and benefits, and the nature of your participation including any compensation.

40. Before proceeding with the study, obtain the informed consent of the subject, or proxy, and advise prospective subjects that they have the right to decline or withdraw from the study at any time, without prejudice to their ongoing care.

Responsibilities to Society

41. Recognize that community, society and the environment are important factors in the health of individual patients.

42. Recognize the profession's responsibility to society in matters relating to public health, health education, environmental protection, legislation affecting the health or well-being of the community and the need for testimony at judicial proceedings.

43. Recognize the responsibility of physicians to promote equitable access to health care resources.

44. Use health care resources prudently.

45. Recognize a responsibility to give generally held opinions of the profession when interpreting scientific knowledge to the public; when presenting an opinion that is contrary to the generally held opinion of the profession, so indicate.

Responsibilities to the Profession

46. Recognize that the self-regulation of the profession is a privilege and that each physician has a continuing responsibility to merit this privilege and to support its institutions.

47. Be willing to teach and learn from medical students, residents, other colleagues and other health professionals.

48. Avoid impugning the reputation of colleagues for personal motives; however, report to the appropriate authority any unprofessional conduct by colleagues.

49. Be willing to participate in peer review of other physicians and to undergo review by your peers. Enter into associations, contracts and agreements only if you can maintain your professional integrity and safeguard the interests of your patients.

50. Avoid promoting, as a member of the medical profession, any service (except your own) or product for personal gain.

51. Do not keep secret from colleagues the diagnostic or therapeutic agents and procedures that you employ.

52. Collaborate with other physicians and health professionals in the care of patients and the functioning and improvement of health services. Treat your colleagues with dignity and as persons worthy of respect.

Responsibilities to Oneself

53. Seek help from colleagues and appropriately qualified professionals for personal problems that might adversely affect your service to patients, society or the profession.

54. Protect and enhance your own health and well-being by identifying those stress factors in your professional and personal lives that can be managed by developing and practising appropriate coping strategies.

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

Submission to:	**Council**

Meeting Date:	Submitted by:		
February 28, 2019	Mr. Shawn Knight		
Agenda Item Title:	Standard of Practice: Boundary Violation		
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 endorse the *Boundary Violation Standard of Practice (SOP) as a standalone SOP.* *Endorse the submission of the SOP* to the Department of Health for consideration that section 133 of the HPA, requiring consultation with the Minister, has been meet as none of the content remaining has changed.		
Issues/Rationale:	Council approved consultation on the *Boundary Violations* standard in September 2017; based on input received, further work was required to meet the feedback obtained, and resolution for implementation was postponed until May 2018 to allow for a reconsultation on the revised draft. The amended *Boundary Violations* standard was reissued by Council July 1, 2018 (attachment 1). During the course of work related to Bill 21, a number of clauses were removed from the *Boundary Violations* standard (attachment 2) and added to the draft *Sexual Abuse and Sexual Misconduct* standard (attachment 3): the intent of the *Boundary Violations* standard remains the same as what Council approved last spring. Given the extensive consultation done in the recent past, the professions' knowledge of the existing standard, and acknowledging content has not been lost – only relocated – College staff approached the Department of Health to determine if there was support for adopting the modified *Boundary Violations* standard to complement the Bill 21 work. The Department has indicated support of this proposal. Our intention is to illustrate fulfillment of our obligations under Section 133 of the *Health Professions Act* and include the modified version of the *Boundary Violations* standard with our Bill 21 package for implementation by April 1.		

College of Physicians & Surgeons of Alberta

Proposed Revisions/Key Changes:	1. Removal of clauses specific to sexual abuse or sexual misconduct (3 (a) and (c)). 2. Removal of "sexual" from the phrase "close personal or sexual" (clauses 3 (a), (b), (d), (e), and the stem of clause 4).

List of Attachments:

1. Original approved for implementation July 2018
2. Draft *Boundary Violations* standard with Bill 21 clauses removed
3. Draft *Sexual Abuse and Sexual Misconduct* standard with inserted *Boundary Violations* standards marked

College of Physicians & Surgeons of Alberta

Standard of Practice

Boundary Violations

Under Review: No
Issued by Council: January 1, 2010
Reissued by Council: July 1, 2018

Boundary Violations

The ***Standards of Practice*** of the College of Physicians & Surgeons of Alberta ("the College") are the **minimum** standards of professional behavior and ethical conduct expected of all regulated members registered in Alberta. Standards of Practice are enforceable under the *Health Professions Act* and will be referenced in the management of complaints and in discipline hearings. The College of Physicians & Surgeons of Alberta also provides **Advice to the Profession** to support the implementation of the Standards of Practice.

A regulated member who is uncertain about the potential for a boundary violation should consult with the College or another relevant advisory body (e.g., Alberta Medical Association or Canadian Medical Protective Association).

Physician-Patient Relationship

(1) A regulated member **must** maintain professional boundaries in any interaction with a patient, including but not limited to:

(a) providing adequate draping;

(b) providing privacy while the patient is undressing or dressing;

(c) obtaining informed consent for intimate or sensitive examinations; and

(d) using appropriate examination techniques when touching sensitive or personal areas of the body, including but not limited to breasts, genitalia or anus.

(2) A regulated member **must** consider and minimize any potential conflict of interest or risk of coercion when engaging with a patient in a non-clinical context (i.e., in a personal, social, financial or business relationship).

(3) A regulated member **must not:**

(a) make sexual comments or gestures toward a patient;

(b) enter into a close personal or sexual relationship with a patient or any person with whom a patient has a significant interdependent relationship (e.g., parent, guardian, child or significant other);

(c) request details of a patient's sexual or personal history unless related to the patient's care;

(d) socialize or communicate with a patient for the purpose of pursuing a close personal or sexual relationship; or

Terms used in the Standards of Practice:

- *"Regulated member"* means any person who is registered or who is required to be registered as a member of this College. The College regulates physicians, surgeons and osteopaths.
- *"Must"* refers to a mandatory requirement.
- *"May"* means that the physician may exercise reasonable discretion.
- *"Patient"* includes, where applicable, the patient's legal guardian or substitute decision maker.

(e) terminate a physician-patient relationship for the purpose of pursuing a close personal or sexual relationship.

(4) A regulated member **must not** enter into a close personal or sexual relationship with a former patient unless:

(a) the regulated member has **never** provided the patient with psychotherapeutic treatment;

(b) there is minimal risk of a continuing power imbalance; and

(c) sufficient time has passed since the last clinical encounter, given the nature and extent of the physician-patient relationship.

(5) A regulated member **must not** promote his/her personal or religious beliefs or causes to a patient in the context of the physician-patient relationship.

Physician-Learner and Physician-Subordinate Relationships

(6) A regulated member **must not**:

(a) sexualize a teacher-learner relationship by making sexual comments or gestures toward a learner[1];

(b) enter into a close personal or sexual relationship with a learner while directly or indirectly responsible for mentoring, teaching, supervising or evaluating that learner; or

(c) enter into any relationship with a learner that could present a risk of conflict of interest or coercion while directly or indirectly responsible for mentoring, teaching and/or evaluating that learner.

(7) A regulated member who has a pre-existing (current or past) close personal or sexual relationship with a learner or a subordinate physician **must**:

(a) notify the applicable clinical and academic leaders of the relationship;

(b) remove him/herself from any role teaching or evaluating the subordinate physician or learner; and

(c) remove him/herself from any discussion of the performance of the subordinate physician or learner.

[1] "Learner" includes but is not limited to clinical trainee, medical student, other health professional learner, graduate student, resident or fellow.

College of Physicians & Surgeons of Alberta

Standard of Practice

Boundary Violations

Under Review: No
Issued by Council: January 1, 2010
Reissued by Council: July 1, 2018

Boundary Violations

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(2) A regulated member **must** consider and minimize any potential conflict of interest or risk of coercion when engaging with a patient in a non-clinical context (i.e., in a personal, social, financial or business relationship).

(3) A regulated member **must not:**

(a) ~~make sexual comments or gestures toward a patient;~~

(b) enter into a close personal ~~or sexual~~ relationship with a patient or any person with whom a patient has a significant interdependent relationship (e.g., parent, guardian, child or significant other);

~~(c) request details of a patient's sexual or personal history unless related to the patient's care;~~

~~(d)~~(c) socialize or communicate with a patient for the purpose of pursuing a close personal ~~or sexual~~ relationship; or

Commented [CB1]: Covered in definition of "sexual misconduct": page 2 of *Sexual Abuse & Sexual Misconduct* standard of practice.

Commented [CB2]: Clause (a), page 3.

Commented [CB3]: Clause (b), page 3.

Commented [CB4]: No longer relevant to this clause/standard.

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- *"May"* means that the physician may exercise reasonable discretion.
- *"Patient"* includes, where applicable, the patient's legal guardian or substitute decision maker.

~~(c)~~(d) terminate a physician-patient relationship for the purpose of pursuing a close personal ~~or sexual~~ relationship.

Commented [CB5]: Clause (c), page 3.

(4) A regulated member **must not** enter into a close personal ~~or sexual~~ relationship with a former patient unless:

Commented [CB6]: No longer relevant to this clause/standard.

(a) the regulated member has **never** provided the patient with psychotherapeutic treatment;

(b) there is minimal risk of a continuing power imbalance; and

(c) sufficient time has passed since the last clinical encounter, given the nature and extent of the physician-patient relationship.

(5) A regulated member **must not** promote his/her personal or religious beliefs or causes to a patient in the context of the physician-patient relationship.

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(c) enter into any relationship with a learner that could present a risk of conflict of interest or coercion while directly or indirectly responsible for mentoring, teaching and/or evaluating that learner.

(7) A regulated member who has a pre-existing (current or past) close personal or sexual relationship with a learner or a subordinate physician **must**:

(a) notify the applicable clinical and academic leaders of the relationship;

(b) remove him/herself from any role teaching or evaluating the subordinate physician or learner; and

(c) remove him/herself from any discussion of the performance of the subordinate physician or learner.

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- *"Patient"* includes, where applicable, the patient's legal guardian or substitute decision maker.

College of Physicians & Surgeons of Alberta

Standard of Practice

Sexual Abuse and Sexual Misconduct

Introduction

This Standard of Practice addresses Sexual Abuse and Sexual Misconduct. This Standard of Practice establishes who is considered to be a "patient" for the purposes of a complaint of unprofessional conduct in relation to Sexual Abuse or Sexual Misconduct under the *Health Professions Act (*("HPA").

Definitions

"Patient" is defined in section 1(1)(x.1) of the *Health Professions Act* as:

- "patient" for the purposes of a complaint made in respect of unprofessional conduct in relation to sexual abuse or sexual misconduct, means a patient as set out in the standards of practice of a council;

"Adult interdependent partner" is defined in section 3(1) of the *Adult Interdependent Relationships Act* as:

- Subject to subsection (2), a person is the adult interdependent partner of another person if

  (a) the person has lived with the other person in a relationship of interdependence

  (i) for a continuous period of not less than 3 years, or

  (ii) of some permanence, if there is a child of the relationship by birth or adoption,

  or

  (b) the person has entered into an adult interdependent partner agreement with the other person under section 7.

"Regulated member" is a member of the College of Physicians & Surgeons of Alberta registered as a member under section 33(1)(a) of the *Health Professions Act.*

"Sexual Abuse" is defined in section 1(1)(nn.1) of the *Health Professions Act* :

- "sexual abuse" means the threatened, attempted or actual conduct of a regulated member towards a patient that is of a sexual nature and includes any of the following conduct:

  (i) sexual intercourse between a regulated member and a patient of that regulated member;

(ii) genital to genital, genital to anal, oral to genital, or oral to anal contact between a regulated member and a patient of that regulated member;

(iii) masturbation of a regulated member by, or in the presence of, a patient of that regulated member;

(iv) masturbation of a regulated member's patient by that regulated member;

(v) encouraging a regulated member's patient to masturbate in the presence of that regulated member;

(vi) touching of a sexual nature of a patient's genitals, anus, breasts, or buttocks by a regulated member;

"Sexual Misconduct" is defined in section 1(1)(nn.2) of the *Health Professions Act* as;

- "sexual misconduct" means any incident or repeated incidents of objectionable or unwelcome conduct, behaviour or remarks of a sexual nature by a regulated member towards a patient that the regulated member knows or ought reasonably to know will or would cause offence or humiliation to the patient or adversely affect the patient's health and well-being but does not include sexual abuse

Commented [CB1]: Covers *Boundary Violations* clause 3(a).

"Sexual nature" is defined in section 1(1)(nn.3) of the *Health Profession Act* as not including "any conduct, behaviour or remarks that are appropriate to the service provided."

- In other words, touching of the patient's body by a regulated member does not constitute Sexual Abuse if the touching is appropriate to the health care service being provided. However, regulated members are reminded of the obligation to obtain a patient's informed consent prior to an examination, assessment, treatment or procedure. (See the CPSA's Standard of Practice on "Informed Consent" and its Advice to the Profession on "Informed Consent for Adults" and "Informed Consent for Minors".) As noted in "Informed Consent for Adults", written consent or explicit oral consent should be in place and documented whenever an examination or treatment involves touching the patient (page 4).

"Spouse" is a person who is married.

Prohibitions

A regulated member must never engage in sexual conduct with a "patient". The consequences are as follows:

1. If a regulated member is found by a Hearing Tribunal to have committed unprofessional conduct based in whole or in part on "Sexual Abuse", then the Hearing Tribunal must cancel the regulated member's registration and practice permit. The regulated member is never permitted to apply for reinstatement.
2. If a regulated member is found by a Hearing Tribunal to have committed unprofessional conduct based in whole or in part on "Sexual Misconduct", then the Hearing Tribunal must at least suspend the regulated member's practice permit for a period of time determined by the Hearing

Tribunal to be appropriate. The Hearing Tribunal can impose more severe sanctions than a suspension. If a regulated member's registration and practice permit are cancelled because of "sexual misconduct" then the regulated member cannot apply for reinstatement for at least 5 years.

All types of sexual relationships with patients are prohibited even if the regulated member believes that the patient is "consenting." The *Health Professions Act* does not recognize such alleged "consent" as a valid defence because of the existence of the inherent power imbalance that typically exists in the regulated member-patient relationship.

If a regulated member engages in the type of behaviour set out in the definition of Sexual Abuse or Sexual Misconduct with a person who is not his or her patient (such as colleagues, staff, or others) then this conduct may still be considered "unprofessional conduct" by the regulated member but the mandatory sanctions for Sexual Abuse and Sexual Misconduct would not apply. If a Hearing Tribunal found that this conduct constituted "unprofessional conduct", then a Hearing Tribunal would have the discretion to impose the type of orders that it considers appropriate up to and including suspension and cancellation of registration and practice permit.

If a regulated member engages in inappropriate conduct with a patient that does not fall within the definition of "Sexual Abuse" or "Sexual Misconduct", a Hearing Tribunal may still consider the conduct to be "unprofessional conduct" subjecting the regulated member to sanctions.

A regulated member must not:

a. enter into a sexual relationship with any person with whom a patient has a significant interdependent relationship (eg. parent, guardian, child or significant other);

b. request details of a patient's sexual or personal history unless related to the patient's care;

c. terminate a regulated member-patient relationship for the purpose of pursuing a sexual relationship.

Commented [CB2]: *Boundary Violations* clause 3(b).

Commented [CB3]: *Boundary Violations* clause 3(c).

Commented [CB4]: *Boundary Violations* clause 3(d).

A violation of (a) to **(c)** is not considered to be Sexual Abuse but may be considered by a Hearing Tribunal to be unprofessional conduct under the *Health Professions Act*. After making a finding of unprofessional conduct, a Hearing Tribunal can impose a range of sanctions including suspensions and cancellation of registration and practice permit.

Who is considered to be a "patient"?

The Sexual Abuse and Sexual Misconduct provisions in the *Health Professions Act* apply to "patients". For the purposes of this standard of practice, an individual is a regulated member's "patient" in two circumstances:

1. When a regulated member-patient relationship has been formed and has not ended.
2. When a regulated member engages in the type of sexual acts described in the definition of "Sexual Abuse" with a "former patient" within 1 year from the date the individual ceased to be the regulated member's patient.

An individual becomes a patient when a regulated member-patient relationship is formed. This type of relationship is formed when there is a reasonable expectation that care will extend beyond a single encounter and the regulated member has engaged in one or more of the following activities:

1. Gathered clinical information to assess a person;

2. Provided a diagnosis;
3. Provided medical advice or treatment;
4. Provided counselling to the patient.
5. Created a patient file for the patient.
6. Billed for medical services provided to the patient.
7. Prescribed a drug for which a prescription is needed to the patient.

A regulated member who engages in the type of sexual acts described in the definition of "Sexual Abuse" with a patient commits Sexual Abuse.

Sexual Conduct after the End of the Regulated Member-Patient Relationship

For the purposes of the sexual abuse provisions in the *Health Professions Act,* an individual may still be considered a "patient" after the date on which the individual ceased to be the regulated member's patient.

An individual is considered to be a "patient" for the purposes of the Sexual Abuse provisions for a 1 year period after the date on which the individual ceased to be the regulated member's patient. As a result, a regulated member must not engage in the type of sexual acts described in the definition of "Sexual Abuse" with such an individual for a minimum of 1 year after the individual ceased to be the regulated member's patient. If a regulated member has any doubt as to whether or when a regulated member - patient relationship ended they may wish to seek advice from the CMPA or the CPSA.

Sexual conduct may still be considered to be inappropriate after the 1 year period has elapsed. Sexual conduct with a former patient is inappropriate if there is more than a minimal risk of a continuing power imbalance. A non-exhaustive list of factors in determining whether there is more than a minimal risk of a continuing power imbalance is as follows (in this list the patient is referred to as the "individual"):

1. Whether the individual understands the inherent power imbalance that typically exists in a regulated member-patient relationship.
2. Whether sufficient time has passed since the end of the regulated member -patient relationship, given the nature and extent of the regulated member -patient relationship.
3. The nature of the individual's clinical problems.
4. The type of medical care provided by the regulated member.
5. Whether the individual has confided close personal or sexual information to the regulated member.
6. The length and intensity of the former regulated member-patient relationship.
7. Whether this is a situation where there is a likelihood of transference.
8. The vulnerability of the individual including a consideration of whether the individual is a member of a vulnerable population such as, for example: those who have diminished capacity, those who are economically disadvantaged, those suffering from addictions and the homeless.
9. Whether the regulated member-patient relationship was established while the individual was a minor.

Commented [CB5]: We purposely removed this from other locations: did we miss this one?

10. Whether there is a history of the regulated member prescribing to the patient drugs associated with substance use disorders or substance-related harms.

Sexual conduct with a former patient beyond the 1 year period that is considered inappropriate given all the circumstances is not considered to be Sexual Abuse. However, such conduct may be considered by a Hearing Tribunal to be unprofessional conduct under the *Health Professions Act*. After making a finding of unprofessional conduct, a Hearing Tribunal can impose a range of sanctions including suspensions and cancellation of registration and practice permit.

Any regulated member who engages in sexual conduct with a former patient after the 1 year period has elapsed runs a risk that the conduct will be considered inappropriate and unprofessional conduct. Regulated members with any doubt as to the propriety of their conduct may wish to seek advice from the CMPA or the CPSA.

Psychotherapeutic Treatment

A regulated member who has provided psychotherapeutic treatment to a patient must never engage in sexual conduct with the former patient regardless of the amount of time that has passed since the end of the regulated member-patient relationship. In other words, for the purposes of the Sexual Abuse provisions in the *Health Professions* Act, the individual is always considered to be a "patient" regardless of the amount of time that has lapsed since the end of the regulated member-patient relationship.

Episodic Care

For the purposes of the sexual abuse and sexual misconduct provisions, a regulated member-patient relationship is formed when a regulated member provides "Episodic Care" as defined in the Standard of Practice on "Episodic Care." However, the regulated member-patient relationship does not extend beyond the conclusion of the episodic care. The individual is considered a patient during the episodic care. Therefore, a regulated member who engages in the type of activity described in the definition of Sexual Abuse or Sexual Misconduct while providing episodic care will be considered to have committed Sexual Abuse or Sexual Misconduct, as the case may be.

Sexual conduct between a regulated member and a former patient after the completion of episodic care may still be considered to be inappropriate. This conduct is considered to be inappropriate if there is more than a minimal risk of a continuing power imbalance. A non-exhaustive list of factors in determining whether there is more than a minimal risk of a continuing power imbalance is set out in the section "Sexual Conduct after the End of the Regulated member-Patient Relationship."

Sexual conduct with a former patient after the conclusion of episodic care that is considered inappropriate given all the circumstances is not considered to be Sexual Abuse **even if it takes place within 1 year of providing episodic care.** However, such conduct may be considered by a Hearing Tribunal to be unprofessional conduct under the *Health Professions Act*. After making a finding of unprofessional conduct, a Hearing Tribunal can impose a range of sanctions including suspensions and cancellation of registration and practice permit.

The provisions of this Standard of Practice concerning episodic care are only for the purposes of defining who is a patient for the purposes of the sexual abuse and sexual misconduct provisions in the *Health Professions Act.* The provisions of this Standard of Practice do not diminish any ongoing professional responsibilities of the regulated member under the Episodic Care Standard of Practice.

Medical Treatment of Spouses, Adult Interdependent Partners and those in Pre-Existing Sexual Relationships

For the purposes of the sexual abuse provisions in the *Health Professions Act,* a person receiving medical treatment from a regulated member is not considered a patient if the regulated member is their spouse or adult interdependent partner or if they are in a pre-existing sexual relationship with the regulated member.

However, it is considered to be unprofessional conduct for a regulated member to provide medical treatment to a spouse, adult interdependent partner or person with whom they are in a pre-existing sexual relationship unless all the following conditions are met:

1. The treatment is limited to a "minor condition" or an "emergency".
2. Another physician is not readily available or the individual receiving treatment could suffer harm from a delay in obtaining the services of another physician.

"Minor condition" is considered a non-urgent, non-serious condition that requires only short-term, routine care and is not likely to be an indication of, or lead to, a more serious condition requiring medical expertise.

An "emergency" is considered to exist when an individual is experiencing severe suffering or is at risk of sustaining serious bodily harm if medical intervention is not promptly provided.

After making a finding of unprofessional conduct, a Hearing Tribunal can impose a range of sanctions including suspensions and cancellation of registration and practice permit.

College of Physicians & Surgeons of Alberta

Submission to:	**Council**

Meeting Date:	Submitted by:		
28 February 2019	Mr. Shawn Knight		
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 updated standard of practice (SOP) for resubmission to the Minister of Health for her approval in March 2019. ***It is recommended that*** Council allow this approval to 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.		
Background:	The draft *Sexual Abuse and Sexual Misconduct SOP* was submitted to the Minister on December 21, 2018. The Department has requested a few changes and asked for rationale on a number of items. Primarily, the suggestions were clarifications around hearing tribunal sexual misconduct discretion, language linkages to the *Health Professions Act* and a clarification regarding pre-existing sexual relationship. The feedback is being vetted through Field Law, who assisted in the creation of the SoP, and we are working with the Department to provide them rationale on several items. A new SOP will be provided to Council for approval on February 28, 2019 as the resubmission to the Minister is due on the same day. The department has informed us the Minister will likely have the SOP's returned sometime in late March 2019 for implementation.		
Proposed Revisions/Key Changes:	1. TBD – Documents will be provided as soon as they are finalized.		
List of Attachments:			
1. Draft *Sexual Abuse and Sexual Misconduct* standard approved by Council on December 21, 2018 2. Draft *Sexual Abuse and Sexual Misconduct* standard marked Date February 28, 2019 (to be brought in hard copy to the meeting).			

College of Physicians & Surgeons of Alberta

Standard of Practice

Sexual Abuse and Sexual Misconduct

Introduction

This Standard of Practice addresses Sexual Abuse and Sexual Misconduct. This Standard of Practice establishes who is considered to be a "patient" for the purposes of a complaint of unprofessional conduct in relation to Sexual Abuse or Sexual Misconduct under the *Health Professions Act (*("HPA").

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"Patient" is defined in section 1(1)(x.1) of the *Health Professions Act* as:

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- Subject to subsection (2), a person is the adult interdependent partner of another person if

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(ii) genital to genital, genital to anal, oral to genital, or oral to anal contact between a regulated member and a patient of that regulated member;

(iii) masturbation of a regulated member by, or in the presence of, a patient of that regulated member;

(iv) masturbation of a regulated member's patient by that regulated member;

(v) encouraging a regulated member's patient to masturbate in the presence of that regulated member;

(vi) touching of a sexual nature of a patient's genitals, anus, breasts, or buttocks by a regulated member;

"Sexual Misconduct" is defined in section 1(1)(nn.2) of the *Health Professions Act* as;

- "sexual misconduct" means any incident or repeated incidents of objectionable or unwelcome conduct, behaviour or remarks of a sexual nature by a regulated member towards a patient that the regulated member knows or ought reasonably to know will or would cause offence or humiliation to the patient or adversely affect the patient's health and well-being but does not include sexual abuse

"Sexual nature" is defined in section 1(1)(nn.3) of the *Health Profession Act* as not including "any conduct, behaviour or remarks that are appropriate to the service provided."

- In other words, touching of the patient's body by a regulated member does not constitute Sexual Abuse if the touching is appropriate to the health care service being provided. However, regulated members are reminded of the obligation to obtain a patient's informed consent prior to an examination, assessment, treatment or procedure. (See the CPSA's Standard of Practice on "Informed Consent" and its Advice to the Profession on "Informed Consent for Adults" and "Informed Consent for Minors".) As noted in "Informed Consent for Adults", written consent or explicit oral consent should be in place and documented whenever an examination or treatment involves touching the patient (page 4).

"Spouse" is a person who is married.

Prohibitions

A regulated member must never engage in sexual conduct with a "patient". The consequences are as follows:

1. If a regulated member is found by a Hearing Tribunal to have committed unprofessional conduct based in whole or in part on "Sexual Abuse", then the Hearing Tribunal must cancel the regulated member's registration and practice permit. The regulated member is never permitted to apply for reinstatement.
2. If a regulated member is found by a Hearing Tribunal to have committed unprofessional conduct based in whole or in part on "Sexual Misconduct", then the Hearing Tribunal must at least suspend the regulated member's practice permit for a period of time determined by the Hearing

Tribunal to be appropriate. The Hearing Tribunal can impose more severe sanctions than a suspension. If a regulated member's registration and practice permit are cancelled because of "sexual misconduct" then the regulated member cannot apply for reinstatement for at least 5 years.

All types of sexual relationships with patients are prohibited even if the regulated member believes that the patient is "consenting." The *Health Professions Act* does not recognize such alleged "consent" as a valid defence because of the existence of the inherent power imbalance that typically exists in the regulated member-patient relationship.

If a regulated member engages in the type of behaviour set out in the definition of Sexual Abuse or Sexual Misconduct with a person who is not his or her patient (such as colleagues, staff, or others) then this conduct may still be considered "unprofessional conduct" by the regulated member but the mandatory sanctions for Sexual Abuse and Sexual Misconduct would not apply. If a Hearing Tribunal found that this conduct constituted "unprofessional conduct", then a Hearing Tribunal would have the discretion to impose the type of orders that it considers appropriate up to and including suspension and cancellation of registration and practice permit.

If a regulated member engages in inappropriate conduct with a patient that does not fall within the definition of "Sexual Abuse" or "Sexual Misconduct", a Hearing Tribunal may still consider the conduct to be "unprofessional conduct" subjecting the regulated member to sanctions.

A regulated member must not:

a. enter into a sexual relationship with any person with whom a patient has a significant interdependent relationship (eg. parent, guardian, child or significant other);

b. request details of a patient's sexual or personal history unless related to the patient's care;

c. terminate a regulated member-patient relationship for the purpose of pursuing a sexual relationship.

A violation of (a) to **(c)** is not considered to be Sexual Abuse but may be considered by a Hearing Tribunal to be unprofessional conduct under the *Health Professions Act*. After making a finding of unprofessional conduct, a Hearing Tribunal can impose a range of sanctions including suspensions and cancellation of registration and practice permit.

Who is considered to be a "patient"?

The Sexual Abuse and Sexual Misconduct provisions in the *Health Professions Act* apply to "patients". For the purposes of this standard of practice, an individual is a regulated member's "patient" in two circumstances:

1. When a regulated member-patient relationship has been formed and has not ended.
2. When a regulated member engages in the type of sexual acts described in the definition of "Sexual Abuse" with a "former patient" within 1 year from the date the individual ceased to be the regulated member's patient.

An individual becomes a patient when a regulated member-patient relationship is formed. This type of relationship is formed when there is a reasonable expectation that care will extend beyond a single encounter and the regulated member has engaged in one or more of the following activities:

1. Gathered clinical information to assess a person;

2. Provided a diagnosis;
3. Provided medical advice or treatment;
4. Provided counselling to the patient.
5. Created a patient file for the patient.
6. Billed for medical services provided to the patient.
7. Prescribed a drug for which a prescription is needed to the patient.

A regulated member who engages in the type of sexual acts described in the definition of "Sexual Abuse" with a patient commits Sexual Abuse.

Sexual Conduct after the End of the Regulated Member-Patient Relationship

For the purposes of the sexual abuse provisions in the *Health Professions Act,* an individual may still be considered a "patient" after the date on which the individual ceased to be the regulated member's patient.

An individual is considered to be a "patient" for the purposes of the Sexual Abuse provisions for a 1 year period after the date on which the individual ceased to be the regulated member's patient. As a result, a regulated member must not engage in the type of sexual acts described in the definition of "Sexual Abuse" with such an individual for a minimum of 1 year after the individual ceased to be the regulated member's patient. If a regulated member has any doubt as to whether or when a regulated member -patient relationship ended they may wish to seek advice from the CMPA or the CPSA.

Sexual conduct may still be considered to be inappropriate after the 1 year period has elapsed. Sexual conduct with a former patient is inappropriate if there is more than a minimal risk of a continuing power imbalance. A non-exhaustive list of factors in determining whether there is more than a minimal risk of a continuing power imbalance is as follows (in this list the patient is referred to as the "individual"):

1. Whether the individual understands the inherent power imbalance that typically exists in a regulated member-patient relationship.
2. Whether sufficient time has passed since the end of the regulated member -patient relationship, given the nature and extent of the regulated member -patient relationship.
3. The nature of the individual's clinical problems.
4. The type of medical care provided by the regulated member.
5. Whether the individual has confided close personal or sexual information to the regulated member.
6. The length and intensity of the former regulated member-patient relationship.
7. Whether this is a situation where there is a likelihood of transference.
8. The vulnerability of the individual including a consideration of whether the individual is a member of a vulnerable population such as, for example: those who have diminished capacity, those who are economically disadvantaged, those suffering from addictions and the homeless.
9. Whether the regulated member-patient relationship was established while the individual was a minor.

10. Whether there is a history of the regulated member prescribing to the patient drugs associated with substance use disorders or substance-related harms.

Sexual conduct with a former patient beyond the 1 year period that is considered inappropriate given all the circumstances is not considered to be Sexual Abuse. However, such conduct may be considered by a Hearing Tribunal to be unprofessional conduct under the *Health Professions Act*. After making a finding of unprofessional conduct, a Hearing Tribunal can impose a range of sanctions including suspensions and cancellation of registration and practice permit.

Any regulated member who engages in sexual conduct with a former patient after the 1 year period has elapsed runs a risk that the conduct will be considered inappropriate and unprofessional conduct. Regulated members with any doubt as to the propriety of their conduct may wish to seek advice from the CMPA or the CPSA.

Psychotherapeutic Treatment

A regulated member who has provided psychotherapeutic treatment to a patient must never engage in sexual conduct with the former patient regardless of the amount of time that has passed since the end of the regulated member-patient relationship. In other words, for the purposes of the Sexual Abuse provisions in the *Health Professions* Act, the individual is always considered to be a "patient" regardless of the amount of time that has lapsed since the end of the regulated member-patient relationship.

Episodic Care

For the purposes of the sexual abuse and sexual misconduct provisions, a regulated member-patient relationship is formed when a regulated member provides "Episodic Care" as defined in the Standard of Practice on "Episodic Care." However, the regulated member-patient relationship does not extend beyond the conclusion of the episodic care. The individual is considered a patient during the episodic care. Therefore, a regulated member who engages in the type of activity described in the definition of Sexual Abuse or Sexual Misconduct while providing episodic care will be considered to have committed Sexual Abuse or Sexual Misconduct, as the case may be.

Sexual conduct between a regulated member and a former patient after the completion of episodic care may still be considered to be inappropriate. This conduct is considered to be inappropriate if there is more than a minimal risk of a continuing power imbalance. A non-exhaustive list of factors in determining whether there is more than a minimal risk of a continuing power imbalance is set out in the section "Sexual Conduct after the End of the Regulated member-Patient Relationship."

Sexual conduct with a former patient after the conclusion of episodic care that is considered inappropriate given all the circumstances is not considered to be Sexual Abuse **even if it takes place within 1 year of providing episodic care.** However, such conduct may be considered by a Hearing Tribunal to be unprofessional conduct under the *Health Professions Act*. After making a finding of unprofessional conduct, a Hearing Tribunal can impose a range of sanctions including suspensions and cancellation of registration and practice permit.

The provisions of this Standard of Practice concerning episodic care are only for the purposes of defining who is a patient for the purposes of the sexual abuse and sexual misconduct provisions in the *Health Professions Act.* The provisions of this Standard of Practice do not diminish any ongoing professional responsibilities of the regulated member under the Episodic Care Standard of Practice.

Medical Treatment of Spouses, Adult Interdependent Partners and those in Pre-Existing Sexual Relationships

For the purposes of the sexual abuse provisions in the *Health Professions Act,* a person receiving medical treatment from a regulated member is not considered a patient if the regulated member is their spouse or adult interdependent partner or if they are in a pre-existing sexual relationship with the regulated member.

However, it is considered to be unprofessional conduct for a regulated member to provide medical treatment to a spouse, adult interdependent partner or person with whom they are in a pre-existing sexual relationship unless all the following conditions are met:

1. The treatment is limited to a “minor condition” or an “emergency”.
2. Another physician is not readily available or the individual receiving treatment could suffer harm from a delay in obtaining the services of another physician.

“Minor condition” is considered a non-urgent, non-serious condition that requires only short-term, routine care and is not likely to be an indication of, or lead to, a more serious condition requiring medical expertise.

An “emergency” is considered to exist when an individual is experiencing severe suffering or is at risk of sustaining serious bodily harm if medical intervention is not promptly provided.

After making a finding of unprofessional conduct, a Hearing Tribunal can impose a range of sanctions including suspensions and cancellation of registration and practice permit.

College of Physicians & Surgeons of Alberta

Submission to:	**Council**

Meeting Date:	Submitted by:		
28 Febraury 2019	David Kay		
Agenda Item Title:	Progress on Bill 21 Implementation Work Plan		
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) :	***Please refer to the attachments***
Background:	• Bill 21: *An Act to Protect Patients* was passed in the Legislative Assembly on Thursday, 8 November 2018 and Royal Assent occurred on Monday, 19 November 2018 • A CPSA implementation work plan is in place to guide the implementation next steps up to 1 April 2019. Council was briefed on the high-level work plan at its 28-29 November 2018 meeting. • Attached is a progress report on the more detailed work plan
Next Steps:	• College staff will continue to implement the required actions described in the implementaiton work plan

List of Attachments:

- Progress on Bill 21 Implementation Work Plan

Bill 21 Implementation Report Date: 13 February 2019

Implementation Checklist		Overall Completion Status			
Action	**Comments**	**Previous Period**	**Current Period**	**Delivery Risk Trend**	**Forecast Next Period**
Implementation Date					
Internal communication to College of implementation date. Sections listed in s. 28 come into effect 1 April 2019 with balance coming into effect on Royal Assent (19 November 2018).	• Email updates provided to College Leadership, Council and Registrants during the Bill's legislative consideration, November 2018 • Field Law implementation workshop held 5 December 2018 for College Leadership • COO convened department head work group to coordinate implementation activities, December 2018. Monthly meetings being held		G	⇨	G
Complaints Director					
Transition: Develop system to identify what complaints are processed under the HPA prior to Bill 21 and which are processed under the HPA with the Bill 21 amendments.	• Bill 21 compliance provisions under development by Professional Conduct department		G	⇨	G
Identification of sexual abuse and sexual misconduct complaints: develop system to identify these complaints since special processes apply.	• Bill 21 compliance provisions under development by Professional Conduct department		G	⇨	G
Informal resolution: amend informal resolution process to ensure do not use processes under s. 55(2)(a) and (b) for complaints of sexual abuse or sexual misconduct.	• Bill 21 compliance provisions under development by Professional Conduct department		G	⇨	G
Notification of status: develop system to diarize file and develop standard format for report letter every 60 days advising the complainant and investigated person of the status of investigation.	• Bill 21 compliance provisions under development by Professional Conduct department		G	⇨	G
Interview complainant: amend investigation procedures to always make reasonable efforts to interview complainant.	• Bill 21 compliance provisions under development by Professional Conduct department		G	⇨	G
Other interviewees: amend investigation procedures to ask complainant for names of other persons who might have information related to the investigation that the investigator may choose to interview.	• Bill 21 compliance provisions under development by Professional Conduct department		G	⇨	G

⇧ Delivery risk greater this period ⇨ Delivery Risk the same this period ⇩ Delivery Risk less this period

	Green – Project on track compared to anticipated time scales, benefits and overall business case.
	Amber – Change to project deliver by without overall change to timescales, benefits or business case.
	Red – Not on track to meet planned timescales and/or benefits and overall business case
●	Completed

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Action	**Comments**	**Previous Period**	**Current Period**	**Delivery Risk Trend**	**Forecast Next Period**
Interim conditions and suspensions: understand that orders under s. 65(1) may be made any time after complaint is made until Hearing Tribunal makes an order under s. 82.	• Bill 21 compliance provisions under development by Professional Conduct department		G	⇨	G
Drafting of allegations: after complaint is referred to a hearing, work with legal counsel to prepare allegations that specify whether member is charged with sexual abuse or sexual misconduct.	• Bill 21 compliance provisions under development by Professional Conduct department		G	⇨	G
Appeal to Court of Appeal: Amend appeal procedures to consider Council review panel decisions.	• Bill 21 compliance provisions under development by Professional Conduct department		G	⇨	G
Develop process to ensure Registrar advises CD of self-reporting by regulated member. Develop process to determine impact of information.	• Under development by Registration and Professional Conduct departments		G	⇨	G
Hearings Director					
Advising complainant of hearing: Amend hearing procedures to advise complainant at least 30 days before the hearing of the date, time, and location of the hearing.	• Hearings Director procedures updated overall and incorporate Bill 21 provisions		G	⇨	G
Recruitment of members to the Hearing Tribunal: develop communication for current members of the Hearing Tribunal to determine whether they wish to voluntarily disclose their gender identity.	• Definition of Gender Identity and best practice to canvass gender identity developed by Field Law • Hearings Director procedures updated overall and incorporates Bill 21 provisions • Current and future panel members to be canvassed for voluntary disclosure		G	⇨	
Composition of Hearing Tribunal: in cases of complaints of sexual abuse or sexual misconduct, make every reasonable effort to ensure at least one member of the Hearing Tribunal is same "gender identity" as patient.	• Hearings Director procedures updated overall and incorporate Bill 21 provisions		G	⇨	G
Identification of "gender identity" of patient: Understand the meaning of "gender identity" and develop processes to identify the gender identity of patient.	• Definition of Gender Identity and best practice to canvass gender identity developed by Field Law • Bill 21 compliance provisions under development by Professional Conduct department		G	⇨	G
Hearing Tribunal Member Selection: Where subject matter of hearing relates to a complaint alleging sexual abuse or sexual misconduct, make every reasonable	• Hearings Director procedures updated overall and incorporate Bill 21 provisions • Field Law workshop covering Trauma Informed Practice, Key Requirements Established in HPA when Adjudicating Complaints Relating to Sexual Abuse/Sexual Misconduct, Key Legal Principles that Hearing Tribunals Must Understand When Adjudicating Complaints Relating to Sexual Abuse/Sexual		G	⇨	G

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effort to ensure that all members of Hearing Tribunal have had training on "trauma informed practice and sexual violence" and any other training specified by Minister before hearing case involving allegations of sexual abuse or sexual misconduct.	Misconduct, held 8 and 9 February 2019. CRC, HT and Council Appeals Committee members invited, and many attended. These trained panel members to be used for tribunals. Additional workshops to be held as required. On-line content to be available via Albert Federation of Regulated Health Professions (AFRHP) by Dec. 2019. • Hearings Director has obtained list of public members trained in trauma informed practice and sexual violence				
Amend Steps and Procedures for Hearing Tribunals					
Immediate suspension required if finding of sexual abuse.	• Hearings Director procedures updated overall and incorporate Bill 21 provisions • Panel chair guidance instruction sheets and template decisions updated overall and incorporate Bill 21 provisions		G	⇨	G
Victim impact statement- opportunity must be provided to patient if finding of sexual abuse or sexual misconduct.	• Hearings Director procedures updated overall and incorporate Bill 21 provisions • Panel chair guidance instruction sheets updated overall and incorporate Bill 21 provisions		G	⇨	G
Mandatory sanctions.	• Hearings Director procedures updated overall and incorporate Bill 21 provisions • Panel chair guidance instruction sheets and template decisions updated overall and incorporate Bill 21 provisions		G	⇨	G
No gender-based conditions if finding of sexual misconduct.	• Hearings Director procedures updated overall and incorporate Bill 21 provisions • Panel chair guidance instruction sheets and template decisions updated overall and incorporate Bill 21 provisions		G	⇨	G
Standards of Practice					
Review current Standards of Practice to determine whether current Standards address anything addressed by Bill 21, and if so whether revisions are required.	• Completed		●		
Determine process to be used to develop new Standards of Practice.	• Completed		●		
Develop new Standards of Practice to address: • Who is considered to be a patient • When a sexual relationship between a regulated member and a former member can occur	• Completed with assistance of Field Law		●		

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• When a person who is a spouse or in an interdependent adult relationship can also be a patient.					
Provide Standards of Practice to members for consultation. Review and consider feedback and make necessary amendments.	• Completed		●		
Consider whether consultation with others is desirable.	• Completed		●		
Provide Standards of Practice to Minister. Review and consider feedback and make necessary amendments.	• SOP approved by Council on 21 Dec 2018 • Council to consider feedback and revised SOP at 28 Feb 2019 meeting		G	⇩	G
Council must adopt Standards of Practice.	• Council to consider feedback and revised SOP at 28 Feb 2019 meeting		G	⇩	G
Submit Standards of Practice to Minister for final approval in accordance with timelines established by the Minister.	• Revised SOP to be provided to Minister after 28 Feb-1 Mar 2019 Council meeting		G	⇩	G
Make Standards of Practice available on website.	• To occur after Ministerial approval (est. 18 Mar 2019)		G	⇩	G
Registration and Reinstatement					
Amend applications for registration to include information required by Bill s. 5.	• The Criminal Records Check have been included and the details on process and requirements will be going to Council for review at 28 Feb 2019 meeting, Updated application questions have been drafted and will be reviewed by CPSA Leadership prior to implementation		G	⇨	G
Develop processes to assess the impact of this additional information.	• Bill 21 compliance provisions under development by Registration department		G	⇨	G
Develop processes to address requests by regulated member to correct information on public register.	• Bill 21 compliance provisions under development by Registration department		G	⇨	G
Amend steps and procedures to address ineligibility to apply for reinstatement and timing of applications for reinstatement.	• Bill 21 compliance provisions under development by Registration department		G	⇨	G
Develop processes to be followed when information is obtained that indicates that member was found guilty of sexual abuse or sexual misconduct by another regulator in Alberta or in another jurisdiction.	• Draft procedure developed and under Registrar review. See comments under Complaints Director		G	⇨	G
Renewal					

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Given the self-reporting obligation in Bill s. 9, consider whether College wishes to also ask about these issues during applications for renewal of practice permit.	• Bill 21 compliance provisions under development by Registration department Updated renewal will be reviewed prior to annual renewal		G	⇨	G
Website					
Audit College website to determine what information will need to be added at the appropriate time to comply with Bill s. 26 and what information is currently on the website that is not identified in section 26 so can pass Bylaw authorizing.	• Web site audit to be completed by Hearings Director mid-March 2019		G	⇨	
Determine if Hearing Tribunal decisions are already posted on website. If so, obtain legal advice on issue.	• Completed		●		
Review current publication policy to see whether it complies with Bill 21. If college does not have a publication policy, consider developing policy.	• Proposed bylaw developed by Field Law. •		G	⇨	G
Bylaws					
Pass Bylaws respecting additional information to be published on website.	• Council to consider proposed bylaw at 1 Mar 2019 meeting (Sec 47. Publication, PART 4 – COMMUNICATION WITH THE PUBLIC, Section A – General)		G	⇨	G
Communication to Employers					
Consider communication plan for employers advising of at least: • Obligation to provide notification under s.57 HPA "as soon as reasonably possible." • Obligation to report sexual abuse and sexual misconduct under s. 57(1.1).	• Guidance document being document with Field Law, COO and Complaints Director • Harmonized messaging may be developed via AFRHP		G	⇨	G
Communication to Members					
Substance of Bill 21.	• Bill 21 communications strategy developed and being implemented by Communications department • 2nd member video under development		G	⇨	G
Mandatory self-reporting under Bill s. 22.	• Advice to the Profession under development • Bill 21 communications strategy developed and being implemented by Communications department		G	⇨	G

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Mandatory reporting of other regulated members under Bill s. 22. Need to include education about meaning of terms "sexual abuse" and "sexual misconduct".	• Advice to the Profession under development • Bill 21 communications strategy developed and being implemented by Communications department		G	⇨	G
Develop Patient Relations Program					
Educational requirements for regulated members.	• UofC CME & CPD office program committee established. Program elements being scoped. • Initial video to be completed for 31 Mar 2019		G	⇨	G
Educational guidelines for conduct of regulated members towards patients.	• Bill 21 communications strategy developed and being implemented by Communications department • 2nd member video under development		G	⇨	G
Training requirements- staff, Council, HT and CRC members (both regulated members and public).	• Sexual Assault Centre of Edmonton (SACE) workshops for staff (Professional Conduct & Hearings Director office) scheduled for 11 & 26 March 2019 • Field Law session (described above) held for CRC, HT & Council members, 8 & 9 Feb 2019. Additional sessions to be held as required.		G	⇨	G
Develop publicly available information on College's complaint process.	• Harmonized material being developed by AFRHP working group chaired by COO		G	⇨	G
Develop information on appropriate resources to refer individuals to.	• Harmonized material being developed by AFRHP working group chaired by COO		G	⇨	G
Develop funding program for treatment and counselling in accordance with Regulations.	• Treatment & Counselling Fund framework being developed by AFRHP working group chaired by COO		G	⇨	G
Other functions as set out in Regulations.	• Regulations will not be available before 1 April 2019		G	⇧	G
Summary of Training Required					
Consider education for CD, prosecuting counsel, and independent counsel.	• Bill 21 compliance provisions under development by Professional Conduct department • ILC compliant		G	⇨	G
Hearing Tribunal Training: • Provisions relating to the substance of the sexual abuse and sexual misconduct provisions in Bill 21 including: • Definitions of sexual abuse and sexual misconduct. • Immediate suspension required if finding by HT of sexual abuse.	• Field Law workshop covering Trauma Informed Practice, Key Requirements Established in HPA when Adjudicating Complaints Relating to Sexual Abuse/Sexual Misconduct, Key Legal Principles that Hearing Tribunals Must Understand When Adjudicating Complaints Relating to Sexual Abuse/Sexual Misconduct, held 8 and 9 February 2019. CRC, HT and Council Appeals Committee members invited, and many attended. These trained panel members to be used for tribunals. Additional workshops to be held as required. On-line content to be available via Albert Federation of Regulated Health Professions (AFRHP) by Dec. 2019. • General adjudicator training underway. CRC, HT & Council Review Panel orientation guides updated. On-line adjudicator modules mounted to SharePoint site. Handout material being updated. To be available by 31 March 2019		G G	⇨ ⇨	G G

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• Mandatory sanctions for sexual abuse and sexual misconduct. Other provisions that are relevant in context of a complaint about sexual abuse/sexual misconduct, including: • Assessing credibility; • Admissibility of evidence about sexual reputation or sexual history; • Admissibility of similar fact evidence; • Applications for production of third party records; • Information that can be included in victim impact statement. • Where subject matter of hearing relates to a complaint alleging sexual abuse or sexual misconduct, make every reasonable effort to provide training to members of Hearing Tribunal on "trauma informed practice and sexual violence" and any other training specified by Minister.	• Field Law webinar on Tips & Traps for Hearing Tribunal Members available 19 March 2019. Panel members – registrant and public - invited to participate				
College Staff- training required under Patient Relations Program.	• See above		G	⇨	G
Council-training required under Patient Relations Program.	• See above		G	⇨	G
Regulated members sitting on Hearing Tribunals and CRC's- training required under Patient Relations Program.	• See above		G	⇨	G
Public members sitting on Hearing Tribunals and CRC's- training required under Patient Relations Program.	• See above		G	⇨	G
College Communications- Report to Minister					
Include information on sexual abuse and sexual misconduct complaints in annual report to the Minister.	• To be included by Communication department		G	⇨	G

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Council to provide report on Patient Relations Programs.	• To be included by Communication department		G	⇨	G
Other					
Reflect and determine what additional implementation steps College needs to take.	• As required. COO & department head work group to assess		G	⇨	G

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College of Physicians & Surgeons of Alberta

Submision to:	**Council**

Meeting Date:	Submitted by:		
28 February 2019	Dr. Susan Ulan		
Agenda Item Title:	Request for feedback from Council regarding Criminal Record Checks		
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 :	**It is recommended that *Council accept the following policy documents:*** ***1. Criminal Record Check Policy; and*** ***2. Assessing Criminal Record Check Information Policy***		
Background:	The *Health Professions Act* was amended by Bill 21: *An Act to Protect Patients* on November 19, 2018 and all applicants applying for registration must now provide criminal record checks (CRC) as part of the application for registration, effective **November 20, 2018**. Currently, an application for registration will not be considered complete until the CPSA has received a criminal record check for every jurisdiction in which the applicant has ever held any form of registration, license or practice permit. A final decision on the application for registration will not be made until the CRCs have been received in order to comply with the legislation. We have conducted surveys of other Canadian medical regulators, other Alberta health profession regulators, Alberta Health Services and consulted with Field Law to draft policies that are informed by the environmental scan. The *Criminal Record Check Policy* has been drafted and your feedback is requested on the following: 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? 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? 3. At periodic intervals such as every 3 to 5 years once in independent practice?		

College of Physicians & Surgeons of Alberta

	When the CRC comes back not clear, the *Assessing Criminal Record Check Information Policy* has been drafted to outline the factors to be considered prior to making a decision on the outcome of the application for registration or renewal. The applicant or regulated member will be informed of the CRC findings and have an opportunity to respond and provide additional information to be considered. The *Assessing Criminal Record Check Information – Procedure List* provides Council with the operational steps that will be taken prior to making a decision on the outcome.
Next Steps:	1. Implement policies. 2. Continue to engage with stakeholders regarding the implications of the policy and align processes. 3. Evaluate the CRC policies and procedures in 3 years and bring back results and any recommended policy changes to Council at that time.
List of Attachments:	
1. *Criminal Record Checks Policy* 2. *Assessing Criminal Record Check Policy* 3. *Assessing Criminal Record Check Information Procedure*	

College of Physicians & Surgeons of Alberta

Administrative Policy

Good Medical Practice – it's what we're all about

Policy Title	Criminal Record Check. Version
Date Revised	
Date of next Review	

1 POLICY STATEMENT

The *Health Professions Act* (*HPA*) Section 28(1)(h) requires that an application for registration is not complete for the purpose of consideration unless it includes a criminal record check.

For the purposes of this Policy, a criminal record check must include information as to whether an individual is currently charged with a criminal offence and has ever been convicted of a criminal offence. A criminal record check will be considered valid for a period of one year from the date on which it is issued.

The Registrar will require a valid criminal record check from:

- All applicants when they apply for registration with the CPSA; and
- All regulated members when they apply for a change in their registration category and prior to transfer from independent practice on the Provisional Register to the General Register.

A criminal record check may be provided to the CPSA directly from the source, the applicant or regulated member or a third party that is satisfactory to the Registrar.

When an applicant or regulated member is required to provide a criminal record check, they must:

- Provide a valid criminal record check from within Canada if they have resided in Canada for over 90 days; and

- Provide a valid criminal record check from any jurisdiction outside of Canada where they resided for over 90 days within the last 10 years.

If an applicant or regulated member is, for exceptional reasons that are satisfactory to the Registrar, unable to provide a valid criminal record check in its usual form from a jurisdiction other than Canada or the United States, the Registrar may require other evidence from the applicant or regulated member, which may include an affidavit attesting to the fact that the applicant or regulated member is not currently charged with a criminal offence and has not pled guilty to or been found guilty of a criminal offence. The Registrar may also require the applicant or regulated member to provide criminal record checks on a periodic basis as a condition of their registration.

The results of any criminal record check will be assessed in accordance with the *Assessing Criminal Record Check Information Policy*.

If an applicant or regulated member provides a false or inaccurate criminal record check or other false or inaccurate information related to a criminal record check, this may be used to determine that they lack good character and reputation and/or may be referred to Professional Conduct as evidence that they have engaged in unprofessional conduct.

2 PURPOSE

The *Criminal Record Check Policy* is guided by the principles of transparency and fairness. The CPSA's objectives when requiring applicants and regulated members to provide criminal record checks are to maintain the public's confidence in the integrity of the profession and protect the public by ensuring that all regulated members of the CPSA have good character and reputation.

3 SCOPE

This policy applies to all applicants and regulated members.

4 RESPONSIBILITIES

The Registrar is accountable for ensuring compliance with this policy and responsible for the review of the policy and supporting documents at least every three years:

(a) unless otherwise required by legislation; or

(b) at the Registrar's discretion to review more frequently as required.

5 APPROVAL

This policy requires approval by Council.

6 AUTHORITY DOCUMENTS (Hyperlink documents for access)

Health Professions Act (*HPA*) Section 28(1)(h), Section 28(1)(e)
Physicians, Surgeons and Osteopaths Profession Regulation Section 12

7 SUPPORTING DOCUMENTS

Criminal Record Check Procedure.

8 DOCUMENT HISTORY

VERSION NO.	Version Date	DESCRIPTION OF CHANGE
1	_____	Initial
APPROVAL	DATE	Signature

College of Physicians & Surgeons of Alberta

Administrative Policy

Good Medical Practice – it's what we're all about

Policy Title	Assessing Criminal Record Check Information. Version
Date Revised	
Date of next Review	

1 POLICY STATEMENT

The *Health Professions Act* (*HPA*) Section 28(1)(h) requires that an application for registration is not complete for the purpose of consideration unless it includes a criminal record check. Pursuant to *HPA* Section 28(1)(e) and the *Physicians, Surgeons and Osteopaths Profession Regulation* Section 12, an applicant for registration as a regulated member in any category must also provide evidence of having good character and reputation. The results of an applicant's or a regulated member's criminal record check may be considered in the determination of whether the person has good character and reputation.

In deciding whether information relating to an applicant's or regulated member's criminal record check is indicative of the person's good character and reputation, the Registrar may request additional information from the applicant or regulated member as well as other sources with consent.

In considering the results of the criminal record check and any additional information provided, the following factors, which are listed in no particular order, are or may be relevant:

- The nature and gravity of the offence and the facts giving rise to the offence;
- The relevance of the offence to the profession;
- The public's perception of the applicant or regulated member, the offence and the profession if the application for registration is not refused or the regulated member is permitted to remain registered;

- The period of time since the applicant or regulated member committed the offence;
- Whether a finding of guilt or a conviction was recorded for the offence;
- Whether the charge is still pending;
- The sentence imposed for the offence;
- The age of the applicant or regulated member at the time they committed the offence;
- Whether the conduct that constituted the offence or to which the charge relates has been decriminalized since the applicant or regulated member committed the offence;
- The applicant or regulated member's behaviour since they committed the offence and whether the individual has demonstrated that they have been rehabilitated;
- The likelihood of future threat to a patient of the applicant or regulated member or any member of the public;
- Any information given by the applicant or regulated member; and/or
- Any other matter that the Registrar considers relevant.

Based on the Registrar's assessment of the factors, the Registrar may make the following decision:

For applicants:

- Approve the application for registration;
- Approve the application subject to conditions; or
- Refuse the application.

For regulated members:

- Approve the application for renewal or a change in registration category and/or continued registration;
- Approve the application and/or continued registration subject to conditions; or
- Cancel registration and practice permit.

A decision to approve any application subject to conditions or refuse any application will not be made without the applicant or regulated member first being informed of this possibility and provided with an opportunity to respond.

If the Registrar approves any application subject to conditions, the conditions imposed may include but are not limited: supervised practice, restrictions on the applicant's or regulated member's practice and obtaining additional references.

The Registrar's authority to make assessments regarding good character and reputation may be delegated pursuant to the HPA. Accordingly, references in this Policy to the Registrar also include any person to whom the Registrar has delegated their authority.

2 PURPOSE

The *Assessing Criminal Record Check Information Policy* is guided by the principles of transparency and fairness. The CPSA's objectives when considering the results of an applicant or regulated member's criminal record check and any other related information are to maintain the public's confidence in the integrity of the profession and protect the public by ensuring that all regulated members of the CPSA have good character and reputation. The objective is not to punish applicants or regulated members for crimes that they have committed.

3 SCOPE

This policy applies to all applicants for registration including changes in registration category and upon request by the Registrar.

4 RESPONSIBILITIES

The Registrar is accountable for ensuring compliance with this policy and responsible for the review of the policy and supporting documents at least every three years:

(a) unless otherwise required by legislation; or

(b) at the Registrar's discretion to review more frequently as required.

5 APPROVAL

This policy requires approval by Council.

6 AUTHORITY DOCUMENTS (Hyperlink documents for access)

Health Professions Act (*HPA*) Section 28(1)(h), Section 30
Physicians, Surgeons and Osteopaths Profession Regulation Section 12

7 SUPPORTING DOCUMENTS

Assessing Criminal Record Check Information Procedure.

8 DOCUMENT HISTORY

VERSION NO.	Version Date	DESCRIPTION OF CHANGE
1	_____	Initial
APPROVAL	DATE	Signature

College of Physicians & Surgeons of Alberta

PROCEDURE MANUALS:
-_____

Assessing Criminal Record Check Information – Procedure List

1. Registrar receives the results of the criminal record check as part of an applicant's or regulated member's application for registration, renewal or change in registration category or at any other time when the regulated member has been required to provide the criminal record check.
    a. If the results are clear, no further action is required and registration process will proceed normally.
    b. If the results of the criminal record check are not clear, Registrar to consider whether application is complete.
2. Registrar conducts a preliminary assessment of the factors listed in the *Assessing Criminal Record Check Information Policy*:

The nature and gravity of the offence and the facts giving rise to the offence
The more serious the offence, the more weight the Registrar will assign to it. • *Is the offence a criminal offence or a provincial statute offence?* • *Was there a "victim"? How old was the victim? Was the victim known to the applicant or regulated member?* • *Was anyone injured as a result of the offence?* • *Was it a violent crime (e.g. assault)?* • *Was it a crime relating to integrity and honesty (e.g. fraud)?* • *Is the offence particularly relevant or related to the profession?* • *Did the court issue a written decision concerning the offence?* • *Is there a transcript from the trial?* • *Are there other materials relating to the trial, such as disclosure from the Crown or victim impact statements?*
The relevance of the offence to the profession
The more related the offence is to the profession, the more weight the Registrar will assign to it. • *Is the offence itself particularly relevant or related to the profession?* • *Are the facts giving rise to the offence particularly relevant or related to the profession?*
The public's perception of the applicant or regulated member, the offence and the profession if the application for registration is not refused
The public's confidence in the integrity of the profession must be maintained. • *Was the offence reported on in the media?* • *Is the applicant or regulated member's name and offence widely known?*

- *What will the public think if the applicant becomes a member of the profession or is allowed to continue as a regulated member?*

The period of time since the applicant or regulated member committed the offence

The Registrar will generally place greater weight on more recent offences.

- *What year did the offence occur?*
- *How many years have passed since the offence occurred?*

Whether a finding of guilt or a conviction was recorded for the offence

In considering the relevance of the information, the Registrar is to have regard to the type of information provided. The following types of information are to be considered, in descending order of relevance.

- *An applicant or regulated member may have been **convicted** of an offence. This means that they pled or were found guilty of the offence, received a conviction, and then received a sentence for the offence other than an absolute or conditional discharge.*
- *An applicant or regulated member may have **pled or been found guilty** of an offence, but then received an absolute or conditional discharge for the offence. In this case, the person will not have been convicted of the offence. Absolute or conditional discharges are granted if the court considers a discharge to be in the best interests of the person and not contrary to the public interest.*
- ***Non-conviction charges** are charges that have been resolved but that did not result in a conviction and/or finding of guilt. This includes charges that have been dismissed, withdrawn and stayed. They also include charges for which the person was found to be not criminally responsible. This is another area where it will be extremely important for the Registrar to gather more information about the charge and the circumstances giving rise to the non-conviction.*

Whether the charge is still pending

If the charges against the applicant or regulated member are still pending, this means that they have not yet been convicted or found guilty. The weight that can be placed on a pending charge is significantly less than the weight that can be placed on a conviction or finding of guilt. If a charge is pending, the same factors may still be relevant, but it will be extremely important for the Registrar to gather more information about the charge and the circumstances giving rise to the charge.

The sentence imposed for the offence

Possible sentences for offences may include: absolute/conditional discharges, fines, alternative measures, imprisonment for under two years and imprisonment for over two years. The weight the Registrar will give to sentence will generally increase as the significance of the sentence increases. The sentence imposed usually corresponds to the seriousness of the offence. However, this is not always the case. This is because various other factors are considered by the court when it comes to determining sentence.

- *Has the applicant or regulated regulated member finished serving their sentence?*
- *What factors did the court consider in determining sentence?*
- *What were the aggravating and mitigating circumstances?*
- *Did the court issue a written decision on sentence?*
- *Is there a transcript from the appearance concerning sentence or the court's decision on sentence?*

The age of the applicant or regulated member at the time the applicant committed the offence

The Registrar may place less weight on offences committed when the applicant or regulated member was younger, and particularly under 18 years old. This factor should be considered in connection with the period of time since the person committed the offence. Even if the applicant or regulated member was

relatively young when they committed the offence, this factor will carry less weight if the offence is also recent.

Whether the conduct that constituted the offence or to which the charge relates has been decriminalized since the applicant or regulated member committed the offence

The Registrar will generally place less weight on offences that have been decriminalized since the applicant or regulated member committed the offence. However, this factor will not often be relevant. In cases where it is relevant, it may or may not carry much weight. Even if the offence has since been decriminalized, it may still be significant that the person broke the law. That is, the very fact that the applicant or regulated member broke the law might reflect their good character and reputation.

The applicant or regulated member's behaviour since they committed the offence and whether the person has demonstrated that they have been rehabilitated

Indications that the offence was an aberration and evidence of good character or rehabilitation since the commission of the offence will tend to be a mitigating factor. However, indications that the offence is part of a pattern of behaviour will tend to have the opposite effect.

- *What were the applicant or regulated member's personal circumstances at the time they committed the offence?*
- *Have the applicant or regulated member's personal circumstances changed since then?*
- *How has the applicant or regulated member changed? What did they learn?*
- *Are there other individuals who can speak to changes in the person's character since the time of the offence?*

The likelihood of future threat to a patient of the applicant or regulated member or any member of the public

The Registrar will place significant weight on the likelihood of future threat to a patient of the applicant or regulated member.

- *Was there a "victim"? How old was the victim? Was the victim known to the applicant or regulated member?*
- *Was anyone injured as a result of the offence?*
- *Was it a violent crime (e.g. assault)?*
- *Is the offence particularly relevant or related to the profession?*

Any information given by the applicant or regulated member

Any information provided by the applicant or regulated member such as an explanation or mitigating factors will be reviewed by the Registrar and taken into account in considering the information.

- *What were the circumstances giving rise to the offence?*
- *What did you learn?*
- *What steps have you taken to rehabilitate yourself or make amends?*
- *Do you nevertheless meet the good character and reputation requirement? Why?*

Any other matter that the Registrar considers relevant

The Registrar may take into account any other matter that it considers relevant to any application or renewal of registration and practice permit.

- *Are or were there reports about the offence in the media?*

3. Based on preliminary assessment of the factors, Registrar decides whether results of criminal record check raise concerns about applicant or regulated member's good character and reputation.
    a. If no concerns are raised, applicant or regulated member will be deemed to meet good character and reputation requirement absent any other concerns.
    b. If concerns are raised, the applicant or regulated member will be provided with the results of the criminal record check and provided with an opportunity to respond.
4. If concerns are raised, the Registrar's letter to the applicant or regulated member will include:
    a. summary of results of criminal record check;
    b. reference to and copy of *Assessing Criminal Record Check Information Policy*;
    c. statement that results of criminal record check and related information may be used to determine whether applicant or regulated member meets good character and reputation requirement for registration;
    d. statement that possible outcomes include approval, approval subject to conditions and refusal;
    e. request for additional information. Additional information requested to be determined in accordance with factors as outlined above. However, in all cases, letter should request at least the following:
        i. What were the circumstances giving rise to the offence?
        ii. Do you nevertheless meet the good character and reputation requirement? Why?
        iii. Please provide any other information that you feel is relevant;
    f. statement that failure to provide information requested may lead to refusal of application; and
    g. request for information, documents and/or responses to be provided.
5. After additional information is received, Registrar to reassess factors listed in the policy and decide whether applicant or regulated member has established their good character and reputation.
    a. If Registrar intends to rely on information received from a source other than the applicant or regulated member and of which person is unaware, Registrar to provide that information to applicant or regulated member and provide the person further opportunity to respond to that information.
    b. If decision to approve application or to renew registration and practice permit subject to conditions, Registrar to decide what conditions are appropriate with reference to factors listed in the policy. Conditions imposed may include but are not limited to supervised practice, restrictions on the applicant or regulated member's practice and obtaining additional references.
6. Registrar to advise applicant or regulated member of decision.
    a. If decision is to approve application or renewal of registration is subject to conditions or refuse application or renewal of registration, letter to applicant or regulated member to include:
        i. Reasons for decision, with reference to information considered and application of factors listed in policy;

ii. Statement that applicant or regulated member has right to review decision under sections 30 and 31 of *HPA*.

7. All reference in the Criminal Record Check – Procedure List to the Registrar should be interpreted to include any person to whom the Registrar has delegated their authority.

College of Physicians & Surgeons of Alberta

Submission to:	**Council**

Meeting Date:	Submitted by:		
28 February 2019	Dr. John Bradley		
Agenda Item Title:	Role of Council Members		
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) :	Not applicable		
Background:	One of the themes I have consistently heard from Council is the desire to participate in more high level, "blue sky" discussions. As well, there continues to be a lack of consensus regarding what is the role of a councillor? With this in mind, I would like to try something new. For 1 hour during our next Council meeting, I would propose having a discussion in order to stimulate debate and self-reflection, but not necessarily come forward with an "action item". With this in mind, I would like each of you to consider the following prior to the session: 1. What is the role of a councillor? 2. Who do we actually represent? 3. Besides protection of the public, what should be the motivation of our decisions and thought processes? 4. Do physician and public councillors have different roles and/ or allegiances? Obviously, any other insights you have would be welcomed. Finally, when you give feedback following the Council meeting, please specifically comment on the utility and/ or satisfaction of such an initiative.		
Next Steps:			
List of Attachments:			

College of Physicians & Surgeons of Alberta

Submission to:	**Council**

Meeting Date:	Submitted by:		
1 March 2019	Dr. Pauline Alakija		
Agenda Item Title:	Physician Member Elections		
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 Council Feedback and recommendations are 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 revise the Bylaws regarding Physician Member Elections so that only registered members who are in independent practice will be eligible to vote and/or run for Council:*** It is recommended that Section 12(1) be amended to read: 12(1) Only a physician, surgeon or osteopath registered as a regulated member on the General Register or the Provisional Register-Conditional Practice, and who is in good standing, may vote in an election. A new subsection 12(2) should be added to read: 12(2) Only a physician, surgeon or osteopath registered as a regulated member on the General Register or the Provisional Register-Conditional Practice, and who is in good standing, may be nominated or stand for election.
Background:	**Physician Member Elections:** **Eligible voters:** - Currently the bylaw states: Bylaws section 12 Entitlement to Vote - A regulated member on the General Register, the Provisional Register or the Limited Practice Register, (whether a physician, surgeon, osteopath or physician assistant), who is in good standing, may vote in an election. Web link to Bylaws -This recommendation would change this policy to only regulated members on the general register and the provisional register – Conditional Practice. For further details of these registers see attachment 1. **Eligibility to run for Council** -In 2018 two independent legal opinions were sought after members of the profession questioned why a Resident Physician would be able to run for Council.

College of Physicians & Surgeons of Alberta

	Legal Counsel indicated the Bylaws were not clear, thus they did not specifically exclude any registered member from running for Council. -This recommendation would clarify who is eligible to run for council to be only regulated members on the general register and the provisional register – Conditional Practice. For further details of these registers see attachment 1. **Rationale for Recommendation** Those that are elected to govern in the interest of the public, and who sit on appeal panels, should have a fulsome body of experience, including being independently accountable for their own practice. To create credibility of Council's decisions and its appeal decision it is important that regulated member Councillors are fully independent practitioners. **Other Jurisdictions** Medical regulators such as B.C. and Saskatchewan do not allow Resident Physicians to vote or run for Council. Ontario does allow Resident Physicians to vote and run for Council, however due to its strict bylaw requirement making Councillors commit to three years of meetings, no Resident Physicians have run for Council. Manitoba has one dedicated council position for a Resident Physician elected yearly. **Potential Pitfalls** - There will likely be push back and negative social media posts from registered members who are currently allowed to vote and now will not be eligible following this clarification, as it may be viewed as their right to vote is being taken away. - There maybe push back from some groups regarding being ineligible to run for Council, however it is likely to be less vocal as those members may not have known they were eligible. - The Governance Committee received a letter from the Professional Association of Resident Physicians of Alberta expressing their wish to have Resident Physicians eligible to run for Council and maintain observer status on Council. (see attachment)
Next Steps:	1. If Approved bylaws are updated. 2. Communicate to profession the eligibility requirements and rationale. 3. Incorporate new eligibility requirements for Council positions and voter list into the 2019 Council election.
List of Attachments:	
1. Registration Information 2. PARA Position Statement on CPSA Involvement 3. Alberta and Calgary MSA Statements	

Registration Information for Council

Register, Definition, Fees:

1. General Register - This register is for physicians who are responsible and accountable for their medical practice, **without supervision by another physician** or the College of Physicians & Surgeons of Alberta, and are the most responsible physician in the care of their patients. Currently there are approximately 10336 members on this register and pay full fees of $1960/yr.

2. Provisional Register Conditional Practice - This register is for physicians do not meet the criteria for the General Register, as they do not hold full Canadian certification. These members are responsible and accountable for their medical practice **without supervision by another physician** and are the most responsible physician in the care of their patients. Currently there are approximately 868 members on this register and pay full fees of $1960/yr.

3. Telemedicine Register - This register is for physicians located outside Alberta who are practicing telemedicine pertaining to patients in Alberta, who are licensed in home jurisdiction, and meet all criteria as the General Register. Currently there are approximately 9 members on this register and pay $1960/yr.

4. Provisional Register Post Graduate Training - This register is for physicians who are enrolled as a resident or fellow in a postgraduate training programme approved by the Registrar, who are not the most responsible physician in the care of patients, and whose practice of medicine is subject to the supervision of the Programme Director or designate. Currently there are approximately 1594 members on this register and pay a one-time fee of $400.

5. Limited Practice Register - This register is for physicians who have successfully completed the Clinical Assistant or Surgical Assistant orientation programme of Alberta Health Services, who are not the most responsible physician in the care of patients, and whose practice of medicine is limited (intra-operative surgical assist for Surgical Assistant) to assignment by Alberta Health Services and is subject to the supervision of the Programme Lead or designate. Currently there are 219 members on this register and pay $1960/yr.

The proposed bylaw change:

- **Regulated members on registers 1, 2 & 3 <u>would</u> be eligible to vote and run for Council.**
- **Regulated members on the registers under 4 & 5 would <u>not</u> be eligible to vote or run for Council.**

Note: The bylaw does not specifically mention Telemedicine however they are considered part of the General Register as they have the same qualifications.

Position Statement re: Resident Physician Involvement with the CPSA
February 2019

Background

Concern has been expressed by some members of the CPSA Council regarding the possibility of having a resident physician elected to the CPSA Council. It is felt that resident physicians already have a voice on the Council through the PARA Observer position.

The CPSA Governance Committee has requested PARA's position on the following:

> *Does PARA place greater value on the Observer position on the CPSA Council or on the ability for resident physicians to run for elected Council positions and potentially serve on the Council as elected members?*

Response

PARA's position is that any resident physician elected to CPSA Council and the PARA Observer on CPSA Council would perform separate and distinct roles.

1. Resident physicians elected to the CPSA Council

It is PARA's understanding that resident physicians, as regulated CPSA members, are treated no differently than any other regulated member according to the CPSA Bylaws. This holds true for both the privileges and the responsibilities of regulated members. Since the CPSA Bylaws allow regulated members the opportunity to run for Council, this same opportunity should be afforded to resident physicians.

Creating "tiers" of regulated membership – and singling out resident physicians specifically as a tier with reduced opportunities – sends a message to these members and diminishes their likelihood of engaging with the CPSA as they move further into their professional careers.

A resident physician who chooses to run for CPSA Council would be running as an individual CPSA regulated member. The same commitment and requirements for the position would apply to the resident physician as would apply to any regulated member. Through the CPSA election process, the CPSA membership determines the appropriate makeup of the Council.

Any resident physician choosing to run for CPSA Council would not be representing resident physicians. PARA would not endorse or provide support to any particular candidate (resident

…/2

Calgary Medical Students Association
Health Sciences Centre
Foothills Campus, University of Calgary
3330 Hospital Drive NW
Calgary, Alberta Canada T2N 4N1

February 25th, 2019

Council Members
College of Physicians and Surgeons of Alberta

The Calgary Medical Students' Association (CMSA) Council has recently been made aware of and are concerned a motion proposed for your March 1, 2019 meeting, which would disenfranchise resident physicians and prohibit them from running for CPSA Council positions. We oppose this change on the grounds that it would muffle the voices of important, front line Alberta doctors and therefore runs contrary to the best interests of Albertans. We have absolute respect for your Council and appreciate all you do to uphold the integrity of our profession, but as elected representatives for medical students studying at the University of Calgary, we do oppose this particular motion. Below is a statement passed by the CMSA Council, which represents our official position on the matter:

"As future physicians, the Calgary Medical Students' Association (CMSA) feels an obligation to advocate for the health, wellness and protection of Alberta's general public. The CMSA believes that the opportunity for Professional Association of Resident Physicians of Alberta (PARA) members to be elected to the College of Physicians and Surgeons of Alberta (CPSA) Council in addition to having PARA observer on the CPSA Council serve distinct and valuable roles. Therefore, having reviewed pages 194-198 of the CPSA Council Meeting Agenda for February 28th and March 1st, 2019, we, the CMSA Council support PARA in their Position Statement re: Resident Physician Involvement with the CPSA February 2019."

Sincerely,

Alex Corrigan,
President · Calgary Medical Students Association
University of Calgary Cumming School of Medicine
MD Program · Class of 2021
alex.corrigan1@ucalgary.ca · 403-969-2196

Medical Students' Association
Faculty of Medicine & Dentistry, University of Alberta

1-002 Katz Group Centre for Pharmacy and Health Research
Edmonton, Alberta, Canada T6G 2E1
Tel: (780) 492-7639

February 24th, 2019

Council Members
College of Physicians and Surgeons of Alberta

We have been asked by our CPSA Medical Student Observer, Ryan Chee, to address a motion proposed for your March 1, 2019 meeting which would amend the College's bylaws to prohibit Residents from voting and running for Council positions.

As medical students, we are often far removed from the day to day concerns of regulatory bodies such as the CPSA. However, we greatly appreciate the work you do to protect the public and guide our profession to ensure excellence in care. As future physicians we are cognizant of the integral role you play in our training and professional development.

We ask you to carefully consider the message sent by passing this amendment. This motion would completely disenfranchise your junior colleagues, and yet physicians at all levels of training abide by the regulations of the CPSA. If a new-to-practice family physician may vote, why not a third year general surgery resident? We recognize that one is fully independent and the other in training, but the regulations governing them are identical and each has opinions which should be heard. There will always be members with more experience to share, and new generations with valid concerns that must be voiced - both contribute to the betterment of the medical profession.

As a practical matter, *there is no mathematical possibility of a resident being a successful candidate unless supported by an overwhelming number of physician members.* Why then is it important to eliminate this remote possibility by prohibiting the democratic participation of one sector of the College? We encourage the College to consider alternate ways of addressing this issue, in particular options that work to foster collaboration with Residents rather than reinforcing the hierarchical nature of medicine.

In other provinces this dilemma has been solved without the need to take away the resident vote. With that in mind, I ask that you reflect on the stated values of the CPSA: *We do the right thing; we make informed choices; we empower people.*

Thank you for your work - we sincerely hope that you reconsider this proposed amendment.

Eleanor Crawford
President of the Medical Students' Association (MSA)
University of Alberta

physician or independently practicing physician). The individual would run like any other CPSA regulated member.

2. PARA Observer on the CPSA Council

In contrast to an individual running for Council, the PARA Observer represents all resident physicians in Alberta, providing the PARA/resident physician perspective on issues and during discussions. The Observer has the support of PARA and its resources to ensure that the CPSA understands the comprehensive perspective of postgraduate trainees.

Of primary significance, the PARA Observer plays a critical role in supporting the CPSA's mandate of protection of the public by providing the resident physician perspectives and experiences related to patient care in Alberta.

The Observer also provides the CPSA and the Council with a more complete understanding of how certain issues and decisions might impact those about to enter independent practice. As well, the position fosters collaborative relationships between trainees and independently licensed physicians, which positively impacts the profession. And the position provides for opportunities in leadership – a value of importance to both the CPSA and PARA.

PARA values both opportunities, as they are distinct and separate. Maintaining both opportunities will ensure that resident physicians, the CPSA and the profession are best served. Removing either of these opportunities may serve to diminish resident physician involvement in leadership roles as they move further into their professional careers, which will not best serve the profession or the people of Alberta.

Submitted by,

2018-2019 PARA Executive Board

College of Physicians & Surgeons of Alberta

Submission to:	**Council**

Meeting Date:	Submitted by:		
1 March 2019	Shawn Knight		
Agenda Item Title:	Bylaw Change to Formalize the position of Past President		
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 Council. Pre-meeting review is required on this matter.	☐ The attached is for information only. No action is required.

AGENDA ITEM DETAILS

Recommendation (if applicable) :	***It is recommended that Council formally recognize the past-president as a non-voting member of Council by amending section 1 of the Bylaws as follows:*** 1(2) Council may invite the regulated member 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. As well it is recommend the following provision be added in section 2 of the Bylaws as follows: 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.
Background:	**Formalizing the Role of Past President** -November 2018 Council meeting: MOTION (C45-18): That Council retain the past president role and that the duties of this role may include running the executive elections, new councillor orientation and retreat planning. -The Governance Committee is recommending the best manner to formalize the position of Past President in the bylaws for both the position and to ensure authority for expenses. -The Governance committee will formalize the roles and responsibilities of the Past President, as directed by Council, in the Governance Committee Terms of Reference.
Next Steps:	1. Amend the bylaw to include Past President 2. Amend the Governance Committee Terms of Reference to include the roles and responsibilities of the Past President 3. Bring Terms of Reference to May Council meeting for approval.

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Submission to:	**Council**

Meeting Date:	Submitted by:		
1 March 2019	David Kay		
Agenda Item Title:	**Bill 21 Compliance (Sec 47. Publication, PART 4 – COMMUNICATION WITH THE PUBLIC,** Section A – General)		
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 that the CPSA Bylaws be amended to revise section 47 as follows: Proposed Bylaw (see below)***		
Background:	• Bill 21: *An Act to Protect Patients* was passed in the Legislative Assembly on Thursday, 8 November 2018 and Royal Assent occurred on Monday, 19 November 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 • The proposed amendment was prepared by Field Law **Proposed Bylaw**: **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.		

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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 registration number,
      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,

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(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.

Current Bylaw to be Replaced:

47. Publication

1. The Registrar may publish or distribute information regarding:
   (a) Part 2 or Part 4 of the Act,
   (b) any condition imposed on a regulated member's practice permit under Part 2 or Part 4 of the Act,
   (c) any direction made pursuant to section 118(4) of the Act,
   (d) any order or direction made under Part 4, Division 4 and Division 5 of the Act, including the reasons and the testimony given before the hearing, except the part of the testimony that was given while the hearing was held in private.
2. For the purpose of section 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.
3. The Registrar shall consider the following factors in any decision regarding publication of information described section 119(1) of the Act:
   (a) the public interest, including transparency of the College's discipline process,
   (b) the education of regulated members, and

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	(c) any other factors that the Registrar considers relevant to the matter.
Next Steps:	• College staff will continue to implement the required actions described in the Bill 21 implementaton work plan
List of Attachments:	

College of Physicians & Surgeons of Alberta

Submission to:	**Council**

Meeting Date:	Submitted by:		
1 March 2019	Shawn Knight		
Agenda Item Title:	Annual Report Preview		
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:	• Under the *Health Professions Act (HPA)*, the College 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.
	  o We'll release a digital version of the annual report, called the "Report to Albertans" in early April.
	  o The legislated print report will be submitted to the Minister in June, along with the Report to Albertans, once we receive an auditor's report and deliver the final print preview to Council in May.
	• The print and digital report will contain the same content, but each will use different media to enhance how stakeholders absorb the information.		

Next Steps:	• Content preview to Council in early March • Report to Albertans preview & final Council approval in April. • Hardcopy report preview and approval in May Council before print and distribution in June		
List of Attachments: N/A			

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Submission to:	**Council**

Meeting Date:	Submitted by:		
1 March 2019	Dr. Jeremy Beach		
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) :	***Not applicable***		
Background:	Some years ago there was considerable discussion within Council on the topic of physician fatigue. A project was established under the guidance of Dr. Monica Wickland-Weller which made considerable progress. However, it became apparent that the CMA were also working on this topic. The understanding was that the CMA would be producing a policy on management of physician fatigue, as well as a tool box that could be used to help manage physician fatigue in everyday practice. As a consequence, in order not to unnecessarily duplicate work, the work being undertaken at the CPSA was paused pending the development of these documents. A CMA Policy on management of physician fatigue was published in 2014 (attachment 1). The 'tool box' however has not yet been released. Given the delay, a discussion was initiated within CPSA about re-starting the work on fatigue. At the same time, the CPSA was considering how to react to the legalisation of cannabis. One consideration for dealing with the potential impact of cannabis on physicians' fitness to practice was to focus on the problem in terms of impairment. The report by Dr. Maria Todor (attachment 2) a recent elective resident at the CPSA, discusses the feasibility of such an approach. This led to a recognition that 'impairment' might be used for physician fatigue as well as a number of other issues in physician health such as burnout, cognitive impairment, and the aging physician more generally. Notably, each of these is being considered as a priority issue for possible inclusion in the CPSA five year strategic action plan. Using impairment in this way is not new. As a concept, impairment is closely tied to capacity, or loss of capacity. Moving to such an approach would entail considerable work in terms of defining expectations of what would constitute relevant capacities, and the level of capacity needed, so that impairment could be		

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	recognised. Many parts of industry jobs have been defined in terms of capacities needed, and a worker can be assessed against these – a functional capacity evaluation (FCE). At present such evaluations are mostly linked to musculoskeletal demands and capacities. To an extent the definition of the relevant capacities is occurring through the adoption of competency based training. This process will develop 'entrustable professional activities' but it is unlikely these will cover all needs to define capacity. For example, intact cognitive function may be assumed rather than explicitly stated. Further, tools to effectively measure all relevant capacities are not currently available. While capacity is important in fitness to practice, it is not the only consideration. A widely used model of fitness for return to work includes the elements risk, capacity and tolerance. All of these would need to be incorporated into the process of assessing a physician's fitness to practice. At this point the College is looking to explore the utility of this approach in addressing a number of issues in physician health. It is potentially applicable to both the individual and populations, and there may be applications outside of health. PHMP is seeking feedback of Council on further developing this approach.
Next Steps:	
List of Attachments:	
1. CMA Policy on Fatigue 2. Report from Maria Todor	

ASSOCIATION MÉDICALE CANADIENNE | CANADIAN MEDICAL ASSOCIATION

CMA POLICY

MANAGEMENT OF PHYSICIAN FATIGUE

Background

Health systems around the world are struggling with how to best meet the health needs of their populations. Health leaders speak with urgency about the need to improve the individual experience of care, improve the health of populations, and maximize return on investments. Physicians concur - they are continually focused on providing better care to their patients.

Concurrently, concerns over patient safety have arisen over the last two decades, rooted in studies of adverse events. The incidence of adverse events (AEs) in acute care hospitals has been reported in the United States (US),[1,2,3] Australia,[4] United Kingdom,[5] and Canada.[6] Between 5% and 20% of patients admitted to hospital experience one or more AEs; between 36.9% - 51% of these AEs are preventable; and AEs contribute billions of dollars through additional hospital stays as well as other costs to the system, patients and the broader society.[7] Leape et al. maintain that more than two-thirds of AEs are preventable.[8] These outcomes have prompted decision makers, policy makers and healthcare providers to examine contributing factors, including the increasingly complex health system and its impact on the well-being of providers.

Patient safety and physician well-being are the key drivers leading to restrictions on resident and/or physician duty hours aimed at reducing their fatigue. The European Working Time Directive (EWTD) was first established in 1993 to place limits on all workers' hours throughout Europe under the umbrella of health and safety legislation. That directive included physicians but excluded doctors in training. In 2000, a new directive passed to include the "junior doctor" constituency accompanied by a requirement that by 2009 all health systems in the European Union limit resident work to a maximum of 48 hours averaged per week. The intention was to improve the working lives of doctors in training and to increase patient safety. A systematic review on the impact of the EWTD on postgraduate medical training, patient safety, or clinical outcomes found studies to be of poor quality with conflicting results.[9]

In 2003, the Accreditation Council for Graduate Medical Education (ACGME) in the US adopted a set of duty hour regulations for physicians in training. The ACGME issued revised regulations that went into effect in July 2011, reflecting the recommendations of a 2008 Institute of Medicine report *Resident Duty Hours: Enhancing Sleep, Supervision, and Safety*, calling for elimination of extended duty shifts (more than 16 hours) for first year residents, increasing days off, improving sleep hygiene by reducing night duty and providing more scheduled sleep breaks, and increasing oversight by more senior physicians.[10] The Institute of Medicine's report bases its recommendations on the growing body of research linking clinician fatigue and error.

Correspondence and requests for additional copies should be addressed to the Member Service Centre, Canadian Medical Association, 1867 Alta Vista Drive, Ottawa, ON K1G 5W8; tel 888 855-2555 or 613 731-8610 x2307; fax 613 236-8864.

All polices of the CMA are available electronically through CMA Online (www.cma.ca).

In 2013, the National Steering Committee on Resident Duty Hours released Canada's first comprehensive, collaborative and evidence-based report on fatigue and duty hours for Canada's approximately 12,000 residents. The Committee stresses that a comprehensive approach is necessary in order to enhance safety and wellness outcomes. Fatigue risk management is a predominant theme in the recommendations.

Fatigue management systems are in place in other sectors/industries that have a low threshold for adverse outcomes including aviation, transportation, and the Department of National Defence. In 2010, the Canadian Nurses Association released a position statement *Taking Action on Nurse Fatigue* that speaks to system, organizational and individual level responsibilities of registered nurses.

There are currently no specific policies in Canada for physicians in practice with respect to fatigue management. Given the heterogeneity of medical practice (i.e. various specialties) and of the practice settings (i.e. rural and remote versus urban, clinic versus hospital, etc.), the solutions emanating from a fatigue management policy may be different - one size will not fit all.

Impact of Physician Fatigue

Patient Safety

Sleep deprivation is the condition of not having enough sleep and can be either chronic or acute. It impairs cognitive and behavioural performance. "Sleep is required for the consolidation of learning and for the optimal performance of cognitive tasks. Studies of sleep deprivation have shown that one night without sleep negatively affects the performance of specific higher cognitive functions of the prefrontal cortex and can cause impairment in attention, memory, judgment, and problem solving."(p. 1841)[11] A seminal study by Williamson and Feyer found that after 17-19 hours without sleep, performance on some cognitive and motor performance tests was equivalent or worse than that at a blood alcohol concentration (BAC) of 0.05%.[12] Wakefulness for 24 hours is equivalent to a blood alcohol level of 0.10%.[13]

A chronic sleep-restricted state can cause fatigue, which is a subjective feeling of tiredness, lack of energy and motivation. A large body of research exists linking sleep deprivation/fatigue, performance and adverse patient outcomes, particularly for medical residents. [14,15,16,17,18,19, 20, 21,22, 23,24] However, literature on the impact on performance varies based on a number of factors. There are significant inter-individual differences in the global response to sleep loss, as well as significant intra-individual variations in the degree to which different domains of neurobehavioral function (e.g., vigilance, subjective sleepiness, and cognitive performance) are affected. Inter-individual differences are not merely a consequence of variations in sleep history. Rather, they involve trait-like differential vulnerability to impairment from sleep loss. [25]

Evidence suggests an inconclusive relationship between duty hour reductions (primarily those implemented in the US) and patient safety, suggesting that restrictions on consecutive duty hours have not had the anticipated impact on this crucial outcome as anticipated.[26] Several large studies have revealed only neutral or slightly improved patient mortality and other clinical parameters since implementation of the ACGME work hour limits in the US.[27,28, 29,30] In complex and ever changing health systems, it is difficult to isolate the impact of restricted duty hours alone.

Research on the effects of practicing physician sleep deprivation and extended work shifts on clinical outcomes is limited and inconclusive.[31, 32]

The issue of physician fatigue is complex, and is affected by much more than duty hours. Other contributing factors affect performance including work patterns, individual response to sleep loss, experience of the worker, the context of which sleep deprivation is necessary, hours of actual sleep, patient volume, patient turnover and patient acuity, environmental factors, personal stressors, workload, etc. Limiting work hours alone is not sufficient to address sleep deprivation among physicians. Reduced or disturbed periods of sleep, more consecutive days or nights of work, shift variability, and the volume of work all increase

fatigue and thus can contribute to errors.

One of the biggest concerns with a fatigue management strategy is continuity of care, linked to the number of transfers of care (handover) among providers. Transfers of care inevitably increase in an environment of work hour limitations.[33, 34] Handovers are considered critical moments in the continuity of patient care and have been identified as a significant source of hospital errors, often related to poor communication. There is a growing body of literature on how to do these well and how to teach this well. This is an important skill for physicians in the context of a fatigue management strategy: "Standardization of the handover process has been linked to a reduction in the number of errors related to information transfers. In addition, effective mechanisms for the transfer of information at transition points have been recognized as patient safety enablers."[35]

Provider Well-being

Provider well-being (physical, mental, occupational) is linked to system performance and patient outcomes. It is affected by fatigue and work patterns including night shift and extended hours. Comprehensive, systematic reviews of the health effects of on-call work in 2004 showed that nighttime work interrupted sleep patterns, aggravated underlying medical conditions, and increased the risk of cardiovascular, gastrointestinal, and reproductive dysfunction.[36,37.38] Other research suggests an elevated risk of breast cancer,[39,40] prostate cancer,[41] colorectal cancer,[42] asthma[43], diabetes,[44] and epilepsy[45] for shift workers. Disruption of the body's circadian rhythms is thought to be one of the main pathways for adverse health effects from shift work, particularly for work schedules that involve night work.

Given that 24-hour work is unavoidable in various industries, including healthcare, researchers have evaluated different shift schedules designed to reduce some of the negative health effects of working at night. Optimal shift schedules are aligned as much as possible with the circadian rhythm, promote adaptation of the circadian rhythm with shift work, reflect workers' needs and preferences, and meet organizational or productivity requirements. The following interventions appear to have the most beneficial effects on the health of shift workers:[46]

- Schedule changes including changing from backward (counterclockwise) to forward (clockwise) rotation, from eight hour to 12 hour shifts, and flexible working conditions, self-scheduling, and ergonomic shift scheduling principles
- Controlled exposure to light and day;
- Behavioural approaches such as physical activity, scheduled naps and education about sleep strategies; and
- Use of pharmacotherapy (i.e. caffeine and melatonin) to promote sleep, wakefulness, or adaptation

Sleep deprivation and on-call shifts consistently point to deterioration of mood resulting in depression, anger, anxiety, hostility, and decreased vigilance.[47 ,48, 49] A Canadian study found that shift workers reported significantly higher burnout, emotional exhaustion, job stress and psychosomatic health problems (e.g. headaches, upset stomach, difficulty falling asleep) than workers on a regular day schedule.[50] Prolonged duty hours by residents has been found to contribute to marital problems, pregnancy complications, depression, suicide and substance abuse,[51] as well as serious conflicts with attending physicians, other residents, and nurses, in addition to increased alcohol use and instances of unethical behaviour.[52] Surprisingly however, the abolishment of 24-hour continuous medical call duty for general surgery residents at one facility in Quebec was associated with self-reported poorer quality of life.[53]

In contrast to other recommendations on the health benefits of 8 hr shifts, the risk of a work safety incident increases markedly after more than eight hours on duty. The risk in the twelfth hour is almost double than in the eighth hour (and more than double the average risk over the first eight hours on duty).[54] Extended work duration and nighttime work by interns is associated with an

increased risk of reported percutaneous injuries (PIs).[55] Fatigue was reported more often as a contributing factor for nighttime compared with daytime injuries. Fatigue was also more commonly reported as a contributing factor to PIs that occurred after extended work than those that occurred after non-extended work.[56] Other research found that residents were most exposed to blood-borne pathogens through needle punctures or cuts during overnight duty periods.[57]

Health care facilities that have physicians working in them have a role in supporting and promoting provider well-being, including providing enablers of extending and continuing resiliency such as nutritious food, on call rooms, appropriate numbers of staff, locums, etc. They also have a role in working jointly and collaboratively with physicians to ensure that on-call schedules do not place work demands on individual physicians that prevent the physicians from providing safe patient care and service coverage. For example, research with emergency physicians suggests that a nap at 3 AM improves performance in physicians and nurses at 7:30 AM compared to a no-nap condition despite the fact that memory temporarily worsened immediately after the nap.[58]

Individual resilience, intergenerational differences, illness-related issues, as well as family commitments also need to be considered. Physicians should also be encouraged to take the necessary time to rest and recover on their time off. The obligation of physicians to provide after hour coverage and care is unavoidable and should be considered by an individual when they choose a career in medicine, and as a physician in managing their schedule/call.

A review of 100 studies from around the world indicates the culture of medicine contributes to doctors ignoring the warning signs of fatigue and stress and in many cases suffering from undiagnosed ailments such as stress and depression, or from burnout.[59] The authors suggest the culture of medicine is such that doctors feel they don't need help; they put their patients first. Of the 18% of Canadian doctors who were identified as depressed, only a quarter of them considered getting help and only two per cent actually did. The report suggests that burnout from working long hours and sleep deprivation because of understaffing seems to be the biggest problem worldwide.[60] The Canadian Medical Protective Association (CMPA) states that physicians should consider their level of fatigue and if they are clinically fit to provide treatment or care.[61] Fatigue is not a sign of weakness. All members of the health care team should support their colleagues in recognizing and managing sleep deprivation and fatigue.

Physician fatigue has several ethical dimensions. The Canadian Medical Association Code of Ethics states that physicians have an ethical responsibility to self-manage their fatigue and well-being. [62] However, physicians must be trained and competent to know their own limits and evaluate their own fatigue level and well-being. The system must then support physicians in this recognition. The doctrine of informed consent is another dimension of physician fatigue. If physician fatigue is an added risk for any aspect of patient care, whether it is surgical or medical, elective or emergent, then some have argued that the doctrine of informed consent suggests that physicians have an obligation to inform patients of that risk.[63,64] "The medico-legal considerations for physicians centre on the ethical duty to act in the best interests of their patients. This may mean that if a physician feels that his or her on-call schedule endangers or negatively impacts patient care, reasonable steps are taken to ensure patients do not suffer as a result and that the physician is able to continue providing an adequate level of care for patients."[65]

System Performance

Addressing physician fatigue may have workforce implications.

Physician workload is multifaceted comprised of clinical, research, education and administrative activities. If physician workload or duty hours are reduced, any one of these activities may be impacted.

It has been suggested that implementing fatigue

management strategies such as a workload ceiling for physicians may result in a greater need for physicians and thus increase system costs. However, new models of team based care delivery that incorporate technology, reduce redundancy, utilize a team based approach, and optimize the role of physicians offer an opportunity to better manage physician fatigue without necessarily requiring more physicians. Other strategies also need to be explored to improve the on-the-ground efficiency of physicians.

Some of the strategies to address practicing physician sleep deprivation/fatigue such as scheduling changes and reduced workload may affect access to care, including wait times. Surgeons or others may have to cancel surgeries or other procedures because of fatigue and hours of work, forcing rescheduling of surgery/procedures and potentially increasing wait times. This is particularly relevant given Canada's large geography and varied distribution of physicians. Therefore, flexibility in strategies to address physician sleep deprivation/fatigue are needed to reflect the variety of practice types and settings in existence across the country, in particular solo practices; rural, remote and isolated sites; community locations; etc. The same holds true for smaller specialties, which has been the experience in the UK with the implementation of the EWTD.

Fatigue management is a competency that needs to be taught, modelled, mentored, and evaluated across the medical education continuum, from medical student to practicing physician.

Recommendations

1. Educate physicians about the effects of sleep deprivation and fatigue on the practice of medicine and physician health, and how to recognize and manage their effects.
2. Create a national tool-box of self-awareness tools and fatigue management strategies and techniques.
3. Advocate for the integration of fatigue management into the continuum of medical education.
4. Advocate for the creation of system enablers with the flexibility to:
   - Consider the full workload of physicians (clinical, teaching, administrative, research, etc.);
   - Optimize scheduling to coordinate on call and other patient care following call; and
   - Implement organizational/institutional level fatigue risk management plans.
5. Develop and advocate for implementation of standardized handover tools.
6. Enhance and reaffirm a culture within medicine that focuses on patient-centered care.
7. Reaffirm the culture shift within medicine that encompasses physician well-being.
8. Encourage physicians treating physicians to be aware of the aggravating effects of fatigue on their well-being and practice.

Conclusion

Physicians are interested in how to best meet the needs of the population, in continually improving the care provided to Canadians. To do so requires that they also care for themselves including managing the effects of sleep deprivation and fatigue. It is a complex issue that requires multifaceted solutions. Strategies must address physician fatigue at an individual, organizational/institutional and system level.

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Briefing Note: Preventing Physician Recreational Cannabis Use and Impairment

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Issue

On October 17, 2018, Government of Canada introduced the Cannabis Act (bill C-45) to legalize, regulate, and restrict access to cannabis for non-medical purposes. Bill C-45 allows adults to legally possess, consume, grow and purchase non-medical cannabis. The legalization of recreational cannabis inevitably creates concerns regarding the possibility that cannabis might impair workplace performance and safety. Results from the 2018 Canadian Cannabis Survey released on November 2018 indicate that 22% of adults used cannabis in the past 12 months and 64% of these had not used cannabis to get "high" before or at work in the past 12 months. Fifteen percent (15%) of individuals reported using cannabis before or at work rarely (less than once a month), and 8% used cannabis before or at work weekly or more often. Most individuals (90%) indicated they did not miss work as a result of their recreational cannabis use. Physicians and medical students are by no means exempt from inappropriate substance use or abuse; they abuse drugs, both controlled substances and illicit drugs, at similar rates to the general population (Dumitrescu et. al. 2014). Considering the degree of responsibility entrusted in physicians, this number among physicians is cause for concern. Legalization of recreational cannabis prompted employers, regulatory bodies and other stakeholders to address substance use in their workplace policies and practices considering that more individuals may use cannabis in a regulated market for adult use (Cerda et al. 2012) and the negative effects are ranging from acute physical and decision-making impairments to long-term cognitive deficits of user with impact on health and safety to the public (Spicer et al. 2003). This guidance document was developed to assist College of Physicians and Surgeons of Alberta (CPSA) in addressing physician impairment issues related to the use of cannabis. It summarizes current evidence regarding cannabis consumption and impairment, reviews existing policies/standards and guidelines on cannabis use and impairment in safe-sensitive professions and provide policy recommendations.

Background

Policy Context: What does the Legislation at the Federal, Provincial and CPSA levels dictate regarding physician recreational cannabis use and impairment?

Substance use policies and practices in the workplace are at a relatively early stage across all sectors, and research and information in this area is limited. There are no federal or provincial legislation or professional body formal policies or standards on the recreational consumption of cannabis for physicians. The Canadian Medical Association (CMA)'s Code of Ethics, however, requires that physicians practice unimpaired, seek help for personal problems and report unprofessional conduct. The CPSA Code of Conduct is consistent with the CMA Code of Ethics which states that *"As a physician, I will avoid misuse of alcohol or drugs that could impair the ability to provide safe care to patients."*

The Occupational and Environmental Medical Association of Canada recently released a position statement on the implications of cannabis use for safety-sensitive work which states that duration of impairment from cannabis may persist for 24 hours or longer, and the user may not be aware of the impairing effects; until definitive evidence is available, it is not advisable to operate motor vehicles or equipment or engage in other safety-sensitive tasks for 24 hours following cannabis consumption, or for longer if impairment persists (Occupational and Environmental Medical Association of Canada, 2018).

The National Defence and Canadian Armed Forces recently introduced strict policies regarding cannabis consumption, generally stating that cannabis consumption both at work, and during the eight hours before work, is prohibited. Those in the military who perform high risk duties are further prohibited from consuming cannabis during the 24 hours before such tasks or 28 days before any expected hyperbaric work, operation of an aircraft and other specifiers (National Defence and the Canadian Armed Forces, 2018).

Occupational health policies are emerging also in health care organizations to keep pace with cannabis legalization. Alberta Health Services (AHS) recognizes that the use and consumption of cannabis on AHS property and AHS workplace settings can place the integrity, safety, and well-being of patients at risk. The use or consumption of all non-medical cannabis at work is

prohibited by AHS Representatives and they are always expected to work safely and ensure that they do not endanger the health, safety or well-being of others. AHS representatives who choose to use cannabis outside of work must ensure it does not impact their ability to be fit for work (AHS, 2018).

Overview of Cannabis Metabolism and Impairment

Cannabis is not a single-agent compound but a complex combination of more than 100 different chemicals, which include cannabinoids, flavonoids, and terpinoids. The primary psychoactive component of cannabis is delta-9tetrahydrocannabinol (THC). Other cannabinoid compounds including cannabidiol (CBD), cannabinol, cannabichromene, cannabidivarin, cannabigerol, and tetrahydrocannabivarin have also actions on the central nervous system and may modify the effects of THC ("entourage effects") (Potter et al. 2008). The concentration of these compounds can vary substantially across the cannabis products, making it difficult to identify the specific positive or negative health effects (Potter et al. 2008).

The concentration of THC in products vary substantially from 1% in the 1980s to 80% currently (e.g. shatter can have THC levels as high as 80%) (Weedlist.ca). As THC is thought to be related to many of cannabis's adverse effects, this increase in potency means that relying on older studies for data about cannabis's safety profile may be risky (ElSohly 2014).

Routes of administration for cannabis use are diverse. Cannabis is often inhaled via vaporising cannabis concentrates or smoking of dried herbal product; it can also be ingested by pill form or in food, and absorbed through the skin from creams, salves, or skin patches (Russel 2018). Impairment periods vary with the route of administration, the dose administrated and level of tolerance.

When smoked or vaporised, THC is rapidly absorbed through alveolar capillary membrane, producing subjective impairment within minutes which peaks in about 1 hour and lasts up to 6 hours (Huestis, 2007; Ramaekers et al., 2006). Higher concentrations of THC were detected in blood after inhalation of vaporized cannabis compared with the same doses of smoked cannabis but there were no significant subjective drug effect ratings, cognitive and psychomotor performance (Spindle et al., 2019). Experimental studies have demonstrated that

measurable impairment after acute use of cannabis can last up to 24-48 hours (e.g. impairment on flight simulators persisted up to 24 hours after smoking a cannabis cigarette while the users were not aware of their impairment (Klugman et al, 2003; Heishman et al. 1990).

Oral cannabis doses have a delayed onset of psychotropic effects by 30–120 min, produce delayed, lower and irregular peak plasma levels compared to inhaled THC, and prolonged action duration of 4-12 hours. Delayed onset with ingestion means that edible products do not allow titration as inhaled cannabis and can lead to overconsumption of cannabis compounds. The effects of cannabis are also dependent on weight, metabolism, gender, and prior digested meals (Barrus et al. 2016; Grotenhermen 2003).

Acute intoxication with cannabis affects a number of cognitive and motor skills including reaction time, attention, information processing speed, verbal learning and recall, impulsivity inhibition, and motor coordination (Crean et al. 2011, Schwope et al. 2012). Impairment from acute cannabis use differs between occasional users and long-term users, presumably due to tolerance. Chronic frequent cannabis users exhibit lower degree impairment from acute cannabis use than occasional users (Theunissen et al. 2012; Hart et al. 2001) but over time chronic use is associated with persistent impairment of attention, verbal memory, working memory, decision making, and executive function (Messinis et al. 2006). Early evidence, using traditional neuropsychological assessments showed that cognitive deficits associated with cannabis use can persist even after 28 days of abstinence (Goldsmith et al 2015; Crean 2011). Greater doses use results in greater cognitive deficits (Sewell et al 2009).

Chronic cannabis use is linked to several adverse health outcomes, including addiction, impaired cognition, pulmonary effects, mental illness, and other problems (Volkow et al. 2014).

Absorption through the skin is difficult to measure and variable (Goldsmith et al 2015).

Overall, there is considerable uncertainty around the extent and duration of impairment, especially taking into account different routes of administration, doses, products potency, tolerance and individual differences. Moreover, combining cannabis with alcohol eliminates compensatory strategies and results in impairment even at doses that would be insignificant for either drug alone (Sewell et al. 2009).

Magnitude of Impaired Physicians Due to Cannabis Use

There is no data regarding the cannabis use among physicians and the number of impaired physicians due to cannabis use. Moreover, identifying impaired physicians is often difficult because the manifestations are so varied. A physician may be impaired/unable to fulfill his/ her professional or personal responsibilities due to other causes such as physical or psychiatric illness, alcoholism, or other drug dependency.

Detecting Cannabis Impairment

Assessment of impairment is not a simple process. Currently, there are limited options to detect cannabis impairment through testing methods. Most testing methods have been explored in terms of testing for impairment while driving. Current testing methods can often only determine if THC is present/ if that person has used cannabis at some point (e.g. THC in urine can last for many weeks or months after cannabis use). Obtaining a positive test result that indicates the presence of THC and THC metabolites is not necessarily a clear indication of the risk of impairment; tolerance may develop, and the levels of THC may not correlate with impairment. Blood test and clinical signs of impairment has been considered most accurate but not practical in workplace. THC blood level of 5 ng/mL is usually used as benchmark of impairment (Phillips et al. 2015). For instance, Canadian impaired driving laws use the following limits for THC (Government of Canada, 2017):

- for the summary conviction offence for 2 ng but less than 5 ng of THC per millilitre (ml) of blood
- for the hybrid offence for 5 ng or more of THC per ml of blood
- for the hybrid offence for a combination of 50 mg of alcohol per 100 ml blood + 2.5 ng or more of THC per 1 ml of blood

So far, there is heavy reliance on observation (i.e. odor of alcohol or drugs, glassy or red eyes, unsteady gait, slurring, poor coordination (CCOHS, 2018) to determine possible impairment (i.e. if there is a change in physical or mental functioning, which may result in difficulty completing tasks in a safe manner and may put individuals, co-workers and the public in danger (Government of Canada, 2018).

Cannabis Impairment Policy Analysis and Recommendations

The development of cannabis science including testing for cannabis impairment, areas necessary to inform workplace regulation of cannabis has not kept pace with recent federal legislation changes. There is no biological marker or test that can differentiate cannabis impairment than no impairment in workplace. Moreover, there is a considerable uncertainty around the extent and duration of impairment which vary from few hours up to 28 days, especially taking into account the cannabis routes of administration, doses, frequency of use, and individual differences. Therefore, additional evidence is required to inform smart regulatory actions with regard to cannabis workplace strict policies, monitoring and enforcement.

Even though CPSA did not set up formal policies or standards on the recreational consumption of cannabis for physicians, all physicians are required to show up fit for work and capable of performing their duties in a safe and effective manner. As outlined in CPSA Code of Conduct and consistent with the CMA Code of Ethics, physicians are expected to practice medicine and provide safe care to patients avoiding misuse of alcohol and drugs that could cause impairment. In keeping with the Code of Conduct, the expectations are that physicians are using recreationally cannabis if the immediate or lasting effects will impact their work and performance.

While high risk industries such as air transportation and Canadian Armed Forces pledge to keep the public safe by laying out strict standards regarding cannabis consumption, CPSA should consider keeping the general concept of “impairment” in their regulations as this approach will be relevant to all sources of impairment including fatigue, physical illness, life stresses, shiftwork, medications, other substance use etc), not just cannabis. This broad and conservative approach will help to protect the public. Moreover, clear impairment policies and education are vital to ensuring compliance with CPSA expectations.

Resources

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