Council Meeting Agenda

March 6 and 7, 2025
Fort Edmonton Park (Mar 6) & CPSA Council Chambers (Mar 7)
Edmonton

ATTENDEES

Council Members: Voting:

- Nicole Cardinal, MD, CCFP, Chair
- Daisy Fung, BMSc, MD, CCFP, Vice Chair
- Richard Buckley, MD, FRCS
- Garnet Clark, MBA, CPA, CMA
- Logan Day, BA
- Patrick Etokudo, M.Sc, FSCMP
- Nahla Gomaa, MBBCH, MSc, MD PhD, SFHEA, FAcadMEd
- Hon. Robert Merrifield, PC
- Oluseyi Oladele, MD, CCFP, FCFP - (Virtual Day 1 / Regrets Day 2)
- Laurie Steinbach, BSW, BEd - (In-person Day 1 / Virtual Day 2)
- Ian Walker, MD, MA - (Virtual Day 1 & Day 2)
- Pan Zhang, MBA, BSc, BA

Council Members: Non-Voting:

- Todd Anderson, MD, FRCP(C), FCAHS, Dean Cumming School of Medicine
- Tamara Yee, MD, PhD, Past-President, PARA
- Jenna Salem, Student Observer

CPSA Executive Leadership Team

- Scott McLeod, MD, CCFP, FCFP, Registrar
- Dawn Hartfield, BScMed, MPH, MD, FRCPC, Deputy Registrar & Hearings Director
- Jeremy Beach, MBBS, MD, FRCPC, Assistant Registrar, Accreditation
- Michael Caffaro, MD, CCFP FCFP, Assistant Registrar, Continuing Competence
- Gordon Giddings, MD MBA FCFP, Assistant Registrar, Professional Conduct & Complaints Director (Regrets Day 2)
- Ed Jess, BA, Chief Innovation Officer
- Sayra Khandekar, MD, MD MBA FRCPC FACC, Assistant Registrar, Registration
- Michael Neth, PEng, Chief of Staff
- Tracy Simons, CPA, CA, Chief Financial Officer

CPSA/Council Support Team

- Jason MacDonald, B.Sc, B.EH, CPHI(C), CIC Director, Office of the Registrar
- Kerry-Ann McPherson, MSc, CAPM, Program Manager, Governance
- Kimberley Murphy, Senior Executive Assistant, Recording Secretary
- Nazrina Umarji, B.Ed, JD, Director, Legal Services & General Counsel
- Sondra Mackenzie-Plovie, Senior Advisor, Community Engagement
- Nicole Bertram, Communications Advisor
- Sameha Dahir, Coordinator, Social Media & Digital Experience

CPSA Staff Presenters

- Rachael Gronberg, Communications Advisor (Day 2)
- Agatha McKechnie, Communications Advisor (Day 2)

External Attendees

- Martha Cardinal, Saddle Lake
- Elder Louis Lapatack, Saddle Lake
- Elder Rick Lightning, Ermineskin Cree Nation

Public Attendees

- CPSA staff and members of the public are invited to attend the meeting virtually

Regrets

- Brenda Hemmelgarn, MD, PhD, Dean FoMD
- Rhonda Laboucan, Member-at-Large
- Maryana Kravtsenyuk, MD, MSc, FRCPC

Resources for Council Members:

- **Council Culture Agreement**
- **CPSA Strategic Plan**
- **CPSA Council Reference Manual**
- **Principles to Guide Council Interactions**
- **Council Conflict of Interest Policy**
- **In-Camera Sessions Policy**
- **Social Media Guidelines**
- **Council Member Code of Conduct Policy**
- **Councillor's Oath**
- **CPSA Values**
- **Commonly used Acronyms**
- **Council Decisions Terminology**

Council Meeting Agenda

March 6 and 7, 2025
Fort Edmonton Park (Mar 6) & CPSA Council Chambers (Mar 7)
Edmonton

Thursday, March 6, at Fort Edmonton Park, Edmonton

(Breakfast for Council, Executive Team Members and CPSA/Council Support Team available at 0700)

Time		Topic		Presenters
0700		**Breakfast**		All
0745	**IC1**	**In-camera Session** **(Attendees: Council, Executive Leadership Team, CPSA/Council Support Team)**		Council Chair
		IC1.1	Call to Order, Introductions & Meeting Logistics	Council Chair
		IC1.2	Reflection on the Council Culture Agreement & Coin	
		IC1.3	Adoption of In-camera agenda and approval of In-camera Minutes	
			IC1.3.1 Adoption of In-camera Agenda	
			IC1.3.2 Approval of In-camera Minutes from December meeting	
			IC1.3.3 Council Meeting Feedback – December 2024	
0840		**Adjournment of In-camera session**		
		Transition to Special Induction Ceremony for Council Chair		
0900		**Special Induction Ceremony for Council Chair**		
1100	**1.0**	**Call to Order of Public Session**		Council Chair
		1.1	Chair Opening Remarks & Introductions	
		1.2	Traditional Territory Acknowledgement	Tamara Yee
		1.3	Conflict of Interest Declaration (Real, Potential or Perceived)	
1110	**2.0**	**Adoption of Agenda and Approval of Minutes**		Council Chair
		2.1	Adoption of Agenda	
		2.2	Approval of Minutes 2.2.1 December 5 and 6, 2024 CPSA Council Meeting Minutes 2.2.2 Decisions from In-Camera Meeting (December 2024)	

Time	Item		Description	Presenter
1115	**3.0**		**Consent Agenda** *The Consent Agenda has been prepared by the Executive Committee using the consent agenda checklist and contains items that are proposed for unanimous consent and without debate. However, Council members may seek clarification or ask questions.* ***Consent Agenda Process:*** *To move a consent agenda item to the regular agenda, identify the agenda number and title to be moved via:* (1) *An email to the Council Chair OR* (2) *A point of information to the Council Chair prior to the adoption of the agenda on the day of the Council meeting.*	Council Chair
		3.1	Executive Committee Meeting Meeting Summary Report (for information)	
		3.2	Governance Committee 3.2.1 Meeting Summary Report (for information) 3.2.2 Council Learning Report for 2024 (for information) 3.2.3 Committee Appointments (for approval) 3.2.4 Council Resource – Role of the Council Member (for approval) 3.2.5 Council Resource – Role of the Committee Chair (for approval)	
		3.3	Finance and Audit Committee Meeting Summary Report (for information)	
		3.4	Standards of Practice 2025 Standards of Practice Review Timeline (for information)	
		3.5	Accreditation – Diagnostic Imaging Accreditation Standards Teleradiology Revision Update (for information)	
		3.6	Accreditation – Diagnostic Imaging Accreditation Standards Medical Director Revision (for approval)	
	4.0		**Executive Reports**	
1120		4.1	Chair’s Report (for information/discussion)	Nicole Cardinal, Council Chair
1130		4.2	Registrar’s Report (for information/discussion)	Scott McLeod CEO/Registrar
1230			LUNCH	

Time	No.		Item	Presenter
	5.0	**Department Reports**		
1330		5.1	Office of the Registrar 5.1.1 CPSA Partnership Agreement with G4 Health (for approval) 5.1.2 CPSA Path to Truth and Reconciliation (for information)	Michael Neth, Chief of Staff
	6.0	**Council Committee Reports**		
1400		6.1	Governance Committee 6.1.1 Succession Planning for Committee Chairs (for discussion) 6.1.2 Council Learning Plan 2025 (for approval) 6.1.3 Council Competency Matrix, Nominations and Elections (for approval)	Richard Buckley Committee Chair
1440		6.2	Anti-Racism Anti-Discrimination Action Advisory Committee (ARADAAC) Meeting Summary Report (for information)	Daisy Fung Committee Chair
1450		6.3	Indigenous Advisory Circle (CIRCLE) Meeting Summary Report (for information)	Nicole Cardinal Committee Co-Chair
1500			COMFORT BREAK	
1515		6.4	Ad Hoc Bylaw Review Project Committee Presentation of Revisions of Bylaws, Section 1-5 (for discussion & approval)	Michael Neth Committee Secretariat
1600	**7.0**		**Adjournment of Public Session**	
			BREAK	
1610	**IC2**	**In-camera Session**		Council Chair
		IC2.1 Selection of Registrar/CEO (for discussion/approval) **(Attendees: Council only)**		Council Chair
1700			**Adjournment of In-camera session**	
1830			Dinner for Council Members only	

Council Meeting Agenda

March 6 and 7, 2025
Fort Edmonton Park (Mar 6) & CPSA Council Chambers (Mar 7)
Edmonton

Friday, March 7, 2025, CPSA Council Chambers

(Breakfast for Council, Executive Team Members and CPSA/Council Support Team available at 0730)

Time		Topic		Presenters
0730		**Breakfast**		All
0800	**IC3**	**Call to Order of In-Camera session** **(Attendees: Council, Executive Leadership Team, CPSA/Council Support Team)**		Council Chair
		IC3.1	Chair Opening Remarks	
		IC3.2	Traditional Territorial Acknowledgement	Pan Zhang
0810		IC3.3	Key Performance Indicators (KPI) Dashboard (for information)	Ed Jess Chief Innovation Officer
		IC3.4	Update on the CPSA Annual Report 2024 (for discussion)	Rachael Gronberg & Agatha McKechnie Advisors, Communications
		IC3.5	CPSA’s Response to Legislative Changes (for approval)	Scott McLeod, Registrar & CEO
		IC3.6	Council Meeting Feedback Survey (for discussion)	Council Chair
0915			BREAK	
0930		**Council Learning Session** **Due Diligence in Non-Expert Topics Part 2**		
1000	**IC4**	**In-Camera Meeting Session**		
			IC4.1 Registrar Update to Council (for verbal discussion) **(Attendees: Council, Registrar & CEO)** IC4.2 Performance Goals, Objectives and Leadership Expectations of Current Registrar/CEO (for verbal discussion) **(Attendees: Council only)**	

	IC4.3 Council Member Performance (for verbal discussion) **(Attendees: Council only)**
1200	**Adjournment**
1200	LUNCH BREAK
1230	COUNCIL PHOTOS

Council Meeting Draft Minutes - Public

December 5 and 6, 2024
CPSA Council Chambers
2700-10020-100 Street, Edmonton

ATTENDEES

Council Members: Voting:

- Jaelene Mannerfeldt MD MSc FRCSC, Chair
- Richard Buckley, MD, FRCS
- Nicole Cardinal, MD, CCFP
- Garnet Clark, MBA, CPA, CMA
- Patrick Etokudo, MSc, FSCMP, Vice Chair
- Daisy Fung, BMSc, MD, CCFP, Member-at-Large
- Maryana Kravtsenyuk, MD, MSc, FRCPC (virtual)
- Rhonda Laboucan
- Hon. Robert Merrifield, PC
- Oluseyi Oladele, MD, CCFP, FCFP
- Laurie Steinbach, BSW, BEd (virtual)
- Ian Walker, MD, MA
- Pan Zhang, MBA, BSc, BA

Council Members: Non-Voting:

- Todd Anderson, MD, FRCP©, FCAHS, Dean Cumming School of Medicine
- Tamara Yee, MD, PhD, Past-President, PARA
- Brenda Hemmelgarn, MD, PhD, Dean FoMD
- Maren Kimura, MPH, Student Observer

CPSA Executive Leadership Team

- Scott McLeod, MD, CCFP, FCFP, Registrar
- Jeremy Beach, MBBS, MD, FRCPC, Assistant Registrar, Accreditation
- Michael Caffaro, MD, CCFP, FCFP Assistant Registrar, Registration
- Gordon Giddings, MD, MBA, FCFP, Assistant Registrar, Professional Conduct & Complaints Director
- Dawn Hartfield, BScMed, MPH, MD, FRCPC, Deputy Registrar & Hearings Director
- Michael Neth, PEng, Chief of Staff
- Tracy Simons, CPA, CA, Chief Financial Officer

CPSA Council Support Team

- Kerry-Ann McPherson, MSc, CAPM, Program Manager, Governance
- Nazrina Umarji, BEd, JD, Director, Legal Services & General Counsel
- Jason MacDonald, BSc, BEH, CPHI©, CIC, Director, Office of the Registrar
- Kimberley Murphy, ACEA, Executive Assistant to the Chief of Staff, Recording Secretary

Regrets

- Ed Jess, BA, Chief Innovation Officer

External Presenters

- Lillian Wong & Leslie Dornan, MNP Consultants

Public Attendees

CPSA staff and members of the public are invited to attend the meeting virtually.

Thursday, December 5, 2024, at CPSA Office

IC1 In-camera Session
Council met in-camera with the Executive Leadership Team and CPSA/Council Support team.

1.0 Call to Order of Public Session

1.1 Chair Opening Remarks & Introductions

The Chair welcomed everyone to the meeting, including Dr. Manu Sarasat, a University of Alberta Resident observer completing part of his clinical rotation in Occupational Health at CPSA. Roundtable introductions were made by all.

1.2 Traditional Territory Acknowledgement
At each Council meeting, individuals are invited to share a personalized message to recognize and respect Indigenous Peoples who lived and continue to live on this territory, and for the land to which we are all connected. This type of acknowledgement is part of CPSA's ongoing efforts to develop healthy and reciprocal relations with Alberta's Indigenous communities—a key element of reconciliation, a process we are committed to.

Oluseyi Oladele provided the land acknowledgement.

1.3 Conflict of Interest Declaration (Real, Potential or Perceived)

No additional conflicts were declared at this time.

2.0 Adoption of Agenda and Approval of Minutes

2.1 Adoption of Agenda

MOTION C48-24

Moved by Richard Buckley and seconded by Laurie Steinbach that the agenda be adopted. Carried.

2.2 Approval of Minutes

2.2.1 CPSA Council Meeting Public Minutes – September 2024

2.2.2 Decisions from In-Camera Meeting - September 2024

2.2.3 Approval of E-Vote Minutes

- 2.2.3.1 – Approval of Committee Appointments
- 2.2.3.2 – Ratification of Council Election Results
- 2.2.3.3 – Approval of Terms of Reference for Registrar and CEO Search Committee

2.2.3.4 – Approval of Appointment of Members to the Registrar and CEO Search Committee

MOTION C49-24

Moved by Ian Walker and seconded by Patrick Etokudo that the minutes of the meeting on September 12 and 13, 2024, decisions from the in-camera session in September, and minutes of the four e-votes between the September and December Council meetings, be approved. Carried.

3.0 Consent Agenda

Purpose: *The Consent Agenda has been prepared by the Executive Committee using the consent agenda checklist and contains items that are proposed for unanimous consent and without debate. However, Council members may seek clarification or ask questions.*

Consent Agenda Process: *To move a consent agenda item to the regular agenda, identify the agenda number and title to be moved via:*

(1) *An email to the Council Chair OR*

(2) *A point of information to the Council Chair prior to the adoption of the agenda on the day of the Council meeting.*

3.1 Executive Committee Meeting

3.1.1 Meeting Summary Report (for information)

3.1.2 Decisions for Ratification (for approval)

3.1.3 Governance Review Implementation Plan – Timelines (for approval)

3.2 Governance Committee

3.2.1 Meeting Summary Report (for information)

3.2.2 Committee Member and Chair Appointments (for approval)

3.2.3 Terms of Reference – Nomination Committee (for approval)

3.2.4 Terms of Reference Revision – Ad Hoc Bylaw Review Project Committee (for approval)

3.3 Finance and Audit Committee

3.3.1 Meeting Summary Report (for information)

3.4 Ad Hoc Building Fund Initiatives Committee

3.4.1 Meeting Summary Report (for information)

3.5 Accreditation Standards

3.5.1 Revision of Hyperbaric Oxygen Administration Standards (for approval)

3.5.2 Revision of the Cardiac Stress Testing (CST) Standards (for approval)

3.6 General Register Policy for Physician Assistants – Policy Revision (for approval)

MOTION C50-24

Moved by Rick Buckley and seconded by Pan Zhang that the Consent Agenda be approved. Carried.

In passing the above motion, the following items are approved:

- Executive Committee – Decisions from Ratification
- Executive Committee – Governance Review Implementation Plan – Timelines
- Governance Committee – Committee Member and Chair Appointments
- Governance Committee – Terms of Reference – Nomination Committee
- Governance Committee – Terms of Reference Revisions – Ad Hoc Bylaw Review Project Committee
- Accreditation Standards - Revision of Hyperbaric Oxygen Administration Standards
- Accreditation Standards – Revision of the Cardiac Stress Testing (CST) Standards
- General Register Policy for Physician Assistants – Policy Revision

The following items were received as information:

- Executive Committee – Meeting Summary Report
- Governance Committee – Meeting Summary Report
- Finance and Audit Committee – Meeting Summary Report
- Ad Hoc Building Fund Initiatives Committee – Meeting Summary Report

4.0 Executive Reports

4.1 Chair's Report (for information/discussion)

The Chair's written report reflected on the work of the past year with commendation to Council for their commitment to good governance. The report captured the various meetings attended as Chair. The Chair encouraged Council to consider today what they would like to do more of in the coming year and what they would like to leave behind. She expressed pride in the work accomplished and stated it was an honour to serve.

The report was received as information.

4.2 Registrar's Report (for information/discussion)

Scott McLeod's Registrar report touched on events related to the Senior Leadership Team at CPSA, the Registration Renewal process and provincial and national updates regarding Legislation, CanMEDS and the National Registry of Physicians.

Of note, Council discussed the *Commend Your Physician* option on the CPSA public website. Communications reported receiving 124 commendations in 2024. Each physician was sent a letter on their Physician Portal to inform them of this activity. Council recommended CPSA explore ways to tailor the portal notifications to reflect the activity is a commendation versus a complaint or concern. This would help avoid any unintended worries members have reported experiencing when portal notifications are received. Council also requested

the *Commend Your Physician* option be expanded to include a tab to *Commend Your Colleague*.

The Registrar concluded his report by thanking Dr. Mannerfeldt for her dedication, hard work and leadership as Council Chair throughout 2024.

5.0 Department Reports

5.1 Analytics, Innovation and Research (AIR)

5.1.1 A Comparative Study of Performance of Internationally Trained Family Physicians and Canadian Graduates in Alberta (for information)

Dr. Nicole Kain, Program Manager for the Research and Evaluation Unit provided an overview of the findings from the Analytics, Innovation and Research's (AIR) department study. The report and presentation were received as information.

During the presentation, several key points were explored regarding the evaluation of physicians and their practices. A question was raised about the time spent on each patient and its potential correlation with the number of complaints received. Councilors noted that there are over 1000 physicians in both the Low and Medium TI groups and highlighted differences in Family Medicine (FM) training between Canada and other countries. CPSA staff commented that the duration of training or practice for International Medical Graduates (IMGs) in Canada, before full registration, has not been measured.

Council cautioned that data reporting might unfairly depict physicians from lower TI countries as providing worse care due to longer working hours that are only meant to offset various personal and professional pressures such as entering practice later in life, supporting large families, building up retirement, working both day and evening clinics, etc. It was noted that while prescribing patterns were similar across providers, differences were noted in the number of complaints. The types and themes of complaints, including urban versus rural distinctions, were also explored.

The potential for data manipulation by physicians was also raised and the potential for inaccuracies in the data if the Registration Information Form (RIF) forms are not filled out correctly. Assurances were given that Alberta Health billing records were reviewed and found to correlate with the self-reported RIF data.

The discussion also touched on Alberta Health's initiative to improve pathways for Family Physicians, aiming to reduce discrimination. Council pointed out that conclusions were being drawn despite claims to the contrary.

AIR expressed a desire to know what questions Council wants to pursue further and was asked to consider the next steps with the data, whether to pursue it independently or in

partnership with other organizations, and to continue the conversation without drawing immediate conclusions.

Council cautioned that CPSA needs to consider the political implications of the data and possibly seek ministerial support.

5.2 **Registration (for information)**

Michael Caffaro, Assistant Registrar, Registration provided an update on the Registration department. The report was received as information.

Dr. Sayra Khandekar was introduced as the new Assistant Registrar, Registration and Assessment. Dr. Khandekar will join CPSA Jan 2025. Dr. Caffaro will move from this role to the Assistant Registrar role in Continuing Competence at that time.

During the presentation, the following key points were raised:

- On the National Registry of Physicians (NRP) – the Medical Council of Canada (MCC) and NRP will have some ability to coordinate the Practice Readiness Assessment process so all jurisdictions are using the same criteria.
- Increased frequency of Therapeutic Decision Making (TDM) exam is important for IMGs who were already in their subspecialty prior to coming to Canada.

5.3 **Health and Practice Condition Monitoring (HPCM)**

Dawn Hartfield, Deputy Registrar, provided an overview of the Health and Practice Condition Monitoring program. The report and presentation were received as information.

Dr. Hartfield was joined by HPCM staff including Phong Van, Director, Assessment & Competency Enhancement; Leanne Minkler, Program Manager, HPCM; and Dr. Teresa Eliason, Senior Medical Advisor, HPCM.

During the presentation, the following key points were raised:

- Bill 46 prompted the review of the former Physician Health Monitoring Program (PHMP). The changes in legislation required clear distinction between regulator and association functions.
- This created an opportunity to modernize the approach to assessment and monitoring of regulated members with health conditions and shifted an independent department at CPSA to a program within the Continuing Competence Department.
- Quality improvement methodology has been incorporated to help guide improvements in the work.
- Files are closed based on the direction received in the 3rd party assessment. Third party assessors do not provide care, they only assess.

- The other line of business of the program is practice condition monitoring, which includes a chaperone program. The chaperone program has been in place since 2013.
- Office personnel take training at Grant MacEwan. HPCM vets the attendees directly so they understand the terms in the specific agreement prior to approving them for the chaperone course.

6.0 Council Committee Reports

6.1 Governance Committee

6.1.1 Council Retreat 2025 (for approval)

Richard Buckley, Committee Vice Chair, presented the 2025 Annual Council Retreat agenda for approval, which was further developed since the September Council meeting.

MOTION C51-24

Moved by Ian Walker and seconded by Oluseyi Oladale that the 2025 Annual Council Retreat Agenda be approved as presented, with room for committee to improve. Carried.

6.1.2 Update on the Council Competency Matrix and Nomination Project (for information)

Lillian Wong and Leslie Dornan from MNP provided an update on the project.

- Council noted that under competency, there is no mention of the commitment to attend all Council and Committee meetings. As a core trait, Councilors need to be dedicated and engaged.
- The vetting process for public versus physicians is different. Different government will bring in different processes. Ministers will often take feedback from CPSA/Council on the needs of the Council, i.e. a financial background. From there a few candidates will be provided. Council recommended that location of candidate be incorporated into the selection process.
- MNP advised all comments will be taken into consideration.
- The draft Matrix is expected to be brought to Council for approval in March 2025.

6.2 Finance and Audit Committee

6.2.1 Approval of Therapeutic Decision-Making (TDM) Exam Fee (for approval)

Daisy Fung, Committee Chair, presented the background on the approval of therapeutic decision-making exam fee. The Medical Council of Canada (MCC) is increasing its fee, but CPSA is keeping its amount at $50.

- The TDM exam is specifically for Internationally Trained Physicians not eligible for independent practice on the general register.
- A TDM fee was discussed and approved at the September Council meeting.
- Fee amount is in two parts: $50 CPSA and $2,850 MCC = $2900 CAD
- Fee to take effect April 1, 2025

MOTION C52-24

Moved by Richard Buckley and seconded by Garnet Clark that Council approves the fee of $2,900 + GST for the Therapeutic Decision Making (TDM) Examination Fee effective April 1, 2025. Carried.

6.2.2 Approval of annual fee for Limited Register Clinical Assistants (for approval)

Daisy Fung, Committee Chair, presented the background on the approval of the annual fee for limited register Clinical Assistants.

- It was clarified that those on the Limited Practice Register (LPR) are typically physicians who have a medical degree but don’t have Post Graduate Training (PGT), are not independent, not the most responsible physician, and must practice under supervision.
- This register includes:
  - LRAA – limited register administrative medical assistant
  - LRCA – limited register clinical assistant
  - LRCS – limited register clinical and surgical assistant (doing work in and out of an operating room)
  - LRRA – limited register medical research assistant
  - LRSA – limited register surgical assistant
- Given the limited scope of practice for these physicians and the information presented, the LPR fees going forward will be 25% of the annual physician fee.

MOTION C53-24

Moved by Rob Merrifield and seconded by Pan Zhang that Council approves the fee reduction in annual fees for those registered on the Limited Practice Register for 2025 in the following categories: The fee would be 25% of the physician annual fee. For 2025, the fee would be $500. Carried.

6.3 **Indigenous Advisory Circle (CIRCLE)**

6.3.1 Meeting Summary Report (for information)

Nicole Cardinal, Interim Circle Chair, provided the meeting summary report on behalf of the Circle, which was received as information.

The following key discussion points are noted:

- CPSA will need to keep in mind the learnings from the Canadian Medical Association (CMA) apology when making their apology. For example, broadcasting of ceremony may be inappropriate to some nations and (unintentionally) seen as performative by others.
- CPSA will need to be clear on who we are apologizing to, what we are apologizing for (past, present and ongoing harms) and on whose behalf the apology is being made (physicians' or CPSA). The Circle will guide CPSA on the best approach.

6.3.2 CPSA Path to Truth and Reconciliation (for information)

Michael Neth, Chief of Staff, presented CPSA's Path to Truth and Reconciliation sharing a high-level overview of the Path.

The following key discussion points are noted:

- A small project team is working with Great Country Consulting. Each department in CPSA has a representative known as Path Liaisons who will help set the stage for small and large changes across the organization.
- CPSA wants to hear from Indigenous communities what a safe and trusting experience with a physician looks like. This level of community engagement leads to a sense of safety with CPSA. It is an important trust, and CPSA is mindful to be careful stewards of these relationships. Relationship building and work done in communities is run by reputation.
- It was noted that CPSA must consider succession planning to ensure plans and improvements made today are durable and sustainable. This work connects directly to patient safety.

6.4 **Ad Hoc Bylaw Review Project Committee**

6.4.1 Meeting Summary Report (for information)

Oluseyi Oladele, Committee Spokesperson, provided the meeting summary report for the Ad Hoc Bylaw Review Project Committee, which was received as information.

The following key discussion points are noted:

- Legal review of full draft of new Bylaws is occurring concurrently with other ongoing activities.
- After completion of the bylaw review, the Committee will meet with the Governance Committee to go through the new Bylaws together.
- It will be after that time that the Committee will recommend that Council approve the Bylaws.

7.0 Standing Items

7.1 Key Performance Indicators (KPI) Dashboard (for information)

Nicole Kain, Program Manager for the Research and Evaluation Unit, presented on the key performance indicators for Quarter 3.

- The dashboard is a learning process. Indicators will change as it is developed to make better use of learnings.
- KPI data will be updated with Q4 data early in the new year.
- An inquiry was made about whether an email push could be sent when updates are made. REVU will investigate whether this is possible from the backend by the developer.

The public session was adjourned at 3:44 pm.

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: December 5 and 6, 2024

Council met in-camera at various times during the December 5 and 6 Council meeting to discuss sensitive issues. The following motions were made:

Motion C45-24

Moved by Ian Walker and seconded by Oluseyi Oladele that the in-camera agenda be adopted. Carried.

Motion C46-24

Moved by Rob Merrifield and seconded by Pan Zhang that the in-camera minutes for September 12 and 13, 2024 be approved. Carried.

Motion C47-24

Moved by Oluseyi Oladele and seconded by Daisy Fung that Council confirms the appointment of Rhonda Laboucan for the position of Member-at-Large for a term of one year commencing January 1, 2025. Carried.

<table>
<tr><td>Submission to:</td><td colspan="3">Council</td></tr>
<tr><td>Meeting Date:</td><td colspan="3">Submitted by:</td></tr>
<tr><td>March 6, 2025</td><td colspan="3">Nicole Cardinal
Committee and Council Chair</td></tr>
<tr><td>Agenda Item Title:</td><td colspan="3">3.1 Consent Agenda - Executive Committee Meeting Summary Report</td></tr>
<tr><td>Action Requested:</td><td>☐ The following items require approval by Choose an item. See below for details of the recommendation.</td><td>☐ The following item(s) are of particular interest to Choose an item. Feedback is sought on this matter.</td><td>☒ The attached is for information only. No action is required.</td></tr>
<tr><td colspan="4">AGENDA ITEM DETAILS</td></tr>
<tr><td>Recommendation:</td><td colspan="3">N/A</td></tr>
<tr><td>Background:</td><td colspan="3">The Executive Committee met on February 4, 2025, and discussed the following matters:

1. Committee Resources: Resources that are useful for supporting the Committee members in achieving its mandate were reviewed, such as the Terms of Reference, Consent Agenda Checklist, Council Decision Terminology and policies that directly impact the work of the Executive Committee.
2. Request from public advocacy group: A public advocacy group requested that CPSA Council make a public statement regarding the harms of trans and gender diverse legislation passed by the Government. The Committee examined a critical review of references and sources cited in the public group's article, which was prepared by the CPSA's Analytics, Innovation and Research department. The Committee also discussed an analysis and recommendation to the public group's request. The Committee decided to add this discussion to the Council meeting's in-camera agenda. In accordance with Bylaw 20(27), this will take place in-camera because the sensitive nature of this discussion is such that avoiding public disclosure of information outweighs adhering to the principle that Council meetings be open to the public. It is noted that any decisions taken will be shared in the public minutes of the meeting for the May 2025 Council meeting.
3. Council Meeting Agenda for March 2025: The Committee used the following inputs to develop the agenda for the March Council meeting:
• Minutes from previous meetings.
• Council Meeting Action Items and Follow-up List.
• Data from the December Council Meeting Feedback Survey.</td></tr>
</table>

	4. **Governance Review Implementation Plan (GRIP):** The Committee discussed one of the recommendations from the Governance Review Implementation Plan, which was to define public interest. Since this was discussed at the 2025 Council Retreat in January, wherein Council determined that it was impossible to define the public interest, the Committee considered if a section of the report should still include a briefing on the public interest, which is another recommendation in the GRIP. The Committee requested that a jurisdictional scan be completed to review how other regulatory organizations keep the public interest front of mind in their discussions. 5. **External Meetings:** An update on meetings with provincial officials and stakeholders was provided. 6. **Executive Committee in 2025:** The Committee discussed its workplan and schedule for the year, and a schedule for traditional territorial acknowledgments for Committee meetings in the year.
Next Steps:	N/A
List of Attachments:	
N/A	

Submission to:	**Council**		
Meeting Date:	Submitted by:		
March 6, 2025	Governance Committee		
Agenda Item Title:	3.2.1 Governance Committee Meeting Summary Report		
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:	N/A		
Background:	At its January 30 meeting, the Governance Committee considered the following items: 1. **Council Learning Plan:** A report on Council's Learning engagement in 2024 was presented, along with a draft of the 2025 Council Learning Plan. The Committee provided input for improvement and accountability in Council learning for the new year. 2. **Council Workload:** The Committee discussed the current workload of Council and its Committees. One of the results of the discussion in balancing Council's workload was for the Governance Committee to assume the roles and responsibilities of the Nomination Committee for 2025. 3. **Council Competency Matrix:** The draft matrix was presented to the Committee for feedback. Following input, the matrix was revised and will be presented as a recommendation for Council's approval. Consultants from MNP attended the meeting to address questions raised. 4. **Council Orientation & Retreat:** The Committee engaged in a debrief about the event in January and began preliminary discussions on the theme for the retreat in 2026. 5. **Succession Planning for Committee Chairs:** The Committee began preliminary discussions on ensuring that Committees engage in succession planning for Chairs. This item will be brought forward to the Council meeting for further discussion and feedback from Council. 6. **Bylaw Review Project:** A status update on the Bylaw Review project was provided. 7. **Role of the Council Member:** The Committee reviewed an updated version of the resource document on the role of the		

	Council member. This is an output from the Governance Review Implementation plan. The Committee provided input to the document and will present to Council as a recommendation for approval. 8. **Committee Appointments:** The Committee reviewed and approved the recommendations for Council Committee membership appointments, which are being recommended to Council for approval. 9. **Council Policy Review Schedule:** The Committee received as information the policy review schedule for 2025. 10. **Annual Documents:** The Committee received the annual reports signed by Council members as information. There were no responses to bring forward to the Executive Committee. 11. **Governance Committee in 2025:** The Committee discussed its workplan and schedule for the year, and the institution of a traditional territorial acknowledgment schedule for Governance Committee meetings.
Next Steps	N/A
List of Attachments	
N/A	

Submission to:	**Council**

Meeting Date:	Submitted by:		
March 6, 2025	Governance Committee		
Agenda Item Title:	3.2.2 Consent Agenda - Governance Committee - Council Learning Report for 2024 Review		
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:	N/A		
Background:	In 2024, Council approved a learning plan with the following goals: 1. To enhance the understanding of the role of a health regulator and the fiduciary duty of CPSA Council. 2. To build capacity for bringing the Council Culture Agreement to life. 3. To build leadership skills. 4. To promote an exchange of learning amongst Council members. 5. To develop as individual Council members and as Council in working towards CPSA's Strategic Directions: • Highest quality, compassionate and ethical care • Authentic Indigenous Connections • Anti-Racism and Anti-Discrimination • Enhanced Partnerships • Proactive and Innovative Approach These goals were to be accomplished through individual learning, group learning within and outside of Council meetings. **Individual Learning** • <u>Learning Opportunities:</u> Each council member has access to an annual $1500 learning allocation. This can be used to take a course or participate in a learning opportunity that helps them fulfill CPSA's mandate of public protection. *In*		

2024, four (4) Council members utilized their learning allocation.

- Mandatory Training: Fair Registration Practices Act: Under Alberta's Fair Registration Practices Act, CPSA must ensure our registration practices are transparent, objective, impartial and procedurally fair. CPSA Councillors may be involved in hearing appeals of registration decisions. To help ensure CPSA's registration processes comply with legislation, the Fair Registration Practices Act Training is required. *In 2024, this mandatory training applied to all new Council members. Three out of four new Council members completed this training.*
- Voluntary Training: Microaggressions Training: There are no updates to report on this training currently.
- Voluntary Training: Hearings Director Office: The HDO organizes training so that Council members can effectively support sessions for the Complaints Review Committee and Hearing Tribunal. *In 2024, 5 Council members attended the Annual Orientation for Complaints Review Committee and Hearings Tribunal. There were trainings for Unconscious Bias and Decision Writing; however, no Council members were able to attend.*

Group Learning (Council Meeting Learning Sessions)

Speaker Series at Council Meetings

As part of each Council meeting, the Executive Committee uses a list of suggested topics by Council members to decide on the Council learning sessions that will be explored during each Council meeting.

- At the March Council meeting, external consultant Margot Ross-Graham, Sandbar Consulting, delivered a session on Giving Feedback, to strengthen the Council's culture and reinforce the Council Culture Agreement.
- At the May Council meeting, external consultant Margot Ross-Graham, Sandbar Consulting, delivered a follow up session on receiving feedback.
- At the December Council meeting, Council engaged in a panel discussion on the role of the Council member in applying due diligence in non-expert topics. This was facilitated by Jaelene Mannerfeldt, Scott McLeod and Michael Neth. Although this topic was not listed in the 2024 Council Learning Plan, it was explored because of its relevancy to Council's current needs.

	Group Learning (Outside of Council Meetings) • At the Council Retreat in January, Council explored the theme of Authentic Indigenous Connections, in collaboration with G4 Health, on the Tsuut'ina Nation, as planned for January 2024. • At the September Council meeting, a one-day learning session was held at Blue Quills University, St. Paul, as part steps toward learning and reconciliation during the month of Truth and Reconciliation, as planned for September 2024. • A ½ day session on Chairing meetings and Robert's Rules was to be organized for the Council Chair and Executive Committee, all Committee Chairs and Vice Chairs. This session was not implemented, due to competing priorities. **Additional Learning Opportunities** Throughout the year, Council members took advantage of different learning opportunities that were not listed in the Council Learning Plan for 2024. • Each Council member received a copy of the book *Thanks for the Feedback: The Science and Art of Receiving Feedback Well* by Douglas Stone and Sheila Heen, to reinforce the learnings from the March and May Council learning sessions. • Council members were invited to attend a workshop on Creating Authentic Acknowledgments of Peoples and Lands with Rise Consulting, offered as one of CPSA's activities for truth and reconciliation. Two Council members attended the session. • To enhance learning on Indigenous culture, Council members were invited to read a copy of the book *Valley of the Birdtail: An Indian Reserve, a White Town, and the Road to Reconciliation* by Andrew Stobo Sniderman and Douglas Sanderson. The book is being read individually by each Council member then passed on to another Council member.
Next Steps:	Topics that were not explored in the Council Learning Plan for 2024 will be reviewed for 2025 by the Governance Committee, which a recommendation made to Council for the 2025 Council Learning Plan.

List of Attachments:

- Council Learning Plan 2024
- Council Learning Policy

2024 CPSA Council Learning Plan

Draft 2, Revised: April 24, 2024

Introduction:

Individual and group learning is important to good governance, and fulfilling CPSA's mandate as a regulator to govern in a manner that protects and serves the public interest.

Learning Plan Goals:

1. To enhance the understanding of the role of a health regulator and the fiduciary duty of CPSA Council.
2. To build capacity for bringing the Council Culture Agreement to life.
3. To build leadership skills.
4. To promote an exchange of learning amongst Council members.
5. To develop as individual Council members and as Council in working towards CPSA's Strategic Directions:
    - Highest quality, compassionate and ethical care
    - Authentic Indigenous Connections
    - Anti-Racism and Anti-Discrimination
    - Enhanced Partnerships
    - Proactive and Innovative Approach

TABLE 1: Individual Learning

Activities	Resources	Measuring and Reporting Outcomes	Strategic Plan Alignment
Council members participate in individual learning. **Learning Plan Goals:** ALL	• Each council member has access to an annual $1500 learning allocation. This can be used to take a course or participate in a learning opportunity that helps them fulfill CPSA's mandate of public protection. • List of learning opportunities compiled by CPSA staff and updated regularly (**please see the Learning Opportunities appended to each Council agenda**). • If desired, Council member meets with CPSA Office of the Registrar staff to discuss and tailor a learning plan. • An example related to Strategic Direction: Authentic Indigenous Connections, is the online University of Alberta **"Indigenous Canada"** course. • Regulated members sitting on CPSA Council may have access to the AHS Indigenous Learning modules: Required Organizational Learning (ROL) on "My Learning Link". AHS' Indigenous Health Program has public videos available on its **webpage**, which will be of interest and helpful to CPSA Council members in their learning journeys. • An example related to Strategic Direction: Anti-Racism Anti-Discrimination is a new online University of Alberta course: **Black**	• The annual **Councillor self assessment survey** includes the following question: "During the year, I identified governance/leadership learning goals and devoted some time to achieve those goals."	All Strategic Directions (dependent on the content of the individual courses taken): • Highest quality, compassionate and ethical care, • Anti-Racism and Anti-Discrimination • Authentic Indigenous Connections • Enhanced Partnerships • Proactive and Innovative Approach

Activities	Resources	Measuring and Reporting Outcomes	Strategic Plan Alignment
	Canadians: History, Presence, and Anti-Racist Futures		
Mandatory Training: *Fair Registration Practices Act* – online modules **Learning Plan Goal:** 1	Under Alberta's *Fair Registration Practices Act*, CPSA must ensure our registration practices are transparent, objective, impartial and procedurally fair. CPSA Councillors may be involved in hearing appeals of registration decisions. To help ensure CPSA's registration processes comply with legislation, the *Fair Registration Practices Act* Training is required.	• Course completion will be tracked.	• Highest quality, compassionate and ethical care
Voluntary Online Education: Micro-aggression Training for Physicians	Online Education: Micro-aggression Training for Physicians 1-1.5-hour online learning	• Will be voluntary for all regulated members. • Course completion can be tracked.	• Anti-Racism and Anti-Discrimination, • Highest quality, compassionate and ethical care,

Activities	Resources	Measuring and Reporting Outcomes	Strategic Plan Alignment
Learning Plan Goals: 2, 3	Course was developed in partnership by CPSA, AMA, AHS. The course is hosted by CPSA, and Council members have access to the course.		• Authentic Indigenous Connections
Voluntary – when the Hearings Director Office (HDO) organizes training for CRC/HT members, Council members will also be given the option of participating **Note: for these courses, there may be limits on the numbers of attendees. **Learning Plan Goals:** 1, 4	Examples include: • Appeals Orientation and Training • Anti-Racism training delivered by the Centre for Race and Culture • Decision-writing workshop delivered by the Canadian Institute for Administrative Justice (CIAJ)	• Number of Council members taking the courses can be tracked	• Highest quality, compassionate and ethical care

TABLE 2: Group Learning: 1 hour in-Council Meeting Learning Session

Activities	Resources	Measuring and Reporting Outcomes	Strategic Plan Alignment
Speaker Series Council includes a 1-hour (minimum) learning session as part of each Council meeting Agenda. **Learning Plan Goals:** All	Engage speakers who can help meet Council's learning goals through their presentation on a specific topic. Schedule: • **March 2024**: Council Culture: Giving feedback. Speaker/Facilitator: Margot Ross-Graham Topics for May, September and December 2024 will be organized from the following list: • Receiving Feedback (part 2 of Margot Ross-Graham's March 2024 session) • Bringing joy and fun to Council meetings. Suggested speaker: Michelle Cederberg. • Diminishing trust in public institutions, mal-/mis-/dis-information and what to do about it. • Artificial Intelligence (AI) and medicine • Presentation from the Canadian Medical Protective Association	The Annual Evaluation of Council Effectiveness includes the following question: "Looking back over the meetings of this year, I see growing evidence of the impact of group learning in Council's discussions and decision-making."	• Highest quality, compassionate and ethical care • Proactive and Innovative Approach • Anti-Racism and Anti-Discrimination • Enhanced Partnerships

Activities	Resources	Measuring and Reporting Outcomes	Strategic Plan Alignment
	(CMPA) – context and understanding of complaints at the national level. • Presentation from the Health Quality Council of Alberta (HQCA) – their mandate, and trends in Alberta • Presentation from Dr. Patrick McFarlane on cultural competence • Presentation and Round Table Discussion with AMA • "Research 101 and Research for Professional Regulation" presentation/session from CPSA's Analytics Innovation and Research Department. Some topics may be postponed/scheduled as part of the 2025 Learning Plan and future Council Retreats. The Executive Committee plans the CPSA Council Meeting Agendas and will use this list to make decisions on in-Council learning sessions.		

TABLE 3: Group Learning: Outside of Council meetings

Activities	Resources	Measuring and Reporting Outcomes	Strategic Plan Alignment
A ½ day session on Chairing meetings and Robert's Rules is organized for Council Chair and Executive Committee, all Committee Chairs (may include Council members and non-Council members) and Vice Chairs. An invitation will be extended to all Council members who may be thinking about volunteering to Chair a committee or run for Council in the future. **Date TBD** **Learning Plan Goals:** 1, 3	CPSA will seek a facilitator of this session.	The Annual Evaluation of Council Effectiveness includes the following question: "Looking back over the meetings of this year, I see growing evidence of the impact of group learning in Council's discussions and decision-making."	Highest quality, compassionate and ethical care
2024 CPSA Council Retreat – Authentic Indigenous Connections	CPSA worked with G4 Health to organize and hold the Retreat January 26-27, 2024	Desired strategic outcomes of the Retreat: • Enhanced learning and	Authentic Indigenous Connections

Activities	Resources	Measuring and Reporting Outcomes	Strategic Plan Alignment
		understanding about the impacts of colonization and how it affects Indigenous access to safe medical care and/or Indigenous health outcomes. • Advancing the dialogue and understanding related to Strategic Direction: Authentic Indigenous Connections. • Council celebrates and commits to continuously working on culture through signing the Council Culture Agreement.	Anti-Racism Anti-Discrimination
****<u>Proposed:</u>** additional Retreat at Saddle Lake/Blue Quills University/St. Paul September 2024 (perhaps in combination with the September Council	CPSA will work with Blue Quills University and Council Member Nicole Cardinal to organize this visit/retreat.	Similar desired outcomes to the January retreat, however may be modified.	Authentic Indigenous Connections Anti-Racism Anti-Discrimination

Activities	Resources	Measuring and Reporting Outcomes	Strategic Plan Alignment
meeting, week of September 9)			

Submission to:	**Council**

Meeting Date:	Submitted by:		
March 6, 2025	Governance Committee		
Agenda Item Title:	3.2.3 Consent Agenda - Governance Committee - Committee Appointments		
Action Requested:	☒ The following items require approval by Council. See below for details of the recommendation.	☐ The following item(s) are of particular interest to Choose an item. Feedback is sought on this matter.	☐ The attached is for information only. No action is required.
AGENDA ITEM DETAILS			
Recommendation (if applicable) :	That Council approves the following Committee appointments: 1. Appointment of Nahla Gomaa (Council Physician Member) to the Finance and Audit Committee. 2. Appointment of Rhonda Laboucan to the Indigenous Advisory Circle. 3. Appointment of Nicole Cardinal, Oluseyi Oladele and Ian Walker to the Ad Hoc Bylaw Review Project Committee, until the completion of the bylaw review project. 4. Appointment of Richard Buckley, Nicole Cardinal, Patrick Etokudo, Ian Walker to the Ad Hoc Building Fund Initiative Committee, until all reports have been received from grant recipients. 5. Reappointment of one regulated member, Dr. Goldees Liaghati-Nasseri, for a third term of membership on the Complaint Review Committee/Hearing Tribunal list. 6. Appointment of six (6) regulated members for a first term on the Complaint Review Committee/Hearing Tribunal membership list: a. Dr. Monica Lau b. Dr. Laura Stovel c. Dr. Jeff Grant d. Dr. Papanna Praveen e. Dr. Dennis Kunimoto f. Dr. Saifee Rashiq		
Background:	Committee member appointments are outlined in the Governance Structure and Committees Policy as follows: "Council appoints the members of Council and Operational Committees for a three-year term which is renewable once. Due to the subject matter, and because priorities might change, Council Priorities Committee		

members will be asked to confirm their committee membership annually and may exit the Committee before having completed a full term.

The Governance Committee generally tries to recommend appointments based on the skills and interests of the Council member however sometimes the needs of the organization outweigh the needs of individual Council members.
The following appointments are recommended.

Finance and Audit Committee
At its January 30, 2025 meeting, the Governance Committee supported recommending Nahla Gomaa, elected physician member to the vacant physician member position on the Finance and Audit Committee.

Indigenous Advisory Circle
Through a Governance Committee e-vote on February 26, 2025, the Committee supported the Circle's recommendation of public member, Rhonda Laboucan to the Indigenous Advisory Circle.

Ad Hoc Bylaw Review Project Committee
At its January 30, 2025 meeting, the Governance Committee supported recommending existing members Nicole Cardinal, Oluseyi Oladele and Ian Walker to the committee, until the bylaw review is completed.

Ad Hoc Building Fund Initiatives Committee
At its January 30, 2025 meeting, the Governance Committee supported recommending existing members Richard Buckley, Nicole Cardinal, Patrick Etokudo, Ian Walker to the committee, until all reports have been received from grant recipients.

Complaint Review Committee/Hearing Tribunal
The Health Professions Act directs that CPSA must maintain a membership list of regulated members from which HT and CRC panels are appointed. The Bylaws of CPSA state that members are appointed to this committee for a three-year term, with an optional further appointment of an additional three-year term for a total of six years. The Hearings Director reviewed each member's resume, conducted personal interviews and examined each member's complaint/disciplinary record before making the recommendation to the Governance Committee. The Governance Committee supported the recommendation to appoint all submitted regulated

	members for the CRC/HT membership list at its January 30, 2025 and through e-vote on February 18, 2025.
Next Steps:	Following Council appointments, Committee secretariat will inform Committee Chairs and members of their appointments.
List of Attachments:	
N/A	

Submission to:	**Council**

Meeting Date:	Submitted by:		
March 6, 2025	Governance Committee		
Agenda Item Title:	3.2.4 Consent Agenda - Governance Committee - Council Resource - Role of the Council Member		
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) :	That Council approves the Council resource document on the Role of the Council Member.		
Background:	The governance review report by external consultant, John Dinner in 2022 pointed out that council member engagement could be enhanced by more explicitly defining the roles of expectations of Council members, beyond the threshold obligation to prepare for, attend and participate in meetings. In response to the recommendation to develop a document that outlines the role of the Council member, the Governance Committee reviewed and provided input on different versions of the resource document. At its January 30, 2025 meeting, the Governance Committee supported the recommendation to Council for the approval of a Council resource on the role of the Council member.		
Next Steps:	This resource document will be useful for recruitment, orientation and overall Council member engagement.		
List of Attachments:			
1. Council Resource – Role of the Council Member			

Role of the CPSA Council Member

The purpose of this document is to provide clarity on the role of all Council members in the discharge of their duties.

Strategic Oversight and Guidance

- Provide strategic direction and oversight for the organization.
- Provide strategic direction and guidance to the CEO, regularly reviewing and evaluating the CEO's performance against set goals and objectives.
- Understand CPSA's mission and strategic priorities, and CPSA's mandate as outlined in the *Health Professions Act.*

Integrity, Accountability, and Confidentiality

- Act honestly and in good faith, in the best interest of the public, rather than their personal interest or the medical profession.
- Uphold the highest standards of integrity and accountability, ensuring transparency in all actions.
- Maintain confidentiality on all Council matters during and after one's tenure on Council.

Participation and Engagement

- Attend and participate in Council meetings, Committee meetings, and hearings consistently to contribute effectively to the work of Council.
- Exercise their best judgment when voting on decisions, being informed and prepared for meetings and hearings.
- Participate in professional, leadership and governance development opportunities and learning sessions.

Collaboration, Respect, and Culture

- Commit to following the Council Culture Agreement and all established codes of conduct, which foster compassion, collaboration, trust, curiosity and respect.

Knowledge and Professional Development

- Develop a working knowledge of the healthcare system and healthcare industry.

The *Health Professions Act* also outlines the legislative mandate of Council, which would be considered the legislated role of the CPSA Council Member.

Appointments and Designations

- Appoint an individual for the following offices:
    - Registrar
    - Chief Executive Officer
    - Other officials, committee members, and chairs required under the Act, including a Hearings Director and Complaints Director.
- Appoint regulated members to a membership list to be used for hearing tribunals and complaint review committees.
- Provide members of Council to sit as a panel of Council for the purpose of hearing registration reviews, and appeals, applications to orders, and provide for the designation of a panel member to act as chair.
- Designate members of council to committees of council and establish terms of reference for the Committees.

Governance, Regulations, and Policy Approval

- Approve and adopt regulations and bylaws in accordance with the HPA.
- Approve and adopt documents for the purpose of regulating and directing the practice of regulated members, such as standards of practice, code of ethics, any other documents or resources the Council deems necessary to achieve its mandate under the Act.
- Approve policies that govern the Council and its members in the discharge of council duties, monitor conformance, and take corrective action when necessary.
- Approve policies that govern the delegation of Council powers and duties to college officers and statutory committees, monitor conformance, and take corrective action when necessary.

Financial Oversight and Accountability

- Approve a business plan and budget for the college, monitor progress, and take corrective action when necessary.
- Approve all obligatory fees and levies payable to CPSA by regulated members or others, as permitted by the Act.

Due Diligence and Legal Compliance

- Undertake reasonable due diligence to ensure that the college fulfills its statutory mandate and complies with all relevant legal and fiduciary responsibilities.

Draft Date: January 30, 2025

Approval Date: (to be inserted)

Review Date: (3 years from approval date)

Submission to:	**Council**

Meeting Date:	Submitted by:		
March 6, 2025	Governance Committee		
Agenda Item Title:	3.2.5 Consent Agenda - Governance Committee - Council Resource - Role of the Committee Chair		
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):	That Council approves the Council resource document on the Role of the Committee Chair.		
Background:	At its January 2025 meeting, the Governance Committee began preliminary discussions on succession planning for Committee Chairs. During its deliberations, the Committee revisited a resource document on the role of the Committee Chair. This document was developed in 2020 but was not recommended to Council for use by Committees. To address the appointment and succession planning of Committee Chairs, the Committee considered it important to provide clarity on the roles and responsibilities of the Committee Chair. Therefore, the Committee supported a recommendation to Council for approval of the Role of the Committee Chair as a Council resource document for Committees.		
Next Steps:	This resource document will be useful for supporting Committees in understanding the role of Committee Chairs, as well as successful succession planning.		
List of Attachments:			
1. Council Resource – Role of the Committee Chair			

Role of a Committee Chair

At CPSA, we are guided and advised by committees made up of physicians, healthcare partners and Albertans. Participating in these committees is an excellent way to positively impact health care in Alberta, while also gaining valuable skills in governance and leadership.

All Committees are supported by CPSA team members but are led by Council members or Committee members willing to take on the role of Chair for that Committee. This document was created to provide some general information around the Role of a Committee Chair, the Expectations of a Committee Chair as well as information about the Support for a Committee Chair. Individual committees may have additional responsibilities and expectations, but these are the general roles, expectations and supports.

Role	Expectation
Chair the Committee meeting	• Ensure timeliness • Maintain order • Allow fair and open discussions • Summarize discussions and ensure agreement and understanding on the outcomes and next steps.
Assist in the development of the meeting agenda	• Meet with CPSA team members at least 2 weeks in advance of the meeting to develop an agenda • If applicable, ensure items are added to the Committee's Planning Calendar to track items for future meetings.
Present Committee reports and recommendations to Council	• CPSA Team members will draft written reports to be presented to Council • For Committees that are not chaired by a Council member, the Committee chair is generally not required to be in attendance, but would be welcome, particularly if a matter is expected to generate a fulsome discussion.
Report back to the Committee regarding and questions or feedback from Council	• CPSA Team members will keep track of matters requiring follow up at a Committee meeting

DRAFT

Ensure the Committee fulfills its roles and responsibilities as outlined in the Committee's Terms of Reference	• At least annually, each Committee should review their activities of the past year. • Council's standing Committees will provide a report to Council through the Governance Committee outlining their activities from the previous year. • The Committee chair should respectfully bring Committee members back to a topic at hand if they are engaging in discussions outside the purview of the Committee.

Support for Committee Chairs

In addition to the support offered by the CPSA Team member assigned to a Committee, Committee Chairs can access the following additional supports:

- Meeting dates will be planned/rescheduled so as to be at a time most suitable for the Chair
- Orientation to the role of Committee Chair as necessary or requested
- Professional learning courses around meeting facilitation or other matters pertinent to the role of Chair as requested
- Individual support from the Governance Program Manager
- One on one support from the Chief of Staff

Submission to:	**Council**

<table>
<tr><td>Meeting Date:</td><td colspan="3">Submitted by:</td></tr>
<tr><td>March 6, 2025</td><td colspan="3">Patrick Etokudo
FAC Chair</td></tr>
<tr><td>Agenda Item Title:</td><td colspan="3">3.3 Consent Agenda - Finance & Audit Committee (FAC) Meeting Summary Report</td></tr>
<tr><td>Action Requested:</td><td>☐ The following items require approval by Council See below for details of the recommendation.</td><td>☐ The following item(s) are of particular interest to Council Feedback is sought on this matter.</td><td>☒ The attached is for information only. No action is required</td></tr>
<tr><td colspan="4">AGENDA ITEM DETAILS</td></tr>
<tr><td>Recommendation (if applicable):</td><td colspan="3">N/a</td></tr>
<tr><td>Background:</td><td colspan="3">The Finance & Audit Committee (FAC) met on February 21, 2025, and addressed the following items:

1. Pension Investment Performance Review 2024 (Defined Benefits Pension Plan)

FAC invited Mr. Neil Lloyd, and Mr. Justin Palmier from Mercer to present their report pension investment returns for 2024 for the defined benefit (DB) pension plan. Total registered DB pension assets at December 2024 are $50,766,000 (Dec 2023 - $47,429,000).

In 2024, the pension investments saw a gross return increase of 10.5%, compared to 8.0% in 2023. After accounting for fees, the net return was 10.0%, up from 7.5% in 2023.. This was below the benchmark of 14.6% primarily due to the underperformance of a Canadian equity fund, a low volatility fund and global equity funds.

Over a four-year period, the returns of 4.3% (2023 - 5.3%) gross of fees are below the market benchmark of a 5.4% (2023 - 4.5% return). The pension fund objectives to achieve a 5% nominal return over 4 years are not currently being met.

Performance of investment managers was discussed at the May 2024 FAC meeting.</td></tr>
</table>

In order to assess if a change in investment managers is necessary, the first step is to conduct a comprehensive asset mix review of the DB assets. As part of the 2025 budget, funds were approved to engage an independent consultant for a strategic asset allocation review for our DB pension investments. Management will proceed with identifying and selecting a consultant to perform this review.

Upon completion of the asset mix review, management, with input from the consultant, will assess the performance of the current investment managers to ensure their portfolios align with the revised asset allocation. Feedback will be reported to FAC for approval of the investment manager selection.

The FAC reviewed the Statement of Investment Policies & Procedures (SIPP) for the DB pension assets and approved an administrative change updating values from the most recent valuation conducted as of December 31, 2023.

2. **Investment Performance Review 2024** (non-pension assets)

Mr. Graeme Baker from Philips, Hager & North (PH&N), and Mr. Eric Vachon and Mr. Borja Theurillat from Industrial Alliance (IA) provided overviews of the performance of their respective investments in 2024 and shared their thoughts on market expectations for 2025.

Total investments as at December 31, 2024:

Investment Manager	$ Market Value	% Return net of fees – 12 months	% Market benchmark
Industrial Alliance Insurance and Financial Services Inc. (IA)	$16,545,000 ($513,128) outstanding capital call commitments)	10.01%	-1.94% behind benchmark
RBC Phillips, Hager & North Investment Counsel Inc (PH&N)	$17,556,000	12.37%	-0.49% behind benchmark
Total	$34,101,000		

Investment performance below market benchmarks is primarily attributed to the underperformance of real estate and global equity funds. However, the balanced and diversified portfolio remains aligned with CPSA's investment strategy and is poised for uncertainty in the future, especially 2025.

Although the plans did not meet benchmark performance during a period when U.S. equities outperformed the market, which was largely driven by gains in a select few stocks, CPSA's funds remain well diversified, positioning them to weather the potential volatility of 2025. At this time, no changes to the investment strategy are recommended. However, management will continue to closely monitor returns throughout the year.

FAC and management will conduct a comprehensive annual review each February to ensure that returns remain competitive relative to benchmarks and that the asset mix aligns with CPSA's long-term investment strategy.

3. Annual Renewal Timing

Management is currently evaluating the possibility of adjusting the timing of the physician & physician assistant annual renewal information form (RIF) or the Professional Corporation renewal information form (PCIF) and payment of their annual fees deadline to address several ongoing challenges and concerns.

Frustrations with December 31 deadline include:

- Regulated members are busy over the December holiday time period and forget to complete their renewal
- CPSA does not have staff available to assist physicians or physician assistants if they have issues while completing the RIF due to the holiday closure (CPSA office is closed between Dec 25 -Jan 1)
- Call and email volumes upon return from holiday closure indicate that some physicians need help in the lead up to the due date
- The volume of work is extensive the first week to 10 days in January to return phone calls, update member status for retirement/ voluntary erasure/change registers and enter payments.

Management has assessed a variety of dates and impact on workloads and is considering January 31 as the renewal date.

Benefits of January 31st deadline include

- Impact to physicians and physician assistants would be reduced during the CPSA holiday office closure occurring earlier in the renewal period. Many physicians and physician assistants complete their renewal in the last week of the renewal period when the CPSA offices would be open, providing increased customer service.
- Maintaining the 2-month period for annual renewal allows sufficient time for renewal.
- Cut off for bank receipts for Dec 31 fiscal year end is not as demanding for the accounting staff anticipating fewer payments will be received in future years over the holiday office closure.

- Avoids overlapping with AMA renewal deadline, September 30.
- Pre-cancellation notices would go out in early February and cancellation would take place in early March, which would not coincide with an office closure.

Transition
CPSA management is reviewing the internal priorities of projects for our IT department in assessing if the change would be implemented for the 2026 or 2027 billing year.

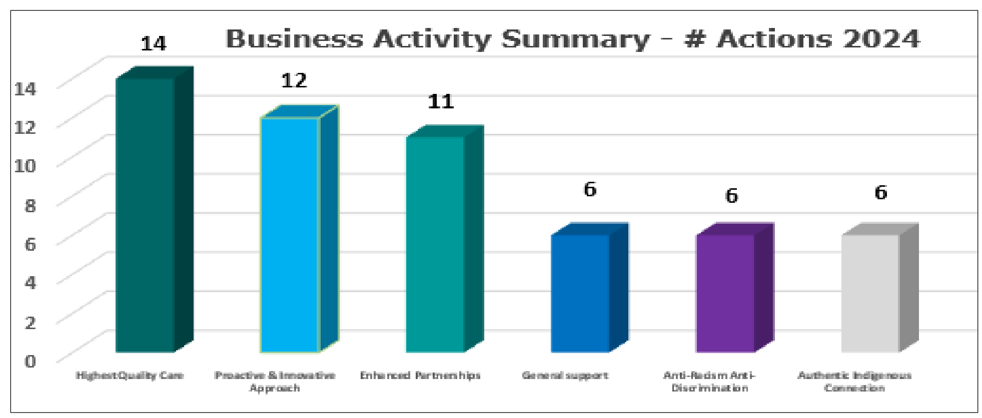
The CPSA bylaws would be impacted as the renewal date is listed in the bylaws. Communication to physicians and physician assistants would also be needed with any change.

4. 2024 Results

Activity Update – Q4 December 2024
FAC received a report from management on the Business Activity Update.

In 2024, CPSA identified 55 actions in the 2024 business plan which was approved by Council. CPSA leadership team reviews the business activity accomplished to the end of the quarter compared to the approved Business Plan for 2024.

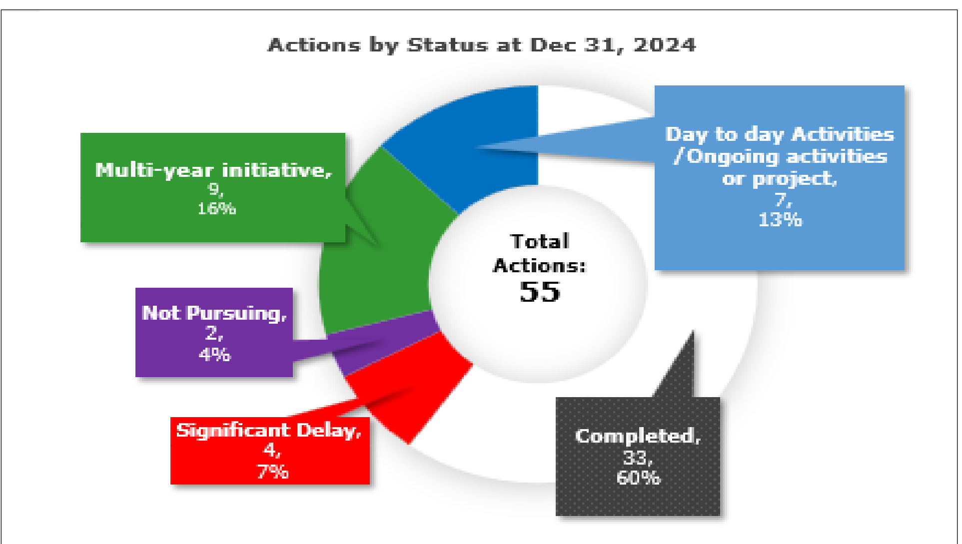
The Business Plan update is shared with FAC on a quarterly basis.



The 55 actions were categorized are as follows:

- Complete
- Multi Year Initiated
- Below target Day-to-day; plan to be on target by end of year
- Significant Delay
- Day to day Activities /Ongoing activities or project

- Not pursuing the initiative



A total of 33 actions were successfully completed in 2024, with another 9 actions under multi-year initiatives continuing in 2025 and 7 actions were identified as day-to-day activity. These three categories account for the 89% of the actions all of which are on track or completed in 2024.

The committee was informed that the seven actions, which previously categorized as a new work, will not be included in the next year report as it was identified that they are routine day-to-day activities of the department.

For the actions under Significant Delay, the committee was notified that the actions will be continued in 2025.

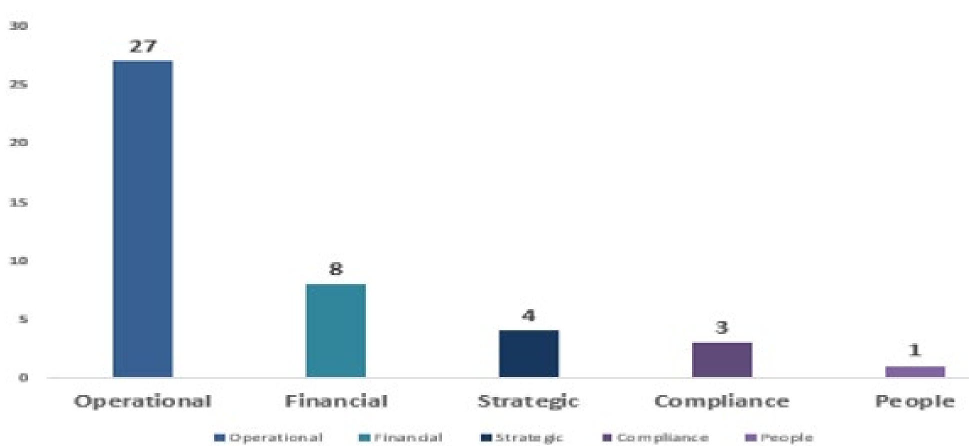
For actions under Not Pursuing, FAC was informed that those are the actions that are not accomplished for the year 2024. These actions relate to partnership opportunities that did not materialize in 2024 and are not being pursued further. The budgets for these actions were repurposed towards the additional complaint costs in 2024.

CPSA Risk Register Report
The committee received the report from management on the Risk Register Report Update.
Quarterly, the leadership team identifies new risks and reviews existing risks to CPSA. Risks are classified under the following categories:

- Financial
- Operational
- Strategic

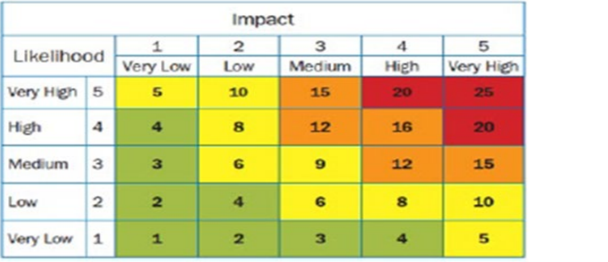
- Compliance
- People

In 2024, there were 43 Risk that were identified by the leadership team and majority of the risk are under Operational Risk, followed by Financial Risk categories.



Leadership Team used the 5x5 Matrix scales to grade and categorized the risk based on its impact and likelihood.

Risk Grade



Likelihood		Impact				
		1 Very Low	2 Low	3 Medium	4 High	5 Very High
Very High	5	5	10	15	20	25
High	4	4	8	12	16	20
Medium	3	3	6	9	12	15
Low	2	2	4	6	8	10
Very Low	1	1	2	3	4	5

Risk Level:

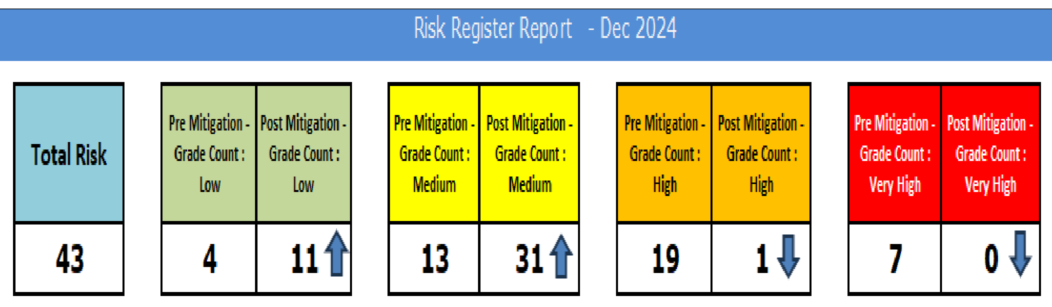
1, 2, 3, 4	Low
5, 6, 8, 9, 10	Medium
12, 15, 16	High
20, 25	Very high

The risks are then graded into four risk levels:

- Low
- Medium
- High
- Very High

Mitigation actions are identified to reduce either/both the likelihood or impact of the risk, and the risk is then evaluated post mitigation actions.

The evaluation of pre- and post- mitigation at Dec 2024 is represented below.



Risk Register Report - Dec 2024

Total Risk	Pre Mitigation - Grade Count : Low	Post Mitigation - Grade Count : Low	Pre Mitigation - Grade Count : Medium	Post Mitigation - Grade Count : Medium	Pre Mitigation - Grade Count : High	Post Mitigation - Grade Count : High	Pre Mitigation - Grade Count : Very High	Post Mitigation - Grade Count : Very High
43	4	11 ↑	13	31 ↑	19	1 ↓	7	0 ↓

The illustration demonstrates that the mitigation control measures have been helpful in reducing the very high and high level of risks.

There is an increase in number of Low-Risk and Medium Risk Level and a decrease in the High Risk and Very High-Risk levels risks.

FAC assessed the identified risks and closely reviewed the process and the emerging trends to ensure a comprehensive understanding of the potential challenges and provide insights for decision making and future planning.

Draft Financial Results
FAC received the draft financial results and draft financial KPIs for 2024. The year-end audit is on schedule to commence in April with the draft audited financial statements to be reviewed at FAC's May meeting and be presented to Council for approval in May.

5. Possible Unbudgeted Activity for 2025

FAC received a report explaining an increased use in benefit costs in 2024 than budgeted and estimated impact to 2025. The benefit costs included in the 2025 budget were estimated based on the limited data available on usage of the new benefit plan.

Based on the staff actual benefit usage of the plan in 2024, if the same usage continues in 2025, the possible additional costs could be $400,000.

This estimate is based on the number of single vs family staff members currently on staff and those positions planned to be filled in 2025.

Management will bring updated 2025 forecast figures to the May 2025 FAC meeting once Q1 activity has been reviewed.

Management is also conducting a review of staff total compensation which was included in the 2025 budget. This review is conducted every three years. The review allows management to consider salaries, pension and benefits for staff to be in alignment with Council's approved Total Compensation Philosophy. Any recommendations from the review will be included in the draft 2026 budget.

6. Security Management Committee

FAC received a report from the staff Security Management Committee. The Committee reviews security incidents, issues and responses to determine if further action is necessary; provides direction as required; and distills and distributes lessons learned to staff and Council through the Leadership Team.

The report included an overview of the November 2024 to February 2025 breach report.

The FAC was satisfied with the level of reporting and the continued staff education sessions to address awareness of privacy breaches.

7. Treatment & Counselling Fund

FAC received a report summarizing the costs incurred to date for the Treatments & Counseling Fund.

Under the *Health Professions Act* each health profession's regulatory college is required to create and administer a fund for therapy and counselling for patients who allege sexual abuse or sexual misconduct by a regulated health professional.

Currently funding of $23,900 is available to eligible patients of sexual abuse or sexual misconduct. The funding is available up to five years after the date on which a finding of unprofessional conduct in whole or in part on sexual abuse or sexual misconduct towards a patient is made. The funding is provided by CPSA.

Year	# eligible active cases	# cases requesting treatment costs	Total Expenses to Dec. 31, 2024	Maximum Funding Remaining
2019 *	6	4	$44,963	$0
2020	13	8	$108,679	$110,900
2021	10	4	$37,203	$58,400
2022	4	1	$1,833	$88,200
2023	3	2	$8,564	$37,900
2024	1	1	$1,479	$22,500
Total	37	20	$202,721	$317,900

* Program commenced April 1, 2019

8. Pre-Authorized Payment (PAP) Metrics

Credit card transactions cost CPSA over half a million dollars in credit card fees annually (2023 - $547k; 2022 - $534k). The majority of credit card payments are made by members and PCs during annual renewal. The processing of credit cards costs the merchant (CPSA) between 2.5% - 3.5% in fees per transaction (approximately $50 on physician annual renewal). CPSA does not currently pass the costs of processing credit card payments back to physicians.

For 2025 annual renewal, CPSA held a contest in fall of 2024 to promote payment of annual fees by PAP.

2025 payments via PAP as compared to 2024 were:

Financial Group	2024 # of PAP payments	2025 # of PAP payments	Year-Over-Year (YOY) Change
Member	1,618	2,318	+ 700 (43%)
Professional Corporation (PC)	1,085	1,644	+ 559 (52%)

At an average cost per credit card transaction of $50 (physicians) and $5 (professional corporation), savings on credit card fees for the 2025 annual renewal consisted of:

	Members ($50 x 700) = $35,000 Professional Corporations ($5 x 559) = $2,795 **GROSS COST SAVINGS = $ 37,795** Less: Cost of contest (14 x $250) = ($ 3,500) **COST SAVINGS NET OF CONTEST COSTS $34,295** CPSA will continue to promote PAP as a method of paying the annual renewal fee. FAC will further review progress and next steps in the first half of 2026.
Next Steps:	N/A
List of Attachments:	
N/A	

Submission to:	**Council**

Meeting Date:	Submitted by:		
March 6, 2025	Dr. Dawn Hartfield, Deputy Registrar		
Agenda Item Title:	3.4 2025 *Standards of Practice* Review Timeline		
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:	The 2025 schedule for review of Standards of Practice is attached for the awareness of Council. This information is provided to Council on an annual basis. The Health Professions Act requires all regulators to develop Standards of Practice. CPSA's *Standards of Practice* are the minimum standards of professionalism and ethics expected from physicians and physician assistants practising medicine in Alberta. Standards are developed and updated in consultation with the profession, Albertans, the Minister of Health and applicable partners. Once approved by the Ministry, all standards must be approved by our Council before taking effect.		
Next Steps:	None		
List of Attachments:			
1. 2025 *Standards of Practice* Review Timeline			

CONSULTATION 30 – out for consultation: March

2025 *Standards of Practice* Review Timeline

- *Re-entering Medical Practice or Changing Scope of Practice* (no review since 2010)
    - New AtP

- *Relationships with Industry* (no review since 2010)
    - New AtP

- *Sale of Products ~~by Physicians~~* (no review since 2010)
    - New AtP/AtA

CONSULTATION 31 - out for consultation: May

- *Charging for Uninsured Professional Services* (reviewed 2014)
    - New AtP/AtA

- *Non-Treating Medical Exams* (reviewed 2013)
    - New AtP

- *Responding to Third-Party Requests* (no review since 2010)
    - New AtP/AtA

CONSULTATION 32 – out for consultation: Sept

- *Continuing Competence* (per Council direction at its September 2022 meeting)
    - Update Program Manual (Continuing Competence)

- *Patient Record Content* (reviewed 2016)
    - New AtP/AtA

- *Patient Record Retention* (reviewed 2016)
    - New AtP/AtA

CONSULTATION 33 – out for consultation: Nov

- *Cannabis for Medical Purposes* – for rescission

- *Human Health Research* (reviewed 2015)
    - New AtP/AtA

- *Prescribing: Drugs…* (reviewed 2017)
    - Update AtP/AtA

2025 *Standards of Practice* Review Timeline

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- *Relationships with Industry* (no review since 2010)
    - New AtP

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    - New AtP/AtA

- *Prescribing: Drugs…* (reviewed 2017)
    - Update AtP/AtA

Submission to:	**Council**

Meeting Date:	Submitted by:		
March 6, 2025	Scott McLeod Registrar & CEO		
Agenda Item Title:	3.5 Consent Agenda - Accreditation – Diagnostic Imaging Accreditation Standards: Teleradiology Revision Update		
Action Requested:	☐ The following items require approval by the Registrar. 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:	The purpose of the memo is to provide an update on activities in the review of the V4 DI Accreditation Standards, Appendix E.2.1 - Tele-Ultrasound		
Background:	Accreditation Standards are reviewed for minor updates annually and undergo a more extensive revision roughly every four years. The V3 DI Accreditation standards review and revision was initiated in 2018. The Advisory Committee on Diagnostic Imaging (ACDI) lead the review and proposed revisions of the standards. In 2021/2022, input on draft DI standards was gathered through broad provincial stakeholder consultation rounds. The subsequent drafting and approval of the standards occurs through multiple hierarchal CPSA committee levels, including the ACDI (recommendation only), Medical Facilities Accreditation Committee (MFAC) and Council. Council approved the final V4 Diagnostic Imaging Accreditation Standard, including Appendix E.2.1 Teleradiology Ultrasound at its December 2023 meeting, requesting a third-party review of tele-ultrasound provision to occur in a year’s time. V4 DI Accreditation Standards came into effect October 1, 2024.		

Timeline and related information:

2018:

- A review of the remotely supervised imaging accreditation standards (teleradiology) started; substantive revisions throughout, however, most were administrative or purely clinical in nature.

Spring 2023:

- MFAC approved all the draft revised teleradiology standards for the exception of the draft teleradiology standard criteria: 25km radius (provision of tele-ultrasound).
- Noted for continued discussion were the current limitations of V3 (provision of tele-ultrasound) and how V4 could be improved to support improved tele-ultrasound imaging access while maintaining equitable quality and safety for all Albertans

April 26, 2023

- After discussion the MFAC members agreed that it would be advantageous to invite the ACDI Chair to the next MFAC meeting to engage in further discussion regarding this change to standards prior to making a decision on this revision.

October 25, 2023

- At the request of MFAC, ACDI Chair and 2 ACDI members attended MFAC to engage in further discussion regarding this change to standards prior to MFAC deciding on this revision

- After discussion, MFAC members felt that the ACDI members did not provide sufficient evidence for the requested change to the standards. Members agreed that a recommendation be made to Council for the acceptance of the v4 standards, however, removing the time and geographical restrictions around the provision of tele-ultrasound which were proposed by ACDI.

- MFAC decided to also seek guidance from Council as to whether an additional stakeholder review is necessary for the teleultrasound provision and whom the review should be conducted by.

December 5/6, 2023

- Council approved the V4 standards with the caveat of revisiting the 25km criteria in one year, after a third-party review of the 25km criteria was completed.

	• Accreditation Department engaged two reputable third-party organizations (University of Alberta {U of A}/ Canada's Drug Agency {CDA, formerly CADTH}) to perform a teleultrasound provision review. **February 2025** • CDA report received by CPSA, awaiting U of A School of Public Health report with expected delivery by end of February. **Next Steps:** • The third-party reports will be shared with ACDI for a review and recommendation to MFAC on the teleultrasound provision. • MFAC will review the report and recommendation from ACDI at its next scheduled meeting for further direction to ACDI or a recommendation to the Registrar regarding Appendix E.2 Teleradiology Ultrasound (E.2.1).
Next Steps:	

List of Attachments:

1. Current V4 Appendix E.2
2. Canadian Journal of Health Technologies (Canada's Drug Agency) February 2025 Volume 5 Issue 2 – Health Technology Review – *Comparative Effectiveness of Real-Time Teleultrasound verses In-Person Ultrasound*

E.2 Teleradiology Ultrasound (Standard Reference: US.2.1.2)

In addition to E.1:

1. Tele-Ultrasound is not permitted inside of a 25 kilometer (km)** radius city central point (census tract)* coordinate for the below. If the proposed imaging facility address (decimal degree) lands directly **on** the defined 25km radius line, it will be considered inside the radius and therefore be ineligible to provide tele-ultrasound imaging services.

   - Grande Prairie (WGS84: 55.173038, -118.788224)
   - Edmonton (WGS84: 53.54399, -113.489804)
   - Red Deer (WGS84: 52.268819, -113.809235)
   - Calgary (WGS84: 51.045644, -114.05646)
   - Lethbridge (WGS84: 49.694394, -112.837759)
   - Medicine Hat (WGS84: 50.041492, -110.678366)

   **Census Tract (CT): city hall address of the central municipality/Statistics Canada*
   ***CPSA adopts and utilizes Statistics Canada trusted data and statistical insights; refer to glossary and definitions*

2. Sonographers are registered with Sonography Canada, certified in their specialty (ies) and:

   - have a minimum of one year of full-time post-certification ultrasound experience and will receive documented yearly training to a minimum total of 5 face to face days per calendar with an ultrasound imaging specialist (employed by the group / Zone that is responsible for supervision and reporting of ultrasound examinations, ***or***

   - have a minimum of 6 months full-time post certification ultrasound experience (acquired within same group/Zone), would be deployed only to that same imaging group/Zone's tele-ultrasound facility and will receive documented yearly training to a minimum total of 5 face to face days per calendar year with an ultrasound imaging specialist (employed by the group / Zone) that is responsible for supervision and reporting of ultrasound examinations

3. As a quality assurance measure, CPSA may conduct ad-hoc tele-ultrasound image reviews

Canadian Journal of Health Technologies

February 2025 Volume 5 Issue 2

Health Technology Review

Comparative Effectiveness of Real-Time Teleultrasound Versus In-Person Ultrasound

Key Messages

What Is the Issue?

- Ultrasound imaging requires highly trained professionals for accurate diagnostic exams and interpretation.[1,2]
- Ultrasound is more affordable and portable than CT and MRI and does not expose patients to radiation. This makes ultrasound the preferred method for real-time assessment and soft tissue imaging. For more detailed or complex imaging, or when clinically indicated, CT and MRI may be more appropriate.[3]
- In Canada, less than 28% of rural hospitals have in-house access to ultrasound, leading to patient transfers.[4]
- Ultrasound exams are often conducted by sonographers, and there is a notable shortage of sonographers both in Canada and worldwide.[5,6]
- Limited access to skilled ultrasound professionals has led to the development of teleultrasound (TUS), which supports remote clinical decision-making.[2,5]
- TUS can be delivered in real time with remote guidance from a sonographic expert.
- TUS can be used by a variety of health care professionals with minimal ultrasound training. However, as the use of real-time TUS continues to expand to different clinical areas, its clinical effectiveness compared with traditional in-person ultrasound remains unclear.

What Did We Do?

- We received a request related to the use of real-time TUS to support policy decision-making.
- A literature search was conducted to identify studies examining the clinical effectiveness of real-time TUS compared with conventional in-person ultrasound and any evidence-based guidelines for TUS use in clinical practice.
- We also report some of the advantages and challenges of TUS as described in the literature.

What Did We Find?

- Real-time TUS was comparable to conventional in-person ultrasound for exam image quality and diagnostic consistency.
- Exams took, on average, more than 25% (or 6 minutes) longer to complete compared with in-person ultrasound.

Key Messages

- Real-time TUS was associated with high clinician satisfaction for comfortability, telecommunication quality, exam duration and quality, and accessibility.
- Several studies reported transient safety-related complications (e.g., increased pressure, pain), patient discomfort or fear, and technical difficulties during 10% of robotic-assisted TUS exams.
- Real-time TUS was studied in a wide range of clinical indications in various settings, highlighting its growing role and potential for expanded application in clinical practice.
- No evidence-based guidelines were identified for the use of TUS in clinical practice.

Abbreviations

ECG	electrocardiogram
SR	systematic review
TUS	teleultrasound

Background

Ultrasonography is a portable and noninvasive imaging method that uses soundwaves to visualize internal organs, structures, and systems within the body in real time. According to the WHO, ultrasound and/or X-ray is sufficient for 80% to 90% of patients that require medical imaging for diagnosis.[5] WHO considers ultrasound an essential diagnostic imaging technology, and access to ultrasound has been declared a minimal global standard. However, two-thirds of the world's population lack access to medical imaging services.[1]

Ultrasound imaging is a highly operator-dependent imaging modality that requires well-trained professionals to provide accurate diagnostic exams and interpretation of exam images.[1,2] The quality of an ultrasound exam varies depending on the sonographer's experience with operating the equipment, whereas the image quality of CT or MRI exams are less dependent on the operator's performance.[2] As well, ultrasound is much more affordable and portable than CT and MRI and, unlike CT, does not expose patients to radiation.[3] As a result, ultrasound is the preferred method for soft tissue imaging in cases in which the higher image quality of CT and MRI is not crucial.[3]

Access to ultrasound services in rural or underserved regions is often limited by the lack of qualified professionals, appropriate equipment, and insufficient infrastructure or resources.[1,5,9] In Canada, less than 28% of rural emergency departments have in-house access to ultrasound, requiring patient transfers to facilities with capacity.[4]

Ultrasound exams are conducted by imaging professionals, and a shortage of these professionals both in Canada and in many countries worldwide has been reported.[10,11] Poor job satisfaction is cited as 1 reason for high turnover rates of these health care professionals.[10] As well, recruitment and retention challenges have exacerbated existing staff shortages and contribute to wait times.[10,11]

Limited access to ultrasound professional expertise has led to the development of TUS, an imaging technique that utilizes advances in information technology and ultrasound to support remote clinical decision-making.[2,7] TUS allows for the electronic transmission of ultrasound images from 1 location to another, so images are obtained at a distance from where the interpreting ultrasound professional is located.[2,9]

TUS is intended to enhance patient care by offering access to specialized expertise, either to complement existing services or to provide care in resource-limited settings. By expanding access to these services, TUS has the potential to improve time to diagnosis, reduce costs for both patients and the health care system, and decrease patient travel time.[1,12-14]

How Is TUS Delivered?

TUS involves either real-time (synchronous) or asynchronous ("store and forward") video transmission.[5,15]

Real-time "supervised" transmission: The ultrasound exam occurs with real-time supervision by an imaging expert, often a radiologist or sonographer. The imaging expert is located in a remote location and provides guidance to an onsite ultrasound operator. In some cases, the imaging expert will remotely perform the exam using robotic ultrasound technology with the assistance of an in-person assistant to help position

the equipment. Real-time TUS is often used in emergency settings, where valuable contextual information is needed to aid interpretation and the operator may have limited ultrasound experience.[2,16]

Asynchronous transmission: The ultrasound images are captured locally, stored, and sent to the remote expert later for review and interpretation. Using this method, individuals with limited or no imaging experience (e.g., medical students, nonimaging health care professionals) can be trained to obtain images of the body using basic scanning protocols, which are sent to the expert without degradation in image quality.[2,5,15,17]

Purpose of This Review

With rapid advances in diagnostic imaging technology, various TUS systems exist, such as robotic-assisted ultrasound, portable pocket-sized hand-held ultrasound scanners (i.e., point-of-care ultrasound), and AI-integrated solutions.[2,14,18,19] TUS systems support decision-making across a wide range of clinical settings, and examinations can be conducted at point-of-care, in emergency or community settings, or in dedicated imaging facilities.

Real-time TUS, which allows the remote expert to be virtually present during the ultrasound scan, has gained greater use with the changing health care landscape, access to new technologies, and its utility for mentoring and training. More recently, the unprecedented demand on the health care system during the COVID-19 pandemic led to the rapid development and use of innovative tools to provide urgently needed ultrasound services in a minimal-contact setting for screening and diagnosing symptoms.[35]

Real-time TUS can be used by a variety of health care professionals with minimal to no ultrasound training when guided by an imaging professional. However, as the use of real-time TUS continues to expand to different clinical areas, the clinical effectiveness of real-time TUS compared with traditional in-person ultrasound remains uncertain.[7,8]

The current report aims to provide a summary of the clinical effectiveness of real-time TUS (i.e., synchronous remotely supervised ultrasound) compared with ultrasound delivered using the traditional in-person model. This report also aims to summarize the relevant recommendations from evidence-based guidelines relating to TUS.

Research Questions

1. What is the comparative effectiveness of real-time TUS (remotely supervised ultrasound) compared with the traditional service model of ultrasound with an in-person imaging specialist insofar as patient care quality, service quality, and access to care are concerned?
2. What are the evidence-based guidelines regarding the use of TUS in clinical practice?
3. What are some reported perceived strengths and challenges associated with the use of TUS in clinical practice?

Methods

Literature Search Methods

An information specialist conducted a literature search on key resources including MEDLINE, the Cumulative Index to Nursing and Allied Health Literature (CINAHL), the Cochrane Database of Systematic Reviews, the International HTA Database, the websites of Canadian and major international health technology agencies, as well as a focused internet search. The search approach was customized to retrieve a limited set of results, balancing comprehensiveness with relevancy. The search strategy comprised both controlled vocabulary, such as the National Library of Medicine's MeSH (Medical Subject Headings), and keywords. Search concepts were developed based on the elements of the research questions and selection criteria. The main search concepts were telemedicine or remote supervision and ultrasound. The search was completed on August 27, 2024, and was limited to English-language documents published since January 1, 2019.

Selection Criteria

One reviewer screened citations and selected studies. In the first level of screening, the titles and abstracts were reviewed, and potentially relevant articles were retrieved and assessed for inclusion. The final selection of full-text articles was based on the inclusion criteria presented in Table 1. Articles published before 2019 were excluded due to the rapid timelines for this report and focus on current literature.

Table 1: Selection Criteria

Criteria	Description
Population	Patients seeking ultrasound exams, of any age
Intervention	Real-time TUS (remotely supervised ultrasound)
Comparator	Traditional service model (standard ultrasound delivered in-person by an imaging specialist)
Outcomes	Q1: Clinical effectiveness (e.g., patient care quality, service quality, access to care) Q2: Recommendations related to the appropriate use of TUS in clinical practice Q3: Strengths and challenges associated with the use of TUS in clinical practice
Study designs	Health technology assessments, systematic reviews, randomized controlled trials, nonrandomized studies with a control group, evidence-based guidelines
Exclusion criteria	• **Interventions:** Asynchronous TUS or any intervention without real-time expert supervision, guidance, or feedback • **Comparators:** Standard in-person ultrasound delivered by a nonspecialist (e.g., student, nonclinician, patient) • Articles published before 2019 • Simulation setting • Duplicate publications • Case reports

TUS = teleultrasound.

Critical Appraisal of Individual Studies

The included publications were critically appraised by 1 reviewer using the following tools as a guide: The Downs and Black checklist[20] for primary studies, the A Measurement Tool to Assess Systematic Review 2 (AMSTAR 2)[21] for systematic reviews (SRs), and the Appraisal of Guidelines for Research and Evaluation (AGREE) II instrument[22] for guidelines. The strengths and limitations of each included publication were described narratively.

Summary of Evidence

Quantity of Research Available

A total of 555 citations from the literature search were identified. Following screening of titles and abstracts, 453 citations were excluded and 102 potentially relevant reports from the electronic search were retrieved for full-text review. Fifty-two potentially relevant publications from the grey literature search were also retrieved. Of these potentially relevant articles, 143 were excluded for various reasons. Overall, 11 publications met the inclusion criteria. These comprised 6 prospective nonrandomized studies, 1 nonrandomized controlled trial, 1 randomized noninferiority trial, and 3 SRs. Appendix 1, Figure 3 presents the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA)[23] flow chart of the study selection.

Additional references of potential interest are provided in Appendix 5.

Study Characteristics

- Eight primary studies and 3 SRs were included in this report, totalling 1,591 participants across 7 countries who underwent TUS or traditional in-person ultrasound.
- No relevant evidence-based guidelines for TUS were identified.

Detailed characteristics of the 11 included studies are presented in Table 4 and Table 5 in Appendix 2.

Study Design

Primary Studies and Systematic Reviews

- Eight primary studies[24-31] (6 prospective nonrandomized studies;1 randomized noninferiority trial; 1 prospective, parallel, nonrandomized controlled trial) were published between 2019 and 2024.
- Three SRs[9,32,33] were published between 2020 and 2024 and included 4 relevant primary studies published between 1996 and 2017. Only results of the relevant studies from the following SRs are included in the present report:
  - the SR by Alhussein et al. (2024)[32] included 9 publications, of which 1 validation study was relevant to the present report
  - the SR by Duarte et al. (2021)[9] included 10 publications, of which 1 prospective nonrandomized controlled trial was relevant to the present report

- the SR by Salerno et al. (2020)[33] included 15 publications, of which 2 feasibility studies were relevant to the present report.

Evidence-Based Guidelines

No relevant evidence-based guidelines were identified for TUS.

Country of Origin

The included primary studies were conducted by authors in China, France, Poland, and the US.[24-31] The SRs[9,32,33] were conducted by authors in Brazil and the US, and the 4 studies included in the SRs originated from France, Norway, and 2 from Korea.

Patient Population

A summary of the patient population and clinical setting are provided in Table 4 (primary studies) and Table 5 (SRs).

- The 8 primary studies included 1,337 adult and pediatric participants. All studies compared real-time TUS with conventional ultrasound.
- A total of 254 participants from the relevant studies included in the 3 SRs comprised of both adult or pediatric populations who were referred for an electrocardiogram (ECG) or abdominal exam for various reasons.

Interventions and Comparators

The intervention used in all studies included in this report was real-time TUS delivered through various methods:

- 6 primary[24-27,30,31] studies and 1 SR[32] reported the use of robotic-assisted TUS
- 1 study[29] reported on the use of a hand-held pocket-sized ECG
- 1 primary study[28] and 2 SRs[9,33] reported on the use of real-time telementored ECG.

In all cases, the comparator was the use of conventional in-person ultrasound delivered by a trained imaging professional.

A summary of the intervention, comparator, and operator characteristics are provided in Table 4 (primary studies) and Table 5 (SRs).

Outcomes

The relevant outcomes reported by the included studies are summarized in Table 2.

Table 2: Outcomes Reported by the Included Studies

Type of outcome	Description
Procedural effectiveness outcomes	• Image quality[23,24,26,27,29-31] • Scan duration[23-27,29,30] • Diagnostic consistency[8,23-32]

Care and service quality outcomes	• Patient satisfaction:[23,24,26,28-30]
	  ◦ comfortability
	  ◦ fear
	  ◦ acceptance of TUS and telecommunications
	  ◦ exam duration
	• Clinician satisfaction:[24,26,29,30]
	  ◦ comfortability
	  ◦ exam satisfaction
	  ◦ exam duration
	  ◦ technical performance and telecommunications
	• Accessibility[24,26,28-30,32]

TUS = teleultrasound.

Summary of Findings

- Real-time TUS was comparable to conventional in-person ultrasound in relation to exam image quality and diagnostic consistency for various types of exams, as determined by expert review. However, real-time TUS exams took significantly longer to complete in most studies, averaging 6 minutes longer.
- Patients expressed a high level of satisfaction with real-time TUS regarding comfortability, telecommunication quality, exam duration, and accessibility for various types of exams. However, in some studies where robotic-assisted TUS systems were used, up 10% of patients reported feeling discomfort, pain, or fear, although no serious adverse events were reported.
- Clinicians and operators expressed a high level of satisfaction with real-time TUS in terms of the quality of exam images, telecommunication quality, and scan duration. However, some clinicians and operators reported that they experienced physical discomfort with using the system and technical difficulties for a subset of exams.
- Three evidence-based guidelines were included in this review to provide clinical guidance on the use of point-of-care ultrasound for central venous catheter insertion in the acute care setting (i.e., emergency department and intensive care unit).

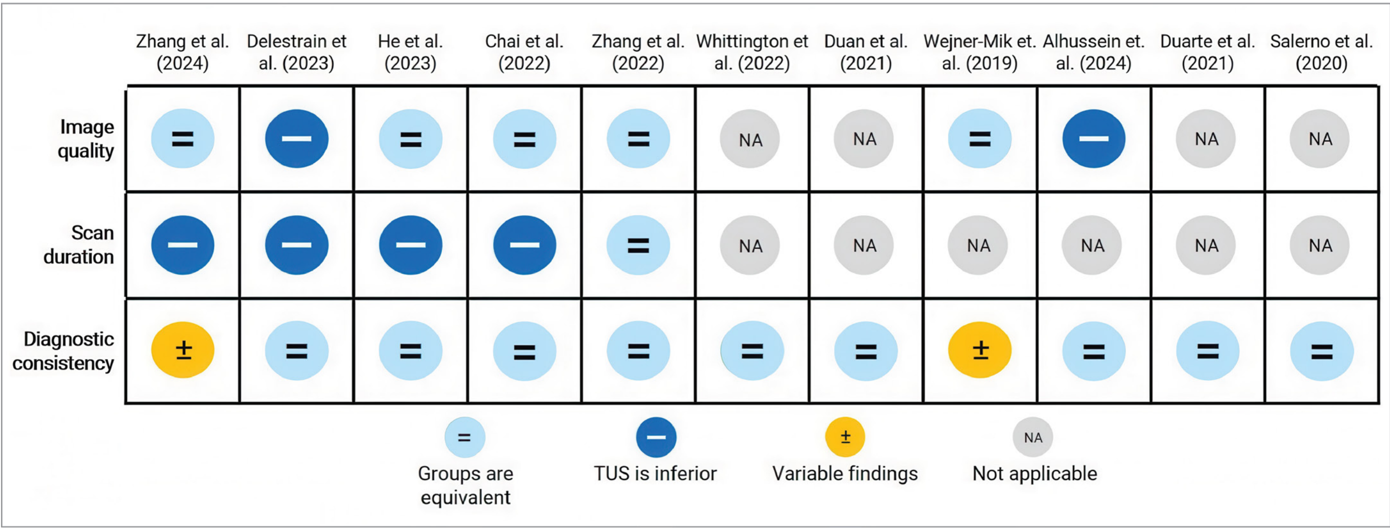
Appendix 3 presents the main study findings by outcome.

Summaries of the outcomes related to procedural effectiveness (i.e., image quality, scan duration, diagnostic consistency) are presented in Figure 1 and Table 6.

Summaries of outcomes related to care and service quality (i.e., safety and complications, patient satisfaction, clinician satisfaction, accessibility) are presented in Figure 2 and Table 7.

Real-Time TUS in Clinical Practice: Procedural Effectiveness

Figure 1: Summary of Findings Related to Procedural Effectiveness



NA = not applicable; TUS = teleultrasound.

Notes: The coloured circles and symbols represent the findings from studies that compared procedure-related outcomes between real-time TUS and conventional ultrasound groups.

Light blue with equal sign = Real-time TUS and conventional ultrasound findings were equivalent or not significantly different ($P \geq 0.05$).

Blue with minus sign = TUS was inferior to conventional ultrasound.

Orange with ± sign = Variable findings were reported for the outcome (equivalence and differences between groups).

Grey with NA = The study did not report on this outcome or no comparisons were made between groups.

Exam Image Quality

Overall, the image quality of the ultrasound exams was not statistically significantly different between TUS and conventional ultrasound groups (Table 6). Seven of the 11 studies reported this outcome:

- Five[24,27,28,30,31] of the 8 primary studies reported that the quality of images obtained for real-time TUS were comparable to images obtained using conventional ultrasound, with no statistically significant differences between groups ($P > 0.05$).
- Delestrain et al. (2023)[25] and Alhussein et al. (2024)[32] reported that the image quality was significantly higher for the conventional ultrasound group than the TUS group ($P < 0.05$).
- The remaining 2 primary studies[26,29] and 2 SRs[9,33] either did not report on this outcome or did not report on image quality for the conventional ultrasound group.

Scan Duration

Overall, the mean length of time to complete the ultrasound was statistically significantly longer for the TUS group compared with the conventional ultrasound group (Table 6). Five primary studies[24,25,27,30,31] reported this outcome:

- The average scan time ranged from 5.6 minutes to 26 minutes for the TUS group, and 5.2 minutes to 13.9 minutes for the conventional ultrasound group. Four studies[24,25,27,30] reported significantly longer average scan times for the TUS group compared to the conventional ultrasound group ($P < 0.05$), while 1 study[31] did not find significant differences between groups.
- The remaining 3 primary studies[26,28,29] and all 3 SRs[9,32,33] either did not report on this outcome or did not report on scan duration for the conventional ultrasound group.

Diagnostic Consistency

Overall, TUS and the conventional ultrasound groups did not show statistically significant differences in diagnostic consistency (e.g., agreement, correlation), although the results were mixed (Table 6). This outcome was reported by all 11 studies:

- Six primary studies[24-27,29,31] and all 3 SRs[9,32,33] reported "good" to "excellent" agreement, with similar diagnostic values and no statistically significant differences between the TUS and conventional ultrasound groups.
- Two primary studies reported variable findings for diagnostic consistency.[28,30] Zhang et al. (2024)[30] reported "very good" consistency in the diagnosis of 29 types of disease and most structural measurements between the 2 ultrasound methods. Zhang reported that TUS underestimated the transverse diameter of the kidney compared with conventional ultrasound ($P = 0.024$ to 0.006). Similarly, Wejner-Mik et al. (2019)[28] reported good correlation for cardiac anatomical dimensions and agreement on cardiac abnormalities between groups but reported weaker correlation on the measurement of the right ventricle's systolic function ($r = 0.52$; $P = 0.0037$).

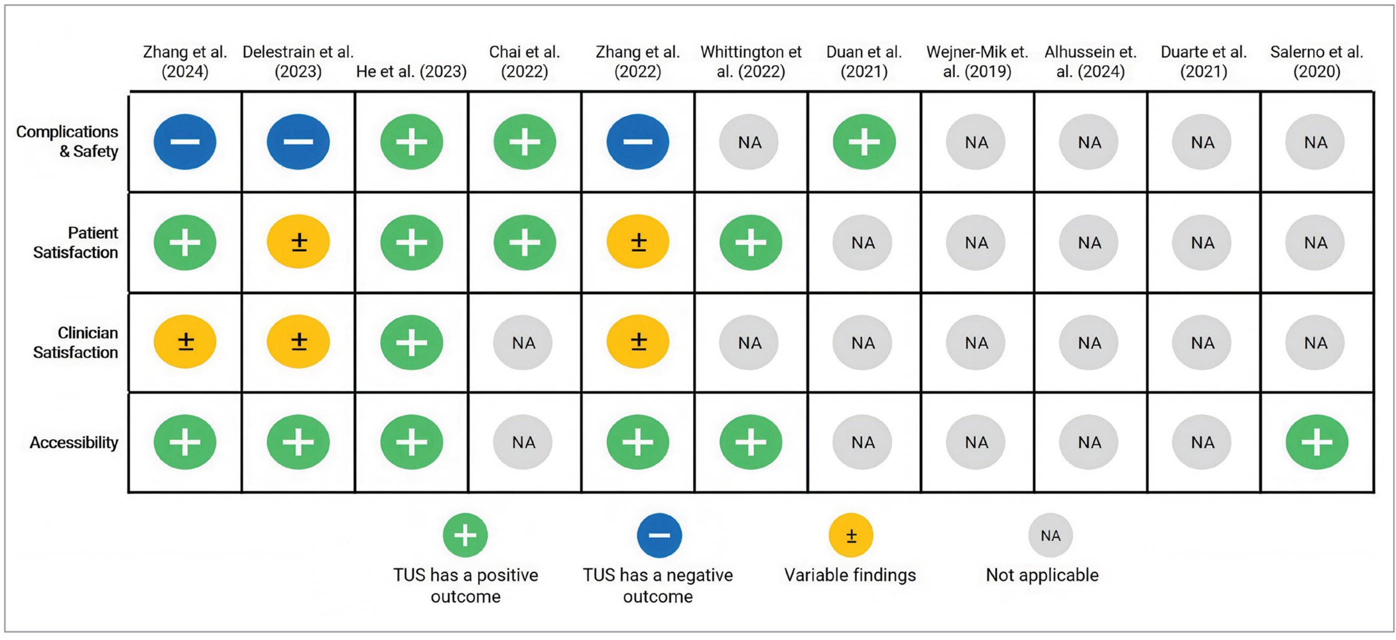
Complications and Safety

Findings related to patient-reported complications and safety were mixed across the 6 primary studies that reported this outcome (Table 7). Reported complications included temporary pain and discomfort during the exam.

- Three primary studies reported no injuries,[24,27] complications,[26] or significant changes in vital signs[26] for patients who underwent TUS.
- Three other studies[25,30,31] reported complications or adverse events relating to robotic-assisted TUS:
  - Zhang et al. (2024)[30] reported that 8.4% of patients experienced mild pain during the abdominal exam.
  - Zhang et al. (2022)[31] reported that 7.2% of patients experienced neck discomfort or temporary suffocation during the thyroid exam.
  - Delestrain et al. (2023)[25] reported that 5.3% of patients reported temporary pain during the exam, although no severe adverse events occurred.

Real-Time TUS in Clinical Practice: Care and Service Quality

Figure 2: Summary of Findings Related to Care and Service Quality



NA = not applicable; TUS = teleultrasound.

Notes: The coloured circles and symbols represent the findings from studies that examined care and service quality–related outcomes for real-time TUS.

Green with plus sign = A positive experience with TUS relating to the outcome of interest was reported.

Blue with minus sign = A negative experience with TUS relating to the outcome of interest was reported.

Orange with ± sign = Variable findings were reported for the outcome of interest.

Grey with NA = The study did not report this outcome.

Patient Satisfaction

Overall, patients indicated a high level of satisfaction with TUS according to several domains captured in self-reported questionnaires, although there were variable findings relating to comfort with TUS (Table 7). Six[24,25,27,29-31] of the 11 studies reported this outcome.

Acceptance

- In 3 studies[27,30,31] that assessed patient acceptance, 85.6% to 95.3% of patients indicated acceptance of the TUS system.

Comfort

- In 5 studies[24,25,27,30,31] that assessed patient comfort, 90% to 100% of patients indicated no discomfort during the TUS exam or indicated comfort in knowing the robotic TUS device was controlled from elsewhere.
- In a study[25] that used robotic TUS in a pediatric population, 45% of parents reported that the child felt less pressure with the system compared with conventional ultrasound. Conversely, 16% of parents reported that their child felt increased pressure from the robotic system.

Fear

- In 3 studies[27,30,31] that assessed patient fear, 89.2% to 96% of patients reported no fear of the robotic TUS system.

Telecommunications

- Three studies[25,29,30] assessed patient satisfaction with communicating with the TUS sonographer during the TUS exam or during remote consultation or image interpretation after the TUS exam. For each of the 3 studies, more than 90% of patients and parents were either satisfied or comfortable with the remote procedure and consultation.

Scan Duration

- In 3 studies[27,30,31] that assessed patient satisfaction with TUS exam duration, 85.8% to 94.3% of patients indicated acceptance or satisfaction with the length of time.

Clinician Satisfaction

Overall, both teleclinicians (i.e., teleradiologists, telesonographers) and patient site assistants indicated a high level of satisfaction with real-time TUS, although there were variable findings relating to comfort and technical performance (Table 7). Four[25,27,30,31] of the 11 studies reported this outcome.

Comfort

- Delestrain et al. (2023)[25] assessed comfort levels in the telesonographers' handling of the remote robotic ultrasound probe and patient site assistants holding the robotic system. The authors reported that 34% of telesonographers experienced more physical strain than conventional ultrasound, and 16% of site assistants experienced significant physical strain.

Exam Satisfaction

- In 2 studies[30,31] that assessed overall satisfaction with exam quality, 83.3% to 98.6% of exams were considered satisfactory and accepted by the teleclinicians.

Technical Performance

- In 3 studies[27,30,31] that assessed satisfaction with the technical performance of the TUS system, teleclinicians reported difficulty during 11.8% to 18.1% of exams. Additionally, some telesonologists (a sonographer that provides remote ultrasound services) expressed concern in the scope of scanning of study participants with large breasts.

Telecommunications

- In 3 studies[27,30,31] that assessed communication quality between the remote and patient sites, telesonographers reported no obvious transmission delays in 84.3% to 97.6% of exams.
- In the study by Delestrain et al. (2023),[25] 98% of telesonographers felt the audio was sufficient to communicate with the site assistants. Similarly, all patient site assistants reported feeling comfortable communicating with the remote sonographer using the TUS system.

Scan Duration

- In 3 studies[27,30,31] that assessed clinician satisfaction with TUS scan duration, on average, 85.7% of exams (range, 84.9% to 86.7%) were reported as satisfactory in duration by the teleclinicians.

Accessibility

The accessibility of TUS was assessed most frequently by studies that used patient- and clinician-completed questionnaires to examine the following areas: patient willingness to pay for TUS as a service, patient willingness to undergo TUS in the future, and the use of TUS in routine clinical practice (Table 7). Six of the 11 studies reported this outcome:

- In 3 studies,[27,30,31] 87.1% to 90% of patients were willing to pay a certain amount of extra money to undergo TUS by an expert compared with conventional ultrasound.
- In the same 3 studies, 88.3% to 100% of teledoctors accepted TUS as a routine ultrasound tool in clinical practice.
- Delestrain et al. (2023)[25] reported that 87% of parents agreed to the use of TUS in the future for their child.
- Whittington et al. (2022)[29] found that patient satisfaction with TUS was not significantly associated with age, race, parity, body mass index, rurality, or external referral practice. However, the patient satisfaction analysis was focused on remote exam interpretation following the real-time TUS procedure.
- The relevant study included in the SR by Alhussein et al. (2024)[32] reported that successful clinical application of TUS used social network video call technology, indicating a free and widely available telecommunication tool can be used for TUS application in clinical practice.

Advantages and Challenges of Teleultrasonography

Some potential advantages and challenges associated with TUS application in clinical practice, as reported and perceived by various authors that reviewed the current literature are summarized in Table 3.[12,14,34]

Table 3: Potential Strengths and Challenges Associated With Teleultrasonography

Potential strengths	Potential challenges
Health care system and clinical practice	
• Reduced health care system spending because of lower costs of dedicated imaging centres • Increased diagnostic imaging capacity and variety of exams offered in underserved, rural, or remote regions • Increased equitable access to ultrasound services and specialists • Enhanced ability to deploy in emergency situations • Reduced cost of transporting or temporarily relocating trained clinicians to geographically distant areas • Cost savings associated with transporting patients to health facilities that have ultrasound capacity	• The acquisition costs (including imaging equipment, video conferencing technology, piloting, and troubleshooting) may be high for individual practitioners or small communities using TUS technology, particularly robotic-assisted TUS • Uncertainty around image quality and diagnostic quality compared with conventional ultrasound • Regulations for telehealth practice may be underdeveloped in many countries • No standardized regulatory guidelines regarding patient care responsibilities (e.g., obtaining consent, patient preparation, examination, safety) and professional liability

Potential strengths	Potential challenges
• Lower out-of-pocket costs for patients requiring travel for ultrasound exams • Flexibility in training and supervision of ultrasound operator • Multiple expert opinions are available for consultation and exam review, including for specialty or complex exams • With access to experts, TUS may expand the variety of examinations offered to include more complex or specialty scans • Quicker time to diagnosis and consultation with patients	• Special considerations may be required for transmission and progression of personal data across jurisdictions • Legal regulations may restrict sharing of patient data and images between medical professionals and facilities across jurisdictions • Lack of standardized training and technical protocols, guidelines, and regulations as relates to TUS operation and patient engagement and communication • Complex ultrasound examinations may not be possible without technological advancements and/or the use of AI assistance
Technical implementation	
• Internet bandwidth requirements are low for satisfactory image quality • International standard quality assessment tools exist to grade images • Hand-held portable devices can be used both standalone (without requiring additional hardware) or compatible with Android and iOS devices • Mobile applications may be more user-friendly than traditional ultrasound software (relevant for point-of-care or patient end use) • Certain devices allow immediate sharing and storing of images to a cloud system	• Internet network connectivity is a requirement for both real-time and asynchronous TUS • Software requires regular updates and compatibility is not guaranteed • Subscription and storage fees may increase costs • Devices that require USB power may experience significant battery drain • Hand-held portable devices may have limited diagnostic functionality to be used as a standalone imaging tool, depending on the scope of the requested exam or protocol • Android/iOS based hand-held ultrasound devices require sophisticated mobile devices for application compatibility • The screen size is smaller for TUS devices that connect to mobile devices or tablets • Smaller devices may be susceptible to loss or theft

TUS = teleultrasound.

Summary of Critical Appraisal

Appendix 4 provides details regarding the strengths and limitations of the included primary studies[24-31] (Table 8) and SRs[9,32,33] (Table 9).

Primary Studies

The included studies were explicit in terms of reporting the methodological characteristics required for critical appraisal but had several limitations related to the external and internal validity that may reduce the certainty and generalizability of the findings.

For reporting, the authors of all included studies[24-31] clearly described the objective of the study, the main outcomes to be measured, the intervention of interest, and the main findings. Most authors reported on the characteristics of the participants,[24,26,27,29-31] and the randomized controlled trial compared group differences (i.e., potential confounders) in demographics of the randomized participants. Of the 8 studies, 7 reported adverse events of the intervention and 6 reported patient-related experiences.[24,25,27,29-31] The actual P values

for the main outcomes were reported in all studies. All the predefined outcomes were relevant and valid and adequately reported.

For external validity, the studies were conducted in both inpatient and outpatient hospital or clinic settings (i.e., hospital, disability care centre, mobile car) located in urban and rural or remote areas, representing high ecological validity. However, TUS can require technological (e.g., 5G internet connectivity, robotic system) and human-related resources that may not be widely accessible and, therefore, not representative of the imaging mode received by most patients in rural or remote settings. Furthermore, the patients included in the studies may not be representative of the entire population from which they were selected, which may limit the generalizability of findings to different settings or patient groups outside the study settings; 7 of the 8 primary studies[24-28,30,31] recruited patients from a single centre, and half of the studies[24-26,28] had small sample sizes of less than 50 patients.

For internal validity related to bias, there were potential risks of selection, performance, and detection biases because 7 of the 8 studies were not randomized controlled trials by design.[24-28,30,31] Four studies reported a lack of operator masking (an unawareness of group assignment).[26,28-30] Additionally, 2 studies[26,30] that used robotic TUS excluded certain exams due to limitations with the robotic arm, which may have increased the risk of performance and detection bias to favour TUS. Similarly, robotic-assisted TUS was limited to scanning specific organs due to limitations of the robotic probe, which may have resulted in selection and performance bias.[24-27,30,31] However, statistical tests were used appropriately, and the main outcome measures were valid and reliable.

For internal validity related to confounding, there were some differences between groups in recruitment strategies and in the experience of operators who performed the procedures. The work experience and clinical expertise of the various teleclinicians and TUS operators differed across the studies, and often the exact level of experience was not reported.[24-31] It is possible that lower-skilled teleclinicians and operators could negatively impact procedure-related outcomes. Similarly, each study used a different protocol and length of time to train the teleclinician and operators, particularly with the use of robotic-assisted TUS. Individual differences in learning and mastering the technology may have significantly influenced the interpretation of ultrasound findings.

None of the authors of the included studies identified and adjusted for potential confounding factors in the analyses. None of the authors of the included studies reported whether sample size calculations were performed, leaving it unclear whether any nonsignificant differences in certain outcomes were due to insufficient power in the studies. Similarly, clinical and patient satisfaction assessments were collected only for patients who underwent real-time TUS.[25,27,30,31] Satisfaction with service and care quality was not assessed in the conventional ultrasound group; therefore, no direct or statistical comparisons could be made for these outcomes.

Systematic Reviews

Overall, the 3 SRs met a limited number of the AMSTAR 2 criteria, indicating low to moderate quality of the evidence.

The authors of all 3 SRs[9,32,33] included components of the PICO (population, intervention, comparison, outcome) process that were clearly defined in research questions and inclusion criteria. The reviews were comprehensive in their search strategies, clearly defined their inclusion criteria and objectives, and included a variety of study designs. The literature search strategy was comprehensive and clearly described in all SRs and it used multiple combinations of keywords, enhancing the reproducibility of the reviews. The authors of 1 SR[9] searched the reference lists of the included studies for additional potentially relevant studies. All review authors disclosed the funding sources and potential conflicts of interest but did not report the funding sources or conflicts of interest for the included studies.

One of the 3 SRs[33] reported that study selection was performed in duplicate, and it is unclear if data extraction and quality assessment were also conducted in duplicate for any of the SRs. The SRs did not include a list of excluded studies or reasons for study exclusion.

The review authors of all 3 SRs narratively summarized the findings from the included studies, with limited numerical results, thereby reducing the clarity of findings. Alhussein et al. (2024)[32] noted that a meta-analysis was not conducted due to the heterogeneity of included study designs. None of the SRs included an assessment of methodological quality or heterogeneity among the included studies.

Limitations

This report is limited by the quantity and quality of research identified that met our inclusion criteria. First, the primary studies and SRs identified are at risk of bias due to several important limitations outlined in the Summary of Critical Appraisal section. Only 4 of the 32 studies in the included SRs were relevant to this report, and all showed low to moderate quality of evidence. Additionally, no evidence-based guidelines concerning the use of TUS in clinical practice were identified.

Second, the literature search was limited to English-language articles and articles published within the past 5 years. Therefore, the strength of the conclusions in this report may be limited by the exclusion of relevant articles published before 2019.

Third, this report was limited by clinical scope, which focused on real-time TUS. Although real-time and asynchronous (“store and forward”) methods of TUS are both widely used, this report did not examine the use of asynchronous TUS and its effectiveness compared with in-person ultrasound.

Finally, 6 of the 8 primary studies examined robotic-assisted real-time TUS, which may limit the generalizability of findings to other types of TUS systems. However, this report includes studies published through the height of the COVID-19 pandemic when remote robotic-assisted TUS systems were proposed for screening or diagnosing COVID-19 symptoms.[25] The unprecedented demand on the health care system during that time led to the rapid development and clinical expansion of innovative tools to provide urgently needed ultrasound services in a minimal-contact setting.[35] Therefore, it is possible that the high representation of robotic-assisted TUS systems in this report is reflective of the changing landscape of real-time TUS.

Conclusions and Implications for Decision- or Policy-Making

We reviewed the clinical evidence from 8 primary studies (6 prospective nonrandomized controlled trials;1 randomized noninferiority trial; 1 prospective, parallel, controlled nonrandomized trial) and 3 SRs, all comparing real-time TUS systems (i.e., robotic-assisted, pocket hand-held ECG, general) with conventional in-person ultrasound. The role of ultrasound imaging specialists and the scope of practice varies globally, and this review included various imaging professionals (i.e., sonographer, sonologist, radiologist, specialist physician) that reflect the practices relevant to each study's setting.

The 8 primary studies identified in this report showed high-quality evidence, although most were limited by a single-centre nonrandomized controlled study design and small sample size. The 3 SRs met a limited number of the AMSTAR 2 criteria, showing low to moderate methodological rigour.

Overall, real-time TUS was found to be comparable to conventional in-person ultrasound with regards to diagnostic consistency and exam image quality, and it was well tolerated and accepted by patients and clinicians. However, real-time TUS took, on average, more than 25% (or 6 minutes) longer to complete than in-person ultrasound. For some studies that used robotic-assisted TUS, temporary safety-related complications or discomfort was reported by up to 10% of patients, and technical difficulties occurred in up to 20% of exams. Notably, the included studies performed a wide range of exam types (i.e., abdominal, thyroid, obstetrics, renal, cardiac, pulmonary, and breast exams) and included both comprehensive and point-of-care exams, highlighting the growing role and expanding application of TUS in clinical practice.

To date, most studies report outcomes relating to the technical feasibility and image interpretation of real-time TUS. When there is acceptable variability in population and intervention characteristics, conducting a systematic review with network meta-analysis, when appropriate, may be helpful to understand the relevant differences between real-time TUS and conventional in-person ultrasound.

Considering the current limitations of the body of evidence, future well-controlled larger studies are needed to evaluate care quality beyond feasibility and safety of TUS. This includes examining patient perspectives relating to accessibility (equitable access to services, financial burden) and personal preference and expectations. This may include designing studies that incorporate surveys into both study arms or into the preintervention and postintervention design. Studies that examine the real-world community and health system impact of real-time TUS are also needed to determine the benefit of TUS for increasing access to services and providing timely and accurate diagnoses, particularly in resource-limited settings.

As many real-time TUS devices are more portable and reportedly less expensive and easier to use than traditional ultrasound, they are increasingly available globally. Real-time TUS has been shown to be an effective, accessible, and safe method of imaging patients, which may lead to improved patient outcomes. Other studies have found that TUS is associated with reduced wait times, patient care load, and system-level costs, as well as improved treatment planning and intervention.[1,12-14] Studies that evaluate current clinical unmet needs and training programs with well-defined procedural competencies are needed.[1,12] Finally, regulations supporting the adoption of real-time TUS in clinical practice and development of data-sharing agreements across different legislative spaces are also needed.[12,36]

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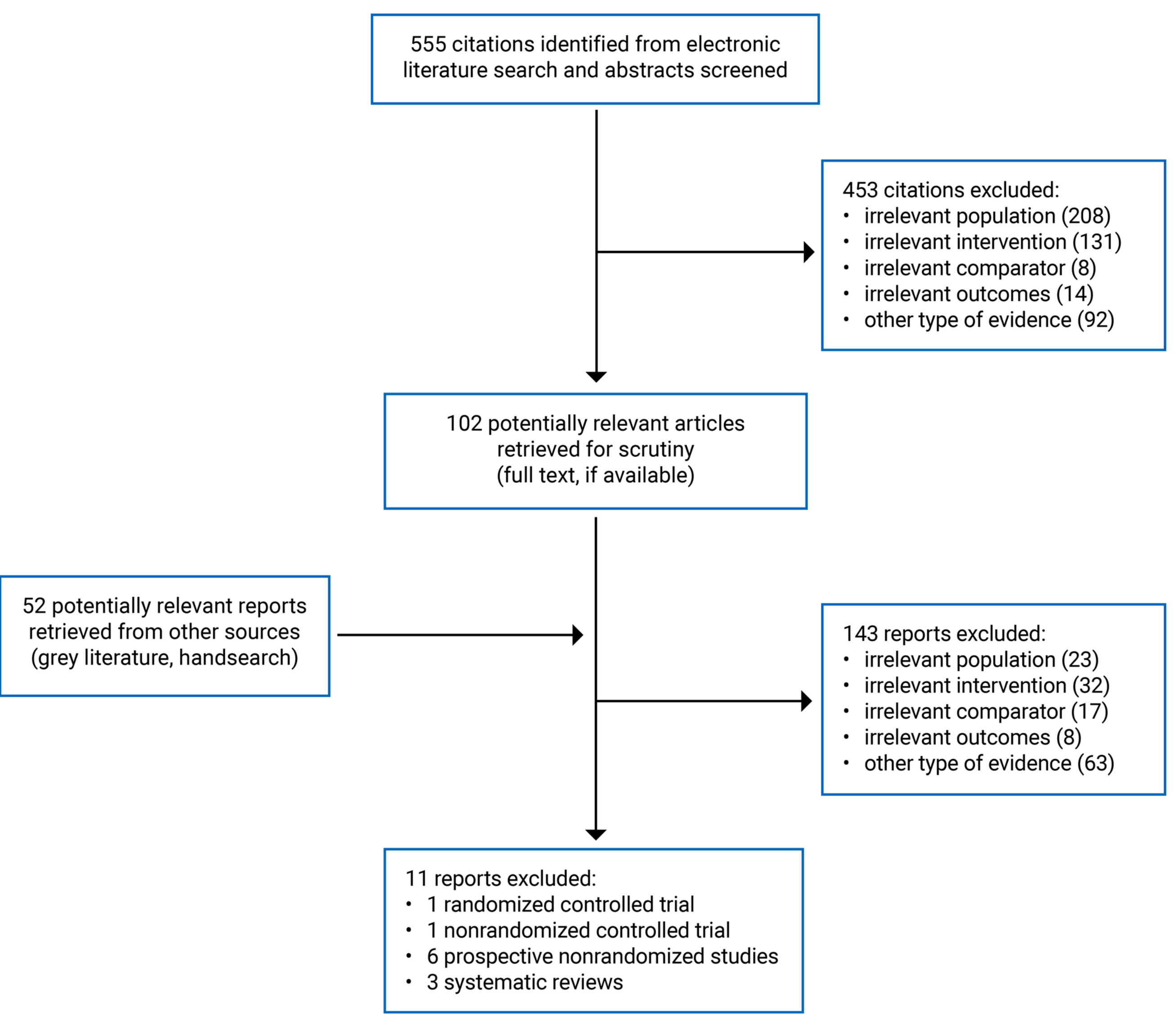
Appendix 1: Selection of Included Studies

Figure 3: Selection of Included Studies



Appendix 2: Characteristics of Included Publications

Please note that this appendix has not been copy-edited.

Table 4: Characteristics of Included Primary Studies

Study citation, country, funding source	Study design, outcomes	Population characteristics	Intervention and comparator(s)
Zhang et al. (2024)[30] **Country:** China **Funding source:** Various	Prospective non-RCT design **Type of ultrasound:** Robotic **Sample size**: 401 **Relevant Outcomes:** • diagnostic consistency • image quality • safety • scan duration • patient acceptance	Patients scheduled for an abdominal ultrasound examination. **Mean age, years ± SD:** 54.96 ± 15.43 (range: 12 to 88 years) **Sex, %:** • Female: 54.1 • Male: 45.9	**Intervention:** 5G-based telerobotic abdominal ultrasound (MGIUS-R3, MGI Tech Co., Ltd., Shenzhen, China). Teleultrasound Operator: Onsite assistant who received training session; tele-radiologist guided. **Comparator:** Conventional in-person ultrasound with the Wisconic Clover 60. Conventional ultrasound operator: Onsite radiologist with 5 to 15 years of clinical experience in abdominal ultrasound.
Delestrain et al. (2023)[25] **Country:** France **Funding source:** Grant from European Space Agency	Prospective interventional crossover design **Type of ultrasound:** Robotic **Sample size**: 38 **Relevant Outcomes:** • diagnosis agreement • patient satisfaction • safety • scan duration	Children aged 1 to 10 years in 2 regional hospitals in the pediatric department, requiring lung, abdominal, or cardiac ultrasound **Mean age, years ± SD:** 5.7 ± 2.7	**Intervention:** MELODY telerobotic ultrasound system Teleultrasound Operator: Pediatric caregivers with specific skills in using the MELODY system with children; expert sonographer guided. **Comparator:** Conventional in-person ultrasound with the Mindray TE7 system. Traditional ultrasound operator: Senior expert sonographers

He et al. (2023)[27]
Country: China
Funding source: Various
	Prospective non-RCT design
	Type of ultrasound: Robotic
	Scenario A: Teleultrasound exam and conventional exam conducted at a rural hospital
	Scenario B: Teleultrasound exam conducted in mobile car setting in remote setting.
	Sample size: 83 (Scenario 1: 63; Scenario 2: 20)
	Relevant Outcomes:
	• diagnostic agreement
	• image quality
		Patients referred for breast examinations.
		Mean age, years ± SD:
		• Scenario 1: 53.5 ± 13
		• Scenario 2: 41.8 ± 8.7
		Sex, %:
		• Scenario 1:
		  ◦ Female: 96.8
		  ◦ Male: 3.2
		• Scenario 2:
		  ◦ Female: 100
		  ◦ Male: 0
			Intervention: 5G based telerobotic ultrasound-MGIUS-R3; MGI Tech Co., Ltd., Shenzhen, China
			Teleultrasound Operator: Onsite assistant- hospital auxiliary personnel with 1 year experience; expert sonographer guided.
			Comparator: Conventional in-person ultrasound onsite sonologist with 15 years of experience.
			Traditional ultrasound operator: Sonologist with 15 years of experience.

Study citation, country, funding source	Study design, outcomes	Population characteristics	Intervention and comparator(s)
	• safety • scan duration		
Chai et al. (2022)[24] **Country:** UK **Funding source:** Zhejiang Medicine Scientific and Technology Project	Prospective non-RCT **Type of ultrasound:** Robotic **Sample size**: 49 **Relevant Outcomes:** • diagnosis agreement • image quality • scan duration • safety (complications: pain, skin lesions, swelling, bleeding, crush injuries)	Adult patients located at a remote long-term care centre requiring abdominal ultrasound. **Mean age, years (range):** 61 (19 to 91) **Sex, %:** • Female: 0 • Male: 100	**Intervention:** 5G-base robot-assisted remote ultrasound Teleultrasound Operator: Sonographers with 5-year experience **Comparator:** Conventional bedside ultrasound Traditional ultrasound operator: Sonographers with 5 years of experience
Zhang et al. (2022)[31] **Country:** China **Funding source:** Various	Prospective, parallel, and controlled study non-RCT design **Type of ultrasound:** Robotic **Sample size**: 139 **Relevant Outcomes:** • diagnostic consistency • image quality • patient acceptance • safety • scan duration	Patients undergoing thyroid ultrasound. **Mean age, years ± SD:** 58.6 ± 12.7 **Sex, %:** • Female: 76.3 • Male: 23.7	**Intervention:** 5G-based telerobotic ultrasound (MGIUS-R3, MGI Tech Co., Ltd., Shenzhen, China) Teleultrasound Operator: Onsite assistant who received systematic training session; expert sonographer guided. **Comparator:** Conventional ultrasound examination with the Wisonic Clover 60 system. Traditional ultrasound operator: Doctor with 15 years of clinical experience in thyroid ultrasound

Whittington et al. (2022)[29]
Country: US
Funding source: Centers for Disease Control and Prevention National Center on Birth Defects and Developmental Disabilities
	Randomized noninferiority study design
	Type of ultrasound: General
	Sample size: 585
	Relevant Outcomes:
	• patient satisfaction
	• sensitivity
		Women referred to a maternal-fetal medicine clinic to assess fetal abnormalities.
		Mean age, years ± SD:
		• Intervention: 30.4 ± 6.7
		• Comparator: 29.5 ± 6.6
		Race, %:
		• Intervention:
		  ◦ Black: 24.2
		  ◦ White: 70.1
		  ◦ Other: 5.8
		• Control group:
		  ◦ Black: 22.7
		  ◦ White: 69.1
		  ◦ Other: 8.3
		No significant differences
			Intervention: Teleultrasound and telemedicine counselling; remotely directed and interpreted ultrasound (n = 294)
			Teleultrasound Operator: Registered diagnostic medical sonographers.
			Comparator: Conventional in-person ultrasound and counselling (n = 291)
			Traditional ultrasound operator: Registered diagnostic medical sonographers.

Study citation, country, funding source	Study design, outcomes	Population characteristics	Intervention and comparator(s)
		in demographics between groups.	
Duan et al. (2021)[26] **Country:** China **Funding source:** Medical Research Council	Prospective non RCT **Type of ultrasound:** Robotic **Sample size**: 32 **Relevant Outcomes:** • diagnosis agreement • image quality • scan duration • safety	Patients in the intensive care unit with stable conditions requiring ultrasound to assess for pleural and abdominal effusion. **Mean age, years (range):** 61 ± 20 (13 to 94) • Sex, %: ◦ Female: 37.5 ◦ Male: 62.5	**Intervention:** 5G powered robot-assisted teleultrasound (MGIUS-R3) Teleultrasound operator: Ultrasound physician **Comparator:** conventional in-person ultrasound Teleultrasound operator: Ultrasound physician
Wejner-Mik et al. (2019)[28] **Country:** UK **Funding source:** Medical Research Council	Prospective non RCT **Type of ultrasound:** Pocket-sized hand-held ECG **Sample size**: 30 **Relevant Outcomes:** • diagnosis agreement • diagnostic correlation • image quality	Patients admitted to various hospital departments (i.e., infectious diseases, internal medicine, and cardiology) for TTE. **Mean age, years (range):** 54 ± 14 (24 to 74) **Sex, %:** • Female: 40 • Male: 60 BMI, kg/m^2: 27 ± 6	**Intervention:** Inexperienced operator performed focused TTE using Lumify with real-time collaboration with an experienced cardiologist Teleultrasound operator: Either a nurse or 2 students trained in using the device **Comparator:** Conventional bedside TTE Traditional ultrasound operator: Experienced cardiologist

BMI = body mass index; ICU = intensive care unit; RCT = randomized controlled trial; RTMUS = real-time telementored echocardiography; SD = standard deviation; SR = systematic review; TTE = transthoracic echocardiographic examination.

Table 5: Characteristics of Included Systematic Reviews

Study citation, country, funding source	Study design, outcomes	Population characteristics	Intervention and comparator(s)	Included studies
Systematic reviews				
Alhussein et al. (2024)[32] **Country:** US **Funding source:** None	SR of various study designs (i.e., feasibility, evaluation, pilot, experimental) **Type of ultrasound:** RTMUS **Sample size**: 30 (from relevant study included) **Relevant Outcomes:**	Use of RTMUS in adult population.	**Intervention:** Various RTMUS modalities **Comparator:** Various	1 of 9 studies relevant to present report. Arbille et al. (2014) **Intervention:** Robotic ultrasound Teleultrasound Operator: Nonsonographer operator; sonographer guided **Comparator:** Conventional TTE.

Study citation, country, funding source	Study design, outcomes	Population characteristics	Intervention and comparator(s)	Included studies
	• diagnosis accuracy • image quality			Traditional ultrasound operator: Sonographer
Duarte et al. (2021)[9] **Country:** Brazil **Funding source:** None	SR of various study designs (e.g., prospective, RCT, cohort, cross-sectional) **Type of ultrasound:** Various but all requiring synchronous transmission and real-time oversight. **Sample size:** 115 (from relevant study included) **Relevant Outcomes:** Diagnostic confidence	Use of teleultrasound in various settings with experience ultrasound physician as distant mentor.	**Intervention:** Various teleultrasound methods **Comparator:** Various	1 of 10 studies relevant to present report. Kim et al. (2015) **Population:** Pediatric cases with suspected acute appendicitis in the emergency department **Intervention:** Telementored real-time ultrasound with a resident and expert sonographer Teleultrasound operator: Emergency medicine residents; sonographer guided **Comparator:** Expert-performed conventional ultrasound. Traditional ultrasound operator: Expert
Salerno et al. (2020)[33] **Country:** US **Funding source:** None	SR of various study designs (e.g., prospective, RCT, cohort, cross-sectional) **Type of ultrasound:** Various but all requiring synchronous transmission and real-time oversight. **Sample size**: 98 (from relevant study included) **Relevant Outcomes:** Diagnostic confidence	Use of RTMUS in various settings in adults	**Intervention:** Various teleultrasound methods **Comparator:** Various	2 of 15 studies relevant to present report. **#1.# Afset et al. (1996)** **Country:** Norway **Population:** Patients with known or suspected heart disease (n = 38) **Intervention:** Learner's measurement with real-time remote telementored echocardiography Teleultrasound Operator: learner (inexperienced doctor); sonographer guided **Comparator:** Expert-performed conventional ultrasound. Traditional ultrasound operator: expert sonographer **#2.# Kim et al. (2017)** **Population:** Patients presenting to the ICU and requiring an ECG exam

Study citation, country, funding source	Study design, outcomes	Population characteristics	Intervention and comparator(s)	Included studies
				(n = 60). **Intervention:** Novice sonographer performing ECG with a remote offsite expert. Teleultrasound operator: Novice sonographer; sonographer guided **Comparator:** Expert-performed conventional ultrasound. Traditional ultrasound operator: onsite cardiologist

RTMUS = real-time telementored echocardiography; SR = systematic review; TTE = transthoracic echocardiographic examination.

Appendix 3: Main Study Findings

Table 6: Summary of Findings — Procedural Effectiveness–Related Outcomes

Citation study	Primary study	Image quality, score		Mean scan duration, minutes		Diagnostic consistency
		TUS	Conventional ultrasound	TUS	Conventional ultrasound	
Primary studies						
—	**Zhang et al. (2024)**[30]	4.54 ± 0.63 Each scanned organ was visible in 97.9% of the ultrasound exams using TUS.	4.57 ± 0.61 **P = 0.112** Image quality scores were similar between groups.[a]	12.54 ± 3.20[b] (range 6 to 25)	7.23 ± 2.10 (range 5 to 16) **P = 0.001** TUS took significantly longer than conventional ultrasound.[b]	• Good consistency in the diagnosis of 29 types of disease between the 2 methods: κ = 0.773 to 1.000 • General consistency was achieved in diagnosing renal masses and bladder calculi: κ = 0.664 and 0.661 • No significant group differences in measurements for the aorta, portal vein, gallbladder, kidney (longitudinal diameter), prostate, and uterus. • Small but statistically significant differences were found in the transverse diameters of the kidney (P < 0.05).
—	**Delestrain et al. (2023)**[25]	18.9 ± 3.6	23.1 ± 10.5 **P = 0.011** Image quality score was significantly higher for the conventional ultrasound group.[c]	26 ± 12.5 (range 18 to 30)	13.9 ± 11.2 (range 9 to 15) **P < 0.0001** TUS took significantly longer than conventional ultrasound.	• Substantial agreement between the telerobotic and conventional ultrasound (κ = 0.74, 95% CI, 0.53 to 0.94; P < 0.005). • Abdominal organs and abnormalities were similarly visualized except for the spleen (95%) and pancreas (79%). • Visualization and total lung score were similar between telerobotic and conventional ultrasound.[d] • Cardiac reliable diagnoses with both and nonsignificant differences in measurements were identified. • TUS was able to detect 2 anatomic features, atrial septal defect and patent

Citation study	Primary study	Image quality, score		Mean scan duration, minutes		Diagnostic consistency
		TUS	Conventional ultrasound	TUS	Conventional ultrasound	
						foramen oval, while the conventional ultrasound did not.
—	**He et al. (2023)**[27]	4.86	4.90 **P = 0.159** Image quality did not differ significantly between groups.[e]	10.3 +/− 3.3 (range 5 to 22)	7.6 +/− 3.0 (range 4 to 16) **P = 0.017** TUS took significantly longer than conventional ultrasound.	• 32 of the 34 breast nodules identified using TUS were consistent with those detected using conventional ultrasound (n = 35). • No significant differences between the TUS and conventional ultrasound examinations in the transverse and anteroposterior diameter measurements of the same breast nodules and axillary lymph nodes • Good interobserver agreement between groups for features of the same breast nodules for shape, orientation, margin, echo pattern, posterior features, calcifications, and Bi-RADS[f] category: ICC = 0.893, 0.795, 0.874, 1.000, 0.963, 0.882, and 0.984, respectively)
—	**Chai et al. (2022)**[24]	4.7[g] (IQR 4.5 to 5.0) 68.7% images were scored 5/5	5[g] (IQR 4.7 to 5.0) **P = 0.176** 73.1% of images were scored 5/5 Image quality did not differ significantly between groups.[a]	12.2 ± 4.5 (range: 5 to 26)	7.5 ± 1.8 (range: 5 to 13) **P < 0.001** TUS took significantly longer than conventional ultrasound.	• Overall diagnosis results similar with no significant differences between ultrasound methods (McNemar value = 0.727, kappa value = 0.601 P < 0.001) • 62 and 64 lesions out of 67 lesions were detected by TUS and conventional ultrasound, respectively.
—	**Zhang et al. (2022)**[31]	4.63 ± 0.60 69.8% images were scored 5/5	4.65 ± 0.61 **P = 0.102** Image quality did not differ significantly between groups.[h]	5.57 ± 2.20 (range 2 to 13)	5.23 ± 2.1 (range 2 to 15) **P = 0.164** No significant difference in scan	• Diameter measurement of the thyroid, cervical lymph nodes, and thyroid nodules were not significantly different between methods (P > 0.05) • 124 and 127 thyroid nodules were detected by TUS and conventional

Citation study	Primary study	Image quality, score		Mean scan duration, minutes		Diagnostic consistency
		TUS	Conventional ultrasound	TUS	Conventional ultrasound	
					duration between groups.	ultrasound, respectively; 122 were the same nodules. • Good agreement achieved in the ultrasound features (component, echogenicity, shape, and calcification) and ACR TI-RADS category of the same thyroid nodules between groups (ICC = 0.788 to 0.863).
—	**Whittington et al. (2022)**[29]	—	—	—	—	• TUS is not inferior to conventional ultrasound for the detection of fetal anomalies: ∘ **TUS:** Sensitivity = 85% (63.1% to 93.9% CI) ∘ **Conventional ultrasound:** Sensitivity = 82.14% (63.1% to 93.9% CI) • Specificity, NPV, PPV, and accuracy were than 94% for both groups. • Near perfect agreement with reference standard for anomaly detection: ∘ **TUS:** k[i] = 0.89; Conventional ultrasound: k = 0.87.
—	**Duan et al. (2021)**[26]	4.73[a] (Expert 1: 4.75 Expert 2: 4.71) 70% images were scored 5/5	NR	17 +/− 7[b] (range 9 to 37)	NR	• The overall diagnosis results were basically the same, and there was no significant difference in the level of diagnosis (McNemar value near 1, k[j] = 0.711, P < 0.001) • No significant difference in the diagnosis of 14 disease types and the level of consistency was high (k = 1) • 5 cases of inconsistent diagnoses between the 2 groups: ∘ 3 cases where a positive diagnosis

Citation study	Primary study	Image quality, score		Mean scan duration, minutes		Diagnostic consistency
		TUS	Conventional ultrasound	TUS	Conventional ultrasound	
						was missed by the TUS group ◦ 2 cases where a positive diagnosis was missed by the conventional ultrasound group.
—	**Wejner-Mik et al. (2019)**[28]	Acceptable image quality sufficient for diagnostic use was obtained in over 70% of patients for all the basic views and showed good correlation with conventional ultrasound.[k]	—	12 ± 4	—	• fTTE (TUS) was feasible in all patients: • The dimensions of left ventricle left atrium, and the aorta obtained during fTTE showed good correlation with TTE (conventional ultrasound): r = 0.89, r = 0.82, r = 0.92 respectively (P < 0.0001). • Very good agreement between groups on morphological and functional valvular abnormalities (k = 0.648 to 0.823). • The correlation for TAPSE[l] measurements was less pronounced (r = 0.52; P = 0.0037).
Systematic reviews						
Alhussein et al. (2024)[32]	Arbeille et al. (2014)	Quality of cardiac views was lower than that of the reference	—	—	—	• TUS generated similar measurements to the conventional ultrasound group in 93% to 100% of cases without significant differences (P > 0.05). • TUS detected 86% of the valve leaks or aortic stenoses • TUS provided reliable and acceptable measurements in 86% and 93% of cases respectively, with no false-positive diagnoses.
Duarte et al. (2021)[9]	Kim et al. (2015)	—	—	—	—	• Diagnostic values were similar between TUS and conventional ultrasound groups: ◦ **TUS:** sensitivity: 1.000, specificity: 0.975, PPV: 0.947, NPV: 1.000

Citation study	Primary study	Image quality, score		Mean scan duration, minutes		Diagnostic consistency
		TUS	Conventional ultrasound	TUS	Conventional ultrasound	
						○ **Conventional ultrasound:** sensitivity: 1.000, specificity: 0.987, PPV: 0.973, NPV: 1.000
Salerno et al. (2020)[33]	Afset et al. (1996)	—	—	—	—	• No difference between TUS and conventional ultrasound of mean M-mode and Doppler variables.
	Kim et al. (2017)	—	—	—	—	• There was excellent agreement between the 2 methods, with a correlation coefficient of 0.94 ($P < 0.001$)

ACR TI-RADS = American College of Radiology Thyroid Imaging Reporting and Data System; Bi-RADS = Breast Imaging Reporting and Data System, fTTE = focused transthoracic echocardiographic examination; NPV = negative predictive value; NR = not reported; PPV = positive predictive value; TAPSE = tricuspid annular plane systolic excursion; TTE = transthoracic echocardiographic examination; TUS = teleultrasonography.

Note: This table has not been copy-edited.

[a]The subjective quality scoring method (MOS: Mean Opinion Score) was used to score the quality of the transmitted ultrasound images on the basis of an internationally prescribed 5-level absolute evaluation scale (5 points: No deterioration in the image quality is observed at all, very good; 4 points: a change in image quality can be seen but viewing is unhindered, good; 3 points: it can be clearly seen that the image quality has deteriorated, which hinders viewing slightly, fair; 2 points: viewing is hindered, poor; 1 point: viewing is severely hindered, very poor.

[b]Scan duration included diagnosis consultation time.

[c]The image quality was qualitatively scored from 1 (very poor) to 5 (excellent), and a visualization score, expressed as a percentage, was calculated with respect to the reference ECG.

[d]A total lung ultrasound (LUS) score was calculated: 6 lung regions of interest, delineated by a parasternal line, anterior axillary line, posterior axillary line, and paravertebral line, were examined on each side. All regions were characterized, and a score based on aeration from normal (0 score) to complete loss of lung aeration (3 scores) was calculated. The LUS score was calculated as the sum of the 12 regional scores.

[e]The scoring was as follows: 1 point: very poor (image quality is severely impaired); 2 points: poor (image quality is impaired); 3 points: fair (image quality hinders viewing slightly but acceptable for interpretation); 4 points: excellent (minor suggestions for improvement but viewing is unhindered); 5 points: perfect (no suggestion for improvement).

[f]The ultrasound characteristics and categories of the breast nodules were assessed based on the BI-RADS of the American College of Radiology.

[g]Medians were reported for image quality scores.

[h]The quality of the ultrasound images was scored using a five-point Likert scale (5 points: perfect, no suggestions for improvement of ultrasound image quality; 4 points: excellent, minor suggestions for improvement of ultrasound image quality; 3 points: fair, ultrasound image quality is acceptable for interpretation; 2 points: poor, ultrasound image quality may affect the interpretation; 1 point: meaningless, ultrasound images were not meaningful or undiagnosable).

[i]The levels of agreement (kappa) are characterized by Landis and Koch (1977) as slight agreement (0 to 0.20), fair (0.21 to 0.40), moderate (0.41 to 0.60), substantial (0.61 to 0.80), and almost perfect agreement (0.81 to 1.00).

[j]Kappa ≥ 0.75 indicated there was good consistency between the 2; 0.75 > kappa ≥ 0.4 indicated there was general consistency between the 2; kappa < 0.4 indicated poor consistency.

[k]Quality (the possibility of interpretation) of acquired images was graded as acceptable or unacceptable.

[l]Right ventricular function was assessed using TAPSE.

Table 7: Summary of Findings — Care and Service Quality–Related Outcomes

Citation study	Primary study	Complications/safety	Patient satisfaction	Clinician satisfaction	Accessibility
Primary studies					
—	**Zhang et al. (2024)**[30]	• 8.4% of patients reported pain during the examination. • Overall, the TUS provided a high level of safety.	• 90.1% indicated no discomfort with ultrasound robotic arm. • 96% of patients were not afraid of the robotic arm. • 85.8% of patients were entirely or somewhat satisfied with the duration of TUS. • 95.3% of patients accepted the telerobotic ultrasound exam. • More than 90% and were satisfied with the remote consultation.	• Tele-radiologists reported: • 83.3% satisfaction with TUS exams. • 85.5% satisfaction of the duration. • 11.8% of the examinations were difficult. • 15.7% of exams were felt to have transmission delays.	• 90% of patients were willing to pay a certain amount of extra money for TUS by an expert. • 88.3% of tele-radiologists accepted TUS as a routine ultrasound tool in clinical practice.
—	**Delestrain et al. (2023)**[25]	• Two patients experienced pain with the telerobotic exam. • No severe adverse events were reported.	• 95% of parents felt comfortable communicating with the TUS-sonographer remotely. • 45% of parent reported their children felt less pressure with the telerobotic system vs the conventional system. • Conversely, 16% of parents reported that their children felt more pressure with the tele robotic system vs the conventional system. • 92% of parents felt comfortable knowing someone elsewhere was controlling the TUS probe.	• 98% of TUS-sonographers felt the audio was sufficient to communicate with site assistant. • 34% of TUS-sonographers reported the handling of the remote ultrasound probe resulted in more physical strain than conventional ultrasound. • 100% of patient site assistants felt comfortable communicating with the remote expert. • 16% of patient site assistants felt that holding the robotic system caused significant physical strain.	• 87% of parents agreed to the use of TUS in the future for their child.

Citation study	Primary study	Complications/safety	Patient satisfaction	Clinician satisfaction	Accessibility
—	**He et al. (2023)**[27]	• No injuries reported during TUS	• 91.6% of patients reported no discomfort or uneasiness during TUS. • 94% of patients were not afraid of the robotic arm (TUS). • 92.7% of patients considered the duration of the TUS exam acceptable. • 90.4% of patients indicated acceptance of the TUS system for future exams.	• Tele-sonologists survey: • 97.6% reported no obvious delay during the TUS exam. • 81.9% reported no difficulty during the TUS exam. • 86.7% were satisfied with the exam duration. • Some expressed concern in the scope of scanning of patients with large breasts.	• 89.2% of patients were willing to pay an extra fee for it in the future • 84.3% of tele-sonologists were willing to use the TUS system as a routine exam tool.
—	**Chai et al. (2022)**[24]	• No patient hurt by robot arm • All patients completed the TUS exam.	• No patient complained of discomfort	—	—

—	**Zhang et al. (2022)**[31]	• 7.2% patients reported neck discomfort or suffocation at the trachea.	• 92.8% patients felt comfortable during the TUS exam.
			• 85.6% patients accepted the telerobotic ultrasound.
			• 89.2% of patients reported no fear of the robotic arm.
			• 94.3% of patients were completely or somewhat satisfied with the duration of the telerobotic ultrasound exam.
			• 10.8% patients felt nervous when robotic arm was moved around neck.
				• Tele-doctors reported that:
				  ◦ 85.6% of exams did not have significant TUS transmission delays.
				  ◦ 98.6% of exams were accepted.
				  ◦ 90.6% of the telerobotic system exams were performed without difficulty.
				  ◦ 9.4% of exams were difficult to perform.
				  ◦ 84.9% were satisfied with the duration of the TUS exam.
					• 87.1% of patients were willing to pay an extra fee for the telerobotic ultrasound.
					• 100% of tele-doctors believed that the TUS system could be used as a routine tool.

Citation study	Primary study	Complications/safety	Patient satisfaction	Clinician satisfaction	Accessibility
—	**Whittington et al. (2022)**[29]	—	• Patient satisfaction was more than 95% on all measuring relating to remote interpretation following TUS.	—	• Patient satisfaction was not significantly associated with age, race, parity, BMI, gestational age, rurality, or referral practice.
—	**Duan et al. (2021)**[26]	• No reported complications related to the TUS exam. • All vital signs of the patients showed no significant changes.	—	—	—
—	**Wejner-Mik et al. (2019)**[28]	—	—	—	—
Systematic Reviews					
Alhussein et al. (2024)[32]	Arbeille et al. (2014)	—	—	—	—
Duarte et al. (2021)[9]	Kim et al. (2015)	—	—	—	—
Salerno et al. (2020)[33]	Afset et al. (1996)	—	—	—	—
	Kim et al. (2017)	—	—	—	• The offsite expert was able to perform the exam remotely via a social network video call by mentoring the onsite novice sonographer.

TUS = teleultrasonography.

Note: This table has not been copy-edited.

Appendix 4: Critical Appraisal of Included Publications

Please note that this appendix has not been copy-edited.

Table 8: Strengths and Limitations of the Included Primary Studies Using the Downs and Black Checklist[20]

Strengths	Limitations
Zhang et al. (2024)[30]	
• The objective of the study, study design, the main outcomes to be measured, the characteristics of the participants included in the study, the interventions of interest, and the main findings were clearly described. • The training level of the operators and was described. • Actual probability values were reported for the main outcomes. • Data on patient discomfort was collected for the intervention arm. • Safety outcomes including adverse events of the intervention were reported. • Statistical tests were used appropriately, and the main outcome measures were accurate and reliable.	• The study has limited generalizability due to the single-centre design and limited number of patient with a high BMI. The analyses did not adjust for confounding factors. • The authors did not report on the use of masking. • The study has limited generalizability due to its focus on 5G, which may be limited to regions with access to this technology. • Certain exams were not carried out due to limitation with the robotic arm, which may have introduced bias. • The study did not report whether sample size was calculated. • The study did not report on patient discomfort in the comparator arm. • Safety outcomes were not directly measured.
Delestrain et al. (2023)[25]	
• The objective of the study, study design, the main outcomes to be measured, the interventions of interest, and the main findings were clearly described. • The study design included 2 hospitals which increases external validity. • The onsite sonographer was masked to the results of the intervention. • Actual probability values were reported for the main outcomes. • Patient caregivers, clinicians, and site assistants were asked to assess the intervention. • Safety outcomes including adverse events of the intervention were reported. • Statistical tests were used appropriately, and the main outcome measures were accurate and reliable. • Interobserver reproducibility was measured.	• The study has limited generalizability due the focused age group. • The characteristics of the participants included in the study and participant inclusion criteria were not well described. • The study did not report whether sample size was calculated.
He et al. (2023)[27]	
• The objective of the study, study design, the main outcomes to be measured, the characteristics of the participants included in the study, the interventions of interest, and the main findings were clearly described. • The intervention arm included 2 different scenarios in, increasing ecological and external validity.	• The study has limited generalizability due to the single-centre design and focuses on a single medical specialty. The analyses did not adjust for confounding factors. • The study has limited generalizability due to its focus on 5G, which may be limited to regions with access to this technology.

Strengths	Limitations
• The training level of the operators and was described. • The operators were masked to each other's results to minimize bias. • Actual probability values were reported for the main outcomes. • Patients and clinicians were asked to evaluate the clinical benefit of the intervention. • Safety outcomes including adverse events of the intervention were reported. • Statistical tests were used appropriately, and the main outcome measures were accurate and reliable.	• One of the intervention scenarios did not compare the intervention to the comparator. • The study did not report whether sample size was calculated. • Safety outcomes were not directly measured.
Chai et al. (2022)[24]	
• The objective of the study, study design, the main outcomes to be measured, the characteristics of the participants included in the study, the interventions of interest, and the main findings were clearly described. • Actual probability values were reported for the main outcomes. • The training level of the operators and was described. • Safety outcomes including adverse events of the intervention were reported. • Statistical tests were used appropriately, and the main outcome measures were accurate and reliable.	• The study was conducted in a disability care centre. The patients may not be representative of the entire population from which they were treated. • The study has limited generalizability due to its focus on 5G, which may be limited to regions with access to this technology. The analyses did not adjust for confounding factors. • The study did not report whether sample size was calculated. • The small sample size limits the generalizability of findings.
Zhang et al. (2022)[31]	
• The objective of the study, study design, the main outcomes to be measured, the characteristics of the participants included in the study, the interventions of interest, and the main findings were clearly described. • The experts and onsite doctors were masked to each other's diagnostic results to minimize bias. • A standardized exam protocol was used to minimize bias and confounding. • Actual probability values were reported for the main outcomes. • Patients and clinicians were asked to evaluate the clinical benefit of the intervention. • Statistical tests were used appropriately, and the main outcome measures were accurate and reliable. • Interobserver reproducibility was measured.	• The study was conducted at a hospital located on a remote island. The patients may not be representative of the entire population from which they were treated. • The study has limited generalizability due to the single-centre design and focuses on a single medical specialty. • The study did not report whether sample size was calculated. • Variability in the expert professional experience may introducing confounding. • Safety outcomes including adverse events of the intervention were not reported.
Whittington et al. (2022)[29]	
• The objective of the study, study design, the main outcomes to be measured, the characteristics of the participants included in the study, the interventions of interest, and the main findings were clearly described. • Demographic and clinical features of patients were	• The study was conducted at a single medical clinic. The patients may not be representative of the entire population from which they were treated. • The intervention protocol was not clearly described. • The study has limited generalizability due to the single-centre

Strengths	Limitations
compared. • The study included a substantial sample size to power the analysis. • Estimates of the random variability in the data was reported using median (IQR) for non-normality distributed data. • Actual probability values were reported for the main outcomes. • Patient satisfaction was a reported outcome. • Statistical tests were used appropriately, and the main outcome measures were accurate and reliable.	design and focuses on a single medical specialty. • The study did not report whether sample size was calculated. • The authors did not report on the use of masking. • Variability in the expert professional experience may introducing confounding. • Safety outcomes including adverse events of the intervention were not reported.
Duan et al. (2021)[26]	
• The objective of the study, study design, the main outcomes to be measured, the characteristics of the participants included in the study, the interventions of interest, and the main findings were clearly described. • Actual probability values were reported for the main outcomes. • Safety outcomes including adverse events of the intervention were reported. • Statistical tests were used appropriately, and the main outcome measures were accurate and reliable.	• The study was conducted at a single-centre hospital and recruited patients from the ICU department. The patients may not be representative of the entire population from which they were treated. • The study has limited generalizability due to its focus on 5G and highly controlled environment, which may be limited to regions with access to this technology. • Certain exams were not carried out due to limitation with the robotic arm, which may have introduced bias. • The training level of the operators and was not described. • The study did not report whether sample size was calculated. • The small sample size limits the generalizability of findings.
Wejner-Mik et al. (2019)[28]	
• The objective of the study, study design, the main outcomes to be measured, the characteristics of the participants included in the study, the interventions of interest, and the main findings were clearly described. • Patient from various departments were included in the study. • Actual probability values were reported for the main outcomes. • The training level of the operators and was described. • Safety outcomes including adverse events of the intervention were reported. • Statistical tests were used appropriately, and the main outcome measures were accurate and reliable.	• The study was conducted in a single-hospital setting. • The analyses did not adjust for confounding factors. • The study has limited generalizability due to its focus on pocket-sized imaging devices, which may be limited to regions with access to this technology. • The study did not report whether sample size was calculated. • The small sample size limits the generalizability of findings.

BMI = body mass index; ICU = intensive care unit; IQR = interquartile range.

Table 9: Strengths and Limitations of the Included Systematic Reviews Using AMSTAR 2[21]

Strengths	Limitations
Alhussein et al. (2024)[32]	
• The research question or objective and inclusion criteria included the components of the PICO table.	• The review authors did not use a tool for assessing the risk of bias in the include studies.

Strengths	Limitations
• The literature search strategy was comprehensive and multiple databases were searched. • The authors included the list of keywords used for the database search. • The review authors declared no conflict of interests.	• The authors did not explain their selection of eligible study designs, although the study type was included in the results. • It is unclear if the reviewers performed study selection, extraction, and quality assessment of the included studies in duplicate. • The review authors did not provide detailed summary of included study findings. • A review of bibliographies from included studies was not conducted. • The review authors did not measure the interstudy heterogeneity. • The review authors did not include evidence-based guidelines. • A list of excluded studies and reason for exclusion were not provided. • The review authors did not report the sources of funding for the study or the included studies.
Duarte et al. (2021)[9]	
• The research question or objective and inclusion criteria included the components of the PICO table. • The authors explained their selection of eligible study designs, which included any study design. • The literature search strategy was comprehensive and multiple database were searched and reviews of bibliographies of included studies were conducted. • The review authors declared that they did not have any competing interests. • The review authors declared that they did not receive any funding relevant to the SR.	• Selection and confound bias due to the inclusion of nonrandomized studies. • The authors did not report the patient sample size for included studies. • The review authors did not use a tool for assessing the risk of bias in the include studies. • The review authors included evidence-based guidelines. • The review authors did not discuss the interstudy heterogeneity. • It is unclear if the reviewers performed study selection, extraction, and quality assessment of the included studies in duplicate. • A list of excluded studies and reason for exclusion were not provided. • The review authors did not report the sources of funding for the included studies.
Salerno et al. (2022)[33]	
• The research question or objective and inclusion criteria included the components of the PICO table. • The authors explained their selection of eligible studies and extract and review process. • The reviewers performed study selection, extraction, and quality assessment of the included studies in duplicate. • The authors included the list of keywords used for the database search. • The review authors discussed the interstudy heterogeneity. • The review authors declared that they did not have any	• The literature search strategy was limited to 2 databases. • The authors did not report if a review of the bibliographies of included studies, grey literature, or other manual searches were conducted. • The review authors did not use a tool for assessing the risk of bias in the include studies. • The review authors included evidence-based guidelines. • A list of excluded studies and reason for exclusion were not provided.

Strengths	Limitations
competing interests. • The review authors declared that they did not receive any funding relevant to the SR.	• The review authors did not report the sources of funding for the included studies.

SR = systematic review.

Appendix 5: References of Potential Interest

Please note that this appendix has not been copy-edited.

This is a list of studies from the literature search that were excluded from this report but may be of interest to decision-makers working in the field of TUS.

Primary Articles

Jensen SH, Weile J, Aagaard R, et al. Remote real-time supervision via tele-ultrasound in focused cardiac ultrasound: A single-blinded cluster randomized controlled trial. *Acta Anaesthesiol Scand.* 2019;63(3):403-409. PubMed

Kaneko T, Kagiyama N, Nakamura Y, et al. Effectiveness of real-time tele-ultrasound for echocardiography in resource-limited medical teams. *J Echocardiogr.* 2022;20(1):16-23. PubMed

Kory PD, Pellecchia CM, Shiloh AL, Mayo PH, DiBello C, Koenig S. Accuracy of ultrasonography performed by critical care physicians for the diagnosis of DVT. *Chest.* 2011;139(3):538-542. PubMed

Li XL, Sun YK, Wang Q, et al. Synchronous tele-ultrasonography is helpful for a naive operator to perform high-quality thyroid ultrasound examinations. *Ultrasonography.* 2022;41(4):650-660. PubMed

Liu L, Duan S, Zhang Y, Wu Y, Zhang L. Initial Experience of the Synchronized, Real-Time, Interactive, Remote Transthoracic Echocardiogram Consultation System in Rural China: Longitudinal Observational Study. *JMIR Med Inform.* 2019;7(3):e14248. PubMed

Olivieri PP, Verceles AC, Hurley JM, Zubrow MT, Jeudy J, McCurdy MT. A Pilot Study of Ultrasonography-Naive Operators' Ability to Use Tele-Ultrasonography to Assess the Heart and Lung. *J Intensive Care Med.* 2020;35(7):672-678. PubMed

Siu M, Dan J, Cohen J, et al. Impact of Telemedicine on Extended Focused Assessment With Sonography for Trauma Performance and Workload by Critical Care Transport Personnel. *Air Med J.* 2023;42(2):105-109. PubMed

Sun YK, Li XL, Wang Q, et al. Improving the quality of breast ultrasound examination performed by inexperienced ultrasound doctors with synchronous tele-ultrasound: a prospective, parallel controlled trial. *Ultrasonography.* 2022;41(2):307-316. PubMed

Reviews

Adams SJ, Burbridge B, Obaid H, Stoneham G, Babyn P, Mendez I. Telerobotic Sonography for Remote Diagnostic Imaging: Narrative Review of Current Developments and Clinical Applications. *J Ultrasound Med.* 2021;40(7):1287-1306. PubMed

Salerno A, Tupchong K, Verceles AC, McCurdy MT. Point-of-Care Teleultrasound: A Systematic Review. *Telemed J E Health.* 2020;26(11):1314-1321. PubMed

Shi R, Rosario J. Paramedic-Performed Prehospital Tele-Ultrasound: A Powerful Technology or an Impractical Endeavor? A Scoping Review. *Prehospital Disaster Med.* 2023;38(5):645-653. PubMed

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Submission to:	**Council**

Meeting Date:	Submitted by:		
March 6, 2025	Scott McLeod Registrar & CEO		
Agenda Item Title:	3.6 Consent Agenda - Accreditation – Diagnostic Imaging Accreditation Standards: Medical Director Revision		
Action Requested:	☒ The following items require approval by the 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:	That Council approves the revised Version 4 Diagnostic Imaging Accreditation Standard, Appendix A – Medical Director criteria.		
Background:	Version 4 of the Diagnostic Imaging Accreditation Standards came into effect October 1, 2024. The latest round of revisions culminating into the V4 of the DI standards, was based on multiple broad stakeholder consultations, standard revision requests from accredited facilities and other partners and latest leading industry references, recognized guidelines from international accreditation bodies. The subsequent drafting and approval of the standards occurred through multiple CPSA committee levels, including the Advisory Committee on Diagnostic Imaging (ACDI) and Medical Facilities Accreditation Committee (MFAC). Recent feedback from some current accredited DI facility Medical Directors, as well as other stakeholders, indicated that the V4 Medical Director criteria exclude specialties which use imaging as an adjunct supporting their health care provision niche. Since the release, CPSA received a significant amount of Medical Director Standard exemption requests which were reviewed for consideration by ACDI. Considering the amount of requests and stakeholder feedback, ACDI recommended a revision to V4 Medical		

	Director criteria. The recommended revision provides greater flexibility to accommodate those facilities / Medical Directors where niche imaging occurs (e.g. fluoroscopy only for pain management = anesthesia, plastics, orthopedics, dedicated OB/GYN = maternal fetal medicine, MSK (only) imaging – physical medicine and rehabilitation, orthopedics, etc.). This change removes unnecessary barriers to physicians with relevant qualifications and experience in a specific form of imaging acting as Medical Director of an imaging facility which may be central to their routine work. This should reduce barriers for patients seeking treatment without any detrimental impact on imaging quality. In November 2024, ACDI held an electronic documented e-vote on the proposed revision and unanimously recommending the revision be taken to MFAC for approval. On January 28, 2025, MFAC reviewed ACDI's recommendation and recommended the proposed revision, which is attached, be approved by Council.
Next Steps:	Once approved by Council, the standard would be updated and communicated to relevant stakeholders.
List of Attachments:	
1. V4 Diagnostic Imaging Accreditation Standards Appendix A: Medical Director criteria	

<table>
<tr><th><u>Current Standard (Appendix A: Medical Director Requirement):</u></th><th><u>Draft Revision to Standard (Appendix A: Medical Director Requirement):</u></th></tr>
<tr><td>The DI facility Medical Director is a recognized specialist in Diagnostic Radiology, and/or Nuclear Medicine and/or Cardiology (with recognized advanced echocardiography training e.g. CCS/CSE) in good standing with the CPSA:

• on the General Register
or
• on the Provisional Register having completed any required assessments and having been deemed to be in independent practice</td><td>The Medical Director of a diagnostic imaging facility must be:

a) A physician with a speciality in
• Diagnostic Radiology, or
• Nuclear Medicine, or
• Cardiology (with appropriate training), OR

b) A physician with other skills and knowledge acquired through recognized training, as approved by the Medical Facility Accreditation Committee, pertinent to the imaging services being provided at their accredited diagnostic imaging facility.

The Medical Director must be in good standing with the CPSA and:

• On the CPSA General Register; or
• On the Provisional Register having completed any required assessments and having been deemed to be in independent practice.</td></tr>
</table>

CPSA
COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

Council Chair Report
March 6, 2025

It has been an interesting time the past two (2) months as Chair as I am learning more about CPSA and the different areas of work they are involved in. I am always very impressed with the CPSA staff, and the committee work being done. I have had the privilege to see the work from a broader perspective and listen to the conversations at these tables.

We started January with our Retreat, and it was successful in exploring "public trust." The conversations and engagement of Council and CPSA staff resulted in thoughtful discussions. We might not have come to any actionable outcomes which may have been a little frustrating for some but there were other positive outcomes from the retreat. Thank you to the Governance Committee and CPSA staff for organizing the retreat. I know we will continue to reflect on public trust in future conversations at the council table.

Most of my involvement so far has been participating in the recruitment process for the Registrar/CEO position. There have been many meetings to ensure the recruitment process is on time and there is adequate feedback from the Committee. It seems to being going well so far as we have entered into the interview part of the process. We have a committed group of Council members who have been actively providing feedback on recruitment to ensure the most appropriate candidate fills the position. We will continue to update Council throughout the process.

I have listed the meetings below which I have attended and will try to answer any questions to the best of my ability. It has been a pleasure to serve as the Council Chair for the new year.

January 9, 2025: Registrar Search Committee Meeting
Jan 10, 2025: CPSA truth to reconciliation planning workshop
Jan 16, 2025: AMA/CPSA President and CEO meeting
Jan 24-25, 2025: CPSA council retreat
January 25, 2025: Registrar Search Committee meeting
Jan 30, 2025: Governance meeting

February 4, 2025: Executive Committee Meeting
February 6, 2025: Registrar Search Committee Meeting
February 14, 2025: ARADAAC meeting, Registrar Seach Committee Meeting
February 19, 2025: Indigenous Circle Meeting
February 24, 2025: Registrar Search Committee Meeting

March 4, 2024: Registrar Search meeting
March 6-7, 2024- CPSA council meeting

Hiy Hiy, nanaskomon,
Nicole Cardinal

Registrar Report

To: CPSA Council
From: Scott McLeod
Date: March 6th, 2025

Introduction

As I'm sure you can all appreciate, 2025 is turning out to be a year of unpredictability. Provincial, National and International politics have added to the already volatile and uncertain nature of life for everyone. The health system in Alberta continues to move forward with the plans of establishing the four core agencies for the delivery of care and there have been serval changes to the leadership structure of AHS as it transitions to Acute Care Alberta.

This year is going to see a great deal of change for Alberta's Health System and for CPSA. With this comes tremendous uncertainty for many people within our organization and beyond, but I'm confident we have a strong team that can weather whatever comes forward.

1. CPSA Organizational Updates

a. Professional Conduct

As you can see from the attached report, there was an increase in the number of complaints received, however there does not appear to be a specific cause for such an increase. Many of the complaints that have gone to investigation or expert opinion are still pending an outcome, therefore it's still too early to say if there is a specific problem that needs to be addressed.

All that can really be said is that the results represent nothing out of the ordinary other than the increase in the numbers overall.

We will continue to track this over time and report back to Council.

b. Registration Sponsorship update

During the last Council meeting there were two questions asked that require follow-up:

(1) What was the distribution list used to share the new sponsorship opportunities and;

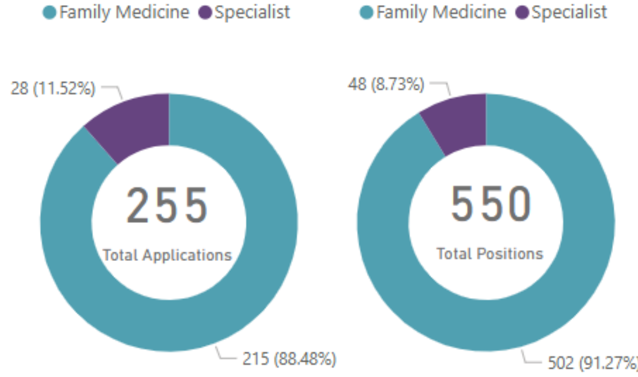
(2) where are physicians currently who went through sponsorship.

When CPSA's sponsorship model was launched in 2024, a media release was shared with local/provincial media outlets, health care media contacts, government and partner contacts and CPSA team members. We also posted on our website and social media channels. We also engaged in targeted outreach with the Health Minister's Office, Alberta Health Services, Medical Council of Canada, the University of Alberta and the University of Calgary, Albera Medical Association, Alberta College of Family Physicians, Alberta International Medical Graduate Program and the Rural Health Professions Action Plan.

As of February 12,2025

255 total sponsor applications for 550 positions.	**196 approved sponsors able to post 343 positions**

Box 1- These numbers represent a cumulative total since the program launched in March 2024.
Box 2- These numbers will fluctuate as they represent the current number of approved sponsors and positions able to be posted. They do not include filled (closed) positions (i.e. once an applicant fills a position, the sponsor and position are no longer reflected in this box total).



- 93 sponsored positions have been filled, 73 of those in the metro areas of Calgary and Edmonton, and 20 in non-metro areas (referred to as closed in the community breakdown below).
- Applications that have been submitted but not approved could be for several reasons, such as the application is awaiting review, requires further information, was cancelled due to withdrawal or non-payment, or was denied.

Non-Metro Community	Applications	Total Positions	Closed Positions
Airdrie	5	12	2
Barrhead	1	1	
Canmore	1		
Chestermere	1	1	
Cochrane	1	3	
Daysland	1	2	
Didsbury	1	2	
Fort McMurray	4	6	3
Fort Saskatchewan	1	3	1
Grande Prairie	4	8	1
Leduc	1	1	
Lethbridge	1	2	
Maskwacis	3	9	
Medicine Hat	1	1	
Morinville	1	2	1
Red Deer	1	4	
Rocky View County	1	2	
Sherwood Park	8	14	4
Spruce Grove	3	7	2
St. Albert	9	18	4
Stony Plain	1	2	1
Strathmore	1	1	
Wabasca	1	2	
Total	**53**	**104**	**20**

Metro Community	Applications	Total Positions	Closed Positions
Calgary	111	246	35
Edmonton	90	183	38
Total	**201**	**429**	**73**

Applications

Metro Non-Metro

54 (21.18%)

201 (78.82%)

Positions

Metro Non-Metro

Closed 20 (4%)

85 (16%)

Closed 73 (14%)

356 (67%)

Accelerated Jurisdictional Route (condensed Practice Readiness Assessment):

Accelerated PRA stats (since Jan. 16, 2023)	Number of physicians (as of Feb 10, 2025)
Total eligible applications for accelerated route	**415**
In assessment (SPA)*: Setting up assessment Scheduled/ongoing Completed/passed	**123** 33 22 68

*There are two factors that affect the number of physicians who progress from application to assessment: 1) they must obtain sponsorship for a posted job 2) they must then complete the registration process (verification of documents, etc).

c. Hearings Director Office update

Attached is a briefing note from the Hearings Director outlining the work completed in 2024. This is for your information only. No action is required.

Overall, the key message from the report is that the numbers of CRCs and Hearings appear to have remained stable. The CRC/Hearing Tribunal roster saw 11 members' terms expire, but 21 new members were added.

d. Engagement Survey Results Exploration and Action Planning Initiative

The Pulse survey completed in the Fall of 2024 showed an improvement in the CPSA staff engagement overall, however there were some distinct areas for improvement. Even those departments with very high scores had areas identified for improvement and therefore we have once again taken this opportunity to learn from the feedback we have received.

In collaboration with an external consultant and our Clinical Quality Consultant, we are hosting a series of interactive sessions across all departments to review and analyze the results of the pulse check. These sessions will be taking place over the next few months and conclude by spring. They will provide an opportunity for teams to gain valuable insights into key findings from the survey and collaboratively identify areas for improvement.

Each session fosters open dialogue, allowing participants to co-create actionable solutions aimed at addressing specific opportunities for growth. As a result, teams will leave each session with a tailored action plan focused on implementing the identified improvements. This process ensures that every department not only understands the survey findings but is also actively involved in shaping the path forward.

By the conclusion of this initiative, we will have actionable, department-specific strategies in place to enhance overall engagement and performance, contributing to a positive organizational culture.

e. Continuing Competence update

For Council to remain up to date on the work of different departments and not be overwhelmed by a report from every department at the same time, we will be presenting an update for one or two departments each meeting so you can remain current on all the great work our teams are doing. This meeting we have chosen to highlight Continuing Competence. Please see the attached report for the details of the work being done in that department.

2. Committee Reports

a. Competence Committee

Please see the attached briefing note. This is for your information and there are no action items for Council.

The report highlights the new team members who have joined the competency program and how this has enabled the department to regain some stability in the program after much disruption last year.

The Terms of Reference and the Membership list for the IPAC Advisory Committee were also approved with the exception of the Code of Conduct section. The Code of Conduct section was introduced to the Committee at the February meeting and will be submitted for approval in June.

Dr. Nikki Kain provided the results of her team's comparative study of the performance of internationally trained family physicians and Canadian graduates in Alberta to the Committee.

Dr. Cliff Lindeman provided an update on his work on a 30-day prescribing AI model in partnership with OKAKI and the University of Alberta School of Public Health.

b. Medical Facilities Accreditation Committee (MFAC)

Please see the attached briefing note. This is for your information and there are no action items for Council.

This is a very thorough report that highlights the tremendous amount of work going on in Accreditation.

The Committee welcomed newly appointed public members, Josephine Naicker and Yannick Hebert.

There continues to be a growth in the number of facilities being accredited, standards continue to evolve and be updated, and there is work that needs to be done in reportable incidents.

I recommend you read the report to get a full understanding of what was discussed.

3. Provincial Update

a. CPSA Proposal to help address concerns around overbilling by physicians

The AIR department/CINO has met with the Alberta Health Audit and Compliance team members to move forward our Claims Data report proposal. Two meetings have been held in the last month to review current AH reporting capabilities, claims data structure and data sharing protocols. CPSA has been asked to refine their most recent project proposal and to resubmit based on a more limited data request. This will be submitted in early March and follow up discussions will be held in late March.

b. Additional Route to Licensure.

The Minister of Health has approved funding to advance the concept of training, licensing and employing house physicians in the acute care setting. These house physicians would be the first of their kind in Canada and would be similar to those trained in the UK and Australia. They would have a focused postgraduate training program enabling them to provide tier one medical support in Alberta's acute care setting.

This would allow for internationally trained physicians, who lack postgraduate training and can't access residency training positions, a route to licensure that currently does not exist. It will also provide a needed service to Alberta's acute care setting.

A team of consultants will be assembled to provide a report on how this can be accomplished, and it would be expected that a report will be available as early as the Fall of 2025.

4. National Updates

a. Federation Of Medical Regulatory Authorities of Canada (FMRAC)

National License continues to be a topic of discussion with the Canadian Medical Association despite FMRAC's continued efforts to work with them to shift the focus to something more constructive. A national license would not solve anything because there are many other things that restrict mobility other than a license to practice.

As a result of a recent public media release by the CMA, FMRAC is contemplating a more direct approach in developing a counter narrative. The issue of greatest concern for FMRAC is the misrepresentation that lack of a national license is leading to poor patient outcomes. There is no evidence to support such a comment and its disingenuous to make such claims. The main reasons for CMA proposing a national license comes from the poll of physicians that highlight the cost of licensure and the

administrative burden as the reason for a national license. There is no evidence to support a patient safety issue.

All the MRAs do however recognize the benefit to physician mobility. We recognize we can streamline the process and make mobility easier for physicians to support care across the Country. This is why we are working with the Medical Council of Canada to develop the National Physician Registry.

5. International Updates

a. International Association of Medical Regulatory Authorities (IAMRA)

The 2025 IAMRA meeting will be held in Dublin, Ireland from September 3rd to 6th. The theme of the conference is "People-focused regulation for a safer global community."

b. Federation of State Medical Boards (FSMB)

Nothing to report.

Conclusion

Despite the significant turmoil in the world around us, CPSA continues to do the hard work of regulating the medical profession in Alberta. Our team continues to development as a learning organization looking for new and innovative ways to do our work. We also recognize the important role we play as partners in Alberta's health system and continue to advise and support our partners in that system.

Professional Conduct 2024 Complaints

February 2025

Introduction

This report is intended to provide a descriptive epidemiological overview of complaints received by CPSA in 2024 in light of the increase in volume. Broadly speaking, the trends follow the Alberta physician population distribution. It is, however, not possible to draw any firm conclusions at this time or from this type of analysis, as a significant number of files opened in 2024 have not yet reached a terminal process. Additional work is being carried out by the CPSA REVU team to further inform our understanding of complaints and the appropriate resources to assist physicians in improving their practices.

Complaint Distribution by Biological Sex

The majority of physicians who received a complaint in 2024 were male, between the ages of 45-54 and practising family medicine in either the Edmonton or Calgary metro zones. This aligns well with the overall demographics of the profession in Alberta.

Complaint Distribution by Biological Sex

Distinct Complaints

1,000
800
600
400
200
0

Male
Female
Did not Identify

Complaint Distribution by Age

Distinct Complaints

500
400
300
200
100
0

25 - 34
35 - 44
45 - 54
55 - 64
65+
missing

Case Distribution by Specialty

Distinct Cases

800
600
400
200
0

Family Medicine/General Practice
OBGYN, Ophthalmology, Otolaryngology, Surgery, Urology
Cardiology, Dermatology, Hematology, Internal, Neurology
Psychiatry
missing
Emergency
Diagnostic Radiology
Pediatrics
Anesthesiology, Critical Care Management

Complaint Distribution by Geographic Zone

Distinct Complaints

600
500
400
300
200
100
0

Metro - Edmonton
Metro - Calgary
Rural
Urban
Other

Complaint Submissions

The majority of complaints in 2024 were submitted by patients and involved one issue (quality of care, diagnosis, communication, boundary violations, etc.). Few complaints are about more than two issues—the more complex a complaint, the more issues it is likely to involve.

Complainants

Number of Distinct Complaints

1000
800
600
400
200
0

Patient (or legal guardian)
Family member of patient
Other physician
Third party
Complaints Director
Lawyer
Phys Self-Reporting

Distinct Issues

Issues per Complaint

Number of Complaints

800
600
400
200
0

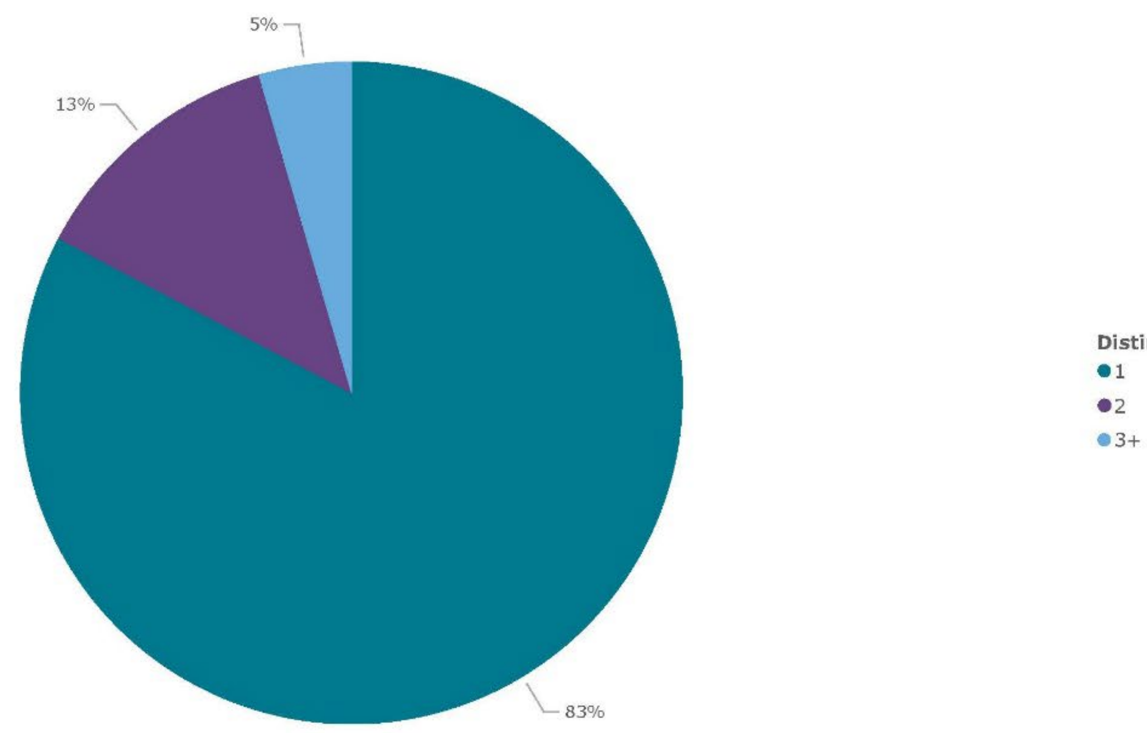
1
2
3
4

Distinct Issues

Physicians with Multiple Complaints

While complaints are not uncommon and most physicians will receive at least one at some point in their careers, a physician getting more than one complaint in a year remains uncommon. In 2024, less than 20 per cent of the physicians who received a complaint received more than one.

Distinct Complaints per Physician



Closed Complaints

Of the complaints filed in 2024 that have been closed, most were dismissed. As capture in the chart below, there are times when we are unable to proceed with a complaint. This typically means the complaint submission was missing information, the complainant was unresponsive to our requests for additional details, or the subject of the complaint was not regulated by CPSA (e.g. from another health profession).

Nature of Complaints

The most common nature of complaint is Quality of Care followed closely Practice Management *see Figure 1. 2024 Complaint Natures*. Since complaints can have multiple natures, the total denominator may be higher than the total complaints received in a calendar year.

1200
1000
800
600
400
200
0
COVID
Ethics
Medical Reporting
Practice Management
Quality of Care
Systemic
Third Party
Unclassified

Figure 1 2024 Complaint Natures

500
450
400
350
300
250
200
150
100
50
0

COVID
Ethics
Medical Reporting
Practice Management
Quality of Care
Systemic
Third Party
Unclassified

Figure 2 2023 Complaint Natures

Breakdown of 2024 Complaint by Subtypes (no 2023 comparison data was available)

Office - Scheduling 4%
Office - Environment 2%
Communication - Time 0%
Financial 6%
Office - Staff Relations 6%
Communication - Attitude 39%
Communication - Explanation 13%
Practice Management
Availability 30%

Release of Records
22%

Record Accuracy
50%

Report Completion
28%

Medical Reporting

Ethics

Professional Behaviour 28%

Professional Behaviour - Racism/Discrimination 19%

Regulatory Compliance 17%

Confidentiality 12%

Informed Consent 12%

Boundary Violation - Other 6%

Sexual Misconduct - patient (HPA (1)(nn.2)) 3%

Advertising/Self Promotion 2%

Sexual Abuse – patient (HPA (1)(nn.1)) 1%

Boundary Violation - Sexual 0%

Sexual Misconduct - not patient 0%

Quality of Care

Assessment-Diagnosis-Treatment 62%

Treatment-Procedure 11%

Referral/Consultation 8%

Treatment - Prescribing Non TPP Alberta Meds 6%

Follow-up - Other 5%

Treatment - Prescribing TPP Alberta Meds 4%

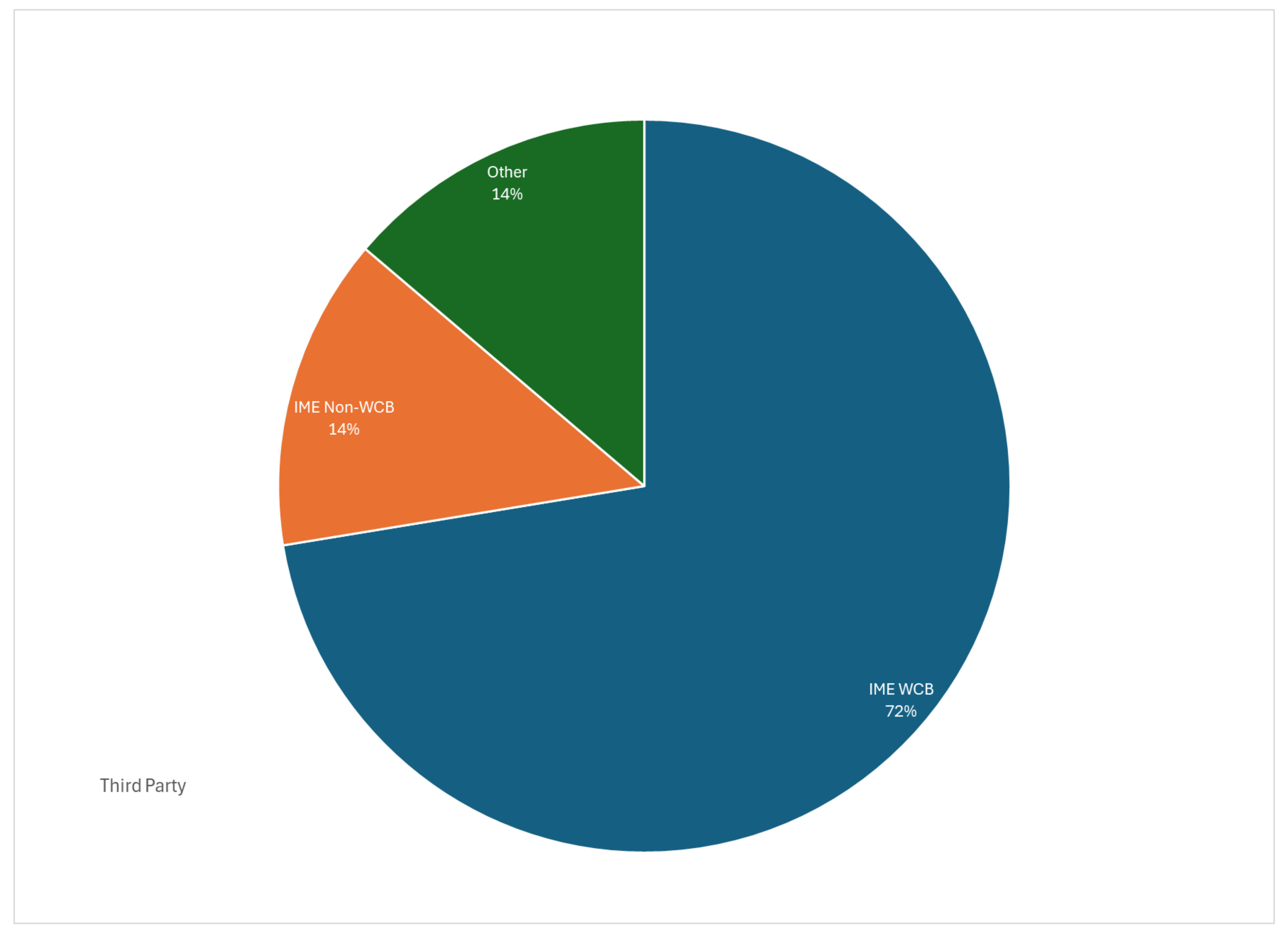
Follow-up of Significant Test Results 2%

Diagnosis Delayed 2%

Diagnosis Incorrect 0%

Treatment - Counselling/Advice 0%

Treatment - Complimentary/Alternative Medicine 0%


Other
14%
IME Non-WCB
14%
IME WCB
72%
Third Party

Submission to:	**Council**

Meeting Date:	Submitted by:		
	Dawn Hartfield		
Agenda Item Title:	Report from HDO		
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:	In 2024, the Hearings Director's office coordinated 34 meetings for the Complaint Review Committee (CRC); at these meetings, the CRC reviewed 134 files. There were 97 new requests for review received in 2024. Requests for review of dismissed complaints have remained steady in 2024, slowly decreasing from a high volume of requests that were reflective of Professional Conduct's dismissal backlog. There were 22 hearings held in 2024. The Hearings Director's office also coordinated two meetings for a review panel of CPSA Council. Both were appeals regarding Hearing Tribunal decisions. There is an appeal of an accreditation decision, and an appeal of a Hearing Tribunal decision scheduled for 2025. Terms for eleven regulated members on the CRC/Hearing Tribunal roster expired in December 2024. Effective January 1, 2025 we onboarded 5 new regulated members to our membership list and welcomed 16 new public members in October 2024.		

	The Hearings Director’s office continues to actively recruit candidates with diverse backgrounds, specialties and experience to join the membership list. The Hearings Director’s office held three significant opportunities for comprehensive professional development for CRC/Hearing Tribunal members (as well as Council members) in 2024. The annual orientation day was held in April; an anti-racism session was held in September and a decision-writing workshop in November.

Memorandum

To: Dr. Scott McLeod, Registrar
From: Dr. Michael Caffaro, Assistant Registrar
Date: February 5, 2025
Subject: Registrar's Report to Council – March 2025
CC: Phong Van, Director, Continuing Competence

Team Updates:

The Continuing Competence team is looking at 2025 with optimism. Our staff resources are back at the level we need to carry the work to meet KPIs and our legislative delegated duties this year. Our team held a retreat last month to plan program actions for 2026. We will be submitting proposals for technology enhancements and the adoption of AI tools to make improvements to program processes. This year we will conduct a needs assessment to determine if it would be best practice for our IPAC team to divest Clinic Registration to another team in 2026. We will also conduct a comparative analysis to determine if it would be more efficient and economically effective to staff assessors for QI and IPAC instead of continuing with the contractor approach.

Quality Improvement (QI):

Physician Practice Improvement Program (PPIP) continues to observe an upward trend in regulated members engagement and meeting CPSA expectations for continuous improvement in daily practice.

We met our annual target by initiating a minimum of 50 clinics in Group Practice Review (GPR). The program still was under-resourced for the number of facilitators needed to support the work. We continue to search and onboard new facilitators, but the recruitment has been slow.

MCC360 stayed on target throughout 2024. With more regulated members reporting they participate in their own personal development, participation in MCC360 through CPSA will see a decline in future years, as planned. Similar to GPR, we are under-resourced when it comes to needed facilitators to support the program. We continue to search for new facilitators to onboard.

As the PPIP program continues to evolve, we are expanding the number of audits performed and we continue to make improvements to the process. We currently audit regulated members who self-report that they have engaged in PPIP activities to expectation. We contact a randomly selected group of this population to learn about their activities and provide additional guidance when needed. The program is still in its introductory phase. The team continue to make improvements in

communication and education to establish clarity for the regulated members in the coming years. We are coming to the end of the first PPIP cycle and have started to distribute PPIP tracking reports to regulated members annually.

Quality Assurance (QA):

We have now branded our QA program Competence Assessment (CA) Program and changed the position title of our Program Manager to reflect this. This CA team oversees the administration of three programs: the Individual Practice Review (IPR), the Physician Assessment and Feedback (PAF) and the Accelerated Registration Competence Assessment (ARCA) pilot.

The IPR program experienced a lower referral rate in 2024, and the majority of referrals were still from PAF. We only received one referral from Complaints Director. By mid-year, we were down to only 0.5FTE for Senior Medical Advisor (SMA) capacity instead of the needed 3.0FTE to support the program, therefore, decided to stop initiating PAF. We did not meet the target of engaging 200 regulated members in PAF this past year. Because of this pause in PAF, we will expect a lower number of referrals to IPR in 2025 as well. We ended the year successfully with the onboarding of one full time SMA and another starting part-time in February 2025 (full-time projected in June 2025). With SMA capacity back to the required level, we expect to meet PAF annual target of 200 this year.

In collaboration with Registration, ,our team began assessments for the accelerated jurisdiction route pilot. This supports our legislative responsibility under Part 2 of the *Health Professions Act*. We initiated 34 eligible regulated members and completed 8 assessments by the end of 2024. Out of the 8, there was 1 who was directed to engage in remedial activities. All 8 are scheduled for their second competence assessment one year out from the first assessment. We have 15 who completed their Supervised Practice Assessment at the end of 2024 and are waiting to be initiated for their first competence assessment. The challenge with ARCA is the recruitment of assessors, as we are receiving candidates practicing in a spectrum of specialties, the majority to date has been anesthesia. The recruitment of assessors in each of the specialties needed has taken up most of the staff time resources. As the sponsorship is expanding to community practice beyond AHS, we are expecting the volume of eligible regulated members entering this pilot will increase in the next few years.

Health and Practice Condition Monitoring:

The team has been focused on divestment, including recruitment of service providers, establishing consent and agreements to transfer health monitoring out of CPSA. Divestment was completed by the end of June 2024. The program operated with the support of only 0.5FTE SMA. By th end of 2024, the team had successfully onboarded a new Senior Medical Advisor (SMA) after spending the second half of

the year in recruitment. Using process learnings, the team also promptly determined that an administrative assistant was required. This new position was approved, and we expect the onboarding process for the new Assistant to begin in February 2025. There are still opportunities to improve our processes, such as enhancing cooperation and communication with health monitors and independent medical examiners (IME). A collaboration session was planned to bring our team and service providers together in Spring 2025. Our team is continuously working towards making our new monitoring process more effective and efficient. We currently have 93 regulated members being monitored for fitness for practice.

Practice Conditions Monitoring:

We continue to see an increase in the number of conditions required monitoring. The upward trend of complaints this past year was a contributing factor to this increase. We had a total of 143 regulated members with 172 conditions actively monitored at the end of 2024. There are currently 19 regulated members with 40 conditions participating in our chaperone program.

Infection Prevention and Control (IPAC):

The IPAC team exceeded the annual target of 150 MDR assessments this past year. A change in Program Manager motivated the team to engage MDR clinics in assessment in the early months of 2024. This provided the opportunity for the team to conduct more follow-up assessments and explore the expansion of IPAC assessments beyond MDR and into general IPAC practices in community clinics. IPAC plans to further operationalize the assessment of adherence to infection prevention and control standards beyond MDR in 2025 in response to community concerns towards increased viral infections in the last five years.

Since the program inception, we have registered more than one thousand non-accredited community medical clinics on a voluntary basis. This engagement is continuing to grow for better understanding and control of medical practices in community settings. This is the opportunity for CPSA to have knowledge of where our regulated members are providing care to Albertans. At this rate, we expect to have close to 100 percent clinics registered at CPSA by 2027.

Competence Committee Meeting Report Form

Meeting Date:	Submitted by:		
February 13, 2025	Dr. Michael Caffaro, Assistant Registrar, Continuing Competence		
Agenda Item Title:	Competence Committee Report to Registrar		
Length of Time:			
Action Requested:	☒ The attached is for info only. No action is required.	☐ The following item(s) are of particular interest to Competence Committee. Feedback is sought on this matter.	☐ The following items require approval by the Registrar. See below for details of the recommendation.
AGENDA ITEM DETAILS			
Recommendation: (if applicable)	N/A		
Background:	The Competence Committee reunited on Wednesday, February 5, 2025, for a full day in-person meeting. Dr. Christine Kennedy chaired the meeting. **Membership and Staff Updates** The Committee welcomed a new member, Dr. Leigh Beamish, a family physician from Hinton. Dr. Beamish attended an orientation session with Dr. Caffaro, Mr. Van and Ms. Belanger from the Continuing Competence department a few days prior to the Committee meeting. The first meeting of 2025 was also Dr. Caffaro's initial meeting as the Assistant Registrar, Continuing Competence. Dr. Caffaro formerly introduced himself to the Committee and reaffirmed his enthusiasm to work with the Committee in the future. The team successfully recruited three new Senior Medical Advisors (SMAs). In late 2024, Dr. Florence Obianyor and Dr. Teresa Eliasson, joined the IPR and the HPCM team respectively, and Dr. Damian Haworth was the newest addition to the IPR team in February 2025. The HPCM team also gained a new administrative assistant, Ms. Sarwani Dev who joined the team on February 10. This recruitment effort will help the department slowly regain momentum in all programs and facilitate distribution of the workload. **Terms of Reference and Membership** Terms of Reference and the Membership list for the IPAC Advisory Committee were approved. The Competence Committee Terms of Reference were also approved with the exception of the Code of Conduct section. The Code of Conduct section was introduced to the Committee at the February meeting and will be submitted for approval in June.		

	Program Updates The Committee received a department update from Mr. Van as well as updates from PPIP from Ms. Northfield, Competence Assessment for Accelerated Route with Ms. McKenzie, and the HPCM program with Ms. Minckler. The following key points were raised: • The main focus for the second half of 2024 and early 2025 have been the recruitment and reallocation of resources. • The team managed to recruit 41 specialist reviewers in the last eight months to perform competence assessments for the accelerated path to registration program. 13 candidates already completed the first competence assessment, and a candidate from this cohort is expected to go through the second assessment in April 2025. • After an important period of transition, the Health and Practice Condition Monitoring (HPCM) program continues to build relationships within the monitoring and physician health community, and the program is exploring meeting with new IMEs and service providers in the near future. The program will also be doing a pulse survey with users who have completed the new monitoring process and share findings with the Committee in the near future. • The Committee expressed great satisfaction with the additional features and the ease of access to information on the PPIP website, which has seen numerous enhancements in recent months. The Committee's next meeting in June will include a presentation of the 2024 RIF results. **Other Presentations:** In addition to updates from Continuing Competence's various programs, **Dr. Nikki Kain** provided the results of her team's comparative study of the performance of internationally trained family physicians and Canadian graduates in Alberta to the Committee. **Dr. Cliff Lindeman** provided an update on his work on a 30-day prescribing AI model in partnership with OKAKI and the University of Alberta School of Public Health. Dr. Lindeman likewise gave some insights into a recent scoping review conducted by his team to evaluate the use of AI by regulators in the health industry. The goal of this scoping review is to better understand how other health authorities are regulating the clinical application of AI and how they use it in their day-to-day work.
Next Steps:	The Competence Committee will meet next on June 6, 2025, via Teams. Dr. Catherine Patocka will be chairing the next meeting.

Submission to:	**Council**

Meeting Date:	Submitted by:		
March 6 & 7, 2025	Dr. Jeremy Beach, Assistant Registrar, Accreditation		
Agenda Item Title:	Medical Facility Accreditation Committee Report		
Action Requested:	☐ The following items require approval by Choose an item. See below for details of the recommendation.	☐ The following item(s) are of particular interest to Choose an item. Feedback is sought on this matter.	☒ The attached is for information only. No action is required.
AGENDA ITEM DETAILS			
Recommendation (if applicable):	Not applicable		
Background:	**The Medical Facility Accreditation Committee (MFAC) met on January 28, 2025 and addressed the following:** **1. New Public Members** The Committee welcomed newly appointed public members, Josephine Naicker and Yannick Hebert. **2. Facility Accreditation** MFAC Approved Accreditation for the following number of facilities: Existing Facilities - 4-Year Assessments • Pulmonary Function Diagnostics– 6 facilities • Sleep Medicine Diagnostics – 4 facilities • Diagnostic Imaging – 39 facilities • Neurodiagnostics – 2 facility Existing Facilities - Facility Moves, Renovations and New Modalities: • Pulmonary Function Diagnostics – 2 facility moves • Sleep Medicine Diagnostics –1 facility move • Diagnostic Imaging –4 new modalities • Non-Hospital Surgical Facilities – 1 facility move New Facility Assessments • Pulmonary Function Diagnostics– 3 facilities • Sleep Medicine Diagnostics – 3 facilities • Diagnostic Imaging – 4 facilities • Psychedelic-Assisted Psychotherapy – 1 facility		

3. **Advisory Committee – New Member Approvals**

   Psychedelic-Assisted Psychotherapy
   - Dr. Peter Silverstone – Edmonton, Psychiatry

4. **V4 Medical Director Criteria / Standard Revision**

   The Committee approved revisions to the V4 Medical Director criteria for Diagnostic Imaging facilities, expanding eligibility to include niche imaging specialties. The updates address compliance challenges and align with accreditation processes. Effective January 29, 2025.

5. **2024 Year in Review**

   MFAC received a behind-the-scenes update from the Accreditation Department with key highlights over the past year. In all, there was a 6.7% increase in accredited facilities over the previous year. The department welcomed a new team member to bolster field-work capacity and recruited to replace retired staff and cover a maternity leave. Additionally, the department instituted a new Program Area dedicated to Accreditation Standards-related research, development and maintenance. Given the staffing changes, fostering team cohesion and defining a shared purpose (departmental WHY statement) was a major focus of the annual retreat. The team also spent time learning and applying the Complex adaptive model of healthcare to accreditation to contextualize its work and inter-play of cross-cutting factors from a systems-perspective.

6. **Reportable Incidents (2018 – 2023)**

   The Committee was presented with a report on 471 reportable patient safety incidents in NHSFs. Hospital transfers and admissions each made up 49% of cases, while deaths and wrong patient/site/side errors were under 1%. 67% of incidents involved female patients (mean age: 37.9 years). The report highlighted the need for proactive safety initiatives through facility-level learning systems and a standards-based incident management approach that enables effective use of accreditation as a knowledge translation tool.

7. **Request for Prescribed Health Services**

   The Committee was presented with a request to update CPSA Bylaws to allow bone marrow harvesting via bone biopsy in physician office/clinic settings. Recommended changes include removing certain procedures from Plastic Surgery and Other categories and renaming the stem cell section for clarity. The updates align with CPSA's office-based procedure allowances and

require revisions to NHSF Stem Cell Regenerative Therapy Accreditation Standards. The Committee approved the proposed bylaw updates.

8. NHSF Design Exemption Requests

The Committee reviewed three design exemption requests for NHSFs, addressing challenges related to operating room size, ventilation, and infrastructure limitations.

- Renew Oral and Facial Surgical Center – Approved exemption for operating room size due to building constraints.
- Ross Medical, Red Deer – Approved exemption for ventilation standards, with conditions limiting procedures until facility expansion.
- Holy Cross – Exemption for operating room size was deferred pending further engineering documentation

9. Resetting Accreditation Cycle

The Committee approved resetting the 4-year accreditation cycles for two NHSFs:

- Chinook Oral & Maxillofacial Surgery – Reset due to recent renovations with an assessment originally due in less than 12 months.
- Kingsway Oral Surgery, Edmonton – Reset due to renovation delays causing misalignment with its Grande Prairie location.

Both facilities will now begin new 4-year accreditation cycles in 2027 to ensure compliance with regulatory requirements.

10. Northern Alberta EMG & Neuromuscular clinic

The Committee reviewed the four-year accreditation assessment for the Northern Alberta EMG & Neuromuscular Clinic, addressing key compliance issues:

- Approved continued use of the 2nd edition of the Manual of Electromyography (2005), as its content aligns with the 3rd edition (2015).
- Required the clinic to submit facility-specific training materials, as CPSA's general Occupational Health and Safety documents were insufficient.
- Approved updates to the "Further Response Required" section of the reaccreditation report for clarity and alignment with CPSA standards.

Submission to:	**Council**

<table>
<tr><td>Meeting Date:</td><td colspan="3">Submitted by:</td></tr>
<tr><td>March 6, 2025</td><td colspan="3">Michael Neth
Chief of Staff</td></tr>
<tr><td>Agenda Item Title:</td><td colspan="3">5.1.1 CPSA Partnership Agreement with G4 Health</td></tr>
<tr><td>Action Requested:</td><td>☒ The following items require approval by Council See below for details of the recommendation.</td><td>☐ The following item(s) are of particular interest to Choose an item. Feedback is sought on this matter.</td><td>☐ The attached is for information only. No action is required.</td></tr>
<tr><td colspan="4">AGENDA ITEM DETAILS</td></tr>
<tr><td>Recommendation (if applicable) :</td><td colspan="3">Council supports the partnership and provides approval for CPSA Council Chair to participate in the signing on Council's behalf.</td></tr>
<tr><td>Background:</td><td colspan="3">In early 2023, Margo Dodginghorse (G4 Health Director and founding member of the Indigenous Advisory Circle to CPSA) identified opportunities for G4 Health and CPSA to collaborate outside of the Circle's work. That fall, members of the G4 Health and CPSA teams (together referred to as the partnership's technical team) began meeting to explore a potential partnership to support each organization's vision and mandate.
Over the next few months, the technical team collaborated to prepare a draft partnership agreement, which includes collaborative commitments of anti-racism anti-discrimination, cultural competency, patient-centered practices and continuous quality improvement.
In the summer of 2024, this proposed partnership agreement was presented to the G4 Health Steering Committee and CPSA senior leadership team for feedback, discussion and support. With both organizations expressing support for the partnership, the technical team is now planning to finalize the partnership through a signing event.
Recently, G4 Health advised that signatories for G4 Health will be Bearspaw Chief Darcy Dixon, G4 Health CEO Dean Manywounds and Health Director Margo Dodginghorse. As the signing will now involve participation at a Chief level, we are seeking Council's involvement in signing. Specifically, we are seeking Council support for the partnership and approval to participate in the signing.</td></tr>
</table>

	Additional background: • G4 Health is a department within the Stoney Nakoda Tsuut'ina Tribal Council Ltd. (SNTTC/G4) and is governed by a Board of Directors comprised of the Chiefs of the Sovereign Nations (Bearspaw, Chiniki, Goodstoney and Tsuut'ina First Nations). • While distinct from the MOU with Siksika Health Services, this partnership has similarities, including the proposed approach of having the current Council Chair as a signatory.
Next Steps:	• Prepare for partnership signing event (tentatively scheduled for May 2025) • Co-create with G4 Health action plan in consultation with Îyethka and Tsuut'ina Peoples, G4 Health Steering Committee and CPSA senior leadership

List of Attachments:
1. G4 Health and CPSA: Partnership Principles & Collaborative Commitments

G4 Health and CPSA:
Partnership Principles & Collaborative Commitments

Background

G4 Health represents Îyethka (Bearspaw, Chiniki, Goodstoney) and Tsuut'ina First Nations as an Advocate, Advisor, Collaborator and Capacity Builder. G4 Health is a department within the Stoney Nakoda Tsuut'ina Tribal Council Ltd. (SNTTC/G4) and is governed by a Board of Directors comprised of the Chiefs of the Sovereign Nations.

The College of Physicians & Surgeons of Alberta (CPSA) is the regulator for physicians and physician assistants in Alberta. CPSA plays an essential role in protecting the public, ensuring regulated members in Alberta are knowledgeable, professional and ethical in their professional practice.

G4 Health and CPSA share the following mutual goals:

- influence change in the health care system by advancing culturally safe, competent, ethical care provided by regulated members
- promote safe, high-quality and informed patient-centered care
- nurture sustainable, authentic connections between Îyethka (Bearspaw, Chiniki, Goodstoney) and Tsuut'ina Peoples and CPSA in the areas of health equity

Towards these goals, G4 Health and CPSA will co-develop joint reconciliation activities rooted in Îyethka and Tsuut'ina ways of knowing and values.

Vision

The Îyethka (Bearspaw, Chiniki, Goodstoney) and Tsuut'ina Peoples receive the highest quality, culturally safe, and ethical care from CPSA-regulated members.

Principles

The wellbeing of the Îyethka (Bearspaw, Chiniki, Goodstoney) and Tsuut'ina Peoples is supported through mutual respect and equal standing in a partnership between G4 Health and CPSA.

Towards this, we commit to a relationship that incorporates:

- applying a 2-Eyed Seeing approach to our shared work
- respecting each other's differences and honouring opportunities to learn from one another
- being authentic in our work together and rooting our interactions in integrity
- valuing relationships over outcomes
- having a patient-centered approach to our work
- developing measurable actions together and supporting each other's accountability
- updating all stakeholders with regular progress updates and annual check-ins
- acknowledging that anti-oppressive practices exist and embedding them into our partnership

Collaborative commitments

In our collaborative work, we acknowledge the strengths of the Îyethka (Bearspaw, Chiniki, Goodstoney) and Tsuut'ina Peoples and take actions to enhance their healthcare experiences with regulated members.

Anti-racism anti-discrimination

- incorporating anti-oppressive practices into our partnership work
- addressing racism and identifying actions to support both patients and regulated members towards better health care
- challenging stereotypes and promoting culturally safe care regulated members provide to Îyethka and Tsuut'ina Peoples
- ensuring accurate representations of Îyethka and Tsuut'ina Peoples
- identifying opportunities for the Îyethka and Tsuut'ina Peoples to participate in and contribute towards medical regulation and culturally safe, high-quality care

Cultural competency

- improving patient experiences through training and resources for regulated members
- ensuring guidance and resources are accessible to regulated members
- applying learnings and successes from this partnership to inform approaches for other related organizations

Patient-centered practices

- creating and strengthening a connection between G4 Health and CPSA on behalf of Îyethka and Tsuut'ina Peoples towards culturally safe patient services
- supporting regulated members in incorporating patient-centered, culturally competent practices
- collaborating on patient resources that are presented in the Îyethka and Tsuut'ina languages

Continuous quality improvement

- engaging with the Îyethka and Tsuut'ina Peoples to develop an evaluation framework that demonstrates progress toward shared goals, and evaluating the impact of joint actions towards improved patient experiences
- growing awareness of CPSA and its mandate to support patient safety and open feedback channels for continually improving culturally safe practices
- sharing research and learnings towards improving the healthcare experiences of Îyethka and Tsuut'ina Peoples, following the First Nations principles of ownership, control, access, and possession (OCAP ®)
- reflecting on wise practices, such as other partnerships towards culturally safe, equitable health care for the Îyethka and Tsuut'ina Peoples

Submission to:	**Council**

Meeting Date:	Submitted by:		
March 6, 2025	Michael Neth, Chief of Staff		
Agenda Item Title:	5.1.2 CPSA Path to Truth and Reconciliation		
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 guidance of the Indigenous Advisory Circle, CPSA has developed an outline of CPSA's Path to Truth and Reconciliation (the Path), which received support and acceptance from CPSA Council in March 2024. The Path has a small project team that acts as a hub for this priority work. Under the guidance of the Indigenous Advisory Circle and with help from project management firm Great Country Consulting, this team is finalizing an implementation plan to ensure the Path is effective and sustainable, and that CPSA's engagement with First Nations, Métis and Inuit Peoples is authentic and meaningful. We have prepared and attached "Path to Truth and Reconciliation: where we are going and why," a report for Council's review that provides context for the direction CPSA intends to take with the Path, highlights why this work is critical, and outlines the important steps we plan to take in 2025 with Council's support.		
Next Steps:	With the Circle's support, we intend to focus on three main areas for Path-related work in 2025. 1. Through research, identify and confront the ways CPSA has directly and indirectly caused harm to First Nations, Inuit and Métis Peoples to gain a clearer understanding of the scope of CPSA's involvement in harms how we may restore trust. 2. Review, analyze and assess the Truth and Reconciliation Commission of Canada's Calls to Action, United Nations Declaration on the Rights of Indigenous Peoples and other		

	key foundational documents, and incorporate learnings towards reconciliation. 3. Hear from First Nations, Métis and Inuit leaders and communities about how broken trust has been experienced in the past and today, and how to improve cultural humility in healthcare interactions.

List of Attachments:
1. Path to Truth and Reconciliation - where we are going and why

CPSA's Path to Truth and Reconciliation:

Where we are going and why

February 2025

Path to Truth and Reconciliation
Where we are going and why
February 2025

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Warning: this report includes reference to residential schools and harms First Nations, Inuit and Métis individuals, families and communities have experienced in the health system and may bring up difficult emotions in those reading it.

For anyone who has experienced these harms and may require culturally safe support, please contact:

The Indian Residential School Crisis line: 1-866-925-4419

Hope for Wellness Helpline: 1-855-242-3310
(or chat online at hopeforwellness.ca)

Suicide Crisis Helpline: call or text 9-8-8 (toll-free)

Background

Since it was established in late 2021, the Indigenous Advisory Circle (the Circle) has guided CPSA on our reconciliation journey, helping us reflect on our processes and identify better ways to support First Nations, Métis and Inuit patients, guide the regulated members who care for them, and improve the regulatory environment for Indigenous physicians.

It is with the guidance of and in collaboration with the Circle that we have developed an outline of CPSA's Path to Truth and Reconciliation (the Path), which received support and acceptance from CPSA Council in March 2024. As CPSA prepares to begin this journey in earnest, this report shares where we are heading and why.

Indigenous individuals have an **equal right** to the enjoyment of the **highest attainable standard of physical and mental health**.

Article 24
United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)

Drivers of CPSA's Path to Truth and Reconciliation

Life expectancy and health disparities

Alberta Health publishes health data annually, comparing life expectancy for First Nations people in Alberta to non-First Nations peoples. Alberta Health's latest report (Dec. 2024) reveals the gap in life expectancy between these populations is now 19.1 years (higher than the 17.2 years difference in 2022). This alarming statistic means life expectancy in First Nations people is now similar to life expectancy in Canada in the 1930s and to what was reported by WHO in countries like Afghanistan, Angola, and Niger in 2019.

Suicide, unintentional injury, cancer, and diseases of the digestive system account for proportionally more deaths in First Nations than non-First Nations people.

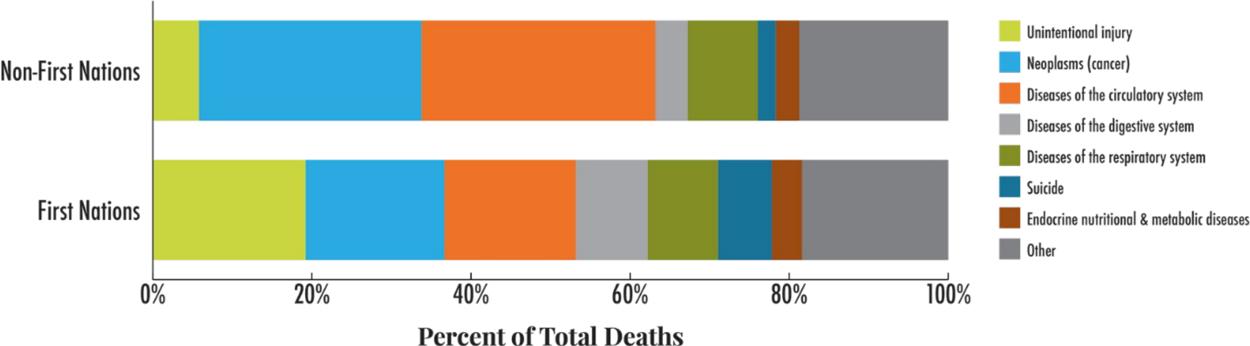


Figure: Proportion of total deaths by cause of death for First Nations and non-First Nations people in Alberta, 2017
Source

The Truth and Reconciliation Commission of Canada's report "What We Have Learned: Principles of Truth and Reconciliation" sheds light on health disparities, one of the legacies of residential schools:

> When reporting on First Nations health in 1905, Indian Affairs Chief Medical Officer Dr. Peter Bryce wrote that "the death-rate is wholly abnormal, amounting to, on an average, 34–70 per 1,000." One hundred and ten years later [2015], there continue to be troubling gaps in health outcomes between Aboriginal and non-Aboriginal Canadians. For example:
>
> - The infant mortality rates for First Nations and Inuit children range from 1.7 to over 4 times the non-Aboriginal rate.
> - From 2004 to 2008, the "age-specific mortality rate" at ages one to nineteen in the Inuit homelands was 188.0 deaths per 100,000 person-years at risk, compared with only 35.3 deaths per 100,000 in the rest of Canada.
> - First Nations people aged forty-five and over have nearly twice the rate of diabetes as compared with the non-Aboriginal population.
> - First Nations people were six times more likely than the general population to suffer alcohol-related deaths, and more than three times more likely to suffer drug-induced deaths.
>
> The overall suicide rate among First Nation communities is about twice that of the total Canadian population. For Inuit, the rate is still higher: six to eleven times the rate for the general population. Aboriginal youth between the ages of ten and twenty-nine who are living on reserves are five to six times more likely to die by suicide than non-Aboriginal youth.
>
> Health disparities of such magnitude have social roots. They are stark evidence of federal policies that separated Aboriginal people from their traditional lands and livelihoods, confining them to cramped and inadequate housing on reserves that lacked the basic sanitary services. It was from these communities that residential schools recruited students, and it was to them that the students returned with their health further weakened.

Anti-Indigenous bias reported in health system

A 2023 survey[1] found explicit anti-Indigenous bias was present among Albertan physicians:

> (The survey found that) about 10%–25% reported explicit anti-Indigenous bias and that overall, physicians had moderate implicit anti-Indigenous bias. Importantly, implicit anti-Indigenous bias varied between demographic groups and was greatest among white cisgender male physicians and least among BPOC cisgender female physicians. Older physicians, those practising in urban or large rural settings, those in surgical disciplines and those without academic affiliations had greatest implicit anti-Indigenous bias.

According to the report, "concerns about 'reverse racism' targeting white people and discomfort discussing racism may act as barriers to addressing these biases." It goes on to state perceptions of reverse racism indicate "a lack of understanding of the concept of

[1] Roach P, Ruzycki SM, Hernandez S, et al. Prevalence and characteristics of anti-Indigenous bias among Albertan physicians: a cross-sectional survey and framework analysis. BMJ Open 2023;13:e063178. doi:10.1136/ bmjopen-2022-063178

equity and a false equivalency of equity and oppression by the perceived loss of societal advantage."

Broken trust in CPSA and regulated members

We have heard from members of the Circle, our partners and Indigenous health leaders about how, for many Indigenous people, trust in physicians and in CPSA has been broken.

Historical causes of broken trust include:

- Medical harms to Indigenous children in residential schools and on Indigenous patients in Indian hospitals, including conducting research without informed consent.
- Physician participation in the forced sterilization of Indigenous women and physicians' role in Alberta's eugenics program (also known as the Sexual Sterilization Board), a program that ran from 1928 to 1972.
- CPSA's role in nominating physicians for appointments to the Sexual Sterilization Board.
- Physicians administering treatments to Indigenous patients without informed consent.
- Physician involvement in policies and programs under Canada's Indian Affairs system.

Indian hospitals

Segregated Indian hospitals operated across Canada from 1945 until the mid-1980s, with seven of these located in Alberta:

- Blackfoot Indian Hospital
- Blood Indian Hospital
- Charles Camsell Indian Hospital
- Hobbema Indian Hospital
- Morley Stoney Indian Hospital
- Peigan Indian Hospital
- Sarcee Indian Hospital

Among harms to the patients of these facilities were forced sterilization. The largest facility of its kind, the Camsell was the setting for 125 sterilizations of First Nations and Inuit patients from 1971 to 1974 alone.
Source

Contemporary contributors to broken trust include:

- Physician biases and discrimination, including assumptions about life choices, addiction, and alcoholism.
- Leadership by physicians in health services and systems that perpetuate bias and discrimination against Indigenous patients.
- Suppression or dismissal of the significance of Indigenous culture, community, and spirituality as vital components of well-being.
- Barriers to medical care that Indigenous patients face that non-Indigenous patients may not.
- Media stories about Indigenous experiences of racism and discrimination in healthcare, including:
    - Joyce Echaquan in Quebec

        - Echaquan's tragic death resulted in Joyce's Principle
    - Dexter Adams in Alberta
    - Myra Crow Chief in Alberta
    - Brian Sinclair in Manitoba

This broken trust has very real impacts on health and well-being. From what we've heard, the lack of trust in physicians manifests as psychological, social, and emotional barriers to seeking care. Many Indigenous patients only turn to physicians for physical or psychological care when their health has deteriorated to a crisis point. This not only affects individuals but also their families and communities and places a strain on the healthcare system as preventative care is typically more effective and cost-efficient than crisis care.

As the sole regulatory body for physicians in Alberta for over 124 years, CPSA has been responsible for setting standards and holding physicians accountable during a time when Indigenous people were subjected to harmful experiences within the health system. In some instances, CPSA may have been unaware or indifferent; in others, CPSA was complicit. One example is CPSA's active involvement with the Sexual Sterilization Board for over 40 years. We've also heard several Indigenous patients and advocates who approached CPSA in the past with concerns who have expressed to us that their concerns were not adequately addressed.

A common theme we've heard is the acute lack of agency felt by Indigenous people in their patient-physician experiences. This lack of agency prevents them from receiving the care they expect and prevents them from seeking appropriate redress in these cases when the care they expect is not received. When a person's trust is never achieved, is broken, or lack of agency prevents it from being restored, it further erodes the willingness of that person to proactively seek care. This lack of agency might be difficult for many non-Indigenous Albertans to identify but this does not diminish the prevalence or impact that we've heard of through our Indigenous engagement work.

Next steps to promote trust

Although these issues have largely gone unnoticed by CPSA decision-makers until recently, they are significant and warrant targeted action. To illustrate the impact, imagine if the combined populations of Lethbridge, Medicine Hat, Red Deer, and Grande Prairie all lost trust in physicians, leading to adverse health outcomes across these communities. Now that we are aware of this situation, CPSA must investigate further and take appropriate actions. The big question is which actions should be taken by CPSA that will bring meaningful change where it is needed, that uses resources proportionately and effectively, and that fit within CPSA's mandate as Alberta's medical regulator?

Although the feedback we've received to date has come from reliable and trusted voices, the number of people engaged so far is small. In 2025, we are aiming to broaden our engagement to include a wider cross-section of First Nations, Métis and Inuit populations, as well as Indigenous and non-Indigenous physicians. We also plan to avoid re-inventing the

wheel by further reviewing existing literature on how trust in physicians was lost and how it might be restored.

CPSA could take action based on what we've learned so far, but doing so may risk overlooking key information that could help us make informed decisions. The additional input we are seeking, with Council's support, will ensure that our actions are well-calibrated, focused within CPSA's mandate, make the best use of limited resources, and have the greatest potential to rebuild trust in the physician-patient relationship and in CPSA.

The Path and CPSA's role in earning trust

There are many causes of broken trust in physicians, CPSA and the overall health system, and it will take action from all parts of this system to begin repairing trust and addressing health disparities. CPSA is only one piece of a bigger picture, but with a mandate to protect and serve the public interest and with influence over more than 14,000 regulated members, the actions we take will have a positive impact if we proceed in a meaningful and sustainable way.

The Path outlines the actions we will take that fit within our scope as Alberta's medical regulator. Along the way, we intend to seek ongoing input from First Nations, Métis and Inuit leaders and communities, our internal team, regulated members and partners within the health system to ensure our approach is both impactful and sustainable.

Much of the foundational work is already underway or complete:

- We have received ongoing guidance from the Circle since it first began meeting in 2022. The Circle has advised us throughout the development of the Path and will continue to guide us along each step.
- Relationships are growing with partners who share our goal of high-quality and accessible health care.
- We have engaged a firm who works closely with First Nations and Indigenous organizations across Treaty 6, 7 and 8 to scope out an implementation plan to ensure we have allocated appropriate time and resources for the actions outlined in the Path. This plan reflects the firm's expertise in Indigenous engagement as well as input from teams across CPSA (currently being finalized).

In 2025, implementation will begin.

Implementing the Path: our approach

Informed decision-making

The first actions on the Path are rooted in listening to and learning from the experiences and wisdom of First Nations, Métis and Inuit people through unpacking the Truth and Reconciliation Commission of Canada's 94 Calls to Action and other foundational documents. We will also seek out input from Indigenous people, communities and organizations across Treaty 6, 7 and 8 territories about how trust in regulated members and CPSA may be earned. What we learn will inform our decision-making for subsequent actions on the Path.

Engagement and consultation

> **UNDRIP Article 23**
> … Indigenous peoples have the right to be **actively involved** in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.

We have heard the call to action, "Nothing about us without us," which means that solutions for First Nations, Métis and Inuit people are best developed through engagement and collaboration. This approach recognizes that many answers exist within Indigenous communities, and that Indigenous Peoples have a legislated right to active involvement in developing programs that affect them.

Through earning and maintaining reciprocal relationships rooted in cultural humility, we hope to invite ongoing input from First Nations, Métis and Inuit leaders and communities, including check-ins to assess the impact and effectiveness of our work.

Regulated members will also have insights and feedback to share and it will be important for us to seek their feedback during the development of any standards, policies and guidance towards improved physician-patient experiences.

Sustainable action

The Path outlines actions we can take to strengthen our regulatory functions in a way that supports First Nations, Métis and Inuit people, our team and regulated members. Good work is already being planned or underway in some CPSA departments, and this work is being aligned with the Path to ensure consistency and sustainability.

The journey ahead of us requires change, both large and incremental. The Path is not linear, nor is it short term. Some Indigenous partners have described this work as generational, and the resulting relationships and outcomes will require a sustained, long-term commitment for many years.

2025: first steps on the Path

2025 actions will provide a foundation for future years on CPSA's Path to Truth and Reconciliation. The CPSA business plan includes a budget of $200,000 for the following actions:

Identify and confront CPSA's role in harms → Unpack TRC Calls to Action and foundational documents → Hear from First Nations, Metis and Inuit leaders and communities → 2026 and beyond

Appendix 1: Path to Truth and Reconciliation outline

The Path is essentially an action plan, with each step on the path identified and supported by the Indigenous Advisory Circle. For background and a high-level overview of the entire Path, see *CPSA's Path to Truth and Reconciliation: An Outline of the Path Ahead*.

These actions, or steps along the Path, are:

	ACTION	ANTICIPATED TIMING
1	**Explore sources of wisdom and confront CPSA's role in harms and broken trust** Review, analyze and assess the TRC Calls to Action and foundational documents, and incorporate learnings towards reconciliation. Uncover the ways CPSA has directly and indirectly caused harm to First Nations, Inuit and Métis Peoples to gain a clearer understanding of how we may restore trust.	Q2-3 2025
2	**Witness Sharing Circles and Gathering Experiences** Listen to and document the experiences Indigenous people in Alberta have had with regulated members and CPSA.	Q2-4 2025
3	**Release Statement of Action and Apology** Publicly acknowledge CPSA's role in the experiences of and harms to Indigenous people and state actions we will take to address the harms.	Q2 2026
4	**Develop and Implement standards and policies** *For Standards of Practice:* Outline and set the minimum professional and ethical expectations for regulated members in their interactions with Indigenous patients and colleagues based on learnings. *For Accreditation:* Assess and revise Accreditation standards *For Registration:* Assess and revise Registration policies	2026
5	**Provide Training for Regulated Members** Ensure regulated members are educated about and aware of how to provide appropriate care to Indigenous people.	Begin 2026; assess in 2027

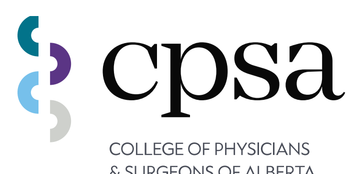
	ACTION	ANTICIPATED TIMING
6	**Enhance Patient Experience with CPSA** *For Professional Conduct:* Revise processes to be culturally appropriate and accessible to Indigenous people who have concerns about care they have received and to reflect expectations outlined by standard of practice. *For Customer Experience:* CPSA staff have training and appropriate dialogue when supporting Indigenous patients who contact CPSA	2025; continual and ongoing improvement
7	**Assess Continuing Competence Programs** Revise program expectations and materials to be culturally appropriate and support regulated members in providing Indigenous people with safe, high-quality care.	Begin in 2025; deliver 2026; assess in 2027
8	**Facilitate Ongoing Connections with Indigenous People and Communities** Establish regular connections with Elders, communities, and organizations to continue learning about the experiences of Indigenous people with regulated members and CPSA.	Continual and ongoing improvement
9	**Align Internal CPSA Operations** Provide training for CPSA Council and team, review policies and processes for negative impacts towards Indigenous people and develop appropriate policies for supporting Indigenous people working in and with CPSA. Engage the CPSA team throughout the Path's implementation.	Continual and ongoing improvement
10	**Lead Healthcare Partners Toward Safer Patient Care** Partner with other regulators towards consistent and appropriate expectations for all healthcare professionals (e.g., joint or aligned standards, guidance, training, and professional conduct processes).	2026; continual and ongoing improvement

Appendix 2: Principles of Reconciliation

Excerpted from "What We Have Learned: Principles of Reconciliation,"
Truth and Reconciliation Commission of Canada

The Truth and Reconciliation Commission of Canada believes that in order for Canada to flourish in the twenty-first century, reconciliation between Aboriginal and non-Aboriginal Canada must be based on the following principles.

1. The United Nations Declaration on the Rights of Indigenous Peoples is the framework for reconciliation at all levels and across all sectors of Canadian society.
2. First Nations, Inuit, and Métis peoples, as the original peoples of this country and as self-determining peoples, have Treaty, constitutional, and human rights that must be recognized and respected.
3. Reconciliation is a process of healing of relationships that requires public truth sharing, apology, and commemoration that acknowledge and redress past harms.
4. Reconciliation requires constructive action on addressing the ongoing legacies of colonialism that have had destructive impacts on Aboriginal peoples' education, cultures and languages, health, child welfare, the administration of justice, and economic opportunities and prosperity.
5. Reconciliation must create a more equitable and inclusive society by closing the gaps in social, health, and economic outcomes that exist between Aboriginal and non-Aboriginal Canadians.
6. All Canadians, as Treaty peoples, share responsibility for establishing and maintaining mutually respectful relationships.
7. The perspectives and understandings of Aboriginal Elders and Traditional Knowledge Keepers of the ethics, concepts, and practices of reconciliation are vital to long-term reconciliation.
8. Supporting Aboriginal peoples' cultural revitalization and integrating Indigenous knowledge systems, oral histories, laws, protocols, and connections to the land into the reconciliation process are essential.
9. Reconciliation requires political will, joint leadership, trust building, accountability, and transparency, as well as a substantial investment of resources.
10. Reconciliation requires sustained public education and dialogue, including youth engagement, about the history and legacy of residential schools, Treaties, and Aboriginal rights, as well as the historical and contemporary contributions of Aboriginal peoples to Canadian society.



Submission to:	**Council**

<table>
<tr><td>Meeting Date:</td><td colspan="3">Submitted by:</td></tr>
<tr><td>March 6, 2025</td><td colspan="3">Governance Committee</td></tr>
<tr><td>Agenda Item Title:</td><td colspan="3">6.1.1. Governance Committee – Succession Planning for Committee Chairs</td></tr>
<tr><td>Action Requested:</td><td>☐ The following items require approval by Choose an item. See below for details of the recommendation.</td><td>☒ The following item(s) are of particular interest to Council. Feedback is sought on this matter.</td><td>☐ The attached is for information only. No action is required.</td></tr>
<tr><td colspan="4">AGENDA ITEM DETAILS</td></tr>
<tr><td>Recommendation (if applicable) :</td><td colspan="3">That Council reviews the Governance Committee’s suggestions for succession planning for Committee Chairs and provide their feedback.</td></tr>
<tr><td>Background:</td><td colspan="3">The Governance Committee’s terms of reference states that the Committee is responsible for bringing forward recommendations for appointments of Committee Chairs (and Co-Chairs or Vice Chairs as needed) based on the following principles:
a. Each committee has an annual discussion about the Chair for the upcoming year.
b. All councillors have been given an opportunity to express their interest in becoming Chair.
c. Committee chairs are a Council member unless extenuating circumstances exist to justify the appointment of a Chair who is not a sitting Council member.
d. Chairs are appointed for one year only, with an opportunity to renew for up to six years.

While this process underlines how to appoint Committee Chairs, a standard process for the succession planning of Committee Chairs is not articulated for Council Committees. This can result in difficulties in filling the Committee Chair role for subsequent years.

At its January 2025 meeting, the Committee considered these challenges and discussed preliminary actions that could be taken by Committees to address succession planning. The following considerations are being put forward by the Governance Committee for Council’s review and feedback:</td></tr>
</table>

	• If approved by Council, the role of the Committee Chair document is used by Committees to help Chairs and members understand the role of the Committee Chair. • It is recommended that potential Committee Chairs should be members of the Committee for one year, so that they have an informed knowledge and understanding of the Committee's mandate. This recommendation would be optional, however, so that it does prevent new Committee members from standing for the role of Chair. • It is recommended that Committees begin discussions on the selection of an upcoming Committee Chair early enough in the year so that the Committee can bring their recommendation to the Governance Committee in time for the second Council meeting of the year (i.e., May). This could help to reduce tensions and pressures of selecting a Chair toward the end of the year. • It is recommended that the Governance Committee intervenes through informal discussions and negotiations with Committees to help them with finding a Chair in time for the following year, if Committees experience difficulties with finding a Chair. • The Governance Committee will monitor the outcome of the above-noted approach and may use other tactics (e.g., incorporating a Vice Chair role into all Committees) if succession planning continues to present a challenge.
Next Steps:	Following the outcome of the discussion, the Governance Committee will continue to develop its process to support succession planning for Committee Chairs.
List of Attachments:	
N/A	

Submission to:	**Council**

Meeting Date:	Submitted by:		
March 6, 2025	Governance Committee		
Agenda Item Title:	6.1.2 Governance Committee - Council Learning Plan 2025		
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:	That Council approves the 2025 CPSA Council Learning Plan.		
Background:	One of the purposes of the Governance Committee is to recommend practices and educational opportunities to improve Council effectiveness. Through the development and monitoring of a Council Learning Plan, the Committee ensures that Council members are benefitting from continuous learning opportunities. **Development of the 2025 Learning Plan** The draft 2025 Council Learning Plan was developed from the 2024 Learning Plan and ideas from members within the Alberta Federation of Regulated Health Professions (AFRHP). In reviewing the draft, the Committee recommended that the learning plan formalizes opportunities for **peer-to-peer learning**, in the form of verbal or written reflections shared during Council meetings. This would allow everyone to benefit from each other's knowledge and identify learning opportunities that may not be useful for Council. In February, the Executive Committee agreed that including this sharing session in the Council meeting agenda would be beneficial. The Committee also asked for additional opportunities for learning on Authentic Indigenous Connections, one of our strategic directions. There was also special attention given to Council learning on Artificial Intelligence and the need for Council's foresight in this area.		

	A draft 2025 Learning Plan is attached for Council's consideration and approval.
Next Steps:	The 2025 Council Learning Plan will be implemented. Council members are encouraged to give feedback to the Governance Committee on whether the learnings are useful and to suggest other learning opportunities for Council members.
List of Attachments:	
1. Draft 2025 CPSA Council Learning Plan	

2025 CPSA Council Learning Plan (Draft)

Introduction:

Individual and group learning are important to good governance and fulfilling CPSA's mandate as a regulator to govern in a manner that protects and serves the public interest.

Learning Plan Goals:

1. To enhance the understanding of the role of a health regulator and the fiduciary duty of CPSA Council.

2. To build capacity for bringing the Council Culture Agreement to life.

3. To build leadership skills.

4. To promote an exchange of learning amongst Council members.

5. To develop as individual Council members and as Council in working towards CPSA's Strategic Directions:
   - Highest quality, compassionate and ethical care
   - Authentic Indigenous Connections
   - Anti-Racism and Anti-Discrimination
   - Enhanced Partnerships
   - Proactive and Innovative Approach

Learning Plan Areas

The learning plan is organized by the following areas:

1. Individual Learning

2. Peer to Peer Learning

3. Group Learning (Council Meeting Learning Session)

4. Group Learning (Outside of Council meetings)

LEARNING AREA 1: Individual Learning

Activities	Resources	Measuring and Reporting Outcomes	Strategic Plan Alignment
MANDATORY LEARNING			
Fair Registration Practices Act (ONLINE) **Learning Plan Goal:** 1	Under Alberta's *Fair Registration Practices Act*, CPSA must ensure our registration practices are transparent, objective, impartial and procedurally fair. CPSA Councillors may be involved in hearing appeals of registration decisions. To help ensure CPSA's registration processes comply with legislation, the *Fair Registration Practices Act* Training is required.	Course completion will be tracked.	Highest quality, compassionate and ethical care
VOLUNTARY LEARNING			
Council members can participate in training for Complaint Review Committee/ Hearing Tribunal members, organized by the Hearings Director Office (ONLINE). **Learning Plan Goals:** 1, 4	Training examples include: • Appeals Orientation and Training • Anti-Racism training delivered by the Centre for Race and Culture • Decision-writing workshop delivered by the Canadian Institute for Administrative Justice (CIAJ)	Number of Council members taking the courses can be tracked	Highest quality, compassionate and ethical care
Council members participate in individual learning (ONLINE OR IN-PERSON). **Learning Plan Goals:** ALL	• Each council member has access to an annual $1500 learning allocation. • Learning opportunities are appended to each Council meeting agenda. • Council members can develop a tailored learning plan with the Office of the Registrar staff.	The usage of allocation of funds and Council member self-reporting on learning engagement.	All Strategic Directions (dependent on the content of the individual courses taken).

Activities	Resources	Measuring and Reporting Outcomes	Strategic Plan Alignment
Micro-aggression Training for Physicians (ONLINE) **Learning Plan Goals:** 2, 3, 5	This is training developed in partnership with CPSA, AMA and AHS accessible through MyCPSA. It is 1 – 1 ½ hours.	Course completion can be tracked.	• Anti-Racism and Anti-Discrimination, • Highest quality, compassionate and ethical care, • Authentic Indigenous Connections

LEARNING AREA 2: Peer-to-Peer Learning

Activities	Resources	Measuring and Reporting Outcomes	Strategic Plan Alignment
VOLUNTARY LEARNING			
Written or verbal learning reflections **Learning Plan Goal:** 4	Council members share their knowledge and insights from individual learning opportunities they engage in.	Number of times this is listed on the Council meeting agenda.	Highest quality, compassionate and ethical care

LEARNING AREA 3: Group Learning: (Council Meeting Learning Sessions)

Activities	Resources	Measuring and Reporting Outcomes	Strategic Plan Alignment
Speaker Series Council includes a 1-hour (minimum) learning session as part of each Council meeting Agenda. **Learning Plan Goals:** All	The Executive Committee plans the CPSA Council Meeting Agendas and will use this list to make decisions on in-Council learning sessions. Topics from this list can also inform themes for Council Retreats. **Anti-Racism and Anti-Discrimination** • Cultural Competence with Dr. Patrick McFarlane **Authentic Indigenous Connections** • Council's Role in Truth and Reconciliation with Will Fong, Great Country Consulting (follow up from Council Retreat 2024) • Presentation from Lisa Higgerty, Assistant Deputy Minister from Indigenous Health • Presentation from Dr. Alika Lafontaine Presentation from Dr. Wayne Clark, Indigenous Advisory Circle Member (played pivotal role in assisting the College of Physicians and Surgeons of Manitoba with their apology to Indigenous communities) **Council Culture** • Bringing joy and fun to Council meetings with Michelle Cederberg.	The Annual Evaluation of Council Effectiveness includes the following question: "Looking back over the meetings of this year, I see growing evidence of the impact of group learning in Council's discussions and decision-making."	• Highest quality, compassionate and ethical care • Proactive and Innovative Approach • Anti-Racism and Anti-Discrimination • Enhanced Partnerships

Activities	Resources	Measuring and Reporting Outcomes	Strategic Plan Alignment
	Enhanced Partnerships • Canadian Medical Protective Association (CMPA) – context and understanding of complaints at the national level. • Health Quality Council of Alberta (HQCA) – their mandate, and trends in Alberta • Round Table Discussion with AMA **Proactive and Innovative Approach** • Artificial Intelligence (AI) and medicine **Strategic Planning** • Strategic Planning discussions with Peter Wright • Presentation from HIROC on the FMRAC Integrated Risk Management System		

TABLE 3: Group Learning: Outside of Council meetings

Activities	Resources	Measuring and Reporting Outcomes	Strategic Plan Alignment
A ½ day session on Chairing meetings and Robert's Rules is organized for Council Chair and Executive Committee, all Committee Chairs (may include Council members and non-Council members) and Vice Chairs. An invitation will be extended to all Council members who may be thinking about volunteering to Chair a committee or run for Council in the future. **To be completed by September 2025** **Learning Plan Goals:** 1, 3	CPSA will seek a facilitator for this session.	Attendance will be tracked, and post-training survey will be given.	• Highest quality, compassionate and ethical care • Proactive and Innovative Approach

Submission to:	Council

Meeting Date:	Submitted by:		
March 6, 2025	Governance Committee		
Agenda Item Title:	6.1.3 Council Competency Matrix, Recruitment and Nominations		
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 is sought on this matter.	☐ The attached is for information only. No action is required.
AGENDA ITEM DETAILS			
Recommendation:	That Council approves the proposed core and technical Council Member Competencies.		
Background:	In 2022, John Dinner of Board Governance Services was engaged to carry out a governance review for CPSA. Based on the recommendations in that report, Council approved an implementation plan that included the development of a competency-based model for CPSA Council nominations. MNP was engaged to support this work in fall 2024. Specifically, MNP was to (i) create a detailed competency matrix and accompanying tools and materials, and (ii) review and recommend enhancements or revisions to the current nominations and election processes. **Competency Matrix** MNP has developed core and technical competencies that reflect an "ideal profile" for a CPSA Council member (Attachment 1). These competencies were informed based feedback provided during interviews with CPSA Council members and members of the CPSA Executive Leadership Team. A conceptual tool has been created (Attachment 2) to demonstrate how the competencies of each Council member could be assessed. For consideration: • MNP suggests that core competencies could remain the same over time, but that technical competencies may evolve depending on environmental changes. Approval of these competencies would be a starting point, with ongoing analysis to follow.		

- MNP has signaled that under the current model (i.e., where public members are appointed and physician members are elected), it is possible that an identified deficiency in a Council competency would not be satisfied through physician election. MNP's report points to other strategies that CPSA can use to address deficiencies should they arise.
- MNP has advised that a Nominations Committee could contemplate the need for a "weighting" scheme but offered that in their experience scoring nominations in this way provides little value.

Physician Nominations & Elections
MNP heard Council's desire to keep the nominations process simple and not onerous but pointed out that professionalizing the nomination process could better distinguish the importance of, and elevate, the opportunity.

The nomination submission process would therefore seek the following:

1. Demonstrated adherence to eligibility criteria (as are currently required)
2. Submission of a resume/CV, cover letter and professional references
3. A pledge of understanding of time and commitment required of a Councillor
4. A brief description of relevant experience, such as:
    a. Years of experience in the medical field
    b. Medical specializations/areas of interest
    c. Other professional designations and pursuits
    d. Where in the province they have practiced or resided (urban, rural, remote.)
    e. Experience with underrepresented or marginalized groups
5. Completion of a short survey (e.g., 1=basic, 5 = expert) where technical competencies in finance, technology, data management, human resources and legal are self-selected.

The Nomination Committee would review each submission and follow up by conducting interviews and reference checks to gather more information around the individual's attitudes, feelings, motivations and competencies.

Recommendations for Enhancement
Recommendations for enhancements to the nomination and election processes are summarized in Attachment 3.

Next Steps:	1. MNP will conduct a competency assessment of the current Council. 2. CPSA staff and MNP will continue to work to support the Nominations Committee in developing nomination materials and recruitment tactics in support of the 2025 election. 3. CPSA staff have proposed bylaw amendments to enable competencies to be assessed by the Nominations Committee in the 2025 election process.

List of Attachments:

1. CPSA Council Competency Profile
2. Assessment of Council Member Competencies
3. Recommendations for Enhancement Report

College of Physicians and Surgeons of Alberta - Council Member Competencies

Competencies are the knowledge, skills and behaviors that are necessary to be successful in a role or position. There may be different levels in each competency and not all individuals will have all competencies. This is an ideal competency profile for a CPSA Council member. It was built based on feedback from current Council members and executive leadership as well as competencies of other Councils/ Boards. Competencies should be revisited every year and revised based on changing conditions.

How to use the competency profile:

- Provide potential candidates for CPSA Council, when combined with information about the organization, role of a Councillor, and education and experience requirements, with a clear description of what it will be like in this role and the ideal competencies necessary to be successful as a Council member
- Enable potential candidates to tailor their submissions to CPSA and understand what type of questions will be asked during any type of screening process
- Provide guidance for the CPSA, any third party recruitment firm and the Nomination Committee in the design of questions that will elicit responses demonstrating these competencies in previous roles and positions

Core Competencies *(everyone should have at some level)*

Competency	Behavioral Descriptions
Integrity	• Always keeps the greater good of the organization and the people it represents in mind • Makes principle-centered decisions based on the governance principles of the organization • Appropriately manages sensitive and confidential information
Accountability	• Assumes responsibility, accountability and follows through when making commitments to Council and committees
Humility	• Demonstrates empathy, sincerity, honesty and respect • Adheres to the values of the organization
Resiliency	• Maintains composure and perspective in difficult or volatile situations • Is not threatened by ambiguity and conflict
Effective Communication	• Actively listens to messages being communicated by others • Is transparent but constructive about opinions • Articulates complex ideas in a clear understandable way

Competency	Behavioral Descriptions
	• Effectively participates in meetings and discussions to assist participants in reaching shared decisions, and fostering positive relationships
Strategic and Inclusionary Leadership	• Has broad knowledge and perspectives • Understands the trends in the environment and the impact it may have on the organization • Adopts a long-term view of organizational strengths, weaknesses, opportunities, and risks in a changing operational environment • Demonstrates awareness and ongoing personal and professional learning on a variety of topics including diversity, equity, inclusion and anti-racism, Truth and Reconciliation • Clearly articulates a practical and common vision for the future and builds a credible case for change or improvement
Political Acumen	• Understands the mandate of CPSA and its 'arms-length' relationship from government • Understands and respects the role, responsibilities and authorities of the Council/Board, governments, leadership and staff • Demonstrates diplomacy and good judgement in sensitive situations • Understands structure and decision-making at senior and political levels
Excellent Judgment	• Efficiently and effectively perceives and assesses situations related to Council/ Board deliberations • Asks the right questions to get the information needed by the team • Draws sound conclusions and makes good decisions based on the information available
Understanding of the Canadian and Alberta Healthcare ecosystem	• Knowledge of various groups and their role in the system • Understanding of patient rights • Awareness of the social determinants of health • Awareness of success indicators for the health care system

Technical Competencies *(should be present with some on the Council)*

Competency	Behavioral Description (Basic)	Behavioral Description (Advanced)
Financial Acumen	• Understands the basic revenue/ expense model of the organization • Basic knowledge of accounting, budgeting, financial reporting and monitoring processes • Understands financial statements and balance sheets	• Understands the complete financial model of the organization and the elements that impact the model and performance • Expert knowledge of leading practice accounting, budgeting, financial reporting and monitoring processes

Competency	Behavioral Description (Basic)	Behavioral Description (Advanced)
		• Expert knowledge of a risk-based approach to financial management and the policies that should be in place
Technology and Data Management Acumen	• Working knowledge of the applications/programs used in conducting the work of the Council – email, portals, social media, data storage • Awareness of the advances in technology and how they could be used to advance the organization's capabilities • Awareness of the importance of investment balanced with the cost/benefit of implementation	• Advanced knowledge of the technological environment and it's data management framework • In-depth understanding of the advances in technology and how they could be used to advance the organization's capabilities • Advanced knowledge of the required technology investment and the cost/benefit of implementation
Human Resource Management	• Basic understanding of the importance of culture and its impact on the performance of the organization • Basic knowledge of the elements of human resource management- recruitment and selection, compensation, performance management, training and professional development, succession management	• In-depth understanding of the elements of culture and its impact on the performance of the organization • Advanced knowledge of the interdependent and inter-related elements of human resource management- recruitment and selection, compensation, performance management, training and professional development, succession management
Diversity, Equity, Inclusion and Anti-Racism	• Basic understanding of diversity, inequity, exclusion and racism effect experiences in healthcare • Awareness of how the lived experience of some Albertans impacts their interactions with the healthcare system	• Advanced knowledge of how diversity, inequity, exclusion and anti-racism concepts are translated into organizational programs and strategies
Legal Acumen	• Basic understanding of all relevant legislation and regulation	• In-depth knowledge of how legislation and regulation impact the organization • Advanced understanding of organizational legal obligations and liabilities • Ability to know when to apply a 'legal' lens when making decisions

Assessment of Council Member Competencies

This is an example of a tool that could be used to assess the current Council member competencies relative to the core and technical competencies established and approved. This assessment when complete will inform the identification of gaps that may be targeted in the search for future candidates for the CPSA Council. This tool assumes a simple 'check mark' will be used during the assessment. This tool could be built in Excel if it is determined that weighting and scoring is desired.

Competencies are the ideal knowledge, skills and behaviors necessary to be successful in the role of Council member. The core competencies should remain the same over time but the specialized competencies may evolve dependent on environmental changes. The competencies are written to reflect the ideal candidate, and as a Council member. CPSA in its recruitment and nominations process will be looking for examples of how the candidates have demonstrated these competencies in past roles and positions and as CPSA Council members. The assessment will be completed by a third-party for the first cycle only. In subsequent cycles, the Nomination Committee will be responsible for completion of this tool.

Core Competencies *(everyone should have at some level)*

		Physician Members							Public Members						
Competency	**Behavioral Descriptors**	**CM 1**	**CM 2**	**CM 3**	**CM 4**	**CM 5**	**CM 6**	**CM 7**	**CM 8**	**CM 9**	**CM 10**	**CM 11**	**CM 12**	**CM 13**	**CM 14**
Integrity	• Always keeps the greater good of the organization and the people it represents in mind • Makes principle-centered decisions based on the governance principles of the organization • Appropriately manages sensitive and confidential information														
Accountability	• Assumes responsibility, accountability and follows through when making commitments to Council and committees														

Competency	Behavioral Descriptors	Physician Members							Public Members						
		CM 1	CM 2	CM 3	CM 4	CM 5	CM 6	CM 7	CM 8	CM 9	CM 10	CM 11	CM 12	CM 13	CM 14
Humility	• Demonstrates empathy, sincerity, honesty and respect • Adheres to the values of the organization														
Resiliency	• Maintains composure and perspective in difficult or volatile situations • Is not threatened by ambiguity and conflict														
Effective Communication	• Actively listens to messages being communicated by others • Is transparent but constructive about opinions • Articulates complex ideas in a clear understandable way • Effectively participates in meetings and discussions to assist participants in reaching shared decisions, and fostering positive relationships														
Strategic and Inclusionary Leadership	• Has broad knowledge and perspectives • Understands the trends in the environment and the impact it may have on the organization • Adopts a long-term view of organizational strengths, weaknesses, opportunities, and risks in a changing operational environment														

Competency	Behavioral Descriptors	Physician Members							Public Members						
		CM 1	CM 2	CM 3	CM 4	CM 5	CM 6	CM 7	CM 8	CM 9	CM 10	CM 11	CM 12	CM 13	CM 14
	• Demonstrates awareness and ongoing personal and professional learning on a variety of topics including diversity, equity, inclusion and anti-racism, Truth and Reconciliation • Clearly articulates a practical and common vision for the future and builds a credible case for change or improvement														
Political Acumen	• Understands the mandate of CPSA and its 'arms-length' relationship to government • Understands and respects the role, responsibilities and authorities of the Council/Board, governments, leadership and staff • Demonstrates diplomacy and good judgement in sensitive situations • Understands structure and decision-making at senior and political levels														
Excellent Judgment	• Efficiently and effectively perceives and assesses situations related to Council/ Board deliberations														

		Physician Members							Public Members						
Competency	Behavioral Descriptors	CM 1	CM 2	CM 3	CM 4	CM 5	CM 6	CM 7	CM 8	CM 9	CM 10	CM 11	CM 12	CM 13	CM 14
	• Asks the right questions to get the information needed by the team • Draws sound conclusions and makes good decisions based on the information available														
Understanding of the Canadian and Alberta Healthcare ecosystem	• Knowledge of various groups and their role in the system • Understanding of patient rights • Awareness of the social determinants of health • Awareness of success indicators for the health care system														

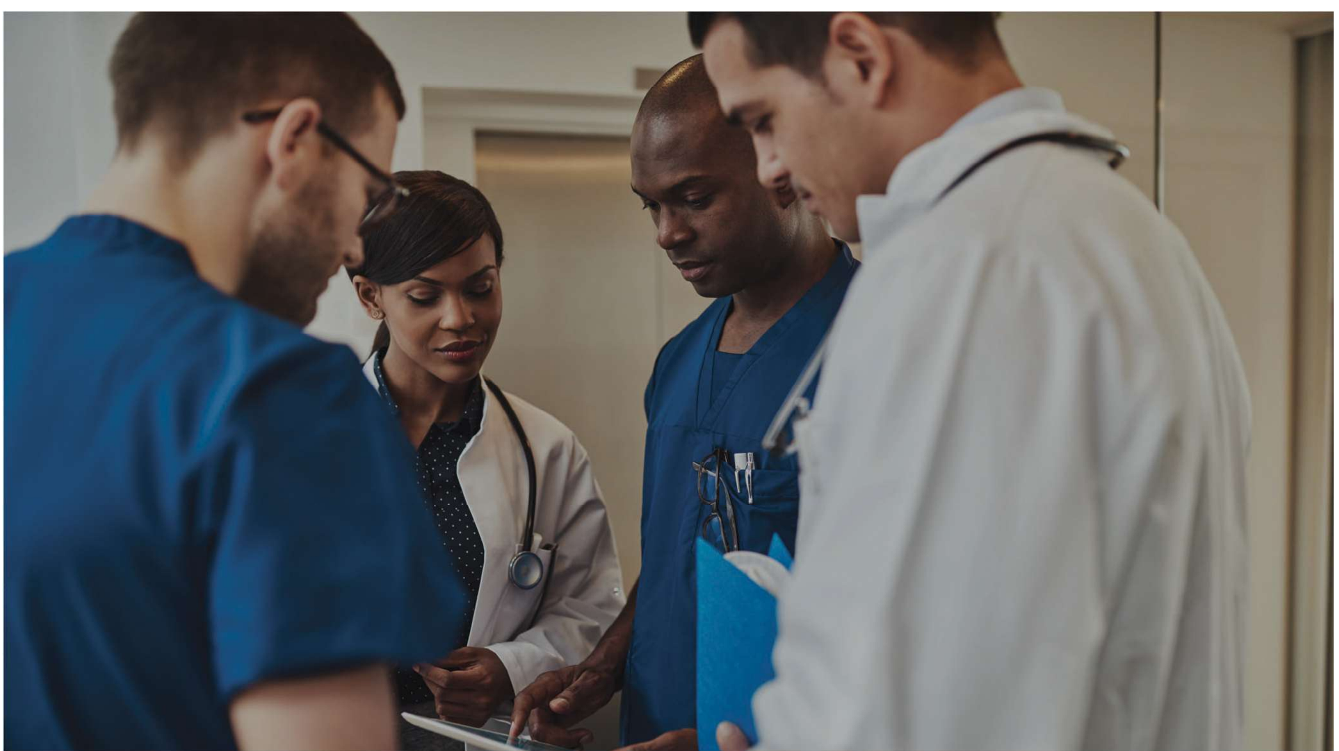
Technical Competencies *(should be present with some on the Council)*

			Physician Members							Public Members						
Competency	Behavioral Descriptors *Basic*	Behavioral Descriptors *Advanced*	CM 1	CM 2	CM 3	CM 4	CM 5	CM 6	CM 7	CM 8	CM 9	CM 10	CM 11	CM 12	CM 13	CM 14
Financial Acumen	• Understands the basic revenue/ expense model of the organization • Basic knowledge of accounting, budgeting, financial reporting and monitoring processes	• Understands the complete financial model of the organization and the elements that impact the model and performance • Expert knowledge of leading practice accounting, budgeting, financial														

Competency	Behavioral Descriptors *Basic*	Behavioral Descriptors *Advanced*	Physician Members CM 1	CM 2	CM 3	CM 4	CM 5	CM 6	CM 7	Public Members CM 8	CM 9	CM 10	CM 11	CM 12	CM 13	CM 14
	• Understands financial statements and balance sheets	reporting and monitoring processes • Expert knowledge of a risk-based approach to financial management and the policies that should be in place														
Technology and data management acumen	• Working knowledge of the applications/programs used in conducting the work of the Council – email, portals, social media, data storage • Awareness of the advances in technology and how they could be used to advance the organization's capabilities • Awareness of the importance of investment balanced with the cost/benefit of implementation	• Advanced knowledge of the technological environment and it's data management framework • In-depth understanding of the advances in technology and how they could be used to advance the organization's capabilities • Advanced knowledge of the required technology investment and the cost/benefit of implementation														

			Physician Members							Public Members						
Competency	Behavioral Descriptors *Basic*	Behavioral Descriptors *Advanced*	CM 1	CM 2	CM 3	CM 4	CM 5	CM 6	CM 7	CM 8	CM 9	CM 10	CM 11	CM 12	CM 13	CM 14
Human Resource Management	• Basic understanding of the importance of culture and its impact on the performance of the organization • Basic knowledge of the elements of human resource management- recruitment and selection, compensation, performance management, training and professional development, succession management	• In-depth understanding of the elements of culture and its impact on the performance of the organization • Advanced knowledge of the interdependent and inter-related elements of human resource management- recruitment and selection, compensation, performance management, training and professional development, succession management														
Diversity, Equity, Inclusion and Anti-Racism	• Basic understanding of how diversity, inequity, exclusion and racism effect experiences in health care • Awareness of how the lived experience of	• Advanced knowledge of how diversity, equity, inclusion and anti-racism concepts are translated into organizational														

			Physician Members							Public Members						
Competency	Behavioral Descriptors *Basic*	Behavioral Descriptors *Advanced*	CM 1	CM 2	CM 3	CM 4	CM 5	CM 6	CM 7	CM 8	CM 9	CM 10	CM 11	CM 12	CM 13	CM 14
	some Albertans impacts their interactions with the healthcare system	programs and strategies														
Legal acumen	• Basic understanding of all relevant legislation and regulation	• In-depth knowledge of how legislation and regulation impact the organization • Advanced understanding of organizational legal obligations and liabilities • Ability to know when to apply a 'legal' lens when making decisions														



Recommendations for Enhancement

Prepared for the College of Physicians & Surgeons of Alberta

January 2025

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Introduction

As one deliverable of the project described below, MNP is to create a detailed competency matrix and accompanying tools and materials for the College of Physicians & Surgeons of Alberta ("CPSA") Council. Additionally, MNP is to develop and implement a recruitment plan for Council members for the next election cycle.

MNP was asked to review and recommend enhancements or revisions to the current Nominations and Election processes. The following report provides the findings of our assessment and recommendations for enhancements. It also contains a draft combined competency framework for CPSA Council and a selection criteria matrix tool to be used in the Nominations and Election process.

Project Goals, Scope, and Objectives

The overarching goal of this work is a high-performing, diverse CPSA Council that is focused on protecting Albertans through oversight of the medical profession. The specific objectives of this project are to:

- Create easy-to-use tools and supporting materials, including a list of CPSA desired Council competencies, an assessment tool to evaluate the competencies of current Council members and Council member effectiveness, and a competency matrix to assess nominees / candidates for Council;
- Assess, using the approved tool, the current Council competencies and identify gaps;
- Develop a comprehensive recruitment plan, including an awareness strategy and materials, aimed at regulated members and the public, as well as nomination materials and an interview guide for shortlisted candidates;
- Implement the recruitment plan, including acceptance and management of candidate submissions and the screening and assessment of candidates; and
- Prepare a candidate recommendation package and report for the CPSA Nomination Committee.

Please note: A competency-based model has numerous benefits to organizations governed by Councils/ Boards including that the model:

- Ensures the Council/Board composition is reflective of the people it represents
- Ensures the competencies, identified and defined, support the organization's vision, mission, strategic directions, values and culture
- Ensures the Council/ Board has the required competencies to understand the complexities of the organization and the issues it must address, and to make informed decisions
- Provides members and potential candidates with clear information about what is required to be successful in the role of Council/Board member
- Ensures the Council/ Board can easily identify its strengths and weaknesses and address gaps through targeted recruitment processes
- Supports an objective, transparent and fair evaluation of Council/ Board candidates

The Current State

Background

In 2022, the CPSA commissioned a comprehensive governance review. The review addressed the nomination and election process, among other items, and concluded;

- "CPSA does not have the mandate to serve the majority of Albertans, but all Albertans. As such, the case for diversity is not merely a response to societal pressure and practice. CPSA serves an inherently diverse population"
- "To give strategic direction to CPSA and fulfil the mandate defined by the *Health Professions Act,* Council-level decisions need to reflect this diversity. A diverse Council will be equipped to deliver on this challenging mandate. Using the status quo elections process to populate Council means that diversity on Council may be a target, however there is no way that Council has the diverse perspectives needed to keep the interest of all Albertans at the forefront of deliberation and decision"
- "A merit and competency- based process that is transparent and fosters the independent oversight needed to fulfill CPSA's mandate. It is outcomes- focused with the goal of creating a coordinated and collaborative effort to identify individuals to serve on Council who collectively, possess the skills, knowledge and experience required to make governance-level decisions on behalf of Albertans."
- "A skills/competencies matrix that reflects the optimal Council would be developed by Council with an objective third party helping to operationalize this. It was noted that the nominations process and matrix must inspire the confidence and trust of key stakeholders."

Subsequently, in 2023, the same consultant was retained to provide recommendations for the Governance Committee's consideration for a model that could be used. Two options for selecting and appointing regulated Council members to CPSA Council:

- Establish a Nominating Committee that reviews and recommends regulated Council members to CPSA Council, with the assistance of a third-party assessor.
- Establish a Nominations Committee that conducts the competency-based review of applicants/ nominees for enhanced vetting of individuals, again with assistance of a third- party assessor, and then move to an election by the regulated members of CPSA

The competency-based nominations model would have the following features:

- An outcomes- focus that strengthens how CPSA is governed in tangible and impactful ways
- A commitment to clarity and transparency as to how the process works for both regulated members and public members of Council and what each nominee to Council should possess in terms of needed skills, knowledge, experience and other attributes
- Focused accountability on the achievement of CPSA's legislated mandate and other organizational and strategic foundations

In May 2023, CPSA Council chose the second model and also agreed to consult with regulated members. The

consultation was conducted on-line and was focused on making members aware of the Council decision and invite feedback. The process resulted in nine (9) on-line responses, a letter from 17 former CPSA council members and a letter from 23 past presidents of AMA. The feedback was predominantly negative to a change in the process, with concerns expressed that there is not enough detail about the Nomination Committee membership, in particular, the 'arbiter'. There was a general feeling that elections are a better method of determining Council membership. There appears to be a concern that the current Council would be developing/ approving the competencies that they want to see and future Councils may have differing views. Concerns were raised that this change would reduce credibility with regulated members and there would be further disengagement.

One of the letters stated that elections have worked for 100 years, the implication being that there is no need to change. Further commentary suggested that if the perceived problem is that physician Council members serve their self-interests rather than the interests of Albertans, they have never seen evidence of that. As in almost all major change implementations, the question of "why change is needed" must be clearly answered.

Upon receipt of this feedback, the CPSA Registrar/ CEO contacted each signatory to the letters to ask them for clarification and elaboration. The general themes of the feedback were confirmed.

The Governance Committee requested additional details about what the new model could look like. Examples of other organizations with selection models incorporating a review of competencies were provided- Canadian Medical Association, College of Registered Nurses of Alberta, Canadian Medical Protective Association, the Association of Professional Engineers and Geoscientists of Alberta and the Medical Council of Canada.

In December 2023, the Governance Committee recommended that Council move forward with the Nomination and Election Model for physician Council Member selection with process recommendations to be provided by the organization. In September 2024, MNP was retained to assess the current nominations and selection processes and develop a detailed competency matrix and accompanying tools and materials for the CPSA. In addition, MNP will develop and implement a recruitment plan for Council members for the next election cycle.

To support this engagement, MNP facilitated a consultation process. Between October 28 and November 18, 2024, MNP interviewed 10 Council members and 9 members of the CPSA leadership team. Foundation questions about the role and mandate of CPSA and the Council, questions regarding the necessary competencies for success as a Council member and questions about the evaluation processes for Council candidates was the focus of these interviews. A more detailed summary of what we heard was provided in November 2024 and is attached in Appendix A.

The feedback provided was considered in the assessment and development of recommendations for enhancement and in the development of the ideal competencies of Council members. The following is a summary of the feedback we received:

Primary Role/ Mandate of the CPSA

- Both Council members and the Executive leadership team believe the primary role and mandate of the CPSA is to protect the public and ensure patient safety by regulating physicians and physician assistants. Most also believe CPSA conducts research to inform their primary mandate.

Organizational Environment

- Council members believe the organization exists in an environment of political and organizational change, a lack of public understanding of the role of CPSA, growing public distrust in the healthcare system and specific challenges with rural healthcare. The executive leadership also mentioned the impacts of the pandemic, the need for authentic Indigenous connections, perceived increased government influence and a push for systematic changes.

Desirable Council Member Competencies

- Council members stated that diversity and representation, communication and collaboration, integrity and ethical orientation, healthcare knowledge and learning adaptability, governance and strategic thinking and compassion and public focus were important competencies for Council members. But MNP found that the definition of these competencies and how they are demonstrated differed.
- The Executive leadership emphasized the experience needed such as diverse leadership experience, social justice and community engagement experience, technology, understanding of social determinants of health and experience in finance and risk management. They also needed to have many qualities such as transparency, integrity to avoid personal agendas, understanding of diversity, politically savvy and sensitive, good standing in the community, open-mindedness and willingness to listen.
- Council members described diversity as diverse experiences, backgrounds and gender reflecting a wider representation of Albertans. Rural representation is also valued.
- Some Council members said that there is value in 'lived experience' and underrepresented perspectives. They were including the following groups- Indigenous, immigrant and LGBTQ+. However, there was also a notable preference for older, more experienced physicians with semi-retired individuals being ideal due to their availability. Integrity and ethical orientation was considered a very important competency, defined as trustworthiness, kindness, respect and a commitment to public service.
- Commentary was provided that familiarity with the healthcare system is beneficial but not a strict requirement. Adaptability and willingness to learn are necessary and expectations must be established that members must develop that knowledge over time and be able to engage about healthcare issues.
- Council members commented that governance experience gained through working on Boards and other large organizations.
- Strategic thinking was also mentioned and further defined as the ability to anticipate future challenges such as AI and regulatory developments.
- MNP received feedback that the competencies needed to be weighted as some are more important than others. Weighting will require the development and use of a scoring process.

The Nominations and Election Process

- Most Council members and the Executive team members preferred a structured process for evaluating potential candidates with candidates presenting resumes outlining specific achievements, areas or improvement and relevant experience. It was also stated that submissions should include cover letters, statements of interest, commitment statements and information highlighting how the candidate experience aligned with Council goals.

- There were many suggestions for evaluation processes and how candidates can demonstrate these competencies- volunteer work, involvement in different boards and committees, resumes, interviews, presentations, campaigns and references. There was some suggestion that a shortlist of candidates could demonstrate competency by joining current Council meetings and assessing how they interact with others.
- However, concern was expressed from the majority of stakeholders that if the process is too complex and onerous, participation will be discouraged. There was support for simpler applications, complemented by interviews and references to validate candidate's competencies and commitment.
- Concerns were also raised about potential biases in the nominations process, including discrimination based on race, religion or geographic residency.
- Many Council members believe that interviews are an important evaluation tool as it allows for a personal assessment of candidate's communication style, interpersonal skills and compatibility with Council's culture. They acknowledged interviews are time consuming but valuable for understanding intentions and commitment.
- There was some concern that elections are " a popularity contest" and are a barrier to highly qualified physicians who don't want to go through an election process.
- Most Council members and the Executive team emphasized the need for a fair, inclusive and objective process to evaluate potential candidates. Some mentioned the need for a competency matrix and a Nomination Committee. Some suggested moving to a nominations and appointment process only. There was some support for alternative nomination pathways to ensure self-governance and member input.
- Council members acknowledged low election turn-out among physician members and the challenge of re-electing rural or less well-known individuals. They want to ensure anything that is changed must improve engagement and enhance representation.

Current Make-Up of CPSA Council

The by-law addressing the composition of Council states the voting members of Council shall consist of:

a) Seven (7) regulated members elected by regulated members of the College
b) Seven (7) public members appointed by the Lieutenant Governor in Council

At the discretion of Council, the non-voting members of Council shall consist of:

a) The Deans of the Faculties of Medicine from the University of Alberta and the University of Calgary
b) An observer from the Professional Association of Resident Physicians of Alberta
c) An observer from either the University of Alberta's Medical Students' Association or the University of Calgary's Medical Students' Association

At this time, there are:

- Physician members- elected by their medical colleagues- Seven (7)
- Public members- appointed by Alberta's Lieutenant-Governor in Council- Seven (7)

- Medical school deans from the University of Alberta and the University of Calgary-Four (4) (non-voting observers- 2)
- Medical students and residents (non-voting observers -2)

Council has several standing committees for serving Council members:

- Council Executive
- Governance
- Finance and Audit

Role of a Councillor

The role of a Councillor is described on CPSA's website:

"Simply put, Councillors are responsible for governing CPSA and fulfilling its legislative mandate, making policy decisions that help CPSA meet its obligations to Albertans. Councillors also develop and monitor CPSA's Strategic Plan and ensure the plan is being implemented by the Registrar (CEO), who is responsible for running the entire organization. Councillors are not involved in running CPSA programs or day-to-day operations."

Eligibility Requirements for Council

Eligible regulated members may stand for nomination or nominate a colleague in CPSA elections. The eligibility requirements are:

- Not owing fees, fines, assessments, levies or any other sums to CPSA
- Holding a valid and current practice that is not currently suspended
- Complying with all orders or directions under *the Health Professions Act*

There are also numerous conditions where you aren't eligible to be a Councillor including several related to unprofessional conduct as well as holding previous or existing roles that have responsibility and authority over the management and operations within the Alberta healthcare system.

CPSA also defines its expectations of Councillors on its website including that Councillors should have knowledge about the healthcare system and understand CPSA's vision and mission. They go on to state that Councillors should be strategic, thoughtful, objective and focused on protecting Albertans and be responsible stewards of public safety aspects of the medical profession. Further expectations are that candidates will carefully read and thoroughly consider Council reading material and maintain confidentiality on Council matters. These expectations should be reflected in the education, experience and competency requirements.

CPSA describe the time commitment required and subtly say that they want Councillors to commit to attend and fully participate in all Council and committee meetings. Feedback was provided that "this was the most important competency".

Members of the public who are interested in serving on councils like CPSA, apply through the Alberta government's posting for public members on Health Professions College Councils. It does not appear that there is any formal coordination between CPSA and the Government of Alberta about the competency needs of Council and any gaps that may exist.

The Nominations and Election Process

The current process is as follows:

CPSA issues a call for nomination to regulated members

Late August (this year August 28 with deadline of September 25,2024). Communication through:

- **CPSA's on-line newsletter**
- **CPSA website**
- **Social media (LinkedIn, Twitter, Facebook)**
- **Word of mouth**

Candidates complete the Nomination form on-line

- First and last names
- CPSA registration number
- Primary practice location-city or town
- Close ended questions- if they have ever served on CPSA council or are currently sitting on Council
- Medical training and experience
- Motivation for running
- Unique experience (governance, communication, financial management)
- Additional information
- Names and contact information for three regulated members in good standing with CPSA who will endorse the candidate
- A high-resolution headshot

CPSA sends Council Nomination Endorsement Form to named endorsers

A website contact form is created, with the candidate's consent, for individuals to ask questions about their nomination and interest.

- Candidate's first and last name
- Candidate's email
- Candidate's ID number
- Endorser first and last name
- Endorser email
- Endorser address
- Endorser CPSA registration number

Two close-ended questions – "are you in good standing with CPSA" and "do you endorse this candidate to be nominated for election to CPSA Council"

Office of the Registrar reviews and screens candidate submissions

Team within the Office of the Registrar reviews and screens candidate submissions based on CPSA Council Election and Eligibility Requirements:

- Not owing fees, fines, assessments, levies or any other sums to CPSA
- Holding a valid and current practice that is not currently suspended
- Complying with all orders or directions under *the Health Professions Act*

Election is organized

Election is organized and held virtually if more eligible candidates than vacant seats on Council October – this year October 2 to 30, 2024

Election results and new councilors named in Messenger

New Councilors start their term January 1st

Findings and Conclusions

General

Despite direction from CPSA Council to move to a more structured nomination/ election model and process and several consultation attempts, there are still differing opinions and views.

The commentary provided during MNP's recent consultations appears to be moving toward increased desire or maybe acceptance of a competency-based model and a nomination process.

However, some engaged CPSA regulated members still have basic questions about the suggested changes including 'why this change is needed' and 'what is the business case for change?'. There appears to be a belief among some, that the current model is "working well" and "has for a hundred years" and that these changes will further disengage regulated members.

Some feel there still needs to be nominations of individuals from the membership who don't go through the nominations process. This negates the objective of making these changes and circumvents the role of the Nominations Committee. Change management needs to be a big part of implementation including clear statements of what is negotiable and what is not.

CPSA has a mixed Council selection model including election of regulated physician members, appointment of public interest members and role-based invitations.

Although the members of higher education are non-voting Council members, when combined with appointed public interest members, approximately 61% percent of Council are not or may not be selected based on needed and desired competencies. The representatives of higher education institutions/ associations are selected based on the roles they hold. While we can assume these individuals and those appointed by the government have many of the desired competencies they will not be selected through a competency-based selection model.

Electing physician members to Council may limit the ability of the CPSA to create a Board with the balance of all required knowledge, experience and competencies.

Under the current model, it is possible that an identified gap in Council competency would not be satisfied through physician election. In the event that Council felt it remained deficient in certain technical competencies after an election, other tactics should be used to enhance competencies including organizing focussed Council learning, seeking increased support from CPSA staff, using outside consultants or seeking presentations from experts to name a few.

All Council selection models identified and analyzed in previous reports have some form of a nominations and election model including identification of needed experience and competencies.

Organization	Model and Other Process	Considerations
Canadian Medical Association	• Nominations Committee • No election • Candidates submit expressions of interest • Working groups review submissions based diversity, demography, skills, competencies • Candidates are interviewed and short-listed • Short-listed candidates undergo background checks • Working groups recommend candidates to the Nomination Committee • Nomination Committee reviews all candidates and presents them to the General Council for ratification at the AGM	Nomination Committee: • One member from each province/territory • One member from affiliate societies • One resident member • One student member • Chair of the Appointments Committee • Immediate past president
Canadian Medical Protective Association	• Nominating Committee and election • Seven committee members, two are external • Two methods of seeking nomination • Both require completion of Council Candidate Submission Form • Practicing members, including current councillors seeking re-election, submit their names to Nomination Committee • Nomination Committee releases their names-Report of the Nominating Committee • Second option-practicing members can be nominated through the membership • Second option also requires completion of a Member Nomination Form accompanied by 10 signatures of current members who reside in the same geographic area	
Medical Council of Canada	• Governance and Nominating Committee- 6 members • Committee identifies and recommends a slate of candidates to Council • Council votes • No nominations can come from the Council table	• Slate must reflect the composition identified in the by-laws-regulatory experience in healthcare professions, current registrars of medical regulatory authorities, experienced medical educators, public members who meet the skills experience and diversity attributes

Organization	Model and Other Process	Considerations
College of Registered Nurses of Alberta	• Nominating Committee- 6 members • No election process • The Nominating Committee reviews all applications against the approved Council Competencies and Attributes profile • Vetting process may include resume review, interviews and/or reference checking	• The Competencies and Attributes profile is revised annually • The profile is provided to the Government of Alberta and its use encouraged

The Nominations and Election Process

The current Council member recruitment and selection process is passive, relying on individuals to become aware of the opportunity and submit an application.

Although the CPSA employs several methods of communication of the nomination call, it relies on individuals actively engaging through these methods. Most organizations find recruitments more successful if candidates, with potential experience and competencies, are identified and contacted directly to make them aware of the opportunity and entice them to apply.

The current Council Nomination Form limits narratives, encourages inconsistency and has minimal connection to specific experiences and competencies.

There have been several comments that the Nominations process must be simple and not onerous or individuals will not participate in it. CPSA desires a Council with the knowledge, experience and competencies needed in today's environment. To do this, you must have a customized process of assessing whether candidates have the required experiences and competencies.

In addition, one method of assessing an individual's commitment of the time and energy necessary to be effective on Council is how much time and energy they are willing to spend 'getting on Council'.

The objective of this project is to develop a model and process that results in Council members with the experience and competencies to be effective Council members (individual). Some feedback we received was more about overall Council effectiveness which should be assessed through another process.

For example, while the time and effort commitment should be explained during the recruitment process, an individual's attendance and commitment should be tracked as part of an annual Board evaluation process. They could make a commitment statement in a cover letter as part of their submission. This commitment should then align with an annual Board evaluation process.

The current Nomination Endorsement form and process is not designed to get more information about the candidate and/or confirm information collected in other processes.

This is in-fact a method of reference-checking. In today's world, letters of endorsement have limited use. Most organizations don't ask for them and prefer to have targeted discussions with referees. This enables you to ask probing questions, confirm what has been discovered through other methods and connect questions to the type of experience and competencies you say you need.

Weighting of competencies necessitates the development and use of a scoring process in all evaluation processes.

In MNP's experience, a lot of time and effort is spent developing scoring methods that few selection bodies ever use. It requires that every question is scored, then translated into the identified competencies and consolidated into one score based on individual committee member scoring. While providing a numerical score, many find recruitment at this level requires more nuance and scoring provides little value.

Foundational eligibility, education and specific experience requirements have to be determined and assessed in addition to identified competencies.

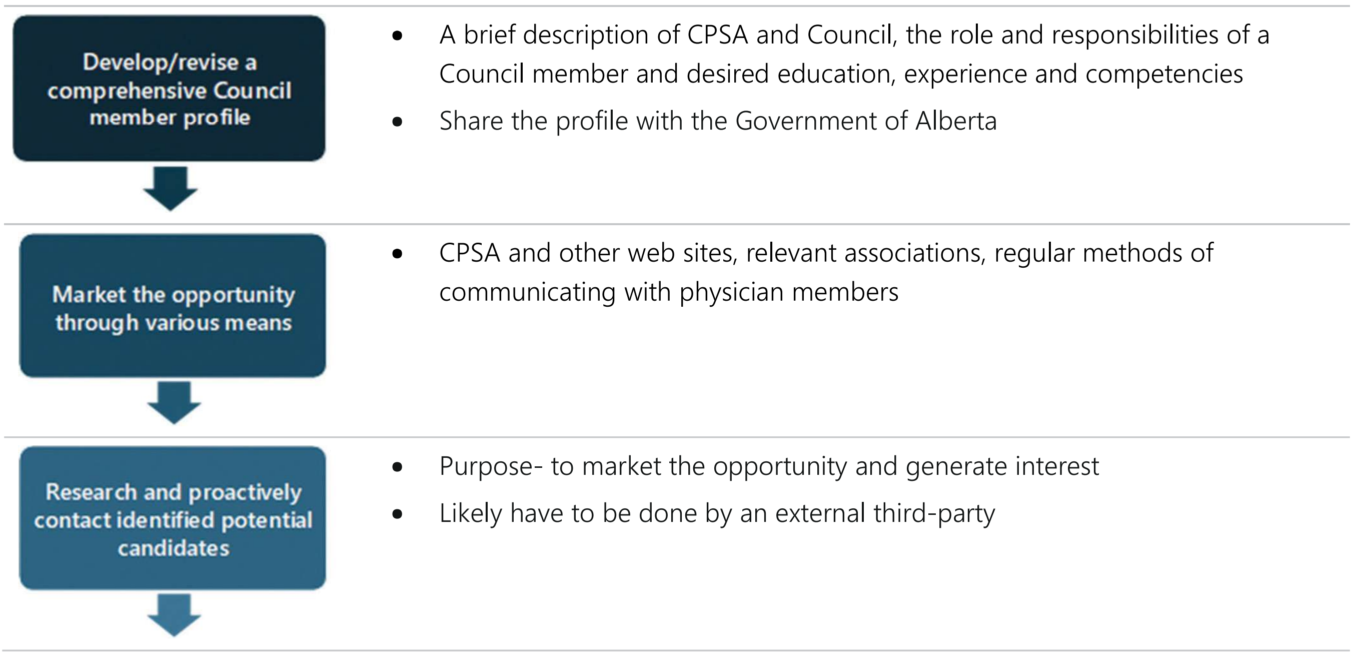
There are basic eligibility requirements, as well as specific educational and experience (type and number of years) that must be assessed using a variety of methods. These requirements should be specified and evaluated as part of a comprehensive selection process. These will include iterative processes of preliminary screening-document and brief interview; more in-depth interviews; presentations and reference-checking. MNP is suggesting one comprehensive assessment tool that will be used by CPSA, third-party recruiters and the Nomination Committee.

Recommendations

Further coordinate with the Government of Alberta, the necessary and desired experience and competencies of Council members.

The Government of Alberta has a distinct process for recruiting and appointing individuals to health organizations and many are 'political' appointments. However, it would be optimum if the appointments could be used to address gaps in lived experience and competencies.

Modernize the Council recruitment and selection process as follows:

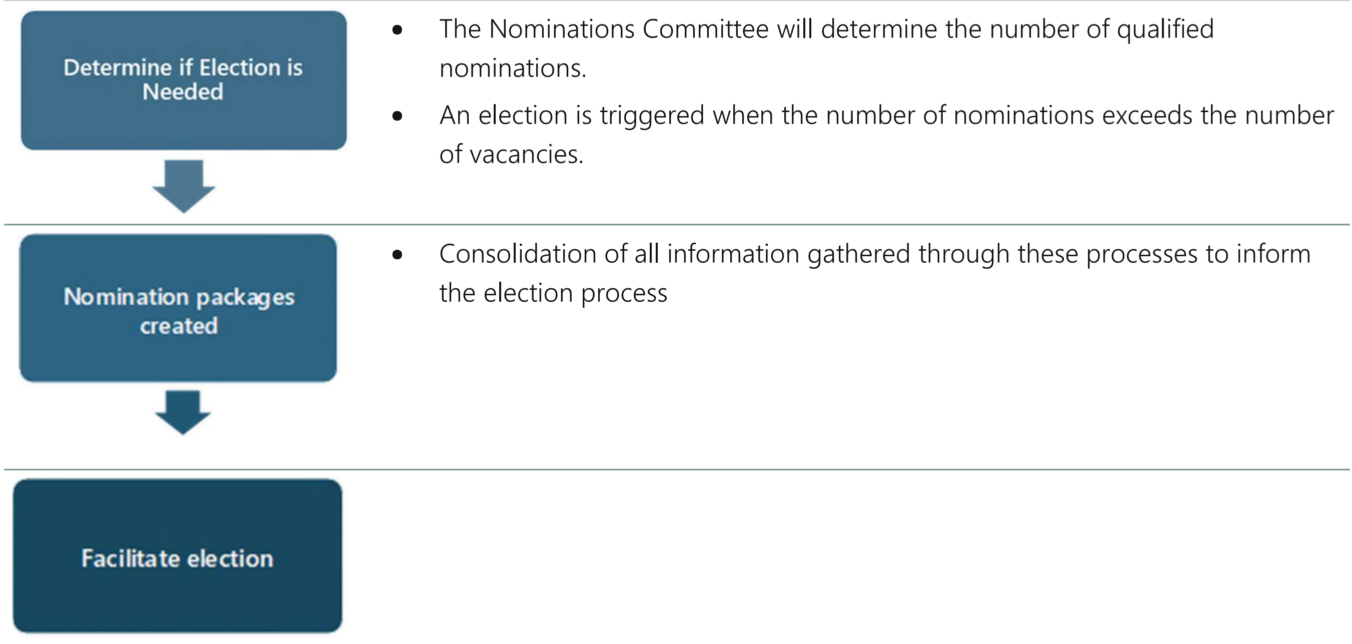


- A brief description of CPSA and Council, the role and responsibilities of a Council member and desired education, experience and competencies
- Share the profile with the Government of Alberta

- CPSA and other web sites, relevant associations, regular methods of communicating with physician members

- Purpose- to market the opportunity and generate interest
- Likely have to be done by an external third-party

Step	Activities
Monitor volume and quality of submissions	
Review submissions and conduct preliminary screenings	• Using new assessment tool, review the submissions for basic eligibility and evidence of desired experience and competencies
Preliminary review with the Nominating Committee	• Review status of recruitment efforts with Committee • Discuss candidates not recommended to move forward
Comprehensive interview conducted by independent third-party	• Using behavioral descriptive interview questions, request more detail about experience and competencies
Results reviewed by the Nomination Committee	• Provide short-list profiles to Nomination Committee • Discuss the candidates and determine who will move forward to an interview with the Nominating Committee
Candidates interviewed by the Nomination Committee	• Schedule and organize materials for the interview process
Conduct Reference Checking	• Conduct reference check interviews with three individuals and provide results to Nominating Committee



- The Nominations Committee will determine the number of qualified nominations.
- An election is triggered when the number of nominations exceeds the number of vacancies.
- Consolidation of all information gathered through these processes to inform the election process

Conclusion

The competency profile and tools are developed based on acceptance of all recommendations. They are interrelated. Modification will be required if there are changes to recommended processes.

Appendix A: Summary of Consultations

Introduction

MNP has been engaged to create a detailed competency matrix and accompanying tools and materials for the College of Physicians & Surgeons of Alberta ("CPSA") Council. Additionally, MNP will develop and implement a recruitment plan for Council members for the next election cycle. The objective is to establish an assessment tool for evaluating the competencies of Council members and a competency matrix for assessing nominees during the nomination process.

As part of this initiative, MNP conducted stakeholder interviews with CPSA Council members and members of the CPSA Executive Leadership Team to gather insights and feedback. This was conducted to ensure that the developed tools, processes, and methodologies align with the needs and expectations of those affected by this work. This document provides a comprehensive summary of the consultations held with key stakeholders of CPSA.

In cooperation with CPSA, all collected feedback, opinions, and insights will be used by MNP to refine and improve the competency matrix and nomination process, ensuring that the information gathered meets the requirements of the CPSA Council and its members.

Disclaimer

Some quotes from participants have been incorporated into the summary to enhance context and support key insights. However, the information collected has been anonymized to protect the privacy and identity of participants, thus no identifying information has been included in the summary. This approach ensures the integrity and confidentiality of the insights provided, allowing for candid and honest feedback from all contributors.

Project Goals, Scope, and Objectives

The overarching goal of this work is a high-performing, diverse CPSA Council that is focused on protecting Albertans through oversight of the medical profession. The specific objectives of this project are to:

- Create easy-to-use tools and supporting materials, including a list of CPSA desired Council competencies, an assessment tool to evaluate the competencies of current Council members and Council member effectiveness, and a competency matrix to assess nominees / candidates for Council;
- Assess, using the approved tool, the current Council competencies and identify gaps;
- Develop a comprehensive recruitment plan, including an awareness strategy and materials, aimed at regulated members and the public, as well as nomination materials and an interview guide for shortlisted candidates;
- Implement the recruitment plan, including acceptance and management of candidate submissions and the screening and assessment of candidates; and
- Prepare a candidate recommendation package and report for the CPSA Nomination Committee.

Summary of Consultations

Between October 28 and November 18, 2024, twenty-two (22) consultations were requested with members of the CPSA Council and Executive Leadership Team. Of the twenty-two (22) consultation requests, nineteen (19) consultations were accepted, which included ten (10) consultations with members of the CPSA Council and nine (9) consultations with members of the CPSA Executive Leadership Team (**Error! Reference source not found.**).

Table 1: Comparison of CPSA Stakeholder Interview Requests versus Scheduled and Completed Interviews

CPSA Stakeholder	Interviews Requested	Interviews Scheduled and Completed
Council	13	10
Executive Leadership Team	9	9

The information collected during the consultations was documented in the form of interview notes, which were then analyzed to identify recurring themes and insights. The interview questions were categorized into three main categories: Foundation, Competencies, and Evaluation, each with their own focus areas.

- **Foundation** questions focused on understanding the mission and vision and overall goals and objectives of the CPSA. These questions aimed to identify the fundamental principles that guide the organization.
- **Competency** questions focused on assessing the abilities, skills, and knowledge that are expected and required from Council members. This category aimed to identify the key attributes necessary for effective performance.
- **Evaluation** questions focused on gauging how potential Council members should demonstrate that they have the competencies required to be an effective leader of the CPSA. This category aimed to identify how Council members' effectiveness can be measured.

The themes from the consultations with CPSA Council members are outlined in Table 1, whereas the themes from the consultations with CPSA's Executive Leadership Team are outlined in Table 2. These tables are categorized into distinct focus areas within each stakeholder consultation group to emphasize the key themes identified.

Summary of Consultations

Table 1: Key Themes Identified, CPSA Council

Category	Focus Area	Council
Foundation	**Role & Mandate of the CPSA**	• **Legislated Purpose**: The CPSA's primary mandate is to protect the general public through the credentialization and regulation of physicians and physician assistants, focusing on public safety and competency in healthcare providers. *"[…] to protect the public through regulating physicians and licensing them"* • **Political Environment**: The CPSA must navigate the political landscape while ensuring the organization functions effectively. Despite changes in political ideology or leadership, the focus remains on public safety, which serves as a guiding principle to ensure medical providers' behaviours

Category	Focus Area	Council
		align with the general public's expectations. *"We have to take into consideration [the] political [landscape] because we are created by a legislation and exist because of it"* • **Diversity in Council**: The selection of council members should ensure diversity and inclusivity to avoid perpetuating existing power dynamics. This highlights the challenge of balancing representation with the necessary skills and expertise.
	Role of CPSA Council Members	• **Strategic Oversight**: The council is responsible for setting the strategic direction, ensuring financial oversight, and making key policy decisions for the CPSA. • **Corporate Governance**: Council members apply corporate governance standards, aiming to ensure compliance, transparency, and accountability within the CPSA. *"Council [provides] oversight"* • **Selection of Registrar**: One of the Council's responsibilities is to select the Registrar. • **Accountability and Diversity**: The Council holds the CPSA accountable to its mandate, ensuring a diverse Council with both physician and non-physician members. *"Ensure Council is accountable to the public or government [...] to ensure that the Registrar is overseeing the functioning of the CPSA and making sure that they're doing the work that needs to be done to ensure that physicians are providing safe care"*
	Success Indicators	• **Public Perception**: The CPSA's success can be perceivably measured by public satisfaction, complaint management, and how well it meets healthcare needs. While complaints don't always accurately reflect performance, managing them efficiently and being publicly visible are key indicators. *"[...] we would hope to know that we're doing a good job because there's not a lot of complaints"* *"I'm not sure [complaints] is actually the best way to measure it, but certainly complaints are a method by which the public can question their care [...]"* • **Legislative Collaboration**: The CPSA works closely with the government to improve healthcare delivery, ensuring physicians are licensed, regulated, and equipped to meet the needs of the public. • **Credentialing Efficiency and Education**: Success is also noted by how efficiently the CPSA can credential physicians, ensuring there are consistently enough qualified physicians to meet public needs. • **Research Involvement**: The CPSA's role in researching physician behaviour provides insights into the reasons behind physicians' actions.

Category	Focus Area	Council
		This research offers a qualitative perspective to support the assessment of physician effectiveness and success in Alberta.
	Changes in the Operating Environment and Major Trends	• **Political and Organizational Changes**: Council should be adaptable to changes in leadership, political environment, and societal expectations, particularly related to current political issues, however Council could benefit from maintaining focus on its mandate. *"[the biggest external factor that could affect how CPSA Council operates] is how political the Registrar's role is because [the] government feels they have the right to come in and tell the Registrar what to do [...]"* • **Diversity and Representation**: The challenge of balancing diverse council membership while ensuring effective governance without compromising the mandate's goals. *"I would caution the Council not to pay too much attention to rabbit trails; to be focused on the mandate [...]"* • **Public Understanding**: There's a gap in the public's understanding of the CPSA's role, which affects how council members are selected and their effectiveness in governance. • **Public Distrust**: There is a growing global public distrust in the healthcare system, which has influenced the Canadian healthcare system by impacting the level of trust that the public has in physicians. • **Rural Healthcare Challenges**: The current generation of doctors is perceivably less willing to relocate to rural settings to practice medicine, affecting medical care in those regions.
Competencies	**Diversity and Representation**	• Emphasis on diverse experiences, backgrounds, and gender, reflecting a wider representation of Albertans. Rural representation is also valued. *"It seems like there's a fairly diverse set of views [...] rural, urban, female, male, different ethnicities"* • Value placed on lived experience and underrepresented perspectives, including those from Indigenous, refugee, and LGBTQ+ communities. However, there is also some notable preference for older, more experienced physicians, with semi-retired individuals being ideal due to their availability and commitment to the role. *"[It would be nice to have] people with lived experience on Council"*
	Communication and Collaboration	• Openness to diverse perspectives and ability to effectively communicate and work with others. • Balanced communication styles, acknowledging that quieter voices can be just as knowledgeable as more assertive ones.

Category	Focus Area	Council
	Integrity and Ethical Orientation	• Qualities such as trustworthiness, kindness, respect, and a commitment to public service are highly valued. • Focus on candidates driven by the mission rather than personal agendas.
	Healthcare Knowledge and Learning Adaptability	• Familiarity with the healthcare system is beneficial but not a strict requirement; adaptability and willingness to learn are prioritized. • Council members are expected to develop knowledge over time and engage critically with healthcare issues.
	Governance and Strategic Thinking	• Governance experience is desirable, given the learning curve in Council roles. *"Ideally a little bit of [governance] experience with some sort of Board work"* *"It would be nice if they [Council] had previous board experience. […] previous experience with governance to understand how governance works]"* • Strategic thinking and the ability to anticipate future challenges, including AI and regulatory developments, are seen as crucial.
	Compassion and Public Focus	• Kindness, compassion, and empathy are core values, supporting respectful dialogue and constructive disagreement. • Focus on the public's best interest, including awareness of social issues affecting vulnerable populations.
Evaluation	**Thorough Application Process**	• Emphasis on candidates presenting a CV with specific achievements, areas of improvement, and relevant experiences. • Preference for a structured process, including cover letters or statements of interest, highlighting how candidates' experiences align with Council goals.
	Importance of Interviews	• Interviews allow for a personal assessment of candidates' communication style, interpersonal skills, and compatibility with the Council's culture. • Recognized as time-intensive but valuable for understanding candidates' intentions and commitment.
	Inclusion and Fairness	• Desire for a competency matrix or nomination committee to objectively prioritize candidates who offer unique contributions. *"I'm concerned about the lack of inputs"* *"There is a benefit to having a nominations committee and sort of being explicit about [the nomination process]"*

Category	Focus Area	Council
		• Support for an alternative nomination pathway for members outside the committee process to ensure self-governance and member input.
	Transparency and Diversity Concerns	• Concerns about potential biases in the selection process, including possible discrimination based on race, religion, or geographic background. • Emphasis on the need to address inherent biases within Council while maintaining open pathways for diverse applicants.
	Election Process and Member Engagement	• Acknowledgment of the low election turnout among physician members and the challenge of re-electing rural or less well-known candidates. *"Fewer than 5% of those eligible to vote voted […] if physicians are complaining, then they don't have a say, they need to become engaged, they need to vote"* • Interest in streamlining but strengthening the election process to improve engagement and fair representation.
	Efficiency and Practicality	• Mixed views on the need for extensive documentation as some feel it may deter candidates, particularly experienced professionals. • Support for simpler applications, complemented by interviews and references to validate candidates' commitment.

Table 2: Key Themes Identified, CPSA Executive Leadership Team

Category	Focus Area	Executive Leadership Team
Foundation	**Role and Mandate of the CPSA**	• **Public Protection and Patient Safety:** Ensuring physicians provide the best possible healthcare to Albertans while guiding the medical profession to ensure safe, high-quality care. "[…] serve the public and protect the public" • **Professional Regulation:** Regulating physicians and physician assistants for safe and competent care. "CPSA [is] responsible for the professional regulation of […] the members" • **Compliance and Adaptation:** Fulfilling the Health Professions Act and adapting to government changes. • **Behaviour Oversight:** Ensuring physicians' behaviour aligns with societal expectations. • **Innovation and Relationship Building:** Guiding the Innovations,

Category	Focus Area	Executive Leadership Team
		forming partnerships, and addressing anti-racism and discrimination.
	Role of the CPSA Council	• **Strategic Direction and Governance:** Deciding on strategic direction and ensuring adherence to key performance indicators. In addition, influencing policy through government collaboration. "[…] I think most importantly, they [Council] have to set the strategic direction for the organization" • **Accountability:** Holding the Registrar accountable. • **Fiduciary Duty:** Protecting the organization and serving the public interest over personal agendas. • **Public Representation:** Balancing expertise and public representation with a mix of physicians and public members. "Their additional responsibility is to represent CPSA to the larger public of Alberta […]"
	Success Indicators	• **Government and Public Feedback:** Some stakeholders expressed that the absence of negative feedback from the public and government is a good sign. Fewer complaints can be a sign of better performance but also a sign underreporting. There was agreement however that a combination of fewer complaints, respect from the public, high levels of patient safety, patient satisfaction, and public awareness of CPSA's role are important measures of success when used together. • **Recognition and Influence:** Having influence on health policy and collaborating with regulatory authorities are indicators of success. Also, being invited to discussion and international recognition is considered a success factor. • **Patient and Public Outcomes:** Timely adjudication of complaints and ongoing competence, as well as Albertans' access to medical care are important factors. • **Organizational Performance:** Maintaining and increasing the number of physicians in the province, handling complaints effectively, and meeting key performance indicators. An example would be the implementation of an online complaint portal that increased accessibility and doubled the number of complaints handled without burdening the department.
	Changes and Major Trends	**External Pressures and Visibility:** The environment has become more visible and reactive due to external pressures, such as political influences and public opinion. There has also been an increased antagonism between organized medicine and government. CPSA also experiences increased government interference which affects Council members' required competencies. **Impact of COVID-19:** COVID-19 has changed the operations and as such the competencies that are expected of Council members. This includes a

Category	Focus Area	Executive Leadership Team
		shift to hybrid/remote work and all the technological impacts that involves. "COVID had a huge impact on our work and on professional regulation [...]" • **Other Changes in the Environment and Trends**: Shifts in the government, the pandemic, increasing distrust in science, and self-regulation challenges created a new environment. There are also trends including a push for systemic changes, freedom of speech, and the need for authentic Indigenous connections and anti-racism initiatives. In addition, the social contract between healthcare providers and society is being tested along with a loss of community practice. There is also a recognition that primary care needs restructuring. *"There's a sense that what we would have called loosely a community of practice has been largely lost in healthcare, not just in medical practice but in healthcare generally."*
	Nomination Process: Key Elements	• **Nominee characteristics:** Candidates need to understand CPSA's mandate and have relevant experience. They need to be transparent and maintain integrity as to avoid personal agendas. They need to be impartial, understand diversity, and avoid political biases. Consequently, council members should be politically savvy and sensitive, as well as have good standing in the community. Other key characteristics are open-mindedness, willingness to listen, and a wide range of experiences. • **Switch to an Appointment System**: Some stakeholders were in favour of moving to an appointment system. "I believe this should purely be an appointment process, and we should not be leaving this up to a popularity vote" • **Process Integrity:** Regardless of the process, mechanisms need to be in place to ensure effectiveness and integrity of the process.
Competencies	**Important Competencies**	• **Experience and Background:** Council members should have experience in different organizations and roles. They should also have governance experience as to be able to navigate the complex systems CPSA has to deal with. Council needs to have a wide variety of experience ranging from financial to legal knowledge. "But I would like to see it as experience, not just as a consultant like I'd like to see people that were in organizations and worked with an organization and have proven kind of their themselves [...] over the years." • **Social Justice and Community Engagement:** Council members should have social justice experience and the ability to engage authentically with marginalized populations. They need to represent diverse communities

Category	Focus Area	Executive Leadership Team
		• **Technology:** Council members need to be able to understand new technology such as AI and GPT and how they are being used in the clinical setting.
	Desired Competencies	• **Diverse Experience and Leadership:** Broad experiences across different industries, leadership roles, diverse opinions are valuable for governance. There needs to be expertise in finance and risk management. • **Understanding of Barriers to Access:** Knowledge of social determinant of health, experience in social sciences, and the ability to contribute to anti-racism and anti-discrimination efforts. There needs to be youth representation, understanding of climate impacts, and experience with other marginalized or vulnerable populations. • **Public Engagement:** Having an ability to bridge gaps within the system and with the public is desirable. Some suggested that the Council should not be solely physician-run to better represent public interests.
Evaluation	Demonstrating Competencies	• **On-File Competencies:** Show their competencies through a mix of volunteer work, involvement in different boards and committees, resumes, interviews, presentations, campaigns, and references. "Well, it's an imperfect tool, but for everybody, it's going to start with some sort of a resume or an application. Something along the process that we have now, people want someone to run, and they get nominated [...]" • **Assessment:** Some suggested that a shortlist of candidates should demonstrate competency through joining current council meetings and assessing how they interact with others and the material presented.
	Additional Insight	• **Concerns About Election Process:** Some stakeholders are concerned about the idea of elections referring to it as a popularity contest. This presents a barrier to qualified doctors as they do not want to engage in the process. "I would find the idea of having to run and put yourself out there just incredibly intimidating" • **Government Interference:** Worry about the Government abolishing, diminishing, or influencing the role of the CPSA.

Wherever business takes you

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Submission to:	Council

Meeting Date:	Submitted by:		
March 6, 2025	Daisy Fung Committee Chair		
Agenda Item Title:	6.2 Anti-Racism Anti-Discrimination Action Advisory Committee – Meeting Summary Report		
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:	The Anti-racism Anti-Discrimination Action Advisory Committee (ARADAAC) met on February 14th. This was the first meeting of the committee since May 3, 2024. In the meeting, Ian Walker and Charlene Lyndon were acknowledged as committee members after Council approval on May 30, 2024. Kannin Osei-Tutu was also confirmed as Vice Chair. Erin Davis, an award-winning consultant dedicated to advancing diversity, equity, and inclusion provided a climate assessment report in the meeting. The report summarizes what was heard during in-person and virtual interviews with ARADAAC members throughout the fall of 2024. At that time, Committee members were asked to assess the current state of ARADAAC and identify strengths, challenges, and opportunities. The report summarizes the feedback received and goes on to provide actionable recommendations for sustainable growth. Erin found that ARADAAC members bring passion and expertise to a safe and respectful space for anti-racism and anti-discrimination discussion. ARADAAC also has strong potential to drive systemic change, but has encountered organizational and systemic barriers. ARADAAC has opportunity to clarify its role, mandate and authority while improving committee supports, structure and measurable outcomes for reporting.		

	ARADAAC is planning a two-day in-person meeting in April to put action to the immediate, short and long-term recommendations and priorities that were provided in the report. The next ARADAAC meeting is March 11, 2025 (virtual, 1 hour).
Next Steps:	
List of Attachments:	
N/A	

Submission to:	Council		

Meeting Date:	Submitted by:		
March 6, 2025	Dr. Nicole Cardinal Committee Co-Chair		
Agenda Item Title:	6.3 Indigenous Advisory Circle – Meeting Summary Report		
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):	CPSA Council continues to support the implementation of CPSA's Path to Truth and Reconciliation.		

Background:	On February 19, the Indigenous Advisory Circle (Circle) had their first meeting of 2025.
	During this meeting, the Circle:
	• Welcomed the newest member, Dr. Tibetha Kemble (PhD).
	• Provided guidance on CPSA's Path to Truth and Reconciliation, specifically on three proposed focuses for 2025, all of which are intended to inform subsequent actions on the Path:
	  ◦ Conducting research into CPSA's past and current role in broken trust and harms to First Nations, Métis and Inuit Peoples.
	  ◦ Unpacking the TRC Calls to Action, United Nations Declaration on the Rights of Indigenous Peoples and other foundational documents to identify the actions CPSA is positioned to carry out.
	  ◦ Hearing from First Nations, Métis and Inuit Peoples about how broken trust has been experienced in the past and today, how to remove barriers to accessing CPSA, and how to improve the quality and safety of healthcare interactions.
	• Shared advice on draft principles for engaging with First Nations, Métis and Inuit Peoples as well as approaches to outreach and engagement with sovereign Nations, settlements and communities. Advice included:
	  ◦ taking a distinctions-based approach,
	  ◦ demonstrating respect for Treaties, land agreements and the sovereignty of First Nations, and		

	- validating insights and experiences Indigenous Peoples share with CPSA. • Emphasized that CPSA's Path to Reconciliation, which the Circle co-created, is essential work. The Circle reflected on CPSA's responsibility to act, especially in light of the alarming statistics from Alberta Health, which reveal the gap in life expectancy between First Nations and non-First Nations people in Alberta is now 19.1 years (higher than the 17.2 years difference reported previously).
Next Steps:	The Circle plans to meet virtually three more times in 2025 to continue guiding CPSA on its efforts towards more equitable care for Indigenous patients.
List of Attachments:	
N/A	

Submission to:	**Council**

Meeting Date:	Submitted by:		
March 6, 2025	Ad Hoc Bylaw Review Project Committee		
Agenda Item Title:	6.4 Presentation of Revision of Bylaws		
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):	That Council approves the revised version of the CPSA Bylaws, with an adoption date of May 1, 2025.		
Background:	In March 2024, Council approved the Terms of Reference for the Ad Hoc Bylaw Review Project Committee ("Committee") to conduct a fulsome review of the bylaws. Beginning in April 2024, the Committee has since conducted line-by-line review of the drafted bylaws, looking into each at length and in fine detail. Changes that are being proposed in the bylaws are reflective of direction set out by Council, the Governance Review Implementation Plan (2022) and CPSA subject-matter experts. Work completed so far includes: • Interviews with each affected CPSA team / department. • Drafting and line-by-line review by the Bylaws Secretariat (Chief of Staff, In-House Legal Counsel, Program Manager Governance, and Director Office of the Registrar). • Line-by-line review of Parts 1-4 of the current bylaws by the Committee over 17 meetings (April 2024 – January 2025). • In-person reviews with each affected CPSA team / department. • Final validation review through all affected teams / departments • 3rd party legal review by Field Law LLP. The new CPSA bylaws are being brought to Council for approval in a phased approach. Phase 1: Council approval of the revised version of the bylaws is sought on March 6, 2024 (Attachment 1). These include a		

	combination of the existing bylaws and the proposed bylaws, differentiated by their dates, pending Council approval. **Type of Bylaw** / **Identifier**: Existing / Unchanged — No identifier Amended bylaw — *"Repealed, May 2025"* New bylaw — *"Adopted, May 2025"* Phase 2: Council approval on the remaining Parts of the bylaws (Parts 5 – 6) is forecasted for later in 2025. Any significant or contentious issues that were uncovered in the review of the first four parts have been set aside for future discussion by Council. While it is hoped that Council will have confidence in the rigorous process of development and review undertaken to date, in reviewing the drafted bylaws, Council members may wish to draw their attention to the most notable changes being brought forward. Within Attachment 1, it is signalled by comments denoting points of interest. • Definitions • Nominations Committee • Selection of Regulated Members of Council • Eligibility for Election • Unplanned Vacancies • Leave of Absence • Eligibility of Officials and Statutory Committees • Conduct of Council Members • Acting Registrar and CEO
Next Steps:	Pending Council approval: • The secretariat will conduct comprehensive formatting and editorial changes. • The revised CPSA full bylaws will be published on the CPSA website, effective May 2025. • A Bylaw Review Implementation Plan will be initiated to communicate and implement changes. • Further bylaw revisions will be completed in 2025 to meet the objectives of a full refresh of the bylaws per the Bylaws Review project.

Type of Bylaw	Identifier
Existing / Unchanged	No identifier
Amended bylaw	*"Repealed, May 2025"*
New bylaw	*"Adopted, May 2025"*

List of Attachments:

1. Proposed new full bylaws
2. Current (outgoing) Bylaws

College of Physicians & Surgeons of Alberta

BYLAWS (DRAFT)

Effective May 1, 2025

(PROPOSED / PENDING COUNCIL APPROVAL)

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Definitions

Other than as specified in these bylaws, words and expressions defined in

a. the *Health Professions Act* (HPA),
b. the *Physicians, Surgeons, Osteopaths and Physician Assistants Profession Regulation*[1],
c. the *Interpretation Act*[2], or
d. an applicable statute of Alberta

have the same meanings when used in these bylaws. If a word has multiple meanings in different statutes, the meaning that is most relevant to the intent of the applicable bylaw should be used.

In these bylaws:

a. "Chair" means the President, as per section 7 of the HPA,
b. "College" and "CPSA" mean the College of Physicians and Surgeons of Alberta,
c. "Council" means the governing council of CPSA,
d. "HPA" mean the *Health Professions Act*,
e. "Officials" means individuals named to an office identified in the HPA, or another named statute, and their delegates who act on their behalf using delegated statutory authority,
f. "Primary residence" means where the person typically resides using the same decision-making process as used by the Canada Revenue Agency (CRA), and
g. "Regulations" means regulations relating to CPSA made under the HPA.

Commented [JM1]: Point of Interest:

The Definitions section in the current bylaws runs several pages. The proposed bylaws shortens this considerably by (a) refraining from defining words already defined in the HPA, and (b) moving some definitions into the section of the bylaws where they are most relevant, so that the meaning of the word is easily found near to where readers will use the word.

Reference Aid

In these bylaws the table of contents, section headers, and amendment notations are not part of the bylaws but are inserted for convenience of reference.

[1] Province of Alberta's *Physicians, Surgeons, Osteopaths and Physician Assistants Profession Regulation* (Mar. 31, 2023).
[2] Province of Alberta's *Interpretation Act* (Apr. 1, 2023).

PART 1 – COUNCIL AND ORGANIZATION

Composition of the Council *Repealed, May 2025*

Composition of Council *(Adopted, May 2025)*

1.1 The voting members of Council shall consist of:

a. seven (7) eligible regulated members selected in accordance with these bylaws, and

b. seven (7) public members appointed by the Lieutenant Governor in Council in accordance with the HPA.

1.2 The non-voting members of Council shall consist of:

a. the deans of the Faculties of Medicine from the University of Alberta and the University of Calgary (or designates),

b. a person appointed by the Professional Association of Resident Physicians of Alberta, and

c. a person appointed by either the University of Alberta's Medical Students' Association or the University of Calgary's Medical Students' Association.

Remuneration of Council Members

2.1 Members of Council, including non-voting members and members of committees when attending or conducting business on behalf of the College, may claim expenses and per diem amounts as determined by resolution of Council.

Officers of Council *Repealed, May 2025*

Chair and Vice Chair *(Adopted, May 2025)*

3.1 In these bylaws, "Chair" means the President, as per section 7 of the HPA.

3.2 Council shall select from among the members of Council a Chair and Vice Chair, in accordance with Council policy.

3.3 The term of office for the Chair and Vice Chair shall be one (1) calendar year, starting January 1 and ending on December 31.

3.4 The Chair and Vice Chair may be re-selected by Council subject only to their term limits as a member of Council.

3.5 The Chair shall:

a. perform the duties required of the President, in accordance with, the HPA,

b. chair Council meetings, except if the chair duties have been delegated to the Vice Chair or another member of Council for any reason,

c. be a spokesperson for Council to external parties, if needed, or delegate the role of spokesperson to another member of Council,

d. establish and maintain the reporting relationship and accountability of the Registrar to Council,

e. use discretion in speaking to motions, erring on the side of maintaining neutrality towards the motion except if another member of the Council who is able to maintain neutrality is asked to chair the remainder of the discussion leading to a vote, at which point the Chair may resume their chairing duties for subsequent topics, and

f. refrain from voting on Council motions except to cast the deciding vote on any matter before Council where there would otherwise be a tie vote.

3.6 If the Chair is temporarily absent or unable to act, or at the request of the Chair, the Vice Chair shall perform the duties and exercise the powers of the Chair.

a. If the Chair and Vice Chair are both temporarily absent or unable to act, the third member of the Executive Committee shall perform the duties and exercise the powers of the Chair.

b. If all three (3) members of the Executive Committee are absent or unable to act, Council shall determine who shall perform the duties and exercise the powers of the Chair and shall indicate the time period for which they shall act in the role of Chair.

Vacancies on Council *Repealed, May 2025*

Filling Regulated Member Vacancies on Council *(Adopted, May 2025)*

4.1 When there is a current or anticipated deficiency in the number of regulated members on Council, the vacancy or vacancies shall be filled in accordance with these bylaws.

Nominations Committee *(Adopted, May 2025)*

Commented [JM2]: Point of Interest:

Creation of Nominations Committee to vet regulated member candidates to Council and powers of the committee.

4.2 The Nominations Committee may establish policies sufficient for the purposes of fulfilling its mandate, which may include:

a. processes for administering the nominations process,

b. evaluating candidates,

c. rules for casting and counting ballots,

d. resolving ties and disputes,

e. announcing selection results, and

f. preventing undue influence by anyone over selection outcomes.

4.3 Policies established for evaluating candidates may include processes for assessing candidates against the eligibility criteria established in these bylaws and competency criteria established by Council in policy, if any.

4.4 The Nominations Committee has the ability to disqualify candidates who have exhibited past behaviour that may bring Council into disrepute.

4.5 The process for disqualification and definition of disreputable behaviour will be established in Council policy.

Nominations for Regulated Member Council Positions *(Adopted, May 2025)*

4.6 A call for nominations will be circulated to regulated members when:

a. the term of one (1) or more regulated members of Council will end in that year resulting in a vacancy, or
b. one (1) or more regulated members of Council resigns or is terminated, resulting in a vacancy before August 15.

4.7 Any regulated member on the General Register, the Provisional Register or the Limited Practice Register (whether a physician, surgeon, osteopath or physician assistant), may send nominations to the Nominations Committee.

4.8 Nominations must be endorsed by at least three (3) regulated members.

4.9 Nominated members must indicate their eligibility to be a regulated member of Council, as well as their intention to assume the duties and responsibilities of a Council member if selected.

4.10 The call for nominations:

a. must be open for at least three (3) consecutive weeks, and
b. shall open after February 1 and close no later than May 30th.

Selection of Regulated Members of Council *(Adopted, May 2025)*

4.11 The Nominations Committee shall evaluate the available nominations against the eligibility criteria established in these bylaws and other criteria established by Council in policy, if any.

4.12 Any regulated member who is considered ineligible for Council shall be provided notice, with reasons, and shall be given at least one (1) week to respond by withdrawing their candidacy or by presenting additional proof of their eligibility to the satisfaction of the Nominating Committee.

4.13 Any decision of eligibility made by the Nominations Committee is final and cannot be appealed.

4.14 After the evaluation process is complete,

a. if the number of eligible candidates exceeds the number of vacancies, there shall be an election in accordance with these bylaws,
b. if the number of eligible candidates is equal to the number of vacancies, the candidates shall be acclaimed to Council in accordance with these bylaws, or
c. if the number of eligible candidates is less than the number of vacancies, the nominations process will be reopened for a further three (3) weeks.

4.15 If the initial number of eligible candidates changes before the polls close in an election or before an acclamation is declared by Council, the outcome prescribed by bylaw 11.4 shall be applied using the new number of candidates.

Removal of Council Members *Repealed, May 2025*

Resignation *(Adopted, May 2025)*

5.1 A regulated member of Council may resign at any time by delivering a notice in writing to the Chair.

5.2 The resignation shall take effect immediately upon receipt of the notice or upon a date agreed upon by the Council member and the Chair.

5.3 If the member resigning is the Chair, the notice shall be provided to the Vice Chair.

Removal from Council *(Adopted, May 2025)*

5.4 If a member of Council no longer meets the criteria in bylaws 12 or consistently violates the Council Code of Conduct, Council may, by a two-thirds (2/3) majority vote:

a. remove a voting regulated member of Council,

Commented [JM3]: Point of Interest

Introduces a vetting process that engages the nominations committee to determine if candidates are eligible to run in election. This ties into the Eligibility Criteria established in bylaws, competency matrix work of the governance committee working with MNP and other attributes.

b. remove a non-voting member of Council, with or without seeking a candidate to replace them from the organization they came from, or

c. recommend to the Lieutenant Governor in Council that the appointment of a public member be rescinded.

5.5 A member of Council who is subject to a vote to be removed or suspended shall be given at least seven (7) days' notice before the vote is to take place and may make representation on their own behalf to Council before the vote is cast.

5.6 If a vote to remove a regulated member from Council passes, the Chair shall provide notice to the regulated member that their term has ended and shall declare a vacancy on Council effective on the date when the term ended.

5.7 If a vote to recommend removal of a public member from Council passes, Council may decide whether or not to suspend the person's:

a. attendance at Council and committee meetings,

b. receipt of information intended for Council and committees, or

c. ability to access confidential materials reserved for Council

until direction is received from the Minister of Health pertaining to the public member's status on Council.

Removal from Office *Adopted, May 2025*

5.8 The Chair or Vice Chair may be removed from office by a two-thirds (2/3) majority vote of the Council.

5.9 A former Chair or Vice Chair, if removed from office in accordance with bylaw 5.8, shall remain on Council until the natural end of their term on Council unless they are removed by a separate vote or resign from Council in accordance with these bylaws.

Awards

6.1 Certificates of Merit may be awarded by Council to individuals who promote regulatory excellence.

Bylaws

7.1 A Bylaw or an amendment of a Bylaw requires a two-thirds (2/3) majority vote.

7.2 A Bylaw, or an amendment to a Bylaw, under section 132(1) of the Act may be passed at any meeting of the Council provided:

a. A notice of motion has been given at a previous meeting, or

b. A notice of motion has been sent to all members of Council at least fourteen (14) days prior to the meeting.

7.3 A notice of motion may be waived by a unanimous vote of the Council.

7.4 Whenever an amendment is made to the Bylaws, any consequential editorial changes to the bylaws as required are implied.

Code of Ethics and Standards of Practice

8.1 At least thirty (30) days before Council considers a motion to adopt or amend a code of ethics or a standard of practice, the Registrar shall provide, for review and comment, a copy of the proposed code of ethics or standard of practice in accordance with section 133(2) of the Act.

8.2 A person receiving notice under Bylaw 8(1) may make submissions in writing to the Registrar within the time period stipulated by the Registrar.

8.3 Council shall review and consider any submissions made under Bylaw 8(2).

8.4 Council may, on a two-thirds (2/3) majority vote of members of Council present at a meeting, adopt or amend the code of ethics.

8.5 Council may, on a majority vote of members of Council present at a meeting, adopt or amend standards of practice.

8.6 Whenever amendments are made to the code of ethics or standards of practice, any consequential editorial changes as required are implied.

Grants

9.1 The Council may make grants as it determines from time to time.

Electoral District

10.1 Regulated members on Council are elected from one electoral district, being the entire Province of Alberta.

Entitlement to Vote

11.1 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.

Eligibility for Election Repealed, May 2025

Eligibility

Commented [JM4]: Point of Interest:

The eligibility criteria for Council have been notably redrafted.

12.1 A regulated member on the General Register, the Provisional Register or the Limited Practice Register may be eligible for nomination for election to a regulated member vacancy on Council.

12.2 Notwithstanding bylaw 11.1, a regulated member is not eligible for nomination or election as a member of Council if the regulated member:

a. is serving as a director, officer, or senior employee of a professional association or labour union that represents members of a regulated health profession, or has served in such a capacity in such an organization within five (5) years of the anticipated start of their term on Council,

b. is elected to federal or provincial public office,

c. occupies an executive management position with the Government of Alberta or a health authority in the province of Alberta,

d. has failed to comply with any duly imposed requirement under the HPA in their capacity as Medical Director or as an owner or director of a medical clinic or facility,

e. has failed to complete the requirements for registration renewal or has not complied with conditions placed upon their registration within the timeframe specified in the condition notice,

f. has failed to complete the requirements of the Continuing Competence Program or has not complied with conditions placed upon their registration within the timeframe specified in the condition notice,

g. is subject to a direction due to incapacity under the HPA or a similar enactment in any jurisdiction, unless the Nominations Committee determines that the person’s incapacity does not make them ineligible to be a member of Council.

h. has been found guilty by a hearing tribunal or has agreed that their conduct was unprofessional conduct under the HPA or a similar enactment in any jurisdiction, unless

   i. at least three (3) years have passed since all conditions arising from the finding are resolved to the satisfaction of the appropriate authority, and

ii. the Nominations Committee determines that the person's conduct does not make them ineligible to be a member of Council,

i. has ever been found guilty of unprofessional conduct related to sexual abuse, sexual misconduct or any sexual boundary violation at any time in any jurisdiction, including outside of Canada,

j. has been found guilty of a criminal offense for which a pardon has not been granted, in any jurisdiction, unless the Nominations Committee determines that the person's conviction does not make them ineligible to be a member of Council,

k. has worked more than twenty (20) hours per week, on average, as an employee or contractor for CPSA within the two (2) years preceding the anticipated start of their term on Council, unless they worked as a contracted assessor.

l. has their primary residence outside of Alberta or practices primarily outside of Alberta, unless the arrangement is temporary with a foreseeable end date.

12.3 A person is eligible to be a non-voting member of Council unless that individual:

a. is serving as a director, officer or senior employee of a professional association or labour union that represents members of a regulated health profession, or has served in such a capacity in such an organization within five (5) years of the anticipated start of their term on Council,

b. is elected to federal or provincial public office,

c. occupies an executive management position with the Government of Alberta or a health authority in the province of Alberta,

d. has been found guilty of unprofessional conduct or has agreed that their conduct was unprofessional conduct under the HPA or a similar enactment in any jurisdiction, unless

i. at least three (3) years have passed since all conditions arising from the finding are resolved to the satisfaction of the appropriate authority, and

ii. the Nominations Committee determines that the person's conduct does not make them ineligible to be a member of Council,

e. has been found guilty of a criminal offense for which a pardon has not been granted, in any jurisdiction, unless

i. at least three (3) years have passed since all conditions arising from the guilty verdict are resolved to the satisfaction of the appropriate authority, and

ii. the Nominations Committee determines that the person's conviction does not make them ineligible to be a member of Council.

Election of Council *Repealed, May 2025*

Election of Regulated Members *(Adopted, May 2025)*

13.1 When elections are held, the polls shall be open for a period of at least three (3) weeks and shall close no later than November 15th.

13.2 Any regulated member on the General Register, the Provisional Register or the Limited Practice Register (whether a physician, surgeon, osteopath or physician assistant), may vote in an election.

13.3 Voting shall be by a secure electronic process approved by the Nominations Committee.

13.4 Regulated members entitled to vote shall have one (1) vote for each vacancy on Council.

13.5 The candidate who receives the most votes will be named to fill the first vacancy on Council, the candidate who receives the second-most votes will be named to fill the second vacancy, and so on until all vacancies on Council are filled.

Election Procedure *Repealed, May 2025*

Acclamation of Regulated Members *(Adopted, May 2025)*

14.1 When acclamations are prescribed by these bylaws, the Nominations Committee shall recommend that Council declare each candidate for each available vacancy selected by acclamation.

Unplanned Vacancies *(Adopted, May 2025)*

Commented [JM5]: Point of Interest

Adds method for dealing with unplanned vacancies to Council as a safeguard.

14.2 When an unplanned vacancy or vacancies occur among regulated members of Council, Council may:

a. leave the position vacant until the next scheduled election for regulated members of Council,

b. hold a by-election, in the same manner as an annual election, with all necessary modifications to time limits, deadlines and other necessary modifications as determined by the Registrar, or

c. appoint the regulated member-candidate who had the most votes of all the unsuccessful candidates in the last Council election, subject to such candidate satisfying the eligibility criteria and consenting to act as a regulated member on Council.

   i. Should consent not be provided or the eligibility criteria not be satisfied, Council may then appoint the candidate with the next highest number of votes, subject to that nominee meeting the eligibility criteria and agreeing to act, and so on until a candidate is found for the vacant position.

14.3 The term of office of a regulated member appointed to Council under bylaw 14.2(c) or elected in a by-election under bylaws 14.2(b) expires when the term of office of the Council member whose vacancy has been filled would have expired.

Eligibility for Re-election *Repealed, May 2025*

Term of Office *(Adopted, May 2025)*

15.1 The regular term of office for a voting regulated member of Council is three (3) years.

15.2 A voting regulated member of Council is eligible for a maximum of two (2) consecutive regular terms (total of six (6) years).

15.3 Council may authorize a leave of absence from Council duties for up to one (1) year in accordance with Council-approved policy.

Commented [JM6]: Point of Interest:

Establishes a Leave of Absence from Council duties for voting regulated members. This could be used in times of illness, parental leave, exceptional personal circumstances, etc.

15.4 A voting regulated member of Council may be re-appointed directly to a second, regular three (3)-year term at the conclusion of their first term, subject to any policies established by Council for making such an appointment.

15.5 A voting regulated member of Council who has served two (2) consecutive terms cannot be selected for a further term/term unless 365 days pass between the end of the second term and the start of any new term.

15.6 Each three (3)-year term for voting regulated members of Council who are regulated members shall start on January 1 and end three (3) years later on December 31.

15.7 The start of terms may be staggered so that, to the extent practicable, approximately one-third (1/3) of voting regulated member terms shall end in any given year.

a. Council may direct that terms for upcoming vacancies be shortened to one (1) or two (2) years if needed to achieve a more balanced term

rotation, which candidates shall be so advised ahead of their selection to Council, and

b. the Nominations Committee shall establish policy for advising candidates of shortened terms when they exist and, if there are multiple vacancies of differing term lengths, for deciding which candidate is selected to which term.

15.8 Term of office for non-voting members of Council shall be determined by their term in office if they are a dean of a medical program, or their term of appointment, if they are appointed by an association of medical learners.

15.9 The terms of office for public members shall be in accordance with their appointment by the Lieutenant Governor in Council and the HPA.

Council Committees *Repealed, May 2025*

Council Committees *(Adopted, May 2025)*

16.1 Council may establish standing, priority or any other council committee through terms of reference.

16.2 The Standing Committees established by Council shall include, but are not limited to, the:

a. Executive Committee,

b. Governance Committee,

c. Finance and Audit Committee, and

d. Nominations Committee.

16.3 Council shall, with respect to any committee it establishes:

a. appoint or provide for the manner of the appointment of its members,

b. prescribe the term of office of any member,

c. appoint a Chair and Vice Chair, or direct or approve a process for the appointment of a Chair and Vice Chair, and prescribe the term of such appointments, and

d. approve or provide for the approval of terms of reference for each committee established, in alignment with applicable council policies.

16.4 Council may delegate decision-making authority to Council committees via terms of reference or memorandum of delegation, which shall include any conditions imposed on the delegation and the powers of the committee to sub-delegate and give consideration to performance monitoring.

College Statutory Committees *Repealed, May 2025*

Officials and Statutory Committees

Eligibility *(Adopted, May 2025)*

Commented [JM7]: Point of Interest

CPSA previously didn't have documented rules for eligibility for officials or committee members. "Officials" in this context is the Registrar, the Complaints Director, and the Hearings Director. Statutory Committees in this context are the Medical Facilities Accreditation Committee and the Competence Committee. These two committees have decision-making powers that affect medical practice and physician rights and responsibilities.

16.5 The eligibility requirements for CPSA officials, Statutory Committee members, and regulated members appointed to membership lists for hearing tribunals and complaints review committees, are the same as for regulated members of Council, except

a. candidates to be appointed as CPSA officials may be working as an employee or contractor for CPSA for more than 500 hours within the two (2) years preceding the anticipated start of appointment, and

b. living at a residence outside the province or practicing primarily outside of the province.

16.6 Candidates to be appointed to Statutory Committees may have worked as an employee or contractor for CPSA for more than 500 hours within the two (2) years preceding the anticipated start of their term on a Statutory Committee.

Conduct of CPSA Officials and Statutory Committee Members

(Adopted, May 2025)

16.7 CPSA officials and Statutory committee members, when acting in their appointed capacity, shall conduct themselves in accordance with a Code of Conduct approved by the Council.

Duties and Powers CPSA Officials and Statutory Committees

(Adopted, May 2025)

16.8 CPSA officials and Statutory committees shall exercise the duties and powers given to them under the HPA, these bylaws and any delegation made from a higher authority.

16.9 CPSA officials and Statutory Committees may approve and adopt any policies, processes or procedures necessary to effectively carry out their powers and duties.

Delegation *(Adopted, May 2025)*

16.10 Any delegation made by Council, a CPSA official or a committee may be further delegated without restriction unless a restriction is stated in the delegation or in an applicable policy.

16.11 Notwithstanding bylaw 28.1, a Statutory Committee cannot delegate its power or duty to approve policies.

16.12 A CPSA official may delegate their power or duty to approve policies to one or more persons or committees, but the person or committee to whom the delegation is made cannot further delegate policy-making authority.

16.13 Whenever Council, a CPSA official or a committee delegates any of its powers or duties to an individual or committee, it shall keep records of the delegation, which shall include any conditions imposed on the delegation.

16.14 Further to bylaws 19 and 20 and the "Delegation" section of the HPA, where the HPA provides for a choice among a list of individuals and/or committees to be specified by bylaw, the individual or committee specified by the bylaw cannot delegate their powers or duties to another from the same list.

16.15 Any reference in these bylaws to a person or committee to whom a power or duty is given under the bylaws is deemed to be also a reference to a delegate of the person or committee.

Appointments (Adopted, May 2025)

16.16 Whenever Council, an official or a committee appoints an individual to an office, membership list or committee, it shall keep records of the appointment that include any conditions imposed on the appointment.

16.17 Term lengths and limits for individuals appointed to committees or membership lists will be established in Terms of Reference or policy.

Statutory Committees (Adopted, May 2025)

16.1.1 The Statutory Committees are the:

a. Competence Committee, and

b. Medical Facilities Accreditation Committee (MFAC).

16.1.2 Statutory Committees will include members of the public as established by Council policy.

16.1.3 Council shall approve terms of reference for the Statutory Committees.

16.1.4 The Registrar shall, in accordance with applicable policy, which may be approved by Council;

a. appoint members to the Statutory Committees,
b. prescribe the term of office of any member,
c. designate the Chair and Vice Chair of Statutory Committees and prescribe the term of such designations.

16.1.5 A Statutory Committee may establish or adopt any policies or processes necessary to fulfill its mandate.

Medical Facility Accreditation Committee *Repealed, May 2025*

Medical Facilities Accreditation Committee (MFAC) *(Adopted, May 2025)*

16.1.6 MFAC may exercise the following powers and duties, in addition to any powers and duties prescribed under the HPA [‡], and [Part 6] in these bylaws:

a. develop and direct regular reviews of the ownership and operation of any accredited medical facility and the financial arrangements pertaining thereto,
b. ensure the operation of an accredited medical facility is in accordance with the Accreditation Standards[§],
c. confirm the practice of medicine conducted in an accredited medical facility, and the financial arrangements pertaining thereto, are in accordance with the Code of Ethics and Professionalism[**] and Standards of Practice[††] approved by the Council,
d. assess the adequacy of the design of an accredited medical facility and the equipment utilized therein, along with the standards of operation used in providing medical services, including prescribed health services, to the public, and
e. assess the business and professional relationships between regulated members conducting the practice of medicine and the owners of an accredited medical facility.

Procedures for Meetings of Statutory Committees *(Adopted, May 2025)*

16.1.7 Statutory Committees may adopt rules for the conduct of meetings that address the following:

[‡] Schedule 21 of *Health Professions Act* (Dec. 5, 2024).

[§] Please see CPSA's website for more information.

[**] The Canadian Medical Association's *Code of Ethics and Professionalism* (2018).

[††] CPSA's *Standards of Practice*.

a. guidelines for the conduct of meetings,

b. virtual attendance, virtual meetings and electronic voting,

c. attendance at meetings by observers, applicants, regulated members, witnesses or their representatives,

d. providing information about upcoming meetings, and

e. the taking and keeping of minutes, preparation of decisions and sending of notices.

16.1.8 Rules shall seek to enhance the accountability and transparency of CPSA's activities without jeopardizing reasonable and prudent privacy, confidentiality and operational considerations.

16.1.9 Rules shall be available on the CPSA website.

Quorum for meetings of Statutory Committees *(Adopted, May 2025)*

16.1.10 Quorum for meetings of the Competence Committee or MFAC Committee shall be one-half (1/2) of the current members of the Committee. Where one-half (1/2) of the committee is not a whole number, quorum shall be taken as the whole number which is closet to and greater than one-half (1/2).

16.1.11 No decisions will be made at a meeting of a Statutory Committee for which there is not quorum.

Resignation *(Adopted, May 2025)*

16.1.12 CPSA Officials may resign in accordance with their employment contract if they are employees.

16.1.13 A member of a Statutory Committee or tribunal may resign at any time by delivering a notice in writing to the person or authority who appointed them.

Removal from Office *(Adopted, May 2025)*

16.1.14 The Registrar and/or CEO may be removed from office by a two-thirds (2/3) majority vote of Council, giving consideration to the Registrar/CEO's employment contract.

16.1.15 Other CPSA Officials, members of Statutory Committees and tribunals may be removed by the person or authority who appointed them if:

a. they no longer meet the eligibility criteria for their appointment,

b. they violate an applicable Code of Conduct,

c. they no longer have the confidence of the person or authority who appointed
them, or

d. if they are a CPSA Official, their employment with CPSA is terminated for any reason.

Other Operational Committees *Repealed, May 2025*

Regulated members appointed to Membership List *Repealed, May 2025*

Vacancies on Committees

17.1 If there is a vacancy on a Council Committee, Council may:

a. appoint a new member to fill the vacancy, or

b. allow the vacancy to continue.

Removal of Standing Committee Member

18.1 A member of a Standing Committee may be removed on a two-thirds (2/3) majority vote of the Members of Council participating and eligible to vote at a meeting of Council.

18.2 Before a vote under Bylaw 18(1) may be held, the Chair shall give the members of Council seven (7) days' written notice of the date on which the vote is to be held and the member facing the vote for removal the opportunity to make submissions to Council before the vote is held.

Attendance of Council Members as Observer at Committees

19.1 Members and non-voting members of Council may, with approval of the committee chair and in accordance with the process and expectations determined by Council as well as the applicable Committee Terms of Reference, attend as observer at a committee to which they have not been appointed.

19.2 Despite Bylaw 2.1, members and non-voting members of Council may not claim expenses or per diem amounts when attending as observer at a committee to which they have not been appointed.

Council Meetings *Repealed, May 2025*

Procedures for Council and Council Committee Meetings *(Adopted, May 2025)*

20.1 Council shall establish rules for Council and committee meetings in the form of policies and terms of reference, which address:

a. the calling of meetings and the form of notices,

b. rules of order for the conduct of meetings, including quorum and the manner in which decisions shall be made and votes cast,

c. guidance for when meetings, or portions of meetings, or deliberations can or should be held in camera, as well as rules for the conduct of meetings and reporting out when a decision is made in-camera,

d. virtual attendance, virtual meetings and electronic voting,

e. attendance by observers,

f. announcing upcoming meetings, the broadcasting and recording of same and public reporting if any,

g. the taking and keeping of minutes,

h. recording decisions, and

i. the selection of members to Council committees and of the appointment of members of Council to act as Committee Chair.

20.2 Rules for Council meetings shall seek to enhance the accountability and transparency of Council’s activities without jeopardizing reasonable and prudent privacy, confidentiality and operational considerations.

20.3 Rules for Council meetings shall be available on the CPSA website.

Regular Council Meetings *(Adopted, May 2025)*

20.4 A regular Council meeting is any meeting of Council for which at least ninety (90) days’ notice is provided to members of Council but does not include special meetings or other meetings.

20.5 Council shall, at least four (4) times per year, conduct a regular Council meeting to effectively carry out its duties and powers under the HPA and these bylaws.

20.6 If Council changes the date, time or place of a regular Council meeting, it must provide at least one (1) weeks’ notice of the change to each member of Council and anyone else who has indicated attendance.

20.7 Notwithstanding anything in this section, if a meeting time or location becomes unworkable due to unforeseen or emergent circumstances, best efforts will be made to communicate the change as soon as possible and find an alternative that is similar or proximate to the original time and/or location.

20.8 For the purpose of this section, a "virtual location" is equivalent to a physical location for a meeting.

20.9 A virtual location includes a meeting link, meeting ID number, a meeting application and anything else required to enable and attend a meeting using virtual technology.

Special Meetings of Council *(Adopted, May 2025)*

20.10 A special meeting of Council is any meeting of Council for which the notice requirement of a regular meeting of these bylaws has not been met, including an emergency meeting.

20.11 Special meetings may be called by, or at the request of, the Chair or any three (3) members of Council.

20.12 Special meetings will be held at the CPSA offices unless the person(s) who call the special meeting designates an alternate place within the province and two-thirds (2/3) of the members of Council agree in writing to the location.

20.13 Notice of the time, date, agenda and location of a special meeting of Council shall be given to each member of Council not less than seven (7) days in advance of the meeting.

20.14 A special meeting may be held with less than seven (7) days' notice if two-thirds (2/3) of the voting members of Council agree to this in writing or by vote before the beginning of the meeting.

20.15 Special meetings shall be reserved for addressing specific time-sensitive matters which should not wait for a regular Council meeting.

20.16 For the purpose of this section, a "virtual location" is equivalent to a physical location for a meeting.

20.17 A virtual location includes a meeting link, meeting ID number, a meeting application and anything else required to enable and attend a meeting using virtual technology.

Other Meetings *(Adopted, May 2025)*

20.18 Council, or a subset of Council, may gather or meet for informal purposes to be determined from time to time, including, but not limited to, education, training, orientation, team building or discussion.

20.19 No decision of Council can be made at an "other" meeting, and no decision made at an "other" meeting of Council is binding on CPSA or any person.

Resolution in Writing *(Adopted, May 2025)*

20.20 Notwithstanding bylaw 18, Council may make a decision by way of a Resolution in Writing outside of a Council meeting if the Resolution in Writing is duly made and passed in accordance with the applicable policy established by the Council for the making and recording of such resolutions.

20.21 A Resolution in Writing may only be proposed where a resolution, in the opinion of the Chair:

a. will not require Council discussion, and

b. is time-sensitive and must be determined prior to the next scheduled meeting of Council.

20.22 If any voting member of Council objects to determining a matter by way of a Resolution in Writing, a special meeting of Council shall be called to determine the matter, or the matter shall be postponed to a regular meeting of Council.

Quorum *(Adopted, May 2025)*

20.23 Quorum for meetings of Council or Council Committees shall be one-half (1/2) of the current members of the Council or Committee. Where one-half (1/2) is not a whole number, quorum shall be taken as the whole number which is closest to and greater than one-half (1/2).

Conduct of Council Members *(Adopted, May 2025)*

20.24 Council members, when acting in their Council capacity, shall conduct themselves in accordance with the Council Code of Conduct.

Commented [JM8]: Point of Interest:

Brings a Council Code of Conduct into bylaws and tees up bylaw 16 which makes consistent violation of the Code a possible cause for removal from Council.

Head Office

21.1 The head office of the College is located in Edmonton, Alberta or at such other location as may be determined by the Council.

Registrar Repealed, May 2025

Registrar *(Adopted, May 2025)*

22.1 The person appointed to the Office of the Registrar, for the purposes of the HPA, shall also bear overall responsibility, authority and accountability to Council for all regulatory functions of CPSA, except where Council has retained responsibility and authority for itself under the HPA, these bylaws or in policy.

22.2 The Registrar may also be appointed as the Chief Executive Officer (CEO) of CPSA, subject to any conditions Council may establish in policy or by motion of Council.

22.3 The Registrar is the official spokesperson of CPSA, subject to any limitations Council may establish in policy.

22.4 On receipt of a complete application for registration, the Registrar must consider the application and make a decision in accordance with section 29 of the HPA.

22.5 On receipt of a complete application for renewal, the Registrar must consider the application and make a decision in accordance with section 38 of the HPA.

22.6 If the Registrar determines a regulated member has not complied with conditions imposed under section 40(2) of the HPA, the Registrar may cancel the regulated member's practice permit in accordance with section 43 of the HPA.

22.7 Council may delegate its authority to appoint inspectors under section 53.1 of the HPA to the Registrar.

22.8 The Registrar is designated by Council for the purposes of sections 65 and 86 of the HPA.

Acting Registrar *Repealed, May 2025*

Acting Registrar and CEO *(Adopted, May 2025)*

23.1 The Registrar may appoint an Acting Registrar for a period not to exceed thirty (30) days, subject to conditions the Registrar may impose, when the Registrar is absent or otherwise unavailable to act.

Commented [JM9]: Point of Interest

This is new and codifies rules for people in these critical Acting roles.

a. The Registrar retains ultimate authority, responsibility and accountability during the period.

23.2 The CEO may appoint an Acting CEO for a period not to exceed thirty (30) days, subject to conditions the CEO may impose, when the CEO is absent or otherwise unavailable to act.

a. The CEO retains ultimate authority, responsibility, and accountability during the period.

23.3 Council shall appoint an Acting Registrar, Acting CEO or both for any periods exceeding thirty (30) days or will appoint an Interim Registrar or CEO when the Registrar and/or CEO is unable to retain authority, responsibility and accountability for any reason.

23.4 A person who is Acting Registrar or Acting CEO cannot name a person to act in their absence.

Appointment of Complaints Director and Hearings Director *(Adopted, May 2025)*

23.5 The Registrar shall appoint one person as the Complaints Director and one person as a Hearings Director, for the purposes of the Act, and shall report the appointments to Council.

a. The Complaints Director and Hearing Director appointments must be held by separate individuals.

23.6 The Complaints Director may appoint an Acting Complaints Director, and the Hearings Director may appoint an Acting Hearings Director, for a period not to exceed thirty (30) days, when the Complaints Director or Hearings Director is absent or otherwise unavailable to act, subject to conditions the Registrar may impose.

23.7 A person who is Acting Complaints Director or Acting Hearings Director cannot name a person to act in their absence.

Fees, Charges and Levies

24.1 The fees, charges and levies of the College shall be determined by resolution of Council.

Fiscal Year

25.1 The fiscal year of the College commences January 1 and ends the following December 31.

Auditors

26.1 Council shall appoint one or more chartered accountants registered in the Province of Alberta as auditor for the College.

26.2 The Auditor shall, at least once each year, examine the accounts, books, and securities of the College, and provide a written report to the Council.

26.3 The Registrar shall publish annually a copy of the audited financial statements.

Money on Deposits

27.1 All funds of the College shall be deposited in the banking institution designated by the Registrar.

27.2 The Registrar shall designate the individuals authorized to withdraw and pay out the funds of the College.

Investments

28.1 Investments made by the College shall be made in the name of the College of Physicians & Surgeons of Alberta.

28.2 Council shall establish an investment policy and amend it from time to time.

PART 2 - REGISTERS AND REGISTRATION OF REGULATED MEMBERS

Practice Permits *Repealed, May 2025*

Practice Permit Effective Date and Renewal Deadline *(Adopted, May 2025)*

29.1 For the purpose of this section, "permit year" means the annual period for which a practice permit is active.

29.2 A practice permit;

a. is effective on January 1 or the actual date that it is issued, whichever is later, and
b. expires on December 31 following the date of issue.

29.3 Regulated members must submit a complete application for renewal of their registration and practice permit for the coming calendar year, including payment of any applicable fees and levies, before 11:59 pm Mountain Standard Time, on December 31.

Recognition of Regulated Professionals Registered in Other Jurisdictions
(Adopted, May 2025)

29.4 For the purposes of section 4 of the Regulations, an applicant may provide evidence of competence in the practice of the profession by being registered as an active, regulated, practicing physician, surgeon, osteopath or physician assistant in a province or territory of Canada, or from a jurisdiction outside of Canada that is approved by the Council and named in Schedule 1 of these bylaws.

29.5 For greater clarity, the term "regulated' in this section means the professional practice of the applicant is:

a. governed by legislation enacted by the provincial, territorial, state, or other legislative body, and

b. is subject to oversight by a regulatory body that is responsible for establishing, maintaining and enforcing registration, competence and practice standards substantially similar to those established in the HPA.

29.6 Applicants from a Canadian jurisdiction who meet the requirements of this section shall have their qualifications assessed in accordance with Chapter 7 ("Labour Mobility") of the *Canadian Free Trade Agreement*[‡‡] (CFTA), while meeting the applicable requirements of the HPA.

a. For the purposes of Article 705, paragraph 4(b) of Chapter 7, practice currency will be considered and addressed in a manner that is consistent with the Regulations and CPSA's typical currency requirements.

29.7 For applicants from a Canadian jurisdiction, the Registrar may assess the equivalency of a practice limitation, restriction or condition in accordance with Chapter 7 of the CFTA and apply an equivalent practice limitation, restriction or condition or refuse to register an applicant, as long as the assessment and outcome conform to Chapter 7 of the CFTA, Article 13 (Labour Mobility) of the New West Partnership Trade Agreement[§§], and the HPA.

29.8 Applicants from a jurisdiction listed in Schedule 1 of these bylaws will have their qualifications assessed according to the HPA and applicable policy established by the Registrar, as published on the CPSA website.

[‡‡] The *Canadian Free Trade Agreement* (July 1, 2017).

[§§] The New West Partnership Trade Agreement.

Providing Information *Repealed, May 2025*

Information in Registers *(Adopted, May 2025)*

30.1 For the purposes of this section, "custodian" is defined as a regulated member who is designated as a custodian under the *Health Information Act*[***] (HIA) and *Health Information Regulation*[†††].

30.2 The Registrar may enter the following information for each regulated member into the appropriate category of register:

a. under Part 4 of the HPA, whether the regulated member is the subject of:

i. an ongoing investigation under Division 3,

ii. a hearing under Division 4, or

iii. an Appeal under Division 5.

b. whether the regulated member has been found guilty of unprofessional conduct, or has agreed that their conduct was unprofessional, within the prior five (5)-year period, unless a different period of time is specified in the HPA.

30.3 In addition to any other information required by the HPA or Regulations, all regulated members and applicants must provide the following information to the Registrar:

a. identification and demographics:

i. their full legal and, if applicable, any previous names or relevant aliases,

ii. preferred name, if they practice under a name that is not their legal name,

iii. proof of legal name change, if their name is changed or does not match records submitted to CPSA,

iv. date of birth, and

v. gender,

b. contact information:

i. a home address,

[***] Province of Alberta's *Health Information Act* (Dec. 20, 2024).

[†††] Province of Alberta's *Health Information Regulation* (Dec. 20, 2024).

ii. a mailing address for the purpose of receiving confidential correspondence and notices,

iii. an email address for the purpose of receiving confidential electronic correspondence and notices,

iv. a phone number at which they can be reached during business hours, and

v. emergency contact information, including a phone number, address, and email address,

c. proof of education, training, and experience acceptable to the Registrar, including:

i. qualifying degrees and other relevant qualifications earned, including specializations,

ii. the name of institutions that granted all qualifying degrees and the countries in which the institutions were located,

iii. the years in which degrees were granted,

d. information on their regulated professional practice including:

i. all business or employer addresses and phone numbers,

ii. addresses and facility/clinic names for all practice locations,

iii. areas of practice,

iv. specializations,

v. names of all supervisors, if applicable,

vi. languages in which they can or do provide professional services,

vii. a listing of any services provided or proposed to be provided that require approval under these bylaws or the *Standards of Practice*,

viii. if the regulated member is custodian of patient records, the name of a designated successor custodian for the purposes of the applicable *Standards of Practice* and the HIA,

ix. in the case of a physician, surgeon or osteopath, the name and business mailing address of any physician assistant the member is supervising,

x. in the case of a physician assistant, the name and business mailing address of the supervising physician, surgeon or osteopath,

e. any other jurisdictions outside of Alberta in which the member or an applicant is registered or has been registered, and whether the member

or the applicant continues to practice in those jurisdictions, and

f. any other regulated health profession in which the regulated member or applicant is registered and whether they are a practising member of that profession.

30.4 The Registrar will remove information from a register when CPSA has no legal or business reason to retain the information, or when the Registrar is satisfied that the information is incorrect.

Disclosure of Register Information *(Adopted, May 2025)*

30.5 CPSA will disclose the information of each regulated member that is required by the Act and Regulations by publishing it on the CPSA website.

30.6 In addition to the disclosure of information required by the HPA and Regulations, the following information for each regulated member may be published on the CPSA website:

a. gender,

b. languages in which the regulated member can or does practice, and

c. a listing of relevant qualifications, including degrees earned and the year(s) when qualifications were earned.

30.7 The following information for each regulated member must be published on the CPSA website:

a. information respecting a complaint and ratified settlement in accordance with the Alternative Complaints Resolution Process (HPA sections 58 to 60), when agreed to in the settlement,

b. the date of any upcoming hearings or appeals applicable to the regulated member,

c. any decision, order or direction made under Part 4, Division 4 (Hearings and Decisions) and Division 5 (Appeals) of the Act, including written decisions issued by a hearing tribunal or Council with respect to any matter,

   i. the Registrar may publish a redacted version of a decision when redaction is necessary under the HIA or *Personal Information Protection Act*, and

d. any direction made pursuant to section 118(4) of the HPA (assessing incapacity).

30.8 Information about a regulated member published in accordance with the HPA and this section will remain available on the CPSA website for as long they

are a regulated member plus two (2) years after the date their registration is cancelled.

30.9 Notwithstanding bylaw 40.4, the following rules apply to publication of register information;

a. Information will be published for a different period if required by the HPA.
b. If the regulated member's registration and practice permit have been cancelled under section 82 of the HPA (Order of Tribunal) or through a finding of unprofessional conduct by appeal to Council or the Court, the information will be published indefinitely,
c. If the regulated member receives any order other cancellation, under section 82 of the HPA (Order of Tribunal) or through a finding of unprofessional conduct by appeal to Council or the Court, the information will be published for 10 years from the date of the order or finding, or
d. If the regulated member is the subject of a complaint, investigation, discipline, or appeal process under Part 4 of the HPA (Professional Conduct), the information will be published while the process is underway.

Decision on Application *(Adopted, May 2025)*

30.10 Under Part 2 of the Act, the Registrar shall determine any decision on the:

a. approval,
b. deferral,
c. refusal,
d. suspension,
e. cancellation,
f. reinstatement,
g. renewal, or
h. conditions.

Good Character and Reputation *Repealed, May 2025*

Good Character and Reputation *(Adopted, May 2025)*

31.1 All applicants applying for registration, and all regulated members at renewal or upon request by the Registrar, must provide evidence of having good character and reputation.

31.2 Pursuant to section 29.1(1)(e) of the HPA, the Registrar may request any or all of the following as evidence of good character and reputation:

a. graduation from a medical program or physician assistant program without any academic misconduct finding reported on university records,

b. a clear criminal record check,

c. a positive reference from a colleague, supervisor, professor or other qualified individual,

d. a letter of good standing or similar record from another professional regulatory body,

e. whether they have pled guilty, pled no contest, or been found guilty of a criminal offence for which they have not been pardoned,

f. whether they have been charged with a criminal offence that is currently outstanding,

g. whether they have had a negligence claim made against them, been sued for negligence, had a negligence claim paid on their behalf or paid a negligence claim, or

h. evidence satisfactory to the Registrar that the applicant or regulated member has remediated their character and reputation if any of the preceding or any information provided under the HPA has indicated an absence of good character and reputation.

Reinstatement of Registration *(Adopted, May 2025)*

31.3 A former regulated member whose registration was cancelled under the HPA, except for cancellation under Part 4 of the HPA, may make application to the Registrar for their registration to be reinstated and their practice permit reissued.

31.4 In accordance with Part 2 of the HPA, the process and requirements for reinstatement are the same as the process and requirements for application and registration, except for the following:

a. the former member must indicate their prior registration number on the application form,

b. if the member owed any outstanding amounts to CPSA at the time of their cancellation, except for a renewal amount that was not paid, the outstanding amounts must be paid in full,

c. if the former member has a prior decision of a hearing tribunal on their record with CPSA, evidence satisfactory to the Registrar that all orders of the hearing tribunal have been complied with or satisfied, and

d. if the former member had conditions on their registration or practice permit when it was cancelled, evidence that they have complied with the conditions, or if they have not yet complied, acknowledgement that they will comply with the conditions within a specified time upon reinstatement.

31.5 At the discretion of the Registrar, if CPSA has records on file for the former member that are current enough to fulfill their purpose, the above documents may not have to be resubmitted.

Liability Insurance *Repealed, May 2025*

Professional Liability Insurance *(Adopted, May 2025)*

32.1 All applicants applying for registration, unless exempted in a policy of Council, and all regulated members at renewal or upon request by the Registrar, must provide evidence satisfactory to the Registrar that:

a. they hold, and continue to hold, professional liability insurance that extends to all areas of the member's practice, including any vicarious liability of the member as a result of the conduct of the member's employee or agent, and

b. through a policy issued by a company licensed to carry on business in the province that provides coverage of at least $10,000,000.00 per occurrence.

32.2 Bylaw 44.1 does not apply to a regulated member who is on a Student Register of CPSA and who is not performing medical services outside the member's educational program.

32.3 Membership in the Canadian Medical Protective Association is considered to meet the requirements of this section.

Fitness to Practice

33.1 A regulated member making an application under Bylaw 29.3 must, on the request of the Registrar, submit evidence satisfactory to the Registrar confirming the member's fitness to practice.

English language requirements *Repealed, May 2025*

English Language Proficiency *(Adopted, May 2025)*

34.1 All applicants, unless exempted in policy established by the Registrar, must provide evidence that they are sufficiently proficient in the English language to provide professional services in English.

34.2 Evidence of proficiency is established by achieving an acceptable score on an approved English language proficiency exam within twenty-four (24) months of submitting an application to CPSA, as follows:

a. International English Language Testing System (IELTS) Academic[‡‡‡] – achieving a minimum score of 7.0 in each of the four (4) components in a single report,

b. Occupational English Test (OET)[§§§] – achieving a minimum grade of B in each component in a single test, or

c. Canadian English Language Proficiency Index Program (CELPIP) General test[****] – achieving a minimum score of nine (9) in each component in a single test.

34.3 A policy established by the Registrar under bylaw 45.1 may include exemptions based on:

a. alternative means of demonstrating English language proficiency that the Registrar deems to be substantially equivalent to achieving a minimum score on an approved exam, or

b. practice situations for particular categories of registration where a different measure of proficiency in the English language is more appropriate to the circumstances and does not present a significant risk to patient care.

Limited Liability Partnership

35.1 Regulated members or professional corporations are not permitted to enter into a limited liability partnership for the practice of medicine or osteopathy.

Retired Members

36.1 The Retired Member Register includes the names of those former regulated members who:

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‡‡‡ International English Language Testing System (IELTS).

§§§ Occupational English Test (OET).

**** Canadian English Language Proficiency Index Program (CELPIP).

a. have retired from the practice of medicine, and
b. were in good standing with the College on the date of retirement.

36.2 Each applicant for registration as a retired member must notify the College in writing of the effective date of retirement.

36.3 A retired member shall not practice medicine in Alberta.

Professional Corporation Application *Repealed, May 2025*

Application for Approval *(Adopted, May 2025)*

37.1 A regulated member who files an application for approval of the articles of a proposed professional corporation under section 108 of the HPA shall provide to the Registrar:

a. an application in the form determined by the Registrar,

b. a copy of the proposed articles of incorporation, which must include restriction and provision clauses acceptable to the Registrar,

c. the name of the proposed professional corporation, which must comply with rules for the naming of professional corporations set out in bylaw 48,

d. the business and mailing addresses of the corporation,

e. the legal names and contact information, including email and home addresses, of all voting and non-voting shareholders,

f. a listing of all directors who are regulated members,

g. evidence satisfactory to the Registrar that the corporation complies with sections 109(1)(a) through (f) of the HPA, and

h. other information of an administrative nature required by the Registrar for the expedient processing of the application.

Decision on Application for Approval *(Adopted, May 2025)*

37.2 The Registrar must, as soon as reasonably possible, on receipt of an application for approval of a professional corporation, give notice to the applicant that the application:

a. has been received,

b. whether it is complete or, if it is not complete,

c. what is required to make it complete.

37.3 On receipt of a complete application, the Registrar must consider the application and:

a. approve the articles of the professional corporation,

b. defer the approval if, in the opinion of the Registrar, it is in the best interests of the public to defer the approval until the applicant complies with a direction given by the Registrar, or

c. refuse the application for approval.

Professional Corporation Annual Permit *Repealed, May 2025*

Application for Registration and Issuing an Annual Permit *(Adopted, May 2025)*

38.1 Upon receipt of an application for registration of a professional corporation under section 109 of the HPA, the Registrar must consider the application in accordance with the HPA.

38.2 An annual permit issued by the Registrar under sections 109 or 110 of the HPA:

a. is effective on January 1 or the actual date that it is issued, whichever is later, and

b. expires on December 31 following the date of issue.

Renewal of Professional Corporation Annual Permit *Repealed, May 2025*

Renewal of Annual Permit *(Adopted, May 2025)*

39.1 A professional corporation applying for renewal of its registration and practice permit shall provide to the Registrar:

a. an application in the form determined by the Registrar,

b. evidence satisfactory to the Registrar that the corporation continues to comply with section 109(1)(a) through (f) of the HPA, and

c. other information of an administrative nature required by the Registrar for the expedient processing of the application.

39.2 A professional corporation must submit a complete application for renewal of their registration and annual permit for the coming calendar year, including payment of any applicable fees and levies, before 11:59 pm Mountain Standard Time on December 31.

a. The Registrar will provide a professional corporation notice sixty (60) days prior to the renewal deadline.

Professional Corporation Records *Repealed, May 2025*

Record of Professional Corporations *(Adopted, May 2025)*

40.1 In addition to the requirements of sections 113(1)(a) through (c) of the HPA, the Registrar shall keep and maintain the following information in the record of professional corporations:

a. the business and mailing addresses of the corporation,

b. the legal names and contact information, including email and home addresses, of all voting shareholders,

c. a listing of all directors who are regulated members,

d. the number and type of shares held by a shareholder, and

e. information on expiry or cancellation of the annual permit in accordance with section 114(5) of the HPA.

40.2 The Registrar may remove information from the record of professional corporations when CPSA has no legal or business reason to retain the information, or when the Registrar is satisfied that the information is incorrect.

Notice of Change in Organization *(Adopted, May 2025)*

40.3 The Registrar shall determine the form of notice required by professional corporations making any change in the ownership, directors, or name of the professional corporation in accordance with section 112 of the HPA.

40.4 The required form of notice will be published on the CPSA website and available to all professional corporations.

Disclosure of Information on the Record of Professional Corporations

(Adopted, May 2025)

40.5 In addition to the disclosure of information required by the HPA, the Registrar shall publish a list of active medical professional corporations in Alberta on the CPSA website.

40.6 The list will include, as a minimum, the business name of each professional corporation that holds an annual permit on the date the list is generated.

Cancelled or Expired Annual Permits *(Adopted, May 2025)*

40.7 Pursuant to sections 115(1) and (3) of the HPA, the Registrar may provide any other information that the Registrar, in their sole discretion, deems relevant to the registrar of corporations.

Professional Corporation Names *Repealed, May 2025*

Naming of a Professional Corporation *(Adopted, May 2025)*

41.1 Subject to section 10 of the *Business Corporations Act* and approval by the Registrar, the name of a professional corporation shall contain only the surname, or the surname and any combination of the given names or initials, of one or more regulated members of CPSA who are shareholders of the corporation followed by "Professional" and "Corporation" and an appropriate descriptive term such as "medical" or "surgical."

41.2 Except as provided in this section, a professional corporation shall carry on the practice of medicine under its corporate name.

41.3 A professional corporation may carry on the practice of medicine in partnership under a firm name that does not contain its full corporate name if approved by the Registrar.

41.4 The full corporate name of each professional corporation that is a member of a partnership for the practice of medicine shall be shown on the letterhead and any advertisement used by that partnership.

Professional Corporation Reissue after Revocation *Repealed, May 2025*

Reinstatement of Cancelled or Expired Annual Permits and Registrations *(Adopted, May 2025)*

42.1 A professional corporation whose registration or annual permit was cancelled under the HPA may make application to the Registrar for their registration to be reinstated and their annual permit reissued.

42.2 The process and requirements for reinstatement are the same as the process and requirements for application and registration, except for the following:

a. the former professional corporation must indicate their prior registration number on the application form, and

b. at the discretion of the Registrar, if CPSA has records on file for the former professional corporation that are current enough to fulfill their purpose, such documents may not have to be resubmitted.

PART 3 - RECORDS

Seal

43.1 The Registrar shall:

- a. have custody of the seal of the College; and
- b. affix the seal to all documents requiring the seal.

43.2 Council may amend the design of the seal.

Documents, Records and Forms

44.1 The Registrar is authorized to determine such forms, certificates, permits or other documents that may be required for the purposes of the Act, the Regulations and these Bylaws.

44.2 All deeds, mortgages, securities, documents or other papers not in current use in the Registrar's office shall be retained in safe keeping as determined by the Registrar.

44.3 Subject to any enactment of Alberta or Canada, the Registrar is authorized to prescribe the record retention period for all records, provided all legal requirements are met.

44.4 For the purpose of Bylaw 44(3), “records” shall mean the physical representation or recording of any information, data or other thing that is capable of being represented or reproduced visually or by sound, or by both.

Notices

45.1 Unless otherwise required under an enactment of Alberta or Canada, any notice or document that may be given or required to be given under the Act or these Bylaws may be given by:

- a. mail,
- b. electronic mail,
- c. fax,
- d. posting on the website of the College, or
- e. any other means that may be available for transmission provided such means is as reliable as any of the other means set out in this Bylaw.

Use of Electronic Documentation

46.1 Unless otherwise specified, a requirement for a signature in these bylaws may be satisfied by an electronic signature that reliably identifies the person signing.

46.2 Unless otherwise specified, a requirement for "writing" or "written" in these Bylaws may be satisfied by electronic form of such requirement.

46.3 A reference in these Bylaws to an item being made available to a person, in addition to being made available in paper format, includes availability by way of:

a. the website of the College;

b. an electronic interface hosted by the College or an agent of the College; or

c. electronic mail.

Removal of Information *Repealed, May 2025*

PART 4 - COMMUNICATION WITH THE PUBLIC

Publication of Ratified Settlement

48.1 For the purpose of section 60 of the Act, and subject to the terms of a ratified settlement, the Registrar may publish information regarding the ratified settlement.

Publication *Repealed, May 2025*

PART 5 – COLLEGE ACCREDITATION PROGRAMS

Section A – Medical Facilities

Accreditation of Medical Facilities

50.1 For the purposes of this section, the definitions set out in section 8 of Schedule 21 of the Act shall apply.

50.2 For the purpose of the Health Facilities Act, major surgical services are those that, in the opinion of the Council, may be performed only in a public hospital because there is a significant risk inherent in the procedure or by reason of the pre-operative condition of the patient.

50.3 For the purpose of the Health Facilities Act, specific surgical services which may be performed only in a public hospital and which shall not be conducted in a medical facility include:

a. procedures under general anesthetic on patients less than eighteen months of age;

b. procedures on the contents of the retroperitoneal space;

c. procedures on the contents of the cranium;

d. procedures on the contents of the thorax; and

e. any procedure lacking the approval of the accreditation committee for that medical facility.

50.4 For the purpose of the Health Facilities Act, minor surgical procedures are those which may be performed in a physician's general office.

50.5 In this section and for the purposes of section 8(g) of Schedule 21 of the Act "prescribed health service" includes:

a. diagnostic imaging services; except for unaccredited point-of-care ultrasound[††††] on a physician's own patient;

[††††] Point of Care Ultrasound (POCUS) can be an invaluable ultrasound examination provided in various settings or facilities that are performed at the point of care. The intent of the study is to clarify uncertain findings of the physical exam, identify important conditions in the context of acute care of the unwell patient, or provide image guidance that improves the success and safety of procedures in the acute care setting, particularly when time saving for diagnosis or treatment is critical. POCUS evaluations are limited to the scope of exam types included in the training of those individuals performing the exam. If a POCUS provider extends scanning beyond the scope of their usual practice pattern, education and experience, the likelihood of medical misadventure may cause a potential detrimental effect on diagnosis, treatment and patient care and is therefore to be avoided. Patients on whom POCUS is performed should be informed of the limited scope of a POCUS examination, and be advised that a POCUS exam does not compare to, or replace a consultative diagnostic examination.

Consultative Diagnostic Ultrasound aims to systematically map out normal and disordered anatomy, assess function and dysfunction in the body and/or provide guidance for a wide range of interventional procedures. Necessary components for a consultative sonographic exam include: 1) a professional mastery of the imaging technology (as

b. psychedelic assisted psychotherapy;

c. medical laboratory services, except for unaccredited point-of-care testing on a physician's own patient;

d. pulmonary function testing, except for unaccredited peak flow measurement or vitalometry on a physician's own patient;

e. neurophysiologic diagnostic services;

f. sleep medicine diagnostic services;

g. vestibular diagnostic testing;

h. the use of drugs which are intended or which may induce general anaesthesia or sedation requiring the monitoring of vital signs, including all uses of intravenously administered sedatives or narcotics, except in emergency circumstances;

i. the use of drugs by injection which are intended or may induce a major nerve block, or spinal, epidural, or intravenous regional block;

j. surgical and diagnostic procedures with risk of bleeding from major vessels, gas embolism, perforation of internal organs and other life-threatening complications or requiring sterile precautions to prevent blood-borne, deep, closed cavity or implant-related infections;

k. Hyperbaric oxygen therapy,

l. Cardiac exercise stress testing,

m. Hemodialysis, and

n. the following surgical and endoscopic procedures:

(i) Dermatologic

1) Liposuction to a maximum of five (5) litres total aspirate;

2) Lipolysis by percutaneous application of any form of energy;

3) Mohs micrographic surgery.

(ii) General Surgical

evidenced by Ultrasound Modality approval by the College), 2) a systematic approach that results in a thorough diagnostic imaging assessment of the patient to include image recording, and 3) an interpretation of the exam provided in a well-documented and recorded report of the findings and conclusions – all performed in a College accredited facility. There is robust quality control and assurance around image recording, retention, disaster and back up recovery, report generation, transcription, physician report validation, report audits, equipment preventative maintenance, and confirmation of appropriate regulatory body sonologist credentialing and approvals.

1) Upper gastrointestinal endoscopy with or without biopsy,

2) Colonoscopy with or without biopsy or minor polypectomy,

3) Simple mastectomy,

4) Segmental resection of breast and sentinel node biopsy,

5) Resection of large or deep soft tissue lesions,

6) Deep lymph node biopsies – up to but not including full axillary dissection,

7) Inguinal hernia repair, including femoral,

8) Minor abdominal wall hernia repair, including umbilical hernia repair,

9) Varicose vein ligation and stripping,

10) Hemorrhoidectomy beyond simple single excision,

11) Trans-anal excision of rectal polyps,

12) Laparoscopic procedures,

   a. Diagnostic,

   b. Biopsies – peritoneal,

   c. Laparoscopic Adjustable Gastric Band procedures (insertion or removal).

13) Endovenous ablation (including, but not limited to, laser ablation, radio frequency ablation, mechano-chemical ablation).

14) Procedures limited to facilities approved for extended stay – as per the Standards for Non-Hospital Surgical Facility Accreditation: Bariatric Surgery

   a. Laparoscopic Sleeve Gastrectomy

   b. Laparoscopic Roux-en-Y Bypass (RYGB)

   c. Laparoscopic Single Anastomosis Duodenal–Ileal (SADI)

(iii) Gynecologic

1) Perineoplasty not requiring extensive dissection,

2) Marsupialization of Bartholin cysts,

3) Cervical, vaginal and vulvar polypectomy and biopsy with risk of bleeding requiring surgical control,

4) Dilatation and curettage of uterus,

5) Trans-cervical global endometrial ablation procedures except those performed by resection or by electrocautery that does not have impedance regulation,

6) Cystoscopy,

7) Minimally invasive incontinence procedures: injectables, percutaneous slings,

8) Laparoscopy with minor surgical interventions:

a. Diagnostic,
b. Tubal sterilization,
c. Aspiration of cysts,
d. Minor adhesiolysis,
e. Diathermy for endometriosis (AFS Stages I and II),
f. Abortions – as per the general Non-hospital Surgical Facilities Standards and Guidelines and the Supplementary Standards for the Termination of Pregnancy.

9) Oocyte retrieval,

10) Tumescent anterior and posterior vaginal repair,

11) Hysteroscopic tubal sterilization,

12) Laparoscopy with minor surgical interventions:

a. Ovarian Biopsy,*[‡‡‡‡]

13) Transvaginal ovarian cyst aspiration,*

14) Embryo Transfer,*

15) In Vitro Fertilization.*

(iv) Ophthalmologic

1) Intra-ocular surgery requiring dissection of the tissues of the globe including procedures on:

g. the cornea (including ring segment implants, keratotomies, LASIK and corneal transplant),
h. the lens and implants,

[‡‡‡‡] * Denotes inclusion in an ART program

i. the iris,
j. the sclera,
k. the vitreous.

2) Eyelid procedures requiring implants or dissection of the orbital septum or beyond,

3) Lacrimal procedures requiring incision into the nasal passages.

4) Orbital and socket procedures not associated with risk of intracranial or neurovascular complications, including:

a. orbital tumor excision,
b. insertion of an implant,
c. enucleation/evisceration with or without implant
d. socket reconstruction requiring implant, transplant or exposure of bone.
e. [Note: Minor anterior orbital procedures are considered office procedures.]

5) Strabismus procedures,

6) Rheopheresis for patients enrolled in a research study approved by a research ethics review body acceptable to the College.

(v) Orthopedic

1) Arthroscopy

a. diagnostic,
b. repair and reconstruction of ligaments,
c. meniscectomy, meniscal repair and arthroplasty,
d. excision meniscal cysts, loose bodies and foreign bodies.

2) Amputation

a. finger through MCP or IP joints, hand,
b. toe – through TP or IP joints foot,
c. single ray amputation hand or foot.

3) Arthrodesis

a. hand and wrist,
b. foot and ankle.

4) Arthroplasties

a. acromio-clavicular and sterno-clavicular joints,
b. radial head arthroplasty,
c. wrist and hand joints,
d. foot.

5) Osteotomies

   a. hand/wrist/foot/ankle.

6) Ligament repair

   a. shoulder,
   b. elbow,
   c. wrist,
   d. hand,
   e. knee,
   f. ankle and foot.

7) Tendon or muscle repair or transplant or transfer

   a. transfers repairs and transplants at or distal to elbow or knee,
   b. decompression/repair rotator cuff at shoulder.

8) Fascia or tendon sheath

   a. plantar fasciotomy or fasciectomy of hand or foot,
   b. release or excision Dupuytren's contracture,
   c. excision of minor hand tumors including ganglions
   d. carpal tunnel release,
   e. excision tendon sheaths: wrist, forearm or hand.

9) Arthrotomy or synovectomy

   a. shoulder,
   b. elbow,
   c. wrist and hand,
   d. knee,
   e. ankle and foot,
   f. excision Baker's cyst.

10) Excision of bursa or ganglia

11) Musculoskeletal tumors

   a. biopsy of peripheral tumors,
   b. needle biopsy only of tumors of the spine,
   c. excision of minor tumors.

12) Dislocations

   a. open reduction acromio-clavicular joint,
   b. closed or open reduction of joints of upper extremity,
   c. closed reduction of dislocated total hip,
   d. closed or open reduction of patello-femoral joint,
   e. closed or open reduction of ankle, hindfoot, midfoot or forefoot.

13) Fractures

a. closed and open reduction clavicle, humerus, radius/ulna, wrist and hand,
b. closed reduction of scapula,
c. closed and open reduction of patella, fibula, ankle and foot,
d. closed reduction of tibia.

14) Others

a. single level lumbar discectomy and/or decompression – uncomplicated,
b. procedures listed under podiatric surgery,
c. removal of hardware including plates, pins, screws, nails and wires,
d. peripheral nerve surgery – repairs, decompression or grafts
e. saucerization,
f. sequestrectomy,
g. joint manipulation under general anesthesia or intravenous sedation,
h. harvesting of bone graft,
i. microdiscectomy,
j. minimally invasive lateral recess and central decompression – 3 levels or less,
k. minimally invasive lumbar foraminotomy (with or without central stenosis),
l. Posterior minimally invasive foraminotomy (or laminoforaminotomy),
m. posterior minimally invasive laminotomy for decompression of focal cervical canal stenosis – 2 levels or less.

15) Procedures limited to facilities approved for extended stay

a. hip arthrotomy and primary arthroplasty (including total joint replacement),
b. conversion of partial hip arthroplasty to total hip arthroplasty,
c. knee arthrotomy and primary arthroplasty – (including total joint replacement),
d. tibial osteotomy,
e. shoulder arthrotomy and primary arthroplasty – (including total joint replacement),
f. lumbar posterior spinal fusion – not exceeding two disc-space levels,
g. lumbar spinal laminectomy – not exceeding two disc- space levels,
h. ankle arthrotomy and primary arthroplasty (including total joint replacement),
i. below knee amputation,
j. anterior cervical discectomy two levels or less.

(vi) Otolaryngologic

a. deep*[§§§§] biopsy of the nasopharynx,
b. deep excision of intraoral papilloma,
c. major* excision of lip, nasal, ear or neck lesions,
d. lip shave procedures,
e. major partial glossectomy limited to anterior 2/3 of tongue,
f. adenoidectomy,
g. rigid laryngoscopy,
h. rigid trans-oral nasopharyngoscopy,
i. complete esophagoscopy – flexible only,
j. complete bronchoscopy – flexible only,
k. Caldwell Luc procedure,
l. intranasal antrostomy,
m. intranasal complete ethmoidectomy,
n. turbinate resection,
o. sphenoidotomy,
p. nasal septum reconstruction,
q. nasal septum submucous resection,
r. nasal polypectomy in conjunction with complete ethmoidectomy,
s. rhinoplasty,
t. complicated* nasal fractures,
u. biopsies of the parotid beyond needle aspiration or sampling the tail of the gland,
v. excision of submandibular gland,
w. excision of sublingual gland,
x. otoplasty,
y. complicated myringoplasty,
z. dissection of neck beyond the platysma muscle,
aa. deep cervical node biopsy,
bb. endoscopic soft-tissue surgery.
cc. Canalplasty
dd. Type 1 Tympanoplasty with Autologous Graft
ee. Tympanoplasty
ff. Myringoplasty
gg. Type 1 Tympanoplasty with Non-Autologous Material
hh. Parotidectomy Surgery (Non-Cancer)
ii. Submandibular Gland Resection (Non-Cancer)
jj. Hemithyroidectomy
kk. Parathyroidectomy
ll. Functional Endoscopic Sinus Surgery

(vii) Plastic

1) Skin and subcutaneous

[§§§§] The terms "deep", "major", and "complicated" refer to procedures that may require more resources than are commonly available in a medical office. Surgeons should make decisions as to the appropriate location for these surgical procedures in accordance with the resources necessary for unexpected complications and with generally accepted standards of care in Alberta.

a. excision of deep tumors outside a body cavity requiring exposure of bone or isolation of vascular or nerve supply,
b. grafts, flaps, and tissue expansion where there is a minimal risk of major bleeding or third space fluid loss that may require replacement fluids,
c. liposuction to a maximum of 5 litres total aspirate,
d. lipolysis by percutaneous application of any form of energy,
e. lipectomy,
f. brachioplasty,
g. facial implants,
h. fat grafting,
i. thigh lift,
j. buttocks (gluteoplasty) lift.
k. labiaplasty.

2) Head and neck

a. grafts and flaps as above except where there is a significant risk of airway compromise requiring post- operative or overnight monitoring,
b. eyelids (blepharoplasty, ptosis repair, tarsorrhaphy, canthopexy, canthoplasty),
c. browlift, facelift (rhytidectomy), necklift,
d. nose (SMR, rhinoplasty, turbinectomy, reduction of fractures),
e. ears (otoplasty),
f. genioplasty.

3) Breast

a. deduction mammoplasty,
b. augmentation mammoplasty,
c. mastopexy,
d. mastectomy without chest wall, muscle or axillary node dissection,
e. capsulotomy and capsulectomy,
f. gynecomastia surgery,
g. reconstruction of breast or nipple.

4) Abdomen

a. repair of abdominal wall hernia,
b. abdominoplasty not requiring overnight monitoring of blood or third space fluid loss.

5) Others

a. tendon – repairs, transfers or grafts,
b. peripheral nerve – repairs, decompression or grafts,
c. muscle – flaps or repairs,

d. fascia – flaps, decompression or excision,
e. bone – biopsies, fusions, removal of hardware, excision of exostoses, amputations of digits or rays, open and closed reduction of hand fractures,
f. joints – arthrotomy, arthroscopy, arthrodesis, and reductions of hands, wrists, feet and TMJ,
g. minor treatment of surgical complications such as hematoma or wound separation.

(viii) Podiatric

1) amputation

a. single ray of the foot only.

2) arthrodesis of joints of the foot and ankle

a. Lisfranc's joint procedures.

3) arthroplasty of joints of the foot and ankle

a. foot procedures requiring significant exposure of the joint,
b. ankle procedures which do not require tibial or fibular osteotomy for exposure.

4) arthroscopy

a. ankle/subtalar joint/mid-tarsal joint.

5) fractures and dislocations

a. uncomplicated closed fractures and dislocations of the foot.

6) incision/excision/transfer/repair of tendons and ligaments

a. tendons and ligaments proximal to Lisfranc's joint but not of the rear-foot/leg via the interosseous route.

7) neoplasms

a. benign neoplasms of the cuneiforms,
b. benign neoplasms of soft tissues below deep fascia.

8) neurolysis/neurectomy,

a. deep nerves including and distal to the tarsal tunnel and proximal to Lisfranc's joint.

9) osteotomy of bones of the foot

a. osteotomy of the calcaneus, mid-tarsus and cuneiforms

(ix) Urologic

1) inguinal canal surgery,

2) open procedures on scrotal contents,

3) penile procedures up to but not including implants,

4) Minor urethral reconstruction, urethral fistula repair and distal hypospadius repair,

5) minimally invasive incontinence procedures, including injemtables and percutaneous slings,

6) cystoscopy and ureteroscopy with or without biopsy or minor manipulation of stones or obstruction,

7) percutaneous epididymal sperm aspiration,*[*****]

8) testicular sperm extraction,*

9) testis biopsies,*

10) rectal electroejaculation,*

11) varicocelectomy,*

12) vasoepididymostomy,*

13) vasovasostomy,*

14) Rezum®

(x) Other

1) adipose-derived stem/stromal cells (ADSC)

2) bone marrow aspirate concentrate (BMAC)

50.6 In addition to Bylaw 50(5), "prescribed health service" shall mean only those procedures which will safely allow the discharge of a patient from medical care in the accredited medical facility within 12 hours of completion of the surgical procedure by a regulated member unless the accredited medical facility is approved for extended stays.

50.7 An accredited medical facility shall have a designated medical director who is a regulated member in good standing with the College and with qualifications as set out in the accreditation standards. Notwithstanding, a medical laboratory that is operated by a regional health authority in Alberta may

[*****] Denotes inclusion in an ART program

designate a certified clinical laboratory doctoral scientist with the qualifications as set out in the accreditation standards as a medical director.

50.8 Upon application by a medical director of a medical facility, the Registrar may, subject to the accreditation standards, provide interim approval for the performance of any prescribed health service until the determination of the request by the accreditation committee.

50.9 The medical director of a medical facility shall pay or cause to be paid to the College those fees and expenses determined by the accreditation committee, which shall include:

a. an initial registration fee set by Council,

b. an annual renewal of registration fee set by Council, and

c. the actual cost of any initial or subsequent inspection of the medical facility, including all expenses incurred by the accreditation committee or its sub- committee for any assessment, inspection, or both.

50.10 Any accreditation granted by the accreditation committee under Section 8.3(2) of Schedule 21 of the Act shall expire effective 12:01 a.m. on February 1 following the date of accreditation unless the accreditation has been renewed in accordance with these bylaws.

50.11 The accreditation committee may, from time to time, appoint one or more of its members, consultants or both as a sub-committee with particular expertise in the services provided in a medical facility and delegate to that sub-committee the authority to conduct an assessment of an application for accreditation or renewal of accreditation of a medical facility or to conduct an inspection of a medical facility, or both and report thereafter to the accreditation committee.

50.12 There shall be paid to members of the accreditation committee, a sub-committee and any consultants retained by them such fees for attendance and such reasonable traveling expenses as may be fixed by Council.

50.13 The accreditation committee shall:

a. develop and direct regular reviews of the ownership and operation of any medical facility and the financial arrangements pertaining thereto,

b. ensure that the operation of a medical facility is in accordance with the accreditation standards,

c. confirm that the practice of medicine conducted in a medical facility and the financial arrangements pertaining thereto are in accordance with the code of ethics and standards of practice approved by the Council,

d. assess the adequacy of the design of the medical facility and the equipment utilized therein along with the standards of operation of the medical facility in providing medical services, including prescribed health services, to the public, and

e. assess the business and professional relationships between regulated members conducting the practice of medicine and the owners of the medical facility.

50.14 The accreditation committee shall determine the specific provisions of the accreditation standards which apply to a specific medical facility or class of medical facility.

50.15 As part of an assessment of an application for accreditation, an application for renewal of accreditation or ensuring the continuing compliance of a medical facility with existing accreditation, the accreditation committee shall determine whether the skill, knowledge and training of a specified regulated member is sufficient for that regulated member to perform a prescribed health service in the medical facility.

Responsibilities of a Medical Director of a Medical Facility

51.1 Subject to section 8.4 of Schedule 21 of the Act, the medical director of a medical facility which is the subject of an assessment or inspection by the accreditation committee shall co-operate fully, which shall include:

a. permitting assessors to enter the medical facility and inspect the premises and all diagnostic equipment located therein,

b. permitting the assessors to inspect all records pertaining to the provision of medical services, including prescribed health services, and providing copies of the same if so requested,

c. providing to the assessors information requested by them in respect of the provision of medical services, including prescribed health services, in the medical facility,

d. providing the information described in Bylaw 51(1)(C) in the form requested by the assessors,

e. providing requested samples or copies of any material, specimen, radiological image or product originating from the medical services, including prescribed health services, provided by the medical facility,

f. answering questions posed by the assessors as to procedures or standards of performance and if requested providing copies of records relating to procedures followed and standards of performance applied in the medical facility, and

g. providing requested copies of all documents and information relating to business arrangements involving the practice of medicine conducted in the medical facility, which shall include lease arrangements, management agreements, records of advertising and agreements for the provision of medical services, including prescribed health services.

51.2 A medical director must assess the educational background, qualifications and ongoing experience of regulated members and non-medical personnel assisting a regulated member in the provision of medical services, including prescribed health services, in the medical facility and authorize them to provide services within a specific clinical domain and/or individual clinical procedure(s) in the medical facility.

51.3 The accreditation committee may, with or without notice, suspend the accreditation or impose conditions on the accreditations of a medical facility if the medical director fails to co-operate fully with an assessment or inspection by the accreditation committee or its sub-committee appointed under Bylaw 50(15).

51.4 Any suspension or conditions imposed under Bylaw 51(3) shall be cancelled once the accreditation committee is satisfied that medical director has co-operated fully pursuant to Bylaw 51(1).

Section B – Accreditation Standards

Accreditation Standards

52.1 Despite Bylaws 7 and 8, the accreditation standards for accreditation of all medical facilities required under this section and section 8.1(1) of Schedule 21 of the Act are determined, and amended from time to time, by simple majority resolution of Council.

PART 6 – APPEALS

Delegation of Council Reviews and Appeals to a Review Panel

53.1 Council delegates its duty and authority to hear and determine:

a. a request for review under section 31 of the Act;
b. a request for a review under section 41 of the Act;
c. a request for a review under section 38 of the Regulations;
d. an appeal under section 87(1) of the Act;
e. an appeal under section 118(6) of the Act; and
f. an appeal under section 8.5 of Schedule 21 of the Act; to a panel (Review Panel) of the Council.

53.2 Any voting member of the Council whose participation would not be prevented by a conflict of interest or reasonable apprehension of bias may sit on a Review Panel.

53.3 An appeal or review for all matters other than an appeal under section 87(1) of the Act shall be heard by a Review Panel of four (4) voting members of Council as selected by the Hearings Director. At least two (2) of these four members shall be public members.

53.4 An appeal under section 87(1) of the Act shall be heard by a panel of four voting members of the Council as selected by the Hearings Director. At least two (2) of the four (4) members shall be public members.

53.5 A Review Panel shall select a chair from its members.

53.6 A Review Panel cannot delegate the duty or authority to conduct the review or appeal to any other person.

53.7 For the purposes of ensuring a timely and fair hearing, the Hearings Director may revoke the appointment of a member to a Review Panel which has not yet started to hear a review or appeal and appoint a replacement member of the Review Panel.

Filing Deadlines and Length of Submissions to the Review Panel

54.1 At least six (6) weeks before the date on which the appeal or review is set to be heard by the Review Panel, the appellant in an appeal or review must file with the Hearings Director one complete electronic copy in PDF format of

their written submissions and authorities for the Review Panel, and serve a copy on the respondent party to the appeal or review.

54.2 At least four (4) weeks before the date on which the appeal or review is set to be heard by the Review Panel, the respondent in an appeal or review must file with the Hearings Director one complete electronic copy in PDF format of their written submissions to the Review Panel or a letter of intention not to file written submissions; and serve one additional copy on the appellant party to the appeal or review.

54.3 A party may request the chair of the Panel, through the Hearings Director, that the Panel, with notice to all involved parties, to authorize a different date for the filing deadline.

54.4 Written submissions by the appellant and the respondent must:

a. be formatted using at least 12-point font, one-inch margins, and at least 1.5 line spacing, except for quotations; and

b. not exceed 30 single-sided pages in length.

55.5 A book of authorities is not limited to a specific number of pages, but the parties shall ensure that only relevant portions of any case authorities are reproduced and relevant passages are highlighted.

55.6 A party may request the chair of the Panel, through the Hearings Director that the Panel, with notice to all involved parties, to authorize written submissions in excess of the 30- page limit.

55.7 Oral argument must not exceed 60 minutes for each party in the appeal or review.

55.8 A party may request, in advance of the date of the appeal or review, to the Chair of the Panel, through the Hearings Director, that the Panel, with notice to all involved parties, authorize oral submissions in excess of the 60-minute limit.