MD Dialogue
December 2008
The College of Physicians and Surgeons of Ontario
www.cpso.on.ca

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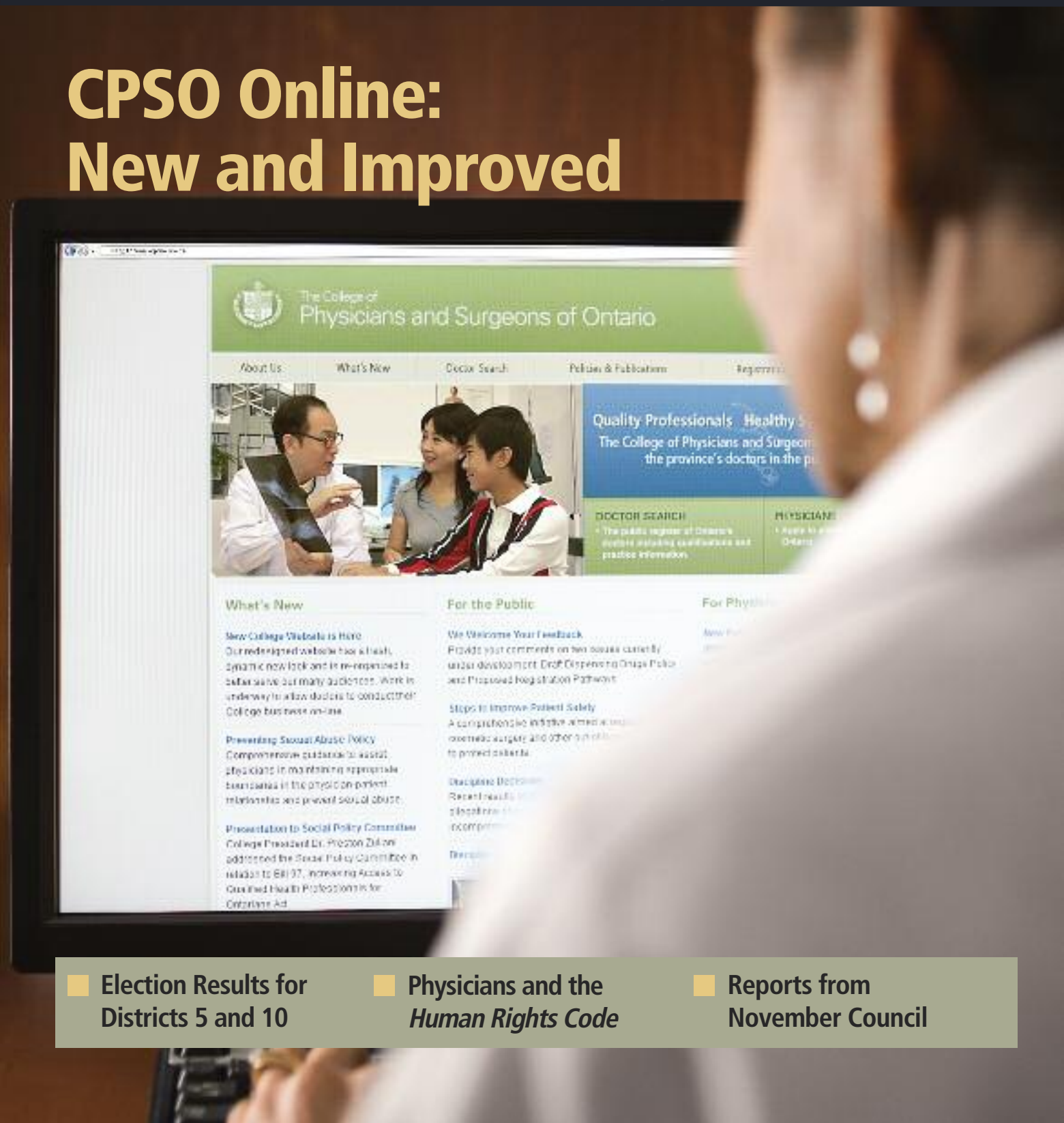

- Election Results for Districts 5 and 10
- Physicians and the *Human Rights Code*
- Reports from November Council

MD Dialogue
Vol. 4, No. 5, December 2008

is the official publication of the College of Physicians and Surgeons of Ontario. The objective of this magazine is to provide clear policy direction and review pertinent legislative and disciplinary information, consult with the profession on issues of concern, and provide a forum for discussion and exchange of information and ideas. This publication does not accept unsolicited manuscripts.

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

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

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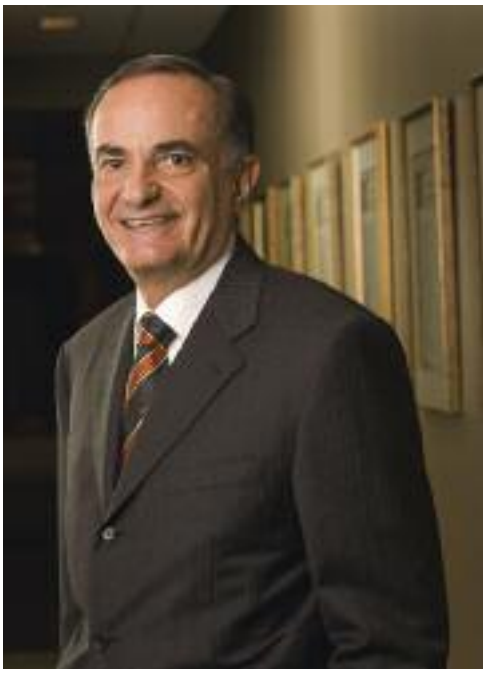
IN THIS ISSUE

HIGHLIGHTS

Dear Colleagues



Preston Zuliani, MD
President

The past year has been among the busiest of my professional life and as I come to the end of my term as President of the College, I am grateful for the opportunity to have had such an experience. It has been an honor for me to serve the public and the profession and it has been an experience that I will cherish.

We did an enormous amount of work this year. We consulted widely on a number of important issues. In fact, in this issue we publish the end result of two extensive consultations – the Physicians and the Ontario *Human Rights Code* policy, and the Maintaining Appropriate Boundaries and Preventing Sexual Abuse policy. The development of both policies had their challenges, but I believe that the policies are better informed by the feedback received.

We also began the process of translating the ideas of the strategic plan into action. Within the mandate of our governing legislation, we have charted a strategy that will allow us to achieve our vision of Quality Professionals, Healthy System, Public Trust. We are using this vision to guide us in our thinking, our actions and how we define and measure success.

Engaging the membership is, of course, critical to our success. When I became President, I made the decision to focus much of my energy on face to face meetings with physicians. We set out a program to meet with members from all 10 districts. I wanted to meet as many of you as possible, to answer your questions, and talk about the issues that you face in your practice.

By the end of the year, at Outreach events throughout the province, we had met with more than 500 individual physicians. The meetings proved to be very rewarding and I was deeply impressed with the very real commitment to patient care that was evident in your comments. I was also heartened by your appreciation for the importance of self-regulation, your willingness to participate, and your recognition that we must address and act on issues, even in controversial areas, if public trust is to be maintained.

In closing, I leave this term with an even greater appreciation of self-regulation than when I assumed the role as President. If there is one thing that I would like to impress upon all my colleagues, it is the understanding that self-regulation is not a vague ivory tower concept. Every physician who acts conscientiously in the care of his or her patients, and who tries to keep on top of the evolving body of medical knowledge embodies the very reason why self-regulation is allowed to continue. I thank all of you for your hard work and dedication in what are often trying times.

I'd also like to thank Council for giving me the privilege to act as President, the Executive Committee for its support and Dr. Rocco Gerace, whose wisdom and insight I often relied upon. I'd also like to give special thanks to Vice-President Dr. Rayudu Koka, who helped me tremendously during the past year. Rayudu has the privilege of serving as your President in 2009, and I wish him every success.

Over the year, I had the opportunity to interact with staff, at all levels, and I quickly came to realize the wealth of talent that we have at the College. They are dedicated, hard-working and energetic but, above all, they are extremely supportive of self-regulation.

Dear Editor:

We welcome your feedback on any issue raised in Dialogue.
We reserve the right to edit letters for length and clarity.

Please send your letters to:
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Re: Discipline Summary, September issue

Perhaps it was just the frame of mind I was in having read a memo from our administration, reminding us that the wearing of any fragrance contravenes our hospital's code of conduct, but the September issue's discipline summary decision pertaining to Dr. Abouelnasr was profoundly troubling.

Undoubtedly, the behaviors described were boorish and disruptive. However, Dr. Abouelnasr was not acting in any sort of professional role, and his behaviors were in no way criminal; both of those scenarios are clearly within the purview of the discipline committee.

Did the fact that the incident took place in a hospital play a role in bringing this action against Dr. Abouelnasr? What if a physician displays similar behaviors in a restaurant, or at a theatre? What about someone who gets into an unpleasant verbal, but non-criminal, interaction while driving? What about an Ontario MD who is apprehended and released without charge at a rally for (or against) abortion, or lights up a joint at a cannabis legalization protest? It does not seem improbable that some of these actions could just as easily be described as "inappropriate and which reflect poorly on the member and/or the profession" and thus subject to disciplinary action by our College.

I suspect that many of my colleagues are similarly troubled by the direction our College has taken. Unfortunately, it is part of a wider trend in society away from personal responsibility and common sense, and towards a corporate need to legislate and regulate minutiae of human interactions in ways that can appear positively Kafkaesque. I hope that enough feedback is generated by this case to make the College, which does have some responsibility towards its members, reconsider an unwise policy.

G.S. Gaind, MD, FRCP(C)
Hamilton, Ontario

The College responds:

The College thanks Dr. Gaind for his letter.

We are not at liberty to discuss the particulars of individual cases, but it is important to correct the perception that the provisions defining professional misconduct, including "conduct unbecoming a physician," are the result of College policy. The College's discipline committee operates under the *Regulated Health Professions Act (RHPA)*, the legislation that governs all Ontario regulatory health colleges. Under the *RHPA*, the provincial government has defined professional misconduct to include conduct unbecoming a physician, which is intended to capture conduct by the member outside the practise of the profession. It includes actions that are inappropriate and which reflect poorly on the member and/or the profession.

While not all private misbehavior is conduct unbecoming a member, misbehavior that reflects on one's integrity or competence to the point where public protection is required is conduct unbecoming.

Finding new pathways

Rocco Gerace, MD
Registrar

Increasing access to medical care has long been a College priority. In 1998, Council directed the College to find ways to register more doctors for the people of Ontario *without compromising standards*. This month, in fact, sees a new registration policy go into effect – one that has four new pathways to registration for some candidates.

This policy sets out a variety of pathways for specific groups of applicants. These pathways recognize training and experience in other jurisdictions in a way that we never have before. Registration requirements vary depending on the source of the applicant's medical degree, where the applicant is currently practising and where the applicant received post-graduate training.

Earlier this year, we reconvened the Physician Resources Task Force, the multi-stakeholder group that has provided the catalyst to so much change. One of its specific mandates was to examine the College's registration policies and regulations to find ways of maximizing the number of potential registrants, without compromising patient safety or quality health care. Because of the past ten years of experience, we quickly focused on new policies that could achieve our objective. Besides the four pathways now available, the task force identified two other potential routes to licensure. They were recently circulated for consultation.

In a submission that we presented to the provincial government in late October, we detailed the successes we have enjoyed in working with our partners to find new ways of enhancing physician supply. Throughout the years, many of our recommendations have been implemented and have resulted in an increase in the number of residency positions available and ever-greater numbers of IMGs being registered in Ontario. In fact, over the past ten years, we have consistently registered more new doctors every year and a growing proportion of these are IMGs.

The College continues to look for additional ways to register even more doctors, including IMGs. However, we cannot do this alone. The training and registration of physicians and surgeons involves a variety of organizations. These include the medical schools, educational colleges, government and many more. To increase Ontario's supply of doctors, all of us must pull together.

You will note that our cover story in this issue celebrates the launch of our revamped website. It has a fresh, dynamic new look and its content is organized in a way that better serves our many users.

Of particular interest to doctors, however, is our plan to develop a portal that will take you to a secure section of the website where you can conduct all your College business. You will be given a password to log on to your account and once there, you can update your practice information – including whether you are accepting new patients; your hospital affiliation status, and any change of address. You will also have the opportunity to submit payments; renew membership; complete surveys; order membership diplomas and certificates of professional conduct; vote in elections; and resign membership all on-line.

We know that at times it can be difficult for members to access our services in a timely manner. So we are very excited about the features of the new system that provide opportunities to enhance our service to physicians. Please stay tuned for more updates in *Dialogue* about this development. MD

Council election results

Votes counted in Districts 5 and 10

The following physicians were named to Council in the election held October 14th:

District 5

County of Simcoe, District Municipality of Muskoka and the regional municipalities of Durham, Peel and York

Dr. Geoffrey Bond, Barrie

Dr. Bond is an incumbent in this district. Most recently, he has served as a chair on the College's Complaints Committee.

Graduated from: Queen's University

Principal Area of Practice: Family Medicine

Current Hospital Appointments: Royal Victoria Hospital

Dr. Carol Leet, Brampton

Dr. Leet is a new member of Council. She has served as a chair of the Complaints Committee.

Graduated from: Queen's University

Principal Area of Practice: Pediatrics

Current Hospital Appointments: William Osler Health Centre, Brampton Civic Campus

District 10

City of Toronto

Dr. Michael Gordon, Toronto

Dr. Gordon was re-elected to Council for a third term. This past year, he has served on the Education and Quality Assurance Committees and chaired the Fitness to Practise Committee.

Graduated from: University of St. Andrews, Scotland

Principal Area of Practice: Geriatric Medicine

Current Hospital Appointments: Baycrest Geriatric Centre, Mount Sinai Hospital

Dr. Kumar Gupta, Toronto

Dr. Gupta returns to Council for a second term. He has served on the Complaints Committee, the Quality Assurance Committee and the chair of the Methadone Committee.

Graduated from: University of Manitoba

Principal Area of Practice: Family Medicine, Emergency Medicine, Coroner

Current Hospital Appointments: Humber River Regional Hospital

Dr. Marc Gabel, Toronto

Dr. Gabel sat on Council in 2002-2005. He has served as a chair of the Discipline Committee.

Graduated from: State University of New York, Downstate Medical Center

Principal Area of Practice: General Medicine

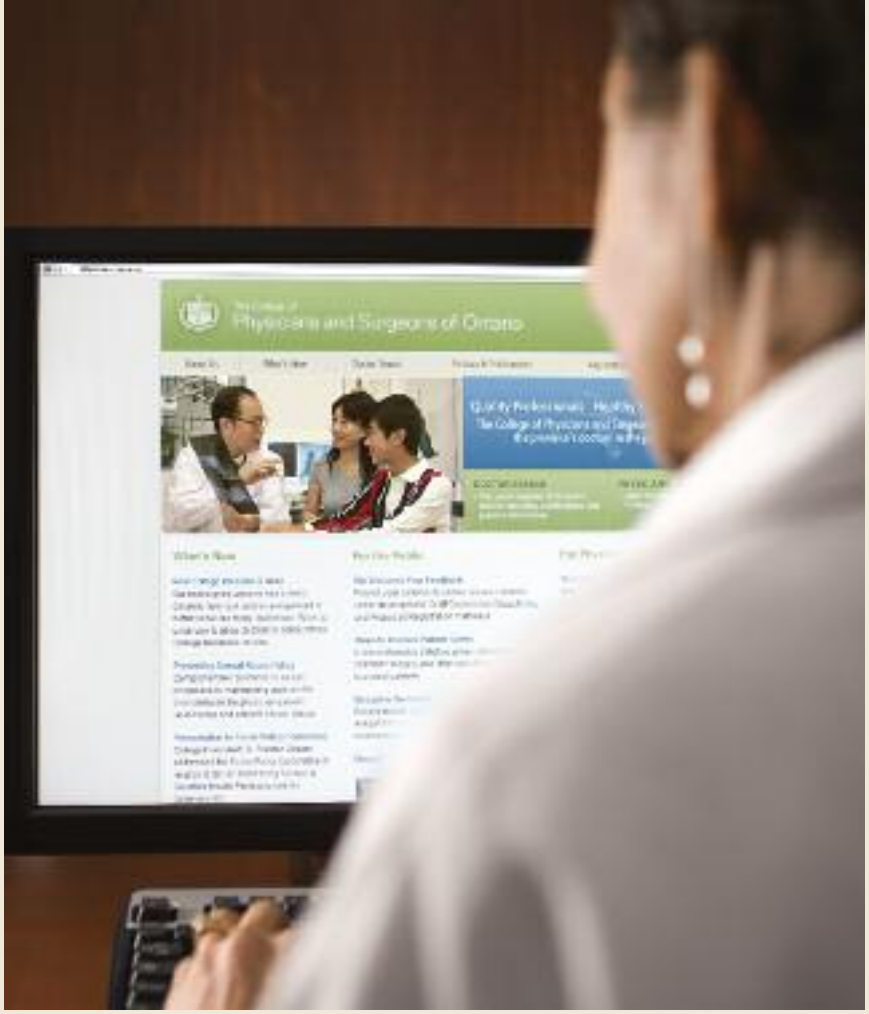
Dr. Jack Mandel, Toronto

Dr. Mandel returns to Council for a third term. He currently sits on the Executive Committee.

Graduated from: University of Toronto

Principal Area of Practice: Family Medicine

Current Hospital Appointments: Humber River Regional Hospital and North York General Hospital



CPSO On-line: New and Improved

College launches revamped website

The College has launched its revamped website, designed with a fresh, dynamic new look and organized in a consistent format that better serves its many audiences. Eventually, the website will allow doctors to conduct all their College business on-line.

For now, the simple navigation and user-friendly design will allow faster access to relevant information for all those who visit the site.

"We get seven million hits a month already on the website. We owe it to our users to make it as easy as possible to find the information they need," said Dr. Rocco Gerace, College Registrar.

The homepage is the new launching pad that directs users to information of particular interest to them and to the latest news on College issues. Content is grouped under six sections – About Us, What's New, Doctor Search, Policies and Publications, Registration, and CPSO Members. The intuitive design allows users to easily navigate into subsections of these categories.

Much work has been done in particular on the Doctor Search section of the site. This is the most visited area of the website and it receives nearly seventy-five percent of the hits on the site each month. We have kept the features that users told us they need, like the various ways to search for doctors, and improved the quality of results that users get back when they search. For example, on the previous site, if a doctor had more than one practice address, the search results would count that doctor numerous times and bring his or her name up for each address. Now, each doctor's name comes up only once, but it is easy to access all the registered practice addresses for that doctor from that one section.

Quick facts about the website

- Average hits of 7 million per month
- Doctor Search most visited area
- Average of 15 pages viewed by each web visitor

In addition, all information about each doctor is easier to find with fewer "clicks."

Work is ongoing on the website. A portal is under development that will take each physician registered with the College to a secure section of the website. Physicians will use passwords to log in to update their practice information – including whether they are accepting new patients; hospital affiliation status; and change of address. They will also have the opportunity to submit payments; renew membership; complete surveys; order membership diplomas and certificates of professional conduct; vote in elections; and resign membership all on-line.

In addition, the College will be implementing a registration wizard that will match applicants to appropriate application packages. As part of that feature, potential members will eventually be able to electronically submit documents and associated payments.

We will keep you posted on the progress of this website development. MD

Note:
If you have bookmarked any sections of the website, including the general address, you will need to refresh those bookmarks as they will not work on the new site.

www.cpso.on.ca

Understanding your legal obligations under the *Human Rights Code*

New policy provides physicians with guidance

Under the *Human Rights Code*, every person has a right to equal treatment with respect to services, goods and facilities, without discrimination because of race, ancestry, place of origin, color, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, family status or disability.

The protection of human rights has always been of fundamental importance in Ontario, but recent developments in this province have made it more important than ever for physicians to understand and comply with their legal obligations under the *Code*.

In June 2008, the Ontario Human Rights Commission introduced changes to its complaints processes which provide Ontarians with increased access to the Human Rights Tribunal. These changes are expected to result in a significant increase in the number of human rights complaints that are heard by the Tribunal.

In this climate of increased awareness of human rights, Council approved a policy that assists the profession in understanding its legal obligations under the *Human Rights Code*, and provides physicians with guidance about how to comply with these obligations in every day practice.

The policy can be found on page 11.

Extensive Consultation

This summer, the College conducted an extensive consultation with the profession, the public and other stakeholders on a draft of the policy. The College carefully listened to the considerable feedback and made revisions to address concerns raised in the consultation. The policy was revised to clarify obligations under the *Code* and the expectations of the College, when decisions are made on the basis of physicians' moral or religious beliefs.

Dr. Preston Zuliani, College President, said the intent of the policy was never

COLLEGE EXPECTATIONS

Assisting physicians in understanding their obligations under the *Human Rights Code* was a key reason for the development of this policy. However, the development of the policy provided the College with an opportunity to articulate its own expectations for physicians who limit their practice, refuse to accept individuals as patients, or end a physician-patient relationship on the basis of moral or religious belief.

In these situations, the College expects physicians to do the following:

- Communicate clearly and promptly about any treatments or procedures the physician chooses not to provide because of his or her moral or religious beliefs.
- Provide information about all clinical options that may be available or appropriate based on the patient's clinical needs or concerns. Physicians must not withhold information about the existence of a procedure or treatment because providing the procedure or giving advice about it conflicts with their religious or moral beliefs.
- Treat patients or individuals who wish to become patients with respect when they are seeking or requiring the treatment or procedure. This means that physicians should not express personal judgments about the beliefs, lifestyle, identity or characteristics of a patient or an individual who wishes to become a patient. This also means that physicians should not promote their own religious beliefs when interacting with patients, nor should they seek to convert existing patients or individuals who wish to become patients to their own religion.
- Advise patients or individuals who wish to become patients that they can see another physician with whom they can discuss their situation and in some circumstances, help the patient or individual make arrangements to do so.

to require physicians to perform procedures that were contrary to their moral or religious beliefs.

"We would not ask physicians to do anything contrary to their beliefs. We do, however, expect that, in those instances where physicians feel that they cannot provide a service for moral or religious reasons, then they must advise patients or individuals that they can see another physician, and in some circumstances, assist them to do so."

The whole umbrella of services that physicians provide – including decisions to accept or refuse individuals as patients, decisions about providing treatment or granting referrals to existing patients, and decisions to end a doctor-patient relationship – is subject to the obligations of the *Human Rights Code.*

The policy, however, points out that this does not prevent physicians from exercising professional judgment in relation to their own clinical competence. "Physicians are always expected to practise medicine in keeping with their level of clinical competence to ensure they provide patients with quality health care in a safe manner," states the policy.

If physicians feel they cannot appropriately meet the health-care needs of a patient or potential patient, they are not required to accept that person as a patient or to continue to act as that patient's physician, provided they comply with the College's Ending the Physician-Patient Relationship policy.

The Physicians and the Ontario *Human Rights Code* policy also addresses accommodation of the needs of persons with disabilities, for example, enabling patients to bring a sign language interpreter or guide dog to an appointment.

Elevated Legal Status

It is essential that physicians appreciate the importance of their human rights obligations, said Jennifer Scott, a human rights lawyer in Toronto. Canadian law recognizes the fundamental importance of the rights and protections afforded by human rights laws, and grants these laws precedence over others. The Supreme Court of Canada, she said, has described human rights legislation as having elevated legal status and as being more important than all other laws.

The gravity of physicians' human rights obligations stems not only from the quasi-constitutional status of the *Code*, but also from legislation that regulates the practice of medicine. Violating the *Code* may constitute professional misconduct for the purposes of the *Regulated Health Professions Act*.

"The Supreme Court of Canada, she said, has described human rights legislation as having elevated legal status and as being more important than all other laws."

Ms. Scott told a meeting of College Council that adherence to the *Human Rights Code* is not irreconcilable with a physician's right to make autonomous decisions about

how he or she wishes to carry out their medical practice.

"Certainly, physicians have the right to decide their practice areas, what patients they will see within these practice areas. They even have a right to limit certain patients from their practice areas, but the important point to make is that it is not an absolute right, it is not an unqualified right," she said.

Ms. Scott presented Council with an example to illustrate how a physician could find himself or herself the subject of a human rights complaint. In 1993 a lesbian couple, living in British Columbia, consulted with an obstetrician/gynecologist. The women were in a long-term relationship and wanted to start a family. They asked the doctor to provide artificial insemination (AI). He advised them that while he did perform AI, he no longer performed it on lesbians. He explained that he had earlier become involved in a high profile, time-consuming lawsuit between two lesbians for financial support of children conceived through artificial insemination and he was wary of becoming involved in a similar situation again.

The couple complained to the BC Human Rights Council. The women argued that the doctor had violated the province's human rights act in refusing them the service because of sexual orientation. The doctor countered that his reasons for refusal constituted a *bona fide* and reasonable justification for denying the service. The Human Rights Council disagreed and ruled in favor of the women.

The Ontario Human Rights Commission acknowledged, in its consultation submission to the College, the pressures that physicians face in managing their caseload and their interactions with patients in a context of doctor shortages, and an aging and increasingly diverse society.

"At the same time, as providers of such an essential service as health care, their efforts to ensure that their policies, practices, and decisions are free of bias and discrimination can have a significant positive impact on the lives of Ontarians," stated the Commission.

Survey of public attitudes

As part of its consultation, the College commissioned Environics to gauge public attitudes and expectations regarding key aspects of the proposed policy.

The survey was conducted by telephone with a random sample of 500 adult Ontarians (18 years of age and older).

	Physician should be required to...	Feel **strongly** that physician should be required to...	Physician should not be required to...
a) Communicate clearly	92%	85%	4%
b) Give information about all options	91%	84%	5%
c) Tell patient they can see another doctor	94%	88%	3%
d) Provide a referral	91%	84%	7%

Finding the balance

What happens when a physician's beliefs conflict with the beliefs or the health care decisions of his or her patients?

Jennifer Scott, a human rights lawyer in Ontario, concedes that the B.C. decision, discussed in the main story, may have had a different outcome had the doctor's decision not to treat the lesbian couple been based on a religious belief, rather than a fear of controversy or inconvenience.

"It would have become very complicated," said Ms Scott, "because then you don't just have the patient's rights, but the physician's right – in this case, creed – which is also protected under the *Code*."

These situations involve a balancing of rights: the rights of physicians, balanced with the rights of their patients. The College's policy recognizes the complexity of these situations and that no clear guidance on how to manage them is contained in either the *Code* or in publications of the Human Rights Commission. Because the law in this area is unclear, the College is unable to advise physicians how the Courts will decide cases where they must balance the rights of physicians against those of their patients. The policy, however, does outline some general principles that Courts have articulated when considering cases where equality rights clash with the freedom of conscience and religion.

A key principle, says Ms. Scott, is that the balancing of rights be done in context. In relation to freedom of religion specifically, Courts will consider how directly the act in question interferes with a core religious belief. For example, she said it would be difficult to imagine the Court ruling against a minister for refusing to officiate at a homosexual union if the minister believed that marriage should only exist between a man and a woman. The more indirectly the act impacts on a religious belief, the more likely Courts are to find that the freedom of religion should be limited.

The attempt to balance doctors' rights to practise in accordance with their views and beliefs, and patients' rights to receive timely and appropriate medical care led the medical regulator in the United Kingdom, the General Medical Council, to produce new guidance on the issue.

Personal Beliefs and Medical Practice was developed in response to an increasing number of enquiries about doctors' and patients' personal, religious and moral beliefs. The guidance explores how doctors should deal with a range of dilemmas including abortion, the wearing of face-veils and male circumcision.

The guidance recognizes that all doctors have personal beliefs which may affect their day-to-day practice. It clarifies the distinction between conscientious objection to a particular procedure and discrimination against a patient or group of patients.

While the GMC paper acknowledges that personal beliefs, values, and cultural and religious practises are just as central to the lives of doctors as they are to patients, it does acknowledge that doctors have to make the care of their patients their first concern.

"We are clear that doctors must not mislead patients about the options available to them or leave them with nowhere to turn," said Dr. John Jenkins, chair of the GMC Committee on Standards and Ethics. MD

Educational Courses

Practical programs designed to help physicians in their medical practices

All courses have been developed with the assistance of expert educators from the Faculties of Medicine at the University of Toronto and the University of Western Ontario, and will provide participants with practical advice and hands-on exercises in small-group workshop settings. All courses have received CFPC MAINPRO and RCPSC Maincert accreditation.*
Fees are subject to change. For more information or to register, call:

Mr. Sidney Biondi at (416) 967-2600 or 1-800-268-7096 ext. 358

Physicians' Prescribing Skills

A focus on the prescribing of addictive and psychoactive drugs

This course has been created to assist physicians in acquiring knowledge of addictive behaviors and developing new skills in the field of pain management, especially in the area of chronic non-malignant pain.

Location: College of Physicians and Surgeons of Ontario

Fees: Member: $900,
Non-Member: $1,060
(two full days, including lunches, course syllabus, plus a reinforcement teleconference call three months post-course, and providing individualized guidance)

2009 Dates: Please check the College website: www.cpso.on.ca/members/resources/ or contact Mr. Sidney Biondi at 1-800-268-7096 ext. 358.

14 MAINPRO-C credits*

Medical Record Keeping for Physicians

This course has been developed for office-based practitioners and describes the many different methodologies of good record keeping, clarifies the multiple medico-legal reasons for good records and demonstrates the benefits of good records for both the doctor and the patient in the provision of quality medical care.

Location: College of Physicians and Surgeons of Ontario

Fees: Member: $475,
Non-Member: $570
(one full day, including lunch, course syllabus, and individualized follow-up review at three months post-course)

2009 Dates: Please check the College website: www.cpso.on.ca/members/resources/ or contact Mr. Sidney Biondi at 1-800-268-7096 ext. 358.

Note: An individualized program on medical record keeping for the surgical specialties is also available. This program is located at the University of Toronto and the dates and fees are established on an individual basis.

8 MAINPRO-C credits*

Understanding Boundary Issues and Managing the Risks Inherent in the Doctor-Patient Relationship

This one-and-a-half day course, offered in a small-group workshop format by expert educators from the University of Western Ontario, will assist participants to understand boundaries and help prevent boundary violations in the doctor-patient relationship. Participants will have the opportunity to work with trained standardized patients and skilled facilitators in the demonstration of respectful clinical interactions and to develop skills in setting appropriate boundaries when faced with challenging situations in clinical practice.

Location: Health Sciences Addition, Room H101, University of Western Ontario, London, Ontario

Fees: Member: $1,200,
Non-Member: $1,440 (includes course syllabus and all materials, meals and nutrition breaks)

2009 Dates: Please check the College website: www.cpso.on.ca/members/resources/ or contact Mr. Sidney Biondi at 1-800-268-7096 ext. 358.

9.5 MAINPRO-MI credits*

New policy addresses sexual misconduct, boundaries

At its September meeting, Council approved a comprehensive policy on sexual misconduct that includes providing guidance on determining when a physician-patient relationship exists.

The new policy has a two-fold objective – to ensure that physicians maintain appropriate boundaries within the physician-patient relationship and to prevent sexual abuse.

One of the significant changes in the Maintaining Appropriate Boundaries and Preventing Sexual Abuse policy is the introduction of flexibility with respect to the rules around when a physician can begin a relationship with a former patient – the one year rule has been eliminated as well as the automatic prohibition on relationships involving psychotherapy.

The policy can be found inserted into the centre of this issue. Below we answer some questions about the policy.

Why is there a new sexual misconduct policy?

The College's guidance to physicians with respect to sexual abuse had been in place since 1992. The College Council recommended that these policies be reviewed, updated and that a more comprehensive policy be developed in accord with development in law.

What hasn't changed in the new policy?

What remains the same is the fact that it is never permissible for a physician to have sexual relations with a patient. The new policy more clearly articulates the legal grounding for this rule: the *Regulated Health Professions Act, 1991* makes it clear that sexual relations with a patient is considered to be sexual abuse. The new policy sets out clearly what acts constitute sexual abuse and sets out what the penalties are for sexual abuse.

The previous guidance included the one-year rule which stated that physicians should not become sexually involved with a former patient for one year from the date of the last clinical contact. This new policy doesn't have that one-year rule. Why?

The problem with the "one-year rule" is that it is both arbitrary and inflexible. There is no evidence to support one year as an appropriate cut-off. Also, the rule may prohibit relationships that could be appropriate as well as allowing those that may not be appropriate.

The following example illustrates the problem with the one-year rule. A patient is treated at a walk-in clinic twice by a physician for a minor injury. Six months later, the two are introduced socially and wish to start dating and commence a sexual relationship. Must they wait another six months? If they don't, the physician would have been in breach of the College policy. If the patient later complains to the CPSO, he/she could refer to the one-year rule to insist that the physician be sanctioned. The Complaints Committee may not believe that the physician has acted improperly, yet, he or she did breach the policy.

Can physicians now date patients shortly after the physician-patient relationship has ended?

No. In some cases, the Courts have found that certain physician-patient relationships endure subsequent to the end of the formal relationship. For example, in the psycho-therapeutic context, the physician-patient relationship may continue for some time after the last formal session. If the physician and patient began a sexual relationship shortly after that session, a finding of sexual abuse might be made.

Whether or not to proceed to a dating relationship with a former patient depends on the length of relationship, nature of relationship, the degree of relationship, etc. It may be fine for a physician to date someone whom he once treated for a sprained ankle in the ER, but it may not be appropriate in a situation where the doctor has been a long-term family physician.

So how does a physician know when it would be appropriate for him or her to date a former patient?

The policy sets out some factors that a physician should consider in determining the propriety of a sexual relationship with a former patient.

If physicians wish further guidance, they should call the CMPA.

Physicians should bear in mind that even after the physician-patient relationship has ended, a physician has an ethical obligation not to exploit the trust and dependence that develops during the physician-patient relationship for the physician's personal advantage. We would urge a physician contemplating a sexual relationship with a former patient to act cautiously, making sure to consider the potentially complex issues.

What are the factors that should be considered?

The length and intensity of the former professional relationship; the nature of the patient's clinical problem; the type of clinical care provided; the extent to which the patient has confided personal or private information; and the vulnerability of the patient are all factors that should be considered.

As stated earlier, when the physician-patient relationship involves a significant amount of psychotherapy, sexual involvement is likely inappropriate at any time after termination of the physician-patient relationship.

As well, it is important for physicians to be aware that if they are in a relationship with a patient (current or former) and a break-up happens, it is possible that the patient will make a complaint to the College.

The previous policy included an automatic prohibition of sexual relationships with former patients when psychotherapy was provided. Why was that removed?

Like the one-year rule, it was determined to be too restrictive. College Council is of the view that the Complaints and Discipline Committees should have discretion when reviewing individual cases. The following example illustrates this point:

A patient is treated by a family physician for approximately one year, during which time the patient's family member dies. The family physician provides supportive psychotherapy during the patient's bereavement. The patient moves out of town and obtains a new family physician. Years later, the patient returns and encounters the physician in a social situation. The two wish to commence a social relationship. Under the former policy, such a relationship would have been automatically prohibited, given that psychotherapy was arguably a significant component of their previous relationship. The new policy gives the committees discretion as to whether the physician should be sanctioned.

How do I terminate a professional relationship with a patient?

A physician must end the physician-patient relationship before starting a sexual relationship with a former patient. It is the physician's responsibility to ensure the termination of the physician-patient relationship is clearly communicated to the patient and

documented in the patient's record. Physicians should also ensure that alternative services are arranged or the patient is given a reasonable opportunity to arrange alternative care. Physicians should consult the College's Ending the Physician-Patient Relationship Policy for further information.

Doesn't the new policy make it impossible for rural physicians to have a social/dating life?

No. In fact, the revised policy has more flexibility to address complex situations, including the challenges of rural practice.

The College understands that practising in rural areas can be challenging, particularly as it relates to a physician's social isolation. But the principles, legislation and policy designed to protect patients from exploitation apply no matter where a physician works.

Why does the College advise against physicians becoming involved with people who have a close relationship with a patient?

Sexual relationships between physicians and individuals who are closely associated with a physician's patients may raise concerns about breach of trust and power imbalance. A sexual relationship between a physician and a person closely associated with a patient – for example, between a pediatrician and a young patient's father – can detract from the goal of furthering the patient's best interest. It has the potential of affecting the objectivity of both the physician and the closely associated person.

Why was it necessary to include advice about maintaining professional boundaries in this policy?

The prevention of sexual contact starts with the careful attention to boundary crossings that may escalate into sexualized behavior. Most cases of sexual abuse are preceded by boundary violations.

For further information about maintaining boundaries, physicians should look at the self-assessment tool which is on the CPSO's website in the CPSO Members section under Resources.

MOVING

New address?

Let us know within 30 days!

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

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

If you change either address, you must notify the College in writing within 30 days of the change.

Inquest recommendations target culture of medical dominance in hospitals

In November 2005, Lori Dupont, a registered nurse was stabbed to death by her former boyfriend, Dr. Marc Daniel, an anesthesiologist, while they were both on shift at a Windsor hospital. Dr. Daniel committed suicide shortly after the murder. In the examination of the events leading up to the two deaths, an inquest found that the greater problem may not be so much the disruptive physician, but a culture that is prepared to bend the rules for physicians.

The doctor is a poster boy for disruptive behavior. He steals drugs from his hospital, makes sexually inappropriate comments to patients, even underage ones, belittles staff members, ignores hospital policies, and makes it abundantly clear that he is accountable to no one.

And although the adventures of Dr. Gregory House might make for great television, one health-care lawyer admits to a queasy, uncomfortable feeling every time he sees the rule-breaking doc on TV.

"He is held up as a kind of messiah-figure because of his skills as a diagnostician. He is protected and tolerated by those who work closely with him. We would never have a show like this about a nurse or a medical radiation technologist, but we indulge and tolerate this kind of behavior in doctors because we see something special about their particular type of knowledge."

Mr. John Morris, a former president of the Ontario Medico-legal Society was using the TV character to bring attention to a situation that he describes as being far from fictional. The reality, he said, is that hospitals operate under two parallel systems of governance, rules and enforcement: one for physicians, and another for everybody else.

Certainly, that was the conclusion reached by the jury in a high profile

inquest of a nurse who was murdered by her former boyfriend, a doctor, at the hospital where they both worked. In November 2005, Lori Dupont, a registered nurse, was stabbed to death by Dr. Marc Daniel, in the hospital's recovery room, while they both were on shift at the Hotel-Dieu Grace Hospital in Windsor. Dr. Daniel, an anesthesiologist, later killed himself with a drug overdose.

In its internal report, released in August 2006, the hospital called the fatal stabbing "an unforeseen event." But during the inquest, testimony from Ms. Dupont's nursing colleagues revealed that numerous hospital managers were aware of Dr. Daniel's prolonged, serious misconduct, not just toward Ms. Dupont, but aimed at others as well. It was revealed that Dr. Daniel had a long history of inappropriate outbursts of anger, of aggression ▸▸

Quality of Care Top Concern

Don't flinch. That's the advice that the Ontario Hospital Association has given to hospital boards when dealing with the delinquencies committed by medical staff.

The policy document entitled "Quality and Patient Safety: Understanding the Role of the Board" states that almost every board is regularly tested on its commitment to quality and safety.

The most common circumstances arise when the Medical Advisory Committee reports to the board on medical record delinquencies, such as not completing operative notes or discharge summaries in a timely manner – which can have an impact on quality of care.

These type of delinquencies are very common in many hospitals and MACs and boards usually regard suspending the privileges of the physicians involved as a rather drastic step, stated the document. But the reluctance to act sends a cultural signal that, while the hospital adopts policies on quality and safety, there will be no consequence if physicians do not adhere to those policies.

"It should come as no surprise then, that when other new safety policies are adopted by the board, these might also be ignored by some medical staff under the cultural rules 'That must not apply to me' and there won't be any consequences, anyway," stated the document.

As a result, important safety policies, such as full barrier precautions for central line insertions, and mandatory timeouts before surgery, are followed by most, but not all doctors, without apparent consequence – except to the patients that suffer hospital acquired infections and wrong site surgeries.

and of harassing nurses at work. The jury also learned of how he damaged expensive operating room equipment, broke the finger of a nurse in the OR, and had exhibited disruptive behavior in front of patients.

Despite significant and documented complaints of serious disruptive behavior problems and violation of the hospital policies and by-laws by Dr. Daniel in the spring of 2004, there seemed to be much confusion and indecision as to how to deal with this physician.

But Mr. Morris said the inquest revealed a situation that went beyond the corridors of Hotel-Dieu Grace Hospital. "The jurors found that the greater problem may not be so much the disruptive physician, but rather, a culture that is prepared to bend the rules for physicians," he said, pointing out that the overarching theme of the inquest jury's recommendations was to encourage hospitals to address the culture of medical dominance.

"It became very clear during this inquest that the rules for physicians were different from the rules for other hospital workers," said Mr. Morris, who represented the Ontario Hospital Association at the inquest. Mr. Morris and Neil McEvoy, CEO of Hotel-Dieu Grace Hospital at the time of the murder, have since joined forces at a number of Ontario Hospital Association-sponsored events, to discuss the lessons learned from the tragedy.

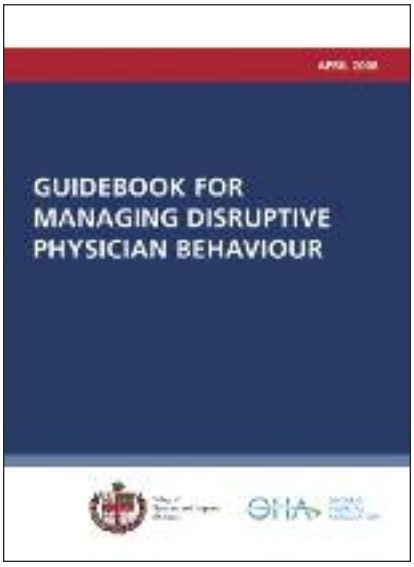
Foremost among the inquest's 65 recommendations was the call for a comprehensive review of the *Public Hospitals Act (PHA)* "with a view to examining the hospital-physician relationship to ensure safety and quality care in hospitals."

Mr. McEvoy acknowledged to an audience at an OHA-sponsored event that the *PHA* bears much responsibility for creating organizations that have different rules for physicians. "There is an alienation between the medical staff and the rest of the hospital. If we had a different history of working with physicians, then many of the choices that we made along the way would have been different."

The mix of cultures in hospital – the consensus-building inclinations of administrators versus the evidence-oriented physicians – created tensions that were never addressed, he said.

Mr. McEvoy said he was uncomfortable, generally, speaking to physicians about their performance. "I found it hard to get that conversation going – the one that begins with me saying to a physician, 'a concern has been raised about you' or even 'you've had a hard year, how are you doing?'" he told the audience.

"And now a tragedy has happened – something unthinkable has occurred – and I now understand that if you want to avoid the perfect storm of November 12, 2005, you



The inquest encouraged hospitals to adopt the model of "progressive discipline" as set out in the CPSO's recently released *Guidebook for Managing Disruptive Physician Behaviour.*

need to pay attention and address the small things that come to your attention in order to minimize the likelihood of having these big things happen," said Mr. McEvoy, who has since left the Windsor hospital.

The experts at the inquest, although critical of the hospital's administration for its failure to address the continuing misconduct of Dr. Daniel, recognized that the process for doing so was cumbersome, overly-legalistic and in need of reform.

The experts recommended a system where hospitals would be able to take action against a disruptive physician on an urgent basis and would not be required to follow a formal, labyrinthian legal process through the Medical Advisory Committee or the board, as is currently required. It was a suggestion which found favor with the jury, which included it in its list of recommendations.

"The main objective would be to give hospitals a freer, more executive authority to deal with physician issues," said Mr. Morris.

And noting that Dr. Daniel had been allowed to return to work only a few months after a suicide attempt, the jury insisted that patient and staff safety, as well as patient care, must be the most important factors "and not be superseded by a physician's right to practise and that hospitals be able to exercise the appropriate degree of authority over physicians working within their institutions, consistent with that of other regulated health professionals."

The jury also recommended that the *PHA* identify processes for hospitals to pro-actively temporarily suspend a physician's privileges for assessment and treatment of significant issues of disruptive behavior.

Currently the *PHA* limits immediate suspension of privileges for serious problems related only to diagnosis, care or treatment of patients and fails to address issues of disruptive behavior which could impact hospital staff or patient care.

The inquest encouraged hospitals to adopt the model of "progressive discipline" as set out in the CPSO's recently released *Guidebook on Managing Disruptive Physician Behaviour*. "This is the first time that we've had something that gave teeth to the process," said Mr. Morris, holding up a copy of the Guidebook.

"Hospital leaders need to recognize that this problem may be a problem in their own hospital," said Mr. Morris. "They need to ensure that physicians who display intemperate, discourteous and intimidating conduct are appropriately reproached. If tackled in its early stages, this is not a legal problem."

The jury's inquest recommended that all health care disciplines throughout their on going professional development receive education in the dynamics of domestic violence and risk assessment and intervention strategies.

In the communication column in this issue of *Dialogue*, we provide an overview of the lethality factors and the use of standardized risk assessment tools that can be used when physicians are treating patients who may be victims or perpetrators of domestic violence.

Please see page 25.

The College's Guidebook makes the point that the hospital's response must be titrated to the nature of the incident and the physician's history with the institution. Intolerance of unprofessional behavior does not mean that punitive action is required. It does mean that some action is required. For a single complaint about a relatively minor breach of behavioral standards, it is likely that a very informal approach would be best.

Where the behavior is particularly offensive or representative of a problematic pattern, a more formal approach will be required and more serious consequences are likely to flow.

Where a serious problem exists, concrete steps need to be taken to address the unacceptable conduct within the appropriate legal framework. A trail of progressive discipline will greatly enhance a hospital's ability to confront a physician who cannot be rehabilitated, and if necessary, will demonstrate that there is good cause for suspension and/or termination even in the complex legal model that now exists, said Mr. Morris.

The jury recommended that information regarding significant behavioral problems of physicians should be identified by the hospital and reported immediately to the College.

In its response to the Chief Coroner, the College agreed that hospitals must be more willing to share such information with the College. "We believe that if hospitals were to share such information with us more freely, we would be better able to help the subject physician as well as his or her colleagues and patients," stated Dr. Rocco Gerace, in his response to the Chief Coroner, Dr. Andrew McCallum.

Over the last year, the College – alone and in conjunction with the Ontario Medical Association and the Ontario Hospital Association – has facilitated a series of meetings and conferences with physicians and other hospital staff in order to introduce the *Guidebook for Managing Disruptive Physician Behaviour*. These educational meetings have provided an opportunity for discussions about the importance of appropriate reporting.

"In all of these efforts, we emphasize the desirability of reporting behavioral concerns to the College in every instance where they have an impact on privileges - or would have been likely to have had an impact but for some agreement or arrangement which circumvents this," Dr. Gerace wrote.

For several years, the College has been voicing its own concerns about the reporting obligations in the *PHA* and the *RHPA*.

"We are less concerned about any apparent inconsistencies between these two acts, and more concerned about the efforts undertaken by hospitals to avoid abiding by them – often upon the recommendation of hospital lawyers," stated Dr. Gerace.

"In the context of the educational efforts that we have been making with respect to the Guidebook, we have also been attempting to emphasize hospitals' obligations in this regard – both under the law and ethically – to inform us of concerns about a physician whenever they have an impact on his or her practice. Ensuring that the regulator is aware of such concerns is a critical component of patient safety," Dr. Gerace stated. MD

Heeding the Message

Hospitals that don't heed the messages sent by the Dupont-Daniel inquest jury do so at their own peril, said Mr. John Morris, a health-care lawyer.

"The expectation is that hospitals will pay close attention to jury recommendations on systemic issues that affect hospitals and exercise due diligence in implementing those recommendations,' he said.

A failure to implement a jury recommendation sent to the hospital by the Coroner may be used in evidence against a hospital in the future, should there be criticism raised in a legal proceeding, said Mr. Morris.

Unprecedented volume of work results in fee increase proposal

As you will read in our Reports from Council, Council is proposing to raise the annual fee by $100. This would bring the fee for 2009 to $1,300.

There are multiple reasons this fee increase was necessary including: ensuring adequate staff resources to manage unprecedented work volumes; additional administrative assistance to support the new Inquiries, Complaints and Reports Committee (which is mandated by Bill 171); and fulfilling goals that flow from our strategic plan.

"These have all added additional pressures to the College's financial circumstances," said College President Dr. Preston Zuliani. "We do, however, recognize the need to provide best value medical regulation. So we have approached those costs which we do have control over in the spirit of economy, efficiency and effectiveness."

We have developed initiatives to achieve our vision of Quality Professionals, Healthy System, Public Trust. As part of our commitment to fostering excellence in medical practice, for example, we will be investing heavily in our physician assessment program. In the coming year, we will be conducting 30% more peer assessments.

As part of our effort to ensure a Healthy System, we have looked for new ways to increase the number of physicians registered to practise medicine in Ontario. As a result of policies that have increased accessibility to a certificate of registration for qualified professionals, the number of applications received has increased significantly, and will continue to do so. In fact, applications are up more than 50% since 2000.

Fee Comparisons

Medical Regulatory Authority	2008	2009
Alberta	$1,500	$1,600
Prince Edward Island	$1,375	$ tbd
Newfoundland and Labrador	$1,300	$1,350*
Nova Scotia	$1,100	$1,350
Manitoba	$1,300	$1,325
Ontario	**$1,200**	**$1,300***
Saskatchewan	$1,200	$1,250
Quebec	$1,100	$ tbd
British Columbia	$1,010	$1,110
New Brunswick	$390	$390
Territories	$200	$200

*Proposed

The unprecedented volume of work demands additional staff resources to check credentials and process successful applications.

"We don't take the issue of fee increases lightly," said Dr. Zuliani. "We are very cognizant that our initiatives are funded by physician fees and we give very careful consideration before proceeding with the projects that we believe hold the most value. But we also have a mandate to protect and serve the public interest in regulating the practice of medicine … and doing a less than exemplary job is something that nobody can afford," he said. MD

Accepting new patients policy approved

This is a brief overview of some of the Council agenda items and actions taken at the November meeting.

After an extensive consultation, Council has approved a policy that sets out expectations for primary care physicians when accepting new patients so that they do so fairly and professionally.

The new policy states that "in a limited resource environment, physicians must ensure that access to care is fair. This may entail prioritizing treatment to those most in need."

The policy states that it is not appropriate for physicians to screen potential patients because it can compromise public trust in the profession, especially at a time when access to care is a concern. Screening may also result in discriminatory actions against potential patients.

The policy will appear in the next issue of *Dialogue*.

eHealth: Implications for Physician Practice and Regulation

Various eHealth initiatives have been brought to the College's attention by physicians, the Ministry of Health and Long-Term Care, members of the public and other stakeholders. Many of these initiatives will have implications for physician practice and regulation. Through a series of educational sessions, members of Council will be learning more about these initiatives and the ways technology is changing the practice of medicine.

At the first session, Council learned more about eHealth Ontario, a new agency responsible for all aspects of e-health in Ontario. The agency has identified three key priorities:

1. the development of a diabetes registry to allow patients to participate in their own care and work with their providers to better manage their disease. The lessons and best practices in implementing the diabetes registry will be used in providing access to information, knowledge and tools relating to other diseases like congestive heart failure, asthma and COPD.
2. the development of an electronic portal to centralize health information on an easily accessible website. The portal will centralize tools and information that are currently presented through a number of non-integrated delivery channels. For example, providers will be able to view patients' CT and MRI images on-line, and it will store test results from Ontario's medical laboratories.
3. the advancement of e-prescribing, which will eliminate handwritten prescriptions and reduce medication errors. In 2009, the focus of ePrescribing will involve a number of pilot projects on a local or regional level.

The ultimate goal of the e-health strategy is to create an electronic health record for all Ontarians.

Policy Allowing Residents to Work Additional Hours for Pay Extended

Council voted to extend a policy which allows residents on a postgraduate educational certificate to apply for a restricted certificate of registration to work for additional hours for extra pay outside of their training requirements.

The applicant needs to have satisfactorily completed rotations in the same discipline in which the additional work is proposed.

The original policy was approved by Council in the fall of 2004, as a pilot project with an expiry date of December 31, 2006. At the request of stakeholders, Council approved extending the policy until December 31, 2008, to allow the parties to explore the issue.

As only a few applications have been submitted to date, Council agreed to a further extension until December 31, 2010 in order to increase awareness of the policy among the residents, program directors and hospitals in Ontario.

Supervision Guidelines Updated

Council has updated its "Guidelines for College-Directed Supervision" document. These Guidelines are directed at supervisors and supervised physicians who are participating in a supervisory arrangement that is borne out of a College process.

Changes include recognition of the team approach concept to supervision and an addition to the tools that the College is endorsing for use by supervisors.

Supervision is increasingly becoming an integral function of the College. The current estimated number of supervised physicians – approximately 300 to 400 – has increased significantly over the last three years and will continue to climb as the new registration pathways come into effect.

Annual Fee Increase Proposed

Council has proposed that the annual fee be raised by $100 to $1,300.

There are multiple reasons this fee increase was necessary including: ensuring adequate staff resources to manage unprecedented work volumes; additional administrative assistance to support the new Inquiries, Complaints and Reports (ICR) Committee (which is mandated by Bill 171); and fulfilling goals that flow from our strategic plan.

"These have all added additional pressures to the College's financial circumstances," said College president Dr. Preston Zuliani. "We do, however, recognize the need to provide best value medical regulation. So we have approached those costs which we do have control over in the spirit of economy, efficiency and effectiveness."

Dr. Diane Zielke, Red Lake GP, presented with a Council Award

Dr. Diane Zielke, a general practitioner with a busy practice in Red Lake, has been recognized with a Council Award for her commitment to her patients and her provision of excellent clinical care.

In nominating Dr. Zielke for this award, her dedication to the community, her commitment to her patients and her wise mentorship of new physicians and nurses were highlighted.

Most recently, Dr. Zielke has been involved in providing palliative care to patients choosing to die at home. "[P]roviding end of life care to patients and families facing death and its many challenges, fears, and losses is a very difficult task. It is made even more difficult by the remoteness, isolation and often limited resources in small northern communities. Dr. Zielke has demonstrated an exemplary commitment to this challenge," said colleague Marjorie McCrea.

The proposed by-law is now being circulated to the profession (see next page).

Proposed by-law changes circulated to profession

The following proposed by-law changes are being circulated to the profession. They will return to Council after circulation. **Please send your comments to cpso@cpso.on.ca.**

By-law No. 51

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

Membership Fees

2.-(1) The annual membership fee for the holder of a certificate of registration other than a certificate authorizing postgraduate education or supervised practice of a short duration is $1,300 plus any outstanding balance owing to the College in respect of any decision made by a committee, including an order for costs by the Discipline Committee and a fee payable under section 3a of this by-law.

By-law No. 53

The Fairness Commission will require an audit of the College for its fairness and equitable registration practices once every three years. The cost estimates for this is estimated at $100,000. Council has passed a motion that these audits be on a cost recovery basis, by increasing the fees for all applicants. All applicants would be charged an additional amount. For 2009, this amount has been determined to be $11.

All applicants are required to have a criminal records check conducted by CPIC (Canadian Police Information Centre). Currently this comes out of the applicant's general application fee. Council has passed a motion that the charge be in addition to, not included in, the application fee. The amount for 2009 is $15.

Subsection 1(1) of By-Law No. 2 (the Fees and Remuneration By-Law) is amended by adding the following paragraphs:

Application Fees

1.-(1) The application fee is,

. . .

(e) an additional fee of $11 to offset the cost of an audit required by the Fairness Commissioner and $15 to offset the cost of a criminal record check will be applied to every application for a certificate of registration.

By-law No. 55

Regulation amendments introduced last year made it mandatory for physicians in Ontario to have professional liability protection that extends to all areas of their practice. The provisions were implemented without consequence for most physicians. However, physicians working for the military were required to obtain additional protection even though they are covered by the Treasury Board Indemnity, because the indemnity did not meet the requirements of the current by-law. The following by-law proposal to include coverage under the Treasury Board indemnity as an adequate form of professional liability protection will provide a solution for these physicians.

1. Clause 50.2 of By-law No. 1 (the General By-law) is amended by adding the following paragraph to it:

(c) coverage under the Treasury Board Policy on Legal Assistance and Indemnification.

By-law No. 56

The proposed amendments would allow for a member's gender and facsimile number to appear as public information on the register.

1. Clause 49(1)2 of By-law No. 1 (the General By-law) is revoked and the following substituted:

2. The member's gender and registration number.

The current provision reads as follows:

49. (1) in addition to the information required under subsection 23(2) of the Health Professions Procedural Code, the register shall contain the following information with respect to each member:

. . .

2. The member's registration number.

2. By-law No. 1 is further amended by revoking clause 50.1(b) and substituting the following:

(b) e-mail address,

The current provision reads as follows:

50.1 (1) all information contained in the register, other than a member's…

(b) e-mail address and facsimile number, …

is designated as public except that …

DOC TALK
By Stuart Foxman

A Support and a Lifeline

That's what doctors can be for victims of domestic violence

As a family doctor in a community health centre, Dr. Rosana Pellizzari saw many female patients who came in with the same all-too-common crisis – domestic abuse.

"I've worked with women who took years to leave an abusive relationship, and other women who I had to help access a shelter," says Dr. Pellizzari, now Medical Officer of Health for Peterborough. "I've had women arrive at my office with their bags packed and children in tow. The only safe place they could think of was the physician's office."

Dr. Pellizzari was one of the authors of the *Intimate Partner Violence Consensus Statement*, produced for the Society of Obstetricians and Gynaecologists of Canada in 2005. The guidelines offer health care providers best practices, tools and resources to support interventions with victims of intimate partner violence (IPV).

(To download a copy of the guidelines, visit www.sogc.org, click on "Women's Health Information", then "General Health," and then on "Intimate Partner Violence.")

"Any physician knowingly or unknowingly deals with women who are experiencing violence," says Dr. Pellizzari. "Physicians have many opportunities to be a support, and in some cases a lifeline, to these women."

How to reach out to victims of domestic violence is the subject of this installment of *Dialogue's* continuing series on communications.

Assuring medication accuracy at transitions in care

Patient Safety

The World Health Organization (WHO) has developed solutions to address nine vital areas of risk for patients in order to help reduce the toll of health care-related harm.

The most important knowledge in the field of patient safety is how to prevent harm from happening to patients during treatment and care. The nine solutions are based on interventions and actions that have reduced problems related to patient safety in some countries.

In this issue of *Dialogue*, we present WHO's recommendations to assure medication accuracy at transitions in care.

Errors are common as medications are procured, prescribed, dispensed, administered, and monitored but, they occur most frequently during the prescribing and administering actions.

Continued on page 29...

Significant public health issue

About 7% of Canadian women, some 650,000, are estimated to be victims of domestic abuse. (See sidebar.) That's considered to be a conservative figure, due to underreporting. In fact, IPV is documented as the most common form of violence experienced by women, and is seen as a major underlying cause of poor health, and a significant public health issue.

Besides their risk of immediate physical harm, victims of violence have an increased risk of chronic health problems, substance abuse, psychiatric disorders, and suicide.

In Canada, the estimated health related cost of violence perpetrated against women is $1.5 billion per year, including $225 million in medical consultations, and $506 million in short and long-term psychiatric care.

Most of the literature on IPV deals with situations where the perpetrator is male and the victim female. Of course, abuse can occur within same-sex relationships, and males can also be victims of abuse at the hands of women.

As Statistics Canada notes, however, the nature and consequences of domestic abuse are more severe for women than for men. Consider that:

- Female victims of IPV are more than twice as likely to be injured as male victims.
- Women are three times more likely to fear for their life, and twice as likely to be the targets of more than 10 violent episodes.
- Female victims are twice as likely as male victims to be stalked by a previous spouse.

Watch for the signs

To offer support, start by recognizing IPV's prevalence, says Dr. Pellizzari, who was previously Associate Medical Officer of Health for Toronto. Regardless of the nature of your practice, assume that at least some of your patients may well be victims.

When should your radar go up? In some cases, the clues are physical – injuries to the head, neck, torso, breasts, abdomen or genitals; fingerprint or strangulation bruises; injuries to multiple sites in multiple stages of healing; or injuries when pregnant.

You might also be concerned when patients have a history of recurrent trauma or "accidents," when their explanation of injuries doesn't fit the physical evidence, or when they've delayed seeking medical assistance.

And there are other common behavioral signs – frequently missed appointments; patients who seldom go anywhere without their partner; partners who speak for the patient; and patients who exhibit poor eye contact, a flat affect, or hypervigilance.

While IPV cuts across all ages and demographics, remember too that the rates are highest among certain segments of the population – people between the ages of 15-24; people in relationships of three years or less; people who are separated; and people in common-law unions.

While certain situations may raise your suspicions, Dr. Pellizzari says that physicians can explore the possibility of violence in the context of probing about health in general. "This can be part of the risk profile of every patient," she says.

Create a safe environment

Screening for potential abuse can involve a series of questions, with one triggering the next depending on the responses. Consider how these queries can follow each other naturally:

- In general, how would you describe your relationship?
- How do you and your partner work out arguments?
- Do arguments ever result in you feeling down or bad about yourself?
- Do arguments ever result in hitting?
- Do you ever feel frightened by what your partner says or does?

Each patient's interpretation of

violence can vary, so questions need to be specific. Forms of abuse can include slapping, punching, kicking, biting, shoving, choking, pulling hair, using a weapon (or other object) to threaten or injure, and forcing sex.

(Beyond physical abuse, victims can suffer a whole range of associated emotional and psychological abuse, from being called derogatory names, to receiving harassing calls, to having a partner threaten to take the children away).

Through their questions, concern and behavior, physicians need to create an environment where victims of IPV feel safe, says Dr. Pellizzari, who also teaches at the University of Toronto, in the departments of Public Health Sciences, and Family and Community Medicine.

"It's about asking questions that are respectful, being non-judgmental, and assuring that anything the woman says is confidential," she says. "If a woman believes that by telling you she's putting herself at greater risk, she isn't going to disclose. You need to let her know that violence is wrong, and that you can help."

How Widespread is Domestic Violence?

- 7% of women and 6% of men end up being abused by their current or former partners. That adds up to an estimated 653,000 women and 546,000 men. (Source: Statistics Canada.)
- The health-related costs of violence perpetrated against women in Canada is estimated at $1.5 billion per year. This includes $225 million in medical consultations and $506 million in short and long-term psychiatric care. (Source: www.sexualityandu.ca, administered by the Society of Obstetricians and Gynaecologists of Canada.)
- 30% of injured women presenting to emergency rooms were injured during domestic altercations. (Source: www.sexualityandu.ca.)
- 22.7% of women seeking health care from family physicians reported assault by their partner in the preceding year. (Source: www.sexualityandu.ca.)
- 44% of abused women report the use of a weapon against them; 36% of these stated that the weapon was a gun or a knife. (Source: www.sexualityandu.ca.)
- One-third of women reporting abuse say they have feared for their lives. (Source: www.sexualityandu.ca.)
- 23% of abused women will make 6-10 independent visits to a physician for abuse-related injuries. 25% of abused women will seek health care at least 11 times for trauma before disclosing abuse. (Source: www.sexualityandu.ca.)

Role is supportive, not curative

As Dr. Pellizzari notes, a physician's role with adults who may be victims of IPV differs from his or her responsibility in the case of child abuse. Any health provider who suspects that a child is at risk of neglect or abuse (even if there's no direct evidence) is obligated to inform the local child protection agency. But with adult patients who are experiencing violence, or the risk of violence, just how much can the physician do?

The website www.sexualityandu.ca, administered by the Society of Obstetricians and Gynecologists of Canada, offers a wealth of advice. (Click on "Health Professionals" and then "Domestic Violence.") As the website points out: "Many practitioners fear disclosure, as they do not feel that they have the tools to 'treat' the problem. The role here is supportive not curative: the task is to validate the woman's experience and find out what she wishes to do."

Support can take on many forms:

- Respond to the disclosure, i.e., "I'm glad you told me that"; "How are you coping?";"How can I help you?";"Have you spoken to anyone about this before?";"Did this happen recently or in the past?", etc.
- Name the violence as abuse, and remind the patient that she is not to blame. Express concern for her safety, and remain empathetic if she chooses to remain in an abusive relationship.
- Document your findings.
- Try to determine her level of risk for serious harm, and ensure she knows how to contact the appropriate resources (even if she does not wish to access them

immediately). That can include a referral to a social worker, counsellor, or other community resource. If you're not sure who can help, says Dr. Pellizzari, contact the local public health department, or a local sexual assault centre or shelter.

- For women who do not appear to be in immediate danger, do not tell them what to do, do not tell them to leave their partner, do not recommend couples counselling (which can actually lead to an escalation of violence), and do not be judgmental. Simply explore the consequences of each option, and support the woman's decision.
- Do not confront the abusive partner, or share what your patient told you if the partner is also your patient.
- Arrange for a follow-up appointment.
- For women in immediate danger, encourage them to stay with a friend or contact shelter services, or, with their consent, call the police. Also encourage the woman to develop a safety plan/escape kit, i.e., emergency numbers, key documents, a packed suitcase (maybe stored at the home of a trusted friend or relative), money, etc.

"Physicians can play an important role in making an assessment of risk, determining if an urgent intervention is necessary to get a women to safety, helping women to access resources, and supporting women whether or not they choose to leave," says Dr. Pellizzari. "It's not about the physician's choice. It's about supporting women to be empowered to make their choices." MD

Stuart Foxman is a Toronto freelance writer.

Game-Based Learning Helps ER Staff Aid Abuse Victims

Domestic violence is no game. But a web-based training program, with the look and feel of a video game, aims to help Ontario's emergency care providers better deal with this abuse crisis.

"People need more than just information," says Dr. Robin Mason of the Women's College Research Institute in Toronto. "Our evaluation shows that people need an opportunity to practise their responses. Game-based learning helps people retain information and skills because it immerses them in the learning situation."

Dr. Mason co-chaired an expert government panel of domestic violence experts and emergency room doctors and nurses, which resulted in the web-based training. The tool, part of the Ontario Government's Domestic Violence Action Plan, is available at no cost at **www.dveducation.ca**, via any computer with an Internet connection.

ER doctors and nurses are often the first people to see the physical signs of domestic violence, when women seek medical attention. The training program will help ER staff to recognize those signs, and give victims the appropriate support and information.

The expert panel developed a list of core competencies deemed essential for best practice responses to domestic violence. They then developed game situations, often based on real-world experiences, to help participants apply what they've learned in an animated patient interaction. Up to six hours of training are available, which can be done in blocks of time as needed.

Assuring medication accuracy at transitions in care Continued from page 25

The nine solutions come under the headings of:

1 Look-alike, sound-alike medication names;
2 Patient identification;
3 Communication during patient hand-overs;
4 Performance of correct procedure at correct body site;
5 Control of concentrated electrolyte solutions;
6 **Assuring medication accuracy at transitions in care;**
7 Avoiding catheter and tubing misconnections;
8 Single use of injection devices; and
9 Improved hand hygiene to prevent health care-associated infection.

The impact is significant, as medication errors harm an estimated 1.5 million people and kill several thousand each year in the US. ISMP Canada, which has been capturing medication incident reports since 2000, states that as of April 30, 2008, there have been 30,612 voluntarily reported medication incidents in Canada. Of those medication incidents, 1169 (3.81%) had an outcome of "harm" or "death." Other industrialized countries around the world have also found that medication adverse events are a leading cause of injury and death within their health-care systems.

In some countries, up to 67% of patients' prescription medication histories have one or more errors, and up to 46% of medication errors occur when new orders are written at patient admission or discharge. Medication reconciliation is a process designed to prevent medication errors at patient transition points. It includes:

- Creating the most complete and accurate list possible or "Best Possible Medication History" (BPMH) of all medications the patient is currently taking – also called the "home" medication list.
- Comparing the list against the admission, transfer, and/or discharge orders when writing medication orders; identifying and bringing any discrepancies to the attention of the prescribing health professional; and, if appropriate, making changes to the orders while ensuring the changes are documented.
- Updating the list as new orders are written to reflect all of the patient's current medications.
- Communicating the list to the next provider of care whenever the patient is transferred or discharged and providing the list to the patient at the time of discharge.

Effectively engaging the patient and family in medication reconciliation is a key strategy for targeting and preventing prescribing and administration errors, and thereby reducing patient harm.

For example, upon implementing a patient-centered medication reconciliation program, three hospitals in Massachusetts experienced an average 85% reduction in related medication errors over a 10-month period. Hundreds of health-care provider teams are spreading and sustaining the implementation of this strategy by participating in the Safer Healthcare Now!, (Canada) and the 100K Lives, (US) campaigns.

There are many challenges to successfully implementing such programs in all settings where medications are used. Successful implementation requires leadership support; active physician, nursing, and pharmacist involvement; effective implementation teams; and collaborative learning sessions.

The Massachusetts Coalition for Prevention of Medical Errors, Institute for Healthcare Improvement, and Safer Healthcare Now! websites now offer sample resources for implementing a medication reconciliation program.

Another critical factor upon which medication reconciliation depends is the appropriateness of the medications prescribed in relation to the patient's illness and underlying conditions. While prescribing practices, including the risks of poly-pharmacy, extend beyond the scope of this solution, the medication reconciliation process provides opportunities to reconsider the appropriateness of a patient's medications over time as the patient's condition may change or as other prescribers become involved.

Patient Safety

The following strategies should be considered:

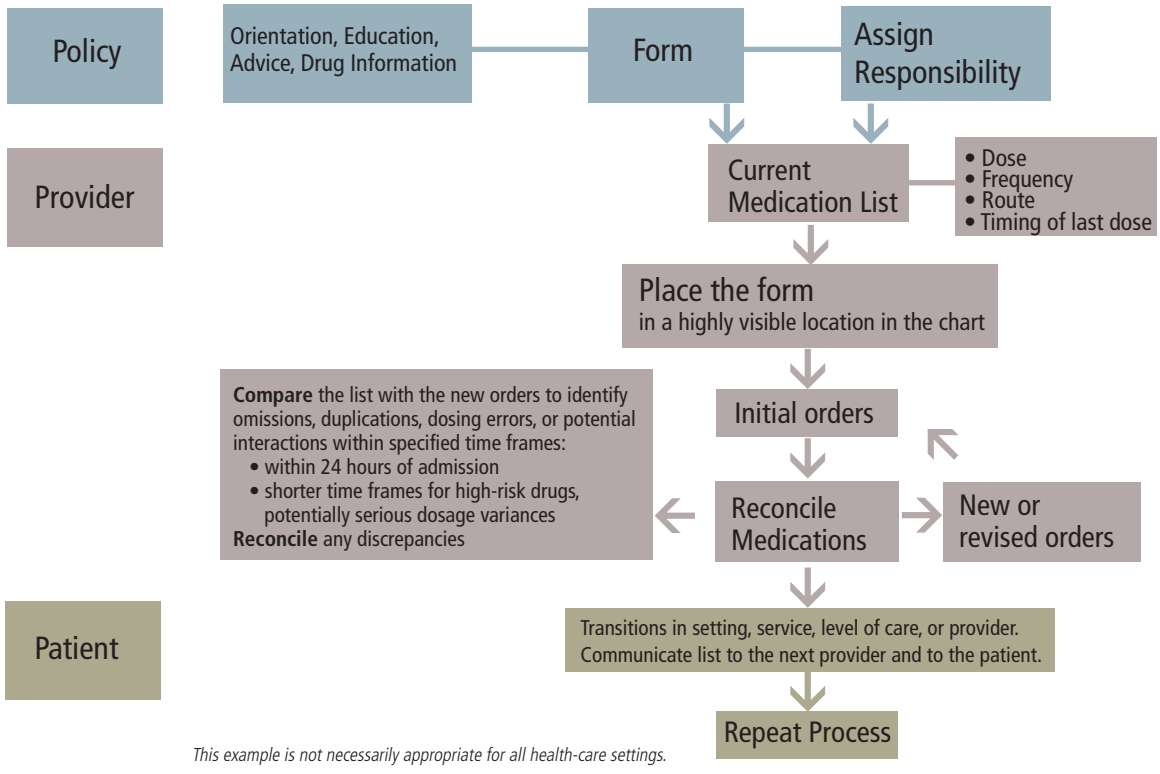
1. Health-care organizations should put in place standardized systems to collect and document information about all current medications for each patient and provide the resulting medication list to the receiving caregiver(s) at each care transition point (admission, transfer, discharge, outpatient visit).

Suggested information to be collected includes:

- Prescription and non-prescription (over-the-counter) medications, vitamins, nutritional supplements, potentially interactive food items, herbal preparations, and recreational drugs.
- The dose, frequency, route, and timing of last dose, as appropriate. Whenever possible, validate the home medication list with the patient and determine the patient's actual level of compliance with prescribed dosing.
- The source(s) of the patient's medications. As appropriate, involve the patient's community pharmacist(s) or primary care provider(s) in collecting and validating the home medication information.

2. Ensure that health-care organizations have clear policies and procedures in place that require:
   - That the patient's current medication list be displayed in a consistent, highly visible location (for example, the patient's chart) so that it is easily accessible to clinicians who are writing drug orders.
   - The use of the home medication list as a reference when ordering medications at the time of treatment in a clinic or emergency unit or upon admission to an inpatient service.
   - The reconciliation of medications (i.e., comparison of the patient's medication list with the medications being ordered to identify omissions, duplications, inconsistencies between

Example of Assuring Medication Accuracy at Transitions in Care



This example is not necessarily appropriate for all health-care settings.

the patient's medications and clinical conditions, dosing errors, and potential interactions) within specified time frames (e.g., within 24 hours of admission; shorter time frames for high-risk drugs, potentially serious dosage variances, and/or upcoming administration times).

- A process for updating the list, as new orders are written, to reflect all of the patient's current medications, including any self-administered medications brought into the organization by the patient.
- A process for ensuring that, at discharge, the patient's medication list is updated to include all medications the patient is to be taking following discharge, including new and continuing medications, and previously discontinued "home" medications that are to be resumed. The list should be communicated to the next provider(s) of care and also be provided to the patient as part of the discharge instructions. Medications not to be continued should ideally be discarded by patients.
- Clear assignment of roles and responsibilities for all steps in the medication reconciliation process to qualified individuals, within a context of shared accountability. Those may include the patient's primary care provider, other physicians, nurses, pharmacists, and other clinicians. The qualifications of the responsible individuals should be determined by the health-care organization within the limits of applicable law and regulation.
- Access to relevant information and to pharmacist advice at each step in the reconciliation process, to the extent available.

3. Incorporate training on procedures for reconciling medications into the educational curricula, orientation, and continuing professional development for health-care professionals.

Opportunities for Patient and Family Involvement

To be optimally effective, the medication reconciliation process must involve patients and their families. Encourage patients to participate and provide them with the tools to do so.

Educate patients about safe medication use and provide access to reliable, relevant, and understandable information about their medications.

The patient is in the best position to be aware of all the medications prescribed by multiple caregivers. Consider asking patients to put all their medications in a bag and bring it with them whenever going to the hospital or a doctor visit.

Encourage patients, family, and caregivers to keep and maintain an accurate list of all medications, including prescription and non-prescription medications, herbal and nutritional supplements, immunization history, and any allergic or adverse medication reactions. These medication lists should be updated and reviewed with the patient/family/caregiver at each care encounter.

Teach patients about the risks of medications, both individually and in combination, with particular attention to patients on multiple medications prescribed by multiple caregivers.

Encourage patients and families to use a single pharmacy, not only as the provider of medications but as a source of information about the medications.

Consider community support systems to assist patients in verifying medication lists in the home.

Please see page 35 for an Ontario project that examines the challenges in the transfer of accountability. MD

Avoid hiring illegal nurses by requesting a register check from regulatory body

Physicians are urged to adopt a pre-hiring routine of ensuring that the people they wish to employ in their offices or private clinics as nurses are, in fact, registered with the regulatory body.

Earlier this year, the College of Nurses of Ontario (CNO) successfully pursued charges against an Ontario resident who repeatedly held herself out as a nurse without having the legal authority to do so. The case showed how important it is for employers to contact the CNO to confirm that applicants for nursing positions have a current CNO membership and are truly qualified to practise nursing.

Like the CPSO, the CNO maintains a register of its members, past and present. CNO registers three types of nurse: Registered Nurses (RNs), Registered Practical Nurses (RPNs) and Nurse Practitioners (NPs). All of these are protected titles, meaning only individuals registered with the CNO can use them or call themselves a nurse. In addition, only CNO members are authorized to perform the controlled acts delegated to nursing.

"Hiring illegal practitioners to provide nursing care is a serious matter that threatens public safety," explains Ms. Karen McGovern, CNO's Director of Investigations and Hearings. "These individuals may have been members of the CNO in the past, but were revoked for professional misconduct. In some cases, the illegal practitioner has never received nursing education."

By contacting the CNO and requesting a register check, employers can learn if someone is currently a registered member of the CNO or if there are any restrictions on their practice.

"A phone call to the CNO to confirm an applicant's registration could have prevented most situations that we've seen," says Ms. McGovern. "A few minutes talking to one of our Customer Service Representatives is nothing compared to the risk posed to the public and the months of inconvenience that can result when an illegal practitioner is discovered on a facility's staff."

Starting in June 2009, physicians will be able to confirm nurses' registrations by visiting www.cno.org.

In the meantime, physicians can contact the College's Customer Service Centre:

Hours: Monday to Friday, 8:30 a.m. to 5:00 p.m.

Phone: (416) 928-0900; **Toll-free:** 1-800-387-5526

E-mail: cno@cnomail.org MD

Close up on peer assessors

Name: Dr. Federico Sanchez

Nature of Practice: Walk In Clinic

City: Toronto

How long have you been a peer assessor? Nearly two years.

Have you made a change in your practice because of something you learned from assessing a peer?

There will always be ways to improve my practice. During the course of doing peer assessments, I have come across several outstanding physicians who were doing things in ways I had not previously considered. This includes some charting ideas, as well as clinical methods. I have incorporated quite a few of these ideas into my own practice as a result.

How has being a peer assessor directed your own learning?

During my assessments, I always stress that I am a peer, and not an expert. I do not pretend to know everything. I believe that the mass of information to know in clinical practice extends far beyond the current clinical guidelines and research. There is a lot to be said for clinical experience, and that is something that only comes with time. I find that pieces of information that I get from well seasoned physicians I meet during the peer assessments have led me to further directed learning in these areas.

Have you ever made suggestions, in the course of an assessment, that directed the physician's CPD?

Physicians want to learn, but are often too busy to do so to the extent that they would like. I often suggest things like the daily InfoPOEMs emails that are available free of charge for OMA members. These are a great way to get clinical pearls every day, in small, manageable doses.

Dr. Federico Sanchez
Peer Assessor

Becoming a Peer Assessor

Peer review is a cornerstone of self-regulation. It assures the public that the physicians of Ontario are helping each other to practise the best possible medicine.

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

If you'd like to learn more, please contact Maureen Gans, Manager of Quality Assurance at (416) 967-2600 ext. 637, toll free (800) 268-7096 ext. 637 or mgans@cpso.on.ca.

New guidelines for prevention of IE prompts joint statement with RCDSO

The American Heart Association (AHA) has issued new guidelines for the prevention of infective endocarditis (IE) that include substantial changes. In the Ontario health-care landscape, these guidelines may be relied upon by dentists, physicians and nurses as they interact across disciplines to provide optimum patient care.

The new guidelines have prompted questions by patients and health-care practitioners alike. In some cases, practitioners advise us that their colleagues are unaware of them. In other cases, we are hearing that there is inconsistency in their application. We are also hearing from patients that they are receiving conflicting advice about whether or not they should take antibiotics.

As the regulators, we view this situation as demonstrative of both the perils and opportunities presented by interdisciplinary health-care delivery. In order to ensure that our members are in a position to work together effectively and efficiently for the benefit of their mutual patients, we must be certain that they have a common understanding. In most cases, the College of Physicians and Surgeons of Ontario (CPSO) and the Royal College of Dental Surgeons of Ontario (RCDSO) believe that this is best achieved by sharing information directly between the professionals involved. We encourage our members to be open to receiving information from their colleagues practising in another discipline, and to discuss how to proceed in the best interests of the patient. We know that these conversations about the new guidelines are taking place, and that most of our members are working together smoothly. However, we are also aware that many solo practitioners are involved, who do not have the opportunity for day-to-day, face-to-face communication. To facilitate communication for these practitioners, the colleges have agreed jointly to advise their members to be aware of the new guidelines.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Royal College of Dental Surgeons of Ontario

With A Common Voice

Where can I get a copy of the new guidelines for the prevention of IE?

The AHA issued new guidelines in April 2007 and subsequently made some minor changes. The most recent version is available at http://circ.ahajournals.org/cgi/reprint/116/15/1736

What changes have been made?

Prophylactic antibiotics are no longer recommended for many patients who routinely took them in the past. In addition, the new guidelines have replaced the previous lengthy list of specific dental procedures with the general recommendation that antibiotic prophylaxis is reasonable for all dental procedures involving the manipulation of gingival tissue or the periapical region of teeth or perforation of the oral mucosa.

Do the new guidelines affect patients with total joint replacements?

No. There have been no changes to the recommendations for these patients. The current Advisory Statement from the American Dental Association and the American Academy of Orthopaedic Surgeons is available at http://jada.ada.org/cgi/reprint/134/7/895.

What is the role of the medical and dental professionals in determining whether antibiotic prophylaxis is necessary for a dental appointment?

The relative roles of the professionals involved are flexible. Usually, however, we anticipate that the medical professional will identify whether the patient has one of the four underlying cardiac conditions associated with the highest risk of adverse outcome from IE. This information should be clearly communicated to the patient, who should then share it with his or her dentist. If prophylactic antibiotics are warranted, often the dentist will prescribe them for a particular dental appointment, but this may be determined on a case-by-case basis in collaboration with the medical professional. The most important issue, of course, is that the patient understands his or her needs, as well as the process of communication between all health-care providers.

What if the patient informs the dentist that his or her medical professional advises to continue taking prophylactic antibiotics, even though they are not recommended under the new guidelines?

In this case, we expect that the medical and dental professionals will speak to each other and come to a common understanding in the best interests of the patient. MD

Ensuring continuity in patient's care

What are the challenges in transferring care among different health-care professionals? That is what the CPSO, the College of Nurses of Ontario, the Ontario College of Pharmacists, St. Michael's Hospital, and Sunnybrook Health Sciences Centre hope to discover through research on a new project.

The project entitled "Transfer of Accountability" (TOA) examines the interactive process of transferring patient-specific information from one caregiver to another, or from one team of caregivers to another. The purpose is to ensure the continuity and safety of the patient's care.

The project works on the assumption that while knowledge and skill are important in safely transferring patient care, exercising good clinical judgment is key.

The researchers also came to realize that because transfers are complex and context-specific, it is difficult to develop a set of standardized guidelines to support them.

A transfer of accountability is complex and demands the sharing of information – such as a comprehensive history, current situation, medications, test results, and outstanding results. It is also a staged process, one that involves pre-planning, involvement of patient and family, and reciprocal exchange of information.

It is important for health-care providers to appreciate that a transfer is the most vulnerable time for a patient and family. The research participants developed a list of the elements of a successful transfer of accountability and the obstacles to success (see sidebar).

Elements of a successful TOA:

- Timely
- Customized to patient needs
- Transparent process
- Flexible
- Comprehensive
- In-person exchange of information
- Ongoing dialogue as required
- Communication is key

Barriers to a successful TOA:

- Many interruptions
- Insufficient resources allocated to conduct transfer
- Unplanned and unprepared, especially off-hours
- Lack of respect between providers
- Lack of understanding of PHIPPA – what can and can't be done MD

Physicians suspended for non-payment of annual fee, failure to return membership form

As of November 1, 2008, 79 physicians have had their certificate of registration suspended. The majority of these physicians were suspended for non-payment of the College's annual fee. Many of these physicians likely continue to practise outside Ontario or have retired and chosen not to pay the fee.

It is in physicians' best interest to officially resign from the College rather than let their membership lapse. Once a certificate of registration is suspended for non-payment of the annual fee, a permanent record of the suspension must be entered in the register. All institutional requests for a physician's status with the College will include this information.

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

And for the first year, we are including the names of physicians who did not return their annual renewal form by the deadline. Amendments to the College by-laws now require both the payment of the annual membership fee and submission of the annual renewal form in order to renew a member's certificate of registration.

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

Certificate of Registration Suspensions – Non-Payment of Fees

Ontario

CPSO#	NAME
13747	Charles William Pearson Lunderville
20929	Samuel Olusoji Adesola Soremekun
21431	Rodolphe Albert Pare
22576	John Thomas Rankin
26790	Douglas Gordon Romans
30391	Constantine Victoros
31811	Charles Randal Smith
52560	Cheuk Fung Tong
54705	Tsze Kwan Jeff Ho
56038	David Martin Fraser
56187	Bruno Bissonnette
56419	Bounmy Thipphawong
70676	Truong Van Nguyen
74308	Naeem Mohammad Faseeh Ali
76708	Anwar Wajdi Abdo M Salam
77669	Paul David Cleve
77739	Jessica Amber Haussmann
78597	Christina Pechin Ricks
80155	Michael James Falk
81718	Timothy Frederick Eaton Brown
86634	Ahmed Rustom Al-Ghoul
87027	Rory Colin MacKay
87727	Richard Charles Kasper

Canada – All Other Provinces

CPSO#	NAME
24778	Benjamin Arthur Sawer
26739	Sadruddin Mohamedali Adatia
28114	Leonidas Nicolaos Dragatakis
31264	Neva Bonita Hilliard
42435	Jeremy Keith Alken Roberts
51208	Avinder Singh Minhas
55849	Lisa Welikovitch
60037	Celine Belhumeur
60316	Bhupinder Singh Bedi
61501	Margaret Alison Berry
62258	Vincent Wing-Sinn Wong
64088	Marie-Josee Filteau
64184	Graham Walter Bishop
64662	Arif Samad
64708	Rosario Rebello
65045	Stanley Laurence Whyte
66087	Claude Pilon
74364	Dominic Harnois
76190	Jay Jonathan Ross
78378	William Stirling Keizer
78572	Mitchell Jeffrey Schipper
78737	Anne Lynette Roche
81559	Luke Raymond Shier
81565	Alexis Turgeon-Fournier
83299	Victor Kevin Wong
83827	Reda Salem
85135	Ronald Christopher Diamond
85976	Robert Bruce Davidson
87527	Benoit Benoit

United States

CPSO#	NAME
26597	Riivo Ilves
30351	Fionnuala Ann Kelly
32943	Michael Ackland
50951	Thomas Robert Love
51712	Shayne Mark Plosker
55396	Christine Patricia Richards
55895	Barry Benjamin Bialek
57050	Mani Subramaniam Mahadevan
57198	Manju Monga
58682	Dina Floriana Eftimescu
59845	Thadeus Leo Trus
59870	Maria Nicola Biard
61249	Darlene Margaret Miltenburg
61806	Casilda Jean Rubio
62777	Paul William Finnegan
64823	Omid Rowshan
67476	Linda Papa
71499	Marwan Samir Haddad
75602	Stephen Richard Hodgins
83906	Mark Edgar Lach

International

CPSO#	NAME
25910	Hak Fai Chiu
56640	Patrick Gerard Doyle

Physicians suspended for failure to return membership form

Ontario

CPSO#	NAME
70765	Peter Kenneth Ross

Manitoba

CPSO#	NAME
66017	David Edward Draper

Newfoundland & Labrador

CPSO#	NAME
56291	Carl Adam Wesolowski

United States

CPSO#	NAME
10909	Charles Sheard

United Kingdom

CPSO#	NAME
27085	Denis Mulholland Oldham

Discipline Summaries

NAME	HEARING DATES	NATURE OF PRACTICE	PAGE
Dr. K.T. Auchinachie	January 10, 2008	General Practice	38
Dr. Y. Derenda	November 26, 27, 2007	General Practice	38
Dr. H. Li	July 30, 2007	General Practice	42

For full decisions please visit our website: www.cpso.on.ca

Dr. Keith Taylor Auchinachie

BRANTFORD

Allegation

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

Response to the Allegation

Dr. Auchinachie admitted to the allegation and the case proceeded on the basis of an Agreed Statement of Facts.

Evidence

An Agreed Statement of Facts established that:

1. In May 2006, the College received a complaint from the daughter of one of Dr. Auchinachie's patients about the care he had provided to her mother, an elderly woman with diabetes.
2. On June 23, 2006, the College received Dr. Auchinachie's response to the patient's daughter's complaint along with a copy of his original office records pertaining to the patient.
3. On July 13, 2006, the College received a letter from Dr. Auchinachie's office, signed by the patient, attesting to her satisfaction with Dr. Auchinachie's care, asking that the complaint be disregarded because it had no merit, and requesting that the College not share this letter with the patient's daughter.
4. On his own initiative, and during the course of the College's investigation, Dr. Auchinachie drafted the letter, had his secretary type it, visited the patient at the nursing home where she was residing, and asked her to sign it. In doing so, he acted inappropriately and unprofessionally.

Finding

The Committee found that Dr. Auchinachie engaged in conduct or an act or acts relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonorable or unprofessional.

Reasons for Penalty

Counsel for the College and counsel for the member made a joint submission as to an appropriate penalty and costs. The proposed order was accepted by the Committee.

The Committee found that Dr. Auchinachie's interference with the College investigation of a complaint by drafting a letter himself and having the patient sign it as if it were her own demonstrates a significant lapse of judgment and lack of integrity. Physicians are in a position of power and authority in the doctor-patient relationship and must not abuse this power. Patients must be able to trust their physicians. This type of behavior cannot be tolerated. The penalty of a suspension of the doctor's certificate of registration for two months expresses the abhorrence of the profession for Dr. Auchinachie's unprofessional behavior. It will serve as a specific deterrent for him in the future, as well as serve as a deterrent against similar conduct by others in the profession.

The Committee considered Dr. Auchinachie's cooperation with the College in the hearing process by an early admission of misconduct and in reaching a joint submission to be a mitigating factor. It was also a mitigating factor that Dr. Auchinachie had no prior findings of professional misconduct in his 33 years of medical practice.

Penalty

The Discipline Committee directed that:

1. The Registrar suspend Dr. Auchinachie's certificate of registration for a period of two months, one month of which shall be suspended if Dr. Auchinachie successfully completes, at his own expense, the College's Medical Ethics and Informed Consent Course and provides proof thereof to the College.
2. Dr. Auchinachie appear before the panel to be reprimanded.
3. Dr. Auchinachie pay costs to the College in the amount of $3,650.
4. The results of this proceeding be included in the register.

At the completion of the hearing Dr. Auchinachie waived his right to appeal and the reprimand was administered.

Dr. Yolanda Derenda

TORONTO

Allegations

It was alleged that Dr. Derenda committed acts of professional misconduct, in that:

1. she engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would rea-

sonably be regarded by members as disgraceful, dishonorable or unprofessional.

2. she has contravened a term, condition or limitation on her certificate of registration.

Response to the Allegations

Dr. Derenda entered a plea of no contest to the allegations. Dr. Derenda acknowledged some of the conduct alleged but denied the facts pertaining to her behavior on a specific encounter with hospital staff at a Toronto hospital.

Evidence

An Agreed Statement of Facts established the following:

1. Dr. Derenda practised general medicine in Toronto.
2. On March 8, 2001, the Fitness to Practise Committee found Dr. Derenda to be incapacitated and made the following Order :

   (1) That the Registrar impose the following terms, conditions and limitations on Dr. Derenda's certificate of registration:

   (a) Dr. Derenda may not practice unless and until:

   (i) Dr. Derenda is monitored by a member holding a certificate of practice in Ontario who is acceptable to the Registrar, which member has executed and is in compliance with an acknowledgment and undertaking in a form agreeable to the Registrar and has delivered such acknowledgment and undertaking to the College within 30 days of the date it is agreed upon by the Registrar. Should any person who has executed an acknowledgement and undertaking for Dr. Derenda pursuant to this order be unable or unwilling to continue under the terms of the acknowledgement and undertaking, Dr. Derenda will provide, within 30 days, a fresh acknowledgement and undertaking from a further person who is satisfactory to the Registrar in a form satisfactory to the Registrar;

   (ii) Dr. Derenda obtain a satisfactory result on a peer assessment on a bi-annual basis; and

   (iii) Dr. Derenda participate in ongoing psychiatric treatment by a psychiatrist certified by the Royal College as frequently as recommended by the psychiatrist and until such time as the psychiatrist advises the Registrar that such treatment is no longer required.

3. On or about April 6, 2001, the College wrote to Dr. Derenda advising her that she could not practise until the conditions of the March 8, 2001 Order were met. This letter was hand delivered to Dr. Derenda on April 19, 2001.
4. Dr. Derenda has not fulfilled the conditions of the March 8, 2001 Order and, accordingly, has not been permitted to practise since March 8, 2001.
5. Dr. Derenda became Patient A's family doctor in approximately 1996.
6. On or about June 2005, Patient A was admitted to a Toronto hospital. Accompanying her admission was a note, authored by Dr. Derenda, containing medical details regarding Patient A's condition.
7. That evening, Dr. Derenda repeatedly called the Emergency Room at the hospital requesting medical information pertaining to Patient A's progress.
8. Neither Patient A nor her husband, Patient B were aware that Dr. Derenda was prohibited from practising medicine.
9. Dr. Derenda became one of Patient B's physicians in approximately 1998 and continued to treat him until approximately 2005.
10. On or about March 2000, Dr. Derenda borrowed $10,000 from Patient A.
11. In order to make this loan, Patient A borrowed $3,000 from her line of credit.
12. Prior to obtaining this loan from Patient A, Dr. Derenda had requested a loan from Patient B. Patient B advised Dr. Derenda that he was unable to make such a loan due to financial constraints.
13. Dr. Derenda has repaid approximately $3,000 to Patient A and Patient B.
14. Despite this suspension on her certificate of registration, Dr. Derenda has continued to practise medicine. Since the Order, Dr. Derenda has written 156 prescriptions for 22 different patients and has self-prescribed.
15. On June 8, 2006, the Executive Committee made an Order directing the Registrar to sus-

pend Dr. Derenda's certificate of registration effective June 9, 2006.

16. Dr. Derenda issued prescriptions after June 9, 2006. Such prescriptions were issued in contravention of the s. 37 Order.

Evidence of Dr. Derenda

Dr. Derenda testified that she was aware of the terms and conditions placed on her certificate of registration. She testified that she had arranged for most of her patients to see other family practitioners but that there were some patients that she continued to help when they called her. She testified that they came to her house, as she had given up her office. It was her evidence that she did not keep charts for these patients but she made notes, ordered tests and gave the notes and test results to the patients to take to their family doctors. She also testified that she called pharmacies regarding prescriptions as outlined in the Agreed Statement of Facts for these patients. Dr. Derenda testified that she did not tell anyone about the limitations on her practising medicine, because she was too proud, too miserable. During her testimony, Dr. Derenda was very detailed in explaining to the panel precisely what she found on physical exams, and how she successfully treated these few patients. She insisted that she was not their family doctor but that she was only helping them. Dr. Derenda testified that she never benefited financially from any of these patient encounters.

In her testimony, Dr. Derenda detailed the story of the borrowed money from Patient A. She stated that the monies were offered to her by Patient A and that after accepting the money she was very, very grateful to Patient A and her family and she continued to help them as their friend.

Evidence of Mr. AA

Mr. AA is the son of Patient A. He testified that he was a patient of Dr. Derenda's between 1999 and 2001. He testified that he went back to his previous family physician on his own accord because he was uncomfortable with the relationship Dr. Derenda had with his parents. He believed that relationship to be intensely personal and emotional.

Mr. AA testified that sometime in late 1999 or early 2000, he went with his mother, at her request to see Dr. Derenda in her office to discuss a request for a loan made by Dr. Derenda to Patient A.

He testified that he did all the talking at the meeting and explained that his family was unable to loan Dr. Derenda any money.

The Contested Allegation

The Committee heard the testimony of Dr. Z, Ms. Y, and Dr. X all from the hospital on behalf of the College. The Committee also heard testimony from Dr. Derenda in her defence regarding her encounters with the hospital staff.

Various exhibits were filed, including Patient A's hospital clinical records contained in an Agreed Book of Documents. Of specific importance is a hand written note on physician's progress paper from Dr. Derenda to the admitting physicians at the hospital which accompanied Patient A to the hospital for admission, in June 2005.

Evidence of Dr. Z

Dr. Z testified that he was working at the hospital on the date in question. He stated that he had two telephone conversations with Dr. Derenda at the request of the nurses looking after Patient A in the emergency room. During the first conversation, he testified Dr. Derenda identified herself as the patient's family physician. He confirmed with Patient A that Dr. Derenda was her doctor and he then had a 30 to 40 minute conversation with Dr. Derenda regarding the care plan for Patient A. Dr. Z testified that Dr. Derenda was quite reasonable.

Evidence of Ms. Y

Ms. Y, a registered nurse employed at the hospital, was the charge nurse in the area where Patient A was in June 2005. Ms. Y testified that Dr. Derenda was quite upset on the phone and that after an unsuccessful conversation she took the mobile phone to the doctor's consultation room on the ward and gave it to one of the members of the medical team responsible for the care of Patient A.

Evidence of Dr. X

Dr. X, a staff physician at the hospital heading the medical team responsible for Patient A in June 2005, testified that she too wanted to clarify the relationship between Dr. Derenda and Patient A prior to any privileged information being given over the phone. She testified that Patient A indicated that Dr. Derenda was her physician. Dr. X testified that a resident on the team looked up Dr. Derenda on the CPSO website and discovered that her license was restricted. When Dr. X shared this information with Patient A, it was clear that the patient did not know of Dr. Derenda's circumstances and did

not want any further information released. Dr. X testified that Dr. Derenda listened quietly and politely to this information over the phone, said that she was the person who sent Patient A to the hospital for assessment and then hung up the phone. These facts were documented contemporaneously in the patient chart marked as an exhibit.

Evidence of Dr. Derenda

Dr. Derenda testified that she was called to see Patient A by her family and that she went to see her as a friend at their home. Dr. Derenda testified that she examined Patient A, felt that she needed to go to the hospital and accompanied Patient A and her husband to the hospital emergency ward. She left the hospital and called the emergency ward after two hours to check on her friend. Dr. Derenda testified that she called a total of three times but was unable to obtain information. Under cross-examination, Dr. Derenda admitted to writing, on physician progress paper, a note detailing a history and physical examination, including blood pressure for Patient A. Dr. Derenda's testimony explaining the exam of Patient A was very detailed, careful and complete. Dr. Derenda continues to insist she was only trying to help her friend and was not rude during any telephone conversation with hospital staff.

Findings

The Committee found that Dr. Derenda committed an act of professional misconduct, in that she has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, in that she has contravened a term, condition or limitation on her certificate of registration.

Given the plea of no contest to all the allegations and the Agreed Statement of Facts, which includes 156 prescriptions issued to 22 different patients, the Committee concludes that Dr. Derenda has breached the Orders of the College to not practise medicine. The Committee noted that Dr. Derenda believed she was acting in kindness and it is clear from her evidence that she lacks insight into her situation.

With respect to the contested allegation, the Committee found that Dr. Derenda represented herself to be Patient A's physician to the staff at the Toronto hospital in March 2005. The Committee considered the evidence of the staff at the hospital to be credible and reliable but found no clear, cogent or convincing evidence that Dr. Derenda behaved in a rude or inappropriate manner toward them on that date.

Reasons for Penalty

College counsel submitted that the finding of professional misconduct coupled with Dr. Derenda's lack of insight into what constitutes practising medicine showed a disregard and disrespect for the College and a serious lack of responsibility to the public. As well, it was submitted that Dr. Derenda displayed a significant lack of personal integrity, and difficulty distinguishing and maintaining interpersonal boundaries. It was submitted that together these facts led the College to seek revocation of Dr. Derenda's certificate of registration, as well as a fine. It was also submitted that her conduct during the proceeding with respect to seeking two adjournments justifies an award of costs.

The Committee unanimously agreed that revocation is necessary in this case as there has been no response to previous efforts by the College to govern Dr. Derenda. She has repeatedly demonstrated her ungovernability through a consistent pattern of inability to follow College Orders.

Dr. Derenda has displayed a disregard for the core values of the profession by transgressing boundaries evident from her intertwining relationship with Patient A and her family. As well, her egregious breach of ethics is evident through repeated self prescribing and prescribing for family members while her certificate of registration was suspended. Dr. Derenda, through her testimony regarding patient exams and treatment plans, displayed a remarkable lack of insight into the seriousness of her choice not to comply with College Orders.

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Revocation is the only penalty suitable to uphold the honor and reputation of the profession and to protect the public. Revocation will also serve as a deterrent to the general membership by sending a message that flagrant repeated breaches of College Orders will not be tolerated.

With respect to costs, counsel for the College submitted an affidavit outlining the costs it is seeking. The

Committee reviewed these documents very carefully and concluded that Dr. Derenda should be responsible for the costs incurred by unreasonable delays instigated by her, namely the second and third adjournments of this hearing. The first adjournment had been granted by the panel in order for Dr. Derenda to seek counsel; she did not follow these orders and reappeared unrepresented again seeking adjournment. The third delay occurred again because counsel was not acquired in a timely fashion. The Committee found this an abuse of its process.

The Committee noted that the hearing was shortened by Dr. Derenda's cooperation through the Agreed Statement of Facts, albeit at the eleventh hour, and so costs are not awarded for any portion of the scheduled hearing. In addition, Dr Derenda was successful in her defense of that portion of the allegation that she contested.

The College submitted that it was not seeking its investigative costs including the costs of the expert witness with respect to the investigative phase and therefore the Committee makes no award with respect to this aspect of the costs.

In summary, the Committee awards costs of $12,215.24 to the College.

Finally as a specific and general deterrent to the membership, the Committee also directed the results of this proceeding to be included in the register.

Penalty

The Discipline Committee directs that:

1. The Registrar revoke Dr. Derenda's certificate of registration, effective immediately.
2. Dr. Derenda pay to the College costs in the amount of $12,215.24 within 90 days of the date of this order.
3. The results of this proceeding be included in the register.

Dr. Derenda did not appeal this decision.

Dr. Heung-Wing Li

SCARBOROUGH

Allegation

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

Response to the Allegation

Dr. Li entered a plea of no contest to the allegation and the case proceeded on the basis of an Agreed Statement of Facts.

Evidence

The Agreed Statement of Facts established that:

1. Dr. Li is a general practitioner who practises in Scarborough. He signed an undertaking with the College on January 19, 2005 that stated in part:

   …

   (iv) I am aware of and agree to abide by the restrictions on my certificate of registration pending my Discipline Hearing which are:

   a) All of Dr. Li's examinations of female patients age 10 years or older must be in the company of a member of a regulated health profession (hereinafter referred to as the "Monitor");

   b) The Monitor shall satisfy the Registrar that s/he has reviewed the Notice of Hearing, is aware of the issues which will be before the Discipline Committee, and has agreed to report any untoward conduct on Dr. Li's part promptly to the Registrar;

   c) The Monitor shall keep a log of the examinations at which s/he is present and shall provide a copy of the log on a bi-weekly basis to the College;

   d) All of Dr. Li's examinations of female patients under the age of 10 years must be in the company of the Monitor or in the company of the child's parent or guardian;

   …

2. On January 25, 2005, counsel for Dr. Li wrote to counsel for the College proposing two people to act as monitors pursuant to the undertaking. Counsel noted in his letter that one of the proposed monitors, Ms. A, was a member of the College of Nurses. He also noted that the other proposed monitor, Ms. B, had been trained as a medical laboratory technician and had applied for membership in the College of Medical Laboratory Technologists. Dr. Li had hired these individuals to function as chaperones while he was seeing female patients and they had been employed prior to his signing the undertaking on January 19, 2005. Counsel stated that he would advise as soon as he learned whether Ms. B's application had been accepted.
3. Attached to this January 25,

2005 letter were signed letters from each of Ms. A and Ms. B stating that they had reviewed the Notice of Hearing and Dr. Li's undertaking and were prepared to act as monitors for the purposes of the undertaking. Ms. B's letter stated that she had applied for membership in the College of Medical Laboratory Technologists of Ontario.

4. On January 31, 2005, counsel for the College wrote to counsel for Dr. Li advising him that Ms. A was approved as a monitor for the purpose of Dr. Li's undertaking. Ms. B was not approved as a monitor as she was not a member of a regulated health profession.
5. Ms. A acted as a monitor for Dr. Li for physical examinations of female patients on approximately six days between January 21, 2005 and January 31, 2005 before she was approved as a monitor by the College.
6. Ms. B acted as a monitor for Dr. Li's physical examination of female patients on approximately four days before Dr. Li's counsel received College counsel's letter of January 31, 2005 stating that only Ms. A was approved as a monitor.
7. Ms. B. also acted as a monitor for Dr. Li's physical examinations of female patients on February 3, 2005, three days after his counsel's receipt of the January 31, 2005 letter stating that only Ms. A was approved as a monitor. On that date, Ms. A was unavailable to act as a monitor for personal reasons.

Finding

The Committee found that Dr. Li committed an act of professional misconduct, in that he engaged in conduct or an act or acts relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

In particular, the facts described in the Agreed Statement of Facts demonstrated a significant breach by Dr. Li of an important undertaking to the College to practise only with a monitor approved by the College in the circumstances set out in the undertaking.

Reasons for Penalty

Counsel for the College and counsel for the member made a joint submission on penalty, the terms of which were a three-month suspension of Dr. Li's certificate of registration, a reprimand and an order for costs in the amount of $2,500.

The Committee found that in light of his lengthy and serious history with the College, Dr. Li could hardly fail to be aware of the importance of adhering to an undertaking given to the College made in the context of another disciplinary hearing. His actions on February 3, 2005 demonstrated, at least, disregard and, at most, disdain for his undertakings to the College.

The Committee considered as mitigating factors that Dr. Li pleaded no contest to the allegation. Further, the fact that Dr. Li examined female patients in the presence of a chaperone, albeit one who had not been qualified by the College, indicated that there was no intent to put the public at risk.

The Committee accepted that the jointly submitted penalty was appropriate.The significant suspension was felt to be appropriate, particularly in light of the fact that Dr. Li had breached an undertaking, the significance of which should have been obvious, considering his prior history. The seriousness of this breach called for a serious penalty. Compliance with undertakings made to the College, the governing body of the profession, is critical to the ability of the College to carry out its mandate of public protection.

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Penalty

The Discipline Committee directed that:

1. The Registrar suspend Dr. Li's certificate of registration for a period of three months.
2. Dr. Li appear before the panel to be reprimanded.
3. Dr. Li pay the College costs in the amount of $2,500.
4. The results of this proceeding be included in the register.

Dr. Li waived his right to an appeal and the Committee administered the public reprimand. MD

Whom to Call at the College

To Dial Known Extensions	(416) 967-2600
Toll Free	(800) 268-7096
Recorded Information	(416) 967-2620
General Inquiries	(416) 967-2603
To Find a New Doctor	(416) 967-2626
To Make a Complaint	(416) 967-2615
Media Inquiries	(416) 967-2611
Licensing Information	(416) 967-2617
Physician Advisory Service	(416) 967-2606

Contact a Doctor at the College

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

Dr. Preston Zuliani – President: #406
E-mail: pzuliani@cpso.on.ca

Dr. Rocco Gerace – Registrar: #400
E-mail: rgerace@cpso.on.ca

Dr. Angela Carol – Quality Management: #288
E-mail: acarol@cpso.on.ca

Dr. Daniel Klass – Quality Management: #338
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Dr. Bill McCauley – Quality Management: #434
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Dr. Michael Szul – Investigations and Resolutions: #299
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Dr. Daniel Way – Quality Management: #401
E-mail: dway@cpso.on.ca

Council Meeting Schedule

Council meetings are open to the membership and the public.

If you plan to attend, please contact the Communications Department at (416) 967-2611 or 1 (800) 268-7096 ext. 611.

2009 Council Meeting Dates:

February 13; April 23; June 25; September 24; November 19–20.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

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