CPSO

Special Board of Directors Meeting

October 13, 2026

Meeting Materials Amended on October 8, 2026

REQUISITION FOR A SPECIAL BOARD MEETING

From: Dr. Patrick Safieh, Board Chair

To: Dr. Nancy Whitmore, Registrar and Chief Executive Officer

Date: September 25, 2026

I hereby ask that a Special Meeting of the Board of Directors be convened at 12:00 p.m. on Tuesday, October 13, 2026, to consider approving amendments to expectations for registrants relating to safer supply prescribing.

This meeting will be held by videoconference and members of the public can register to attend if they wish to observe the meeting.

Patrick Safieh, MD, CCFP(EM), FCFP
Board Chair

NOTICE OF SPECIAL BOARD OF DIRECTORS MEETING

A special meeting of the Board of Directors of the College of Physicians and Surgeons of Ontario (CPSO) will take place by videoconference on October 13, 2026, to consider approving amendments to expectations for registrants relating to safer supply prescribing.

Members of the public who wish to observe the meeting will be required to register online by 4 p.m. on October 8, 2026 to receive the link for the meeting.

The meeting will convene at 12:00 p.m. on Tuesday, October 13, 2026.

Nancy Whitmore, MD, FRCSC, MBA, ICD.D
Registrar and Chief Executive Officer

September 25, 2026

TUESDAY, OCTOBER 13, 2026			
Time	**#**	**Topic and Objective(s)**	**Page No.**
12:00 p.m. (5 mins)	**1**	**Call to Order and Welcoming Remarks** (P. Safieh)	–
12:05 p.m. (55 mins)	**2**	**Proposed Safer Supply Amendments - Addendum** (N. Whitmore, A. Chopra) *Decision*	7 – 26
		* **Proposed Safer Supply Amendments** (circulated September 28, 2026**)**	5 – 6
1:00 p.m.	**3**	**Close Meeting** (P. Safieh)	–

Board of Directors Briefing Note

OCTOBER 2026

Title:	Proposed Safer Supply Amendments (For Decision)
Main Contacts:	Anil Chopra, Associate Registrar Cameo Allan, Director, Policy & Governance Heather Webb, Director, Communications & Government Relations
Attachments:	**Appendix A:** *Clinical Care Obligations* draft revisions **Appendix B**: *Obligations in Practice: Safer Supply Prescribing* draft revisions **Appendix C**: *Prescribing Drugs* policy draft revisions
Question for the Board:	Does the Board of Directors approve the revised *Clinical Care Obligations*, *Obligations in Practice: Safer Supply Prescribing*, and *Prescribing Drugs* policy drafts?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- Amendments to the *Clinical Care Obligations*, *Obligations in Practice: Safer Supply Prescribing*, and CPSO's existing *Prescribing Drugs* policy are proposed to address ongoing concerns relating to safer supply prescribing.[1] The Board is provided with an overview of the key changes and is asked whether it approves the proposed revisions.
- Clarifying expectations for physicians who use safer supply prescribing practices helps ensure patient safety and serves CPSO's public interest mandate.

Current Status & Analysis

- Early in 2026, CPSO updated its *Prescribing Drugs* policy and associated *Advice to the Profession* document to set out expectations related to safer supply prescribing and to clarify the risks related to this type of prescribing.
- Following these updates, CPSO has continued to hear from key stakeholders, including the Office of the Chief Medical Officer of Health, Addiction Medicine Canada, Ontario municipalities, the Ontario Medical Association (OMA) Section on Addiction Medicine, and the Canadian Addiction Treatment Centres about safer supply prescribing practices in Ontario.
- Recognizing the significant harms caused by the diversion of opioids prescribed as safer supply, and in an effort to emphasize the connection between harm reduction measures and treatment, CPSO is proposing to strengthen its obligations relating to safer supply prescribing.
- Specifically, revisions are proposed to the "Prescribing and Dispensing Drugs" section of *Clinical Care Obligations* (**Appendix A**) to indicate that physicians must only prescribe safer supply medications in conjunction with opioid agonist therapy (OAT).
- Revisions are also proposed to the related *Obligations in Practice: Safer Supply Prescribing* document (**Appendix B**). With the proposed amendments, it would require that:
    - Safer supply is only prescribed during titration of OAT and for no more than 8 weeks,
    - Physicians write "safer supply" and "no carries" (no take-home doses) on prescriptions for safer supply medications to communicate the intent and delivery of this medication and to support the supervised consumption of these medications by regulated health-care professionals, and
    - Physicians perform in-person clinical assessments at least once monthly for patients receiving safer supply medication.
- To ensure alignment between CPSO's existing policy framework and incoming *Professional Obligations* framework, these amendments have also been made to the *Prescribing Drugs* policy (**Appendix C**).

[1] As of November 2026, CPSO's existing policies and *Advice to the Profession* documents will be revised and consolidated into *Professional Obligations* and *Obligations in Practice* documents which, together, set out registrants' core obligations across three main areas: medical professionalism, practice management, and clinical care.

- These amendments aim to ensure that safer supply is prescribed and consumed in a manner that minimizes risk by limiting diversion of safer supply medication. They also seek to strengthen clinical oversight over prescribing and support a short transition for patients from safer supply to OAT.
- In proposing these revisions, CPSO has considered feedback from key stakeholders including the Office of the Chief Medical Officer of Health, OMA, Addiction Medicine Canada, Centre for Addiction and Mental Health, addictions leads at Ontario Health and the University of Toronto, and physicians with expertise in addiction medicine.
- While this issue is complex and involves multiple health system partners, these revisions focus on steps CPSO can appropriately take within its regulatory mandate to strengthen oversight of safer supply prescribing and promote public safety.
    - Moreover, the amendments are anticipated to impact only a small number of physicians and pharmacies, primarily those already involved in prescribing or dispensing OAT medications (many of which are initially consumed under supervision).
- Given that these amendments require system-level changes, CPSO expects a transition to compliance by November 16, 2026, with consideration that it may take longer for physicians to taper patients currently taking high dose of short-acting opioids for safer supply. This will enable affected physicians and system partners to implement necessary changes and ensure that appropriate supports are in place to help uphold these new expectations.

Board of Directors Briefing Note – Addendum

OCTOBER 2026

Title:	Revisions to Proposed Safer Supply Amendments (For Decision)
Main Contacts:	Anil Chopra, Associate Registrar Cameo Allan, Director, Policy & Governance Heather Webb, Director, Communications & Government Relations
Attachments:	**Appendix X:** *Clinical Care Obligations* draft revisions **Appendix Y:** *Obligations in Practice: Safer Supply Prescribing* draft revisions **Appendix Z:** *Prescribing Drugs* policy draft revisions
Question for the Board:	Does the Board of Directors approve the revised *Clinical Care Obligations*, *Obligations in Practice: Safer Supply Prescribing* and *Prescribing Drugs* policy drafts?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- This is an addendum to the briefing note included in the package for the October 13, 2026 special Board meeting as posted on September 28th, 2026. Appendices A, B, and C included in the package posted on September 28th have been removed.
- CPSO has received feedback on its proposed amendments to the *Clinical Care Obligations* (**Appendix X**), *Obligations in Practice: Safer Supply Prescribing* (**Appendix Y**), and the existing *Prescribing Drugs* policy (**Appendix Z**) in relation to safer supply prescribing.[1] A revision to the proposed amendments have been made in response to this feedback. The Board is provided with an overview of the feedback and is asked whether it approves the further revised documents.
- Clarifying expectations for physicians who use safer supply prescribing practices helps ensure patient safety and serves CPSO's public interest mandate.

Current Status & Analysis

- Following the distribution of the materials for the October 13 special meeting of the Board of Directors, CPSO received feedback regarding the amended expectations for registrants relating to safer supply prescribing, in addition to feedback that had already been received and considered.
- Several respondents, including physicians with experience and expertise in addiction medicine, municipal representatives, members of the public, Addictions Medicine Canada and the Office of the Chief Medical Officer of Health have expressed support for stronger oversight of safer supply prescribing and for more robust measures to reduce the diversion of safer supply medications.
- There has also been feedback highlighting potential unintended consequences of the proposed amendments, with much of it focused on the proposed 8-week off-ramp from safer supply medications. Respondents have noted that the 8-week limit may:
    - create challenges for retaining patients in treatment;
    - result in the rapid tapering for this patient population, which would likely cause harm; and/or
    - destabilize a cohort of patients who have been stable on long-term safer supply prescriptions.
- This feedback has been provided by a mix of physicians and other individuals working with patients with opioid use disorder; patients; academics in public health, health sciences, and addictions; and the Ontario Drug Policy Research Network.
- In response to these concerns, CPSO is proposing to remove the expectation that safer supply be prescribed for no more than 8 weeks during the titration of opioid agonist therapy (OAT) in both the draft *Prescribing Drugs* policy and the *Obligations in Practice: Safer Supply Prescribing* document. While physicians will continue to be required to only prescribe safer supply in conjunction with OAT, there will be no time limit on these prescriptions.

[1] As of November 2026, CPSO's existing policies and *Advice to the Profession* documents will be revised and consolidated into *Professional Obligations* and *Obligations in Practice* documents which, together, set out registrants' core obligations across three main areas: medical professionalism, practice management, and clinical care.

- Additional feedback was received regarding the proposal that physicians be required to write "safer supply" and "no carries" on the safer supply prescription. In particular, respondents noted that:
    - allowing carries of safer supply prescriptions provides patients with autonomy and day-to-day flexibility, and promotes their retention in treatment; and
    - requiring that consumption be witnessed is stigmatizing for an already vulnerable patient population.
- This feedback was largely received from academics in public health, health sciences, and addictions, and the Ontario Drug Policy Research Network.
- Having carefully considered and balanced this feedback against the harms caused by diversion of safer supply medication, no further changes are being proposed.
- The Board is therefore asked to approve the following revisions to the "Prescribing and Dispensing Drugs" section of *Clinical Care Obligations* (**Appendix X**) and the related *Obligations in Practice: Safer Supply Prescribing* document (**Appendix Y**):
    - Safer supply is only prescribed in conjunction with OAT;
    - Physicians write "safer supply" and "no carries" (no take-home doses) on prescriptions for safer supply medications to communicate the intent and delivery of this medication and to support the supervised consumption of these medications by regulated health-care professionals; and
    - Physicians perform in-person clinical assessments at least once monthly for patients receiving safer supply medication.
- To ensure alignment between CPSO's existing policy framework and incoming Professional Obligations framework, these amendments have also been made to the *Prescribing Drugs* policy (**Appendix Z**).
- CPSO will be closely monitoring the impacts of these amendments. Any further changes to CPSO's expectations around safer supply prescribing that may be needed to address unintended consequences will be brought to the Board.

Clinical Care Obligations

About Physicians' *Professional Obligations*

Ontario physicians have legal obligations established in legislation as well as professional obligations established by the College of Physicians and Surgeons of Ontario (CPSO). CPSO's *Professional Obligations* documents set out expectations related to medical professionalism, practice management, clinical care, and conduct that physicians must meet in their day-to-day practice.

In conjunction with *Essentials of Medical Professionalism*, *Obligations in Practice*, and relevant legislation, *Professional Obligations* will be used by CPSO as a benchmark when evaluating physician practice and conduct.

Providing Safe, Competent Care

1. Physicians **must** obtain informed consent before treatment is provided.
2. Physicians **must** obtain express consent where the examination, procedure, or treatment:
    a. Is an intimate examination;
    b. Carries appreciable risk;
    c. Is surgical or invasive; or
    d. Will lead to significant changes in consciousness.
3. Physicians **must** ensure appropriate practices are followed before, during, and after physical and intimate examinations, including:
    a. Informing patients that they can ask to stop an examination at any time;
    b. Explaining to patients in advance the scope and rationale of any examination, treatment or procedure; and
    c. Using gloves when performing pelvic, genital, perineal, perianal, or rectal examinations.
4. Physicians **must** show sensitivity and respect for a patient's privacy and comfort and **must** offer patients the option of having a third party present during an intimate examination, treatment, or procedure including bringing in their own party if the physician does not have one.
5. Physicians who provide complementary or alternative medicine **must only** do so:
    a. In a manner that is informed by evidence and scientific reasoning; and
    b. To diagnose or treat symptoms, complaints, or conditions that are within their conventional scope of practice.
6. Physicians **must** conduct a conventional clinical assessment of patients in accordance with the standard of practice, and **must**:
    a. Make a conventional or differential diagnosis on the basis of that clinical assessment;
    b. Communicate that diagnosis to the patient; and
    c. Inform the patient of any conventional treatment options that are available to treat their symptoms or conditions.

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7. Physicians **must only** provide complementary or alternative treatment to a patient where the potential benefits of the treatment outweigh the risks.
8. Physicians **must** protect patient privacy and confidentiality and ensure the accuracy of information when using artificial intelligence tools.

Prescribing and Dispensing Drugs

9. Physicians **must** make prescribing decisions in the patient's best interest and, before prescribing, **must** ensure that:
    a. An appropriate clinical assessment has been performed;
    b. There is a clinical indication for the drug; and
    c. The risks and benefits of the drug are considered in light of the other drugs the patient is taking or prescribed, as well as the patient's individual needs, circumstances, and overall health and well-being.
10. Physicians **must** take reasonable steps to mitigate the potential risks and unintended consequences of prescribing (e.g., diversion, misuse, abuse, dependence, overdose, adverse drug interactions), particularly when prescribing narcotics and controlled substances. This includes but is not limited to:
    a. Applying, as appropriate, relevant practice standards, quality standards, clinical practice guidelines, evidence-based research, and general best practices; and
    b. Considering the patient's prior treatments and developing a comprehensive treatment plan.
11. Physicians **must** monitor patients over the course of treatment, identify emerging risks or complications, and adjust or discontinue treatment as clinically appropriate.
12. Physicians **must** provide patients with the information necessary to support the safe use and monitoring of prescribed drugs.
13. Physicians **must not** prescribe drugs that have not been approved for use in Canada except in the limited circumstances permitted by Health Canada (i.e., clinical trials, Special Access Programme).
14. Physicians **must only** prescribe opioids for safer supply in conjunction with opioid agonist therapy (OAT). ~~Prior to prescribing narcotics for safer supply (or continuing a prescription initiated by another prescriber), physicians **must** offer patients opioid agonist therapy, and **must** perform an in-person comprehensive clinical assessment themselves.~~
15. Physicians who dispense drugs **must** meet the same dispensing standards as pharmacists.

Providing End-of-Life Care

16. Physicians **must** proactively engage in advance care planning and goals-of-care discussions, when appropriate.
17. Physicians **must** seek to balance medical expertise with patient wishes, values, and beliefs when making decisions about end-of-life care.
18. Physicians **must** obtain consent from capable patients or substitute decision-makers (SDMs) before withdrawing life-sustaining treatment and **must** try to resolve disagreements where consent cannot be obtained.

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19. Where a physician determines that the risk of harm in providing resuscitative measures would outweigh the potential benefits, before writing an order to withhold resuscitative measures, physicians **must** communicate to patients/SDMs the rationale for the order and the care that will be given, and **must** provide support if disagreements arise.
    a. When a patient's condition is deteriorating rapidly and there is an imminent need for an order to be written (e.g., actual or impending cardiac or respiratory arrest), the physician can write an order to withhold resuscitative measures in the patient's medical record but **must** comply with the expectations above at the earliest opportunity (rather than before writing the order).

Providing Medical Assistance in Dying (MAID)

20. Physicians **must** comply with all legal requirements for MAID, including those pertaining to eligibility criteria, safeguards and reporting, as set out in the *Criminal Code*; the *Regulation for the Monitoring of Medical Assistance in Dying*; and the *Coroners Act*.
21. Physicians **must** include the following in the patient's medical record:
    a. All requests for MAID, including a copy of any written request;
    b. Documentation demonstrating that the eligibility criteria and relevant procedural safeguards were met, including the analysis undertaken to determine if the patient's natural death was reasonably foreseeable;
    c. A copy of any written arrangement that waives the requirement for final express consent;
    d. A copy of any report made to the Office of the Chief Coroner or Health Canada;
    e. The medication protocol used (i.e., drug(s) and dosage(s)); and
    f. The time and date of the patient's death, if known.

Delegation of Controlled Acts

22. Physicians **must only** delegate a controlled act when doing so does not compromise the patient's health, safety, and quality of care.
23. Physicians **must not** delegate the controlled act of psychotherapy.
24. Physicians **must** clinically assess all new patients (in person or, where it meets the standard of care, virtually) prior to delegating or, where this is not possible, within two business days of the delegate initiating a controlled act, unless:
    a. Care is provided by paramedics, community paramedics, or hospital transport teams;
    b. Care is provided in remote and isolated regions of the province by registered nurses, registered practical nurses, or physician assistants;
    c. Care is provided as part of public health initiatives, such as immunizations;
    d. Urgent care is provided during a public health emergency declared by a public health authority;
    e. Post-exposure prophylaxis or vaccination is administered following potential exposure to a blood borne pathogen; and
    f. Care is provided in hospitals, including emergency departments.
25. Physicians **must** delegate through the use of a direct order or a medical directive that is clear and sufficiently detailed.

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26. Physicians **must not** leave a delegate to manage a practice or their patient population independently and **must** be physically onsite to supervise and support delegates, unless:
    a. The delegation is occurring in accordance with provisions 24 (a) to (f);
    b. Another physician who is able to support the delegate as necessary is physically onsite; or
    c. The risk associated with the delegation is low.
27. Where the delegating physician is not onsite, they **must** be available to provide appropriate consultation and assistance within short notice (e.g., in person, if necessary).
28. Physicians **must only** delegate controlled acts they are competent to perform and **must** take reasonable steps to ensure that delegates have the knowledge, skill, and judgment to perform the delegated acts safely.
29. Physicians **must** ensure consent discussions include informing the patient that a delegate will be involved in their care.

Facilitating Continuity of Care

30. Physicians **must** have an effective test results management system in place that enables them to record any tests they have ordered and any results they have received and/or reviewed.
31. Physicians **must** appropriately track and follow up on test results which are, or are likely to be, clinically significant, and **must** communicate these results to the patient and other health-care providers (as needed) in a timely manner.
32. Physicians **must** take clinically appropriate action on results from tests they have ordered, especially where those results are clinically significant.
33. Physicians **must** inform patients if they use a "no news is good news" strategy for managing test results, and **must** inform patients that they have the option to contact the physician to hear their results.
34. Physicians **must** work collaboratively with other health-care providers in the best interests of the patient to ensure that tests and results are managed appropriately and that patient care is not unnecessarily delayed or compromised.
35. Physicians **must** collaborate with other health-care providers to ensure continuity of care for patients.
36. Physicians **must** keep patients informed about who has primary responsibility for managing their care and about their role in the patient's health-care team.
37. Physicians **must** ensure that patients have the information they need prior to being discharged from hospital.
38. When discharging patients from hospital, MRPs **must**:
    a. Complete discharge summaries within 48 hours of discharge;
    b. Ensure the discharge summary includes the information necessary for health-care providers responsible for post-discharge care to understand the patient's post-discharge health-care needs; and
    c. Ensure the discharge summary is provided to the patient's primary care provider or the health-care provider who will be primarily responsible for post-discharge care.
39. Referring physicians **must**:
    a. Make referral requests in writing;

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b. Provide the information necessary for consultant health-care providers to understand the issues they are being asked to consult on;

c. Have a mechanism in place to track the referral requests they make; and

d. Engage patients in the referral process by, for example, informing them that they may contact the referring physician's office if they have not heard anything within a specific timeframe.

40. Consultant physicians **must**:

    a. Acknowledge referral requests in a timely manner, urgently if necessary, but no later than 14 days and indicate to the referring provider whether they are able to accept the referral;

    b. Provide consultation reports that include the information necessary for the health-care providers involved in the patient's care to understand the patient's needs, and distribute this report in a timely manner, but no later than 30 days after an assessment or a new finding or change in the patient's care management plan; and

    c. Communicate the anticipated wait time or the appointment date and time to the patient, unless the referring physician has indicated that they intend to do so, and **must** allow patients to make changes to the appointment date and time directly with them. When providing an anticipated wait time, consultant physicians **must** follow-up once an appointment has been set.

Offering Virtual Care

41. When providing virtual care, physicians **must** continue to meet the standard of care and the existing legal and professional obligations that apply to care that is provided in person.

42. Physicians **must** take appropriate action if, during the course of a virtual encounter it is determined that a patient requires in-person care, including providing or assisting patients in accessing appropriate in-person care in a timely manner (e.g., through a coverage arrangement).

43. Where clinically appropriate and available, physicians **must** prioritize patient preference for in-person or virtual care.

Providing Episodic Care

44. Physicians practising in walk-in clinics **must** meet the standard of practice of medicine, including conducting appropriate assessments, and managing tests and referrals regardless of whether the care is episodic.

45. Physicians working in a walk-in clinic **must** provide a record of the encounter to the patient's primary care provider when:

    a. The patient requests that the physician do so; or

    b. The physician determines that providing a record is warranted from a patient safety perspective and the patient has provided consent to do so.

46. If it is not possible to provide the record to the patient's primary care provider (e.g., because they do not have one), physicians **must** provide the record to the patient.

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Glossary

Clinically significant test result: A test result that a physician has determined requires follow-up in a timely fashion, urgently if necessary. Physicians determine the clinical significance of a test result using their clinical judgment and knowledge of the patient's symptoms, previous test results, and/or diagnosis.

Complementary or alternative medicine: A range of therapeutic concepts, diagnoses, treatments, practices, and products that are not commonly accepted as part of conventional medicine. It also includes conventional treatments, practices, and products being used in non-conventional ways, as well as new or emerging treatments, practices, and products that are based on conventional medical understanding and scientific reasoning.

Controlled acts: Acts specified in s. 27(2) of the *Regulated Health Professions Act, 1991*. These acts may only be performed by authorized regulated health professionals or through delegation in appropriate circumstances.

Delegation: A mechanism that allows a regulated health professional (e.g., a physician) who is authorized to perform a controlled act to temporarily grant that authority, by way of a direct order or medical directive, to another individual(s) (regulated or unregulated) who is not legally authorized to perform the act independently.

Direct order: Written or verbal instructions from a physician to another individual or group of individuals authorizing them to carry out a specific treatment, procedure, or intervention for a specific patient, at a specific time.

Express consent: Agreement that is direct and explicit, provided orally or in writing.

Informed consent: Consent that is provided by a patient after they have understood the information provided and having the opportunity to ask questions about the nature of the treatment, its expected benefits, material risks relevant to their specific circumstances that a reasonable person would want to know, alternative courses of action, and the likely consequences of not having the treatment.

Intimate examinations: Includes examinations of the breast, pelvic, genital, perineal, perianal and rectal areas of a patient.

Life-sustaining treatment: Any medical procedure or intervention that uses mechanical or other artificial means to sustain or replace a vital function essential to the life of the patient (e.g., mechanical ventilation, medically assisted nutrition and hydration, vasopressors and/or inotropes).

Medical assistance in dying (MAID): Circumstances prescribed under the *Criminal Code* in which a physician or nurse practitioner, at the patient's request: (a) administers medications that cause the patient's death; or (b) prescribes or provides medications for the patient to self-administer to cause their own death.

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Medical directive: Written orders from a physician(s) to another individual or group of individuals authorizing them to carry out the treatments, procedures, or interventions specified in the directive for any patient who meets the criteria set out in the directive, provided that certain conditions and circumstances exist.

Opioid agonist therapy: A first-line treatment for opioid use disorder that involves the use of medications (e.g., methadone, buprenorphine, slow-release oral morphine) to prevent withdrawal, reduce overdose risk, and decrease cravings for opioids, including fentanyl.

Resuscitative measures: A suite of medical interventions (e.g., chest compressions, artificial ventilation, intubation and/or defibrillation) that may be provided following cardiac or respiratory arrest in an attempt to restore or maintain cardiac, pulmonary, and circulatory function.

Safer supply: The prescribing of pharmaceutical-grade short-acting opioids ~~medications~~ (~~often~~including hydromorphone ~~or other short-acting opioids~~) to patients with substance use disorder as an alternative to the toxic street supply of illicit drugs.

Substitute decision-maker: A person authorized to consent on behalf of a patient.

Treatment: Excludes capacity assessments, health history-taking, assessment or examination of a patient to determine the general nature of their condition, communication of an assessment or diagnosis, admission to a hospital or other facility, personal assistance services, or treatment that poses little or no risk of harm to the person.

Virtual care: Any interaction between patients and/or members of their circle of care that occurs remotely (e.g., telephone, video conferencing, messaging) for the purpose of providing or supporting care.

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Obligations in Practice: Safer Supply Prescribing

Supervised consumption of safer supply

- As with all prescribing, it is essential that physicians who prescribe safer supply do so in a manner that minimizes the risk of harm and unintended consequences to individual patients (e.g., the potential for misuse or for destabilizing someone previously stable on OAT) and to the broader public (e.g., diversion). ~~Offering safer supply in conjunction with safety measures (e.g., daily and/or observed dosing during the initial period) can help mitigate these risks.~~
- To help mitigate these risks and to support safer supply medication being consumed only under direct observation by regulated health-care professionals, physicians will need to clearly note on the prescriptions for safer supply medication "safer supply" and "no carries" (take-home doses) to communicate the intent and delivery of this medication.

Clinical assessments

- ~~Where safer supply is being prescribed on an ongoing basis, physicians are expected to perform in-person comprehensive clinical assessments themselves at least every three months. Performing these clinical assessments can help establish and maintain a therapeutic rapport and supports safe prescribing and monitoring of medications. It also provides an opportunity for physicians to assess whether continued safer supply prescribing remains in the patient's best interests and to engage in discussions about mitigating individual and broader community risks.~~
- Safer supply is best prescribed, where possible, within the context of a therapeutic relationship in which the physician is providing broader, ongoing care to the patient. Prescribing safer supply in isolation—without adequate clinical assessment, follow up, and monitoring—can increase the risk of harm. Physicians will need to perform an in-person clinical assessment at least once monthly for patients receiving safer supply medication.

Safer supply prescribing in underserviced areas

- In remote or rural areas, where access to care may be limited, local community primary care physicians may wish to collaborate virtually with a clinician who has expertise in safer supply prescribing. In all settings, careful documentation and~~, where appropriate,~~ consultation with more experienced providers can support safe prescribing and ongoing care.

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PRESCRIBING DRUGS

Approved by Council: November 2000
Reviewed and Updated: November 2001, February 2002, November 2007, December 2012, February 2016, September 2016, September 2017, December 2019, May 2026

Companion Resource:

- Advice to the Profession
- Patch-for-Patch Fentanyl Return Program: Fact Sheet

Policies of the College of Physicians and Surgeons of Ontario (CPSO) set out expectations for the professional conduct of physicians and physician assistants ("Registrants") practising in Ontario. Together with *Essentials of Medical Professionalism* and relevant legislation and case law, they will be used by CPSO and its Committees when considering a Registrant's practice or conduct.

Within policies, the terms 'must' and 'advised' are used to articulate CPSO's expectations. When 'advised' is used, it indicates that Registrants can use reasonable discretion when applying this expectation to practice.

Additional information, general advice, and/or best practices can be found in companion resources, such as *Advice to the Profession* documents.

Policy

1. Physicians **must** comply with the requirements for prescribing that are set out in this policy, as well those contained in any other relevant CPSO policies[1] and legislation[2].

Before Prescribing

2. Physicians **must** only prescribe a drug if they have the knowledge, skill, and judgment to do so safely and effectively.[3]
3. Before prescribing a drug, physicians **must**:
    a. undertake an appropriate clinical assessment of the patient (limited exceptions are set out in provisions 4 and 5 of this policy);[4]
    b. make a diagnosis or differential diagnosis and/or have a clinical indication based on the clinical assessment and any other relevant information;
    c. consider the risks and benefits of prescribing the chosen drug, including the combined risks and benefits when prescribing multiple drugs and the risks and benefits when providing long-term prescriptions; and
    d. obtain valid consent.[5]

CPSO is aware that some patients face financial difficulties that limit their ability to afford the drugs prescribed to them. For more information about prescribing drugs in a way that reflects the patient's ability to pay, please see the CPSO's *Advice to the Profession: Prescribing Drugs* document.

Relying on an Assessment Undertaken by Someone Else / Prescribing with no Prior Assessment

4. Physicians are permitted to prescribe on the basis of an assessment conducted by someone else.[6] When doing so, physicians **must**:
    a. have reasonable grounds to believe that the person who conducted the assessment had the appropriate knowledge, skill, and judgment to do so;[7] and
    b. evaluate the assessment and judge it to be appropriate.
5. If no prior assessment of the patient has been undertaken, physicians **must** only prescribe:
    a. for the sexual partner of a patient with a sexually transmitted infection who would not otherwise receive treatment and where there is a risk of further transmission;
    b. prophylaxis as part of a public health program operated under the authority of a Medical Officer of Health; and/or
    c. post-exposure prophylaxis for a health-care professional following potential exposure to a blood borne virus.

Content of Prescriptions

6. Physicians **must** ensure that written prescriptions are legible.
7. Physicians **must** ensure that the following information is included on every written or electronic prescription:
    a. the prescribing physician's printed name, signature[8] (or electronic signature), and CPSO registration number;
    b. the prescribing physician's practice address;
    c. the patient's name;
    d. the name of the drug;
    e. the drug strength and quantity;
    f. the directions for use;
    g. the full date the prescription was issued (day, month, and year);
    h. refill instructions, if any;
    i. if the prescription is for a monitored drug[9], an identifying number for the patient[10] (unless certain conditions set out in regulation are met)[11];
    j. if the prescription is for a fentanyl patch, additional requirements apply (these are set out in provision 36 and 37 of this policy); and
    k. any additional information required by law.
8. Physicians **must** use their professional judgment to determine whether it is necessary to include any additional information on the prescription (g., the patient's weight where this information would affect dosage or the patient's date of birth where this information would assist in confirming the patient's identity).

Authorizing and Transmitting Prescriptions

9. When providing prescriptions, physicians **must** authorize each prescription in one of three ways: with a written signature, electronically, or verbally[12].
    a. When authorizing prescriptions electronically, physicians **must** authorize the prescription themselves. Physicians **must not** permit other members of staff to authorize a prescription unless there is a direct order or medical directive in place, and if so, there **must** be a mechanism within the system to identify who authorized the prescription and under what authority.
10. Regardless of the method of transmission, physicians **must** ensure that patient privacy and confidentiality are protected.[13]

Duplicate Prescriptions

11. Physicians **must not** create duplicate copies of a prescription except for the purposes of retaining a copy in the patient's medical record or to replace a lost or damaged prescription.
12. If physicians wish to provide a copy of the prescription to their patients for information purposes, physicians **must** provide this information in a format that does not resemble a prescription (e.g. a written summary).

Respecting Patient Choice When Choosing a Pharmacy

13. Physicians **must** respect the patient's choice of pharmacy.
14. Physicians **must not** attempt to influence the patient's choice of pharmacy unless doing so is in the patient's best interest and does not create a conflict of interest for the physician.

Communicating with Pharmacists

15. Physicians **must** respond in a timely manner when contacted by a pharmacist or other health-care provider involved in the care of a patient. The timeliness of the communication will depend on a variety of factors, including the degree to which a delay may impact patient safety.

Documentation

16. In addition to complying with the general requirements for medical records[14], physicians **must** specifically document all relevant information regarding the drugs they prescribe. Physicians **must** do this by either retaining a copy of the prescription in the patient's medical record or by specifically documenting the information contained in the prescription (as set out in provision 7, a-k of this policy).
17. Physicians **must** also document the type of prescription it is (e.g. verbal, handwritten, or electronic) and comply with any applicable requirements for the documentation of patient consent, as set out in CPSO's *Consent to Treatment* policy.

Monitoring Drug Therapy

18. Physicians **must** ensure that appropriate monitoring protocols are in place as-needed to identify emerging risks or complications arising from the drugs they prescribe.

19. Physicians **must** inform patients of:
    a. the follow-up care required to monitor whether changes to the prescription are necessary; and
    b. the patient's role in safe medication use and monitoring effectiveness.
20. If patients do not comply with an agreed-upon plan for prescription monitoring, physicians **must** consider whether continued prescribing is safe and appropriate by weighing the risks of continuing prescribing against the risks of discontinuing prescribing.
21. If, in the physician's judgment, drug therapy is not effective or the risks outweigh the benefits, physicians **must** consider discontinuing the prescription.[15]
22. Whenever possible, physicians **must** only discontinue prescribing following discussion with the patient.

Prescription Refills (also known as Repeats or Renewals)

23. Physicians **must** review all requests to refill a prescription and authorize any refills provided unless these tasks are delegated to staff[16] or the person authorizing the refill is a regulated health professional with the authority to prescribe.
24. Physicians **must** ensure that all requests for refills and all authorized refills are documented in the patient's medical record.
25. Physicians **must** ensure that procedures are in place to monitor the ongoing appropriateness of the drug when prescribing refills (e.g., by conducting periodic re-assessments).
26. Physicians **must not** adopt blanket "no refill" policies.[17] While some physicians may rarely, if ever, write prescriptions with refills, physicians **must** decide whether or not to prescribe refills on a case-by-case basis, with consideration for the circumstances of each patient.

Redistributing Returned Drugs

27. Because the integrity of the drugs cannot be ensured, physicians **must not** redistribute drugs that have been returned by a patient.
28. Physicians **must** dispose of returned drugs in a safe and secure manner.[18]

Drugs That Have Not Been Approved for Use in Canada ('Unapproved Drugs')

29. Physicians **must not** prescribe drugs that have not been approved for use in Canada (i.e., drugs for which Health Canada has not issued a Notice of Compliance) except in the limited circumstances permitted by Health Canada.[19]

Distributing Drugs without a Prescription (e.g. Drug Samples)

30. When providing drugs to patients without a formal prescription[20] (e.g. drug samples), physicians **must** continue to meet all of the relevant requirements that apply to prescribing and dispensing drugs generally[21], including those related to patient assessment, documentation, and prescription monitoring.

31. When providing drugs to patients without a prescription, physicians **must** ensure that no form of material gain is obtained for the physician or for the practice with which they are associated (this includes selling or trading).

Narcotics and Controlled Substances

Narcotics and controlled substances[22] can help support the safe, effective, and compassionate treatment of many conditions, including acute or chronic pain and addiction. When prescribing these drugs; however, special consideration is necessary given that they are susceptible to diversion, misuse, and/or abuse, and many carry a risk of dependence and overdose.

Before Prescribing Narcotics and Controlled Substances

32. Before initiating a prescription for a narcotic or controlled substance (or continuing a prescription initiated by another prescriber), physicians **must**:
    a. consider whether the narcotic or controlled substance is the most appropriate choice for the patient;
    b. if prescribing opioids for chronic pain, physicians **must** document in the patient's medical record that there are no appropriate or reasonably available alternatives;
    c. consider the potential risks associated with prescribing, and take reasonable steps to mitigate those risks, consistent with any relevant practice standards, quality standards, and clinical practice guidelines;[23]
        i. Where these do not exist (e.g., in areas of medicine that are less developed), physicians **must** consider any available indirect evidence, clinical trials, evidence-based research or consensus recommendations, and general best practices;
    d. review any previous interventions the patient has undergone and develop a comprehensive treatment plan that includes:
        i. realistic treatment goals;
        ii. a plan for discontinuing prescribing should the risks outweigh the benefits;
        iii. a plan for minimizing risks and unintended consequences (e.g. diversion); and
        iv. a plan for managing withdrawal, where applicable;
    e. take reasonable steps to review the patient's prescription history as it relates to narcotics and controlled substances (e.g., by contacting the patient's other treating physicians or by reviewing electronic sources of information regarding the patient's prescription history, where available[24]); and
    f. obtain valid consent as required by applicable legislation[25] and the CPSO's *Consent to Treatment* policy;
        i. when prescribing narcotics and controlled substances, physicians **must** inform patients of the risks and harms associated with the drug being prescribed, including any risk of dependence, addiction, withdrawal, diversion, and overdose.

When Prescribing Narcotics and Controlled Substances

33. When prescribing narcotics or controlled substances (or continuing a prescription initiated by another prescriber) physicians **must**:
    a. meet the general requirements for prescribing that are set out in this policy, as well as any other relevant policies and/or legislation;

b. consider any relevant practice standards, quality standards, and clinical practice guidelines, and apply them as appropriate;
    i. where these resources do not exist (e.g., in areas of medicine that are less developed), physicians **must** consider any available indirect evidence, clinical trials, evidence-based research or consensus recommendations, and general best practices;[26] and
c. inform patients of how to safely secure, store, and dispose of any unused medication (especially in circumstances where locked storage is considered critical, such as prescription opioids and methadone).

Tapering and Discontinuing Narcotics and Controlled Substances

34. Physicians **must not** taper patients inappropriately or arbitrarily. Physicians are reminded that it is not always possible or appropriate to taper below a specific dose, nor is it usually appropriate to suddenly or rapidly taper prescriptions.
35. When tapering or discontinuing narcotics and controlled substances, physicians **must**:
    a. proceed with consideration for the safety and well-being of the patient;
    b. consider and apply, as appropriate, relevant practice standards, quality standards, and clinical practice guidelines;[27]
    c. explain to the patient the rationale for tapering or discontinuation, and provide an opportunity for discussion;
    d. discuss a strategy to treat withdrawal symptoms, where applicable;
    e. whenever possible, make decisions with respect to tapering or discontinuation in collaboration with the patient; and
    f. carefully document decision-making and any discussions with the patient.

Safer Supply Prescribing

36. Physicians **must only** prescribe opioids for safer supply in conjunction with opioid agonist therapy (OAT). ~~Before prescribing narcotics for safer supply (or continuing a prescription initiated by another prescriber), physicians **must** perform an in-person comprehensive clinical assessment themselves.~~
~~36.~~37. Physicians **must** clearly note on prescriptions for safer supply medication "safer supply" and "no carries" (take-home doses) to communicate the intent and delivery of this medication. ~~Physicians **must** offer patients opioid agonist therapy prior to prescribing narcotics for safer supply.~~
~~37.~~38. Physicians **must** perform an in-person clinical assessment at least once monthly for patients receiving safer supply medication.~~When prescribing narcotics for safer supply on an ongoing basis, physicians **must** perform an in-person comprehensive clinical assessment themselves at least every three months~~.

Prescribing Fentanyl Patches

39. When prescribing fentanyl patches, physicians **must** include the following additional information on every prescription:[28]
    a. the name and address of the pharmacy where the patient has chosen to fill the prescription; and

b. a notation that it is the patient's first prescription for fentanyl patches when the following conditions are met: 1) the physician has not previously prescribed fentanyl patches to that patient, and 2) the physician is reasonably satisfied[29] that the patient has not previously obtained a prescription for fentanyl from another prescriber.

40. Physicians **must** also notify the pharmacy directly. Notification is automatically achieved if the prescription is faxed directly to the pharmacy; however, if the prescription is provided to the patient directly then physicians must notify the pharmacy separately (e.g. via telephone).

"No Narcotics" Prescribing Policies

While some physicians may rarely, if ever, prescribe narcotics or controlled substances in practice[30], arbitrarily refusing to prescribe these drugs without consideration for the circumstances of each patient may lead to inadequate patient care.

41. Unless the prescribing of narcotics and controlled substances falls outside of the physician's scope of practice or clinical competence[31], or the physician has a restriction imposed by CPSO prohibiting prescribing, physicians:
    a. **must not** adopt a blanket policy[32] refusing to prescribe narcotics and controlled substances, and
    b. **must** make prescribing decisions on a case-by-case basis with consideration for each patient.

Reporting the Loss or Theft of Narcotics or Controlled Substances

42. Physicians **must** report the loss or theft of narcotics and/or controlled substances from their possession to the Office of Controlled Substances, Federal Minister of Health[33], within 10 days.[34]

Drug Storage

43. Where physicians stock narcotics and controlled substances, they **must** be securely and appropriately stored in the office to prevent theft/loss.

Endnotes

1. Other relevant policies include (among others): *Protecting Personal Health Information*, *Consent to Treatment*, *Medical Records Management*, and *Virtual Care*.
2. Relevant legislation includes, but may not be limited to: the *Food and Drugs Act*, R.S.C, 1985, c. F-27 (hereinafter *FDA*); the *Controlled Drugs and Substances Act*, S.C. 1996, c. 19 (hereinafter *CDSA*); the *Narcotics Safety and Awareness Act*, 2010, S.O. 2010, c. 22 (hereinafter *NSAA*); and the *Drug and Pharmacies Regulation Act*, R.S.O.1990, c. H.4 (hereinafter *DPRA*).
3. Sections 2(1)(c), 2(5), O. Reg. 865/93, Registration, enacted under the Medicine Act, 1991, S.O. 1991, c.30; *Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice* policy; CPSO's *Essentials of Medical Professionalism*.
4. An appropriate clinical assessment includes an appropriate patient history as well as any other necessary examinations or investigations.

5. For more information on consent, please refer to CPSO's *Consent to Treatment* policy.
6. The prescribing physician is ultimately responsible for how they use the assessment information, regardless of who conducted the assessment.
7. In most circumstances, this will require that the physician know the person conducting the assessment and be aware of their qualifications and training. In some limited circumstances, such as large health institutional settings, the physician may be able to rely upon knowledge of the institution's practices to satisfy him or herself that the person conducting the assessment has the appropriate knowledge, skill, and judgment.
8. Signatures must be authentic and unaltered. Electronic signatures may be acceptable if they meet the requirements of the Ontario College of Pharmacists. For more information, see the Ontario College of Pharmacists' website: http://www.ocpinfo.com/regulations-standards/policies-guidelines/unique-identifiers/.
9. See Section 2 of the *NSAA* for the definition of "monitored drug." For a complete list of monitored drugs, see the Ministry of Health and Long-Term Care's website at: https://www.ontario.ca/page/narcotics-monitoring-system.
10. For example, a Health Card number. See the full list of approved forms of identification here: https://www.ontario.ca/page/acceptable-identity-documents.
11. See Sections 3 and 6 of the *General*, O. Reg., 381/11, enacted under the *NSAA*.
12. There are some limitations on the use of verbal prescriptions (for example, narcotics cannot be authorized verbally). Physicians can contact the pharmacist if they are uncertain about whether a particular prescription is permitted. The Ontario College of Pharmacists (OCP) created a summary of federal and provincial laws governing prescription requirements which can be found here: https://www.ocpinfo.com/wp-content/uploads/2019/05/Prescription-Regulation-Summary-Chart-Summary-of-Laws.pdf.
13. Obligations with respect to the security of personal health information are set out in Sections 12 and 13 of *PHIPA*. For more information on the security of faxed prescriptions, see the Information and Privacy Commissioner of Ontario's "Guidelines on Facsimile Transmission Security".
14. Sections 18-21 of the *Medicine Act, General Regulation*. For full details of the requirements concerning medical records, see CPSO's *Medical Records Management* policy.
15. Specific expectations for discontinuing narcotics and controlled substances are set out in provisions 34 – 35 of this policy.
16. If physicians are delegating this responsibility to staff, they **must** do so in accordance with CPSO's *Delegation of Controlled Acts* policy.
17. A blanket "no-refill policy" means that a physician will not authorize refills for any patient, for any drug, in any circumstances. A blanket no-refill policy is an arbitrary, inflexible position that prevents physicians from exercising independent clinical judgment that takes into account the circumstances of the individual patient. This approach is not consistent with patient-centered care and has no clinical basis.
18. For more information about the safe disposal of drugs, please see CPSO's *Advice to the Profession: Prescribing Drugs* document.
19. For more information, see Health Canada's Notice of Compliance webpage: https://www.canada.ca/en/health-canada/services/drugs-health-products/drug-products/notice-compliance/database.html. There are two circumstances when access to an unapproved drug can be obtained for patient use: the first is when drugs have been authorized by Health Canada for research purposes as part of a clinical trial and the second is when drugs have been authorized under Health Canada's Special Access Programme.

20. Small amounts of drugs are sometimes provided to patients without a formal prescription for the immediate treatment of acute symptoms or to evaluate the clinical effectiveness of the treatment.
21. For more information about dispensing, see CPSO's *Dispensing Drugs* policy.
22. For the purposes of this policy, "Narcotics and Controlled Substances" includes Narcotic Drugs, Narcotics Preparations, and Benzodiazepines and Other Targeted Substances as defined in the Regulations made under the *CDSA,* Controlled Drugs as defined in the Regulations made under the *FDA*, and Monitored Drugs as defined in the *NSAA*. Examples include narcotic analgesics (e.g. Tylenol 3 and OxyNEO), methadone, and non-narcotic controlled drugs such as methylphenidate (e.g. Ritalin), benzodiazepines (e.g. Valium), and barbiturates (e.g. phenobarbital).
23. With respect to the prescribing of opioids for chronic non-cancer pain, relevant guidelines and standards include the 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain, the Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain, and any applicable Quality Standards developed by Health Quality Ontario. Relevant guidelines for the clinical management of opioid use disorder include, among others: the CRISM National Guideline for the Clinical Management of Opioid Use Disorder, the British Columbia Centre for Substance Use: A Guideline for the Management of Opioids Use Disorder, and National Guidelines on the Treatment of Opioid Use Disorder.
24. For more information about accessing patient's electronic prescription histories, please see CPSO's companion *Advice to the Profession: Prescribing Drugs* document.
25. Applicable legislation includes the *Health Care Consent Act, 1996* (HCCA).
26. With respect to the prescribing of opioids for chronic non-cancer pain, relevant guidelines and standards include the 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain, the Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain, and any applicable Quality Standards developed by Health Quality Ontario. Relevant guidelines for the clinical management of opioid use disorder include the CRISM National Guideline for the Clinical Management of Opioid Use Disorder.
27. With respect to the prescribing of opioids for chronic non-cancer pain, relevant guidelines and standards include the 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain, the Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain, and any applicable Quality Standards developed by Health Quality Ontario. Relevant guidelines for the clinical management of opioid use disorder include the CRISM National Guideline for the Clinical Management of Opioid Use Disorder.
28. *Safeguarding our Communities Act, 2015*. Physicians can find more information about their obligations under the Act in CPSO's "Patch-for-Patch Fentanyl Return Program: Fact Sheet", which is a companion to CPSO's *Prescribing Drugs* policy.
29. A physician may be reasonably satisfied based on his or her discussions with the patient as well as any other information available to the physician.
30. For example, because the physician practices in an emergency room setting and feels unable to provide necessary follow-up care and monitoring.
31. Physicians with primary care practices are reminded that given their broad scope of practice, there are few occasions where scope of practice would be an appropriate ground to refuse to prescribe all narcotics and controlled substances.
32. A blanket "no prescribing" policy means that a physician will not prescribe narcotics or controlled substances for any patient in any circumstances. A blanket "no-prescribing" policy is an arbitrary, inflexible position that prevents physicians from exercising independent clinical judgment that takes into account the circumstances of the individual patient.

33. https://www.canada.ca/en/health-canada/corporate/contact-us/office-controlled-substances.html
34. Section 55(g) of the *CDSA*, *Narcotic Control Regulations*; Sections 7(1) and 61(2) of the *Benzodiazepines and Other Targeted Substances Regulations*, S.O.R./2000-217, enacted under the *CDSA*. These requirements are also set out in CPSO's *Guide to Legal Reporting Requirements*.

Board Motion

Motion Title:	Safer Supply Amendments
Date of Meeting:	October 13, 2026

It is moved by_____, and seconded by_____, that:

The Board of Directors[1] of the College of Physicians and Surgeons of Ontario approves the revised *Prescribing Drugs* policy (a copy of which forms Appendix " " to the minutes of this meeting), to be effective immediately, and the revised *Clinical Care Obligations* and *Obligations in Practice: Safer Supply Prescribing* documents (copies of which form Appendix " " and " " to the minutes of this meeting), to be effective as of the date the new CPSO website is launched.

[1] The Board is deemed to be a reference to the Council of the College as specified in the *Health Professions Procedural Code* (Schedule 2 to the *Regulated Health Professions Act*) and the *Medicine Act*.