

Physicians with Health Conditions

Law and Policy Reform
to Protect the Public
and Physician-Patients

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Physicians with Health Conditions:

Law and Policy Reform to Protect the Public and Physician-Patients

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Physicians with Health Conditions: Law and Policy Reform to Protect the Public and Physician-Patients

I. Executive Summary

The impetus for the work behind this Report is an increasing awareness that physicians may face barriers that prevent, or reduce the likelihood of, their seeking out and utilizing beneficial services when they experience health conditions. While physicians are tasked with treating patients, they themselves, at times, are patients and need appropriate care and protections that acknowledge this reality. Physician health is also a concern when considering the goal of maintaining a healthy population of physicians to serve the public through the practice of medicine. While great strides should be taken to eliminate or reduce the barriers that physicians face, an appropriate framework must be in place to protect the public from the harm they could suffer if such physicians' health conditions are not appropriately addressed. The aim of the work leading to our recommendations is to reduce such barriers, increase access to services, whether through physician health programs ("PHPs") or elsewhere, and ensure that the regulators of the profession charged with the protection of the public are able to carry out their legislative mandate.

When physicians become members of the medical profession, they take on legal, ethical and professional obligations to patients and others impacted through their practice of medicine. Given the nature of the profession, physicians have the knowledge, expertise and ability to heal. However, along with the power to maintain or restore health in many circumstances comes the potential to inflict grave harm. One of the key duties discussed in this report is the duty to prevent reasonably foreseeable harm; another is the necessity to place the patient's well-being first. Physicians with health conditions that are negatively impacting their practice must take steps to stop harm from occurring. At-risk physicians have obligations to take steps to avoid causing reasonably foreseeable harm.

While many such duties are well established, others are not necessarily so, or at least are not explicit. The result is that physicians, in certain instances, lack appropriate guidance as to the steps they should take. Many of the recommendations set out in this Report clarify both the duties of physicians, as well as the protections that should be provided to them.



The first set of recommendations is aimed at appropriate licensure questions, both at the time of an initial application for registration as a member of the profession in a given jurisdiction, and at the time of annual renewal applications. Human rights legislation, which is applicable to membership in the medical profession, requires that such questions be non-discriminatory. Information requested should be limited to that which is necessary to carry out the mandate of such a regulatory body. As a result, such licensure questions may not be worded too broadly. However, our review of licensure questions from numerous jurisdictions clearly illustrates the point that licensure questions too narrowly focused on certain health conditions may also be discriminatory. Not only does this potentially violate human rights but it contributes to the barriers physicians and others face in seeking particular types of health services and to the stigma related to certain health conditions. Such licensure questions must meet the needs of the regulatory body mandated to protect the public. While much of the practice of medicine encompasses the provision of health services to patients and, as such, the protection of patients in health care settings is key, it is important that such questions relate to the practice of medicine in a broader sense. Physicians whose practice encompasses other spheres, such as research, administration or education, can also cause harm to individuals and this must be captured in the licensure process.

The second set of recommendations sets out the instances when physicians with health conditions should be reported to the regulatory body. Given physicians' legal and ethical duties, we are recommending a standard of practice that makes the obligation to self-report clear. We are also recommending a standard of practice that establishes a duty on treating physicians and staff of PHPs to report. Further, we recommend that a standard of practice be established for physician-colleagues. In the Alberta context, while such standards of practice exist, our recommendations are aimed at setting different reporting thresholds for each of these groups. We recommend what those thresholds should be based on existing legal, ethical and professional duties of physicians. Where such standards do not exist in other Canadian jurisdictions, or where they are inconsistent with the thresholds we have recommended, we suggest that they be established in keeping with the thresholds set out in this report.

Our next recommendation sets out a framework for the governance and administration of a PHP in Alberta. This recommendation may well serve as a model in other jurisdictions. This model also aims to reduce barriers that physicians face in accessing appropriate services while enabling the regulatory body to meet its legislative mandate to protect the public. As the PHP in Alberta was functioning well in many ways, the key additions we have recommended are the addition of tools that will ensure accountability regarding reporting thresholds, as well as ensuring appropriate oversight and accountability to stakeholders, including the Alberta Medical Association (the "AMA"), the College of Physicians & Surgeons of Alberta (the "CPSA"), the public and others.

Our final set of recommendations encompass the need to appropriately evaluate PHPs, to conduct research to bolster evidence about barriers and effective aspects of PHPs, to minimize financial barriers that physicians may face and to urge other stakeholders, both within and outside of Alberta, to seriously consider the recommendations and rationale set out in this Report.



II. Recommendations

The following recommendations, if viewed in isolation from one another, will not achieve the aims of the work contained in this report. Many are interdependent and will not result in the intended effect if they are implemented in a piecemeal fashion. Therefore, the recommendations should be considered as an overall set of steps to be taken to strike a balance between two key objectives: (i) protecting the public; and (2) reducing barriers that physicians face in accessing appropriate health services. Such services should be provided in a way that protects physicians' interests to the greatest extent possible.

Recommendation 1:

We recommend that the following wording be used, along with other relevant information, for initial application licensure questions directed at health conditions:

Do you presently have a physical, cognitive, mental and/or emotional condition that is negatively impacting your work, or is reasonably likely to negatively impact your work in the future?

Have you ever had a physical, cognitive, mental and/or emotional condition that, were it to reoccur, would or would be reasonably likely to negatively impact your work in the future?

Recommendation 2:

We recommend that the following wording be used, along with other relevant information, for renewal application licensure questions directed at health conditions:

Do you presently have a physical, cognitive, mental and/or emotional condition that is negatively impacting your work, or is reasonably likely to negatively impact your work in the future that has not been previously reported to the College?

Have you ever had a physical, cognitive, mental and/or emotional condition that, were it to reoccur, would or would be reasonably likely to negatively impact your work in the future that has not been previously reported to the College?

Recommendation 3:

We recommend that "negative impact" on work must be defined in the applications. The definition should make clear two main points:

- a. Harm to patients or others as a result of the practice of medicine is the negative impact that these questions intend to address. If the impact of a physician's condition is not related to the well being, health and/or safety of others within his or her practice of medicine, the questions need not be answered in the affirmative.
- b. The practice of medicine includes research, education and administration with respect to health, in addition to the practice associated with patients.



Recommendation 4:

We recommend that the following criteria apply to whatever wording is used for questions asked on initial and renewal applications relative to reportable conditions:

- a. Make it clear that all health conditions are contemplated and included. Wording should list examples of various conditions to illustrate the breadth of conditions being contemplated, and should not be restricted to particular conditions or types of conditions, to the exclusion of others.
- b. Require conditions to be reported only where there is a connection between the condition and a negative impact on the practice of the physician.
- c. Encompass past conditions, as well as present conditions, where such a condition is reasonably likely to negatively impact the practice of the physician should it reoccur.
- d. Make it clear that applicants are not being asked for information about a condition that has been previously provided.
- e. Ensure that licensure questions are identical on both the initial application and the renewal application, with the following exception: the renewal questions should be limited to information not previously collected.

Recommendation 5:

We recommend that a Standard of Practice for Self-Reporting to the CPSA be implemented to align with the recommendations made with respect to the licensure questions.

Recommendation 6:

We recommend that a new Standard of Practice be created setting out the duty of a treating physician to report a physician-patient to the CPSA. The new Standard of Practice for treating physicians should create a duty in instances where it is reasonably foreseeable that patients of the physician-patient (or others in the context of the practice of the physician-patient) could be seriously harmed (whether physically or psychologically) as a result of the physician-patient's condition. This standard would apply to treating physicians whether the health services provided are done so within the PHP, or independently of the PHP. Non-treating physicians working within a PHP should also be subject to this standard.

Recommendation 7:

We recommend that the policies and procedures of any PHP model adopted establish and enforce the same reporting threshold for staff, contractors and/or other affiliated individuals of the PHP as that recommended for treating physicians of physician-patients.

Recommendation 8:

We recommend that the present Revised Draft for Consultation of the Duty to Report a Colleague Standard of Practice be further revised. The basis of reasonable grounds and the reference to health conditions that "could" limit a physician's ability should be retained. The reference to "patients at



risk” should be expanded to others at risk within the context of a physician’s practice of medicine. The list of health conditions set out as examples should be expanded in keeping with the findings of this report.

Recommendation 9:

We recommend that the Physician Health Program Co-Management Model in our report be adopted. This model has most of the PHP functions primarily residing with the AMA, as they currently do. The CPSA continues to conduct monitoring of physicians when such is appropriate. This will see the addition of a Review Panel to assess cases where it is unclear whether the reporting threshold has been met. In each case where this reporting threshold is met, the case will be reported to the CPSA. This Co-Management Model will also see the implementation of a Program Monitoring Feature to ensure quality control, and to satisfy both the public and the CPSA that appropriate policies and procedures are in place, and are being followed.

Recommendation 10:

We recommend that an evaluation mechanism of the new PHP be implemented, to assess the effects of the changes after a specific time period. We recommend that such an initial evaluation be completed within two years of implementation of a new PHP model.

Recommendation 11:

We recommend that research be undertaken to assess the most effective tools for encouraging physicians to seek assistance for the health conditions that have an impact on their work life.

Recommendation 12:

We recommend that an amendment to Alberta’s *Health Information Act* to enshrine a duty, rather than a discretion, to report in instances of imminent danger be proposed to government to be considered.

Recommendation 13:

We recommend that the AMA and the CPSA discuss ways to ensure that physicians are adequately insured, whenever possible, if they are unable to practice (whether temporarily or permanently).

Recommendation 14:

We recommend that the AMA and the CPSA recommend to their counterparts across Canada that they examine the licensing questions, as well as the reporting obligations in place in their respective jurisdictions and consider making changes in keeping with the findings of this report. In particular, instances of certain conditions being singled out should be eliminated. These distinctions not only fail to address the aim of protecting the public, but also, of arguably equal concern, may well contribute to the stigma associated with certain conditions such as mental health issues.



III. Introduction/Background

A. Introduction

The impact of health issues on physicians' practices has recently garnered considerable media attention as one of the ways in which our health care system fails, in some instances, to protect patients from harm. At the outset, we acknowledge that there are a variety of issues that impact patient safety; it is beyond the scope of our research and this report to address all of these issues. However, this analysis focuses on the issue of health conditions of physicians that lead to a negative impact on practice. It examines how the medical profession can best ensure that the public is protected, while appropriately addressing the needs and rights of physicians as patients.

The issues addressed in this policy paper are much more than theory; they have real-life consequences and are of concern to patients and society at large. Recent reports illustrating this matter have received considerable attention in North America. It is appropriate to begin this discussion with a brief summary of a few examples.

The winter 2011 issue of *International Anesthesiology Clinics* (49:1), titled *Anesthesia and Addiction*, was dedicated exclusively to articles discussing the issue of addicted anesthesiologists. Dr. Ethan Bryson, associate professor at Mount Sinai School of Medicine (located in New York, New York), author or co-author of many of the articles in this special edition, and author of the forthcoming book titled *Addicted Healers: 5 Key Signs Your Healthcare Professional May Be Drug Impaired*, describes how addicted physicians will sustain their addictions by diverting drugs from patients. He states that anesthesiologists (who perform life-sustaining functions during surgical interventions) represent up to 30% of all addicted physicians in the United States.¹ The continued practice of anesthesiologists who are impacted by drug addictions may result in extreme harm for patients, potentially leading to injuries such as patient paralysis or irreversible brain damage.²

The second example is contained in an article published in the *Archives of Surgery* in February, 2012, which concludes that "[a]lcohol abuse and dependence is a significant problem in US surgeons."³ This analysis based on existing data found that the percentage of US physicians suffering from a substance use disorder is between 10-15%.⁴ Building from this understanding, the authors of this article surveyed American surgeons to determine the rate of alcohol misuse amongst this subset of physicians, and assessed whether or not this alcohol use was associated with incidents (defined as medical error and/or resulting medical malpractice lawsuits) based on self-reports in the survey.⁵ The survey employed indicated that 15.4% of responding surgeons met diagnostic criteria for alcohol dependence or alcohol abuse.⁶ Additionally, this cross-sectional study stated that "surgeons with

1 Sharon Kirkey, "Addictions in the Operating Room: Patients are in Danger when an Anesthetist's top Priority is feeding a drug habit" *Postmedia News* (12 February 2012), online: Edmonton Journal <<http://www2.canada.com/edmontonjournal/news/sundayreader/story.html?id=747933dc-e0c7-44a0-840f-b19ec5ac9d41>>.

2 *Ibid.*

3 Michael R Oreskovich et al, "Prevalence of Alcohol Use Disorders Among Surgeons" (2012) 147:2 *Arch Surg* 168 at 168.

4 *Ibid.*

5 *Ibid.*

6 *Ibid* at 171.



alcohol abuse or dependency were substantially more likely to report a major medical error in the last three months, suggesting a potential relationship with quality of care.”⁷ The authors conclude that this “provides further evidence in support of a proactive approach to identify and treat a prevalent disorder that may affect the surgeon’s ability to practice with skill and safety.”⁸ Finally, this article is of import as it pointed out the perceived stigma and shame that physicians (and surgeons in particular) associate with admitting to, or accepting treatment for, a chemical dependence. The authors conclude with the hope that increasing discussion will work to reduce such shame and stigma, and alter the culture, such that individuals will be less reluctant to seek the assistance they require.⁹

There are many conditions that can affect physicians besides addictions and substance use. An area of concern currently receiving considerable attention in Canada is mistakes made in pathology and diagnostic imaging. While such errors can occur as a result of a wide range of factors, some recent cases have indicated that errors have occurred, at least in part, as a result of physician impairment due to factors such as physical health conditions. These examples raise important questions not only about impairment, but also about how effective current medical regulatory schemes are at preventing medical mistakes, as well as overseeing and managing the repercussions of harm that do occur, regardless of whether the source of harm was physician impairment or other unrelated factors. Recently, concerns about mistakes or oversights in assessing diagnostic laboratory tests have become public in Ontario, New Brunswick and Alberta. One report alleges that a pathologist, serving at the Hospital of Miramichi in New Brunswick from 1993-2007, was operating with error rates up to 1000% higher than pathology standards.¹⁰ A review of his practice by two physicians indicated that he suffered from a significant tremor and cataract-affected vision; it was on the basis of their review that the College of Physicians & Surgeons of New Brunswick suspended his license to practice. This issue is currently before the courts in New Brunswick as a medical malpractice class action.¹¹ Similarly, alleged misdiagnosis based on pathology reports completed by one pathologist, serving three hospitals in Windsor, Ontario, resulted in a formal investigation as ordered by Ontario’s Minister of Health and Long-Term Care.¹² The physician who made these alleged errors suffered from cataracts that affected his ability to properly assess pathology, yet he kept practicing. His colleagues, despite noticing errors in his reports, did not notify the College of Physicians & Surgeons of Ontario.¹³ Alberta has initiated a review of pathology testing and diagnostic imaging in light of errors at three hospitals throughout the province (in Calgary, Edmonton, and Drumheller) in the last few months of 2011. While it is too

7 *Ibid.*

8 *Ibid.*

9 *Ibid* at 171, 173.

10 Wagners: A Serious Injury Law Firm, “New Brunswick Medical Malpractice Class Action goes to Court” (12 September 2011), online: Wagners Medical Malpractice Lawyer Blog <<http://www.wagnersmedicalmalpracticelawyerblog.ca/2011/09/new-brunswick-medical-malpractice-class-action-goes-to-court.html>>.

11 *Ibid.*

12 Dr. Barry McLellan, Dr. Robin McLeod & Dr. John Srigley, *Report of the Investigators of Surgical and Pathology Issues at Three Essex County Hospitals: Hotel-Dieu Grace Hospital, Leamington District Memorial Hospital and Windsor Regional Hospital* (July 2010), online: <http://www.health.gov.on.ca/en/public/publications/ministry_reports/surgical_pathology_issues/docs/surgical_pathology_issues.pdf> [Report of the Investigators].

13 Andre Picard, “What we should learn from our pathology problems” (2 January 2012), online: <<http://m.theglobeandmail.com/life/health/new-health/andre-picard/what-we-should-learn-from-our-pathology-problems/article2289094/?service=mobile>>. Report of the Investigators, *ibid* at iv.



soon to comment on whether the concerns, if substantiated, are related in part to issues of physician impairment, this review will be important to take into account if such factors are indicated.¹⁴

It is understandably quite disconcerting for the public to read about physicians affected by a condition that could jeopardize patient well-being. This is especially so if the appropriate mechanisms are not in place, and/or there is a perception that they may not be in place, to protect the public from the physician whose practice has been compromised. Trust between patient and physician, and trust in the health care system generally, is essential to build and maintain if the aim is to provide patients with high-quality, safe health care services. However, it is equally important to ensure that affected physicians, assuming that such physicians are in need of or could benefit from services, are: (i) able, encouraged and supported to access the services required to address their conditions; and (ii) dealt with in a manner that protects, to a great degree, the confidentiality of their health information.

The privilege of self-regulation is premised, in part, on the “social contract” between the public and physicians, whereby society permits self-regulation of the profession, and, in return, is guaranteed “high standards of competence and moral responsibility.”¹⁵ Regulatory bodies have a duty to protect the public, and this arises out of the social contract that is entrenched by legislation. Self-regulation of the medical profession¹⁶ exists with the omnipresent possibility of increased direct government regulation and a reduction of autonomy should the self-regulatory bodies fail to carry out their duties. Such failure would, no doubt, also lead to the erosion of public trust in the medical profession.¹⁷ One of the common criticisms levied against a self-regulated medical profession is the perception that they are unable to protect patients from harm by ensuring the competence of their regulated members.¹⁸ Based on this perception, Canadian provinces and territories have recently enacted novel mechanisms to increase the “accountability and transparency” of the profession.¹⁹ One example, which is particularly relevant to this paper, is the 2007 amendment to the *Alberta Health Professions Act* (the “HPA”) that provides the Minister of Health and Wellness with the authority to direct the College of Physicians & Surgeons of Alberta (the “CPSA”), after consultation, to either adopt new, or amend existing, standards of practice, bylaws, etc. if “in the opinion of the Minister it is in the public interest or... a direction would provide for matters related to health, safety or quality assurance.”²⁰ This is a

14 Dawn Walton, “Botched Medical Tests Prompt Alberta to Order Sweeping Review”, *The Globe and Mail* (29 December 2011), online: The Globe and Mail <<http://www.theglobeandmail.com/news/national/botched-medical-tests-prompt-alberta-to-order-sweeping-review/article2286769/>>.

15 Tracey Epps, “Regulation of Health Care Professionals” in Jocelyn Downie, Timothy Caulfield & Colleen M Flood, eds, *Canadian Health Law and Policy*, 4th ed (Markham: Lexis Nexis, 2011) 75 at 78 [Epps].

16 *Health Professions Act*, RSA 2000, c H-7 provides for self-regulation of the medical profession in Alberta [HPA].

17 Tracey Epps, *supra* note 15 at 78.

18 *Ibid* at 85.

19 *Ibid* at 97.

20 HPA, *supra* note 16, s 135. There are other important examples of increased government involvement across Canada. Firstly, in 2009, Ontario adopted the *Regulated Health Professions Statute Amendment Act 2009*, SO 2009, c 26. This statute added section 5.0.1 into the *Regulated Health Professions Act*, SO 1991, c 18. Section 5.0.1 gives the Minister of Health broad authority to appoint a supervisor to govern any health profession college in Ontario in place of its governing council when the Minister has agreement of the Lieutenant Governor in Council. Section 5.0.2 provides factors that the Minister may consider in making their recommendation. This power was recently exercised by



significant change from the greater autonomy that self-regulatory bodies have enjoyed hitherto. This trend is certainly not limited to Canada. There are also examples of increased government regulation in other jurisdictions.

Physicians are susceptible to the same illnesses and potential conditions that afflict society at large.²¹ Physician Health Programs (“PHPs”) exist in provincial and territorial jurisdictions across Canada, and in many other countries, as a mechanism to support physicians in need of assistance. One key rationale for examining PHPs is that existing programs may discourage, rather than encourage, at-risk or compromised physicians from addressing their health concerns. Our review of the literature suggests that additional research is needed in the area to provide a stronger evidentiary basis with respect to barriers that physicians face in accessing services.²² Further research is also needed to form a more evidence-based approach to the design of PHPs. However, the research done to date suggests that there are certain obstacles that should be kept in mind. Specifically, explanations for why a physician may not come forward regarding a potential health condition include:

1. The fear that seeking treatment will lead to professional sanctions or practice restrictions;
2. The fear associated with moving from a position of authority to a place of helplessness;
3. The fear of being diagnosed with a serious medical condition;
4. The belief that physicians should be able to heal themselves;
5. Anxiety that their confidentiality may be breached, or that they may be seen in certain locations while seeking out services;
6. The possibility of being exposed to a stigma (real or perceived) or judgment;

the Minister of Health with the College of Denturists after a government ordered audit called into question the governance of this college (see Nicholas Keung, “Province takes over denturists’ regulator” *The Star* (27 March 2012), online: [The Star <http://www.thestar.com/news/ontario/article/1152870 – province-takes-over-denturists-regulato>](http://www.thestar.com/news/ontario/article/1152870-province-takes-over-denturists-regulato)). In announcing the move, the Minister quoted the audit to effect that “[t]here is an inability of college leaders to distinguish between the public interest and the profession’s self-interest.” (*Ibid.*) Secondly, a number of provinces in Canada have introduced legislation that creates a government office tasked with overseeing the “fairness” of the registration process of self-regulating professions, under the broad framework of the *Agreement on Internal Trade* (see *Agreement on Internal Trade*, online: http://www.ait-aci.ca/index_en.htm). For example, see the *Fair Registration Practices Act*, SNS 2008, c 38 in Nova Scotia, *The Fair Registration Practices in Regulated Professions Act*, CCSM c F12 in Manitoba, and the *Fair Access to Regulated Professions Act*, 2006, SO 2006, c 31 in Ontario.

21 College of Physicians & Surgeons of Alberta, “Frequently Asked Questions: Licensed Physicians”, online: College of Physicians & Surgeons of Alberta http://www.cpsa.ab.ca/Resources/PHMC_Overview/PHMC_Monitoring_Medical_Conditions.aspx.

22 See Margaret Kay, Alexandra Clavarino & Jenny Doust, “Doctors as patients: a systematic review of doctors’ health access and the barriers they experience” (2008) 58:552 Br J Gen Pract 501 at 501 for a systematic review of research in the area. A few other examples of research conducted include: Fiona Fox et al, “What happens when doctors are patients? Qualitative study of GPs” (2009) 59:568 Br J Gen Pract 811; Sandra K Davidson & Peter L Schattner, “Doctors’ health-seeking behaviour: a questionnaire survey” (2003) 179:6 Med J Aust 302; William T Thompson et al, “Challenge of culture, conscience, and contract to general practitioners’ care of their own health: qualitative study” (2001) 323:7315 BMJ 728; and JG Richards, “The health and health practices of doctors and their families” (1999) 112 NZ Med J 96.



7. Denial of the existence of a medical condition;
8. A lack of awareness, or insight, into the condition, or the impact the condition is having, or may have, on their practice;
9. The shame of having let themselves, or others, down;
10. Easy access to medications to facilitate self-treatment;
11. A lack of understanding of, or knowledge regarding, the process that will follow if they seek assistance from a PHP or interact with their professional regulatory body;
12. The fear of potentially losing their ability to earn an income and/or maintain a certain level of income. These fears may be exacerbated if such physicians are without any or sufficient disability or critical illness insurance.²³

With these introductory thoughts in mind, we now turn to a brief introduction of the questions we were initially given, and the approach employed to develop and present this report.

B. Genesis of this Policy Paper, Questions Initially Posed, Process Employed and Roadmap for the Report

i. Genesis of this policy paper

As discussed, the issue of physician health and the risks posed by compromised physicians continuing to practice has recently received wide-spread attention, both from members of the medical profession, as well as in the realm of public discourse, including numerous media reports. The Health Law Institute (the “HLI”) had previously conducted work on related issues and was considering this as the topic of a policy paper. Serendipitously, at the time such a project was under consideration, the HLI was approached by the CPSA and the Alberta Medical Association (the “AMA”) about the possibility of conducting research on, and establishing a Working Group to examine, related issues, and to ultimately make recommendations to the two organizations about the appropriate framework to protect the public, as well as physician-patients. While the research would have been conducted and the report written in any event, this coincidence of interest and concern allowed for the additional involvement of a Working Group to provide feedback on the research conducted, and enhanced the analysis and ultimate recommendations through perspectives from other areas of expertise and experience. The project went ahead with the support of these two organizations on the basis that the final report would be published and disseminated regardless of its findings. Both the AMA and the CPSA fully endorsed this approach. The Working Group acknowledges that the decision made by these organizations to jointly commission this policy paper, without advance knowledge of the conclusions reached, and with knowledge that that it will be publically available, is commendable.

Our task was to examine the issues, conduct research, and respond to the issues from a legal, ethical and public policy perspective. One objective of this report is to assist these entities as they work together and with other stakeholders in Alberta. Another aim of this work is to assist other jurisdictions that may be engaged in or considering a similar review.

²³ See Kate O’Connor & Joanna MacDonald, “Chapter 16: Doctor’s Health” in Ian St George ed, *Cole’s Medical Practice in New Zealand* (Wellington: Medical Council of New Zealand, 2009) at 139 for a list of a variety of reasons why a physician may be reluctant to become a patient [O’Connor & MacDonald].



ii. Questions initially posed

The issues initially posed by the two organizations are listed below. We set out this starting place for our research as it may help to illustrate a number of the initial issues with which the respective organizations were grappling. However, the structure of this report is not organized as a set of answers to each of these questions in the order that they were initially set out. The questions and issues to be addressed were refined over time, through dialogue, to reach consensus regarding the key issues to be addressed. This was done with the involvement of and dialogue among the Working Group, and key members of the AMA and the CPSA.

1. The overarching query is as follows: for Alberta, what is the recommended model for a program that strives to meet both the regulatory imperatives and the rehabilitative needs of at-risk physicians?
2. Related questions include:
 - (i) What should the respective roles of the CPSA and the AMA be in the recommended model?
 - (ii) What agency/organization is best suited to assess the risk of a physician with a condition that could affect his/her ability to provide safe patient care? Who has primary responsibility to assess and determine risk, and what other factors should be considered?
 - (iii) How should questions be framed on regulation applications and annual renewals within the Standard of Practice?
 - (iv) Should the questions only address conditions that have already impacted practice? Should questions attempt to identify risk to patients before practice has been impacted? How should this be balanced with the privacy needs of physicians?
3. Is there any evidence that requiring physicians to report health problems leads to delays in seeking help?
4. Do other regulatory bodies use a different approach to address this issue?
5. Given that self-regulated professions owe a duty to the welfare of the public, does failing to have a proper program in place potentially expose the medical profession to accusations that it is failing to meet this duty?

iii. Process employed

Crafting the most appropriate PHP is of concern across jurisdictions; Alberta is not unique in its search for an effective program that appropriately recognizes the variety of interests, and the legal, ethical and professional duties that are in play. It is clear from the questions initially posed, and the consensus that certain key issues must be addressed, that the AMA and CPSA want to implement the most appropriate PHP, and to deal with the nuances of such a program. While working towards improvements where necessary, the aim was to achieve this without compromising the positive aspects of the programs and frameworks that are currently in place.

In order to address the issues, the Health Law Institute formed a Working Group comprised of the following individuals:

1. Tracey Bailey, Executive Director, Health Law Institute, Faculty of Law, University of Alberta.
2. Cameron Jefferies, Research Associate, Health Law Institute, Faculty of Law, University of Alberta.
3. Elizabeth M. Davis, RSM. Sr. Davis served as a voice for the public interest. She also brought extensive personal and professional experience in health administration.
4. Dr. Philip Hébert, family physician, Professor Emeritus, Department of Family and Community Medicine at the University of Toronto. Dr. Hébert is recognized as having expertise in the field of medical ethics and also provided a physician's perspective.
5. Professor William Lahey, Associate Professor, Schulich School of Law, Dalhousie University. Professor Lahey contributed additional expertise in the area of health law, and combined expertise and experience in the area of human rights and professional regulation in particular.

Our Working Group convened twice in person. The first in-person meeting, held in Edmonton, Alberta in July, 2011, was also attended, in part, by representatives from the AMA and CPSA who introduced the issues and described Alberta's current arrangement. After the HLI completed the necessary research, with conference calls to ensure that we had consensus from all members of the Working Group in terms of issues and work to be done, the Working Group convened again in person in November, 2011, in Toronto, Ontario. Here, the Working Group applied the research to the issues and began crafting the recommendations that form the substance of this policy paper. The HLI drafted an initial report, which was circulated to the members of the Working Group for comment and edits in March, 2011. Following a number of revisions, this policy paper is the final product of the Working Group.

The legal research and analysis contained within this report is not a legal opinion and does not constitute legal advice. The work represents the consensus reached by the Working Group in response to the questions we were tasked with answering by the AMA and CPSA, based on the research conducted. For legal advice, individuals and/or organizations should contact legal counsel.

iv. Roadmap for the report

After completing this discussion of introductory matters, the next section of this report will detail the guiding principles that the Working Group employed during the research, discussion and drafting of this policy paper. The report will then summarize and describe the key findings from our jurisdictional review and analysis, our review of other professions, and the management of health care professionals with blood-borne illnesses in Alberta. We have not included every jurisdiction or profession that we assessed in this portion of the paper, focusing instead on those that provided the most useful analogs for our report and/or aided in formulating our recommendations. Next, the paper will review the legal analysis conducted, addressing the various legal duties and considerations that informed our recommendations. We then offer our recommendations regarding licensure questions (for use in initial application for licensure and annual renewal forms). Our recommendations related to the thresholds for reporting a physician whose practice might be impacted are then set out. We describe our recommended threshold for self-reporting, a physician treating a potentially compromised physician, case managers who are working with such physicians, and a colleague who interacts with a potentially compromised physician. We describe three potential models for the governance and administration of Alberta's PHP, and recommend one of them. We conclude with additional recommendations for consideration by the two organizations.



IV. The Alberta Medical Association and the College of Physicians & Surgeons of Alberta

A. Mandate/Role/Responsibilities

i. The Alberta Medical Association

The AMA serves as “[t]he official voice of the medical profession in Alberta.”²⁴ Representing approximately 96% of the population of Alberta’s practicing physicians, the AMA is concerned with “how Albertans receive care and physicians’ work environment.”²⁵ The stated mission of the institution is that “[t]he Alberta Medical Association stands as an advocate for its physician members, providing leadership and support for their role in the provision of quality health care.” Additionally, the vision of the AMA is a commitment to a “patients first” operational model whereby the priority is optimizing the value patients are receiving from physicians.²⁶ To accomplish this, the AMA facilitates physician involvement in “health care decision-making” and works to support physicians in all aspects of their varied professional careers.²⁷ The AMA, in addition to other functions, performs the following direct services:

1. Representing members;
2. Advocating for a quality health care system;
3. Negotiating annual funding levels for physician (medical) services and payments for various procedures (i.e., fees);
4. Managing the physician services budget;
5. Providing member benefits and services; and
6. Providing practice support.²⁸

The key here is that the AMA serves to represent and advocate for and/or assist Alberta’s physicians, seeking to accomplish these goals with physicians’ duties to patients clearly in mind.

ii. The College of Physicians & Surgeons of Alberta

The CPSA is responsible for the regulation of the medical profession in Alberta.²⁹ The privilege of self-regulation exists pursuant to section 3(1) of Alberta’s *Health Professions Act*.³⁰ The CPSA is governed and guided by a governing Council comprised of physicians, public members, and representatives from

24 Alberta Medical Association, “Who We Are”, online: Alberta Medical Association <<http://www.albertadoctors.org/bcm/ama/ama-website.nsf/AllDoc/3DEFB5AB9ADE7F3087256DE30060543F?OpenDocument>>.

25 *Ibid.*

26 *Ibid.*

27 *Ibid.*

28 *Ibid.*

29 College of Physicians & Surgeons of Alberta, “About Us: Introduction to the College”, online: College of Physicians & Surgeons of Alberta <<http://www.cpsa.ab.ca/AboutUs/Overview.aspx>>.

30 *HPA, supra* note 16.



Alberta's medical schools.³¹ The mission statement of the CPSA is “[s]erving the public by guiding the medical profession.”³² Additionally, the Council has identified four institutional goals “...that identify Council’s expectations for the work done by the College”:

1. The public receives safe and effective medical care from competent physicians.
2. The College of Physicians & Surgeons of Alberta is a trusted contributor to public policy affecting health care.
3. The College is an essential partner in a patient-centered health care system.
The College is a trusted resource to Albertans (public and others) when they have questions or concerns about medical practice.³³

Section 3 of the *Health Professions Act* provides that the CPSA must, in addition to other functions:

1. Protect and serve the public interest of Albertans (s 3(1)(a));
2. Direct and regulate its members (s 3(1)(b));
3. Establish, maintain, and enforce standards for physician registration (s 3(1)(c));
4. Establish, maintain, and enforce standards for continuing physician competence (s 3(1)(c));
5. Establish, maintain, and enforce standards of practice (s 3(1)(c)); and
6. Establish, maintain, and enforce a code of ethics for its members (s 3(1)(d)).

The most important point to take from this is that the CPSA is responsible for protecting the public, and is required by legislation to ensure that the appropriate mechanisms are in place to accomplish this goal.

As part of the CPSA’s mandate to establish registration standards for its members, it, like other such regulatory bodies, has an initial registration process as well as one related to renewal of registration. The *Physicians, Surgeons and Osteopaths Profession Regulation*, established pursuant to the *HPA*, requires applicants for registration to “submit evidence satisfactory to the Registrar confirming the member’s fitness to practise.”³⁴ Members applying for renewal must also meet this requirement.³⁵ Part of this process includes questions posed to applicants, some of which are aimed at health issues that are negatively impacting, or may negatively impact the practice of applicants. Below we set out select questions that are currently used.

31 College of Physicians & Surgeons of Alberta, “Council: Council Membership”, online: College of Physicians & Surgeons of Alberta <<http://www.cpsa.ab.ca/AboutUs/Council/CouncilMembers.aspx>>.

32 College of Physicians & Surgeons of Alberta, “About Us: Mission, Vision, Values”, online: College of Physicians & Surgeons of Alberta <<http://www.cpsa.ab.ca/AboutUs/MissionVisionValues.aspx>>.

33 College of Physicians & Surgeons of Alberta, “About Us: Goals”, online: College of Physicians & Surgeons of Alberta <<http://www.cpsa.ab.ca/AboutUs/Goals.aspx>>.

34 *Physicians, Surgeons and Osteopaths Profession Regulation*, Alta Reg, 350/2009, s 14.

35 *Ibid*, s 29.



Select Initial and Renewal Questions Presently Used by the CPSA:

Initial Application Questions for Registration include:

Have you ever had a medical condition that impaired your ability to perform intricate or hazardous tasks or to assume responsibility for the welfare of others? (Conditions such as, but not limited to: diabetes, psychiatric illness, neurological disorder, brain injury, impairment of a primary sense)

Have you ever tested positive for a transmissible blood borne illness? (Conditions such as, but not limited to: HIV, Hepatitis)

Have you ever had a problem with drug or alcohol consumption?

Annual Renewal Questions include:

Do you presently, or have you ever, suffered from

a) a transmissible blood borne infection (conditions such as HIV, Hepatitis B or C) that has not previously been reported to the College?

No

Yes: (if yes, the following will appear)

Explanation: _____

b) any serious health issue(s) that impairs or has impaired your ability to provide safe patient care that has not previously been reported to the College, including, but not limited to the following

a. Substance or chemical abuse or dependency?

No

Yes: (if yes then the following will appear)

Explanation: _____

b. Medical condition(s) that impair(s) your judgment, cognition, sensory, or motor function?

No

Yes: (if yes then the following will appear)

Explanation: _____

The regulation also provides authority to require members to undergo individualized assessments regarding competence for issues that include their physical or mental health.³⁶ As well, numerous

³⁶ *Ibid*, s 24(2)(c)(iii).



actions may be taken to restrict the practice of members found to be incompetent, including requiring a physician to practice with certain restrictions in place.³⁷ Ultimately, a member's registration and practice permit may be cancelled pursuant to the legislation where necessary. This cancellation may be appealed and the *HPA* provides the process for this.

Two standards of practice established under the *HPA* are relevant to reporting issues addressed in this report. The first is Standard 33, "Self-Reporting to the College"³⁸ and the second is Standard 34, "Duty to Report a Colleague."³⁹ Revised drafts of both standards of practice were issued on March 15, 2010 and circulated for consultation.⁴⁰ Neither has been approved.

The current self-reporting standard requires a physician to report certain personal circumstances, either at the time of his/her application for registration, or at any time if he/she becomes aware of certain conditions including transmissible blood-borne infections, serious health issues that currently impact his/her ability to provide safe patient care, or inappropriate sexual or personal relationships with patients. The draft standard would broaden the requirement to include health conditions that "could" affect the physician's ability to provide such care.⁴¹

The current standard of practice regarding the reporting of colleagues includes a somewhat broader range of circumstances that must be reported as compared to the self-reporting standard, though many of the bases are substantially similar. Again, however, the language regarding health conditions is broadened to include conditions that "could" affect the ability of a physician to provide safe patient care.

The *HPA*, as stated above, also requires the CPSA to establish a code of ethics. Alberta's College has adopted the Code of Ethics of the Canadian Medical Association (the "CMA Code of Ethics"),⁴² elevating it to quasi-legal status in the province as, along with the establishment of a code, the College is to enforce the code it adopts, which may be done through the disciplinary process. The CMA Code of Ethics includes sections covering fundamental responsibilities, as well as responsibilities to the patient, society, the profession and oneself. While the entire CMA Code of Ethics should be referenced, some of the key sections that would apply to issues dealt with in this report are:

37 *Ibid*, s 27.

38 College of Physicians & Surgeons of Alberta, "Self-Reporting to the College: Standard 33" (Effective January 1, 2010), online: College of Physicians & Surgeons of Alberta <http://www.cpsa.ab.ca/Libraries/Res_Standards_of_Practice/CPSA_Standards_of_Practice_Consolidated_Version.pdf> [Standard 33].

39 College of Physicians & Surgeons of Alberta, "Duty to Report a Colleague: Standard 34" (Effective January 1, 2010), online: College of Physicians & Surgeons of Alberta <http://www.cpsa.ab.ca/Libraries/Res_Standards_of_Practice/CPSA_Standards_of_Practice_Consolidated_Version.pdf> [Standard 34].

40 College of Physicians & Surgeons of Alberta, "Self-Reporting to the College: Draft Standard 32" (March 15, 2010); College of Physicians & Surgeons of Alberta, "Duty to Report a Colleagues: Draft Standard 33" (March 15, 2010). Note that these draft standards reference different numbers. The current standards of practice relating to self-reporting and reporting of colleagues are Standard 33 and Standard 34, respectively, and throughout this text we refer to these standards using the current numbering scheme.

41 *Ibid*.

42 The Canadian Medical Association, *CMA Code of Ethics*, Ottawa: CMA, 2004 [CMA Code of Ethics].



- Responsibility 1: Consider first the well-being of the patient.
- Responsibility 5: Practise the art and science of medicine competently, with integrity and without impairment.
- Responsibility 10: Promote and maintain your own health and well-being.
- Responsibility 46: Recognize that the self-regulation of the profession is a privilege and that each physician has a continuing responsibility to merit this privilege and to support its institutions.
- Responsibility 48: Avoid impugning the reputation of colleagues for personal motives; however, report to the appropriate authority any unprofessional conduct by colleagues.
- Responsibility 53: Seek help from colleagues and appropriately qualified professionals for personal problems that might adversely affect your service to patients, society or the profession.
- Responsibility 54: Protect and enhance your own health and well-being by identifying those stress factors in your professional and personal lives that can be managed by developing and practising appropriate coping strategies.⁴³

B. Current Process/Relationship

Currently, both the AMA and CPSA are involved in the process of dealing with affected, at-risk and compromised physicians. It is significant to note that the working relationship that currently exists between the AMA and CPSA appears to be a positive one in many respects. Importantly, the working relationship is maintained while both organizations continue to work diligently to fulfill their respective mandates. If, for reasons related or unrelated to physician health and wellness, this relationship between the organizations changes, or the relationship between key individuals in the relevant portfolios of each organization changes, such alterations could drastically destabilize the aspects of the current arrangement that are positive and functioning effectively. This reality justifies the importance of having robust structures, policies, and procedures in place, in addition to ongoing training and education of staff.

However, we question whether there is consensus between the organizations on the circumstances under which reporting a physician to the CPSA is appropriate and/or required. This speaks to the importance of not only completing the analysis and seriously considering the implementation of the recommendations contained in this report, but also ensuring that the appropriate education mechanisms are in place. The involvement of each organization can be summarized as follows:

i. The Alberta Medical Association

The AMA operates the Physician & Family Support Program (the “PFSP”), serving “Alberta physicians, residents, medical students and their immediate families” (“qualified individuals”).⁴⁴ The PFSP “supports and participates in promoting a healthy culture of medicine” in Alberta, and accomplishes this goal through education (presentations and promotional materials), collaboration with other

⁴³ *Ibid.*

⁴⁴ Alberta Medical Association, “AMA Physician & Family Support Program”, online: Alberta Medical Association <<http://www.albertadoctors.org/bcm/ama/ama-website.nsf/AllDoc/FB63EBAA53FB0B6987256DE3005F370B>>.



programs and stakeholders concerned with physician health and wellness, and clinical services.⁴⁵ Of primary interest in this policy paper is the operation of the clinical services and the interaction of these services with the Physician Health Monitoring Program (the “PHMP”) of the CPSA, and the CPSA in general.

In brief, the PFSP offers the following services:

1. Assessment

The PFSP maintains and publicizes a 24-hour confidential phone service for qualified individuals to use, which is staffed by an external service provider, who takes basic information from the caller (name, number, availability) and assigns the caller a unique identification number.⁴⁶ If permission to do so is provided by the caller, the Service Provider will refer the call (and collected information) to an assessment physician.⁴⁷ The assessment physician contacts the caller directly, provides support, does a risk assessment, and makes any referrals required, including access to a provincial network of qualified counselors maintained by PFSP’s external service provider.⁴⁸ If indicated, the assessment physician may follow up again with the caller (after completing a call report form) or with the caller’s permission, discuss the issue at hand with the Clinical Director. Issues regarding patient-boundary concerns, substance use, or disruptive behaviour are discussed with the Clinical Director to determine the appropriate next step (specific treatment, case coordination, or intervention).⁴⁹ Forms utilized throughout this process do not record identifying information.⁵⁰

2. Case Coordination

Case coordination is made available on a voluntary basis to individuals that present with complex, multi-faceted problems or who are returning from treatment for addiction or behavioural problems.⁵¹ The Case Coordination Team (the “CCT”) (consisting of the Clinical Director and Case Coordinator(s)) will meet the participant through a scheduled interview or an intervention.⁵² Necessary referrals are made that may include arranging appropriate assessment and residential treatment providers.⁵³ CCT works with treating clinicians to assess competency to return to work. Case Coordination utilizes an occupational health model offering follow-up support, as well as providing on-going liaison with clinicians, the Canadian Medical Protective Association, the workplace, family, and other stakeholders as required.⁵⁴

45 Alberta Medical Association, “PFSP WAVE: Winter 2010/2011”, online: <[http://www.albertadoctors.org/bcm/ama/ama-website.nsf/AllDoc/5D1C75001932331F8725782200762F11/\\$File/2010%20Wave%20Newsletter-Final%20for%20Webpage%20Jan%202024.pdf](http://www.albertadoctors.org/bcm/ama/ama-website.nsf/AllDoc/5D1C75001932331F8725782200762F11/$File/2010%20Wave%20Newsletter-Final%20for%20Webpage%20Jan%202024.pdf)> at 7.

46 Alberta Medical Association, “Physician and Family Support Program: Program Guidelines” (2011) at 6.

47 *Ibid.*

48 *Ibid* at 6.

49 *Ibid* at 7.

50 *Ibid.*

51 *Ibid* at 7.

52 *Ibid.*

53 *Ibid.*

54 *Ibid.*



This may include development of Return to Work plans and interaction with the CPSA PHMP, including, but not limited to, instances where biological monitoring is required.⁵⁵

3. Intervention Services

This approach is utilized when the caller (either a self-referring physician or third-party) contacts the PFSP expressing concerns of potential impairment that is jeopardizing workplace relationships or, more importantly, patient care. Collateral information will be obtained prior to an intervention to verify that the concerns are as reported. The PFSP has a set procedure for initiating intervention.⁵⁶

ii. The College of Physicians & Surgeons of Alberta

The CPSA is engaged in monitoring and/or managing physicians with conditions “such as blood-borne illnesses and infections, addiction and substance abuse, other medical conditions, boundary violations and disruptive behaviour” where such conditions are currently impacting practice or pose a high-risk of having an impact.⁵⁷ The monitoring/management process currently employed by the CPSA can be described as follows:

1. Notification

The CPSA will generally become aware that a physician is suffering from one of the conditions that the CPSA arguably needs to assess/monitor to ensure that the public is being protected in one of the following ways: (i) self-reporting by the physician (including instances where the licensure process indicates that the physician is potentially compromised); (ii) notification from a treating physician or other service provider; (iii) notification from a concerned colleague; (iv) notification through the complaints process; and/or (v) notification by the Clinical Director of the PFSP.⁵⁸

2. Action Taken by the CPSA Upon Receiving Notification

Upon notification, the Assistant Registrar assesses the situation. Depending upon the circumstances of the case, she may make one of the following determinations: i) no action is required; ii) the physician is referred to the PFSP or other services/professionals; or iii) additional steps, such as the collection of additional information from within the College or from colleagues or physicians leaders, or a further assessment(s), may be undertaken where deemed necessary.

If, after any necessary information gathering and/or assessment, the situation calls for the monitoring of a physician, he/she will become involved in the CPSA’s PHMP. The policies and procedures for monitoring physicians are created by the Physician Health Monitoring

55 *Ibid* at 7.

56 *Ibid*.

57 Dr. Janet L Wright, “Managing Physicians with Health Concerns”, online: College of Physicians & Surgeons of Alberta <http://www.cpsa.ab.ca/Libraries/Pro_PHMP/Managing_physicians_with_health_concerns.sflb.ashx>.

58 College of Physicians & Surgeons of Alberta, “Policy: Monitoring Medical Conditions” (June 25, 2008), online: College of Physicians & Surgeons of Alberta <http://www.cpsa.ab.ca/Libraries/Pro_PHMP/Monitoring_of_Medical_Conditions.sflb.ashx> at 1.



Committee (the “PHMC”), a group composed of a number of physicians with various areas of expertise, members of the CPSA’s Council, a physician with a condition, a physician in recovery and ex-officio, non-voting members (including the Assistant Registrar and a representative of the AMA). The physician staff member of the CPSA responsible for dealing with all cases (the Assistant Registrar) carries out her work in compliance with such rules.

The management of physicians through the PHMP occurs outside the disciplinary process, and focuses instead on: (i) helping “physicians access diagnostic assessments and treatment programs”; (ii) monitoring “physician’s continued fitness to practice medicine”; and (iii) overseeing “re-entry into medical practice”.⁵⁹ If an independent assessment of the physician indicates that the physician can continue to practice while receiving treatment, he/she is permitted to do so.⁶⁰ This may or may not require certain restrictions on practice, determined on a case-by-case basis. Alternatively, if the CPSA is concerned that the physician’s condition impairs his/her ability to practice and may jeopardize the safety of the public, he/she can be asked to voluntarily withdraw from practice or be suspended from practice pending further assessment. However, “[l]oss of license is extremely rare and occurs only if an independent assessment determines the physician is unfit to practice”.⁶¹

The PHMC, in addition to setting the framework for the PHMP, also serves as an advisory body to the Assistant Registrar in difficult cases. Such cases are discussed in a non-nominal way.⁶²

3. Continuing Care and Return to Practice

If physicians are able to continue in or return to practice (which most are able to do),⁶³ it is general practice that they will enter into a Continuing Care agreement with the CPSA as the mechanism to ensure that the physician is in fact maintaining his/her health, is free from impairment (or the impairment is being appropriately managed), and, if the case involves alcohol or other drugs, that the physician is not using such substances.⁶⁴ Such continuing care will be tailored for each individual, and may include, as indicated, some combination of “individual and group meetings, random body-fluid screening, workplace modifications and updates from treating professionals.”⁶⁵ If the physician is unwilling to participate with monitoring, “suspension and assessment of capacity through the College’s complaint director” is permissible pursuant to the *Health Professions Act*.⁶⁶

59 College of Physicians & Surgeons of Alberta, “Physician Health Monitoring Program (PHMP): Frequently Asked Questions”, online: College of Physicians & Surgeons of Alberta <http://www.cpsa.ab.ca/Services/PHMP/PHMP_FAQ.aspx> [PHMP Frequently Asked Questions].

60 *Ibid.*

61 *Ibid.*

62 College of Physicians & Surgeons of Alberta, “Physician Health Monitoring Program (PHMP)”, online: College of Physicians & Surgeons of Alberta <<http://www.cpsa.ab.ca/Services/PHMP/PHMPoverview.aspx>> [PHMP Overview].

63 PHMP Frequently Asked Questions, *supra* note 59.

64 PHMP Overview, *supra* note 62.

65 *Ibid.*

66 PHMP Frequently Asked Questions, *supra* note 59.



V. Components of Physician Health Programs

In our review of PHPs in various Canadian and international jurisdictions, certain components appear in such programs in various forms. Regardless of who delivers such components, or whether they are delivered by more than one organization at a time, some or all of the following components are utilized in the programs we have reviewed. We will come back to these components when we review our recommended models for PHPs.

1. Access to information and advice – information regarding the services offered and the process followed will be of value to physicians, colleagues, family members and others.
2. Education – proactive and responsive education on services provided and process followed is an important component of all PHPs to raise awareness and encourage access where appropriate.
3. Prevention and promotion – services will ideally include wellness initiatives to prevent, where possible, physicians from becoming affected by a condition.
4. Family support/services – services will ideally include information and service provision to family members of physicians.
5. Access to assessments – assessments may be indicated to assess the nature and/or severity of the condition, reasonable treatment options, and/or case management appropriate for a particular physician-patient.
6. Access to referrals – where treatment outside a PHP is required or desired by a physician-patient, appropriate referral mechanisms are an important component.
7. Case management/follow up – appropriate case management for physicians undergoing assessment, treatment and/or monitoring is key to the provision of appropriate services, as well as establishing oversight mechanisms where appropriate to safeguard the public.
8. Intervention services – with respect to some physicians, intervention services should be part of a PHP where there are reasonable grounds to believe that the physician poses a significant risk to themselves and/or others and they have been unwilling to seek services without such intervention.
9. Biological monitoring – for physicians with particular health issues (e.g. drug addiction and blood-borne infections in certain circumstances), biological monitoring is a necessary component of a PHP in terms of appropriate treatment of the physician and protection of the public.
10. Treatment – appropriate treatment is an essential component of any PHP, whether provided directly or through appropriate referrals.
11. Advocacy – physician-patients may need the assistance of an organization or of the health care providers caring for them to advocate on their behalf.
12. Reporting – when a reporting threshold has been met, a report may be made to the medical regulatory college.
13. Evaluation – given the lack of conclusive research on the effectiveness of PHPs, ongoing evaluation is important in any such program.



VI. Guiding Principles

The actions taken with regard to affected physicians ought to be based on reasonable and defensible ethical and legal principles. The four ethical principles – respect for autonomy, nonmaleficence, beneficence, and justice – are set out in the seminal work by Beauchamp and Childress⁶⁷ and are commonly referred to and used in medical education and practice. These four principles are regarded by many as fundamental in this area. Our Working Group had these in mind from the outset. However, consensus was reached that additional ethical principles should inform our work, as well as the creation and maintenance of a system to report, monitor and treat physicians at-risk or in need of treatment. As a result, we created a list of guiding principles which we referred to as we formulated our recommendations. Some of these principles may seem to be at odds with one another in a variety of circumstances. We do not see this as a problem but rather as recognition that there can be competing principles that must be taken into consideration and balanced appropriately to reach a reasonable and just conclusion.

Physicians, as members of a self-regulating profession, must place the well-being of the patient at the forefront of what they do; this was our primary principle. We note that this is the case as well in the CMA Code of Ethics, adopted pursuant to Alberta's HPA. The remainder of the principles set out below are not listed in any hierarchical order but should be balanced, along with this primary principle, as important considerations throughout the entire context of this report.

The principles we have explicitly considered are:

1. *Primacy of patient well-being and safety* – the CMA Code of Ethics, adopted by the CPSA under the Health Professions Act, states that the “well-being of the patient” should be considered above all other responsibilities. “Patient” here and throughout the report includes patients of at-risk and compromised physicians, as well as physician-patients.
2. *Respect for all patients* – there must be respect for the dignity and worth of every patient. Patients are owed a number of duties and medical practice should strive to respect and support the inherent worth and rights of patients.
3. *Prevention of harm to patients, society, the health care system and the medical profession* – harm in this context must be understood in a broad sense.
4. *Fair and non-discriminatory access to assessments, treatment programs and other services* – health services should be provided and the involvement of regulatory bodies should be conducted, in a way that respects human rights and other related rights/duties.
5. *Minimal intrusion on physician-patient privacy and maximum respect for confidentiality* – in providing health and other services to physicians, confidentiality must be maintained in accordance with legal and ethical obligations. Personal information of a patient-physician should only be shared when necessary in accordance with these duties. The treating health care professionals and staff members of PHPs must have a clear understanding of their duties to maintain confidentiality, as well as when such a duty should be breached to protect others.

⁶⁷ TL Beauchamp & JF Childress, *Principles of biomedical ethics*, 6th ed (New York: Oxford University Press, 2009) (note that the first edition of this book was published in 1979).



6. *Trust between the profession and the public* – a fair, balanced framework is essential to maintain the trust that society has in the medical profession, and to prevent erosion of such trust in the face of increased awareness of compromised physicians in practice.
7. *Optimization of institutional goals and objectives* – it is important to structure the framework for the PHP such that the legitimate institutional goals and objectives of stakeholder organizations are optimized and not compromised.
8. *Holistic approach to physician health* – it is not appropriate to approach physician health by only treating the symptoms of conditions that are or could reasonably be expected to negatively impact his/her work. Rather, it is important to also focus on preventative mechanisms that enable physicians to address concerns, where possible, before compromised practice becomes an issue requiring more serious treatment and/or regulatory action. It is in everyone's best interest to maximize the functional capacity of society's physician population. In addition, physician-patients should be assisted holistically and not merely from a medical model of disability.
9. *Procedural fairness* – physicians should be afforded due process throughout their interaction with PHPs.
10. *Effective, transparent, accountable, and responsive mechanisms to address physician health* – these principles must be made explicit in any PHP in order to promote accountability, generate and foster trust in the medical community, and demonstrate to society that the appropriate mechanisms are in place to safeguard individuals from compromised physicians.
11. *Appropriate stewardship of resources* – finite resources require prudent resource allocation when deciding upon mechanisms to carry out the aims of PHPs.

VII. Review of Other Models

A. Other Jurisdictions

Physician health and wellness, and frameworks such as PHPs designed to address such, are dealt with in numerous jurisdictions around the world. The research that formed the basis of this report reviewed a variety of approaches across Canada, North America, and the world. The aim of this section of the report is not to provide a comprehensive description of every jurisdiction reviewed, but to examine those aspects of alternate models which may provide ideas to improve existing frameworks, or alternative ways of dealing with physician health. Part of the research included a search for whether evidence had been collected as to the efficacy of certain measures. In general, our conclusion is that in most cases, such research is non-existent, scant or of limited applicability. There is some evidence in certain jurisdictions assessing some aspects of PHPs; however, many of the conclusions reached are founded on limited data or indicate that further research is required. It is therefore important to keep in mind that many of the opinions expressed in the literature or that form the basis of policy decisions related to PHP frameworks are based on opinion or speculation.

i. Other Canadian provinces

For the purposes of researching this policy paper, existing PHPs from every Canadian province/territory were surveyed. Despite certain distinguishing features between provinces/territories, there is considerable overlap in the way these programs are run and the sorts of legislated requirements



owed by the respective colleges and physicians; on the other hand, there are key differences. The two jurisdictions that offered the most utility in terms of proposing alternate program options and/or contrasting ways of handling related aspects of such PHPs are British Columbia and Ontario. Consequently, the following descriptions highlight some of the key differing ways in which physician health and wellness is addressed through PHPs in these two provinces:

1. British Columbia

The governing legislation in British Columbia (“BC”) is the *Health Professions Act* (the “BC HPA”).⁶⁸ The College of Physicians & Surgeons of British Columbia (the “CPSBC”), like the CPSA, has adopted the CMA Code of Ethics.

At the time of initial application to become a registered member of the College of Physicians & Surgeons of British Columbia, there is an obligation on behalf of applicant physicians to answer questions, some of which pertain to health and/or impairment issues. The questions asked regarding health conditions as part of the CPSBC Application for Registration include the following:

Have you ever suffered from health problems which have impaired your ability to practise medicine?

Do you have a blood-borne communicable disease which, by its nature, could place your patients at risk if there were an inadvertent exposure?

Have you ever suffered from, been treated for, or been advised to take treatment for misuse or abuse of any drugs, including alcohol?

Have you ever been hospitalized, or advised to be in hospital for any nervous, mental, or emotional ailment?

Have you ever been advised by a treating physician to restrict your practice of medicine?

Have you ever voluntarily relinquished your hospital privileges in the face of disciplinary action, or owing to emotional or psychiatric illness?

Have you ever been restricted in your prescription of opiates or other controlled drugs?⁶⁹

It is significant to note that for an annual license renewal application, the only question related to health conditions inquires about whether or not the physician has a blood-borne communicable disease. This is much narrower than questions posed in Alberta at the time of renewal applications.

Outside the application or renewal process for registration, neither the BC HPA nor the standards of practice established in British Columbia create a duty to self-report. Instead, “the College requests that physicians with such impairments demonstrate insight and professional accountability by notifying the College voluntarily when impairment exists. Such physicians may be asked not to practice until such time as determined fit to do so by their caregivers.”⁷⁰ Compared to the responsibilities that registered physicians in Alberta have to self-report, this is a significantly less onerous standard.

68 *Health Professions Act*, RSBC 1996, c 183 [BC HPA].

69 College of Physicians & Surgeons of British Columbia, “CPSBC Application for Registration” (2011).

70 College of Physicians & Surgeons of British Columbia, “Professional Standards and Guidelines: Physician Health” (October 2009), online: College of Physicians & Surgeons of British Columbia <<https://www.cpsbc.ca/files/u6/Physician-Health.pdf>> [BC Physician Health Standard].



As is the case in Alberta, a survey of the legislation in British Columbia indicates that there is a statutory obligation for a registrant to report colleagues to the regulatory body in certain circumstances. However, the circumstances where such a duty exists are limited. A positive duty to report exists where there is a “danger to the public”⁷¹ as a result of a “physical or mental ailment, an emotional disturbance or an addiction to alcohol or drugs that impairs his or her ability to practice,”⁷² or where a physician has “engaged in sexual misconduct.”⁷³ In both of these instances, the colleague must report only in those cases where there are “reasonable and probable grounds” to do so.⁷⁴ This is a fairly high threshold and one that would require a colleague to have a certain amount of reliable evidence, rather than a well-founded concern, that there was a condition that may pose a danger to others. “Danger” has been interpreted narrowly by Canadian courts. This also contributes to the apparent narrowing of the scope of appropriate reporting.

The only other instance where a duty to report by colleagues exists under the BC *HPA* is where a physician “because of admission to a hospital...for psychiatric care or treatment, or for treatment for addiction to alcohol or drugs...is unable to practise.”⁷⁵ In such instances, a duty lies with the chief administrative officer of the hospital or a physician “who has the care of” the admitted physician to report the physician-patient to the college.⁷⁶ This fails to capture instances where treating physicians are caring for physician-patients outside the hospital context. It also fails to capture many other conditions that could negatively affect a physician’s ability to practice safely. It raises the question as to why such reporting would not include other conditions that may negatively affect a physician’s ability to practice safely (e.g. physical conditions). Finally, it may discriminate on the basis of mental disability against compromised physicians who go to the hospital for help.

The standard of practice under the BC *HPA* regarding physician health does state that a physician “who becomes aware of a health condition or impairment of a colleague...which may constitute a risk to the patients or public, is required...to report such a matter to the registrar of the College....”⁷⁷ If one reads this section of the standard in isolation, it appears to provide for a broader scope of reporting than does the BC *HPA*. However, the standard makes it explicit that it only applies where reporting is required in accordance with s 32.1 (describing what constitutes a compromised physician) and s 32.2 (describing the duty to report a compromised physician) of the BC *HPA*, which only relates to the reporting where there is a danger to the public. Given this, physicians would be restricted by the duties as set out in the wording of the BC *HPA*, and could report in a broader set of circumstances as the standard of practice would suggest.

The Physician Health Program of British Columbia (the “PHPBC”) is unique in several ways. It is jointly funded by the CPSBC, the British Columbia Medical Association, and the British Columbia Ministry of Health, and exists as “an independent, nonprofit society that is governed by an elected board

71 BC *HPA*, *supra* note 68, s 32.2.

72 *Ibid*, s 32.1.

73 *Ibid*, s 32.4.

74 *Ibid*, ss 32.1 & 32.4.

75 *Ibid*, s 32.3.

76 *Ibid*.

77 BC Physician Health Standard, *supra* note 70 at s 5.



of directors.”⁷⁸ It is a separate organization with an independent mission statement and mandate. The PHPBC has been in operation since 1979 “as a confidential service to respond to the needs of physicians who were struggling with substance use disorders.”⁷⁹ The PHPBC has since expanded its focus from substance abuse issues to include the entire compliment of physician health and wellness concerns, including: mental health, career and life transitions, workplace conflict, referral services, professional support, finances, and concern for colleagues.⁸⁰ It is worth noting that besides physicians, the PHPBC also offers its services to spouses and dependent children of physicians, and to physicians in training (medical students and residents).⁸¹

Regarding confidentiality, the PHPBC indicates that it “will only collect, use or disclose your information to provide services and support to you, as consented by you, or as required by law.”⁸² As a result, this does not provide for disclosure to protect others from harm where no positive duty to disclose exists. The PHPBC has created numerous confidentiality policies that address the various circumstances that can arise during the course of interaction between a physician and the program. It is beyond the scope of this policy paper to provide a detailed description of these documents.

2. Ontario

The pertinent legislation in Ontario is the *Regulated Health Professions Act*⁸³ and the *Health Protection and Promotion Act*.⁸⁴ Unlike the CPSA, the College of Physicians & Surgeons of Ontario (the “CPSO”) has not adopted the CMA Code of Ethics. As a result, the CMA Code of Ethics may carry ethical weight with physicians in Ontario but will not carry the same quasi-legal authority as it does in Alberta and British Columbia.

At the time of initial application to become a registered member of the CPSO, there is an obligation on behalf of applicant physicians to answer questions, some of which pertain to health and/or impairment issues. The application form specifically states that “‘medical condition’ includes any mental disorder or illness.” Questions include the following:

Do you now have any medical condition that affects or could affect your ability to practise medicine?

78 Physician Health Program British Columbia, “About Us”, online: Physician Health Program British Columbia <<http://www.physicianhealth.com/node/17>>.

79 Physician Health Program British Columbia, “About Us: Our History”, online: Physician Health Program British Columbia <<http://www.physicianhealth.com/our-history>>.

80 Physician Health Program British Columbia, “What We Help With”, online: Physician Health Program British Columbia <<http://www.physicianhealth.com/node/18>>.

81 See Health Program British Columbia, “Am I eligible to receive services?”, online: Physician Health Program British Columbia <<http://www.physicianhealth.com/node/20>> noting that in addition to serving physicians, residents, and medical students, the PHPBC also offers its services to spouses and dependent children of physicians.

82 Physician Health Program British Columbia, “Confidentiality”, online: Physician Health Program British Columbia <<http://www.physicianhealth.com/node/21>>.

83 *Regulated Health Professions Act* 1991, SO 1991, c 18.

84 *Health Protection and Promotion Act*, RSO 1990, c H7.



Have you ever had any medical condition that has affected or could affect your ability to practise medicine?

Have you ever taken a medical leave of absence, of any duration, from a medical school, a postgraduate medical training program or any professional position or employment?

Do you now have a communicable disease or are you a carrier, whether asymptomatic or otherwise, of an infectious agent of a communicable disease?

Are you now abusing, dependent on, or addicted to alcohol or a drug?

Are you being treated for abuse of, dependence on, or addiction to alcohol or a drug?

Have you ever abused, been dependent on, or addicted to alcohol or a drug?

Have you ever been treated for abuse of, dependence on, or addiction to alcohol or a drug?⁸⁵

Upon application for renewal of registration, the following questions are posed:

1) Do you have an addiction or substance use problem (including alcohol) identified since April 1, 2011 that may compromise your ability to practice medicine *and* for which you are *not* currently enrolled in the OMA's Physician Health Programme?

2a) In your practise, do you perform exposure-prone procedures as defined in the *Instruction Guide*?

If you answered yes to 2a), proceed to questions 2b) and 2c).

If you answered no to 2a), proceed to Section I.

2b) Have you had your blood tested for Hepatitis B, Hepatitis C, and HIV since April 1, 2003?

2c) Are you infected with or have you had a positive blood test with respect to Hepatitis B, Hepatitis C or HIV? (for Hepatitis B, if you test positive for the antibody only, answer no here.)⁸⁶

It is significant to note that the scope of questions on the renewal application in particular is narrower than the scope of questions posed in Alberta.

While a regulation on professional misconduct establishes that "practising the profession while the member's ability is impaired" is an act of professional misconduct,⁸⁷ a survey of the legislation and of the relevant policies suggests that there is no self-reporting obligation in Ontario.

The only duty to report a colleague set out in Schedule 2 of the Ontario *Regulated Health Professions Act*, the *Health Professions Procedural Code*, requires members to report a colleague if they believe on

85 See College of Physicians & Surgeons of Ontario, "Registration Application and Forms", online: College of Physicians & Surgeons of Ontario

<<http://www.cpsso.on.ca/registration/applicationsforms/default.aspx?id=1810>>.

86 College of Physicians & Surgeons of Ontario, "Annual Licensure Renewal Application" (2011).

87 *Professional Misconduct*, O Reg 856/93, s. 1(1)(4).

reasonable grounds that the colleague “has sexually abused a patient.”⁸⁸ The other reporting obligations contained therein apply to persons who operate a facility (required to report a “member who practices at the facility” if there are reasonable grounds to believe that he/she is “incompetent, incapacitated, or has sexually abused a patient”).⁸⁹ There is also a reporting obligation on certain persons (that may or may not pertain to colleagues in some instances) to report members if particular relationships dissolve as a result of certain reasons, including the professional misconduct or incapacity of the member.⁹⁰ The CPSO’s policy statement on mandatory reporting, in the section on permissive disclosure, states that the “College expects physicians to take action when they have reason to believe that another is incapable of properly treating patients due to a physical or mental condition or disorder.”⁹¹ However, it is very clear that there is no duty to do so. It specifically references that the only duty to report such incapacity falls on health facility operators. It goes on to say that appropriate action may include, depending on the circumstances, contacting the Physician Health Program at the Ontario Medical Association (the “OMA”), the Registrar of the CPSO, or the individual’s colleagues or family.⁹² The OMA makes it clear that there is “no specific legislation dealing with a health professional’s obligation to intervene or to warn if there is a significant risk of serious physical harm to self or others”⁹³ resulting from the way that a physician is practicing.

The Ontario Physician Health Program is different from Alberta’s current arrangement in a number of ways. Firstly, the PHP is organized and managed exclusively by the OMA, including the biological monitoring portion of the program (which resides with the CPSA in Alberta). The list of direct services offered includes: information and advice; assessment and referral; case management and monitoring; advocacy; family support; education and prevention; intervention services; and policy development.⁹⁴ Note that while the PHP maintains a clinical staff, they “refer clients to third party clinical resources for assessment and/or treatment to assist them with problems related to stress, burnout, marital and family issues, conduct or behavioural problems, sexual and boundary issues, gambling, mental health, substance abuse and substance dependence.”⁹⁵ The Monitoring Program offered by the PHP includes “case management and formal monitoring”, and is “available for those experiencing substance use disorders, psychiatric disorders and concurrent disorders. In addition, monitoring for physicians identified as behaviourally disruptive is being developed.”⁹⁶

88 *Health Professions Procedural Code*, s 85.1, being Schedule 2 of the *Regulated Health Professions Act*, 1991, SO 1991, c 18.

89 *Ibid*, s 85.2.

90 *Ibid*, s 85.5.

91 College of Physicians & Surgeons of Ontario, *Policy Statement #3-05: Mandatory Reporting* (January/February 2006), online: College of Physicians & Surgeons of Ontario <<http://www.cpso.on.ca/uploadedFiles/policies/policies/policyitems/mandatoryreporting.pdf>> at 11.

92 *Ibid*.

93 Ontario Medical Association Physician Health Program, “Confidentiality Policy”, online: Ontario Medical Association Physician Health Program <<http://php.oma.org/confidentiality.html>> [Confidentiality Policy].

94 Ontario Medical Association, “Physician Health Program”, online: Ontario Medical Association <<https://www.oma.org/Benefits/Pages/PhysicianHealthProgram.aspx>> [OMA PHP].

95 Ontario Medical Association, “Programs and Services”, online: Ontario Medical Association <<http://php.oma.org/programs.html>>.

96 Ontario Medical Association, “PHP Monitoring Programs”, online: Ontario Medical Association <<http://php.oma.org/monitoringPrograms.html>> [OMA Monitoring Programs].



Also of note is that this PHP services a broader client base than Alberta's initiative. The OMA indicates that "clients" qualified to access these direct services include "physicians, residents, medical students, veterinarians and pharmacists, along with supportive services to family members of our clients."⁹⁷

The OMA PHP is overseen by a Program Advisory Panel that convenes twice a year and "reviews and approves program objectives and policies and ensures an ongoing good working relationship between the regulatory colleges and the professional associations in supporting the work of the PHP."⁹⁸ For example, the PHP Advisory Panel oversees the policies and objectives of the PHP Monitoring Programs⁹⁹ and advises the Medical Director of the OMA PHP on the direction and performance of the program.¹⁰⁰ The PHP Advisory Panel includes representatives from each College whose members have access to PHP services.

The following points explain how the PHP interacts with the CPSO and the OMA:

1. The PHP receives all of its funding from the OMA, but remains physically separate from the OMA and utilizes its own operational support;
2. The PHP recognizes that some of the issues that it deals with might require resolution with respective colleges (physicians, pharmacists, and veterinarians), but that the respective college will not be contacted unless the client has provided consent to do so, or a mandatory reporting obligation to the CPSO has been triggered;
3. According to the OMA PHP's Confidentiality Policy, mandatory reporting is triggered in Ontario when a child may be at risk, when an individual may be unfit to drive, when there is suspected sexual misconduct with a patient, or when the individual has a reportable communicable infection/disease. The Policy also states that "[w]hile there is no specific legislation dealing with a health professional's obligation to intervene or to warn if there is a significant risk of serious physical harm to self or others, members of the PHP Clinical Team will follow the guidelines as suggested for physicians by the College of Physicians & Surgeons of Ontario's policy statement (#8-05) which states '...a physician may disclose personal health information about an individual if the physician believes, on reasonable grounds, that the disclosure is necessary to eliminate or reduce a significant risk of serious bodily harm to a person or group of persons'."¹⁰¹ These reporting provisions do not set out a line of reporting to the CPSO in most instances. Instead, they require and/or allow for disclosure of information to other sources, such as to police or the potential victim(s) of significant harm posed by others. Of note is that this policy does not capture all instances of mandatory reporting.

97 OMA PHP, *supra* note 94.

98 Ontario Medical Association, "PHP Program Advisory Panel", online: Ontario Medical Association <<http://php.oma.org/advisory.html>> [OMA Advisory Panel].

99 OMA Monitoring Programs, *supra* note 96.

100 OMA Advisory Panel, *supra* note 98.

101 Confidentiality Policy, *supra* note 93; College of Physicians & Surgeons of Ontario, *Policy Statement #8-05: Confidentiality* (March/April 2006), online: College of Physicians & Surgeons of Ontario <<http://www.cpso.on.ca/uploadedFiles/policies/policies/policyitems/Confidentiality.pdf>> at 3-4.

ii. Other countries

1. United Kingdom

The General Medical Council (the “GMC”) is responsible for the regulation of the medical profession in the United Kingdom, pursuant to the statutory obligations created by the *Medical Act 1983*.¹⁰² This regulatory model is similar to the Canadian experience in so far as physicians are required to be registered with, and licensed by, the regulatory body before they can practice. The registration process for physicians is found on-line, but the document titled *Declaration of Fitness to Practise* provides the questions that “[a]ll doctors applying for registration with a license to practice, restoring their name to the Register, or restoring their license to practise, are asked to complete....”¹⁰³ The pertinent questions are as follows:

Are you aware of anything about your physical and/or mental health that might raise a question about your fitness to practise as a doctor in the UK?

(You may be asked for a full statement from you of the nature of the physical and/or mental condition and how it may impair your fitness to practise)

Are you aware of any aspect of your conduct and/or capability that might raise a question about your fitness to practise as a doctor in the UK?

(You may be asked for a full statement from you of the issue that may be current or have arisen in the past and how it may impair your current fitness to practise or raise a question of your fitness to practise)¹⁰⁴

In addition to screening at the point of initial application for registration and licensure, all physicians in the United Kingdom will soon be required to periodically partake in license revalidation (section 29 of the *Medical Act 1983*), a process intended to assess competence.¹⁰⁵ The main guidance document for physicians regarding revalidation is entitled *Good Medical Practise (2006)*.¹⁰⁶ When fitness to practice becomes an issue (at the time of application for registration/licensure, as a result of a complaint, or in the context of revalidation), it falls to the GMC to ensure that the public is protected; issues are generally referred to a statutorily created panel/committee that is advised by a Legal Assessor.¹⁰⁷ The physician has the option of appealing a decision made by the panel/committee.

The GMC also provides advice on how to raise concerns about the possibility of patients being treated by compromised physicians. This document, titled *Raising and Acting on Concerns About Patient Safety* (January 2012), is a Supplementary Guideline to *Good Medical Practise (2006)*, which establishes the following obligation for physicians:

102 *Medical Act 1983* (UK), c 54.

103 General Medical Council, “Declaration of Fitness to Practise” (2012), online: General Medical Council <http://www.gmc-uk.org/doctors/registration_applications/declaration_of_ftp.asp>.

104 *Ibid.*

105 General Medical Council, “Revalidation” (2012), online: General Medical Council <<http://www.gmc-uk.org/doctors/revalidation.asp>>.

106 *Ibid.*

107 General Medical Council, “Fitness to Practice Legislation” (2012), online: General Medical Council <http://www.gmc-uk.org/about/legislation/ftp_legislation.asp>.



You must protect patients from risk of harm posed by another colleague's conduct, performance or health. The safety of patients must come first at all times. If you have concerns that a colleague may not be fit to practise, you must take appropriate steps without delay, so that the concerns are investigated and patients protected where necessary. This means you must give an honest explanation of your concerns to an appropriate person from your employing or contracting body, and follow their procedures.¹⁰⁸

Raising and Acting on Concerns About Patient Safety contextualizes this obligation by noting that “[a]ll doctors have a duty to raise concerns where they believe that patient safety is being compromised by the practise of colleagues or the systems, policies and procedures in the organizations in which they work.”¹⁰⁹ Further, this document recognizes aspects of medical culture that make colleague reporting difficult, such as a reluctance to question a fellow member of the profession, the possibility of compromising working relationships, and the possibility of becoming the subject of a complaint.¹¹⁰ The guidance in this document is of import because it establishes a hierarchical response to addressing concerns about colleagues/systems:

1. If patients may be at risk of “death or serious harm for any reason,” the necessary organization or individual must be contacted immediately;
2. If possible, raise concerns locally with a manager or organizational officer (which will vary based on your circumstance);
3. The GMC is to be contacted for investigation purposes if: (a) it is impossible to raise the concern locally because the individual in charge is part of the problem; (b) you believe the concerns you raised locally were not addressed adequately; or (c) patients are at immediate risk and the regulator has the obligation to act;
4. The issue can be made public if all other avenues of recourse have been exhausted and the results are unsatisfactory, and patient confidentiality is not compromised.

In assessing the applicability of this hierarchical response structure within the Canadian situation, it is important to note that the employment situation for physicians in the United Kingdom differs from Canada. The delivery of both Primary Care (which is often the point of first contact between citizens and health care providers and includes, amongst other providers, both walk-in clinics and general practitioners) and Secondary Care (which is acute healthcare and includes emergency medicine and elective procedures) is organized by the publically funded National Health Service.¹¹¹ Both Primary Care and Secondary Care are divided into a series of trusts, each of which is locally administered

108 General Medical Council, *Good Medical Practice* (2006), online: General Medical Council <http://www.gmc-uk.org/static/documents/content/GMP_0910.pdf> at s 43.

109 General Medical Council, “Raising and Acting on Concerns About Patient Safety” (January 2012), online: General medical council <http://www.gmc-uk.org/Raising_and_acting_on_concerns_about_patient_safety_FINAL.pdf_47223556.pdf> at 5.

110 *Ibid.*

111 The National Health Service, “The NHS” (24 October 2011), online: The National Health Service <<http://www.nhs.uk/NHSEngland/thenhs/about/Pages/overview.aspx>>.



and employs health care providers.¹¹² This employment situation is noteworthy as it may provide additional avenues for internal redress.

Physician health and wellness programs are operated by the British Medical Association (the “BMA”). Specifically, a qualified individual (physician, medical student, or BMA staff member) who is experiencing difficulties in their professional or personal life in the United Kingdom has one number to call, and at that point they have an election to make given that two services are available. The first is “BMA Counselling”, which allows the individual to speak to a professional phone counselor about the issue at hand.¹¹³ Counseling can remain anonymous and can be one-off or on-going.¹¹⁴ The second option is the “Doctors Advisor Service”, which facilitates discussion between the calling physician and another physician, the Doctor Advisor; this relationship can be on-going or one-off as well.¹¹⁵ Note regarding confidentiality that the “data recorded [by the Doctor Advisor] is anonymised and used to focus resources appropriately, and for lobbying for improved services for doctors’ health issues” but that “[i]f a Doctor Advisor learns that patients may be in danger, he or she has a duty a duty, as a doctor, to act to prevent harm. The doctor-adviser will try and encourage the doctor to change whatever presents a risk to the patient. Failure on the doctor’s part to give an undertaking to stop putting patients at risk will mean that the Doctor Advisor will have to take advice on how to act, and this may be by contacting the GMC.”¹¹⁶

2. Norway

The Norwegian system provides an interesting point of comparison, but at the outset it is important to emphasize that Norwegian society is accustomed to, and expects, a different level of government involvement in civil society. Physician health has been of considerable interest to researchers in Norway since 1993.¹¹⁷ Regulatory licensure for physicians rests with the Norwegian Registration Authority for Health Personnel (the “SAFH”), which is tasked with “authorization” of physicians, somewhat different than our concept of licensure.¹¹⁸ Authorization is distinct from licensure in Norway as authorization entails “full and permanent approval”, whereas licensure imposes “one or more limitations with respect to duration, independent or supervised practise, etc.”¹¹⁹ Once authorized, medical practitioners are allowed to advertise themselves as professionals.¹²⁰

112 The National Health Service, “The NHS Structure” (24 October 2011), online: The National Health Service <<http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhsstructure.aspx>>.

113 British Medical Association, “About Doctors for Doctors and BMA Counselling” (20 July 2011), online: British Medical Association <http://www.bma.org.uk/doctors_health/D4Dabout.jsp>.

114 *Ibid.*

115 *Ibid.*

116 *Ibid.*

117 Karin Isaksson Ro, “Emotional Exhaustion and Distress After a Counselling Intervention for Physicians: A Three-Year Prospective Longitudinal Cohort Study” (2010) Dissertation submitted to the Faculty of Medicine, University of Oslo, at 27.

118 Satens Authorisasjonskontor for Helsepersonell (SAFH), “Welcome to the Web-site of the Norwegian Registration Authority for Health Personnel (SAFH)”, online: SAFH <<http://www.safh.no/english/main.html>>.

119 *Ibid.*

120 *Ibid.* See sections 48 and 49 of the *Act of 2 July 1999 No 64 relating to Health Personnel etc. (Health Personnel Act)* for legislated conditions for authorization and licensure.



The *Act of 2 July 1999 No 64 relating to Health Personnel etc. (Health Personnel Act)* indicates that: (i) the right to be authorized is contingent on not being “considered unfit for the profession” (section 48(d)); (ii) that licenses and authorization can be revoked because the “holder is unfit to practice his profession in a responsible manner for reasons of severe mental illness, mental or physical impairment....use of alcohol or narcotics or substances with a similar effect...” (section 57); and (iii) that licensure or authorization can be suspended if the individual is “considered to be endangering the safety of the health service” (section 58). Rather than being connected to the health programs or licensure questions described in the following paragraphs, the duty of monitoring fitness to practice falls to supervising “public health authorities,” who “[r]egardless of professional secrecy considerations....can demand whatever reports or information are necessary in the carrying out of supervision, enquiries and inspection.”¹²¹

Programs to assist affected physicians are operated by the Norwegian Medical Association (the “NMA”) and not the SAFH. Specifically, two services are offered and government supported: (i) a “doctors for doctors scheme” where physicians specially trained in assisting physicians treat affected physicians for specific concerns; and (ii) “support-doctor scheme” which creates “low threshold” facilities run by local medical associations to serve physicians in need.¹²² The most studied facility of this sort is called Villa Sana, and is jointly operated by the NMA and the Modum Bad psychiatric hospital.¹²³ This facility is available to all Norwegian physicians on a self-referral basis,¹²⁴ and offers two main intervention services: (i) individual counseling; and (ii) a five day group course on practice management and life strategy.¹²⁵ It is important to note that Villa Sana, as a preventative program, has dissociated itself from clinical intervention, meaning no medical records are kept and it is dissociated from any disciplinary action.¹²⁶

This model is quite distinct from the North American paradigm for treating affected physicians in that it dissociates physician health and wellness from the legislated mandate of protecting the public. It has worked quite well in Norway where some conclude that “the most successful initiatives separate medical treatment from disciplinary measures and emphasize self-help groups in confidential programmes.”¹²⁷ The caveat to this conclusion is that this approach to maintaining a healthy population of physicians may require a level of regulatory oversight of the medical profession that would otherwise not be required, and may not be desired, to ensure that the public is adequately protected.

121 Norwegian Board of Health, Faculty of Medicine (University of Oslo) & Norwegian Medical Association, Registration of Medical Practitioners in Norway: A Guide to Norwegian Registration of Medical Practitioners Trained Abroad (January 2000), online:

<<http://www.noruega.es/NR/rdonlyres/F37DAC8D50404A8785C6DF269A8E4215/30424/ik2573.pdf>>.

122 Reidar Tyssen, “Health Problems and the use of Health Services among Physicians: a Review Article with Particular Emphasis on Norwegian Studies” (2007) 45 *Ind Health* 599 at 605 [Tyssen].

123 Karin E Isaksson Ro et al, “Counselling for Burnout in Norwegian Doctors: One Year Cohort Study” (2008) 337 *BMJ* 1, at 2.

124 *Ibid.*

125 *Ibid.*

126 Karin E Isaksson Ro, Tore Gude & Olaf G Aasland, “Does a Self-Referral Counselling Program Reach Doctors in Need of Help? A Comparison with the General Norwegian Doctor Workforce” (2007) 7 *BMC Public Health* 36 at 37.

127 Tyssen, *supra* note 122 at 605.



3. United States of America

Physician regulation in the United States occurs on a state-by-state basis through state medical boards. It is difficult, but not impossible, to speak generally about the approach to physician regulation and physician health and wellness, implemented as PHPs, in the United States given the variety of approaches that exist. State medical boards (branches of state governments) are tasked with "... maintain[ing] the societal contract through the licensure process"¹²⁸ and have been regarded by physicians as being "too focused on protecting the public from physicians impaired by mental illness to support preventative measures, such as treatment for depression, which may lead to impairment."¹²⁹ A survey of the literature suggests that the American approach to the regulation of physicians and physician health and wellness is transforming from something that was initially addiction-focused¹³⁰ and solely focused on patient-protection,¹³¹ to an issue that must be addressed in a holistic manner, covering all forms of physician impairment and working to create a healthy population of physicians better able to serve the public. When discussing America as a potential analog in this context, it is important to note that state medical boards have a policing function that is not necessarily shared to the same extent by Canadian medical regulatory colleges.

Similar to the Canadian experience, state medical boards rely heavily on licensure to assess the fitness of physicians. A considerable body of literature assessing appropriate licensure questions exists in the United States. This literature suggests that "[d]ecisions about professional licensing and credentials should be based on professional performance" rather than on a medical diagnosis.¹³² This shift in the American licensure experience has been driven, at least in part, by the *Americans with Disabilities Act*¹³³ (the "ADA"), which was the first "federal statute that prohibits discrimination on the basis of disability."¹³⁴ The ADA defines "disability" broadly capturing all manner of physical and mental disabilities, and has been used to challenge licensure questions used in the regulation of the medical and legal professions. All told, the use of broad licensure questions such as "[a]re you now, or have you ever been, diagnosed with or treated for mental illness?" has been questioned based on the argument that "broad inquiries about history can amount to an unacceptable screening of individuals based on diagnosis and, thereby, unfairly subject such applicants to more intensive evaluations than others."¹³⁵ Further, the American Department of Justice supports removal of broad questions noting that this generates "false generalizations about a person's functional level based on a diagnosis."¹³⁶

128 Steven Althuler, "Granting Medical Licensure, Honoring the Americans With Disabilities Act, and Protecting the Public: Can We Do All Three" (2009) 84:6 Acad Med 689 at 691.

129 Herbert Hendin et al, "Licensing and Physician Mental Health: Problems and Possibilities" (2007) 93:2 J Med Licensure & Discipline 6 at 6 [Hendin].

130 Lisa J Merlo & William M Greene, "Physician Views Regarding Substance Use-Related Participation in a State Physician Health Program" (2010) 19 Am J Addiction 529 at 529 [Merlo & Greene].

131 Sara Taub et al, "Physician Health and Wellness" (2006) 56 Occupational Medicine 77 at 79.

132 Hendin *supra* note 129 at 7.

133 *Americans with Disabilities Act*, 42 USC (1990).

134 Robin Schroeder et al, "Do State Medical Board Applications Violate the Americans With Disabilities Act?" (2009) 84:6 Acad Med 776 at 776 [Schroeder].

135 Sarah Profflet, "A National Analysis of Medical Licensure Applications" (2008) 36:3 J Am Psychiatry Law 369 at 369 [Profflet].

136 *Ibid.*



The American Psychiatric Association Council on Psychiatry and the Law recommends that questions should be designed with the following parameters in mind:

1. Questions should only inquire about a prospective physician's psychiatric health if investigating current functioning;
2. The only information that should be disclosed is the information on current impairment(s) that impact the prospective physician's ability to function competently; and
3. Applicants filling out questions should be informed of the possibility of public disclosure of information.¹³⁷

This issue has been litigated in the United States, in the context of both the medical and legal professions. In the case of *Medical Society of New Jersey v Jacobs*,¹³⁸ the court defined "safe" questioning in the context of the ADA, noting that: a) the "have you ever" sentence starter should be replaced with a temporally framed period (such as "in the last three years"); b) it is necessary to define, in clear terms, what is meant by "ability to practice" in such questions; and, c) these questions should focus on "functional impairment" and not treatment or diagnosis of a condition.¹³⁹ Similarly, in *Clark v Virginia Bd Of Bar Examiners*¹⁴⁰ (regarding the regulation of lawyers), the question – "Have you, within the past five years, been treated or counseled for any mental, emotional or nervous disorders?," was found to be "overbroad, unproven in its necessity, and potentially discriminatory."¹⁴¹ Further, it did not comply with the rigours established by *Jacobs* by essentially couching broad and open-ended questions within a limited temporal scope.

Despite statements in support of removing such broad questions from both American courts and academics, a survey of state medical board questions from 2006 (and published in 2008) indicates that nearly two decades after the adoption of the *ADA*, the questions being asked by licensing authorities were as broad as they were prior to the introduction of the *ADA*. In the opinion of legal commentator Hendin, medical "...applications could ask if physicians have any physical or mental condition (including alcohol or drug abuse) that is limiting, impairing or may be likely to limit or impair the ability of the physicians to practice their profession. If physicians answer yes, then questions as to whether the limitations or impairments are being addressed by treatment are, and will be perceived as, appropriate."¹⁴² The utility of several academic reviews that have been produced is that they provide examples of questions that likely avoid discrimination:

Do you have a physical or medical condition that currently impairs your ability to practice your profession?

Are you currently addicted to or dependent upon narcotics, intoxicating liquors, or other substances?

137 *Ibid.*

138 *Medical Society of New Jersey v Jacobs*, 1993 WL 413016 (DNJ) [*Jacobs*].

139 Profliet, *supra* note 135 at 369.

140 *Clark v Virginia Board of Bar Examiners*, 880 F Supp 430 (1995) [*Clark*].

141 Profliet, *supra* note 135 at 369.

142 Hendin, *supra* note 129 at 10.



Have you in the last ten years or since the age of 18 been treated for or hospitalized for bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?

Are you currently experiencing any medical condition or disorder that impairs your judgment or that otherwise affects your ability to practice medicine in a safe and competent manner?

Do you currently have a medical condition which in any way limits or impairs your ability to practice medicine or to function as a physician?¹⁴³

In terms of the programs available for American physicians affected by a condition, PHPs are offered in every American state. Similar to the Canadian experience, our review of the American experience indicates that PHPs are operated in a variety of ways: (i) by state medical associations; (ii) by state medical boards; or, (iii) by both the state medical association and medical board. Generally, physicians utilize these programs after a referral rather than having self-reported (usually for addiction issues), and they operate on the basis of a “personalized contract” whereby the physician is provided with a treatment plan that usually involves a “...combination of residential or partial-hospitalization treatment, participation in a 12-step recovery program, psychotherapy, weekly group meetings with other professionals in recovery, and urine testing-based contingency management” for 5 years.¹⁴⁴ Physicians enrolled in these programs are offered support in dealing with the licensure application process, a benefit that many physicians that have successfully completed these programs suggest is the main reason they would recommend PHPs to other physicians.¹⁴⁵

4. Australia

The Australian approach towards physician health is currently experiencing a certain degree of fluctuation. The regulation of physicians in Australia was traditionally governed by each state/territory. This system was altered by the *Health Practitioner Regulation National Law Act 2009*, which came into force July 1, 2010.¹⁴⁶ This legislation created the Australian Health Practitioner Regulation Agency, which is responsible for implementing the National Registration and Accreditation Scheme for 10 health care professions through legislation that is substantially consistent across all states/territories.¹⁴⁷ The National Medical Board of Australia is the agency responsible for physician registration and licensure under this new approach. The introduction of the National Registration and Accreditation Scheme was facilitated by the Council of Australian Governments, an intergovernmental forum that coordinates legislative action between the national and state/territorial governments of Australia.¹⁴⁸ Pursuant to the *Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions* (the “*Intergovernmental Agreement*”), each state/territorial government introduces legislation that will give effect to this national regime.¹⁴⁹ The *Intergovernmental Agreement* directs the

143 Schroeder, *supra* note 134 at 777.

144 Merlo & Greene, *supra* note 130 at 529.

145 *Ibid* at 531 & 533.

146 *Health Practitioner Regulation National Law Act 2009* (QLD).

147 *Ibid*.

148 Council of Australian Governments, “Welcome to the Council of Australian Governments’ Website” (13 February 2012), online: Council of Australian Governments <<http://www.coag.gov.au/>>.

149 Council of Australian Governments, *Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions* (26 March 2008), online: Council of Australian Governments <http://www.coag.gov.au/coag_meeting_outcomes/2008-03-26/docs/iga_health_workforce.pdf> [*Intergovernmental Agreement*].



State of Queensland to “host the substantive legislation to give effect to the national scheme,” which will serve as the model for the other states/territories that are directed to introduce similar legislation in due course.¹⁵⁰

Australian physician health and wellness programs are run by each state/territory. Our survey indicates that the most established program is the Victorian Doctors Health Program (the “VDHP”), established in 2000 by the Medical Practitioners Board of Victoria and the Victorian Branch of the Australian Medical Association to assist physicians and medical students in need.¹⁵¹ The VDHP has the following objectives:

1. to encourage development of, and facilitate access to, optimal services for education and prevention, early intervention, treatment and rehabilitation of medical practitioners and students, and to ensure their well-being
2. to encourage and support research into the prevention and management of illness in medical practitioners and students
3. to facilitate early identification and intervention for medical practitioners and students who are ill and at risk of becoming impaired
4. to act as a referral and co-ordination service to enable access to appropriate support for medical practitioners and students who are ill, and their families, and
5. to ensure access to high quality rehabilitation and encourage re-training and re-entry to the workforce.¹⁵²

The VDHP expressed concern about the host legislation passed in Queensland because “[i]t extends the reporting obligation to all doctors and not just a treating doctor. It fails to identify that any possibly affected doctor who agrees voluntarily to cease practice or alter the scope of practice is no longer a risk to the public and should not be reported to a medical board. Lastly it broadens the type of risk that any ill doctor might pose to the public in a manner that will create considerable dilemmas for other doctors in deciding if or when a report should be made.”¹⁵³ Essentially, “[t]he national legislation places the reporting onus on all health practitioners and is worded in the past tense so that no exception can be made for an affected doctor who seeks help and voluntarily ceases to practise while receiving care.”¹⁵⁴ The updated VDHP website provides the following regarding its service in light of the national legislation – “[the] VDHP develops individual management plans and co-ordinates treatment, including arranging appropriate referrals to external treatment providers. We conduct our service with the utmost discretion. Confidentiality is of utmost priority to VDHP. However, like all

150 *Ibid*, s 6.3.

151 Victorian Doctors’ Health Program, “About: What We Do”, online: Victorian Doctors’ Health Program <<http://www.vdhp.org.au/website/about.html>>.

152 Victorian Doctors Health Program, “Annual Report: 2010-2011”, online: Victorian Doctors Health Program <<http://www.vdhp.org.au/website/publications.html>>.

153 Victorian Doctors Health Program, “Submission re reporting of possibly impaired doctors”, online: Victorian Doctors Health Program <<http://www.ahwo.gov.au/documents/National%20Registration%20and%20Accreditation/Bill%20B%20Submissions/V/Victorian%20Doctors%20Health%20Program.pdf>>.

154 KJ Breen, “Doctors’ health: Can we do better under national registration?” (2011) 194:4 Med J Aust 191.



health practitioners, we are required to remain in compliance with the *Health Practitioner Regulation National Law Act 2009*.¹⁵⁵

Western Australia responded to this suggested deficiency and, prior to implementation, amended the Queensland legislation such that treating physicians do not have a mandatory obligation to report “impaired colleagues” that they are treating.¹⁵⁶ Lobbying continues in Australia to amend the legislation across all states/territories that introduced it without amendments similar to those in Western Australia.

All told, the Australian experience provides an interesting study, in part given the lobbying by stakeholders for a different standard of reporting for colleagues and treating physicians. However, it is of limited assistance in assessing the efficacy of our own established programs.

5. New Zealand

Similar to regulation in the United Kingdom, physicians in New Zealand are regulated by the Medical Council of New Zealand (the “Council”), which is charged with setting standards for physician conduct and competence pursuant to Parts 2 and 3 of the *Health Practitioners Competence Assurance Act 2003* (the “*Competence Assurance Act*”).¹⁵⁷ The Council has clearly expressed their position that “[p]atient safety should come first at all times.”¹⁵⁸ Also similar to the United Kingdom experience is the fact that physician employment in New Zealand operates through hospitals, and this should be kept in mind during the course of the following discussion.

The utility of New Zealand’s approach to potentially compromised physicians is that it is well structured and transparent. Section 45 of the *Competence Assurance Act* provides that:

Notification of inability to perform required functions due to mental or physical condition

- (1) Subsection (2) applies to a person who –
 - (a) is in charge of an organisation that provides health services; or
 - (b) is a health practitioner; or
 - (c) is an employer of health practitioners; or
 - (d) is a medical officer of health.
- (2) If a person to whom this subsection applies has reason to believe that a health practitioner is unable to perform the functions required for the practice of his or her profession because

155 Victorian Doctors Health Program, “About: what we do”, online: Victoria Doctors Health Program <<http://www.vdhp.org.au/website/about.html>>.

156 Australian Doctor, “Mandatory reporting win in WA” (1 September 2010), online: Australian Doctor <<http://www.australiandoctor.com.au/news/latest-news/mandatory-reporting-win-in-wa>>; See also *Intergovernmental Agreement*, *supra* note 149, at s 13 which provides the procedure by which amendments to the initial host legislation (or scheme in general) can be made.

157 *Health Practitioners Competence Assurance Act 2003* (NZ), 2003/48.

158 Medical Council of New Zealand, “What to do when you have concerns about a colleague” (15 February 2010), online: Medical Council of New Zealand <<http://www.mcnz.org.nz/portals/0/news/draft%20statement%20on%20reporting.pdf>> at 1 [Medical Council of NZ].



of some mental or physical condition, the person must promptly give the Registrar of the responsible authority written notice of all the circumstances.

(3) If any person has reason to believe that a health practitioner is unable to perform the functions required for the practice of his or her profession because of some mental or physical condition, the person may give the Registrar written notice of the matter.¹⁵⁹

The *Competence Assurance Act* also provides, in Section 34, that “[i]f a health practitioner (health practitioner A) has reason to believe that another health practitioner (health practitioner B) may pose a risk of harm to the public by practising below the required standard of competence, health practitioner A may give the Registrar of the authority that health practitioner B is registered with written notice of the reasons on which that belief is based.”¹⁶⁰

In the event that notice of potential impairment is provided to the Council Registrar, she passes the issue to the Health Committee, which has been authorized by the Council to oversee the notification process (save registration).¹⁶¹ The Health Committee has the authority to suspend the physician’s practicing certificate, but this is uncommon as the goal is to keep the physician practicing in a functional manner.¹⁶² The Health Committee can order assessment of the potentially affected physician by an external specialist, and failure to comply can result in sanctions.¹⁶³ If the specialist’s report indicates mental or physical impairment, the compromised physician is invited to attend a meeting to discuss the implications at which he/she can make written submissions and be accompanied by representation.¹⁶⁴ If practice is found to be affected, the Health Committee has a variety of options available to it, including:

1. Ask the compromised physician to sign a voluntary agreement that can: limit scope of practice; limit access to prescription medications and self-prescription; provide for mandatory assessments; monitoring by the Health Committee (such as urine testing); and/or supervision of practice. Such an agreement will acknowledge that sanctions will be forthcoming if the agreement is breached.
2. Require the physician to conform to practice restrictions to protect the public and compensate for impairment.
3. Require the physician to complete treatment or counselling.
4. Recommend practice conditions or registration suspension (subject to treatment) to the Council.¹⁶⁵

The Medical Council of New Zealand also provides advice to physicians on how to address the situation when they believe a colleague is potentially compromised. Similar to the hierarchical approach

159 *Health Practitioners Competence Assurance Act 2003*, *supra* note 157.

160 *Ibid.*

161 O’Connor & MacDonald, *supra* note 23.

162 *Ibid.*

163 *Ibid.*

164 *Ibid.*

165 *Ibid* at 145-146.



endorsed by the General Medical Council in the United Kingdom, the Medical Council of New Zealand recommends that physicians take the following steps in dealing with a potentially affected colleague:

1. Raise the concern directly with the colleague.
2. Raise the concern locally with the appropriate superior.
3. Raise the concern externally if there is no internal mechanism, if the individual is part of the internal process, or if the threat to public safety is immediate. The Medical Council is the appropriate body to contact in this situation.
4. Bring the concern to the attention of the Medical Council if it qualifies as a mandatory circumstance for doing so, which includes: suspected mental or physical impairment rendering the physician unable to perform their functions; unprofessional conduct that threatens the public; sexual misconduct. Reporting incompetence is recommended, but not mandatory.¹⁶⁶

B. Other Professions

As part of the research process for completing this paper, we assessed the use of thresholds and guidance documents as they relate to legislated requirements in other professions. The most useful point of comparison that we located, and will describe in this section, is the College & Association of Registered Nurses of Alberta (“CARNA”).

CARNA is the professional association and regulatory body for Alberta’s registered nurses. Its mandate is “...to protect the public by ensuring that Albertans receive effective, safe and ethical care by registered nurses,”¹⁶⁷ and it is responsible for fulfilling the roles and responsibilities of a college that regulates a health care profession as outlined in s. 3(1) of the *HPA*. To this end, CARNA has produced and maintains/enforces Standards of Practice and a code of ethics (by adopting the Canadian Nurses Association (the “CNA”) Code of Ethics for Registered Nurses) for registered nurses in Alberta.

The following excerpts from the Standards of Practice and CNA Code of Ethics have been included as they were considered during the course of completing our recommendations. In terms of self-reporting, Alberta’s registered nurses are provided with the following guidance.

While there is no duty to self-report, principle G4 of the CAN Code of Ethics provides that:

Nurses maintain their fitness to practise. If they are aware that they do not have the necessary physical, mental or emotional capacity to practise safely and competently, they withdraw from the provision of care after consulting with their employer or, if they are self-employed, arranging that someone else attend to their clients’ health-care needs. Nurses then take the necessary steps to regain their fitness to practise.

Further, “fitness to practise” is defined as:

166 Medical Council of NZ, *supra* note 158 at 2-3.

167 College & Association of Registered Nurses of Alberta, “Who We Are / Vision & Mission” (2009), online: College & Association of Registered Nurses of Alberta <<http://www.nurses.ab.ca/Carna/index.aspx?WebStructureID=637>>.



...all the qualities and capabilities of an individual relevant to his or her capacity to practise as a registered nurse, including, but not limited to, freedom from any cognitive, physical, psychological or emotional condition and dependence on alcohol or drugs that impairs his or her ability to practise nursing

With respect to addressing a potentially compromised colleague, principle G5 of the CAN Code of Ethics provides:

Nurses are attentive to signs that a colleague is unable, for whatever reason, to perform his or her duties. In such a case, nurses will take the necessary steps to protect the safety of persons receiving care. See Appendix D.

Appendix D of the CNA Code of Ethics provides guidance on how to apply these principles. Under the heading “Responding Ethically to Incompetent, Non-compassionate, Unsafe or Unethical Care,” Appendix D offers the following guidance on how to implement one’s ethical responsibilities:

- “Nurses question and intervene to address unsafe, non-compassionate, unethical or incompetent practice or conditions that interfere with their ability to provide safe, compassionate, competent and ethical care to those to whom they are providing care, and they support those who do the same. (Code, A4)
- Nurses admit mistakes and take all necessary actions to prevent or minimize harm arising from an adverse event. They work with others to reduce the potential for future risks and preventable harms. (Code, A5)
- Nurses intervene, and report when necessary, when others fail to respect the dignity of a person receiving care, recognizing that to be silent and passive is to condone the behaviour. (Code, D4)
- Nurses, as members of a self-regulating profession, practise according to the values and responsibilities in the *Code of Ethics for Registered Nurses* and in keeping with the professional standards, laws and regulations supporting ethical practice. (Code, G1)
- Nurses are attentive to signs that a colleague is unable, for whatever reason, to perform his or her duties. In such a case, nurses will take the necessary steps to protect the safety of persons receiving care. (Code, G5)¹⁶⁸

Finally, Appendix D indicates that if the possibility of “imminent harm” exists, the nurse “should take immediate steps to protect the safety and dignity of the persons receiving care,” and if they encounter the circumstance where there is the “potential for harm,” the nurse is to “work to resolve the problem as directly as possible in ways that are consistent with the good of all parties.”¹⁶⁹

168 College and Association of Registered Nurses of Alberta, *Nursing Practice Standards with the Canadian Nurses Association Code of Ethics for Registered Nurses* (2008), (2008), online:

<http://www.nurses.ab.ca/Carna-Admin/Uploads/new_nps_with_ethics.pdf> at 41.

169 *Ibid* at 41-42.



C. Alberta's Blood-Borne Infection Model

The system in place in Alberta for managing physicians with blood-borne infections is a useful analog that the Working Group considered while creating potential models for the governance and administration of Alberta's PHP in this report. It is our understanding that the approach to managing physicians with blood-borne infections is in the process of being amended to reflect advances in managing and treating blood-borne infections. The Council of the College of Physicians & Surgeons of Alberta created a committee comprised of physicians and dentists to develop guidelines for healthcare workers with blood-borne infections, understanding that these guidelines will need to be updated and altered as scientific understanding of these infections evolves.¹⁷⁰ The development of these guidelines has been guided by the Canadian Medical Association's opinion "that any policy development in this area should be based on scientific, epidemiologic and ethical principles, and its primary purpose should be to promote effective action in the prevention and control of infection, for the protection of HCWs [health care workers] and the public, while at the same time safeguarding human rights."¹⁷¹

It is worth noting at the outset of this analysis that self-reporting of a blood-borne infection (which includes, but is not limited to HIV and Hepatitis B and C) is required by Standard 33 of the Standards of Practice created by the CPSA and enforceable pursuant to section 3(1) Alberta's *HPA*. Standard 33 provides the following:

- (1) A physician must report the following personal circumstances to the College at the time of registration or whenever the physician becomes aware thereafter:
 - (a) any transmissible blood-borne infection...¹⁷²

The CPSA utilizes licensure questions to facilitate self-reporting of a blood-borne infection. Both the Application for Registration form and Application for Renewal of License form contain questions directed at discovering blood-borne infection status:

Initial Application Question for Registration:

Have you ever tested positive for a transmissible blood borne illness? (Conditions such as, but not limited to: HIV, Hepatitis)

Annual Renewal Question:

Do you presently, or have you ever, suffered from a transmissible blood borne infection (conditions such as HIV, Hepatitis B or C) that has not previously been reported to the College?

No

Yes: (if yes, the following will appear)

Explanation: _____

170 College of Physicians & Surgeons of Alberta, "Physician Health: Blood Borne Infections in Health Care Workers" (December 2003), online: College of Physicians & Surgeons of Alberta <http://www.cpsa.ab.ca/Libraries/Res_Advice_to_the_Profession/Blood_Borne_Infections_in_Health_Care_Workers.pdf> at 1 [CPSA Blood Borne Infections].

171 *Ibid* at 3.

172 Standard 33, *supra* note 38.



The current process utilized by the CPSA is described in detail in the policy document prepared by the College of Physicians & Surgeons of Alberta Physician Health Monitoring Committee titled “Monitoring Physicians with Blood Borne Infections” that was approved on June 25, 2008, and revised April 25, 2010. The task of monitoring physicians with blood-borne infections falls to the CPSA, but the guidance mechanism for determining how individual physicians with different types of blood-borne illnesses are to be monitored and managed falls to the Alberta Expert Review Panel for Blood Borne Infections in Healthcare Workers (the “Expert Review Panel”), created pursuant to s 7 of the *Government Organizations Act*.¹⁷³ Pursuant to Ministerial Order #23/99, the Expert Review Panel is administered by the CPSA’s Assessment and Competency Enhancement department.¹⁷⁴ Further, the Expert Review Panel exists to “provide guidance to any healthcare worker who is infected with Hepatitis B or C, or HIV, to ensure safe practice.”¹⁷⁵ This Expert Review Panel is “composed of medical officers of health, infectious disease specialists, infection control officers, public health nurses, occupational health nurses, and members of the public,” and can enlist the services of others as required.¹⁷⁶ The purpose of the Expert Review Panel is to advise healthcare workers, through their licensing authorities, on how to minimize the possibility of transmission to patients.¹⁷⁷ The Expert Review Panel is responsible for evaluating and counseling healthcare workers who perform exposure prone procedures, and will also consider relevant personal factors in such evaluations (including skill, judgment, and adherence to infection control practices). The following features of the Expert Review Panel are also salient for this discussion:

1. The Expert Review Panel members are “appointed by, advisory to, and provided indemnification by the Alberta Minister of Health and Wellness”;¹⁷⁸
2. The Expert Review Panel is not responsible for monitoring or supervising the physicians personal or professional behaviour; this responsibility resides with the CPSA and the individual’s personal physician;¹⁷⁹
3. Individual physicians are “expected to comply with the recommendations of the Expert Review Panel,”¹⁸⁰ and in terms of the role of the CPSA in monitoring such physicians, the Expert Review Panel produces and/or determines the monitoring guidelines that the CPSA follows (which includes information on updated medical status, treatment compliance, and scope of practice restrictions);¹⁸¹

173 *Government Organization Act*, RSA 2000, c G-10.

174 College of Physicians & Surgeons of Alberta, “Assessment and Competency Enhancement (ACE): Alberta Expert Review Panel (ERP)”, online: College of Physicians & Surgeons of Alberta <<http://www.cpsa.ab.ca/Services/ace/erp.aspx>>.

175 College of Physicians & Surgeons of Alberta Physician Health Monitoring Committee, “Blood Borne Infections: Monitoring Physicians with Blood Borne Infections” (15 April 2010), online: College of Physicians & Surgeons of Alberta <http://www.cpsa.ab.ca/Libraries/Pro_PHMP/Monitoring_Physicians_with_Blood_Borne_Infections.sflb.ashx> [Physician Health Monitoring Committee].

176 CPSA Blood Borne Infections, *supra* note 170 at 3.

177 *Ibid* at 7.

178 *Ibid*.

179 *Ibid*.

180 Physician Health Monitoring Committee, *supra* note 175 at 1.

181 *Ibid*.



4. If the Expert Review Panel is of the opinion that a physician is non-compliant, they will be referred to the CPSA to ensure patient safety,¹⁸² and the CPSA notes that “Physicians who pose a risk through their non compliance may be referred to the Complaints Director, may be asked or required to withdraw from practice, and may have their actions reported to the Medical Officer of Health”;¹⁸³
5. If the physician is found to be putting patients at risk, it is understood, and expected, that confidentiality will no longer apply and the physician will be reported to the CPSA by any individual in possession of this knowledge (be it the treating physician, employer, or member(s) of the Expert Review Panel),¹⁸⁴ and
6. An infected physician will be monitored so long as there is a potential threat to patients. Further, if the physician wishes to change their scope of practice or if a change in infection status occurs another review will be completed.¹⁸⁵

The policies addressing infected physicians are in the process of being updated by utilizing the guidance provided by The Society for Healthcare Epidemiology of America (“SHEA”) in the *SHEA Guideline for Management of Healthcare Workers who are Infected with Hepatitis B Virus, Hepatitis C Virus, and/or Human Immunodeficiency Virus* (the “SHEA Guideline”).¹⁸⁶ As the main interest of this policy paper is to identify the management structure rather as a useful analog for the management of affected physicians generally, it is beyond the scope of this analysis to provide a detailed review of the exact policies/procedures that the *SHEA Guidelines* utilize. Still, it is useful to note a few features of this system that might be useful in the context of PHPs regarding the functioning of a review panel in the context of the *SHEA Guidelines*:

- Upon the infected physician reporting their blood-borne infection to the CPSA, the CPSA will retain discretion in whether or not the physician needs to be referred to the Expert Review Panel as such referrals are not required in all circumstances; and
- The *SHEA Guidelines* recognize the possibility of low viral loads and that varying viral loads, like varying scopes of practice, determine whether or not monitoring is required or simply reporting in the instance of a potential exposure event.

An updated licensure question is anticipated for the annual renewal forms (not the initial licensure application), as follows: (i) does the physician perform exposure prone procedures; and (ii) if so, have they been diagnosed with a blood-borne infection since the last annual licensure renewal (and this question will link to a copy of the *SHEA Guidelines* for an explanation of what constitutes an exposure prone procedure).

182 CPSA Blood Borne Infections, *supra* note 170 at 7.

183 Physician Health Monitoring Committee, *supra* note 175 at 2.

184 CPSA Blood Borne Infections, *supra* note 170 at 7.

185 Physician Health Monitoring Committee, *supra* note 175 at 1-2.

186 Dave K Henderson et al, “SHEA Guideline for Management of Healthcare Workers who are Infected with Hepatitis B Virus, Hepatitis C Virus, and/or Human Immunodeficiency Virus” (2010) 31:3 Infect Control Hosp Epidemiol 203.



Alberta's approach to blood-borne illnesses exemplifies the use of a review panel where appropriate, working in conjunction with the CPSA, to address instances of health conditions with a negative impact on physician practice.

VIII. Legal Issues that Inform Our Recommendations

A. Physicians' Duties to Patients

i. General responsibilities of physicians

We begin this section of the report with a brief description of legal duties owed by physicians to their patients. These duties are owed by compromised or at-risk physicians to the patients they care for, and possibly to others depending upon a physician's role in practice. They are also owed by physicians to patients that happen to be physicians (what we have been referring to as physician-patients). After we outline some of the key legal duties generally, we will discuss specific duties and their application in each of these more specific contexts, including the duties of colleagues to report physicians to the regulatory body.

Patients place immense trust in physicians, sharing with them personal, often intimate, details of their lives in order to seek out appropriate treatment and advice. Physicians, in taking on the care of patients, owe them a number of legal duties. The legal basis for such duties arises from a number of sources. Firstly, physicians have a contractual relationship with their patients and certain legal implications flow from that. Another key source of legal duties, however, derives from the law of torts, which serves as the foundation of the majority of medical malpractice lawsuits against physicians.

Tort law is mostly comprised of a body of common law (that is – law created by the courts) that governs interactions between private citizens. At the heart of tort law duties is the necessity to avoid causing reasonably foreseeable harm to others. If an individual injures others as a result of their actions (where the harm was reasonably foreseeable and could have been avoided), they may be held liable to pay monetary compensation to those who have been injured. For example, a driver on the highway owes a duty to take reasonable steps not to cause other users of the highway reasonably foreseeable harm. As such, if an individual drives down an icy highway at night, during a blizzard, at well above the speed limit, intoxicated after consuming copious amounts of alcohol, without her vehicle's lights on and, as a result, causes a collision with another vehicle, injuring its occupants, tort law would likely say that the harm caused to the driver and passengers of the other vehicle was reasonably foreseeable. Had the intoxicated driver taken greater care and driven in a competent way, the injuries would likely have been prevented. If the intoxicated driver is found legally liable for the collision and resulting injuries, the resulting judgment against her would be founded on her tort law duty to avoid causing such reasonably foreseeable harm.

In the context of the provision of health care, physicians owe such tort law duties to their patients. They must live up to a certain standard of care. That standard has been established in the medical context as taking the same care as a competent physician in similar circumstances would take.¹⁸⁷ In other words, courts will look to what a reasonable physician in like circumstances would do in a given

¹⁸⁷ See generally Ellen I Picard & Gerald B Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 4th ed (Toronto: Thomson Carswell, 2007) at 227 [Picard & Robertson].



situation. If the court finds that a particular physician failed to live up to the standards expected of a reasonably competent physician in like circumstances, and harmed his or her patient as a result, liability will be found and the physician will be liable to pay compensation to the injured patient. Thus, the ethical duty of taking all reasonable steps to prevent harm to patients is supported by this legal duty.

Tort law has established a number of more specific duties that physicians owe to their patients; these include the duty to attend, diagnose, refer as appropriate, and treat.¹⁸⁸ Again, all of these services must be provided in a competent manner.

In addition to legal duties owed by physicians to their patients as a result of contract and tort law, Canadian courts have characterized the physician-patient relationship as fiduciary in nature. The significance of this is that it results in additional legal duties owed by physicians to their patients; such duties do not exist in all private relationships. The establishment of a fiduciary relationship means that “doctors have an obligation to their patients to act with utmost good faith and loyalty, and must never allow their personal interests to conflict with their professional duty.”¹⁸⁹ The nature of this fiduciary relationship is quite important in characterizing specific duties that physicians owe to patients, including the duty of confidentiality and the obligation to not exploit patients.¹⁹⁰

ii. Responsibilities of compromised physicians

Given the general discussion of legal obligations above, including tort law obligations, it is clear that physicians who are compromised or at-risk owe duties to their own patients to prevent harm from occurring to them, at least where such harm is reasonably foreseeable. The fiduciary obligation also suggests that such physicians must put the well-being of their patients before other considerations, including concerns or fears they may have related to the seeking out of appropriate help.

Physicians with a condition that makes harm reasonably foreseeable should, at a minimum, take positive steps to prevent such harm from occurring. Steps to prevent harm to their patients may include seeking out services, including assessment and/or treatment; they may also include taking such actions as voluntarily removing themselves from practice until they are fit and competent to return.

There is no clear duty at common law for a compromised physician to report such condition to their regulatory body. A court may or may not find that such a duty exists in a particular set of circumstances. However, physicians do have a legal obligation to self-report, if provided for under the provincial legislation that governs their profession.¹⁹¹ This duty exists in Alberta given the Standard of Practice on Self-Reporting to the College.¹⁹² It does not exist in all jurisdictions.¹⁹³ Given a regulatory body’s legal obligation to protect the public, it is arguable that all such regulatory bodies should have

188 *Ibid* at 296-346 provides a full discussion of these duties.

189 *Ibid* at 5. See also *Norberg v Wynrib* (1992), 92 DLR (4th) 449 (SCC) affirming that the physician-patient relationship is fiduciary.

190 *Ibid* at 5-7.

191 In the case of Alberta, see *HPA, supra* note 16.

192 Standard 33, *supra* note 38.

193 For example, while self-reporting is encouraged in British Columbia, it is not a duty.



standards in place, both to address safety concerns, and to provide guidance to their members about the expectations.

Some have questioned whether physicians with certain conditions have a legal duty to disclose this to their patients. To date, Canadian common law has not set out such a duty. However, that is not to say that such a duty would not be established in a particular case, depending upon the facts and/or circumstances. The common law related to obtaining consent prior to providing treatment requires that a patient be informed. The legal test requires that the patient be provided with the information that a reasonable person in their circumstances would want to know.¹⁹⁴ The one Canadian case to date that addressed whether a physician should disclose information regarding his or her own personal health was the decision in *Halkyard v Matthew*.¹⁹⁵ Here, a physician with epilepsy operated on a woman. She died afterwards and her estate sued, claiming that, had she known about the health condition of the surgeon, she would not have proceeded with the surgery. The court found that the patient, a nurse, had she been informed about the epilepsy, including the fact that it was well-controlled with medication, would have proceeded with the surgery. As a result, no liability attached on the basis of a failure to disclose information about the physician's own health condition to her. The court declined to deal with whether such a duty to disclose health conditions exists generally.

iii. Responsibilities of treating physicians and colleagues

Given standards of practice that generally exist across jurisdictions establishing a duty to report colleagues, physicians may (or may not) be obliged to contact their regulatory body to report other physicians when they suspect that such a physician has a condition which may, or will, affect their ability to practice safely. To understand the particular basis for making such a report or in what circumstances it should be made, a physician would, at a minimum, need to consider the applicable standard of practice and relevant legislation in their province or territory. As set out earlier in this report, Standard of Practice 34¹⁹⁶ under Alberta's *HPA* clearly provides for specific legal obligations regarding the reporting of colleagues in Alberta.

The tort law duty to prevent reasonably foreseeable harm may also play a role in certain circumstances in creating a positive obligation to take certain steps (which may or may not include reporting to the regulator) to prevent harm from occurring. Physicians should keep this legal duty in mind – particularly, perhaps, those physicians in jurisdictions where there is no duty to report colleagues set out in a standard developed by their regulatory body.

The understanding of the Working Group is that the Alberta Standard is applicable to both treating physicians of physician-patients, and colleagues with no therapeutic relationship with physician-patients. While the regulatory body has the legislative authority to create such a standard, we are of the opinion that reporting obligations of treating physicians should not be the same as that of a

194 See Picard & Robertson, *supra* note 187 at 43-49 for an introductory discussion of consent.

195 *Halkyard v Matthew* (1998), 231 AR 281 (aff'd 2001 ABCA 67).

196 College of Physicians & Surgeons of Alberta, *Standards of Practice: The minimum standard of professional behaviour and good practice expected of Alberta physicians* (2010), online: College of Physicians & Surgeons of Alberta <http://www.cpsa.ab.ca/Libraries/Res_Standards_of_Practice/CPSA_Standards_of_Practice_Consolidated_Version.pdf>; Standard 34, *supra* note 39.



colleague who is not in a therapeutic relationship with the physician-patient. The next part of our analysis and discussion will set out the basis for this conclusion.

The duty of confidentiality is essential to establish and safeguard a relationship of trust between the patient and physician. Without trust, patients may be reluctant to share information with the physician that is necessary or beneficial to provide appropriate health services. This could lead to harm to patients. With this in mind, absent legislation, courts have made it clear that this is a serious legal duty, to be breached in very limited instances only, and only in circumstances where the breach is made to prevent serious harm to the patient or others.

Legislation has set out some instances where a legal duty to breach patient confidentiality does exist. While certain justifiable instances are similar across Canada, it is important to note that legislation in this area is, for the most part, provincial in nature and so varies across Canada. Child welfare legislation¹⁹⁷ and public health legislation, for example,¹⁹⁸ both contain instances where the law requires a breach of confidentiality to report certain cases (such as instances where a child may be in need of intervention, or where information may be necessary to contain or prevent the spread of an infectious disease).¹⁹⁹

Other legislation creates discretion for physicians to disclose confidential health information to prevent harm. Such legislation stops short of setting out a duty to breach confidentiality to prevent harm to others. One example is Alberta's legislation which provides for the reporting of medical conditions which may render persons unfit to drive.²⁰⁰ The legislation, unlike that in some other Canadian jurisdictions, does not require such reporting. However, as a result of case law where physicians have been found liable for injuries caused by unfit drivers, as well as CPSA Advice to the Profession, it is arguable that such a duty exists in Alberta.

Another example of such discretionary authority is contained in Alberta's *Health Information Act*²⁰¹ (the "HIA") which allows physicians to disclose health information without the consent of their patient if they believe, "...on reasonable grounds, that the disclosure will avert or minimize an imminent danger to the health or safety of any person."²⁰²

Our courts have considered instances of ability to disclose to prevent serious harm to others in circumstances where no direction has been provided by legislation. A key decision in this area is that of the Supreme Court of Canada in *Smith v Jones*,²⁰³ where the majority of the court held that public safety can be a justification to breach solicitor-client privilege (and thereby the relatively lesser duty

197 *Child, Youth and Family Enhancement Act*, RSA 2000, c C-12 s 4.

198 *Public Health Act*, RSA 2000, c P-37 s 53.

199 Though we acknowledge that some applicable legislation is federal, and some legislation does set out reporting obligations for specific occupations. See *Railway Safety Act*, RSC 1985, c 32 (4th Supp) s 35(2) regarding patients that are railway workers who hold positions "critical to safe railway operations," and the *Aeronautics Act*, RSC 1985, c A-2 s 6.5(1) regarding patients that are members of a flight crew, air traffic controllers, or Canadian aviation document holders.

200 *Traffic Safety Act*, RSA 2000, c T-6 s 60.1.

201 *Health Information Act*, RSA 2000, c H-5 [HIA].

202 *Ibid*, s 35(1)(m).

203 *Smith v Jones*, [1999] 1 SCR 455.



of confidentiality owed by physicians to their patients). In this case, the Court said that such a breach may be justified where three criteria are met:

1. Where there is “a clear risk to an identifiable person or group of persons,”²⁰⁴
2. Where the risk is that of “serious bodily harm or death”²⁰⁵ (serious psychological harm being included in the concept of serious bodily harm),²⁰⁶ and
3. Where the “danger is imminent”,²⁰⁷ or, in other words, where there is “a serious risk of serious bodily harm”.²⁰⁸

The majority stated that “[i]f after considering all appropriate factors it is determined that the threat to public safety outweighs the need to preserve solicitor-client privilege, then the privilege must be set aside. When it is, the disclosure should be limited so that it includes only the information necessary to protect public safety.”²⁰⁹

This decision did not, however, create a duty to disclose information in these circumstances. The court specifically noted that this was not an issue that was put before them to address and, as a result, they should refrain from ruling on this issue in the absence of proper context and relevant arguments. It is important to note that, given the criteria identified, the court may well establish such a duty in the future.

Another relevant case example is that of *Pittman Estate v Bain*,²¹⁰ as decided by the Ontario Superior Court of Justice, where a physician failed to disclose to a man his HIV+ status as a result of a blood transfusion. His wife subsequently acquired the infection and successfully sued a number of defendants, including the physician for the failure to inform the husband. While again, the court did not discuss nor establish that a duty to warn or inform was owed directly to the wife, liability would not have resulted without the existence of such a duty. As a result, though we have no case that clearly sets out such an independent duty to disclose to protect third parties, the decisions to date provide a strong indication that courts will explicitly establish the existence of such a duty when the appropriate case comes before them.

As a result, while it is likely that such a duty exists in certain circumstances, the law has not provided clarity on this issue to date. However, it provides the discretion necessary to allow for reporting of compromised physicians that may cause serious harm to patients. The decision to breach the confidentiality of a physician-patient (like all other patients) by a treating physician may best be left to the discretion of such a treating physician, who can take into account all of the circumstances of the case, and decide what steps are necessary to take (reporting to a regulatory authority being one possible step) to prevent serious harm to others.

204 *Ibid* at para 77.

205 *Ibid*.

206 *Ibid* at para 83.

207 *Ibid* at para 77.

208 *Ibid* at para 84.

209 *Ibid* at para 85.

210 *Pittman Estate v Bain* (1994), 112 DLR (4th) 257. See also Picard & Robertson, *supra* note 187 at 182.



It is important, however, for such treating physicians to recognize that they may well not be in a position to appropriately assess the risk that their physician-patient poses to others in practice. For example, while it would be advisable for the treating physician to ask their patient whether or not they believe the condition to be negatively impacting their practice, they would likely not be in a position to collect collateral information or to carry out other employment-related risk assessments to come to a well-informed opinion. They may also lack the appropriate expertise to carry out such a risk assessment. As a result, it would be advisable for such treating physicians to call the regulatory body and discuss the case on a non-nominal basis to obtain advice as to whether or not the reporting threshold has been met. Treating physicians making such a judgment call must keep in mind their ethical and legal obligations to their patient. For example, Responsibility 35 in the CMA Code of Ethics states as follows:

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

As a result, a non-nominal call by a treating physician to the regulatory body would not require a discussion with the physician-patient. However, if the treating physician decides that reporting is necessary in the circumstances, in most instances, they should disclose the fact that they will be reporting to the College. This may not be necessary if the College supports the treating physician to encourage the physician-patient to self-report.

However, they must also balance that with the potential risk to others posed by their patient in practice. Whether such a judgment call was made appropriately should be measured in hindsight in accordance with the reasonable physician standard; in other words, did the treating physician in this case act as a reasonably prudent physician in like circumstances would have acted. If the decision that was made is viewed as reasonable, deference to that decision should be shown by the regulatory body, even if it is apparent in hindsight that the decision was incorrect. As with clinical decision-making, not all errors should result in either discipline by the regulatory body, or in legal liability or other legal consequences. However, it is also necessary to be able to review such decisions made by treating physicians. In other words, judgment calls made by treating physicians regarding reporting should be potentially reviewable, as are other decisions made in the clinical context.

In the Alberta context, we recommend that this issue be dealt with in one of two ways:

1. First, we recommend the development of a standard of practice specifically related to the duty of treating physicians to report physician-patients. This would clarify the different roles and obligations of colleagues as opposed to treating physicians. It would provide greater protection of the confidentiality of physician-patients, important to preserve if possible and appropriate to do so, while making it clear that in some instances, such a breach of confidentiality is necessary.



2. Second, we recommend suggesting the consideration of an amendment to Alberta's *HIA*²¹¹ to enshrine a duty (rather than a discretion) to report in instances of imminent danger, which would be applicable to all covered by the *HIA* (which would encompass many health care professionals in the province).

The first recommendation can take into account the therapeutic relationship and be implemented through the process as set out under Alberta's *HPA*. The second would create a duty that would be applicable to all custodians of health information and all individuals receiving health care services to which the *HIA* applies, regardless of occupation, where any patient may pose a serious risk of serious danger to others. While this duty would apply in a narrower set of circumstances than the threshold for treating physicians that we are recommending, it would help to create a level playing field for treating health care professionals other than physicians regardless of whether or not their respective regulatory bodies have implemented standards of reporting that would apply to their patients. This would require an amendment of legislation by the provincial government. Such an amendment would have implications beyond the context of this report, which should be considered by appropriate stakeholders before a decision is made.

In the event that our recommendation regarding the creation of a new Standard of Practice for Alberta is taken up, we will make a few additional comments. As set out earlier in this report, Standard of Practice 34,²¹² under Alberta's *HPA*, captures a wider range of conditions than are encompassed in the other two Canadian jurisdictions this report has focused on, those being British Columbia and Ontario. Given the adoption of the CMA Code of Ethics by the CPSA, and considering the other ethical and legal obligations discussed, the Working Group is of the opinion that the conditions covered in Alberta are appropriate grounds for reporting both colleagues and physician-patients. The relatively narrow scope of obligation to report in certain other jurisdictions, arguably, fails to meet the duties physicians owe to society, as members of a self-regulating profession. We do not see a justification for separating out certain conditions from others. For example, why should a psychiatric condition be the basis of reporting, but not a physical condition? Distinctions such as this may only serve to contribute to the stigma, real and/or perceived, regarding mental health issues and/or drug addictions, for example. Frameworks set out to provide services to physicians (such as PHPs), as well as the regulatory process, should be aimed at harm, or the potential of serious harm, regardless of the condition. A physical condition can pose as significant risk a risk, or possibly a greater risk, to the safety of patients, as can an addiction or psychiatric condition. Such bases for reporting should be reviewed across all jurisdictions.

Our recommendations on these two points are set out in Section X of this report, "Recommendations: Thresholds for Reporting."

B. Human Rights/*Canadian Charter of Rights and Freedoms*

Human rights legislation in Canada exists to protect individuals from discrimination and to ensure that their basic rights are protected and upheld in our civil society. Canadians are protected from

211 *HIA*, *supra* note 201.

212 College of Physicians & Surgeons of Alberta, *Standards of Practice: The minimum standard of professional behaviour and good practice expected of Alberta physicians* (2010), online: College of Physicians & Surgeons of Alberta <http://www.cpsa.ab.ca/Libraries/Res_Standards_of_Practice/CPSA_Standards_of_Practice_Consolidated_Version.pdf>.



discrimination in a variety of ways, including the federal *Canadian Human Rights Act*²¹³ (applicable areas of federal jurisdiction), provincial and territorial human rights legislation (applicable to areas of provincial/territorial jurisdiction), and the *Canadian Charter of Rights and Freedoms*²¹⁴ (the “Charter”). While the *Charter* forms part of the Canadian Constitution, human rights legislation, despite not forming part of the Constitution, is of a “special nature” or has quasi-constitutional stature (“... not quite constitutional but certainly more than the ordinary – and it is for the courts to seek out its purpose and give it effect”).²¹⁵ As noted in the seminal Alberta decision of *Vriend v Alberta*, the purpose of human rights legislation “...is to affirm and give effect to the principle that all persons are equal in dignity and rights.”²¹⁶ Both the federal and provincial/territorial statutes operate primarily on prohibited grounds of discrimination. For example, section 3(1) of the Alberta *Human Rights Act* expressly prohibits discrimination on the basis of “race, religious beliefs, colour, gender, physical disability, mental disability, age, ancestry, place of origin, marital status, source of income, family status or sexual orientation of that person or class of persons.”

The concern that this portion of the paper is raising is that licensure questions drafted too broadly, which lead to decisions affecting an individual’s ability to practice medicine, may run afoul of human rights legislation; such questions may be subject to a human rights complaint. Further, if it violates human rights legislation to ask overly broad questions that require physicians to disclose disability where it is not relevant to functionality, it would also violate human rights legislation for a medical regulatory college to act on such information by, for example, imposing treatment, monitoring or practice limitations on the physician who provides such information (or who refuses to provide it). While human rights legislation does not operate to override the regulatory process, it does require that the regulatory process be operated in accordance with the principles of human rights.

The synthesis below describes how this has unfolded in the American context, followed by a description of the emerging Canadian context.

As described earlier in this report, the *Americans with Disabilities Act* (the “ADA”) was enacted in 1990 to serve as the first “federal statute that prohibits discrimination on the basis of disability” in the United States.²¹⁷ State medical boards (which set licensure questions for the medical profession) are subject to the *ADA* by virtue of being a “Public Entity,” and consequently the *ADA* has been used to challenge the wording and impact of licensure questions. In *Medical Society of New Jersey v Jacobs*, the Medical Society of New Jersey, acting on behalf of its physician members, asserted that qualified physicians were being singled out by being required to answer positively to the following questions: “Have you ever been dependent on alcohol or Controlled Dangerous Substances”; “Have you ever been treated for alcohol or drug abuse?”; “Have you ever suffered or been treated for any mental illness or psychiatric problems”; and “Do you have any uncorrected physical handicap which causes substantial impairment of, or limitation on, your ability to practice medicine and surgery?”²¹⁸ Note that substantially the same line of questioning was used on the renewal applications, and was also

213 *Canadian Human Rights Act*, RSC 1985, c H-6.

214 *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11.

215 *Re Ontario (Human Rights Commission) and Teresa O’Malley v Simpson Sears Ltd*, [1985] 2 SCR 536 at para 12.

216 *Vriend v Alberta*, [1998] 1 SCR 493 at para 95.

217 Schroeder, *supra* note 134.

218 *Jacobs*, *supra* note 138 at 1-2.



subjected to the challenge.²¹⁹ Both lines of questioning require physicians answering in the positive to provide the medical board with information from a treating physician (in the initial application context) or a detailed explanation (in the renewal context). The court noted that these questions create additional burdens as a screening device, and that “these additional burdens are falling, in probably the vast majority of cases, upon qualified individuals with disabilities.”²²⁰ The analysis provided by the court suggests that an appropriate line of questioning should limit the temporal window in question (i.e., remove the ‘have you ever’ wording) and would also focus on functional impairment rather than a mere diagnosis or existence of treatment.²²¹

Similarly, in *Clark v Virginia Bd of Bar Examiners*, the appropriateness of the following licensure question was challenged – “[h]ave you, within the past five years, been treated or counseled for any mental, emotional or nervous disorder?”²²² The court held that this was “overbroad, unproven in its necessity and potentially discriminatory,” noting that even questions limited in temporal scope can still fail to pass muster under the *ADA* if they do not link past treatment with present impairment.²²³ The applicability of the *ADA* to medical licensure was recently affirmed by the Ninth Court of Appeals in California in the case of *Hason v Medical Board of California*.²²⁴ As noted above, despite the court rulings, a survey of medical board licensure questions from 2006 indicates that in many instances the questions being asked by licensing bodies remain as broad, and potentially discriminatory, as they were prior to the *ADA*.

In Canada, medical regulatory colleges qualify as “occupational associations” that are subject to provincial/territorial human rights legislation.²²⁵ Because membership in this form of occupational association can be denied, the potential to challenge this denial based on the discrimination exists. The potential for a challenge on this basis appears to be a live issue given the recent decision by the British Columbia Human Rights Tribunal in *Gichuru v The Law Society of British Columbia* involving the phrasing of certain application questions.²²⁶ Although this case involves an application for an articling position as opposed to a license to practice medicine, it does engage entrance into a professional regulatory body and demonstrates that the wording of licensure questions is a live issue, and one which could certainly have implications for medical regulatory colleges.

Briefly stated, the Law Society required law students to answer the following question in order to secure an articling position: “Have you ever been treated for schizophrenia, paranoia, or a major mood disorder described as a major affective illness, bipolar mood disorder, or manic depressive illness?”²²⁷ The complainant, who had a history of depression with intermittent periods of remission, answered the question in the affirmative and consequently experienced a delay in becoming accepted into the articling program. The Human Rights Tribunal that heard his grievance held that this question was discriminatory, and ordered an award of damages for past wage losses, injury to dignity and

219 *Ibid.*

220 *Ibid* at 6.

221 Profilet, *supra* note 135 at 30.

222 *Clark*, *supra* note 140.

223 *Ibid.*

224 *Hason v Medical Board of California*, 279 F 3d 1167 (2002).

225 *Alberta Human Rights Act*, RSA 2000, c A-25.5 s 44(1)(j).

226 *Gichuru v The Law Society of British Columbia (No. 9)*, 2011 BCHRT 185.

227 *Ibid* at para 3.



feelings, and expenses. In response, the Law Society assembled a medical and legal team to review the wording and ultimately revised the question to read: “Based upon your personal history, your current circumstances or any professional opinion or advice you have received, do you have any existing condition that is reasonably likely to impair your ability to function as a lawyer or articulated student?”²²⁸

Possible ramifications associated with a finding of discrimination based on inappropriate application or renewal questions may include the granting of a monetary remedy and an order requiring questions to be reworded or dropped. It is important to recognize that human rights legislation across Canada affords human rights tribunals with considerable remedial authority. For example, section 32(1) of the *Alberta Human Rights Act* provides that a tribunal can order: (i) that a contravention of the legislation cease; (ii) that similar behaviour not occur in the future; (iii) that the “rights, opportunities or privileges” that were denied to someone who was discriminated against be made available to them; (iv) that any lost wages or income be paid to the individual who was discriminated against and/or that they be compensated for any expenses; or, (v) that the tribunal may take “any other action” it deems necessary to place the individual in the position they were in prior to experiencing discrimination.

It is unclear whether this is a matter that would be best dealt with under Human Rights legislation or the *Charter*. Given a number of human rights precedents in the area, we have focused our analysis on human rights legislation. However, although we have not done an in-depth *Charter* analysis, we believe that the result under the *Charter* would be substantially similar as under human rights legislation. For the purposes of this report, it is therefore not necessary to determine whether the consistency of broad questions with human rights is best dealt with under the *Charter* or human rights legislation. The essential element in either scenario would essentially focus on whether the questions at issue are limited to asking for information that is reasonably necessary for the discharge of valid regulatory objectives. Regulators can ask for the information or take the action that is relevant and reasonably necessary to their valid regulatory functions, but cannot ask for the information or take the action that cannot be established as relevant and necessary to those functions. Human right principles, then, take account of regulatory imperatives so far as such imperatives can be validated by the regulator.

IX. Recommendations: Initial Registration and Annual Renewal Questions

Questions posed by physicians’ professional regulatory bodies, both at the time of an initial application for registration as a member of such body, as well as in annual renewal applications, address, in part, the issue of self-reporting by registered members of such bodies. We have been specifically asked to address such questions in the Alberta context. This section of the report will do so.

However, as a starting point in this part of the analysis, we will refer briefly to self-reporting outside the context of initial registration or renewal applications, to lay some groundwork for our recommendations regarding the questions themselves. The Working Group supports the current approach of the CPSA Standard of Practice on Self-Reporting that a physician’s duty to self report, if established explicitly, should not only exist at the time of registration but “whenever the physician becomes aware” of personal circumstances addressed by the Standard of Practice.²²⁹ If the foundation for, and intent behind, posing such questions is to assess whether the public may be at some risk by

228 *Ibid* at para 140.

229 Standard 33, *supra* note 38.



physician-members in practice, then such a duty is on-going and does not only exist at one or more finite points in time. Given the legal obligation that regulatory bodies have to protect the public, the obligation to collect (and accordingly disclose) relevant information should not only be addressed at the time of an initial application, or once a year at the time of an annual renewal application, but throughout the course of physicians' practices. It is important to note that our review of Canadian jurisdictions indicated that the questions posed across the country vary significantly. In at least some key instances, certain questions are posed at the time of an initial application and are not included on renewal applications. Questions on renewal applications are extremely limited in certain jurisdictions.

In coming to our specific recommendations regarding licensure questions, we have taken into account relevant law, as well as our Guiding Principles, the CMA Code of Ethics and broader ethical decision-making tools. Legal considerations in Alberta include the *Health Professions Act*; the *Physicians, Surgeons and Osteopaths Profession Regulation*; and Standard of Practice 33 entitled "Self-Reporting to the College" (both the version in force, as well as the revised draft that went out for consultation in 2010 but has not been brought into effect). We also considered other relevant law, including human rights legislation and the *Charter*. We have also reviewed licensure questions regarding both initial and renewal applications from every Canadian jurisdiction.

Select Initial and Renewal Questions Presently Used by the CPSA:

The questions set out below are those currently used in Alberta on initial registration applications, and in renewal applications. We have chosen the ones most explicitly related to health conditions.

Initial Application Questions for Registration in Alberta include:

Have you ever had a medical condition that impaired your ability to perform intricate or hazardous tasks or to assume responsibility for the welfare of others? (Conditions such as, but not limited to: diabetes, psychiatric illness, neurological disorder, brain injury, impairment of a primary sense)

Have you ever tested positive for a transmissible blood borne illness? (Conditions such as, but not limited to: HIV, Hepatitis)

Have you ever had a problem with drug or alcohol consumption?

Annual Renewal Questions in Alberta include:

Do you presently, or have you ever, suffered from

a) a transmissible blood borne infection (conditions such as HIV, Hepatitis B or C) that has not previously been reported to the College?

No

Yes: (if yes, the following will appear)

Explanation: _____



b) any serious health issue(s) that impairs or has impaired your ability to provide safe patient care that has not previously been reported to the College, including, but not limited to the following

a. Substance or chemical abuse or dependency?

No

Yes: (if yes then the following will appear)

Explanation: _____

b. Medical condition(s) that impair(s) your judgment, cognition, sensory, or motor function?

No

Yes: (if yes then the following will appear)

Explanation: _____

Factors Considered in Recommended Rewording of Questions:

“Condition”

Our use of the word “condition” in this report includes any kind of health condition that may affect a physician’s practice. It would encompass physical, cognitive, psychological, mental and/or emotional conditions and/or issues that are affecting or may affect a physician’s practice. This would also capture substance or chemical abuse and/or dependency concerns. There must be the connection between the condition and a negative impact on work as a registered member (whether now or in the reasonably foreseeable future). The aim of the questions should not be the collection of information regarding situations that do not meet these criteria.

Past history – length of time and information previously collected

The past practice of the CPSA has been to pose different questions to applicants depending upon whether they are submitting an initial application or a renewal application. The questions in the initial application have been broad temporally, asking about conditions, etc. occurring at any point in time (whether present or in the past). The questions in the renewal application were modified to ask for similar information; however, until recently, the query was restricted to new conditions, i.e., conditions occurring in the past year only. In the current renewal application, the questions were broadened to include conditions occurring at any time in the past not previously reported to the CPSA.

While the earlier version of the questions, restricted to information in the past year, was a reasonable attempt to limit the request for information to only that information that was seen to be needed, it is based on the assumption that responses to questions on earlier applications would have provided all information necessary about that previous time period. However, with the passage of time, individuals may become aware of past conditions, or may gain insight into conditions which they previously lacked. For example, a physician with a substance abuse problem that impacted her practice two years ago may have answered in the negative at the time due to lack of insight into her addiction. At the time of the current renewal application, she may have gained insight due to a number of factors,



including treatment obtained in the interim, and may, with a more temporally open question posed, answer the question in the positive. For this reason, it is justifiable to ask about past conditions without limiting the question to the previous year only.

However, to be sensitive to applicants, and to restrict collection of information to only that information that is necessary for the intended purpose, questions should be restricted to conditions not previously reported. Applicants should not be asked for information they have previously provided.

As a result, we recommend that the relevant questions be identical on both the initial application and the renewal application, with the following exception: the renewal questions should be limited to information not previously collected.

However, if a condition has been previously reported but was stable at the time, there must be a mechanism for reporting should that condition begin to impact practice or pose a reasonably foreseeable risk of doing so. Rather than addressing this possibility in the wording of the licensure questions themselves, we recommend that this be addressed through the practices of the regulatory body. For example, if a condition is reported but currently stable, the CPSA could enter into an agreement with that physician that would require them to report in the future if the above mentioned circumstances were to occur.

Current versus potential impact

The collection of information in this context is clearly reasonable if it concerns a condition currently impacting the work of the registered member in a negative way. Negative impacts may include the risk of unsafe or incompetent care provided to patients, or negative impacts in other areas of work, including work as a researcher or administrator.²³⁰ However, ethical and legal duties as a physician also justify the collection of information about conditions where it is reasonably foreseeable that negative impacts may occur, and where, with appropriate preventative or other measures, such negative consequences may be avoided. Reasonable foreseeability in this context does not include any possible future impact no matter how unlikely. On the other hand, it should not require an extremely high degree of likelihood, such as conditions that will almost certainly have a negative impact on the work of the applicant.

We did not use the words “reasonable foreseeability”, however, as some members of the Working Group were concerned that this might carry with it the connotation of medical malpractice actions. As a result, we have used the language of “reasonably likely to.” However, it should be understood that the standard we are recommending is the same as that which is defined in tort law as that of reasonable foreseeability.

Impact not restricted to patient care

While the work of registered members often relates to patient care, many members will engage in work, in part or in whole, that does not involve the provision of health services to patients. Questions should keep all potential work of registered members in mind – not only that work that directly impacts the provision of health services. Physicians engaged in research or administrative work, for example, can negatively impact the safety of individuals or communities, directly or indirectly, as a

230 HPA, *supra* note 16, s 3(1) of Schedule 21.

result of conditions. Questions must contemplate all aspects of work that a registered member may engage in and the harm that may be caused as a result of a condition. Indeed, section 3(1) of Schedule 21 (“Profession of Physicians, Surgeons and Osteopaths”) of the *HPA* expressly provides that the “practice of medicine” includes more than providing patient care. This section reads as follows:

Practice

3(1) In their practice of medicine, physicians, surgeons and osteopaths do one or more of the following:

- (a) assess the physical, mental and psychosocial condition of individuals to establish a diagnosis,
- (b) assist individuals to make informed choices about medical and surgical treatments,
- (c) treat physical, mental and psychosocial conditions,
- (d) promote wellness, injury avoidance, disease prevention and cure through research and education,
- (e) engage in research, education and administration with respect to health, and
- (f) provide restricted activities authorized by the regulations.

Impairment versus negative impact

In application questions posed in a wide number of jurisdictions, the word “impair” or “impairment” is used. This word connotes disability. While some conditions will result in disability or impairment, we recommend that impact in a negative way on the work of the applicant should be the focus and rationale for the questions posed. The notion of impairment is at times inappropriate, and in other instances misses negative effects of physician health-related issues that are not caused as a result of a disability.

Recommendation 1:

We recommend that the following wording be used, along with other relevant information, for initial application licensure questions directed at health conditions:

Do you presently have a physical, cognitive, mental and/or emotional condition that is negatively impacting your work, or is reasonably likely to negatively impact your work in the future?

Have you ever had a physical, cognitive, mental and/or emotional condition that, were it to reoccur, would or would be reasonably likely to negatively impact your work in the future?

Recommendation 2:

We recommend that the following wording be used, along with other relevant information, for renewal application licensure questions directed at health conditions:

Do you presently have a physical, cognitive, mental and/or emotional condition that is negatively impacting your work, or is reasonably likely to negatively impact your work in the future that has not been previously reported to the College?



Have you ever had a physical, cognitive, mental and/or emotional condition that, were it to reoccur, would or would be reasonably likely to negatively impact your work in the future that has not been previously reported to the College?

Recommendation 3:

We recommend that “negative impact” on work must be defined in the applications. The definition should make clear two main points:

- a. Harm to patients or others as a result of the practice of medicine is the negative impact that these questions intend to address. If the impact of a physician’s condition is not related to the well being, health and/or safety of others within his or her practice of medicine, the questions need not be answered in the affirmative.
- b. The practice of medicine includes research, education and administration with respect to health, in addition to the practice associated with patients.

Recommendation 4:

We recommend that the following criteria apply to whatever wording is used for questions asked on initial and renewal applications relative to reportable conditions:

- a. Make it clear that all health conditions are contemplated and included. Wording should list examples of various conditions to illustrate the breadth of conditions being contemplated, and should not be restricted to particular conditions or types of conditions, to the exclusion of others.
- b. Require conditions to be reported only where there is a connection between the condition and a negative impact on the practice of the physician.
- c. Encompass past conditions, as well as present conditions, where such a condition is reasonably likely to negatively impact the practice of the physician should it reoccur.
- d. Make it clear that applicants are not being asked for information about a condition that has been previously provided.
- e. Ensure that licensure questions are identical on both the initial application and the renewal application, with the following exception: the renewal questions should be limited to information not previously collected.

X. Recommendations: Thresholds for Reporting

Whereas licensure questions focus on a particular form of self-reporting, this section of our report addresses the question of when physicians should report information about themselves, a physician-patient or a colleague to the regulatory body of the profession.

We have considered a number of factors in reaching our recommendations in this section. First, we have looked at the relevant law. In the Alberta context, this would include the Health Professions Act; the regulation under that Act relating to physicians; Standard of Practice 33 entitled “Self-Reporting to the College” (both the version in force, as well as the revised draft that went out for consultation



in 2010 but has not been brought into effect); and Standard of Practice 34 entitled “Duty to Report a Colleague” (both the version in force, as well as the revised draft that went out for consultation in 2010 but has not been brought into effect). We also considered relevant law created by the courts, discussed earlier in this report (including law related to duties physicians owe to their patients).

Further, we considered the CPSA’s policies and procedures related to its Physician Health Monitoring Committee on reporting regarding blood-borne viruses, chemical dependencies, and other health conditions. We also took into account the AMA’s reporting threshold, as set out in its Physician and Family Support Program Guidelines.

Again, we took into account the CMA Code of Ethics, as it has been adopted in Alberta under the *Health Professions Act*. Additionally, we surveyed reporting thresholds in other jurisdictions and professions.

Finally, we requested hypothetical and/or de-identified case examples from the AMA and the CPSA that would highlight instances where differences in how to appropriately handle such cases, and the areas of differing opinion between the two organizations, would be highlighted.

Self-Reporting

Based upon legal and ethical duties of physicians already discussed, as well as the analysis and recommendations regarding appropriate licensure questions, the Working Group considered whether or not a recommendation should be made regarding a Standard of Practice on self-reporting. Given the analysis contained in the licensure section of this report, we believe that a standard should exist that requires a duty to self-report. The standard should take into account the foundation of our recommendations regarding licensure questions. As a result, we recommend that a new Standard of Practice in keeping with our licensure recommendations be drafted and that the CPSA initiate the consultation process with respect to the new draft Standard of Practice and work towards its implementation.

Recommendation 5:

We recommend that a Standard of Practice for Self-Reporting to the CPSA be implemented to align with the recommendations made with respect to the licensure questions.

Reporting by the Treating Physician

The language within Standard 34, entitled “Duty to Report a Colleague”, makes no differentiation between a physician’s duty to report another physician if they are colleagues only, and the duty to report if the physician is in a treatment relationship with the physician-patient.²³¹ It is also our understanding that this non-distinction is how this is currently interpreted by each of the respective organizations. As discussed in the section on legal duties of physicians, it is our recommendation that the reporting threshold for treating physicians should be different than that of colleagues given the legal and ethical duties owed to patients (including physician-patients) in a therapeutic context. It is inappropriate to have the same reporting standard for the physician concerned about the capacity of a colleague, and the treating physician relative to his or her physician-patient. In this section, we are addressing our recommendation regarding the reporting threshold for treating physicians.

231 Standard 34, *supra* note 39.



The obligations as previously discussed in this report, the duty of confidentiality owed by treating physicians, as well as other related duties of such treating physicians, may result in reporting of a physician-patient to a medical regulatory college only when the law would require such disclosure, whether explicitly as set out in legislation (or subordinate legislation such as a standard of practice), or implicitly as a result of court-created law. As the common law has not set out a clear duty to report in certain instances, and there are instances where harm or potential harm to patients may be serious enough that the duty to maintain confidentiality should be breached, we would recommend implementing a standard of practice to provide clarity in this regard.

As stated, we recommend that the threshold for reporting be different than is currently set out in the CPSA's Standard. We recommend the creation of a new standard where a duty would lie with treating physicians to report physician-patients to the CPSA in cases where it is reasonably foreseeable that patients of the physician-patient (or others in the context of the work of the physician-patient – for example, research participants) could be seriously harmed (whether physically or psychologically) as a result of the physician-patient's condition. This threshold is lower than that set out in the Supreme Court of Canada's decision in *Smith v Jones* which, as previously discussed, set out the criteria to allow for disclosure in cases of imminent danger.²³² That threshold is too restrictive in this context. It is justifiable to define the threshold as requiring reasonable foreseeability of serious harm to others.

We recommend this for two key reasons. First, by entering into the medical profession, a physician assumes a fiduciary duty to his or her patients. This results in the necessity to take additional steps beyond which one would have to take in the absence of this extraordinary obligation. It entails the necessity to consider first the well-being of one's patient. Second, the role of a physician is often one that is safety-sensitive; it is akin to the role of a pilot or the operator of a train, for example. While this may not be the case for all physicians in practice, the nature of many physicians' practices would entail the potential to harm others. As discussed in the section of this report on physician duties, the federal government has created legislation requiring reporting in the context of aviation or railway safety where there is information that a health condition is likely to pose a safety threat or hazard.

Imposing such an obligation on treating physicians, however, will require a judgment call to be made by such physicians. As we discussed in the section on physician duties, it is important for such treating physicians to recognize that they may or may not be in a position to appropriately assess the risk that their physician-patient poses to others in practice. As well, they may or may not have the appropriate expertise to carry out such a risk assessment. Consequently, it is prudent practice for such treating physicians to call the regulatory body and discuss the case on a non-nominal basis to obtain advice as to whether or not the reporting threshold has been met if there is any uncertainty about whether they can make such a judgment call on their own, with the information available to them.

Treating physicians making such a judgment call must keep in mind their ethical and legal obligations to their patient. However, they must also balance that with the potential risk to others posed by their patient in practice. Whether such a judgment call was made appropriately should be measured in hindsight in accordance with the reasonable physician standard; in other words, did the treating physician in this case act as a reasonably prudent physician in like circumstances would have. If the decision that was made is viewed as reasonable, deference to that decision should be shown by the

232 *Supra* note 203.



regulatory body, even if it is apparent in hindsight that the decision was incorrect. As with clinical decision-making, not all errors should result in either discipline by the regulatory body, or in legal liability or other legal consequences. However, it is also necessary to be able to review such decisions made by treating physicians as some judgment calls made may not be reasonable or justifiable. As with clinical errors, a review of the decision may or may not take place and may be initiated in a number of ways.

Risk assessment should be conducted by individuals with appropriate expertise and access to the necessary information. This is the case whether the risk assessment is being conducted within a regulatory body, within a PHP or in another setting. There will be a number of relevant factors for such individuals to take into account. This report does not presume to provide direction in this regard. However, for purposes of illustration only, some of the relevant considerations that may be important to explicitly consider include: whether the physician-patient's condition is being appropriately managed; whether harm is only anticipated if such management is not maintained; whether there is information as to the likelihood of the physician-patient appropriately managing their condition; whether there a reasonable possibility that this will only occur with monitoring and/or oversight mechanisms in place; whether the harm anticipated, if it materializes, would be irreversible; and/or whether the harm anticipated, if it materializes, would cause more than minimal pain or other injury.

Recommendation 6:

We recommend that a new Standard of Practice be created setting out the duty of a treating physician to report a physician-patient to the CPSA. The new Standard of Practice for treating physicians should create a duty in instances where it is reasonably foreseeable that patients of the physician-patient (or others in the context of the practice of the physician-patient) could be seriously harmed (whether physically or psychologically) as a result of the physician-patient's condition. This standard would apply to treating physicians whether the health services provided are done so within the PHP, or independently of the PHP. Non-treating physicians working within a PHP should also be subject to this standard.

Reporting by PHP Staff

Although the duties of non-physician staff of PHPs may be arguably different given that they may or may not be found by a court to owe the same legal and ethical duties to physician-patients, the Working Group recommends that the reporting threshold for these individuals be treated as analogous to that of treating physicians. We base this recommendation on the primacy of patient well-being in the CMA Code of Ethics and in our Guiding Principles, as well as the legal duties discussed regarding patient confidentiality, many of which apply beyond the context of a physician-patient relationship. We are concerned that if the threshold for reporting by PHP staff is lower than that of a treating physician, physicians may well be hesitant to contact and/or utilize the services of a PHP, to the potential detriment of their own health and well-being, and indirectly to the potential detriment of others (such as their own patients). The same can be said for other health care professionals that the physician-patient may be referred to (though we recognize that reporting thresholds for other health care professionals will be set for them, in part, by their own regulatory bodies).



Recommendation 7:

We recommend that the policies and procedures of any PHP model adopted establish and enforce the same reporting threshold for staff, contractors and/or other affiliated individuals of the PHP as that recommended for treating physicians of physician-patients.

Colleagues

The threshold obligation of a colleague who is not in a treatment relationship with a physician-patient to report should be lower than that of a treating physician. A colleague does not have the same legal and ethical obligations vis-à-vis his/her fellow physicians. As a result, the well-being of the possibly compromised physician should not be weighted more heavily than other obligations (such as duties owed to the profession, to society, etc.).

The Revised Draft for Consultation of the Duty to Report a Colleague Standard of Practice which was issued on March 15, 2010 by the CPSA (the “Draft for Consultation”) had two key aspects which we would recommend incorporating into a new standard for colleague reporting. The first is the basis of reporting, that being the belief of a colleague based on reasonable grounds. We think a “reasonable grounds” threshold is appropriate for colleagues. The second is the reference to health conditions “that could limit the physician’s ability.”

The reference in the Draft for Consultation to “patients” should be expanded to include others who may be harmed as a result of the medical practice of the physician, in accordance with the definition of medical practice, as set out in Schedule 21 under the *HPA*, as previously discussed. While the Draft for Consultation had a list of example conditions, we recommend that the wording be altered to include a broader list of example conditions in keeping with our Recommendation 4 and other related comments in this report.

Recommendation 8:

We recommend that the present Revised Draft for Consultation of the Duty to Report a Colleague Standard of Practice be further revised. The basis of reasonable grounds and the reference to health conditions that “could” limit a physician’s ability should be retained. The reference to “patients at risk” should be expanded to others at risk within the context of a physician’s practice of medicine. The list of health conditions set out as examples should be expanded in keeping with the findings of this report.

Medical staff bylaws

There are other obligations that physicians have that may cause an apparent conflict regarding reporting thresholds. For example, medical staff bylaws and/or policies and procedures of health care institutions may set out expectations of physicians regarding circumstances in which they may or may not be able to use and/or disclose information regarding patients and/or colleagues. This will be relevant if, for example, such bylaws indicate a process for reporting of colleagues that is in conflict with standards of practice established by a regulatory body. A detailed review of such bylaws in Alberta or in other jurisdictions is beyond the scope of this report. However, it would be inappropriate for such documents to lay out a process that puts physicians in conflict with the regulatory framework they must operate under. Depending upon standards of practice in place or adopted, such documents should be reviewed and amended to align with the standards of practice.



XI. Recommended Model for Governance and Administration of Alberta's PHP

Recommendation 9:

We recommend that the Physician Health Program Co-Management Model (as described below) be adopted. This model has most of the PHP functions primarily residing with the AMA, as they currently do. The CPSA continues to conduct monitoring of physicians when such is appropriate. This will see the addition of a Review Panel to assess cases where it is unclear whether the reporting threshold has been met. In each case where this reporting threshold is met, the case will be reported to the CPSA. This Co-Management Model will also see the implementation of a Program Monitoring Feature to ensure quality control, and to satisfy both the public and the CPSA that appropriate policies and procedures are in place, and are being followed.

The overarching question that was posed to our Working Group was as follows: for Alberta, what is the recommended model for a program that strives to meet both the regulatory imperatives and the rehabilitative needs of at-risk physicians? A secondary question went to what the respective roles of the CPSA and the AMA should be in the recommended model. As the Working Group considered a recommended model, we kept in mind the respective mandates, roles and responsibilities of the two organizations.

It is crucial to explicitly acknowledge that a PHP model is most defensible if it is one that engenders and maintains public confidence in the profession. If such a model is perceived as unworthy of public trust, this may undermine the relationship between the public and the medical profession. It may also serve to erode trust in physicians themselves. As well, if a regulatory body of physicians is seen to be failing to establish a sufficient framework to protect the public, this may well lead to further government involvement in the regulation of the profession. We are not commenting on whether this would be positive or negative; we are merely pointing out that this could be a consequence of establishing a model that does not appropriately protect the public.

It is also critical to emphasize that an ideal model will do everything possible to encourage and support physicians in accessing and utilizing the available services. Any barriers to such access should be addressed both in terms of the organizational structure, as well as other initiatives such as the adequate education of physicians.

In this section of the report, we first outline the key details of our recommended model. We also set out two other models that we considered. In each of these model descriptions, we discuss the organizational structure of the model; where PHP services would primarily reside; two new, key features that should be adopted regardless of the model used; and a brief summary of some of the benefits and drawbacks of each model.

Throughout our discussion of these models we will be discussing three categories of cases. For ease of discussion, we have defined these cases as follows:

1. "Level 1 Cases" – these are the cases where there is clear agreement that reporting to the CPSA is not required. Level 1 Cases are instances where an affected physician contacts a PHP in need of information and/or assistance.



2. “Level 2 Cases” – this category is comprised of those cases where there may be disagreement about whether or not a reporting threshold has been met and, accordingly, whether or not the case should be reported to the CPSA.
3. “Level 3 Cases” – this category encompasses those cases where it is clear that reporting is required.

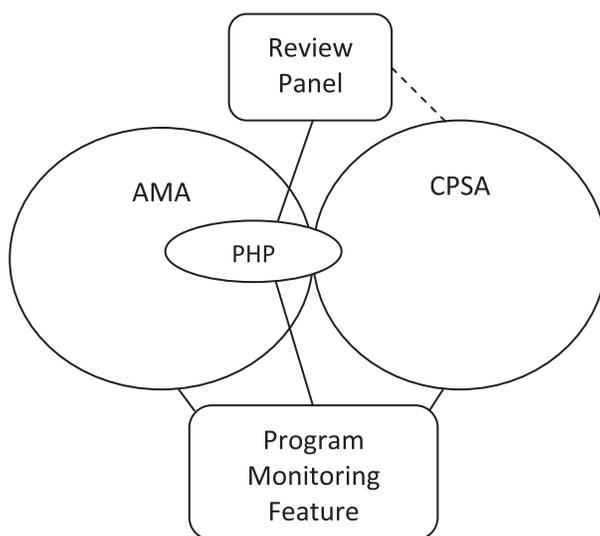
A. Recommended Model: Co-Management

Organizational Structure and Services Provided:

This first model put forth is the model we are recommending. It happens to be the model most closely premised on the existing framework in Alberta. The key aspects of the current framework have been set out in section IV of this report. As set out below, most of the PHP services would primarily reside with the AMA. The monitoring program would continue to be administered by the CPSA. Our aim in maintaining this distribution is to encourage physicians to utilize the services of the PHP. Having most of the services reside with the AMA may reduce some of the previous barriers to access discussed earlier in this report. However, by maintaining the monitoring program within the PHMP, the CPSA can effectively discharge its legislated obligations.

This model introduces two essential additions that should be made to address the deficiencies we perceive in the current framework. One area of concern is whether or not cases are reported by the PFSP to the CPSA, as appropriate. This concern is based both on the mandate of medical associations to represent the interests of physicians and the need of the CPSA to have the information it requires to appropriately discharge its mandate to protect the public. We are, therefore, recommending the creation of a review panel that deals exclusively with Level 2 Cases and whether or not a reporting threshold has been met. The composition and function of this review panel will be discussed in further detail below. The second necessary addition is the implementation of program monitoring to assess and assure both the AMA and the CPSA that the model is functioning appropriately and as intended.

Model 1: Co-Management Model



Keeping in mind that many PHP components may be delivered by multiple sources, this model would see the primary delivery of the PHP components distributed between the AMA and CPSA as follows:

AMA:

1. Access to information and advice – information regarding the services offered and the process followed will be of value to physicians, colleagues, family members and others.
2. Education – it is important for the AMA and CPSA to work together to appropriately educate physicians in Alberta on all matters covered by this report. Generally speaking, proactive and responsive education on services provided and process followed is an important component of all PHPs to raise awareness and encourage access where appropriate.
3. Prevention and promotion – services will ideally include wellness initiatives to prevent, where possible, physicians from becoming affected by a condition.
4. Family support/services – services will ideally include information and service provision to family members of physicians.
5. Access to assessments – assessments may be indicated to assess the nature and/or severity of the condition, reasonable treatment options, and/or whether case management is appropriate for a particular physician-patient.
6. Access to referrals – where treatment outside a PHP is required or desired by a physician-patient, appropriate referral mechanisms are an important component.
7. Case management/follow up – appropriate case management for physicians undergoing assessment, treatment and/or monitoring is key to the provision of appropriate services, as well as establishing oversight mechanisms where appropriate to safeguard the public.
8. Intervention services – with respect to some physicians, intervention services should be part of a PHP where there are reasonable grounds to believe that the physician poses a significant risk to themselves and/or others and they have been unwilling to seek services without such intervention.
9. Treatment – appropriate treatment is an essential component of any PHP, whether provided directly or through appropriate referrals.
10. Reporting to CPSA where appropriate – when the reporting threshold has been met, a report shall be made to the CPSA.
11. Evaluation – given the lack of conclusive research on the effectiveness of PHPs, ongoing evaluation is important in any such program.

CPSA:

1. Biological monitoring – for physicians with particular health issues (e.g. drug addiction and blood-borne infections in certain circumstances), biological monitoring is a necessary component of a PHP both in terms of appropriate treatment and to protect the public.
2. Education – it is important for the AMA and CPSA to work together to appropriately educate physicians in Alberta on all matters covered by this report. Generally speaking, proactive and



responsive education on services provided and process followed is an important component of all PHPs to raise awareness and encourage access where appropriate.

3. Evaluation – given the lack of conclusive research on the effectiveness of PHPs, ongoing evaluation is important in any such program.

Review Panel:

We recommend the creation of a Review Panel to review Level 2 Cases, when necessary, to assess whether reporting thresholds have been met. We also recommend employment of a staff member to conduct risk assessment (the “Staff Member”).

The Staff Member will have expertise in the assessment of risk as related to health conditions. They will have the responsibility and the ability to collect collateral information, as appropriate. For example, collection of information from at least one colleague in the workplace may be indicated. As well, it may be important to contact the Assistant Registrar at the CPSA to collect information on the physician-patient in question. The appropriate drafting of duties for this position will address linkage of information concerns necessary to properly conduct a risk assessment. The Staff Member should also have the responsibility and ability to report Level 3 Cases to the Assistant Registrar at the CPSA without unreasonable delay. This will address concerns regarding protection of the public. This should not detract from the ability and responsibility of other PFSP staff members to report Level 3 Cases directly to the CPSA.

Where the Staff Member is uncertain as to whether a reporting threshold has been met, they shall take such a Level 2 Case to the Review Panel on a non-nominal basis. It is important that the Review Panel only deal with Level 2 Cases. If the Review Panel was required to assess Level 3 Cases, this could result in an unreasonable time-lag during which others could be harmed. The Review Panel is intended to act as an added layer of protection to establish when cases should be reported to the CPSA. The addition of the Review Panel is not intended to replace direct reports to the CPSA, or the seeking of advice from the CPSA on a non-nominal basis as to whether a physician should be reported. As a body of precedent is established and expanded, the frequency with which the Staff Member would need to consult with the Review Panel would decrease. This should provide more expedient decision-making, which will hopefully serve the interests of physician-patients well. Reports regarding physician-patients should be dealt with as quickly as possible; otherwise, physicians that pose insufficient risk of harm may be in a position where they themselves suffer harm, such as a loss of income, while waiting for the convening and decision of the Review Panel.

While the Staff Member will likely be an employee of the PFSP, and thus accountable to his/her supervisor with respect to his/her own personal performance in the position, the function of this position, and whether or not it is being carried out appropriately by the Staff Member, should be subject to assessment by the Program Monitoring Feature, as discussed below.

While it is not the intent of the Working Group to make recommendations on every aspect of the composition of the Review Panel, we have the following recommendations. First, we believe it to be crucial that both the AMA and the CPSA have representatives on the Review Panel to provide assurance to both organizations that the assessment process is being conducted appropriately. Public representation on this panel is also needed to provide the public with this same assurance. Additionally, it is essential to have appropriate expertise on the panel depending on the conditions being assessed.



In addition, we would strongly suggest that the Review Panel have the ability to add and/or consult others on an ad hoc basis who have specific expertise needed to deal with specific cases or issues as they arise. It may also be appropriate to include a physician with a health condition and a physician in recovery as members.

The Review Panel should be appointed in a way that is mutually agreeable to the AMA and CPSA. It should operate independently of either organization and should be established in such a way as to avoid or minimize conflicts of interest. While we are not modeling the Review Panel after the Alberta Expert Review Panel for Blood Borne Infections in Healthcare Workers that exists pursuant to Ministerial Order 23/99, we found this a helpful model to consider in formulating our recommendations here. While we are not recommending a specific number of members, the number chosen should be large enough to address the expertise issues raised above, as well as to ensure that quorum may be met and that unreasonable delays do not occur as a result of the challenges faced in convening a small expert group on short notice. The number chosen should also take into account the consistency needed to set useful precedent for the Staff Member. The ability to take part in meetings through electronic means should be considered to increase the ability for the panel to convene as necessary. There should be no direct access to the Review Panel. Consultation must be made with the Staff Member, who will consult the Review Panel as appropriate.

Program Monitoring:

We recommend the creation of a Program Monitoring Feature. It is important that the Review Panel and the PFSP be monitored to ensure that they function as envisioned. As previously mentioned, while the Working Group has founded its recommendations on a system with most of the services being primarily provided via the AMA, given the mandate of the AMA, it is essential to have oversight mechanisms in place. This Program Monitoring Feature is an essential component of our recommended model and is meant to provide each organization, the profession and the public with reassurance that the processes are working appropriately.

As such, we recommend that the Program Monitoring Feature be conducted by a group whose composition is agreed upon and jointly established through negotiations between the AMA and the CPSA. Both the AMA and CPSA should play a role in the Program Monitoring Feature. It will be essential to retain the appropriate expertise as well. The composition of the group will include expertise in program management and evaluation. We also think it necessary to have public representation as well.

Some of the key functions of the Program Monitoring Feature will include the establishment of policies and procedures for the PFSP, an evaluation mechanism to assess whether cases are being reported appropriately, or not, to the CPSA, and to establish an evaluation mechanism for the PHP, including reporting decisions of the Staff Member.

We recognize that it is not possible to design a perfect system that will handle every case in the most appropriate manner. However, the Program Monitoring Feature and the Review Panel are important measures to ensure quality control, and to satisfy both the public and the CPSA, charged with the duty to protect members of the public, that cases involving at-risk or compromised physicians are indeed being handled appropriately.



Benefits and Drawbacks of the Recommended Model:

One key benefit to the recommended model is the retention of the primary residence of most of the PHP services with the AMA. When considering access barriers that physicians face, it is beneficial to maintain as many services as possible with an organization they will likely perceive as working to protect their interests. As well, there may be a greater uptake of use of the PHP as the AMA is not the regulatory body which many physicians perceive as connected with the discipline process.

Another benefit of the model, given the retention of the monitoring with the CPSA, as well as the addition of the Review Panel and the Program Monitoring Feature, is the ability of the CPSA to ensure it is appropriately discharging its legislated mandate to protect the public.²³³ It would be difficult for the CPSA to ensure it is living up to its legal duties, as well as convince the public and the government that it is doing so, if all aspects of the PHP were to reside with the medical association. This model may well help to support the trust in the profession as a whole as well.

On a practical level, this model is the simplest model to adopt as it would necessitate few changes to the existing structures and lines of reporting. This may well be the most efficient way to go forward. Additionally, and perhaps most importantly, it maintains the features of the PHP that are working well, as reported by both organizations at the beginning of this project.

The key drawback of moving to this model is the necessity of the two organizations, along with other relevant stakeholders, to work towards the implementation of this new model. This would apply both to the new features which must be added, as well as the coordination of education of physicians in Alberta which will be crucial to conduct to ensure the maximum benefits are achieved from the new PHP.

B. Alternative Model 1: Medical Association Management Option²³⁴

Organizational Structure and Services Provided:

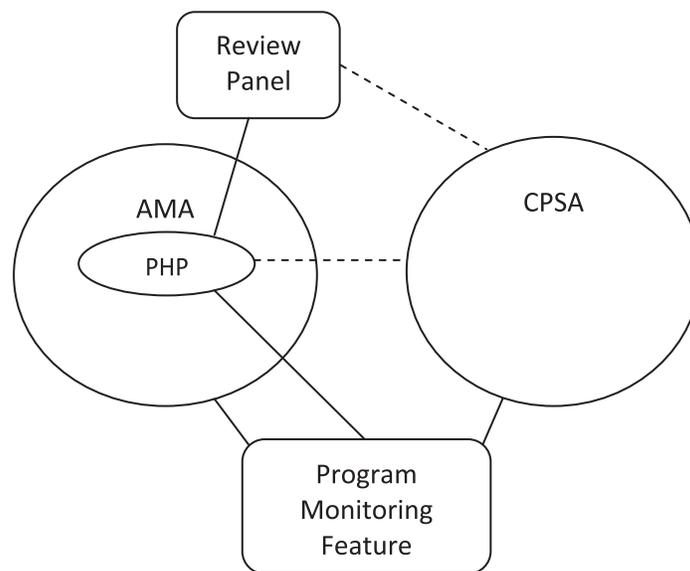
Alternative Model 1 contemplates housing the entire PHP within the AMA, which would require migration of the biological monitoring services from the CPSA:

233 See Carlo Caradang et al, "Data Safety Monitoring Boards and Other Study methodologies That Address Subject Safety in 'High-Risk' Therapeutic Trials in Youths" (2007) 46:4 J Am Acad Child Psy 489 at 489 where the authors describe the use and composition of Data Safety and Monitoring Boards ("DSMB"). DSMBs are increasingly being used to oversee research that may become dangerous to the human participants (i.e. in cancer treatment trials and HIV/AIDS research). Citing to LM Friedman, CD Furberg & DL DeMets, *Fundamentals of Clinical Trials*, 3rd ed (New York: Springer-Verlag), Caradeng et al describe DSMB as "an autonomous structure, independent of study sponsors and investigators, and...composed of individuals with expertise in the study subject area as well as in clinical methodology." A DSMB exists to "review, analyze, and evaluate data" and has the authority to intervene in clinical trials (and even terminate the study) if of the opinion that unacceptable harm is occurring.

234 Note: This is modeled, in part, with the Ontario framework in mind. However, we are not suggesting the implementation of that model as is. There are numerous strengths to the Ontario model. However, there are changes that should be made before adopting such a structure. We have concerns regarding reporting thresholds of physicians in Ontario when their practice is impacted. For a description of key aspects of the Ontario model please see Other Jurisdictions.



Alternative Model 1: Medical Association Management Option



Alternative Model 1 envisages the following list of services being primarily provided by the new AMA PHP:

1. Access to information and advice – information regarding the services offered and the process followed will be of value to physicians, colleagues, family members and others.
2. Education – it is important for the AMA and CPSA to work together to appropriately educate physicians in Alberta on all matters covered by this report. Generally speaking, proactive and responsive education on services provided and process followed is an important component of all PHPs to raise awareness and encourage access where appropriate.
3. Prevention and promotion – services will ideally include wellness initiatives to prevent, where possible, physicians from becoming affected by a condition.
4. Family support/services – services will ideally include information and service provision to family members of physicians.
5. Access to assessments – assessments may be indicated to assess the nature and/or severity of the condition, reasonable treatment options, and/or whether case management is appropriate for a particular physician-patient.
6. Access to referrals – where treatment outside a PHP is required or desired by a physician-patient, appropriate referral mechanisms are an important component.
7. Case management/follow up – appropriate case management for physicians undergoing assessment, treatment and/or monitoring is key to the provision of appropriate services, as well as establishing oversight mechanisms where appropriate to safeguard the public.
8. Intervention services – with respect to some physicians, intervention services should be part of a PHP where there are reasonable grounds to believe that the physician poses a significant

risk to themselves and/or others and they have been unwilling to seek services without such intervention.

9. Biological monitoring – for physicians with particular health issues (e.g. drug addiction and blood-borne infections in certain circumstances), biological monitoring is a necessary component of a PHP both in terms of appropriate treatment and to protect the public.
10. Treatment – appropriate treatment is an essential component of any PHP, whether provided directly or through appropriate referrals.
11. Reporting to CPSA where appropriate – when the reporting threshold has been met, a report shall be made to the CPSA.
12. Evaluation – given the lack of conclusive research on the effectiveness of PHPs, ongoing evaluation is important in any such program.

Review Panel:

We recommend the creation of a Review Panel to review Level 2 Cases when necessary to assess whether reporting thresholds have been met. We also recommend employment of a staff member to conduct risk assessment (the “Staff Member”). See the description of the Review Panel in the above section on our Recommended Model for further details.

Program Monitoring:

We recommend the creation of a Program Monitoring Feature. See the description of the Program Monitoring Feature in the above section on our Recommended Model for further details.

Benefits and Drawbacks of Alternative Model 1:

This alternative model is only acceptable if the CPSA is willing to assume the legal risks of relinquishing direct oversight and involvement in biological monitoring. Additionally, it is only recommended as an alternative to consider if both the Review Panel and Program Monitoring Feature are added. In considering this model, we looked at the PHP in Ontario, as discussed in our jurisdictional review. While this Alternative Model 1 has many similarities with the PHP in Ontario, there are some significant differences.

Housing all of the PHP functions with the AMA may help to reduce the hesitation that physicians have in contacting and/or utilizing PHP services. While there is little evidence to support this, it is clear that some barriers that physicians face to accessing services are based upon fears related to the involvement of the regulatory body. Though perhaps unfounded, physicians’ perception may manifest as under-utilization if they believe that interacting with the PHP may expose them to potential disciplinary actions by the CPSA.

The major drawbacks associated with this model include the inability of the CPSA to assert as a result of direct involvement and oversight that it is living up to its legislated duties. As well, it may be more difficult to reassure the public and government that the system is functioning with the protection of patients at the heart of the PHP’s mandate.

The efficacy of this approach is also contingent on the AMA recognizing that there is a clear duty to report physicians to the CPSA in certain circumstances, and that thresholds are well-understood and



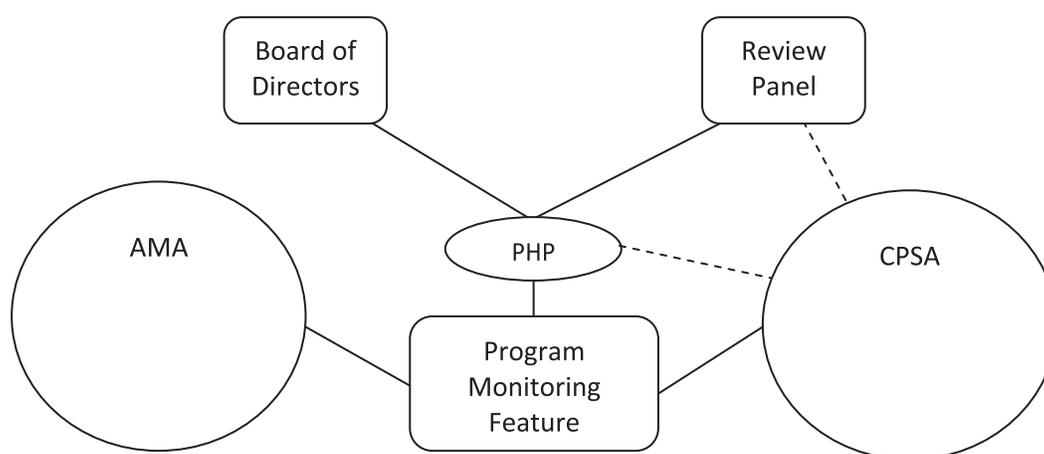
consistently applied. This approach is contingent upon the appropriate education of PHP staff; it is also dependent upon quality education of physicians throughout the province.

C. Alternative Model 2: Independent Administration Option

Organizational Structure and Services Provided:

Alternative Model 2 contemplates the creation of a new, independent organization which is governed by a Board of Directors, and has the institutional capability to perform essential PHP functions that are currently divided between the AMA and CPSA. It also utilizes both the Review Panel and Program Monitoring Feature as described above in our recommended model description.

Alternative Model 2: Independent Administration Option



Alternative Model 2 envisages the following list of services being primarily provided by the PHP of the new independent organization:

1. Access to information and advice – information regarding the services offered and the process followed will be of value to physicians, colleagues, family members and others.
2. Education – it is important for the AMA, CPSA and the new organization to work together to appropriately educate physicians in Alberta on all matters covered by this report. Generally speaking, proactive and responsive education on services provided and process followed is an important component of all PHPs to raise awareness and encourage access where appropriate.
3. Prevention and promotion – services will ideally include wellness initiatives to prevent, where possible, physicians from becoming affected by a condition.
4. Family support/services – services will ideally include information and service provision to family members of physicians.
5. Access to assessments – assessments may be indicated to assess the nature and/or severity of the condition, reasonable treatment options, and/or whether case management is appropriate for a particular physician-patient.

6. Access to referrals – where treatment outside a PHP is required or desired by a physician-patient, appropriate referral mechanisms are an important component.
7. Case management/follow up – appropriate case management for physicians undergoing assessment, treatment and/or monitoring is key to the provision of appropriate services, as well as establishing oversight mechanisms where appropriate to safeguard the public.
8. Intervention services – with respect to some physicians, intervention services should be part of a PHP where there are reasonable grounds to believe that the physician poses a significant risk to themselves and/or others and they have been unwilling to seek services without such intervention.
9. Biological monitoring – for physicians with particular health issues (e.g. drug addiction and blood-borne infections in certain circumstances), biological monitoring is a necessary component of a PHP both in terms of appropriate treatment and to protect the public.
10. Treatment – appropriate treatment is an essential component of any PHP, whether provided directly or through appropriate referrals.
11. Reporting to CPSA where appropriate – when the reporting threshold has been met, a report shall be made to the CPSA.
12. Evaluation – given the lack of conclusive research on the effectiveness of PHPs, ongoing evaluation is important in any such program.

All of the above noted features will be maintained and implemented by the PHP, which exists as one component of the new independent organization.

Alternative Model 2 requires the creation of a board of directors to govern the independent organization. We will not describe in detail how we feel this board should be constituted, but do have comments on some of the relevant considerations regarding the board's constitution:

1. The number of individuals on the board should be odd to avoid the possibility of deadlocked votes. We recommend a board comprised of 5 to 9 individuals; a larger number of board members become unmanageable without an executive.
2. We recognize that there are pros and cons associated with a larger or smaller board. A larger board, for example, offers the benefit of increased participation and the possibility of additional perspectives which may enhance discussion. At the same time, it may make the consensus process more difficult and increase the timeframe for decision making. A smaller board, on the other hand, may offer a more streamlined approach but may limit the representation possible from certain stakeholders.
3. We recommend that the AMA and the CPSA both be represented on the board, and that their representation be equal.
4. We recommend that the public be represented on the board as a means of fostering and promoting trust in the PHP.
5. We recommend that the board receive reports on the functioning of the PHP utilizing non-identifying information.



It is critical that prior to the commencement of operations of the new PHP, an internal assessment process be in place and functioning.

Review Panel:

We recommend the creation of a Review Panel to review Level 2 Cases when necessary to assess whether reporting thresholds have been met. We also recommend employment of a staff member to conduct risk assessment (the “Staff Member”). See the description of the Review Panel in the above section on our Recommended Model for further details.

Program Monitoring:

We recommend the creation of a Program Monitoring Feature. See the description of the Program Monitoring Feature in the above section on our Recommended Model for further details.

Benefits and Drawbacks of Alternative Model 2:

The major benefit of this model is that it should provide a framework that both the public and the government can be confident in as it is run by an independent organization, and not by the medical association. It may also encourage physicians to utilize the services of the PHP as it is independent from the CPSA. In considering an independent organization, we looked to the British Columbia PHP which utilizes an independent organization, as discussed in our jurisdictional review. While this Alternative Model 2 has many similarities with the PHP in British Columbia, there are some key differences.

The major drawback of implementing this model is the cost (both financial and otherwise) of the re-organization that would be associated with creating a new organization capable of performing these tasks. Another drawback is the significant increase in complexity as compared to the current framework. Additionally, in creating a new structure, it fails to build on the many aspects of the current Alberta PHP which are working well.

XII. Other Recommendations

In our review of PHPs, both nationally and internationally, most appeared to lack a means of adequately assessing whether or not the PHP was functioning as intended. As well, it was not clear whether the PHP as established was creating an environment that would facilitate physician utilization. Finally, as mentioned earlier in our report, reliable evidence is either scant or lacking on these and other related issues. As such, we make the following recommendations:

Recommendation 10:

We recommend that an evaluation mechanism of the new PHP be implemented, to assess the effects of the changes after a specific time period. We recommend that such an initial evaluation be completed within two years of implementation of a new PHP model.

Recommendation 11:

We recommend that research be undertaken to assess the most effective tools for encouraging physicians to seek assistance for the health conditions that have an impact on their work life.



As discussed, there is a lack of legal clarity in Canada regarding a duty to report where health care professionals believe an imminent danger exists and may be avoided if confidential health information is disclosed appropriately. As well, while our recommendations will address duties of physicians to report, they will not have an impact on other health care professionals. While standards of practice of other such professionals is beyond the scope of this report, and we have not addressed whether the recommendations we have made for physicians should apply within other health professions, we are of the opinion that such professionals do have a duty in the narrow instances encompassed by the imminent danger test, if not by the broader criteria we have recommended for physicians. As such, we recommend the following:

Recommendation 12:

We recommend that an amendment to Alberta's *Health Information Act* to enshrine a duty, rather than a discretion, to report in instances of imminent danger be proposed to government to be considered.

One of the barriers physicians face in accessing services, as discussed earlier in this report, is the possibility of impacts on income as a result of alterations to practice due to a health condition. Given this, we recommend the following:

Recommendation 13:

We recommend that the AMA and the CPSA discuss ways to ensure that physicians are adequately insured, whenever possible, if they are unable to practice (whether temporarily or permanently).

The scope of our project was Alberta focused. We were tasked with and aimed to make recommendations focused on law and/or policy reform in Alberta. Nonetheless, given the research that was conducted, it became apparent that regulatory bodies, medical associations, patients, physicians, and the medical profession itself may benefit from a review in of licensure questions, reporting obligations and PHPs across Canada. We would suggest that certain changes should be seriously considered with the aim of protecting the public, as well as physician-patients, in mind. We therefore recommend the following:

Recommendation 14:

We recommend that the AMA and the CPSA recommend to their counterparts across Canada that they examine the licensing questions, as well as the reporting obligations in place in their respective jurisdictions and consider making changes in keeping with the findings of this report. In particular, instances of certain conditions being singled out should be eliminated. These distinctions not only fail to address the aim of protecting the public, but also, of arguably equal concern, may well contribute to the stigma associated with certain conditions such as mental health issues.

Conclusion

This Report grapples with numerous factors that are key to addressing physician health issues with an aim to reducing the barriers that physicians face in maintaining wellness and accessing services essential to their health and well-being. It also addresses the need to place the interests of patients



and others who could be negatively impacted by at-risk or compromised physicians first and foremost, given the legal, ethical and professional obligations of physicians as medical professionals.

The ultimate recommendations offered by the Working Group are founded on extensive research and dialogue assessing the full spectrum of components necessary to strike appropriate balances and achieve the objectives stakeholders are striving for. To achieve these aims, the recommendations must be viewed holistically, and not in isolation from one another. As with the human body, the health of a PHP and a profession's overarching regulatory structure needs most, if not all, of its essential organs to function. Therefore, the recommendations should be considered together, each as part of an optimal whole. It is our hope that this Report assists the medical profession, law and policy makers, and others in improving the current framework, both in Alberta and elsewhere.



XIII. Glossary of Terms, Acronyms and Short Forms

ADA – Americans with Disabilities Act

“Affected physician” – We have used the term “affected” to discuss physicians who may be influenced or touched by an external factor (such as personal circumstances which are stressful, e.g. a physician going through a separation or divorce), or who may have a diagnosable condition (e.g. depression), but where those personal circumstances or that condition is neither having a current, negative “impact” on his or her practice, nor is there a reasonably foreseeable risk of it having such an “impact” in the future. Such physicians may well be able to benefit from the services of a “PHP”. See also “at-risk physician”, “compromised physician” and “impaired physician”.

AMA – Alberta Medical Association

“At-Risk physician” – We have used the term “at-risk” in the report when contemplating physicians who have a condition that is not currently impacting their work negatively, but where it is reasonably foreseeable to. This also includes physicians who may not have a condition, but are at high-risk of developing one which, if developed, may have a negative impact on their work. See also “affected physician”, “compromised physician” and “impaired physician”.

BMA – British Medical Association

CARNA – College & Association of Registered Nurses of Alberta

Charter – Canadian Charter of Rights and Freedoms

CMA – Canadian Medical Association

CNA – Canadian Nurses Association

Competence Assurance Act – New Zealand’s Health Practitioners Competence Assurance Act 2003

“Compromised physician” – a physician affected by a condition which results in a negative impact on practice. This term would include the notion of “impaired physicians” but would be potentially broader than that. See also “affected physician”, “at-risk physician” and “impaired physician”.

“Condition” – Throughout this policy paper we use the word ‘condition’ in the broadest sense, intending to include any health condition that may affect a physician’s practice. The term includes physical, cognitive, psychological, mental and/or emotional conditions and/or issues that are affecting or may affect a physician’s practice. This would also capture substance or chemical abuse and/or dependency.

CPSA – College of Physicians & Surgeons of Alberta

CPSBC – College of Physicians & Surgeons of British Columbia



CPSO – College of Physicians & Surgeons of Ontario

Expert Review Panel – Alberta Expert Review Panel for Blood-Borne Infections in Healthcare Workers

GMC – General Medical Council of the United Kingdom

HIA – Health Information Act of Alberta

HLI – Health Law Institute

HPA – Health Professions Act of Alberta

HPA BC – Health Professions Act of British Columbia

“Impaired physician” – The word “impair” or “impairment” is used quite frequently in the context of PHPs, or matters related to regulatory obligations and physician health issues. This word connotes disability. Though many conditions may result in a disability, and disabilities which have a negative impact on the practice of a physician will be relevant to issues discussed in this context, not all conditions result in such. As well, it is important to make clear that the focus should be on conditions that negatively impact practice; not only on disabilities. As a result, we have chosen to avoid the use of “impair” or “impairment” in the discussion and analysis contained in this report. See also “affected physician”, “at-risk physician” and “compromised physician”.

Intergovernmental Agreement – The Australian Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions

NMA – Norwegian Medical Association

OMA – Ontario Medical Association

PFSP – Physician & Family Support Program of the AMA

PHMC – Physician Health Monitoring Committee of the CPSA

PHMP – Physician Health Monitoring Program of the CPSA

PHP – Physician Health Program

PHPBC – Physician Health Program British Columbia

SAFH – Norwegian Registration Authority for Health Personnel

SHEA Guideline – The Society for Healthcare Epidemiology of America SHEA Guideline for Management of Healthcare Workers who are Infected with Hepatitis B Virus, Hepatitis C Virus, and/or Human Immunodeficiency Virus

VDHP – Victorian Doctors Health Program

