OMA Submission
CPSO Policy Consultations:
(1) Boundary Violations
(2) Disclosure of Harm
(3) Prescribing Drugs

August 2, 2019

CPSO Policy Consultations re: (1) Boundary Violations, (2) Disclosure of Harm, and, (3) Prescribing Drugs

The OMA welcomes the opportunity to provide feedback regarding the CPSO's revised policies: (1) Boundary Violations, (2) Disclosure of Harm, and, (3) Prescribing Drugs. We appreciate the CPSO is open to feedback and recommendations about its policies through its public consultation process.

The OMA supports the CPSO's new direction to develop briefer, more concise policies that clearly state the College's expectations. The accompanying Advice to the Profession documents, when available, will be useful tools to help in policy translation and implementation. As well, the OMA appreciates that the CPSO accepted many of the OMA's recommendations and requests for clarification outlined in its preliminary submissions regarding these policies.

In preparation for its response, the OMA conducted a survey of the OMA Council members. Participants were asked questions about specific aspects of each policy under review. As well they were asked to provide: (1) recommendations to improve the policies and, (2) suggestions for tools or resources that may help physicians to implement the policies more easily into their practice. The OMA's Health Policy Committee also reviewed the revised policies and provided feedback. The OMA recommendations are outlined below.

1. Boundary Violations Policy

A. Third Party Attendance at an Intimate Examination:

During the CPSO's preliminary consultation on this policy, the OMA requested that physicians be given the option to have a third party present during intimate examinations. As well, it was requested that physicians be permitted to refuse to perform an intimate examination if a third party was not available or the patient declined to have a third-party present. The CPSO has made the effort to capture this idea in the revised policy. In addition to what's been captured, the OMA proposes that the language be more explicit and that the ideas be addressed in the accompanying Advice to the Profession document as well (please see proposed highlighted language on the next page).

As well, it is recommended that the policy and advice document clarify that the option for physicians or patients to have a third-party present applies regardless of the gender of the physician or the patient.

Third Party Attendance at Intimate Examinations

4. When performing intimate examinations, physicians **must** explain the indication for the examination and consider the patient's comfort at all times. In doing so, physicians **must** give patients the option of having a third party present during an intimate examination, including bringing their own third party if the physician does not have one. As well, physicians have the option to request the presence of a third-party during an intimate examination should they choose to do so. The option to have a third-party present is regardless of the patient's or physician's gender.

5. If a patient requests a third party, physicians **must** provide one if available.

6. If no third party is available or if there is no agreement by either the physician or the patient on whom the third party should be, and the examination is non-emergent, physicians **must** suggest the following options to the patient:

a. either the physician or the patient may withdraw from the examination until a mutually acceptable third party is available and the examination can be rescheduled, or
b. where possible the physician can refer the patient to another physician who has a third party available for the examination.

B. Sexual Relations After the Physician-Patient Relationship has Ended

The policy states that sexual abuse occurs if physicians engage in sexual relations with a patient within one year after the physician-patient relationship has ended (or five years if psychotherapy that is more than minor or insubstantial is provided). The OMA recommends giving consideration to other circumstances where sexual relations between a physician and a patient may be prohibited for a period of time after the physician-patient relationship has ended. For example, if the patient was a minor at the time of treatment (psychotherapy or otherwise) this may contribute to a patient vulnerability that extends beyond childhood. In this circumstance, it may be appropriate for the timeframe prohibiting sexual relations to be longer than one year.

C. Minor or Insubstantial Psychotherapy

Regarding the expectation that sexual relations be prohibited for five years after the physician-patient relationship has ended if psychotherapy that is more than minor or insubstantial is

provided, further clarification is requested regarding what is meant by 'minor or insubstantial'. It is recommended that the policy contain a brief explanation about what these terms mean, and that the advice document contain a more fulsome explanation with specific examples to clarify the expectation.

D. Mandatory Duty to Report Sexual Abuse

While the policy notes that physicians are required to report sexual abuse to the Registrar of the College to whom the alleged abuser belongs, for ease of access and understanding, it would be helpful to have this information contained within the policy itself rather than in a footnote (please see highlighted addition below). As well, clarification is requested regarding to whom the physician would report an abuse should the professional not belong to a regulated College, e.g., physician assistant, paramedic, etc.

11. Physicians must comply with the reporting requirements of the *HPPC*.

    a. Physicians must report if they have reasonable grounds, obtained in the course of practising the profession, to believe that another member of the same or a different regulated health college has sexually abused a patient.
    b. Physicians or others who operate a facility must report if they have reasonable grounds to believe that a member of a regulated health college practising in the facility has sexually abused a patient.
    c. Reports must be made in writing to the Registrar of the regulatory body to whom the alleged abuser belongs, or to the 'XXXX' should the alleged abuser not be a member of a regulated profession.

E. Non-Sexual Boundary Violations

In its previous submission, the OMA had indicated that non-sexual boundary violations should be addressed in a separate document, for example, in a policy dealing with conflicts of interest. The OMA maintains this position. However, if this recommendation is not accepted, it is recommended that:

- The first line in this section, "12. Physicians must not exploit the power imbalance inherent in the physician-patient relationship." be moved to the beginning of the overall policy as this statement applies to both sexual and non-sexual boundary violations.

- Specific examples of non-sexual boundary violations be added to the policy. While this information is contained in the accompanying advisory document, for ease of access and explanation it is recommended that more detail be added to the policy, albeit in a briefer format. For example:

  > 13. Physician obligations to establish and maintain appropriate boundaries with patients are not limited to sexual interactions. Physicians must establish and maintain appropriate boundaries with patients at all times, including with respect to non-sexual social or financial/business matters. Examples of possible non-sexual boundary violations may include: the giving or receiving inappropriate or elaborate gifts, soliciting charitable donations from a patient, or providing a patient a personal or business loan (Please see Advice to the Profession document for more examples and explanation).

- As well, it is recommended that the Advice document provide examples of reasonable interactions that do not rise to the level of a boundary violation. In smaller communities, it may be impossible to avoid some social interactions. For example, many patients and their children attend the same schools, places of worship, sports teams, clubs, etc. as their physicians. It would helpful for the CPSO to provide clarification about how the policy will be applied in these instances.

- At #14., the policy states "Physician must consider the impact in the physician-patient relationship and on others in their practice (emphasis added) …". In the Advice document, the example of non-sexual boundary violations involve direct physician to patient relationships, so it is unclear why "others in their practice" are mentioned in the policy, or who the "others" are referring to (is the reference to staff, for example?). It would be helpful for the policy and/or advice document to provide some context or explanation as to what this means and why it is included.

F. Boundary Violations by Patients

In the policy and/or advice document, clarification is requested regarding expectations for physicians when a patient violates boundaries, sexual or non-sexual, e.g., a patient sends inappropriate e-mails and will not stop even after he or she has been asked to, or a patient repeatedly gives expensive gifts and will not take them back. Would physicians be expected to end the physician-patient relationship? Would physicians be expected to document the interactions, and if so, how? What other steps should be taken?

2. Disclosure of Harm Policy

A. Disclosure of No-Harm Incidents:

The CPSO Advice to the Profession document for the Disclosure of Harm policy provides an explanation as to why no-harm incidents must be disclosed to patients, even if the patient has not experienced any immediate or discernible harmful effects. The OMA recommends that additional explanation be provided.

For example, the CMPA notes that no-harm incidents should be disclosed to the patient as sometimes an incident has the potential for harm that may manifest in the future (emphasis added). For example, "a patient exposed to poorly sterilized equipment might subsequently acquire a viral infection. The infection would take time to declare itself and serial monitoring would be required."[1]

It is recommended that this reason and an example be added to the advice document. As well, for ease of access and understanding, it would be helpful to have a short summary of the reasons in the policy itself.

B. Who Must Disclose?

The policy indicates that where the incident has occurred during the course of team-based care, the Most Responsible Physician (MRP) must determine in conjunction with the health care team who is in the most appropriate person to disclose. The concept of assigning responsibility for disclosure to an MRP may work well in a hospital setting where patients are admitted under a physician or nurse practitioner. However, determining the MRP outside of the hospital setting may not always be clear. For example, a patient with diabetes may have a family physician as well as and endocrinologist. Both professionals are involved in the management of the disease with the patient. In the event of a diabetic event, it may not be immediately evident who would act at the MRP. It is recommended that the CPSO consider other scenarios like this when determining who should be responsible for disclosure to the patient.

[1] https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2015/disclosing-harm-from-healthcare-delivery-open-and-honest-communication-with-patients

As well, the definition of MRP provided in the policy footnote ("the physician who has final accountability for the medical care of a patient when the trainee is providing care") is vague and may not apply outside the hospital setting. It is recommended that the CPSO explore other definitions for the MRP, such as those provided by the CMPA, for example:

- "The physician most directly involved in the patient's care at the time of the adverse event."[2], or,
- "the physician who has overall responsibility for directing and coordinating the care and management of an individual patient at a specific point in time."[3]

C. Postgraduate Learners

The policy states that postgraduate learners must inform the MRP and their clinical preceptor of any incident that requires disclosure. It is recommended that "in a timely manner" be added to this sentence.

As well, the policy states that, "14. In the interest of professionalism and ongoing education, MRPs must encourage the postgraduate learners' active involvement (emphasis added) in the disclosure process, as appropriate in the circumstances." The OMA recommends this statement be made more definitive to state whether the MRP is required or not required to involve the postgraduate learner in the disclosure process.

3. Prescribing Drugs Policy

A. Patient Prescribing History

As indicated in the OMA's preliminary submission regarding the Prescribing Drugs policy, concern remains about the expectation that physicians take reasonable steps to review the patient's prescription history by, for example, contacting the patient's pharmacist or other treating physicians, or by reviewing digital sources of information regarding the patient's prescription history when it is available. Consulting outside sources of information will require appropriate supports such as appropriate funding, universal access to digital sources, and an integrated EMR that is linked directly to digital sources. In addition, they place significant additional constraints on physicians' time and resources.

[2] https://www.cmpa-acpm.ca/en/site-resources/glossary-of-terms
[3] https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2012/the-most-responsible-physician-a-key-link-in-the-coordination-of-care

Until these supports are put in place, it is recommended that this mandatory requirement be removed from the policy.

- The requirement to contact pharmacists or other treating physicians can be time consuming and impractical, especially if they are unavailable when physicians try to initiate contact, causing appointments to run overtime and inconveniencing patients. As well, there are challenges related to problematic patients who attempt to mask their identity or prescribing patterns.
- Digital sources, such as the provincial government's Digital Health Drug Repository, are not universally available with current accessibility only through ClinicalConnect in South West Ontario and through ConnectingOntario in the Greater Toronto Area and Northern and Eastern Region. Setting different expectations for physicians based on their location or access to a specific EMR is not equitable treatment.
- Consulting digital sources that are not seamlessly available through an EMR may be time and/or resource intensive and will add a level of technical complexity to physician practice. More detail regarding how physicians will access this information, the form it will take, etc. is required to determine the impact on physician practice.
- If consulting digital sources of information becomes the standard, then it is important that adequate supports be in place, such as physician training on the use of digital sources, integration of digital information into the EMR, and universal access for all physicians. The OMA would be open to partnering with the CPSO to advocate for these supports with the government. Until such time, it is recommended that this mandatory requirement be removed from the policy.

B. Authorizing and Transmitting Prescriptions

Under #10, the policy notes that physicians must not create duplicate copies of a prescription (except for the purposes of retaining a copy in the patient's medical record). However, in practice physicians must frequently provide patients with duplicate prescriptions, for example, if the patient loses the prescription or the prescription is damaged. Clarification is requested as to whether the policy prohibits this practice, and if so, what reasonable alternative solutions would be recommended.

As well, under 'Prescribing Fentanyl Patches', #38., the policy states, "Physicians must also notify the pharmacy directly, either by telephone or by faxing a copy of the prescription." Clarification is requested about whether the prescription faxed to the pharmacist would be in lieu of a prescription written and provided directly to the patient. Providing the pharmacist with

a faxed copy from the physician and a written copy from the patient may cause confusion and may be contradictory to the requirements outlined in #10 of the policy (referenced above).

C. *Monitoring Drug Therapy*

An additional outstanding issue that warrants consideration is in the Monitoring Drug Therapy section of the policy where it states that "Physicians must ensure that appropriate monitoring protocols are in place to identify emerging risks or complications arising from the drugs they prescribe."

As stated in our preliminary consultation submission, ongoing patient monitoring may not be practical or possible in all instances, and a distinction should be made between medications prescribed for acute pain versus those prescribed for the management of chronic pain conditions. For example, monitoring requirements may be different for a family physician treating patients with long term chronic care needs versus an emergency department physician or hospital surgeon who prescribe medication to address a patient's short-term acute pain but who may have no further relationship or contact with that patient. It is recommended that these distinctions be made explicit in the policy.

D. *Blanket "No Narcotics" Prescribing Policies*

The policy prohibits physicians from adopting a blanket policy to refuse to prescribe narcotics and controlled substances without exception. Physicians must decide whether to prescribe on a case-by-case basis with consideration for each patient. The policy states two exceptions: (1) if the physician has restrictions regarding prescribing imposed by the College, or, (2) if the prescribing is outside the physician's scope of practice. The policy notes that for physicians with primary care practices there would be few occasions where scope would be an appropriate ground to refuse to prescribe all narcotics and controlled substances.

Results from the survey indicate there are physicians that feel that prescribing some drugs is beyond their scope, e.g. opioids for pain management, or cannabis. Others feel they should not be compelled to prescribe drugs they believe to be unsafe, e.g., any drug with addictive properties. The OMA recommends that the CPSO give consideration to these exceptions and that they be made explicit in the policy.

Resources/Tools that May Help with Policy Implementation:

Survey respondents identified tools and resources physicians may find helpful when implementing these policies in their practice, including:

- Explanatory resources for patients regarding the policies, including patient responsibilities in relation to boundary violations,
- Information about how to chart/record disclosure events, and subsequent conversations with patient in EMR/patient charts,
- Access to CPSO staff in real-time to answer questions about whether an incident should be disclosed, and,
- More education about how to conduct a disclosure with a patient, e.g., case studies, podcast, webinar.
- Access to the digital sources of prescribing history linked directly through the EMR,
- Links to the prescribing guidelines and standards in the Digital Health Drug Repository so they are easily accessible,
- CPSO education for the public about its policies and about patient accountabilities so that patients may take more responsibility for their care.

The OMA appreciates the opportunity to provide feedback concerning the CPSO's revised policies. The OMA would like to continue to work with the CPSO to find practical, constructive solutions that support physician practice while enabling the CPSO to fulfil its mandate to protect the public interest.

Thank you.