Introduction

The College of Physicians and Surgeons of Ontario (the "College") is currently reviewing its *Delegation of Controlled Acts* policy.

As part of this review, the College has developed an updated draft of the policy which was released for external consultation was undertaken from March to May, 2019. Invitations to participate in the consultation were sent via email to a broad range of stakeholders, including all Ontario physicians.

In addition, a general invitation to provide feedback was posted on the College's website and social media platforms. Feedback was collected via regular mail, email, an online discussion forum, and an online survey.

This report summarises only the stakeholder feedback that was received through the online survey.

Caveats

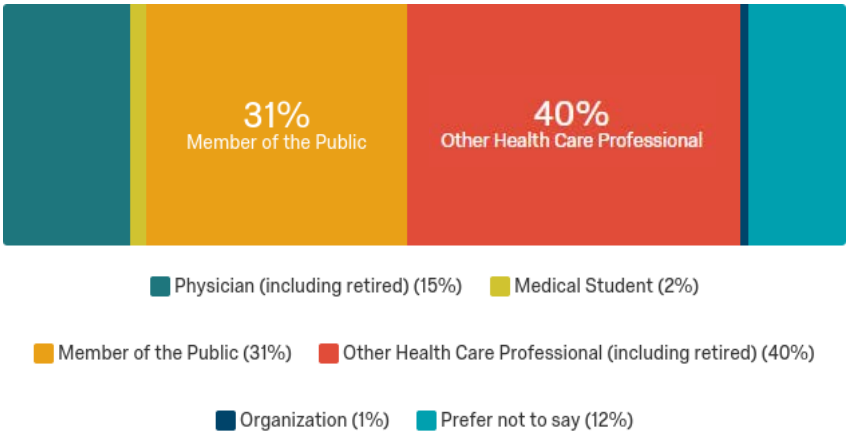
Participation in this survey was voluntary. As such, no attempt has been made to ensure that the sample of participants is representative of any sub-population. In the interest of space, stakeholder feedback to open-ended questions has been summarised to capture key themes and ideas.

Who we heard from

A total of 888 surveys were received in response to this consultation.

The vast majority of respondents were from Ontario (97%).

Respondent Demographics



Organisational responses included:

- College of Nurses of Ontario
- The Pink Parlour
- Ontario Association of Paramedic Chiefs
- Weinject
- Skin Vitality Medical Clinic

The following questions were posed only to respondents who identified as physicians (including retired):

Q1. Delegation allows a physician who is authorized to perform a controlled act to grant that authority to another person (whether regulated or unregulated) who is not independently authorized to perform the act. Controlled acts include, for example, communicating a diagnosis, administering a substance by injection or inhalation, and prescribing a drug.

Please tell us your area of practice and practice setting (i.e., hospital, clinic): (n=125)

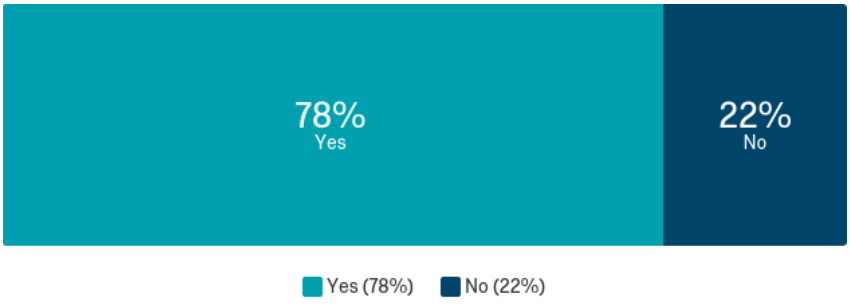
The most reported areas of practice among physician respondents were:

- Primary care, family medicine, or general practice (many of which indicated they also practice medical aesthetics or cosmetic medicine);
- Hospital medicine/hospitalist; and
- Dermatology.

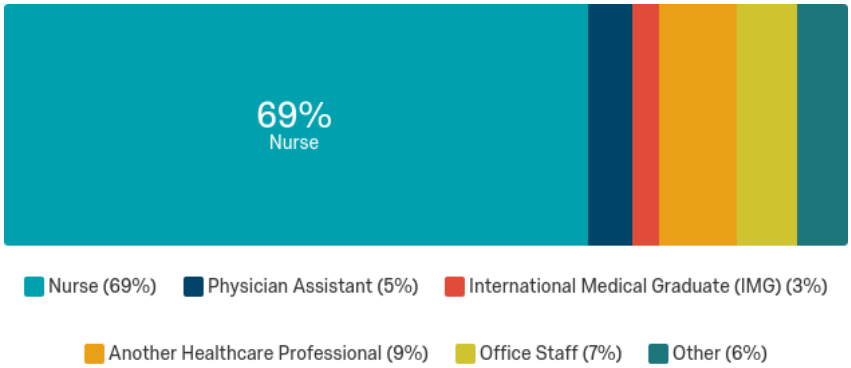
Many physician respondents indicated that they work in multiple practice settings. The most commonly reported practice settings were:

- Clinics;
- Hospitals; and
- Private practice.

Q2. Do you delegate controlled acts in your practice? (n=124)



Q3. Who do you typically delegate to? (n=97)



Q4. If other, please specify. (Optional) (n=6)

Others included:

- Cast technician;
- Medical aesthetician;
- Medical assistant; and
- Trained technician.

Q5. What acts do you typically delegate? (n=89)

The most commonly reported delegated acts were injections, which included:

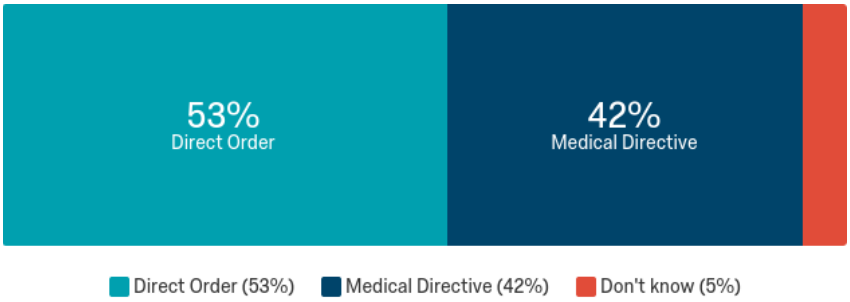
- Botox;
- Dermal fillers;
- Immunizations;
- Intravenous therapy;
- Neuromodulators; and
- Vaccines.

Other commonly reported delegated acts[1] included:

- Administering medications;
- Cast application or removal;
- Communicating (normal) test results, diagnoses, and/or treatment plans;
- Other cosmetic treatments (e.g. laser procedures; chemical peels; cryotherapy or liquid nitrogen);
- Performing pap smears;
- Taking patient history and/or performing physical examinations; and
- Wound care and suture removal.

[1] Not all respondents provided examples of delegation as described in the policy (i.e. delegation of controlled acts under the *Regulated Health Professions Act, 1991 (RHPA)*.

Q6. Which authorizing mechanism do you use to delegate a controlled act? (Select all that apply) (n=133)



Q7. Have you experienced any challenges while delegating? If so, what are they? (n=87)

The majority of physician respondents indicated they have not experienced any challenges while delegating. These physician respondents attributed this to:

- Having a structured training, evaluation, and/or examination program for delegates (e.g. physician assistants or nurses) while maintaining ongoing training and oversight; and
- Working closely and communicating effectively with delegates.

Reported challenges primarily revolved around training and on-site supervision, for example:

- Training, knowledge, or skill levels may vary among delegates;
- The time and effort required to properly train and evaluate the competency of delegates;
- Ensuring on-site supervision to assess and appropriately delegate requires time and planning;
- The difficulty in knowing what the "standard" of supervision is; and
- It is unclear which acts can or cannot be delegated when a physician is not on-site.

Other physician respondents expressed concerns regarding:

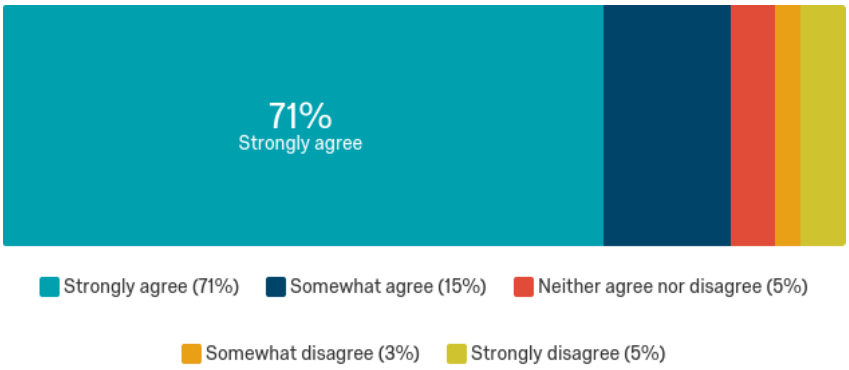
- Difficulty with nurses not accepting a direct order or refusing to assist with procedures they consider to be outside their scope of practice;
- Patients not understanding the rules of delegation; and
- Regulatory challenges.

The following questions were posed to all respondents:

Q8. Delegation allows a physician who is authorized to perform a controlled act to grant that authority to another person (whether regulated or unregulated) who is not independently authorized to perform the act. Controlled acts include, for example, communicating a diagnosis, administering a substance by injection or inhalation, and prescribing a drug.

The policy requires that in every instance of delegation, the primary consideration must be the best interests of the patient. The policy links patient best interest to a number of factors including: the more timely delivery of health care, increased access to care, optimal use of health care resources, patient safety, and quality care.

Please indicate the extent to which you agree or disagree that it is clear what is meant by "patient best interest." (n=795)



Q9. Please feel free to elaborate on your answer above or touch on other issues related to "patient best interest." (Optional) (n=99)

The majority of respondents felt that when delegation allows for increased access to health care resources it is in the "best interest" of the patient. Survey comments predominantly centered around advocating for nurses to continue performing cosmetic treatments, and these respondents suggested that changes to the current policy would impede access and the affordability of such procedures.

- Many respondents felt patient "best interest" includes patients receiving quality care in a timely manner (i.e. accessible healthcare without long wait times).

Many respondents expressed the importance of having access to affordable elective procedures (particularly cosmetic treatments) and felt that delegation facilitates access by allowing physicians to focus on providing medically necessary treatments.

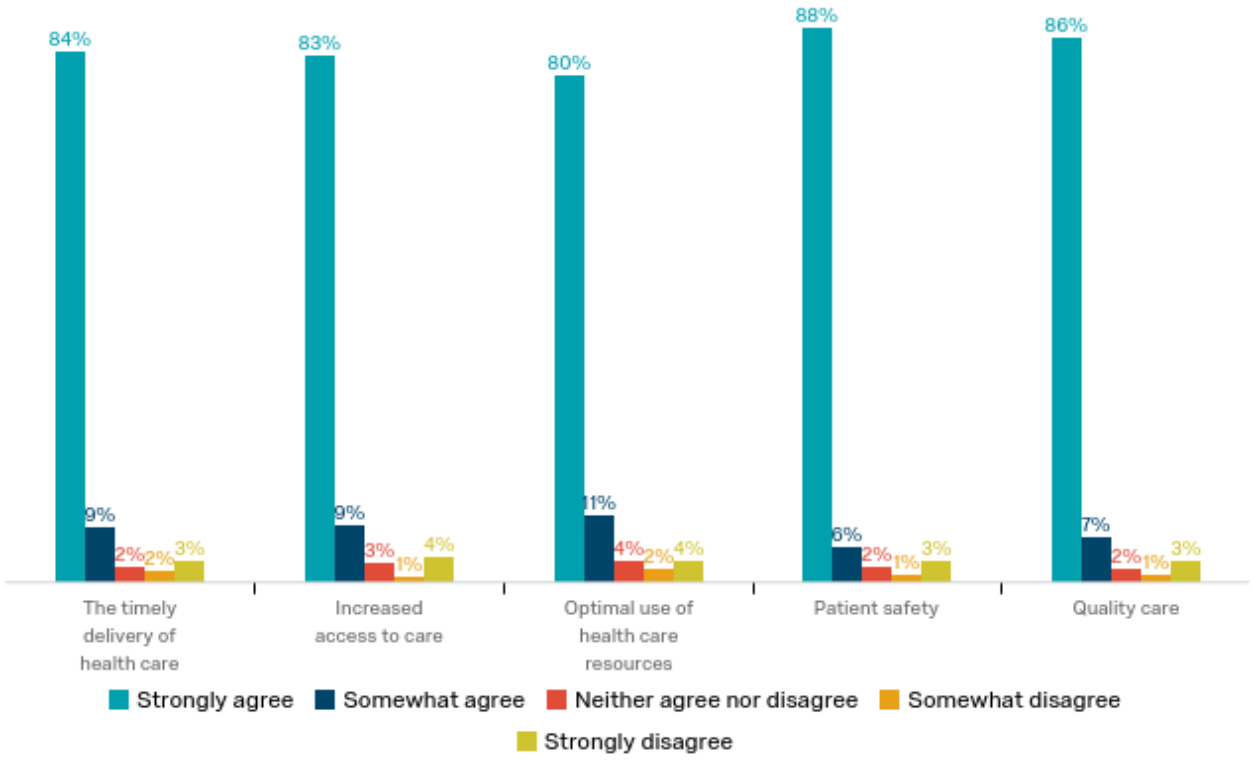
Some respondents were concerned that any changes to the policy restricting delegation would decrease access to health care resources and increase prices for elective procedures (i.e. cosmetic treatments).

- Many respondents indicated patient choice in treatment provider is correlated with patient "best interest."
- Respondents indicated that delegation can be beneficial if the delegate is competent (i.e. knowledgeable, trained, and qualified) to perform the act.
- Several respondents indicated that allowing unregulated or unlicensed practitioners to perform cosmetic treatments is not in a patient's "best interest."

Several respondents noted the concept of "best interest" may conflict with the efficiency or accessibility of health care resources.

- For example, the efficiency or expediency of care does not always result in high quality care, particularly in instances where the patient is receiving treatment from a delegate who is less qualified than the supervising physician.

Q10. Please indicate the extent to which you agree or disagree that each of the following factors is relevant for determining patient best interests. (n=738)



Q11. Are there any *other* factors that should be considered when determining patient "best interest?" (Optional) (n=127)

The most reported factors from respondents included patient choice and preference; the competency of delegates (ensuring delegates are appropriately trained and qualified to perform the act or treatment); and costs of the service or treatment.

Patient choice and preference:

- Many respondents (predominantly members of the public and other health care professionals) felt patients should have the right to choose their preferred health care professional, and noted delegation allows for more variety in treatment providers.
- These respondents felt that inter-professional collaboration between physicians and other regulated health care professionals increases access and reduces wait times for specialists.

Qualifications and competence of delegate:

- Many respondents expressed that patient best interest includes ensuring that delegates have the proper competency, training, and experience to perform the controlled act or treatment. These respondents felt that the delegate must be able to appropriately deal with any adverse events or complications that may occur.
- Respondents highlighted the importance of delegates being held to the standards of care of their respective regulatory bodies, and many felt physicians should never delegate controlled acts to unregulated practitioners.

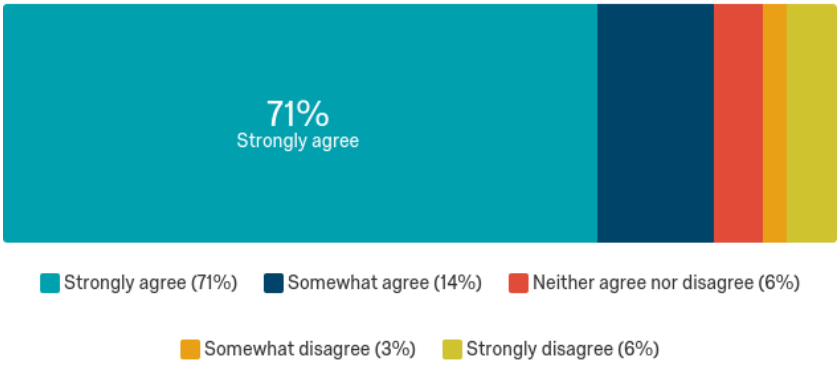
Costs of service or treatment:

- Many respondents indicated costs to the patient should be considered when determining patient best interest (particularly with respect to cosmetic treatments).
- These respondents were also concerned about an increase in price for these services.
- Several highlighted instances of physicians performing cosmetic treatments when they are not sufficiently experienced or trained in aesthetic medicine, or delegating these treatments to individuals without appropriate qualifications. Respondents felt this was being done solely for monetary gain at the expense of patient safety.

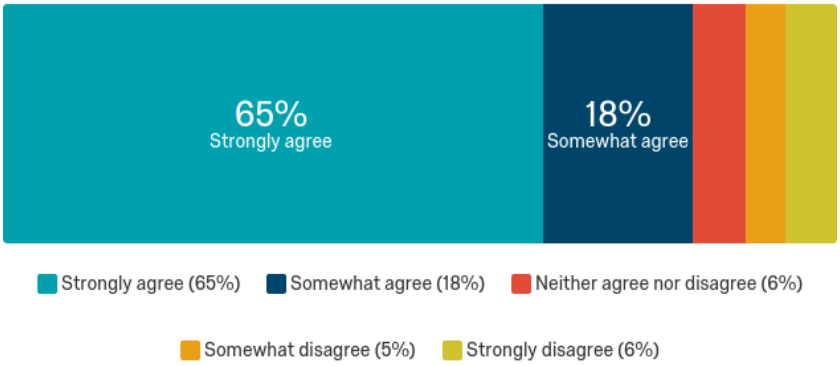
Other reported factors related to patient best interest included: obtaining informed consent and effective communication about the delegation.

Q12. Please indicate the extent to which you agree or disagree with the following statements. (n=701)

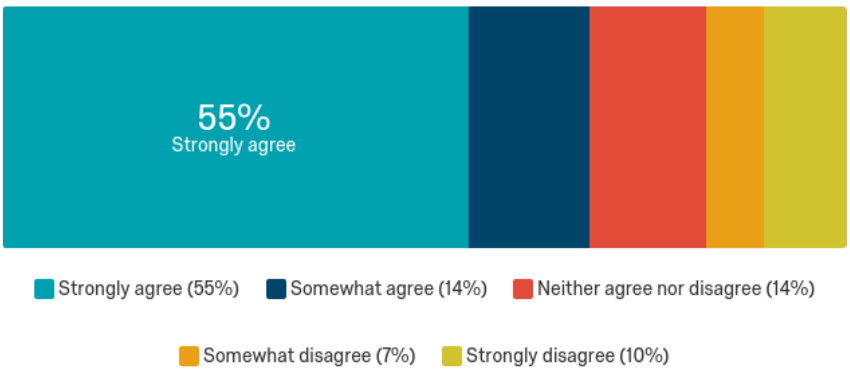
1. Delegation is only appropriate where patient care is not compromised.



2. Delegation is only appropriate where there is no additional risk to the patient.



3. Delegation is only appropriate where monetary or convenience reasons are not the sole reason for delegation.



Q13. Please feel free to elaborate on your answer above or touch on other issues related to appropriate delegation. (Optional) (n=116)

Delegation is only appropriate where patient care is not compromised:

- Many respondents indicated patient care is often compromised when unregulated or unlicensed practitioners perform procedures without appropriate supervision by the physician (i.e. cosmetic treatments).
- These respondents felt that as long as patient care is not compromised, delegating to regulated health care professionals that are working within their scope of practice should be permitted.

Delegation is only appropriate where there are no additional risks to patient:

- Some respondents felt that while delegation may pose an additional risk to patients, this increased risk must be weighed against the alternative of the patient not being able to access services at all (e.g. in remote communities).
- Respondents felt that in some cases, the alternative of not being able to access care may pose a greater risk to patient safety than the potential risks that may result from delegation.
- Other respondents highlighted that risks are inherent in delegation and it can be hard to determine what "no additional risk" means.

Delegation is only appropriate where monetary or convenience reasons are not the sole reasons for delegating:

- Many respondents felt that as long as patient care is not compromised and there is no additional risk to the patient, delegation for monetary or convenience reasons can be appropriate.
- Some respondents felt delegation for monetary reasons is appropriate if it allows the physician to improve access to primary care, which allows for the more efficient use of health care resources and increases overall access to care.
- Some respondents questioned whether delegation for "convenience reasons" was in reference to the physician's convenience or the patient's convenience. Many felt delegation can be convenient for both (i.e. increased access to care by allowing physicians more time to care for more patients).
- Other respondents felt monetary reasons should never be the sole motivating factor for delegating, and some felt that delegation for monetary reasons (i.e. physician profits) should not be permitted.

Q14. The policy states that some procedures in some circumstances carry such a high risk that only a physician should perform them and that in these instances physicians must not delegate. The policy then specifically prohibits delegating the act of psychotherapy because it could reduce the quality of care and negate treatment benefits, and presents an unduly high level of risk to the patient.

Are there any other acts/treatments that should never be delegated? If so, what are they? Please tell us why you feel these acts should never be delegated. (Optional) (n=266)

Many respondents felt physicians should delegate any controlled acts or treatments where necessary, as long as:

- The delegate is a registered health professional working within their scope of practice (some respondents felt that controlled acts should never be delegated to unregulated practitioners);
- The delegate is deemed competent by the supervising physician: the act should not be delegated if the delegate does not have the appropriate skills, knowledge, or judgment to perform the act safely; and
- Patient care is not compromised.

Respondents were divided regarding the delegation of cosmetic injections and treatments (e.g. Botox):

- Several respondents indicated that since these procedures require highly specialised training and carry a high risk of complications, they should only be performed by physicians.
- Some respondents felt these acts could be delegated, but only under the direct supervision by an on-site physician in case of adverse outcomes. Several respondents highlighted the danger of delegating these procedures without direct supervision, to unregulated practitioners, or outside a designated medical clinic.
- Some respondents felt delegation via telemedicine should be prohibited and cited patient safety concerns and the potential for financial exploitation, while others felt that as long as the delegate is appropriately qualified they should be permitted to perform cosmetic treatments without on-site physician supervision.

Other acts or treatments that respondents felt should be prohibited included: high-risk procedures (e.g. surgery or anesthesia); prescribing (particularly narcotics or controlled substances), diagnoses and/or treatment plans, communicating negative results; and obtaining informed consent.

Q15. The policy states that physicians must not delegate the performance of a controlled act to a person whose certificate to practice in any health profession is revoked or suspended by the governing body of his or her discipline at the time of the delegation.

Are there any other individuals who should never be delegated to? If so, which individuals? Please tell us why you feel this way. (Optional) (n=261)

Respondents predominantly reported that the following individuals should never be delegated to:

- Unregulated or unlicensed practitioners (e.g. aestheticians);
- Non-medically trained individuals (e.g. office staff);
- Those who lack the knowledge, skill, or judgment to perform the controlled act or with insufficient education or training; and
- Those who do not have the act within their scope of practice.

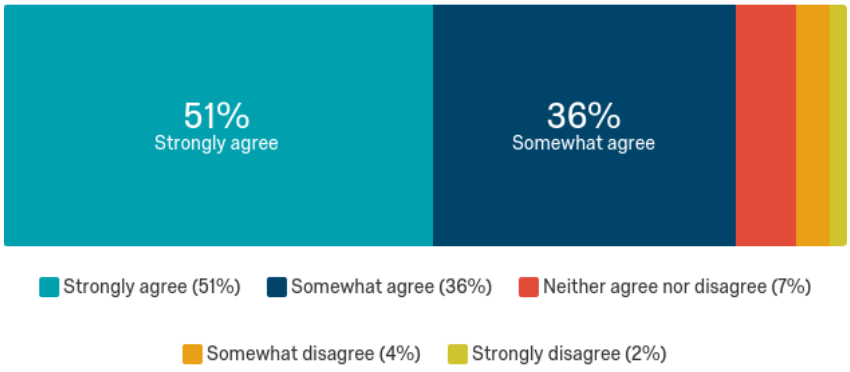
Other responses included:

- Concerns surrounding delegation to international medical graduates (IMGs), highlighting instances of physicians either delegating to unlicensed or unsupervised IMGs.
- A few respondents felt physicians should not delegate to registered practical nurses (RPNs) and instead only delegate to registered nurses (RNs) due to their higher level of training.

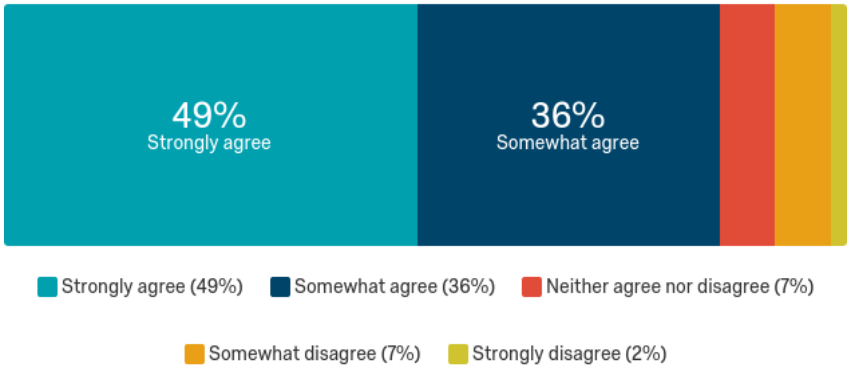
The following questions were posed only to respondents who indicated that they read the *Delegation of Controlled Acts* policy:

Q16. We'd like to understand whether the policy is clear. Please indicate the extent to which you agree or disagree with each of the following statements regarding the clarity of the policy. (n=548)

1. The policy is clearly written.



2. The policy is easy to understand.



Q17. How can we improve the policy's clarity? (Please feel free to elaborate on your answers above or touch on other issues relating to clarity) (Optional) (n=79)

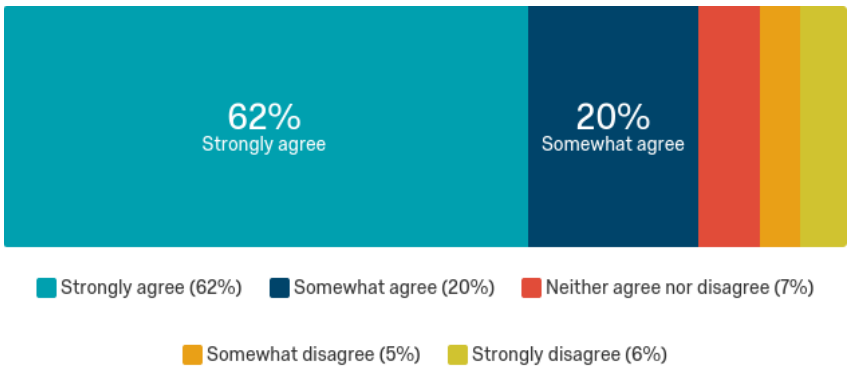
The most common suggestions for improving the clarity of the policy included:

- Provide a detailed description of what acts can or cannot be delegated and to whom under what circumstances, including the required qualifications of the delegate; and why and when it is appropriate to delegate to unregulated practitioners.
- The new policy should be shorter, more concise, and use simpler language.
- The supervision provisions require clarification, including clearly articulating when the physician needs to be on-site and clarifying what constitutes "ongoing monitoring" of the delegated act.
- Clarification is needed around the requirement for a "physician-patient relationship," particularly as this relates to delegating to physician assistants and paramedics.

Q18. It is not considered delegation to authorize the initiation of a controlled act that is within the scope of practice of another health care professional. For example, nurses are legally authorized to "administer a substance by injection" when the procedure has been ordered by a specified regulated health professional. Therefore, a nurse would require an order to perform this procedure, but would never require delegation.

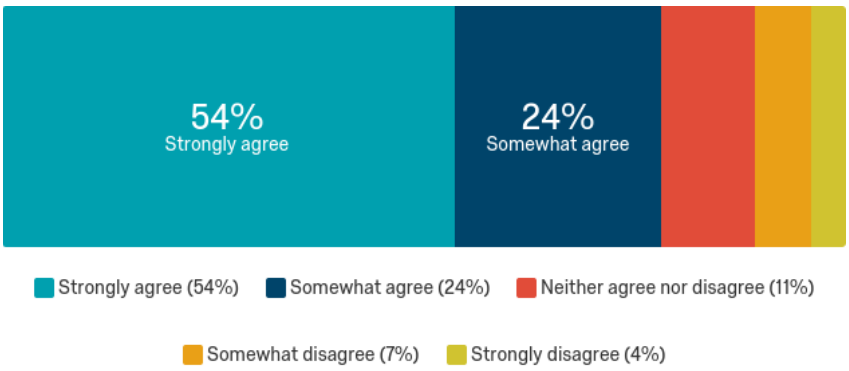
Please indicate the extent to which you agree or disagree with the following statement:

The policy clearly articulates that requirements around delegation do not apply where a regulated health professional (e.g. a nurse) is legally authorized to perform the controlled act. (n=536)



Q19. The policy specifically sets out expectations for delegating *controlled acts* and does not address delegation in the colloquial sense (i.e., assigning a task that does not involve a controlled act). Examples include taking a patient's history, taking vitals, or administering a test that does not involve a controlled act.

Please indicate the extent to which you agree or disagree that it is clear what aspects of care are captured by the policy. (n=530)



Q20. Please feel free to elaborate on your answer above. (n=25)

Respondents generally felt it was clear which aspects of care were captured by the policy, but the following concerns were highlighted:

- Some respondents were unsure about whether the policy expectations applied to both the "technical" and "colloquial" interpretations of delegation.
- Some felt that since those listed examples are not controlled acts, the policy does not apply to these aspects of care.
- Other respondents felt that although not specifically addressed in the policy, these expectations are implied to relate to the delegation of non-controlled acts.

Some respondents felt delegation is not well-defined in the policy, and that it can be difficult to determine whether an act or treatment is controlled or not:

- Several respondents felt the policy would benefit from clarification about the College's expectations regarding assigning tasks that are not controlled acts.
- The updated policy should include a list of permitted and prohibited acts with illustrated examples of when delegation can occur for each respective regulated health care profession.

Q21. Is there value in the College providing guidance related to assigning tasks that do not involve controlled acts (e.g. taking a patient's history, taking vitals, administering a test that does not involve a controlled act, etc.)?

If so, please tell us more about the types of activities where guidance would be valuable and why. (Optional) (n=188)

The majority of respondents did not think additional guidance regarding assigning tasks that do not involve controlled acts was necessary.

- Some respondents felt that since regulated health care professionals already maintain their own standards of practice expected by their respective regulatory body, this would create an extra administrative and unnecessary burden.
- Other respondents felt that while additional guidance is not required, including examples of non-controlled acts may be helpful.

Some respondents felt explicit guidance and clearer expectations from the College for certain activities would allow providers to be more confident in their decision-making, provide better consistency, and improve quality of care. Suggestions from respondents included:

- Outlining which acts or treatments can be delegated and clearly indicate whether they are controlled or not;
- Specialty-specific guidance as delegate roles may vary across different clinical settings;
- Guidance surrounding delegation of cosmetic treatments and clarification of the roles of physician assistants (PAs); and
- Clarification about obtaining informed consent and appropriate communication surrounding delegation.

Q22. The policy sets out expectations related to a number of aspects of delegation including, for example, supervision and evaluation of delegates, and documentation when delegating.

Is there any additional guidance that would be helpful to include in the policy? (Optional) (n=161)

The majority of respondents did not feel additional guidance in the policy would be helpful. Of those that had suggestions for additional guidance, the following provides examples of the feedback:

- A quality assurance program should be required for supervising physicians to help address instances of delegates performing cosmetic treatments without appropriate supervision;
- Standardised evaluation and training is needed within the medical cosmetics industry, and ongoing continuing education and training should be required for physicians who practice aesthetic medicine; and
- Clarifying the role of physician assistants (PAs), especially because the profession is currently unregulated.

Q23. The policy sets out broad principles that apply to delegation in all contexts. Should the policy be updated to address delegation in different contexts (i.e., delegating to a Nurse, Physician Assistant, International Medical Graduate, etc.)?

If so, what scenarios should the policy specifically address and why? (Optional) (n=213)

- Many respondents expressed that the current policy is well-defined and working well and felt that any restrictive changes would challenge healthcare delivery and limit resources.
- Some respondents felt that keeping the policy broad allows for delegation to be applied across multiple clinical scenarios, and that the addition of specific scenarios would detract from the essence of the policy (i.e. delegation should be done competently under supervision of the physician regardless of the individual performing the delegated act).
- Other respondents felt that if the updated policy were to address delegation to different health care providers, it should consider:
    - Including a specific list of which acts or treatments can be delegated to each respective health care profession. Some respondents suggested including guidance for delegating in different contexts or scenarios, including clarifying which acts or treatments require a direct order versus a medical directive.
    - These respondents felt this could be especially helpful within the medical cosmetics industry, as guidelines distinguishing the roles between registered practical nurses (RPNs), practical nurses (PNs), physician assistants (PAs), and international medical graduate (IMGs) would address the variance in skills and training of those performing cosmetic treatments.
- Several respondents felt the policy should address paramedics, particularly within the context of community paramedics and ambulance services.
- Respondents highlighted issues surrounding delegation to PAs, citing administrative burdens resulting from the high number of acts that require delegation and the paperwork necessary for medical directives. These respondents noted this requires consideration since the expansion of PAs within our healthcare system can increase access to care if their roles are utilised effectively.

The following question was posed to all respondents:

Q24. If you have any additional comments that you have not yet provided, please provide them below, by email or through our online discussion forum. (Optional) (n=79)

Many respondents expressed concern about what they perceived to be the College attempting to restrict the scope of practice of nurses (particularly within the medical cosmetics industry) by requiring physicians to be on-site when delegating to nurses and prohibiting the use of telemedicine for these procedures.

- Respondents reiterated that requiring physicians to be on-site would restrict access to procedures, increase wait times for specialists, and drive up service costs for patients.
- Respondents highlighted the benefits of delegation to the health care system, which included increased access to services, reduced wait times, and reduced physician burnout.

Other respondents felt the College should specifically ban telemedicine consultations for cosmetic treatments, and cited the lack of appropriate supervision poses a risk to patient safety:

- These respondents cited instances of off-site physicians delegating services to patients they have never examined in-person, or cosmetic treatments performed when there is no physician on-site to deal with potential complications or adverse events.
- Several respondents expressed concern about unsupervised IMGs performing these treatments.