OMA Ontario Medical Association

Ontario Medical Association Submission

CPSO Delegation of Controlled Acts Policy

November 2020

The Ontario Medical Association (OMA) welcomes the opportunity to provide comments in response to the CPSO's consultation on its Delegation of Controlled Acts Policy. The OMA appreciates the CPSO's efforts make this policy clear and concise. Below are some suggestions to further clarify physician expectations that we hope CPSO finds helpful.

Policy (Line 37)

As a general comment, there are various times in the policy where expectations for physicians may vary based on their practice setting. For example, under the section 'When Not to Delegate' (line 55) the policy indicates that physicians must not delegate the performance of a controlled act to a person whose certificate to practise has been revoked or suspended at the time of the delegation. Physicians delivering care in a hospital and who are not involved in the hiring of delegates would likely rely on the hospital medical director or human resources team to make this confirmation, while physicians in private practice would likely be expected to confirm the status of their delegates' certificates directly.

To provide clarification, it may be advisable to add a general statement under the Policy section indicating that some policy expectations may vary depending upon the practice setting, and that these variances will be noted in the policy, and explained further in the Advice to the Profession document.

When Not to Delegate (Line 55)

In the section from lines 59 to 61 the policy states that physicians must not delegate controlled acts to any health professional whose certificate is revoked or suspended at the time of the delegation. It would be helpful for the CPSO to clarify the expected method to confirm this information and to clarify whether it needs to be documented. Does confirmation of the health professional's current certification need to be documented in the medical record? As noted above under 'Policy', it would be helpful to confirm that physicians delivering care in settings such as hospitals or clinics would not be responsible for confirming the status of practice certificates and that this responsibility would fall on the institution, unless the physicians are directly involved in hiring the delegates.

At line 63 the policy states that physicians must not delegate the controlled act of psychotherapy. The *Regulated Health Professionals Act (RHPA)* defines the controlled act as: "Treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning." The OMA recognizes that this definition was not written

by the CPSO, however, it is vague nonetheless and open to interpretation. It would be helpful to have clarity about whether the CPSO considers complementary supportive activities, such as group therapy, meditation classes, mindfulness courses, etc., part of the controlled act of psychotherapy, or is it possible to delegate these activities?

As well, the footnote that accompanies this expectation (footnote 5) states that "This does not prohibit health care professionals who are authorized to perform the controlled act of psychotherapy from providing psychotherapy." It would be helpful to include the list of professions that are able to practice psychotherapy under the Act, including social workers, so that the information is readily available to physicians.

In the Context of an Established Physician–Patient Relationship (line 74)

At lines 75-79, the policy states that physicians must delegate in the context of an established physician-patient relationship, unless it is in the patient's best interest to do otherwise. For clarity, it is recommended that these ideas be stated in two separate sentences, for example,

> 7. Physicians must only delegate in the context of an established physician-patient relationship and where they have current and sufficient knowledge of a patient's clinical status (i.e., following a clinical assessment[7]). ~~, unless a patient's best interests dictate otherwise~~ Exceptions to this rule are permitted only if it is in the best interest of the patient to do so, and under limited circumstances, for example, in a hospital emergency department ~~room~~, where it is common for some tests to be ordered before a physician has seen the patient.

As a minor edit, we would ask that the policy include the up-to-date terminology "emergency department" rather than "emergency room" that is currently used in line 78 and footnote 8. As well, at lines 91-96, the policy states, "Where delegation is occurring on an ongoing basis, physicians must re-assess the patient to ensure that delegation continues to be in the patient's best interest, including when: (a) there is a change in the patient's clinical status or treatment options; or (b) the patient has requested to see the physician." The use of the word "including" seems to indicate that there are other circumstances where a re-assessment may be necessary, in addition to the two conditions noted in (a) and (b). It is recommended that "including" be removed, otherwise it is not clear what additional circumstances may precipitate a reassessment, and how often. Also, when a patient has requested to see the physician, it would be helpful to note how quickly the re-assessment must be completed, for example, within a reasonable timeframe.

Ensure Consent to Treatment is Obtained (line 97)

This section of the policy indicates that consent must be obtained by a healthcare professional acting under a medical directive prior to providing treatment. The language contained in footnote 10 further outlines the conditions that should be met. This information would be helpful to have within the policy itself to provide clarity, perhaps at 11 (b) "Obtaining informed consent includes the provision of information and the ability to answer questions about the material risks and benefits of the procedure, treatment or intervention proposed. If the individual who will be enacting the medical directive is unable to provide the information that a reasonable person would want to know in the circumstances, the implementation of the medical directive is inappropriate."

Identifying and Mitigating Risks (line 108)

The policy states at lines 109-110 that "Prior to delegating, physicians must identify any potential risks and mitigate them appropriately." The use of the word "any" makes this expectation very broad and perhaps impractical. It would be helpful to use more specific language, for example, physicians must identify "significant or common risks inherent to the delegated practice and mitigate them such that patient safety is at no greater risk than had the task not been delegated and a physician performed the task". As well, it would be helpful for the policy to clarify whether physicians would identify these risks for the delegates so that they are appropriately prepared to identify possible concerns, and the documentation requirements, if any.

Supervision and Support of Delegates (line 135)

At lines 155-157 the policy requires that physicians "must ensure that the individuals to whom they are delegating accurately identify themselves and their role in providing care …". A minor amendment is recommended to indicate that physicians "must instruct the individuals to whom they are delegating that they are required to accurately identify themselves and their role in providing care …". This section also states that patients with questions about the delegate's role must be provided with an explanation. However, it is not clear whether the explanation can be provided by the delegate or whether this is an expectation of the physician. A practical solution would be to enable the delegate to provide answers to patients' questions, with the physician as back up if additional support is needed.

Ongoing Monitoring and Evaluation (line 169)

The policy indicates that where acts are routinely delegated, physicians must have a reliable and ongoing monitoring and evaluation system for both the delegate(s) and the delegation process itself. Clarification is needed as to whether this expectation applies if the healthcare institution where the physician is delivering care has a reasonable monitoring and evaluation

system or processes in place. Similar clarification is required for the expectations outlined in section 22. (a), (b), and (c) (lines 174-182) that specify the actions a physician would take.

The OMA appreciates the opportunity to provide the CPSO with preliminary feedback concerning its Delegation of Controlled Acts Policy. We would welcome the opportunity to engage in further discussions as the consultation feedback is reviewed.