OMA Ontario Medical Association

Ontario Medical Association Submission

CPSO Policy Consultation – Third Party Medical Reports

November 2020

The Ontario Medical Association (OMA) welcomes the opportunity to provide comments in response to the CPSO's consultation on its draft Third Party Medical Reports policy.

In preparation for our response, the OMA consulted both internally and with relevant members and/or sections, including our Uninsured Services Committee, the Section of Family Practice, the Section of Physical Medicine and Rehabilitation and the Section for Occupational and Environmental Medicine.

In addition to the feedback we provide below, an important note for your consideration is to request that any amendments or additional requirements for physicians takes into account the current COVID 19 situation and the new or increased pressures that physicians are facing. Particularly when it comes to the potential influx of patients seeking doctors' notes for several COVID 19 related reasons, including requests for clearance to return to work or school, exemptions from wearing a mask and/or attending work. As it is our shared position that doctor's notes for clearance of patients in this context are not an appropriate use of health care resources, specifically primary care resources, we believe physicians are still receiving these requests. We would therefore appreciate your continued support and understanding, particularly when it comes to timing of these reports/notes, in preventing any undue pressures for our physicians.

Our response below is the consolidation of the comments we received both on the policy in general, and on specific sections.

On the policy generally, we have the following feedback:

- Relevant Legislation:
  We have noted that the draft policy has referred to both *Ontario's Personal Health Information and Protection Act* (PHIPA) and the federal *Personal Information Protection and Electronic Documents Act* (PIPEDA). We understand that PHIPA has been declared "substantially similar" to PIPEDA under that legislation. As the Information and Privacy Commissioner (IPC) has indicated, [1]a health information custodian (HIC) would not be able to collect, use or disclose information in accordance with PIPEDA in the context to which this draft policy applies. While it is understood that the physician is acting on behalf of third-party information, health information of an individual is always personal health information in the hands of a health care practitioner, which includes physicians, of whom this policy is directed toward. Therefore, any collection, use and disclosure of such information would be governed by PHIPA once in the hands of the physician.[2]

  The OMA recommends removal of references to PIPEDA and replace with PHIPA.

- *Seeking Independent Legal Advice*
  The draft policy would benefit from being clear that if a physician is unsure of the particulars of the requirements listed, advice can be obtained from a legal body like the CMPA. We prefer this language to the existing "seek independent legal advice."

[1] 1 https://www.ipc.on.ca/wp-content/uploads/Resources/fact-11-e.pdf

[2] In the hands of a third-party not covered by PHIPA it would be covered by PIPEDA. For example, disclosures to a physician from a third-party may be governed by PIPEDA, which may affect the third-party's ability to disclose, but this does not affect the way this information must be treated by the physician. Also note, once disclosed by the physician (if authorized by PHIPA or another Act) the information may be governed by PIPEDA in the hands of the third-party, but again this policy is directed toward physician's responsibilities.

- *Advice to the Profession*
  The advice to the profession document is very helpful and we appreciate the CPSO taking this additional step to provide further clarification of the outlined duties in this draft policy. We believe it would be helpful to provide a foot note, where relevant, of areas where clarification is provided in the advice document into the policy itself.

Below is feedback to specific sections of the draft policy we received, with proposed recommendations, as relevant:

Definitions

Independent Medical Examinations (IME)
We understand the intention of the new IME definition, our concern is with the inclusion of "not for the provision of health care" as it suggests that a physician should not have any health care recommendations while conducting an IME. This definition should be clear that the understanding is that while the physician does not provide health care directly during an IME, they may recommend additional health care measures/treatments as required or applicable. This distinction also aligns with the new *Clinically Significant Findings* section of this draft policy whereby if a physician becomes aware through an IME of a clinically significant finding, they must act in accordance with this policy (e.g. disclose to the patient, disclose to patient's health care provider, etc.).

The OMA recommends a foot note be included in this definition to note the distinction between providing care directly and having potential recommendations for additional care, where relevant.

Subjects
While the definition for subjects notes that it is referring to "patients or individuals who are the subject of an IME, third party medical report and/or testimony," we are unsure why "patients" isn't the preferred term to be defined. This is most prevalent when using the term "subject" in the section around C*linically Significant Findings*. Although an IME has mandatory disclosure requirements under some legislation, the person they are examining remains their patient in the sense that they have obligations to them as a medical professional.

We believe that for the purposes of this policy, as it is for medical professionals, "patients" or "examinee" (as was the term used previously) would be the more appropriate term. In addition, we recommend the term be consistent within the document.

Physician Participation in Third Party Processes

Scope and Area of Expertise
Concerns have been raised with the new requirement for physicians to have actively practiced in the requisite scope of practice and area of expertise within the past two years to complete a third-party report. We believe this is limiting to physicians, and we believe they are in the best position to gauge their own comfort when requested to complete a report.

The OMA recommends the CPSO revert to the previous *Medical Experts: Reports and Testimony* policy wording of:

> "Before agreeing to act as an expert, physicians must consider, among other things, whether they have the requisite expertise the matter requires…"

Physician Role in Third Party Processes

Personal Information vs. Personal Health Information

The current draft policy under section 8b notes that "physicians must understand and communicate the nature of their role in the third party process to subjects they interact directly with, which includes that their role may involve collecting, using, and disclosing personal information for a third party process." It is unlikely that information used in this context is "personal information" but rather "personal health information" as defined by the PHIPA. Per PHIPA, it is considered personal health information if the information is collected, used and disclosed by a "health care practitioner." In addition, personal health information (subject to sections 3 and 4 of PHIPA) "means identifying information about an individual in oral or recorded form, if the information a) relates to the physical or mental health of the individual including information that consists of the health history of the individual's family or b) relates to the providing of health care to the individual, including the identification of a person as a provider of health care to the individual." As such, even if the purpose of the exam is to provide a report to a third-party, and therefore arguably not "providing health care to the individual" it still, "relates to the physical or mental health of the individual including information that consists of the health history of the individual's family."

Therefore, the OMA recommends that the use of "personal information" in this section (and where else it is used in the draft policy) be replaced with "personal health information" as defined by PHIPA.

Requirements for Independent Medical Examinations, Third Party Medical Reports and Testimony

Comprehensive and Relevant

This section states that physicians "obtain and review all relevant clinical information and opinions relating to the subject that could impact their statements." Our concern with this requirement is that relevant information may be inadvertently left out, even after the physician took reasonable steps to obtain all clinical information. It may be useful to recommend physicians enumerate in their report what information was used to come to their opinion/statement. In parallel with section 18 of this draft policy (identify limitations), this will make it clear to the reader not only the information that was used, but subsequently information that was not provided that could have potentially led the physician to another conclusion.

The OMA recommends that a provision be added to this section requesting physicians enumerate the information used to finalize the report.

In addition, this section of the draft policy also states that "physicians must not deliberately leave out relevant information and/or opinions in any third-party medical reports and testimony they provide." While section 18 of this draft policy also highlights physicians must identify limitations placed on them in completing a third-party medical report or testimony (e.g. consent was withdrawn), the section in question does not account for these circumstances.

The OMA recommends adding "physicians must not deliberately leave out relevant information and/or opinions in any third-part medical reports and testimony they provide, precluding circumstances stipulated in section 18 of this policy."

Accurate

The draft policy states that physicians must "ensure their statements and/or opinions are accurate" and to "communicate any errors they become aware of, and any changes to their statements and/or opinion to the third party in a timely manner." For the first component, we believe using terms such as ensuring

"opinions are accurate" is contradictory and potentially puts physicians at risk. Opinions are neither accurate nor inaccurate and should therefore be clarified in the policy. We believe the policy should clarify that the conclusions made by a physician were based on the information provided to them. This eliminates any potential unnecessary risk to the physician who is acting on the information they were able to obtain, in collaboration with any limitations that may have been placed by the patient.

The OMA recommends the first section read "ensure their statements/or opinions are reasonable based on the evidence at hand."

Regarding the second component, while an "error" should certainly be corrected as soon as possible, we believe the policy should distinguish an error from new evidence.

The OMA recommends the second section read "to communicate any errors or new evidence they become aware of."

Timely

We have concerns with the change in timing from 60 days to 45 days to provide a third-party medical report. We understand that it is a requirement for a physician to provide a report "within a reasonable time" per the Professional Misconduct regulations. We also appreciate that the CPSO has outlined a process in the accompanying Advice document for situations where a physician seeks an extension from the requesting party. But this may pose a challenge for some physicians. In particular, it may be challenging for physicians who practice in more than one setting, where a report is complex and requires more time to appropriately complete and practice volume factors, including vaccinations and seasonal or unexpected surges in patient care. Also as previously stated, physicians may be seeing an influx in requests in response to COVID 19.

The OMA recommends that the original 60-day timeframe for completing a third-party report be preserved. In absence of this, the OMA would appreciate the rationale for the timeframe change.

Independent Medical Examinations:

Documentation, Retention and Access

In this section, it notes that "physicians' documentation of the information must be (e) written in either English or French." Given the diversity of Ontario, there may be circumstances where an alternate language to English and French is preferred.

The OMA recommends this section read "English, French, or an alternate language, if agreed upon by all parties involved."

In addition, this section notes "documenting the information in provision 38, physicians must retain any materials." The OMA recommends that a duration of time is stipulated for how long physicians are to retain these documents.

Clinically Relevant Findings

Upon review of the new "clinically significant findings" section, we have some concerns as it relates to the role of a physician. Although the report is being made for a third-party and it is understood there is a duty to the third party, consented to by the patient, a physician should have at least a parallel (if not primary) duty to the patient.

Our specific concerns to language used, include:

- "If physicians are conducting an IME and become aware of a clinically significant finding that may not have been previously identified, they must determine if the subject is at imminent risk of serious harm and requires urgent medical intervention." The threshold for using "imminent risk of serious harm" is too high. We suggest using wording such as "requires medical intervention."

- "If the subject has a primary health-care provider, communicate the finding to them after obtaining the subject's consent to do so." It is our perspective that when an IME is disclosing personal health information that is of clinical significance to a primary health-care provider they are doing so "for the purpose of providing health care to the individual"[3], and therefore should be permitted to rely on assumed implied consent under PHIPA to communicate this information back to the primary health-care provider. Only if the physician is aware the patient does not consent to the information being communicated back to the primary health-care provider would additional consent be necessary.

- "If no and a third party (not the subject) hired the physician to conduct the IME, physicians must: a) seek independent legal advice regarding the disclosure of the finding and b) consult with the third party to determine whether the third party waives any impediment to disclosure." As previously noted, this runs against the parallel duty of a physician to the patient. Unless incompatible with specific legal obligations, the duty of the physician to the patient and to the third-party should be carried out in a manner that is harmonious and does not undermine the duties of a physician to patient. Thus, while a third-party may need to be informed (aside from limitations in provision 11), this obligation should not generally impede the duty to inform the patient. We suggest adding "unless prohibited by law or valid order of a court or administrative tribunal, the physician must reveal any clinically significant finding to the individual."

The OMA appreciates the opportunity to provide the CPSO with feedback concerning its draft Third Party Medical Reports policy. We would welcome the opportunity to engage in further discussions as the feedback is reviewed and the policy consultation process progresses.

[3] PHIPA s. 20(2)