Delegation of Controlled Acts: General Consultation Survey Report

Introduction

The College of Physicians and Surgeons of Ontario (CPSO) is currently reviewing its *Delegation of Controlled Acts* policy. As part of this review, CPSO has developed an updated draft of the policy and a draft *Advice to the Profession* document.

As part of this review process, an external consultation was undertaken from September to November 2020. 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 CPSO's website and social media platforms.

Feedback was collected via email, an online discussion forum, and an online survey.

This report summarizes 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.

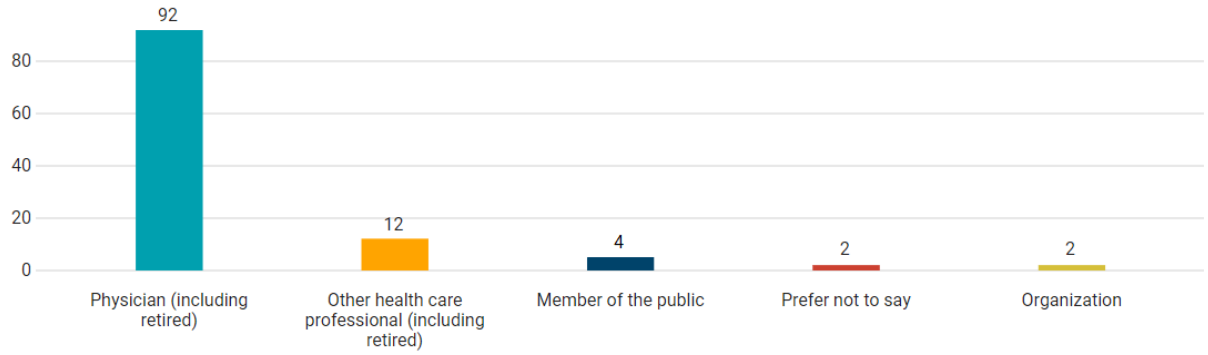
In the interest of space, stakeholder feedback to open-ended questions has been summarized to capture key themes and ideas.

Who we heard from

A total of **112** surveys were received in response to this consultation.

The vast majority of respondents were from Ontario (96%) and were physicians (81%).

Respondent Demographics:



Organizational respondents included:

- Huron County Paramedic Service
- weinject

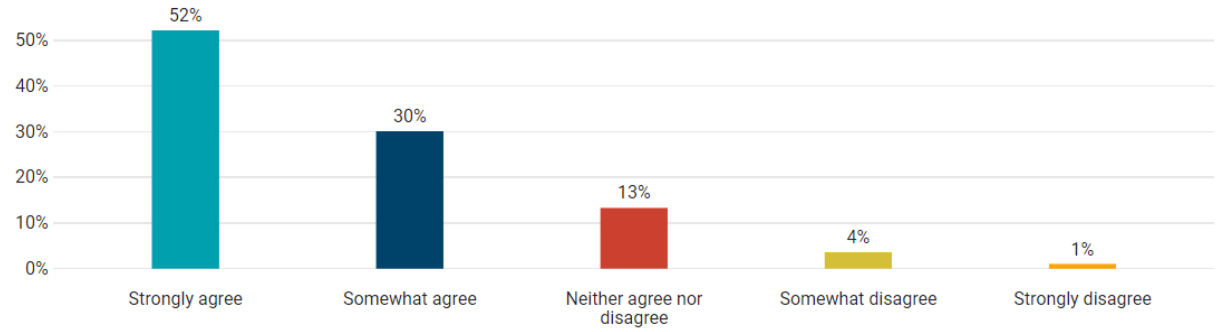
The following questions were posed to all respondents:

The following questions will ask you about the draft *Delegation of Controlled Acts* policy which sets out expectations about when and how to delegate controlled acts appropriately. Controlled acts include, for example, communicating a diagnosis, administering a substance by injection or inhalation, and prescribing a drug.

Q1. The term delegation has a very specific and technical meaning that is defined in the policy however, it is also used more generally in everyday conversation to refer to delegating tasks to staff or providing orders to other health care professionals.

In order to clarify the circumstances covered by the policy the draft states that delegation does not include assigning a task that is not a controlled act (e.g., taking a patient's history), nor does it include ordering the initiation of a controlled act that is within the scope of practice of another health care professional (e.g., an initiating order for a nurse or other health care professional).

Please indicate the extent to which you agree or disagree that this addition clarifies the scope of the policy: (n=112)



Q2. Please feel free to elaborate on your answers above. (Optional) (n=20)

The majority of respondents (82%) agreed (either strongly or somewhat) that this addition clarified the scope of the policy and provided comments such as "this addition is helpful" and "this addition clarifies that delegation only applies to specific acts".

Notwithstanding this support, key comments from respondents to improve the clarity of the scope of the policy included:

- Clarify circumstances where a physician administers a treatment and another physician who is considered the MRP is required to sign off (e.g., an anesthesiologist administers medication to a patient in the course of administering anesthetic agents and the surgeon is required to sign off on the drug administration because they are the MRP);
- Clarify if taking a patient's medical history is considered a "controlled act;"

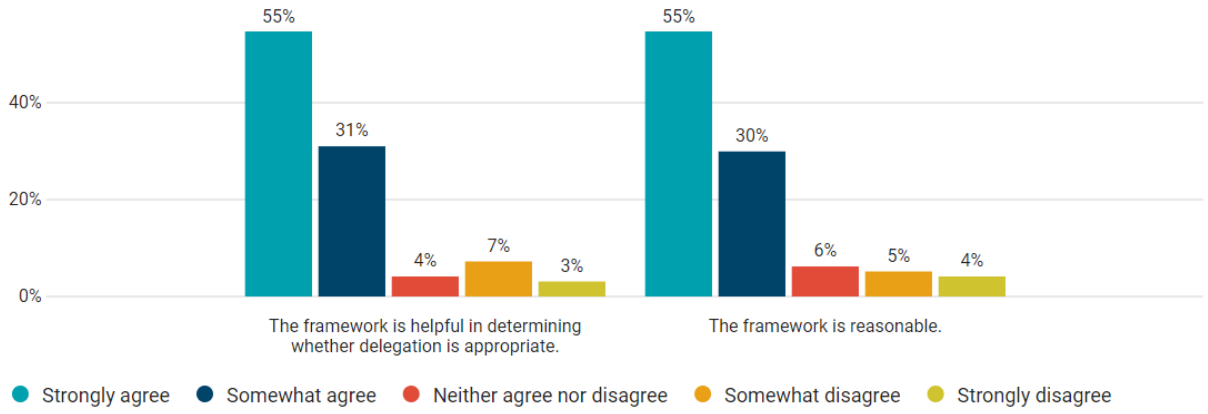
- Indicate that physicians should review the initial history taken and the tasks performed under the medical directives in a timely manner and revise or add to the history; and
- Clarify nurses' ability to administer a vaccination (i.e., if injection is within an RN's scope of practice, is the prescription of the vaccine considered the delegated act).

Q3. The draft policy retains the requirement that physicians only delegate controlled acts when doing so is in the best interest of the patient. It now also states that this includes only delegating when:

- **the act can be performed safely, effectively, and ethically;**
- **the patient's health and/or safety will not be put at risk;**
- **the patient's quality of care will not be compromised by the delegation; and**
- **delegating serves one or more of the following purposes:**
    - **promotes patient safety,**
    - **facilitates access to care where there is a need,**
    - **results in more timely or efficient delivery of health care, or**
    - **contributes to optimal use of health-care resources.**

The purpose of this addition was to help clarify appropriate instances of delegation by setting out a framework that needs to be satisfied in each instance.

Please indicate the extent to which you agree or disagree with the following statements: (n=96)



The majority of respondents agreed that the framework is helpful in determining whether delegation is appropriate (86%) and that the framework is reasonable (85%).

Q4. Are there any factors missing from this framework? If so, what are they? (n=96)

Roughly two-thirds of respondents who provided written feedback did not think there were any factors missing from the draft framework. Key comments from physician respondents who thought the addition clarified appropriate instances of delegation included:

- Summarized the key points clearly with no need to add anything else;
- The factors listed are very reasonable and there are no obvious omissions;
- The framework includes all the important factors;
- Quite clear, defines delegating well, and continuity of care is quite well emphasized;
- It is clear and self-explanatory; and
- By adding "safely, effectively, and ethically," most delegated acts by an assistant having any background, not necessarily health-related, are covered.
- Support for the inclusion of responsible use of health care resources in the framework.

Additional written feedback provided by respondents included:

- The draft expectation that physicians must not delegate where the primary reasons are for monetary or physician convenience is problematic as safely delegating acts is usually motivated by increasing practice efficiency which has financial undertones.
- Requiring delegation to be in the patient's best interest ignores the value of education and appropriate resource utilization, and the expectation should read that there is no detriment to the patient's best interest instead.
- The requirement that each physician must sign the medical directive has hindered their use in large hospitals which would otherwise meet the draft framework: Department Chiefs should be able to endorse directives in limited circumstances.
- A question about whether physicians can delegate the prescribing of controlled substances (e.g., hydromorphone safe supply).
- A request for information on delegating to trainees.
- A suggestion about the importance of transparency in reporting adverse events to the patient (i.e., adverse events should be documented and discussed).

Several respondents highlighted the importance of ensuring delegates have the appropriate knowledge, skill, and judgment to perform the acts.

Q5. Please feel free to elaborate on your answers above. (Optional) (n=16)

Some of the feedback provided by respondents included the following key comments:

- The draft framework helps to ensure continuity of care;
- The mechanism of communication should be addressed (i.e., who is responsible and how would it be communicated to the patient that a controlled act has been delegated by the physician);
- The delegate should be able to handle any adverse events or side effects of the delegated act (i.e., a pharmacist administering a vaccine should be aware of and appropriately treat anaphylaxis); and
- The draft expectation that "physicians must not delegate where the primary reasons for delegating are monetary or physician convenience" is ambiguous (i.e., physician convenience may be completely aligned with the best interest of patients: since physicians bill for their services the "monetary" aspect cannot be excluded).

Delegating in the Context of a Physician-Patient Relationship

Q6. The draft policy specifies the limited circumstances where it is appropriate to delegate in the absence of an established physician-patient relationship (i.e., where patient best interests dictate doing so, in the context of a public health initiative or other public safety program, or as part of established protocols in a hospital setting).

Are there any other circumstances where it might be appropriate to delegate in the absence of an established physician-patient relationship?

If so, please tell us when this might be appropriate. (n=89)

Roughly one third of respondents who provided written feedback did not list any other circumstances where it might be appropriate to delegate in the absence of an established patient-relationship.

- Some of this feedback from physician respondents indicated that the inclusion of "unless a patient's best interests dictate otherwise" *(lines 77—78)* covers most necessary circumstances.

Of those who provided additional examples of circumstances where it might be appropriate to delegate in the absence of an established physician-patient relationship, the most common are set out below:

- Emergency or life-threatening situations, including:
    - Natural disasters or terrorist attacks in public spaces outside of traditional settings or in hospitals that are overwhelmed;
    - Public health emergencies (i.e., when timely access can jeopardize patient safety, including pandemics);
    - In an emergency situation (e.g., an accident with multiple patients injured)
    - Acute threat-to-life situations (e.g., first responders performing CPR or Naloxone);
    - Hospitals and emergency rooms, including emergency anesthesia care;
    - Incompetent patients or vulnerable minors in emergencies;
    - Emergencies where the physician may not be immediately available (e.g., an anaphylactic reaction in an emergency room which requires an EpiPen); and
    - Where the physician's skills or expertise are outweighed by the skills of the delegate in an emergency.
- Community paramedicine programs and first responders
- Physician assistants (PAs) when:
    - Obtaining a comprehensive history and conducting examinations as part of the consultation for the first encounter; and
    - An in-person physician-patient relationship is scheduled for the near future (e.g., an acute care general surgery service PA sees a patient in the emergency

department who can be safely discharged with close in-person follow-up with the supervising physician in a short time).

- Accessibility/access:
    - Remote, rural, or underserviced communities where there is limited access to physicians and only other health care professionals are available; and
    - When a physician is not available, indisposed, or otherwise not able to provide the service in a timely manner.
- Prescribing:
    - Opioid replacement therapy programs (e.g., a PA or NP working with a physician);
    - A home care nurse in an urban setting with a PRN ("as needed") medication directive; and
    - Over-the-counter travel-related prevention treatments (e.g., by a pharmacist).

Some of the additional circumstances listed by respondents included the following:

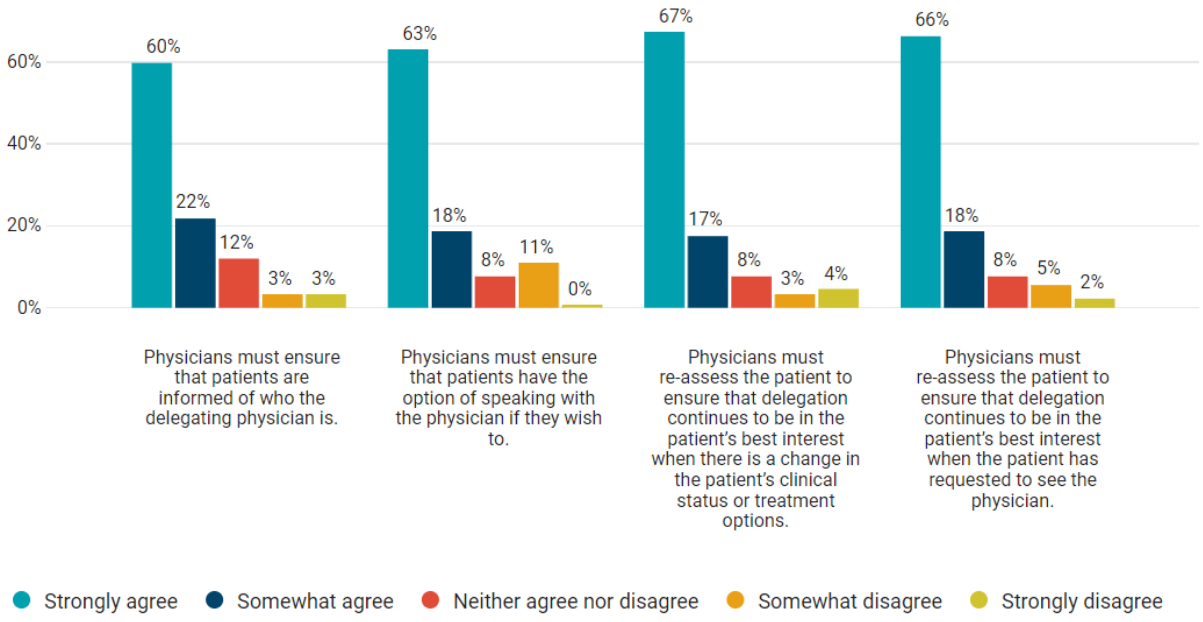
- Immunizations and vaccinations programs (e.g., routine immunizations usually given by an RN or NP through a standing protocol in the clinic);
- When a patient is being referred for a specialist office visit and certain tests or results necessary or appropriate for the consultation where the tests might be requested prior to the actual visit (i.e., this process can be screened by a nurse or staff member under a specific protocol and requested before a physician-patient relationship is established);
- Walk-in clinics (i.e., typically have unique encounters);
- Patients calling in for advice or those who want to know how to be referred; and
- Some specific patient requests (e.g., preferred delegate to perform a pap test).

Additional feedback provided by respondents included:

- One physician respondent felt that only allowing delegation in the absence of a physician-patient relationship in a hospital setting is hospital-centric and does not appropriately address community-based care.
- One physician respondent requested clarification regarding maintaining the physician-patient relationship (i.e., if a file review is adequate and how often a patient should be reassessed to appropriately continue delegating).
- One health care provider questioned if delegating to a caregiver is included in patient best interest and suggested clarifying this in the policy.

Q7. In order to clarify that delegation is intended to be a physician-extender and not a physician replacement the draft policy sets out new expectations for instances where delegation is ongoing.

Please indicate the extent to which you agree or disagree that the following expectations regarding ongoing delegation are reasonable: (n=91)



Q8. Please feel free to elaborate on your answers above. (Optional) (n=23)

The majority of respondents strongly agreed that the expectations regarding ongoing delegation were reasonable. Some of the positive feedback provided by respondents included that these expectations are appropriate, self-explanatory, and that continuity of care is well-respected.

Notwithstanding this, a few respondents questioned the feasibility and practicality of some of these expectations in some instances, particularly in the context of community paramedicine. Some key comments included:

- The name of the delegating physician is not relevant and could be confusing to patients (i.e., there are often many physicians involved in the care of one patient and it becomes impractical to identify and name the specific physician that delegated the intervention);
- None of these are feasible or practical: if these were required, there is a strong possibility delegation to paramedics could cease or be rendered very difficult;
- Knowing and having access to the "delegating physician" is not always possible;
- If the delegate is performing as the patient expects, there may be no need to ensure the patient is informed of the actual physician delegating (e.g., paramedics rarely release this information as a part of regular duties);
- In the scope of pre-hospital emergency response, this is not possible for the delegating physician: if a delegated medical act is performed, a physician will assess the patient, but it will not be the delegating physician; and
- Anesthesia and intensive care: patients have a presumed relationship and presumed consent (e.g., in an emergency when they may be unconscious when care is initiated).

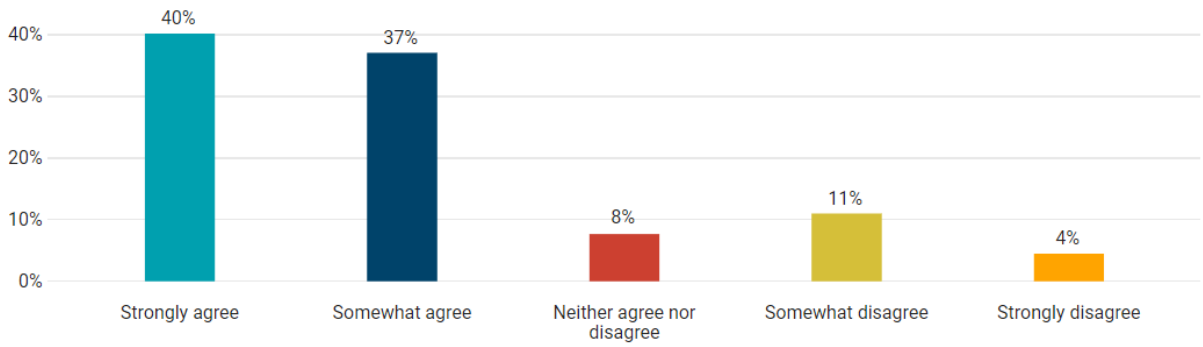
Additional key feedback provided by respondents included:

- A comment that reassessments may not be immediate given the physician's workload and they might have to take place at the next available appointment;
- A few suggestions to include a timeframe in the policy to ensure timely reassessment;
- A suggestion that the reasons for reassessment should be identified and documented in advance by the delegating physician; and
- A comment that the patient must have the right to refuse the delegation without repercussions to their care and that prior to delegation (and as part of the patient's care plan) there should be a discussion to assure the patient has options if they refuse delegation.

Consent

Q9. Thinking about consent, the draft policy requires that consent be obtained for the treatment but does not require that consent be obtained for the delegation itself.

Please indicate the extent to which you agree or disagree with this position: (n=91)



Q10. Please feel free to elaborate on your answer above. (Optional) (n=27)

A majority of respondents agreed that consent should be obtained for any treatments that are delegated, and not the delegation itself, while there were some respondents who expressed that consent for the delegation should be obtained as well.

Physician respondents who strongly agreed with the draft expectation indicated:

- This is reasonable (i.e., otherwise the consent and form-signing would be too complicated and unrealistically time-consuming);
- Any other option would be impractical (i.e., whether a 911 patient prefers treatment directly by the delegating physician is irrelevant as it is not possible);
- As long as the delegate is capable the treatment should be the same as if the physician performed it (as is required by the draft policy expectations); and
- Delegation would not need consent, but the treatment on the other hand would always need consent (verbal, written, or implied).

Some of the feedback provided by respondents who indicated patient consent should also be obtained for the delegation itself included:

- Consent should be obtained for joint treatment and not for a total delegation or transfer of care;
- Patients have the right to approve or decline the referral and discuss other options;
- If delegation is truly to be done in the patient's best interest and with transparency, then consent of the patient should be required (this will lead to better patient satisfaction);
- Patients should also consent to the delegation which relies on an adequate explanation of why delegation is necessary for optimal care;
- Patients should be fully informed in order to understand that the delegate has the authority and skill to accept the delegation and should know that their care is provided by someone who may have less training (e.g., patients should be aware of the roles of physician assistants or IMGs if working as part of a primary care family practice);
- There is a personal element to the physician-patient relationship and feeling comfortable and establishing trust is important (not all delegation is acceptable to the patient, especially when the matter is not trivial or minor); and
- Patients must have the option (e.g., instances where the delegation would have been problematic based on a previous encounter between the patient and the delegate).

Additional key comments provided by respondents included:

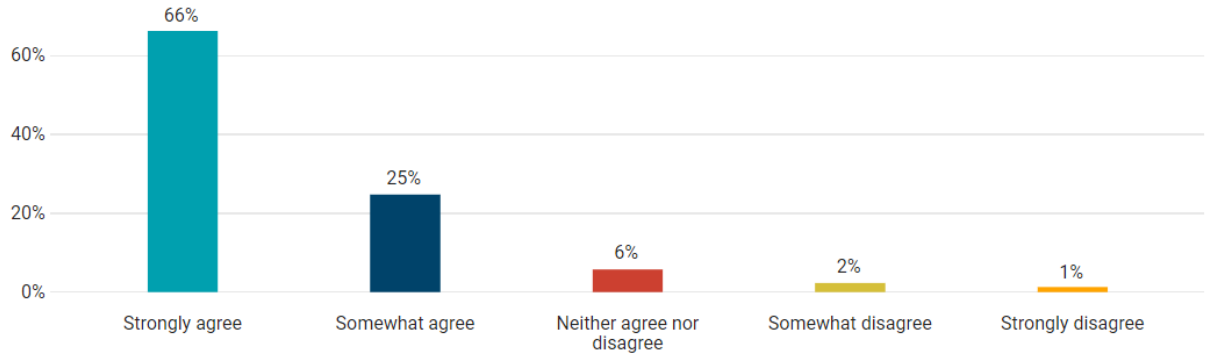
- Delegates sometimes do not explain this process to the patient and sometimes patients are unable to access the delegating physician for clarification;
- Consent may depend on the nature of the delegated act (e.g., simple minor procedures may not need formal consent and verbal consent may be all that is required, a more involved procedure done by a medical student or resident may need consent);
- Obtaining consent for the delegation each time should not be the norm; and
- Consent can be obtained verbally.

Supervision and Support of Delegates

Q11. The draft policy requires that physicians provide a level of supervision and support that is proportionate to the risk associated with the delegation and that is reflective of the following factors:

- **the specific act being delegated;**
- **the patient's specific circumstances (e.g., health status, specific health-care needs);**
- **the setting where the act will be performed and the available resources and environmental supports in place; and**
- **the education, training, and experience of the delegate.**

Please indicate the extent to which you agree or disagree that these are the right factors for assessing risk: (n=89)



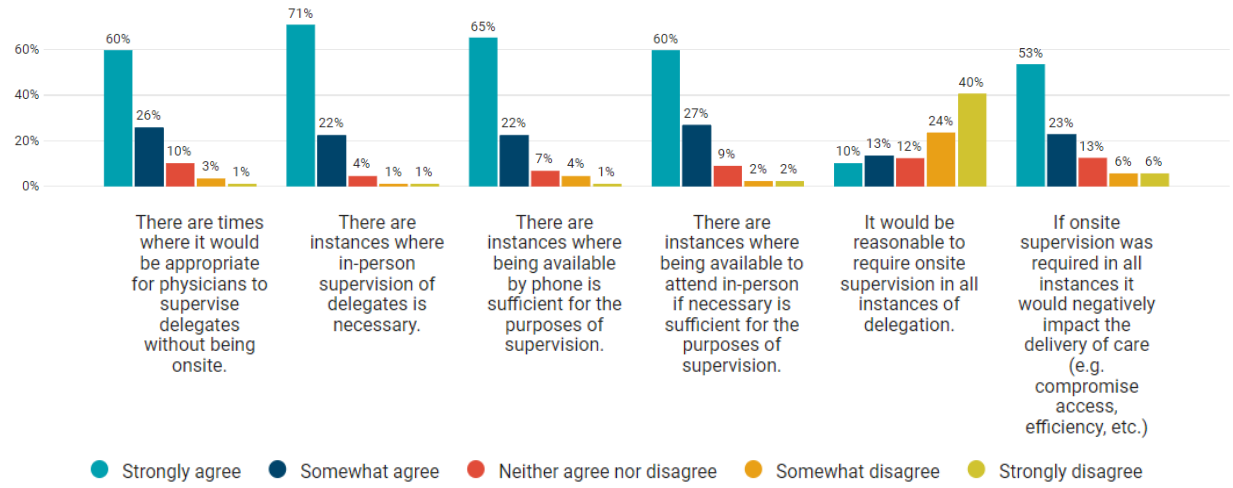
Q12. Are there any factors missing that should be included for consideration when determining appropriate supervision? (n=89)

The majority of respondents agreed that these were the right factors for assessing risk when determining the level of supervision and support of a delegate that would be appropriate in each instance.

- Notwithstanding this support, a few respondents were concerned about tying the level of supervision or support to an individual physician's risk assessment and felt this was vague or subject to interpretation.
- Several respondents highlighted the importance of the delegate's competence, training, and experience and the physician's relationship and familiarity with the individual.
- A few respondents felt that physicians should not delegate or provide off-site supervision until they have provided the initial assessment.
- A few respondents felt there should be a degree of flexibility allowed for physicians given institutional policies or structures (i.e., physicians may not have control over their delegate and placing this responsibility on the physician may not be appropriate).
- Several respondents highlighted patient consent and the importance of patient choice.
- One health care professional indicated that the normal practice for paramedics is to act independently with phone consultation with the delegating physician when necessary.

Q13. When supervising delegates, the draft policy does not require physicians to be onsite in all instances. Instead it requires physicians to use their judgement depending on the specific circumstances of the delegation.

Please indicate the extent to which you agree or disagree with each of the following statements related to supervision: (n=89)



Q14. Please feel free to elaborate on your answers above. (Optional) (n=20)

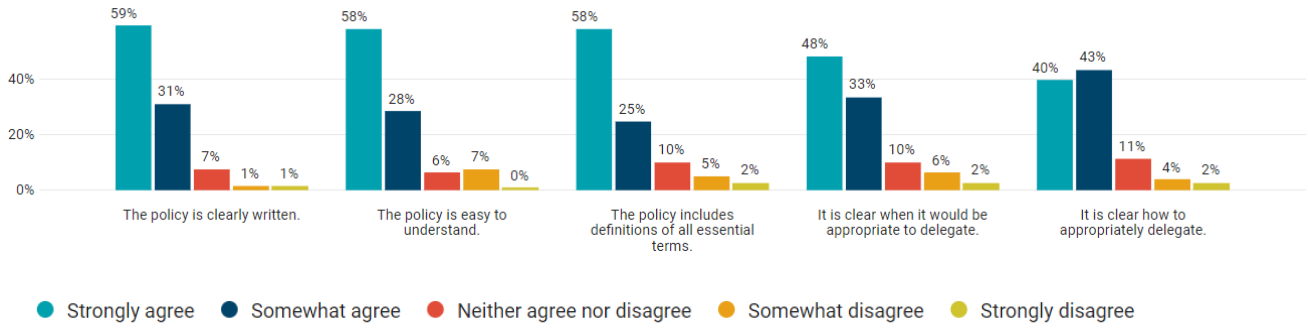
A majority of respondents agreed that there are instances where it would be appropriate to supervise without being onsite, there are instances where in-person supervision is necessary, and that being available by phone and able to attend in-person, if necessary, can also be sufficient for the purposes of supervision.

- Respondents highlighted the importance of communication between physicians and delegates and that physicians must be available to provide support to delegates (i.e., must always have physician's assistance or advice and be able and willing to attend).
- A few respondents commented on the current landscape of virtual care and highlighted its role in promoting remote access to care (i.e., less need for onsite supervision).

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

Q15. We'd like to understand whether the draft policy is clear and comprehensive.

Please indicate the extent to which you agree or disagree with each of the following statements regarding the draft policy. (n=81)



Q16. Please feel free to elaborate on your answers above. For example, how can we improve the policy's clarity? (Optional) (n=25)

A majority of respondents agreed that the draft policy is clearly written, easy to understand, includes definitions of all essential terms, and clearly indicates when and how to appropriately delegate.

Notwithstanding this, some suggestions from respondents to improve the policy's clarity included:

- Address virtual care (i.e., if video is considered "phone" or "in-person" supervision);
- Clarify if history-taking is a controlled act that can be delegated or not;
- Cover delegation for emergency medical services (EMS);
- Clearer definition of how medical directives fit into delegated acts;
- Include information on the role of residents when delegating; and
- Provide additional clinical or case examples (e.g., a checklist-style document or reference document listing which procedures are to be delegated).

Q17. The draft 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=22)

One physician respondent indicated that the draft policy was quite comprehensive and liked that it addressed IMGs, delegates hired by institutions, and those not directly by the physician.

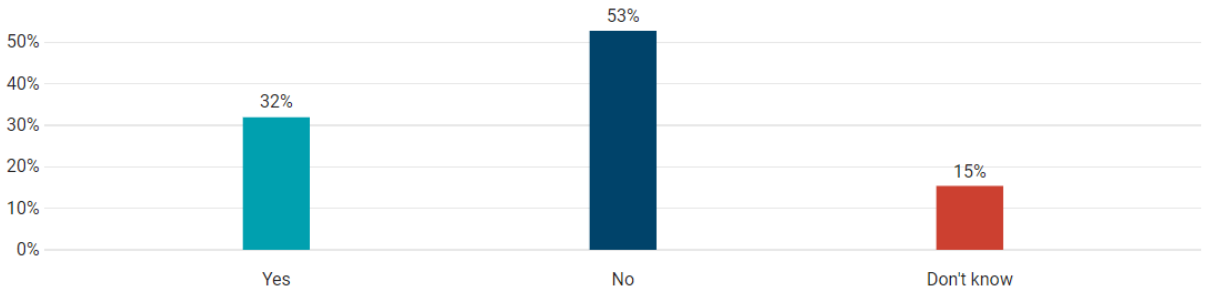
Other respondents requested additional guidance on the following aspects of delegation:

- Delegation to paramedics and recurring delegation in non-emergent settings;
- Adverse events (i.e., include additional information related to responsibility of the delegate to report adverse events to the delegating physician);
- Prescribing (i.e., how the delegate would be required to document on the prescription to demonstrate their authorization by the delegating physician);
- Rural communities (i.e., more detail regarding backup by physicians and specialists should be required);
- Physicians' responsibility to ensure that any care provided on behalf of the physician meets the standard and not just the acts that are controlled acts; and
- Specific guidelines for specialties or sections (i.e., BOTOX in cosmetic medicine).

One physician respondent highlighted the importance of clarifying the role and responsibility of the primary care provider and/or delegate to the patient.

The following questions were only posed to those who indicated that they read the draft Advice to the Profession: Delegation of Controlled Acts document:

Q18. Are there topics or issues that you think could benefit from additional detail, explanation, or examples that should be addressed in the *Advice* document? (n=72)



Q19. Please feel free to elaborate. (Optional) (n=22)

More than half of respondents did not think there were issues that could benefit from additional detail, explanation, or examples that should be addressed in the draft *Advice* document.

One physician respondent indicated the draft *Advice* document was clear and concise, while one health care provider thought the document was very well done and answered questions that would come to mind.

Other respondents requested additional information on the following issues related to delegation:

- Prescribing (e.g., clarify how the delegate should document to demonstrate the prescription is provided under the delegated authority of the physician and if there are restrictions on which medications physicians can delegate to another health care provider to prescribe);
- Delegation and supervision within the setting of virtual care;
- Diagnostics (e.g., radiology or pathology);
- Clarity on procedures less clearly defined by CPSO or the *Regulated Health Professions Act, 1991* (RHPA), such as autopsy (e.g., post-mortem nasal swab during COVID-19 is an autopsy by law and requires appropriate consent and delegation); and
- Clarify how delegation applies to medical students and residents.

Additional key feedback that was provided included:

- One physician respondent felt the draft policy expectation prohibiting physicians from delegating where the primary reasons are for monetary or physician convenience *(lines 56—57)* is contradictory with the guidance provided in the cosmetic procedure section of the draft *Advice* document *(lines 155—162)*.

- One physician respondent questioned how to determine and define boundaries when delegation can both earn physicians money while providing more access to patients.
- One physician respondent suggested clarifying the patient's expectations and to address and document them to avoid any misunderstandings (i.e., to avoid a situation where the patient expects the physician to perform the act and the physician delegates instead).
- Another physician respondent suggested requiring consent for patients to confirm if they are comfortable with the physician performing an examination and if there is a need for a delegate of the preferred gender to attend for the patient's comfort.
- One organizational respondent suggested revising the third example of instances that would not require delegation (*lines 86—89*) to clarify nurses' scope of practice.
- A few respondents suggested including specific case examples or a list of procedures that would require delegation.

Q20. Does the draft *Advice* document contain content that you feel is unnecessary and should be removed? (Optional) (n=20)

The majority of respondents who provided written feedback did not think any of the content in the draft *Advice* document was unnecessary or should be removed.

Additional key feedback that was provided included:

- One physician respondent suggested focusing on what delegating or referring means (i.e., delegation is intended to be a physician extender, not a physician replacement).
- One health care professional described the draft *Advice* as a very good working document and suggested it should be evaluated and reviewed yearly.
- One organizational respondent felt the section on instances that would not require delegation (*lines 72—89*) confuses the already clear expectations in the draft policy.

The following question was posed to all respondents:

Q21. If you have any additional comments that you have not yet provided on the draft policy or *Advice* document, please provide them below, by email, or through our online discussion forum. (n=12)

Additional key feedback that was provided included:

- One physician respondent indicated the draft *Advice* is a great document which clarified a lot of questions from the draft policy.
- One health care professional thought that the draft policy is clear, well-written, and also suggested a diagram showing what needs to be considered when delegating.
- One physician respondent felt the draft expectation that physicians must not delegate where the primary reasons for delegating are monetary or physician convenience (*lines 56—57 of the draft policy*) is redundant and unnecessary: there may be instances where delegation would both serve the patient's best interest and provide for monetary and physician convenience, but it may be difficult to determine the primary reason for delegating.
- One physician respondent expressed concern around the utilization of IMGs who are not certified but still provide care to patients (e.g., taking histories, making diagnosis, ordering tests, and prescribing treatment) under the name of the physician in charge.