CNO Feedback to CPSO's Consultation

Current Policy: Consent to Treatment

- As the policy is written from the physician point of view, it is important when obtaining consent to ensure patient's understanding and comprehension of what they are consenting too. You may wish to add a statement where the physician must be of the opinion that the patient is capable of making decisions and understand and appreciate the decision with respect to the treatment. This may be demonstrated through careful thought and deliberation by the patient.
- Under the *'Obtaining Consent'* sub-heading, we would suggest revising 6. c) to include more context. For example, you may want to consider defining informed consent and clarify the distinction between consent and informed consent.
- Related to the *'Incapable Patients and Substitute Decision-Making'* section of the policy, it may be helpful to provide examples of what is meant by the highest-ranking person in the hierarchy in a footnote. You may wish to add examples, such as the guardian of the person or someone appointed as a representative by the Consent and Capacity Board (CCB).
- Also related to the *'Incapable Patients and Substitute Decision-Making'* sub-heading, we would suggest amending 17. a) to define what a CCB is. There are other sources to draw from and as one example CNO's consent guideline defines a CCB as: "*A board established by and accountable to the government. Its members are appointed by the government. The Board considers applications for review of finding of incapacity, applications relating to the appointment of a representative and applications for direction regarding the best interests and wishes of an incapable person".*

Current Policy: Physician Treatment of Self, Family Members, or Others Close to Them

- We would suggest considering revising this policy to accommodate some of the current realities, such as the ongoing health human resource (HHR) challenges. For example, you could explore broadening the definition of an emergency (e.g., due to HHR issues, a patient may not be able to gain access to their family doctor within a reasonable timeframe or a family member of a physician may not have a family doctor).
- It may be helpful to consider the expanded scope of practice for other regulatory colleges, such as pharmacists. For example, pharmacists are now able to treat minor ailments so there could be an argument made for why physicians cannot treat family members for certain minor ailments when they have access to a pharmacist to alleviate some of the ongoing pressures on the healthcare system. We recommend collecting more evidence on this topic, specifically looking at what the risks are for having physicians prescribe for family members with certain minor ailments.
- You may also want to consider how this policy applies to rural communities with a smaller population of people and GPs. Additional consideration may be needed for Indigenous communities.
- Other considerations that may be important to include are situations or examples of how caring for family members may compromise the physician's professional obligations. This may include:
    - Pressure to treat large/extended families. For example, there may be situations where physicians are pressured by extended family to treat an individual (e.g., there is a doctor in the family and the extended family don't agree with the

treatment options presented, leading them to pressure the family doctor into the course of treatment that they support).
    - You may want to consider adding an expectation around how and when a physician communicates to their family members and how the professional obligations may be compromised by providing care, as demonstrated by the above example.

Draft: Principles of Medical Professionalism

- Overall, we found this document to contain important terms and accountabilities related to Diversity, Equity, and Inclusion (DEI). The values and duties communicated in this document are important for ensuring care is safe, compassionate, equitable and discrimination free. While there are many new terms and accountabilities mentioned in this document, at times we did find it difficult to understand the intent/purpose of this document. For example, in some sections the document refers to physician wellbeing and in others it addresses how physicians can honour patients and the public. We would recommend separating out these accountabilities. For example, you could consider moving all the content related to physician wellbeing/how physicians build and maintain collegial relationships to the draft Professional Behaviour policy, as this document speaks in greater detail to this topic and could be a better fit.
- We noticed there weren't any footnotes/references used in this document. We suggest including references to support the evidence used to articulate the practice expectations.
- Referring to page 4, you may want to consider defining cultural humility and culturally safe care. There are many definitions used to articulate these two terms so it would be helpful to ensure a common understanding.
- Referring to page 4, there is a bullet that states *"seeking to understand what an illness means for a patient and their families, not just what the illness is".* We would suggest including an example here to elaborate further on what this means.
- The *'Recognizing and Honour Humanity'* sub-heading touches on many sensitive topics. You may want to separate some of these topics out, providing definitions and examples to demonstrate the intended behaviour. Additionally, it may be helpful to add sub-headings when referring to the responsibilities that a physician has towards patients versus their colleagues versus the public.
- Suggest defining and including examples on what is meant by trauma-informed approaches (on page 5).

Draft: Professional Behaviour

- Overall, we thought this document was well written, clear, and concise. One recommendation we had related to making the title clearer. For example, instead of 'Professional Behaviour' we wondered if 'Collegial Relationships' described the purpose of this policy slightly better. We also found there was some overlap with the Principles of Medical Professionalism resource and would recommend clarifying the difference between these two resources which may help in reducing any duplication.
- Under the '*Unprofessional Behaviour'* sub-heading, for consistency purposes it may be helpful to share an example for each of the behaviours outlined in the list.
    - Also under this sub-heading, we would recommend revising d. to include 'inappropriate use of force'.

    - Under g. we would suggest removing reference to ‘repeated failure’ and instead use ‘failure’.
- Under the *‘Unprofessional Behaviour by Staff’* sub-heading there is reference to having physicians take appropriate action when staff they have responsibility for demonstrate unprofessional behaviour in the workplace.
    - Could you elaborate further on what is meant by ‘appropriate action’. This is subjective and could be interpreted very differently depending on who is asked. We would suggest either defining ‘appropriate action’ or sharing several examples to provide additional guidance.