Ontario Medical Association (OMA) Submission

College of Physicians & Surgeons of Ontario (CPSO) Policy Consultations:

1) Blood Borne Viruses
2) Decision Making for End-of-Life Care
3) Mandatory and Permissive Reporting

August 2022

CPSO Consultations – Mandatory and Permissive Reporting; Decision Making for End-Of-Life Care; Blood Borne Viruses

The OMA welcomes the opportunity to provide feedback on the following policies out for consultation; **1)** Blood Borne Viruses. **2)** Decision Making for End-Of- Life-Care **3)** Mandatory and Permissive Reporting

To inform our submission, we consulted broadly with our members, through our weekly OMA newsletter, as well as conducted focused member consultations with relevant OMA sections. We have outlined the consolidated feedback for each of these three policies below with recommendations, as relevant.

1) Blood Borne Viruses (BBV) – Preliminary Consultation

General Feedback:

We are pleased to see that the CPSO will review this policy using the Right-tough regulation, and while we understand and appreciate the important role the CPSO plays to ensure patient safety, our hope is that the next iteration of this policy better balances perceived versus actual risk.

Physicians have the ethical and professional duty to act in the best interest of the patient which includes minimizing the risk of patient exposure to BBVs.

As mentioned in our previous submissions on this policy, we continue to believe that evidence needs to be at the foundation of the requirements that are put forward. Given the availability of several comprehensive guidelines for managing seropositive providers, including updated national guidance, we believe the CPSO should leverage:

- The *Public Health Agency of Canada's (PHAC) Guideline on the Prevention of Transmission of Bloodborne Viruses from Infected Healthcare Workers in Health Care Settings* (2019). These guidelines are intended to provide a national framework for developing policies and procedures to prevent the transmission of BBVs from infected healthcare workers to patients.
- The *Society for Healthcare Epidemiology of America (SHEA) Guideline for Management of Healthcare Workers Who are Infected with Hepatitis B Virus, Hepatitis C Virus, and/or*

Human Immunodeficiency Virus (2010, and 2020 versions) which provides useful information on expert panels.

Specifically, we recommend that the following principles outlined in the PHAC guidelines [1] inform the next iteration of the policy:

- "While zero risk of transmission is unattainable, the availability of a vaccine that prevents HBV infection, effective treatment for HCV resulting in a sustained virologic response, and suppression of HIV with strict adherence to antiviral therapy, could render this risk negligible".
- "Measures taken to address the risk of a BBV transmission from provider to patient should avoid triggering public fears, unduly restricting individual freedom, or violating human rights".

Specific Recommendations:

Definitions

a) General – Audience

The audience for this policy is not clearly defined. We understand it is meant for individuals who perform EPP, regardless of serological status, but all relevant guidelines are directed toward managing a seropositive status (post exposure), including any practice limitations, while receiving treatment to sustain virologic response.

[1] Public Health Agency of Canada. *Guideline on the Prevention of Transmission of Bloodborne Viruses from Infected Healthcare Workers in Healthcare Settings,* 2019, https://www.canada.ca/content/dam/phac-aspc/documents/services/infectious-diseases/nosocomial-occupational-infections/prevention-transmission-bloodborne-viruses-healthcare-workers/guideline_accessible_aug-2-2019.pdf.

b) Exposure Prone Procedures

The PHAC guideline provide a comprehensive and evidence-based definition of EPP which outlines necessary conditions for the transmission of a BBV from an infected HCW to a patient during an EPP and also outlines EPPs with risk of transmission. [2]

We recommend that the CPSO adopt the PHAC guideline definition for EPP, which aligns with updated guidance from both the CDC and SHEA.

In addition, the PHAC guideline does not provide risk categories for EPPs, as there is insufficient evidence to accurately categorize most surgical, dental, and medical procedures in terms of transmission of risk. Instead, the approach taken involves providing criteria to help experts determine whether or not a procedure is an EPP.

We recommend that in absence of strict guidance and categorization of EPP by risk, the CPSO should create a mechanism to receive expert advice from appropriate specialists with experience in performing EPP, as well as the institutions where they occur.

Testing

We do not have concerns with the testing requirements for those beginning to perform/assist in performing EPP (this includes physicians who are doing so as part of their education training, changing scope, re-entering practice), as well as the testing requirements post exposure.

We continue to have concerns with the mandatory/periodic testing requirement, at any interval, as it is not supported in evidence or risk and contradicts international guidance. We believe this same objective could be accomplished through education, training, and adherence to infection control practices.

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[2] Public Health Agency of Canada. *Guideline on the Prevention of Transmission of Bloodborne Viruses from Infected Healthcare Workers in Healthcare Settings*, 2019, p.33 https://www.canada.ca/content/dam/phac-aspc/documents/services/infectious-diseases/nosocomial-occupational-infections/prevention-transmission-bloodborne-viruses-healthcare-workers/guideline_accessible_aug-2-2019.pdf.

We recommend the removal of the mandatory/periodic testing requirement, and propose the next iteration instead focus on strict adherence to infection control practices.

Reporting

Currently, the policy requires physicians to disclose their seropositive status for a BBV on the Annual Renewal Survey.

A mechanism already exists for physicians to disclose a positive status, as soon as is reasonably practical upon learning the status, through the Blood-Borne Diseases Surveillance Protocol for Ontario Hospitals. However, we understand the CPSO uses the Annual Renewal Survey to remind physicians of their obligation to know their status.

We recommend that the OMA and the CPSO work together to explore alternative ways of including a reminder in the Annual Renewal Survey that does not require the collection of more personal health information than is necessary.

Monitoring

We understand that the CPSO uses an expert panel to monitor seropositive physicians, which includes monitoring a physician's viral loads and using that to impose practice restrictions, if necessary. This has been the practice for many jurisdictions to date. However, concerns recently have been raised about the effectiveness of convening many individuals to discuss personal health information, and confidentiality is at risk.

Guidance in this area suggests that ongoing monitoring should not be imposed based solely on a diagnosis. Ongoing monitoring of a seropositive individual with a sustained virologic response being treated by an infectious disease physician is unnecessary, as they do not pose a risk to the patient.

We recommend the CPSO implement the PHAC recommendations for circumstances where monitoring is necessary, broken down by virus and viral thresholds.

In absence of clear guidance from the PHAC guideline, we recommend that the CPSO instead follow SHEA guidance, where the monitoring body is comprised of an occupational health physician, and the treating physician, who provide advice to the CPSO.

2) Decision Making for End-of-Life Care – Final Consultation

General Feedback:

Overall, we believe the policy sets out reasonable and clear policy guidelines for physicians related to decision-making for end-of-life care. Members are appreciative that the policy allows physicians to use their medical expertise to provide patients with appropriate and compassionate care at the end of life.

Specific Recommendations:

The specific feedback we heard was related to:

<u>Advanced Care Planning and Goals of Care Discussions</u>

It is recommended that the following is added (lines 49-52):

"Physicians who provide care as part of a sustained physician-patient relationship must determine whether, based on the patient's illness or medical condition, it is appropriate to initiate an advance care planning discussion, and if so:

a. raise end-of-life care issues with the patient, <u>or SDM if the patient is incapable of making medical decisions</u>;

In addition, we recommend that the following statement (line 54) "Physicians who provide care to patients who are palliative…" is changed to patients with serious illness or patients who are receiving palliative care, as a patient is not palliative, but the care provided is palliative.

<u>End-of-Life Care</u>

The policy outlines that physicians must "seek to balance medical expertise and patient wishes, values and beliefs when making decisions about end-of-life care (lines 73-74)."

We recommend that this rephrased to an expectation that the physician must *consider* patient wishes, values and beliefs. Patients may have wishes that are clinically inappropriate or harmful, and while they can be considered, they should not be balanced in making decisions about end-of-life care.

Withdrawing Potentially Life-Sustaining Treatment

It is recommended to add “or primary care provider” (lines 93-96), as a physician may consult with either the patient’s family physician or primary care provider.

> **“**d. making reasonable efforts to support the patient’s physical comfort, as well as their emotional, psychological, and spiritual well-being, by offering supportive services (e.g., social work, spiritual care, etc.) and consultation with the patient’s family physician or primary care provider, where appropriate and available.

Withholding Resuscitative Measures

We support the statement that a physician’s decision to withhold resuscitative measures is not “treatment” and therefore does not require the patient or SDM’s consent. Additionally, this section is helpful in the rare instance when the patient or SDM requests resuscitation despite medical futility or the harms of resuscitation outweigh the benefits. Equally, it provides clear language around when a physician can write a DNR order and requirements for patient/SDM communication.

For clarity, we recommend that the two words “must not” on lines 154-155 are kept on the same line to avoid any risk of misreading this expectation.

Transfer of patients to another health care facility

The policy states in two instances that physicians must take reasonable steps to transfer care of the patient to another facility or health care provider, if possible, when managing disagreements (lines 101-103 and lines 172-173).

In many instances, the transfer to another health facility may not be a reasonable expectation. First, from a practical perspective, this may not be possible. Transfer to another long-term care home is, in most instances, not feasible, and hospitals are often not able to accept transfers due to capacity issues. Second, patients who have a serious illness or are otherwise at risk of clinical deterioration in the near future may face serious negative outcomes from transportation. Finally, attempting to arrange a transfer is a very time-consuming and cumbersome task. The policy says that the physician must “take reasonable steps” to transfer the patient, but it is unclear what is

meant by “reasonable”, e.g., how many attempts should be made at transferring the patient if the potential receiving facility declines the transfer. It would be helpful to specifically outline what steps are required to qualify as reasonable, including what documentation is required.

Many members believe that a reasonable and adequate alternative to transferring to a health facility is to consult another physician within the same institution if the clinical situation allows.

We note that the transfer of patients to either another care facility or provider poses challenges around the DNR order and its applicability. There needs to be an explicit statement advising physicians whether the DNR order is in effect or not, while the disagreement is being worked out.

We note that that the wording around transferring care of the patient is inconsistent in the policy, when comparing lines 101-103 and 172-173 and would recommend that the following provision is used “taking reasonable steps to transfer care of the patient to another health-care provider, if possible, and only when all appropriate and available methods of resolving disagreements have been exhausted.”

We note that there is an expectation in line 173 about taking reasonable steps to transfer the care of the patient if possible “and requested by the patient and/or SDM”. The rationale for this condition is unclear, and in many cases the patient/SDM may not be aware of this option. It also poses the question if it is the responsibility of the physician to make the patient/SDM aware of this option, and this could be a basis for complaints against the physician, should the physician not offer this transfer.

3) Mandatory and Permissive Reporting – Preliminary Consultation

We generally agree with the contents of the policy and appreciate the clear approach the CPSO has used in explaining reporting responsibilities to physicians and that the CPSO has included references to relevant legislation where physicians may seek additional information.

We do not have further feedback at this time. We look forward to reviewing, and potentially providing feedback, the next iteration of the policy.

We hope these comments will be of assistance to the College and appreciate the opportunity to provide feedback.

Thank you.