ISSN 1710-9477

Legislative Assembly of Ontario

First Session, 39th Parliament

Assemblée législative de l'Ontario

Première session, 39e législature

Official Report of Debates (Hansard)

Tuesday 3 March 2009

Journal des débats (Hansard)

Mardi 3 mars 2009

Standing Committee on Social Policy

Regulated Health Professions Amendment Act, 2009

Comité permanent de la politique sociale

Loi de 2009 modifiant la Loi sur les professions de la santé réglementées

Chair: Shafiq Qaadri
Clerk: Katch Koch

Président : Shafiq Qaadri
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Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario

Service du Journal des débats et d'interprétation
Salle 500, aile ouest, Édifice du Parlement
111, rue Wellesley ouest, Queen's Park
Toronto ON M7A 1A2
Téléphone, 416-325-7400; télécopieur, 416-325-7430
Publié par l'Assemblée législative de l'Ontario

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Tuesday 3 March 2009

Mardi 3 mars 2009

The committee met at 1601 in committee room 1.

The Chair (Mr. Shafiq Qaadri): Ladies and gentlemen, colleagues, as you know, we're the Standing Committee on Social Policy, convening here for Bill 141, An Act to amend the Regulated Health Professions Act, 1991.

SUBCOMMITTEE REPORT

The Chair (Mr. Shafiq Qaadri): The first order of business is to enter the subcommittee report, for which purpose I'll ask Mr. Ramal.

Mr. Khalil Ramal: Your subcommittee on committee business met on Monday, February 23, 2009, to consider the method of proceeding on Bill 141, An Act to amend the Regulated Health Professions Act, 1991, and recommends the following:

(1) That the committee meet for the purpose of holding public hearings in Toronto on Tuesday, March 3, 2009.

(2) That the clerk of the committee advertise the information regarding the hearings in the Toronto Star.

(3) That the clerk of the committee post the information regarding the hearings on the Ontario parliamentary channel and the Legislative Assembly website.

(4) That interested people who wish to be considered to make an oral presentation on the bill should contact the clerk of the committee by Monday, March 2, 2009, at 12 noon.

(5) That the deadline for written submissions be Tuesday, March 3, 2009, at 5 p.m.

(6) That amendments to the bill be filed with the clerk of the committee by Thursday, March 5, 2009, at 5 p.m. for administrative purpose.

(7) That if a selection process is required, the clerk of the committee provide a list of all interested presenters to the subcommittee following the deadline for requests.

(8) That the length of presentations for witnesses be 20 minutes for groups and 10 minutes for individuals.

(9) That the committee meet on Tuesday, March 10, 2009, for clause-by-clause consideration of the bill.

(10) That the clerk of the committee, in consultation with the Chair, be authorized prior to the adoption of the report of the subcommittee to commence making any preliminary arrangements to facilitate the committee's proceedings.

The Chair (Mr. Shafiq Qaadri): Thank you, Mr. Ramal. Are there any questions or comments on this subcommittee report before its adoption? No.

All in favour of the subcommittee report as read? Those opposed? The subcommittee report is duly entered.

REGULATED HEALTH PROFESSIONS AMENDMENT ACT, 2009

LOI DE 2009 MODIFIANT LA LOI SUR LES PROFESSIONS DE LA SANTÉ RÉGLEMENTÉES

Consideration of Bill 141, An Act to amend the Regulated Health Professions Act, 1991 / Projet de loi 141, Loi modifiant la Loi de 1991 sur les professions de la santé réglementées.

The Chair (Mr. Shafiq Qaadri): We'll now move to our presenters. We have our first presenter. I'll just remind, collectively, our group: We'll have 20 minutes per association, and 10 minutes for individuals. I understand that we have one cancellation and therefore may be able to move expeditiously.

ONTARIO MEDICAL ASSOCIATION

The Chair (Mr. Shafiq Qaadri): We'll move to our first presenters, on behalf of the OMA, the Ontario Medical Association. I'm just reminding you that you have 20 minutes to make your combined presentation, and any time remaining will be distributed evenly amongst the parties for questions and comments. Please begin, and please identify yourselves as well.

Dr. Ken Arnold: Thank you. I'm Ken Arnold. I'm the president of the Ontario Medical Association, and I'm a family physician in Thunder Bay.

I'd like to start by thanking the government for referring Bill 141 to committee for consultation and to make changes where necessary. Although the bill is only comprised of a single clause, it is a very important clause when it comes to regulatory fairness. Although the bill would affect all regulated professions, my comments will focus on how it will impact physicians.

The OMA is not here to speak against Bill 141, but without changes, we can't support it going forward. We believe that this bill is overly broad in its wording and needs some clarification and limitations. In addition, we think that attention must be paid to the potential impact

that regulations made under this power might have on patients.

As you know, this bill proposes to give the college the authority to write regulations that will allow college inspectors to observe a physician in his or her practice, including the observation of procedures that are conducted by the physician.

The OMA notes that the amendment proposed in Bill 141 is much broader than other powers granted to colleges under the procedural code. Most of the powers under the Regulated Health Professions Act have explicit purposes and limitations attached to them. This helps everyone to understand the exact nature of the powers conferred to the college or its inspectors, and the purposes for which they're intended. Bill 141 is silent about what would cause a college to determine that it will observe a member's practice. A decision to observe practice is significant. We know from experience that even records-based peer reviews are stressful for physicians and can involve disruption of the practice. This will be even more pronounced with observational inspections, since they will, by nature, generally be carried out in the presence of patients.

The OMA believes that a few key amendments to Bill 141 could mitigate against the perception of intrusion and unfairness, including: a clear trigger. We believe the registrar should believe, on reasonable and probable grounds, that the conduct of the member exposes, or is likely to expose, his or her patients to harm or injury, and that the investigator should be appointed for an observational inspection.

We need notice. The member should be given reasonable notice that the college wishes to undertake an observational inspection, and such inspections should be scheduled at a time that takes into account the physician's customary practice routine.

There should be a clear purpose. The college should identify to the member the types of procedures that it specifically wishes to observe by means of its observational inspection.

There should be a focus on risky procedures. The degree of intrusion inherent in an observational inspection should be reserved for clinical activities that involve a reasonable degree of risk. There are existing quality assurance mechanisms to deal with things like communications skills etc., and this mechanism should be limited to circumstances where no other college power is adequate for the purpose.

We need a focus on out-of-hospital procedures. This proposed mechanism is unnecessary in hospitals, since hospital bylaws have for many years allowed the chief of medical staff or designate to observe any member of the medical staff undertaking a therapeutic action, operation or procedure.

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We have to consider patient privacy. Patients should have the opportunity to ask that delivery of their clinical care not be observed by an inspector. This is especially important if Bill 141 is not narrowed to deal exclusively with procedures and more sensitive matters, like psychotherapy, might be subject to observation.

In summary, the OMA asks that you, as a committee, recommend to your colleagues in the Legislature that Bill 141 be amended to put clear limitations on the regulation-making powers of the colleges. These limitations should ensure that the new powers are exercised only where needed and in a manner that respects both the professional being reviewed and the patients being treated. Thank you.

The Chair (Mr. Shafiq Qaadri): Thank you, Dr. Arnold. Are you now available for questions, then?

Dr. Ken Arnold: I am.

The Chair (Mr. Shafiq Qaadri): We'll offer it now to the Conservative side—about four minutes or so per side. Mrs. Witmer.

Mrs. Elizabeth Witmer: Thank you very much, Dr. Arnold. You certainly do, I believe, make some very legitimate points. I'm just wondering, did you have an opportunity to provide your input to the government prior to the drafting of this bill?

Dr. Ken Arnold: No, we did not.

Mrs. Elizabeth Witmer: Okay. So the reason it wouldn't be here is because you weren't able to give advice or weren't asked for advice?

Dr. Ken Arnold: That's correct.

Mrs. Elizabeth Witmer: I would share your concern, I guess, from a patient perspective. I'm not sure that I might want to be observed, and I think that patient privacy needs to be taken into consideration. As you've already indicated, hospital procedures do cover the need—that we don't go there.

The purpose: What kinds of purposes do you think the college should identify to the member? What should be there? What should be in an amendment?

Dr. Ken Arnold: You're asking what information the college should give, what should trigger the—

Mrs. Elizabeth Witmer: That's right. What should trigger this happening?

Dr. Ken Arnold: I think the college does receive complaints, of course, frequently about the conduct of physicians in their offices. Obviously, as a result of that they may feel that they need—paper can only document so much. Obviously, there may be situations where they feel they need to observe, just as happens in hospitals currently.

I think there has to be a fair degree of suspicion, of concern, that the patients are at risk. That's certainly what we would be looking for.

Mrs. Elizabeth Witmer: Can you think of any example?

Dr. Ken Arnold: Obviously, this has come around because of the cosmetic surgery process.

Mrs. Elizabeth Witmer: That's right. That's what has prompted this; yes.

Dr. Ken Arnold: And the skills and training of some of those physicians are unclear. The college could perhaps speak to this, but it may be that those are the situ-

ations where the training is unclear that they would like to observe.

There isn't a Royal College of Physicians and Surgeons of Canada specialty of cosmetic surgery, so some of this has developed with shorter courses that take place sometimes out of this country, where physicians learn the skills they use in the office.

Mrs. Elizabeth Witmer: Did you have any suggestions at all as to these concerns that you've articulated here and the suggestion that some amendments be made to the bill? Have you written amendments as to how it could be worded at all, or have you simply identified the areas where there's a need for some clarification?

Dr. Ken Arnold: I think we're identifying the areas, and I'm sure the committee will have the wisdom—

Mrs. Elizabeth Witmer: To draft.

Dr. Ken Arnold: —to draft. They will understand, and certainly we'll be happy to give further input, should you require it.

May I introduce Ms. LeBlanc, executive director of health policy from the Ontario Medical Association?

Ms. Barb LeBlanc: Thank you. Given that this is only the regulatory enabling clause, we felt that just indicating the issues that need to be there—the trigger, the purpose—would be sufficient at this stage, and then, when the colleges begin to do their own regulatory drafting, those details would be fleshed out then.

Mrs. Elizabeth Witmer: Okay. So you're not saying that all of these amendments should be made to Bill 141?

Ms. Barb LeBlanc: What we're saying is that these issues should be identified in Bill 141 as parameters for the college regulation-making authority.

Mrs. Elizabeth Witmer: Okay. I understand now.

The Chair (Mr. Shafiq Qaadri): To Madam Gélinas.

M^me^ France Gélinas: It's a pleasure to see you, Dr. Arnold. Thank you for coming down.

Dr. Ken Arnold: Nice to see you again.

M^me^ France Gélinas: I will continue on what you just said to Mrs. Witmer and then I have other questions. I was under the impression that you wanted clauses added to the bill to reflect those six points, but is what you're saying that you would be satisfied with a statement in the bill that says that those six parameters should be addressed in the regulations that will follow? I don't want to put words in your mouth, but did I understand that right?

Ms. Barb LeBlanc: What I'm trying to say, perhaps unclearly, is that we think Bill 141 itself should specify the limits on the colleges' regulation-making authority and that the things we've outlined here—a trigger, reasonable and probable grounds, notice—would be included as the factors that the college must act within.

M^me^ France Gélinas: All right. So we could add a statement to the bill that makes reference to the six specific parameters that you've outlined and then, once the colleges—as you said, because it's not only for physicians—work out their regulations, then those would be fleshed out. Okay; I didn't understand it that way the first time, but that's fine.

I was most perturbed by the statement you made at the beginning that you cannot support it going forward as it is, but you would be comfortable with supporting it once we would have added the six parameters that would set limits to the bill. Here, again, I'm looking for a yes or a no.

Dr. Ken Arnold: We couldn't support it as it is, but with those corrections we would be happy to. We're not going to speak against it, but we certainly would not be happy supporting it without those provisions.

M^me^ France Gélinas: Okay. You did say that part of the reason why you could not support it is because of its impact on patients. Certainly you made clear the impact on physicians and the members that you represent. The impact on patients, I guess, is mainly targeted as patient privacy and the rights of patients to refuse, or did you have something else in mind when you made that statement?

Dr. Ken Arnold: I think that's the primary thing. As well, part of the mystique and magic of medicine is the patient's trust in the physician, and that would definitely be eroded if there was an inspector sitting in the corner as the physician-patient interaction took place. The patient would be questioning why the observer was there, and I think that would definitely interfere—it would certainly not be a normal physician-patient interaction.

M^me^ France Gélinas: One of the parameters that you would like set as a limit is the one that has to do with a clean trigger. I just want to go a little bit deeper in this. You mentioned that a patient making a complaint to the college could be identified as a trigger. Talking more specifically about cosmetic surgery and training, you did mention that there is no royal college of cosmetic surgeons. Would you see as acceptable for observation—let's say we do have a complaint against one physician, but then the college realizes that there are other physicians doing the same type of work. If we take, again, cosmetic surgery, a client might have a complaint against one physician, a family physician who practises cosmetic surgery. Would you see it, then, as a trigger for the college to go to other family physicians who practise cosmetic surgery, or did you have it more like one complaint, one trigger?

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Dr. Ken Arnold: Well, absolutely that a specific incident would trigger an observation of that particular physician. There would be no generalization so that any physician carrying a procedure would be eligible for observation—

The Chair (Mr. Shafiq Qaadri): Thank you, Dr. Arnold. Thank you, Madame Gélinas. I now offer it to the government side. Mr. Ramal.

Mr. Khalil Ramal: Thank you very much for your presentation. I just have a quick question: How many members of your association perform cosmetic surgery? Or a percentage, if that's possible?

Dr. Ken Arnold: I don't know; a small number. Actually, in fairness, many physicians deal in their offices with warts or moles that look a little funny. They don't

set themselves up as practising cosmetic surgery, but nevertheless, many physicians have a small amount of that in their practice. Those who are practising cosmetic surgery as their major practice, I can't give you that number; sorry.

Ms. Barb LeBlanc: I think the other thing that's important to realize is that some plastic surgeons, who are fully trained and accredited, do cosmetic surgery as part of their plastic surgery practice.

Dr. Ken Arnold: They are very adequately trained.

The Chair (Mr. Shafiq Qaadri): Mr. Balkissoon.

Mr. Bas Balkissoon: Thank you very much for being here. I just want to clarify: I did hear you say that you would like us to put that particular trigger mechanism in the act itself, and you're prepared to work with the College of Physicians and Surgeons of Ontario in terms of the regulations, to get into more specifics. My concern there is that if we put the wording as you've got it here, or even similar, we're restricting ourselves, that if there's another incident of some other nature in the future, we'll have to come back and amend the act again. Could you explain to me how we could make sure that we also provide opportunity for the future?

Dr. Ken Arnold: I'm not sure that I can do that. I think that this is such a groundbreaking change in the way regulations are carried forward, we have to think very carefully about the wording in this amendment. It's never—I mean, this is such a big change for a lot of—

Mr. Bas Balkissoon: I ask the question too because the medical field is ever-changing today, compared to 20 years ago.

Dr. Ken Arnold: I'm glad to say it is, and it will be a lot changed in 20 years' time—for my benefit, I hope.

So I'm not sure that I can answer that. I mean, we can speculate as much as we want, but of course the reason we're here today is because somebody didn't see a necessity for this when the original act was written.

Mr. Bas Balkissoon: So then am I clear to hear you say that you are prepared to work with the college when the regulations are being developed, to give your input into their process?

Dr. Ken Arnold: I think we'd always be willing to do that.

Mr. Bas Balkissoon: Thank you very much.

The Chair (Mr. Shafiq Qaadri): On behalf of the committee, I'd like to thank you for your presence as well as your written deputation from the Ontario Medical Association: Dr. Arnold, president; Ms. LeBlanc, executive director of health policy; and entourage.

STAN GORE

The Chair (Mr. Shafiq Qaadri): We now move to our next presenter. We have one cancellation, as indicated earlier, and if Dr. Stan Gore is present, then we'll move you up and you're most welcome to come forward.

Dr. Gore, I understand you have given us a written submission. I'll just remind you that as you are presenting in your private capacity as an individual, you'll have 10 minutes in which to make your combined presentation. I'll invite you to begin that officially now.

Dr. Stan Gore: Thank you. My capacity is that of a general practitioner who, until very recently, has been practising cosmetic surgery in Toronto. My comments now are limited to the impact of the bill on members of the college and their patients.

At present, Bill 141 gives the college the unfettered right to observe its members when they are treating patients and performing procedures. It's my firm belief that it is necessary to balance the concerns for public safety with the rights of the member being investigated and the rights of the patient being treated. The issues then become, in what circumstances is it appropriate for a member to be observed performing a procedure, and what procedural safeguards should be incorporated into the legislation?

First of all, circumstances which should trigger an observational component, in my opinion: The physical presence of an investigator during a therapeutic interaction between physician and patient has serious implications. Because of that, I believe there should be a threshold for triggering such an intrusive inspection. The justification for observing a member treat or perform a procedure on a patient is uncertainty about the member's competence and concerns about the patient's safety. I, therefore, suggest that the threshold be when the registrar believes on reasonable and probable grounds that the conduct of the member exposes or is likely to expose his or her patients to harm or injury.

There should also be a logical and predictable path for an investigation, of which competency/safety are the foci and observation is the component. Now, that path currently exists, but it's optional, at the discretion of the registrar rather than compulsory. When the college is concerned about a member's competence, it has two very distinct options open to it. It can trigger either a quality assurance assessment or a section 75 investigation.

Let's look at the quality assurance path. The college has specifically established the quality assurance route for the purpose of assessing and upgrading the skills and training of a member. The assessment made under this program is carried out over the course of a number of days, primarily in a university setting at McMaster, by trained medical educators. The results of the assessment and the recommendations are transmitted to the college. Those recommendations are usually in the form of educational upgrading; however, if the quality assurance committee feels that the member is incompetent, it can request the registrar to launch a section 75 investigation on that basis. In general, the tenor of the quality assurance assessment is the support and education of the member physician. The quality assurance assessment is the logical and appropriate place for an observational component of a doctor's practice because, firstly, it's performed by experts in professional assessment and, secondly, it's performed for legitimate, targeted reasons—competence and safety.

Let's look at the second path, the section 75 path, which is where the current observation component in the

bill seems to lie. This can be launched by the registrar on reasonable and probable grounds that the member has conducted an act of professional misconduct or is incompetent. It can be related to any form of impropriety, from narcotic dealing, sexual abuse or criminal conviction, to a complaint of any nature by a patient. It is wide-ranging. It includes inspection of the physical plant of the doctor, seizure of medical records, computer files etc.

There are two problems with incorporating an observational component into this section 75 investigation. First, at best, it's totally irrelevant in cases of professional misconduct, unless that professional misconduct involves the safety of a patient. It would be irrelevant to investigate how a doctor treats a patient if the doctor is charged, for instance, with—well, I'm trying to think of something silly, but basically something not related to safety or competency. At worst, this can be used in the form of a fishing expedition to find something unrelated to the alleged misconduct being investigated.

But more important, a regulatory body, such as the college, is not itself competent to make a determination of physician competence. The college is a registering body, not an educational or certifying body. It does not possess the standardized assessment tools of an educational institution, nor the experienced assessment staff, nor the assessment protocols.

Instead, it relies on the opinion of one or more ad hoc appointed experts who read the patients' charts and then observe the member for a few hours in an adversarial environment. Appointing one or two medical practitioners, particularly those who are not educators, to observe and make a critical assessment can only lead to conclusions which are unstandardized, arbitrary, inconclusive and possibly invalid and, if the assessors are also business competitors of the physician being assessed, the appearance of bias also exists.

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Therefore, in my opinion, a section 75 investigation should not be a legitimate path for assessing competence and consequently should not afford the registrar the ability to order an observational component, with two specific exceptions: Firstly, when the registrar believes on reasonable and probable grounds that the member has committed an act of professional misconduct which exposes or is likely to expose his patients to harm or injury; secondly, following a quality assurance assessment, after which the quality assurance committee recommends that the registrar initiate a section 75 investigation based on incompetence. These should be the only two occasions in which an observational component is included in a section 75 investigation.

Now let's look at procedural safeguards for an observational component in the course of a section 75. They are particularly important because investigations launched under section 75 are adversarial in nature, they bear the presumption of guilt rather than innocence and have very serious consequences for the party under investigation—namely, a public discipline hearing. Regardless of the outcome of the hearing, the media attention and the innuendo are invariably devastating to the reputation of the doctor.

The first safeguard I recommend revolves around the medical investigators themselves. They not only must be unbiased, they must appear not to be biased. This entails appointing investigators who, firstly, have not demonstrated antagonism to the member or to the group of which the member is a part and, secondly, who are not business competitors or have other interests adverse to the member under investigation. In short, the investigators/observers should most likely be university-based practitioners from a separate geographic area.

Secondly, the appearance of fairness: The member being observed in the course of a section 75 investigation should have the right to a video recording of the proceedings, simultaneously be able to appoint the same number of experts as does the college, and have legal counsel present. Otherwise, it is possible that a hostile or biased investigator could arbitrarily decide that the doctor is incompetent and the doctor would have little or no recourse.

Thirdly, the scope of the assessment: The term "observation" must be defined. Does it include silent observation or may the investigator ask questions, and then of whom? Of the practitioner, his staff, the patient, and just during the observation or afterwards as well? What's the scope of the questioning? Can it be limited just to questions about the procedure or, at the other extreme, is it the equivalent of a specialty oral exam in the field?

Next, the procedural consequences of the assessment: whether or how admissions made during the assessment can be used in further proceedings against the member. There is always a right against self-incrimination accorded to the person under investigation in an adversarial setting.

The Chair (Mr. Shafiq Qaadri): Dr. Gore, just to let you know you have about a minute left.

Dr. Stan Gore: That right is protected during a quality assurance assessment. It must be protected during a section 75 investigation.

Finally, privacy rights of the patient: This is paramount and it extends beyond the period of observation. Should a discipline hearing be held as a result of the investigation, the patients involved can be called as witnesses by either the doctor or the college. This is a further invasion of privacy, forcing the patient, who has no complaint against the treating doctor, to testify publicly about a very private matter.

I can't talk any further because my time's up, but I've included in my written presentation two other things: firstly, a few practical scenarios of what it would be like to both be the doctor and be the patient involved in such an observational episode; and secondly, an actual case study that reflects the potential and the actuality of bias that can exist and that probably will exist—

The Chair (Mr. Shafiq Qaadri): Thank you, Dr. Gore, for your presence as well as your written deputation.

Dr. Stan Gore: Thank you.

The Chair (Mr. Shafiq Qaadri): We do appreciate receiving the written comments, which I'm sure the committee will have a look at formally.

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

The Chair (Mr. Shafiq Qaadri): We'll now invite our final presenters of the day.

Before we do so, I'd just alert the committee that we do have a number of written submissions, so each and every one of you received those from the Canadian Medical Protective Association, the Registered Nurses' Association of Ontario, who were actually scheduled, originally, to be here in person, as well as the College of Nurses of Ontario and others.

With that, I would now invite representatives of the CPSO, College of Physicians and Surgeons of Ontario, to please come forward.

As you've seen, the protocol, you have 20 minutes in which to make your presentations. Any time remaining will be distributed amongst the parties for questions. I'd invite you to please (a) be seated, and (b) introduce yourselves as you speak, for Hansard recording purposes. With that, I would now invite you to begin.

Dr. Jack Mandel: Thank you for this opportunity to appear before the committee. I am Jack Mandel, vice-president of the college and a family physician in Toronto for the past 35 years. With me are Patrick McNamara, the medical director of investigations and resolutions; Lisa Spiegel, counsel; and Louise Verity, director of policy and communications.

Bill 141 is of particular interest to the college as we continue to be concerned about patient safety in unregulated facilities. We have been advocating for legislative change to help address this gap in regulatory oversight.

While the college supports the bill, we wish to be very clear that as it currently stands, and unamended, the people of Ontario will continue to be at risk.

In today's presentation we will explain briefly why the legislative change contained in Bill 141 is an important first step. We will also explain how the bill can be improved to provide even greater protection for patients.

Of course, the provision of health care services has evolved and will continue to evolve. Today, an increasing number of procedures previously performed only in hospitals are taking place in unregulated settings. Accountability systems have not kept up with these changes. The number of procedures performed outside of hospitals is increasing. Such procedures include eye surgeries, obesity surgeries, colonoscopies and gastroscopies. This bill would allow the college to make regulations to inspect such facilities through, among other tools, direct observation of physicians in their practice setting.

While providing the mechanism for the college to implement a thorough facilities inspection regime is a much-needed amendment, the government needs to ensure that equal protection of the public is available wherever a patient is treated, through clarification of the college's investigatory powers. These are the powers utilized by investigators to evaluate a physician's competence, and include both observing and interviewing.

For over a year, many significant college investigations have been put on hold due to legal challenges to the college's investigatory powers. These include investigations into general practitioners performing invasive cosmetic surgical procedures and investigations that arose after patients died.

These challenges question our statutory authority to investigate using tools like interviewing, which we use in most clinical investigations. They also challenge our authority to observe physicians, which we undertake in a limited number of cases where observation is necessary for a complete and meaningful investigation. Observation may be necessary to evaluate the surgical skill of a general practitioner who has not undertaken a formal surgical residency program.

Thus far, the court has agreed with the college that the current wording in section 76 of the Health Professions Procedural Code empowers the college investigators to observe physicians during investigations. The Divisional Court has stated that "observation is particularly important in the case of surgery, where the practice is predominately a manual one ... the observation of surgical practice is an important tool to assess a physician's skill and competence, as well as his or her ability to deal with complications."

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Other interpretation issues remain outstanding. We are still involved in litigation through appeals and other court proceedings. The end of this litigation is many months, if not years, away. These delays will make it possible for some practitioners to continue to practise in areas in which the college has been unable to ascertain whether they have the requisite knowledge and skill to do so. While these issues are before the court, it is possible for physicians who are involved in this litigation to continue practising surgery. Those who are unqualified would pose a significant risk to public safety.

Until the litigation is complete, these significant investigations remain incomplete. The litigation has also had an impact on the tenor of our investigations, as some physicians under investigation have been less than cooperative with the college's investigative process. As a result, the college may be unable to fulfill its mandate to protect the public, with significantly delayed investigations and lengthy, drawn-out challenges to the core of its investigatory regime. This is why we are seeking clarity of our investigatory powers.

We have looked at the investigatory powers of other regulators. In Ontario, for example, veterinarians under Ontario's Veterinarians Act are required to participate in interviews with their college's investigators. The act also provides, in clear language, the member's duty to cooperate.

We believe that the powers of investigation in the practice of medicine should be at least as effective or as

clear as the practice of veterinary medicine. Regulatory oversight of health services for the people of Ontario should be at least as effective as, if not more so than, the oversight of health services for dogs and cats.

Why is the power to interview during the investigation so important? When looking into a doctor's practice, the college retains physician investigators to provide opinions as to whether the physician's practice meets the standards of the profession or is competent. Incompetence is defined in the code as that a physician's care displays a lack of knowledge, skill or judgment or disregard for the welfare of the patient, and whether the physician's practice, behaviour or conduct exposes or is likely to expose patients to harm or injury.

To answer these questions meaningfully, physician investigators often need to meet with and interview the physician under investigation. Without an interview, the physician investigator must rely predominantly on a review of medical records to answer the questions before him. The chart tells only one part of the story; the remainder needs to come from an explanation from the physician. Whether care is simply poorly charted or is in fact poorly provided can often only be told from an interview.

We believe that, in addition to what is contained in the bill, amendments to the Health Professions Procedural Code are urgently needed to confirm our interpretation that college investigators are empowered to interview physicians. We are proposing an amendment that is consistent with the powers of investigators under Ontario's Veterinarians Act.

Thank you very much for this opportunity to make this submission to the committee. We look forward to working with you to enhance public safety in Ontario, and are pleased to answer any questions.

The Chair (Mr. Shafiq Qaadri): Thank you, Dr. Mandel. We'll now move to the NDP side—about four or so per side. Please begin.

M^me^ France Gélinas: Pleased to meet you, and thank you for coming. I was curious to find out: What events or what series of events would trigger an observation by the college?

Ms. Lisa Spiegel: Are you referring to the proposed amendment presented?

M^me^ France Gélinas: No. I'm referring to the bill in general. You were there when the OMA presented, and they felt that they wanted a clear trigger that would then bring the college to do an observation.

Ms. Lisa Spiegel: In the discussion today, there's been a bit of confusion between an investigatory power and this bill, which deals with amendments to the college's regulatory-making powers. The regulatory-making powers that we're talking about that are proposed in this current bill deal with the power to make regulations that deal with inspections of out-of-hospital facilities. One of the tools that the college would seek to implement, if this bill is passed, is observing in these inspections of out-of-hospital facilities, so that's separate and apart from the college's investigatory powers.

The types of triggers that the college has envisioned—the regulation is in the process of being drafted, but it would be triggered by a particular procedure that's performed. Right now there are a number of procedures in the province that are performed in facilities that simply have no regulatory oversight or minimal regulatory oversight. So the college has envisioned that certain procedures would trigger the inspection and that, where appropriate, an observation of those procedures may be undertaken as a tool to inspect.

M^me^ France Gélinas: Okay. I appreciate you writing down the two recommendations that you would like us to add to Bill 141. I guess it's my ignorance, but do you mean to say that if you ask questions, the physicians don't have to participate in the interview as it is now, or they're challenging that?

Ms. Lisa Spiegel: The college's position is that physicians do have an obligation to respond to questions and that the college has the power to ask those questions, but that power is being challenged by various physicians, which has led to delays in investigation and the college being tied up in court for over a year. The question of whether section 76 of the code allows us to interview a physician—the college maintains it's there; we are being challenged as to that power, and that's why we seek clarity through the amendment that we propose.

M^me^ France Gélinas: I guess the same goes with cooperation. I must be naive, but I expected that if my college asked me a question, I would answer really quickly.

Ms. Lisa Spiegel: If you're a lawyer, you'd have that obligation. We say that doctors have that obligation too, but that has been challenged, yes.

The Chair (Mr. Shafiq Qaadri): To the government side.

Mr. Bas Balkissoon: Thank you very much for being here. I just wondered if you could comment on the previous deputant's statement to the regard that maybe the college is not the right body to judge someone's competence, but it should be in a university setting.

Dr. Patrick McNamara: I would say that the college is responsible for the competence of physicians throughout their entire career, from their initial registration with us and their qualifications to their independent practice, through the whole course of their career. Competence doesn't stop the day you register with the college and begin your practice. We have a responsibility to ensure that patients are safe through the entire course of their career. There are many physicians who practise, and we're talking particularly today, in unregulated facilities that are not subject to the academic strictures that one would see in a teaching hospital or in a university setting, and I think it's very important for us to ensure that that level of competence is always there.

Mr. Bas Balkissoon: So you would say that your people who are doing the investigations and inspections are quite capable of doing this?

Dr. Patrick McNamara: Yes. As Dr. Mandel mentioned in his presentation, we retain outside physicians who are expert, who are qualified in the same area in

which the physician is under investigation. We do take care to try and ensure that there is no bias or perceived bias; that's an important point for us. But the college's inspector is an outside practising physician who is eminently qualified in the area in which they are being asked to opine.

Mr. Bas Balkissoon: Can you tell us what the CPSO has done in terms of patient safety since the couple of incidents with cosmetic surgery in terms of improving patient safety?

Dr. Patrick McNamara: I can't speak specifically to any ongoing investigation because of the confidentiality requirements of the RHPA, but I can say that we have surveyed all of the practising physicians in the province of Ontario with a mandatory questionnaire to determine whether or not they are practising cosmetic procedures. There are a number of those physicians currently who are the subject of an investigation at the present time to determine whether or not they are competent to perform those procedures. As Ms. Spiegel has said, unfortunately some of those investigations are now held up by legal proceedings.

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Mr. Bas Balkissoon: Can I get your comment with regard to the previous two deputants, in terms of that they would like to see us strengthen the act in terms of making a statement with regard to what would trigger an investigation? How would you recommend that we deal with that?

Ms. Lisa Spiegel: I'm sorry. Can you repeat the question?

Mr. Bas Balkissoon: The previous two deputants both suggested that, in the act itself, we should clarify the triggering mechanisms that would cause the CPSO to do an investigation.

Ms. Lisa Spiegel: Again, there might be a talking at cross-purposes. I understood that Dr. Gore's presentation dealt with the power of the college to investigate under section 75 of the code. The triggers are there, under 75(a), (b) and (c) of the code. There might be a complaint that comes into the college; there might be information from the quality assurance department of the college that suggests a member is incompetent; or there might be information that comes from a coroner or a hospital that would lead the college to launch an investigation if certain statutory preconditions are satisfied, like the registrar having reasonable and probable grounds to believe a member has committed an act of professional misconduct or is incompetent, and the executive committee approving of an appointment of investigators. Those are the current, existing triggers for investigations. But as I mentioned earlier, what would trigger an inspection, under a regulation that has not yet been passed, of an out-of-hospital facility, that's—

The Chair (Mr. Shafiq Qaadri): I'll need to intervene there. Thank you, Mr. Balkissoon. To Ms. Witmer.

Mrs. Elizabeth Witmer: Thank you very much for your presentation and thank you so much for the copy of the amendment. That's always appreciated.

I just want to ask a couple of questions. You maybe partially responded to Mr. Balkissoon, but what types of procedures are involved in the litigation that you are having with some of your members, and why is the public being put at risk?

Ms. Lisa Spiegel: I'm thinking. The types of procedures that are being performed by the physicians who are currently engaged in litigation are all cosmetic procedures. They are surgical procedures, ranging from abdominoplasty to liposuction, and run the gamut of various cosmetic surgical procedures. The college may be being put at risk because we're unable to complete investigations, and without a complete investigation we don't know whether the member has committed an act of professional misconduct or is incompetent.

Mrs. Elizabeth Witmer: So, if you don't know, then you're suggesting these amendments that you believe would protect the public. Do you believe, then, that if these amendments are made, you could ensure that the public is protected?

Ms. Lisa Spiegel: These amendments would enable us, hopefully, to have an investigatory regime that isn't challenged, where members would comply with requests to be interviewed as they have in the past and are starting not to do going forward. That's our hope: that we could complete investigations in a thorough manner.

Mrs. Elizabeth Witmer: I guess you can never guarantee that the public is not put at risk, but certainly there would be a better chance that the investigations are as thorough as possible and that you are provided with all of the information that would be necessary.

Ms. Lisa Spiegel: That would be our hope.

Dr. Patrick McNamara: I think it's important to realize that these powers that we're asking for are not revolutionary. These are fundamental—

Mrs. Elizabeth Witmer: No, and I see that. They're pretty simple, and I think that most of us would assume that you would be provided with that—

Dr. Patrick McNamara: They are absolutely fundamental to the training and assessment of physicians through the course of their residency training and their teaching. These are done every day, day in and day out, where young residents are questioned and interviewed by their teachers. They're observed for thousands of hours in the operating room to come to a very robust decision about whether that individual is ready to proceed through their training into an independent practice.

Mrs. Elizabeth Witmer: Is this just recently that there has been this lack of co-operation?

Dr. Patrick McNamara: Heretofore, most physicians have been quite co-operative with us in terms of the interview. It's only recently that we're beginning to see challenges to that authority. Our use of the observational power is recent because we have recently realized, through our quality assurance processes, that this is an important aspect of assessing a physician's competence. It's been used for a number of years in our quality management division, and we feel that in terms of a competent and thorough investigation, it is also an important

aspect of that, particularly when we're looking at surgical specialties, which we are in these particular cases.

Mrs. Elizabeth Witmer: So the type of procedures, then, that you're involved in primarily are the cosmetic surgeries.

Ms. Lisa Spiegel: With respect to this particular litigation that's going on now.

Mrs. Elizabeth Witmer: Yes. Okay.

Ms. Lisa Spiegel: But our investigations cover a wide range.

Mrs. Elizabeth Witmer: Exactly, but these are the ones where you're trying to introduce amendments in order to overcome some of the obstacles that you're encountering.

Dr. Patrick McNamara: And we're seeing now, in the last few years, as I'm sure you know, many procedures now being moved out of hospital into unregulated facilities that heretofore were done in an in-hospital setting. There's an explosion of out-of-hospital clinics and facilities where surgical procedures are now being performed, not just in the cosmetic area, but in many other areas: endoscopy, cataract—

The Chair (Mr. Shafiq Qaadri): Thank you, Mrs. Witmer, and thank you, Doctors Mandel and McNamara and Ms. Spiegel and Ms. Verity, for your deputation and written submission on behalf of the College of Physicians and Surgeons of Ontario.

I'll just remind committee members that amendments are due for this bill on March 5, Thursday, at 5 p.m. Then we'll be having clause-by-clause consideration of the bill March 10.

Committee adjourned.

The committee adjourned at 1655.

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